The Arc of New Jersey

Criminal Justice Advocacy Program

985 Livingston Avenue
North Brunswick, NJ 08902
T 732.246.2525 | F 732-733-6804 | www.cjapnj.org

Advocating for equal justice for people with intellectual and developmental disabilities

I. Program Information

The Criminal Justice Advocacy Program (CJAP) is a clearinghouse for information about offenders with intellectual and developmental disabilities (I/DD). This Program is the only one of its kind in New Jersey that provides community-based alternatives to incarceration for individuals with I/DD who are defendants in the criminal justice system.

The Program serves as a liaison between the criminal justice and human services systems and monitors the quality of care and service provide to those with I/DD as they move from one system to another.

Regardless of their placement in the criminal justice process, the Program insures that offenders with I/DD receive fair and equitable treatment.

II. Personalized Justice Plan

The Personalized Justice Plan (PJP) is a combination of community services compiled to supplement the particular needs of the client and minimize the risk of recidivism. The PJP is presented to the court system as an alternative to incarceration.

The PJP emphasizes the use of least restrictive community-based alternatives to incarceration as early as possible in the criminal justice process, while holding individuals accountable for their behavior.

When presented as a special condition of probation or parole, the PJP can help stabilize the individual in the community due to the way supports are identified, coordinated, and monitored.

Once a client is placed on probation or parole, the Program monitors the PJP until the client completes their sentence. Monitoring can be weekly, bi-weekly, monthly, quarterly, or annual depending on the needs of the individual.

Every PJP increases the individual's accountability and responsibility in the community. The goal in every case is to help the client successfully complete probation or parole.

III. Eligibility

Referrals must be involved in the criminal justice system with pending criminal charges, prison, probation, or parole. Referrals must also be willing to comply with program requirements.

All referrals must be eligible for New Jersey Division of Developmental Disabilities (DDD) services. To check a person's eligibility status, contact DDD directly at the regional office where that individual resides.

- Morris, Sussex, and Warren Counties (973) 927-2600
- Bergen, Hudson, and Passaic Counties (973) 977-4004
- Union and Somerset Counties (908) 226-7800
- Essex County (973) 693-5080
- Hunterdon, Mercer, and Middlesex Counties (609) 292-1922
- Monmouth and Ocean Counties (732) 863-4500
- Burlington, Gloucester, and Camden Counties (856) 770-5900
- Atlantic, Cape May, Cumberland, and Salem Counties (609) 476-5200

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Jessica S. Oppenheim, Esq., Director
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Please fill out as much information below as possible, any information provided will only be used to help the client. **Please ensure that Release of Information Forms are returned with this intake form or the box to the right labeled ROI is filled out.** Thank you.

For Official Use Only:

Case Number: _____
Date: _____
Date File Opened: _____
Assigned to: _____

ROI: If you were not provided or are not able to reach the client to get their signature where should we send the ROI Forms to?
_____
_____
_____
_____

CLIENT INFORMATION

Last: _____ **First:**_____

Diagnosis: _____

Date of Birth:____/____/_____ **Age:**_____ **Gender:** M F

Address: _____

County: _____ **Phone**: _____-_____-_____

Is the client a client of the Division of Developmental Disabilities? (Circle One) Yes No Applying

Case Manager: _____ Phone: _____-_____-_____

Region: _____ Supervisor: _____ Fax: _____-_____-_____

What services is the client receiving from the Division of Developmental Disabilities?

Who is referring this client? _____ Relation: _____

Organization:_____ Phone: _____-_____-_____ Fax: _____-_____-_____

CLIENT SERVICES

Are other agencies involved with this client? Yes or No (Circle One) If yes, please specify:

_____

Does the client receive any state or federal benefits? (Circle all that apply)

SSI/SSDI Medicaid Medicare TANF Other:_____

Does the client have a payee? Yes or No (Circle One) If yes, please specify:

Name:_____ Relation:_____ Phone:_____-_____-_____

Is the client their own guardian? Yes or No (Circle One) If no, please specify:

Name:_____ Relation:_____ Phone:_____-_____-_____

What services does the client need assistance with? _____

CLIENT HISTORY

Does the client have a prior history with the criminal justice system? Yes or No (Circle One) If yes, please specify:_____

Is there client currently on Probation or Parole? Yes or No (Circle One) **Probation or Parole**

Does the client have a prior history of substance abuse? Yes or No (Circle One) If yes, please specify:

_____

Has the sought treatment? Yes or No (Circle One) If yes, please specify:

Does the client have a history of mental illness? Yes or No (Circle One) If yes, please specify:

_____

Has the client been admitted to a psychiatric hospital? Yes or No (Circle One) If yes, please specify:

Is the client currently on medication? Yes or No (Circle One) If yes, please specify:

_____

CRIMINAL JUSTICE

Is the case being heard in: Superior court or Municipal court (Circle One): Adult or Juvenile

Case Number (If Available): _____

Pending Charges: _____

_____

Is the client currently in jail? Yes or No (Circle One) If yes, What is the SBI Number? _____

Where is the client? _____ For How Long?_____

Is there an upcoming court date? Yes or No (Circle One) If yes, please specify when and where:

If available, please provide us with the following:

Attorney Information: _____ (Circle One) Private or Public Defender

Address:_____ Phone: _____-_____-_____ Fax: _____-_____-_____

Judge's Name: _____

Address:_____ Phone: _____-_____-_____ Fax: _____-_____-_____

Prosecutor's Name: _____

Address:_____ Phone: _____-_____-_____ Fax: _____-_____-_____

Probation/Parole Officer's Name: _____

Address:_____ Phone: _____-_____-_____ Fax: _____-_____-_____

If there is more information you feel is necessary for us to know moving forward please feel free to write below.

_____

_____

Please return this form, with release of information forms if you have them, by any means listed below Thank you.

Mail: Criminal Justice Advocacy Program
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Authorization to Disclose Information

I, _____**(Print name)** hereby authorize the agency or service provider in receipt of this form to release all confidential information, **including but not limited to** records, documents, evaluations, reports and any other written or electronic document to the Arc's Criminal Justice Advocacy Program (CJAP). This information will be used by the Program to develop a Personalized Justice Plan (PJP) or provide any other appropriate services that **can address** my status with the criminal justice system. I also permit the Criminal Justice Advocacy Program to release or disclose any information to other agencies, service providers, or involved persons they deem appropriate to assist in order to fulfill this purpose. I authorize the Criminal Justice Advocacy Program to provide necessary information when contacting such parties. This information may include but is not limited to physical, psychological, psychiatric, educational, social, medical, and criminal history, in-patient admission and/or discharge, medication management, continuing care, and drug and alcohol usage. I further authorize the Criminal Justice Advocacy Program to participate in meetings and share information on my behalf.

I understand that I have the right to inspect the information to be disclosed and that I have a right to receive a copy of this document. I understand that I have the right to ask any questions regarding my file or services to be received. I understand that I may refuse to sign this authorization and that my refusal to sign may result in the closing of my file with no further action. I may inspect or copy any written information used/disclosed under this authorization. ***A complete copy of this form will be maintained in the consumer file.***

I understand that if the person or entity that receives the information is not a services provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that I may revoke this authorization in writing at any time except to the extent that this action has been taken in reliance on this authorization. The request to revoke this authorization must be provided in writing to the Criminal Justice Advocacy Program. This revocation will be effective on the date that the Criminal Justice Advocacy Program receives the request. Any information disclosed prior to the revocation of authorization will not constitute a breach of my confidentiality. I understand that the terms of this authorization are governed by Health Insurance Portability and Accountability Act (HIPAA) of 1996 and other applicable State and Federal regulations.

This form has been explained to me; I understand its purpose to the best of my ability. Unless otherwise indicated, this authorization will remain in effect until I revoke my consent, the Program determines that I am no longer in need of their services, or one year after the authorization date, whichever comes first. I understand that I may renew my authorization once a year.

_____ _____

Signature of Client Date Authorized

_____ _____

Signature of Guardian/Personal Representative (if relevant) Date Authorized

Attach Guardianship Order if available

Revised 12/20/2016