OFFICE OF THE PROSECUTOR
COUNTY OF CAPE MAY

ROBERT W. JOHNSON
ACTING COUNTY PROSECUTOR

4 Moore Road, DN-110
CAPE MAY COURT HOUSE
NEW JERSEY 08210-1654

PAUL S. SKILL
Acting Chief of County Investigators

Phone: (609) 465-1135
Fax: (609) 465-1347

Cape May County Prosecutor's Office
Veteran's Diversion Program

Application Instructions

Please read the following instructions entirely before making application to the Cape May County Veterans Diversion Program. Attached, you will find the required forms for application to the program. It is important that you review each form entirely and provide all requested information. You must also provide supporting documentation as requested in the forms, and listed below. Upon completion, please submit your application and all required additional documents to CMCVDP@cmcpros.net. Failure to complete all forms or submit required documents will result in your application being rejected.

1. Read and complete the following application forms:
   - Cape May County Veterans Diversion Program Application
   - Cape May County Veterans Diversion Program Medical/Psychiatric Record Release Form
   - Cape May County Veterans Diversion Program Referral Form
   - Dept. of Veteran's Affairs Form 10-5345
   - Dept. of Veteran's Affairs Form 3288
2. Please provide the following additional documents:
   - DD214
   - Proof of Diagnosis if already diagnosed with AXIS I Mental Illness
3. Upon completion of all application forms, please submit application packet and additional documents to CMCVDP@cmcpros.net
4. For questions regarding the application packet, please submit questions to CMCVDP@cmcpros.net
5. For questions regarding veterans' benefits or obtaining your DD214, please contact:

   John Walter, LCSW
   U.S. Dept. of Veterans Affairs
   John.walter@va.gov
   302-379-2085
6. You may terminate the application process at any time after submission of your application by contacting the prosecutor's office through CMCVDP@cmcpros.net

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Cape May County Prosecutor's Office
Veteran's Diversion Program

Application to Participate in the Cape May County Prosecutor's Office
Veteran's Diversion Program

The Cape May County Prosecutor's Office has established a diversion program for Veteran's with serious mental illness. The goal is to work with appropriate individuals who agree to comply with supervised treatment to limit or avoid certain convictions or incarceration based upon continued cooperation.

Defendant's name: [Last, First, MI] _____
Aliases: _____
Defendant's Date of Birth: _____
Defendant's Social Security Number: _____
Defendant's Address: _____
Alternate Contact Information (optional)_____
Prosecutor File Number(s): _____
Complaint Number(s): _____
Charge(s): [List Current Charge(s)]
Indictable Offenses: _____
Disorderly Person Offenses: _____
Local Ordinance or Motor Vehicle Summonses: _____

Please have defendant: (1) read each item listed below then sign and date page 2, and (2) Attach DD214 with paperwork. If defendant doesn't have the form it can be obtained by going online to https://www.ebenfits.va.gov/ebenefits/about/feature?feature=military-personnel-file

I, _____,am requesting and acknowledge that I am being considered for acceptance into the Cape May County Prosecutor's Office Veteran's Diversion Program ("VDP") should I qualify.

I acknowledge and am aware that acceptance into the VDP is determined on a case by case basis, and that there is no right to acceptance, nor guarantee that I will be accepted.

I acknowledge and am aware that the VDP is voluntary and that I may choose at any time to decline and thus have my case proceed by traditional criminal prosecution.

I agree to participate in the evaluation process to determine if I qualify for the VDP and to help me decide if I want to enter the VDP should I qualify.

I agree to cooperate in the intake process, including filling out forms and providing releases so that the VDP, Mental Health Providers and Substance Abuse Treatment Providers can obtain relevant information about me, including medical, mental health, and substance abuse treatment information.

I agree to participate in psychological, substance abuse, and risk evaluations that may include completing written forms and tests and interviews with mental health and/or substance abuse professionals.

I acknowledge and am aware that should I successfully complete the requirements of the VDP my charges will be dismissed.

I acknowledge and am aware that there are additional documents I must sign and attach to this application in order to be evaluated for the VDP. I have signed and attached the following mandatory documents to this application and understand that they will be used in order to determine whether I will be accepted into the VDP:

1. The Cape May County Veteran's Diversion Program Referral Form
2. The Cape May County Veteran's Diversion Program Release Form
3. DD214
4. Veteran's Affairs Authorization for release of medical records or health information

Defendant's or Defendant's Legal Guardian Signature: _____
Date: _____
Defense Counsel's Name: __ _____ Signature: _____
Date: _____
Address: _____
Phone Number: _____
Fax Number: _____

Has defendant submitted an application for PTI or is currently on PTI? Yes _☐_ No _☐_
Has defendant been terminated from PTI? Yes _☐_ No _☐_
Has defendant successfully completed PTI? Yes _☐_ No _☐_
Does defendant have a firearms ID card? Yes _☐_ No _☐_
Does defendant have a pending firearms ID card application? Yes _☐_ No _☐_
Does defendant own or have access to firearms? Yes _☐_ No _☐_
Has the defendant submitted an application to drug court or is currently in drug court? Yes _☐_ No _☐_
Has defendant been terminated from drug court? Yes _☐_ No _☐_

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Cape May County Prosecutor's Office
Veteran's Diversion Program

Referral Form
December 2017

			Prosecutor File No.
Name of Defendant Being Referred:	**DOB:**	**Address:**	
Defense Attorney Name:		**Defense Attorney Phone No.**	
Charges Against Defendant:			
Does Defendant Have Health Insurance: Yes☐ No ☐			
If Yes, specify: VA ☐ Medicaid☐ Medicare ☐ Private (provide name)_____			
Defendant's Living Arrangement: Own house/apt. ☐ With family ☐ Section 8 ☐ **Boarding home ☐ Temporary Shelter ☐ Homeless ☐ Other (describe)_____**			

1. Suspected Mental Illness:		
2. Suspected Substance Abuse Issues:		
3. Has Defendant ever been DIAGNOSED* by a medical/mental health professional? Yes ☐ No ☐		
If Yes, describe diagnosis:		
Doctor's Name:	**Date of Diagnosis:**	**Doctor's Phone No.:**
***Applicants MUST provide proof of AXIS I severe and persistent mental health diagnosis to be accepted into this Program**		
4. Has Defendant ever been prescribed MEDICATION for mental illness? Yes ☐ No ☐		
If Yes, what medications:		
Prescribing Doctor:	**Dates Prescribed:**	**Prescribing Doctor Phone No.:**
5. Has Defendant ever had an EMERGENCY CRISIS SCREENING? YES ☐ No ☐		
If Yes, where did the screening(s) occur:	**Date of screening(s):**	
What were the discharge Recommendations:		
6. Has Defendant ever been hospitalized related to mental illness or substance abuse? Yes ☐ No ☐		
If Yes, where:		
Date(s) of Hospitalization:	**Discharge Recommendations:**	
7. List ALL past and present PSYCHIATRIC and SUBSTANCE ABUSE treatment:		
Doctor/provider names, contact information, and dates of service:		

8. Please describe present problems/reasons for application: (REQUIRED)

VETERANS DIVERSION PROGRAM USE ONLY	
Date Application Received:	**Is Defendant legally appropriate? Yes ☐ No ☐**
Final Decision Date:	**Date Sent to Defense Attorney:**
Date Order of Postponement Filed:	**Length of Diversion (months):**
Other Comments:	

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RELEASE OF PSYCHIATRIC, PSYCHOLOGICAL, MENTAL HEALTH TREATMENT, SUBSTANCE ABUSE, ADDICTION, MEDICAL AND/OR HOSPITAL INFORMATION AND RECORDS, HEREINAFTER "RELEASE"

All Forms Must Be Filled Out Completely Before Consideration For The Program

Please have the defendant read each item listed below, initial page 2, and sign and date page 3

I, _____, do hereby authorize any
(Defendant's Name, Date of Birth, Social Security Number)

psychiatrist, psychologist, mental health provider, substance abuse or addiction provider, physician, hospital, medical attendant, medical provider, or any others to whom this authorization is directed, to disclose any and all information and/or opinions, orally or in writing, regarding my history, diagnosis and/or treatment of any psychiatric condition(s), medical condition(s), mental illness, drug abuse, or alcoholism, which any representative of the Cape May County Prosecutor's Office Veteran's Diversion Program "VDP" may request.

I acknowledge and am aware that both the State of New Jersey and the United States government have statutory and other privileges accorded to confidential communications between a patient and a licensed physician, psychologist and/or other staff involved in providing health care and that my signing this Release waives these privileges.

I acknowledge and am aware that is my medical records contain information regarding sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus

(HIV), this information will be disclosed as part of the medical record to the person authorized to receive records. By initialing this paragraph, I am providing written authorization to the disclosure of that information._____

(Defendant's Initials)

I acknowledge and am aware that the uses and disclosures of my health information authorized by this document may be subject to re-disclosure by the recipient and may not be protected by privacy and confidentiality laws, but shall not be distributed to persons not associated with the VDP. Possible persons/entities associated with the VDP include but are not limited to: Superior Court Judges, the Public Defender's Office, Private Defense Attorneys, the U.S. Attorneys Office, Law Enforcement, the Probation Department, Cape May County Jail, community mental health representatives, Veteran's Mentor Coordinator, Veteran's Mentors, Veteran's Administration and Community Mental Health program providers.

I acknowledge and am aware that I may revoke this release at any time by sending written notice to the VDP and any or all the providers who have released information to the VDP, except to the extent that the VDP or any or all of said providers has already taken action in reliance on it. I understand that revocation of any release will result in immediate termination from the program. If not previously revoked, this consent will terminate in **three (3) years** from the date of execution.

I acknowledge and am aware that participation in the VDP is conditioned upon signing this release.

I understand that I will no longer be eligible for the program is I do not sign or I revoke this release.

Any photocopy of this authorization shall have the same force and effect as the original.

Defendant's Signature: _____ Date: _____

OR

Signature of Defendant's Legal Guardian: _____ Date: _____

Defense Counsel's Name: _____

Signature: _____ Date: _____

Assistant Prosecutor's Name: _____

Signature: _____ Date: _____

Defendant's Phone Number(s): Home: _____

Work: _____

Cell: _____

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE (mm/dd/yyyy)

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA) (Sign in ink)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

Form Approved: OMB No. 2900-0028
Respondent Burden: 7.5 minutes

Department of Veterans Affairs

REQUEST FOR AND CONSENT TO RELEASE OF INFORMATION FROM INDIVIDUAL'S RECORDS

PRIVACY ACT STATEMENT: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, United States Code, and will authorize release of the information you specify. The information may also be disclosed outside VA as permitted by law to include disclosure as stated in the "Notices of Systems of VA Records" published in the Federal Register in accordance with the Privacy Act of 1974.

RESPONDENT BURDEN: VA may not conduct or sponsor, and the respondent is not required to respond, to this collection of information unless it displays a valid OMB Control Number. The Privacy Act of 1974 (5 U.S.C. 552a) and VA's confidentiality statute (38 U.S.C. 5701) as implemented by 38 CFR 1.526(a) and 38 CFR 1.576(b) require individuals to provide written consent before documents or information can be disclosed to third parties not allowed to receive records or information under any other provision of law. The information requested is approved under OMB Control Number 2900-0028 and is necessary to ensure that the statutory requirements of the Privacy Act and VA's confidentiality statute are met.

Responding to this collection of information is voluntary. However, if the information is not furnished, we may not be able to comply with your request. Public reporting burden for this collection is estimated to average 7.5 minutes per respondent, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspects of this collection of Information, including suggestions for reducing this burden, to the VA Clearance Officer (005E3), 810 Vermont Avenue, NW, Washington, DC 20420. **Send comments only. Do not send** this form or requests for benefits to this address.

TO	**Department of Veterans Affairs**	NAME OF INDIVIDUAL *(Type or print)*	
		VA FILE NO. *(Include prefix)*	SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION OR INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERAN'S REQUEST

I hereby request and authorize the Department of Veterans Affairs to release the following information from the records identified above to the organization, agency, or individual named hereon: ▶ NAME

INFORMATION REQUESTED *(Number each item requested and give the dates or approximate dates - period from and to - covered by each.)*

PURPOSE(S) FOR WHICH THE INFORMATION IS TO BE USED.

NOTE: *Additional information may be listed on the reverse side of this form.*

SIGNATURE OF INDIVIDUAL OR PERSON AUTHORIZED TO SIGN FOR INDIVIDUAL *(Attach authority to sign, e.g., POA)*	DATE

Form Approved: OMB No. 2900-0028
Respondent Burden: 7.5 minutes