Seward County Pretrial Diversion

DRUG ACCOUNTABILITY PROGRAM

Denise Janssen, Director
djanssen@co.seward.ne.us
Kellen Hohman, Coordinator
khohman@co.seward.ne.us

APPLICATION FORM

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Home Phone: _____

Cell Phone: _____ E-Mail Address: _____

What is your approximate household income?

☐$0-$9,999 ☐$10,000-$24,999 ☐$25,000-$39,999 ☐more than $40,000

Ethnicity (please circle): Hispanic/Latino Black/African American White/Caucasian
American Indian Asian/Pacific Islander Unspecified (Other)

EMPLOYMENT/EDUCATION

Are you employed? ☐ Yes ☐ No If yes, please check: ☐ full-time ☐ part-time

Name of employer _____ Work Phone: _____

Are you a student? ☐ Yes ☐ No If yes, please check: ☐ full-time ☐ part-time

Name of School: _____

Did you graduate from high school? ☐ Yes ☐ No

If no, please explain: _____

HEALTH

How would you rate your health? ☐ Excellent ☐ Average ☐ Poor ☐ Very Poor

Are you currently taking any medication? ☐ Yes ☐ No

If yes, please list the medications and reason for use: _____

_____

_____

Do you have any physical limitations or have you been diagnosed with a mental health disorder or substance abuse disorder? ☐Yes ☐ No

If yes, please explain: _____

_____

_____

SUBSTANCE ABUSE

Do you smoke or use smokeless tobacco products? ☐Yes ☐ No Packs per day? _____

What is your preferred drug of choice?_____

Do you have any hobbies or things that really interest you? _____

_____

_____

How would you describe your personality? _____

_____

_____

What do you like about yourself? _____

_____

_____

What would you like to change about yourself? _____

_____

_____

Do you think you generally get along with others? ☐Yes ☐ No

Have you ever hurt anyone or harmed something because of your anger? ☐Yes ☐ No

If yes, describe the most recent incident: _____

_____

_____

Do you feel like you need any type of help? ☐Yes ☐ No

What do you hope to gain from the Drug Accountability Program? _____

_____

_____

What goals do you have for yourself? _____

_____

_____

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ASSURANCES

I have completed this application and the information I have provided is true. I understand that any misrepresentation of the information I have provided may constitute rejection of my application for the Drug Accountability Program or may cause immediate termination from the Drug Accountability Program at any time after I am accepted.

_____ _____

Participant Signature Date

SCPD
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ACKNOWLEDGEMENT OF PROGRAM IMMUNITY

I acknowledge that the employees, volunteers and community service providers involved in the Seward County Drug Accountability Program are not liable for any personal injury I may sustain while working to complete the requirements of the program.

_____ _____

Participant Signature Date

322 South 14th Street, #3 ▪ Seward, NE 68434
Phone: 402.643.3055 ▪ Fax: 888.857.3650

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Constitutional Rights Assurances

The purpose of this questionnaire is to assure that you understand your legal rights before entering into the Drug Accountability Program. Please complete the following:

Name _____ Date of Birth_____ Age _____

Citation _____ Date of Citation _____
(State the offense)

Circle the appropriate response:

1. Do you understand that the program is voluntary and that you are under no legal obligation to participate in the Drug Accountability Program? YES NO

2. Do you understand that you are not admitting guilt by entering the Drug Accountability Program? YES NO

3. Do you understand that if you so choose, you have the right to appear in court on this offense? YES NO

4. Do you understand that if you choose to go to court, you have the right to:

   a. A speedy trial? YES NO
   b. Confront and cross-examine your accusers? YES NO
   c. To summon witnesses on your behalf? YES NO
   d. To remain silent or to testify? YES NO
   e. To an attorney? YES NO
   f. To have the State prove your case beyond a reasonable doubt YES NO

5. Do you understand that you are voluntarily setting aside your right to a speedy trial on this offense while participating in the Drug Accountability Program? YES NO

6. Do you understand that if you are accepted and successfully complete this program, the County Attorney will **not prosecute** you for this offense? YES NO

7. Do you understand that if you knowingly give false or incomplete information, or if you withhold any information to questions asked of you at any time (including written questions), you may be terminated from the program and immediately referred back to the County Attorney for prosecution of this offense? YES NO

8. Do you understand that if you do not complete the program successfully, or if you voluntarily withdraw from the program before it is successfully completed, your case will be immediately referred back to the County Attorney for prosecution of this offense? YES NO

9. Do you fully understand all of the questions you have been asked? YES NO

_____ _____
Participant Signature Date

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RECORD RETENTION/STATEMENT OF DISCLOSURE

Upon completion of the Drug Accountablilty Program, your file will be retained for five (5) years. After the time period has lapsed, your file will be destroyed except for a copy of the completion certificate.

If you are terminated from the Drug Accountability Program, arrested or commit another criminal offense after the Drug Accountability Program is completed, information can be released to proper authorities (Law Enforcement, Probation Officers, County Attorney or other Drug Programs) regarding your participation in the program.

After successful completion of the Drug Accountability Program, confirmation can be given to proper authorities of your completion of the Drug Accountability Program. Proof of your completion may be provided pursuant to a lawful request.

By signing below, I acknowledge that I consent to the policy as outlined.

_____ _____

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SEARCH AND SEIZURE NOTIFICATION

Participants enrolled in the Seward County Drug Accountability Program due to controlled substances violations will be subject to search and seizure of person, vehicles, personal property and residence without warrant by authorized law enforcement personnel.

Search and seizure can be conducted by any Drug Accountability Program staff, law enforcement agency, or any agency/individual authorized by the Drug Accountability Program.

By signing below, I acknowledge that I have read and agree to the conditions stated above.

_____ _____

Participant Signature Date

_____ _____

Drug Accountability Program Staff Date

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RELEASE OF INFORMATION

The purpose of client information is to determine participant's needs in the Drug Accountability Program and to document progress. All participant information is confidential. No information may be released to third parties without written authorization as expressed below, except in cases of suspected child abuse and neglect and court subpoenas.

I hereby authorize: Seward County Drug Accountability Program, 322 S. 14th Street, #3, Seward, NE, 68434

☐ To release information to:

☒Seward Deputy County Attorney or Seward County Attorney

☒Participant's Attorney:_____

☐Other_____

Purpose or need for disclosure: Case Planning, Insurance, Follow up, Court Proceedings and Drug Accountability Program Services.

This authorization to release information will be effective throughout the duration of my enrollment in the Seward County Drug Accountability Program. I further understand that this authorization may be revoked by me at any time by my notice in writing, to the Seward County Drug Accountability Program Director.

_____ _____
Participant Signature Date

_____ _____
Drug Accountability Program Staff Date

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AUTHORIZATION TO RECEIVE/RELEASE OF INFORMATION

CLIENT INDENTIFICATION

Name:_____ Date of Birth: ____/_____/_____

Address:_____

City/State/Zip:_____

I, _____ hereby authorize Seward County Pretrial Diversion to

receive ☒ and/or release ☒ information to: ALTERNATE CONTACT
Name: _____
Address:_____
City/State/Zip: _____
Phone: _____

The information to be provided shall include the following:

- ☐ Prior or current treatment
- ☐ Evaluations/Assessments
- ☐ Criminal History
- ☐ Contact Information
- ☐ Education Records
- ☐ Psychological Evaluations
- ☐ Other_____

The purpose for which the information is to be received/released is for participation in the Seward County Pretrial Diversion Program.

This authorization to release information will be effective for one (1) year from the date of this release. This authorization is not to exceed 30 days from discharge. I further understand that I may revoke this authorization in writing at any time except to the extent that the program, agency, or person requested to release the above information has previously acted in reliance upon it. This information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

I hereby release Seward County Pretrial Diversion Program from all legal liability that might arise from the acceptance or disclosure of information requested above.

I consider a photocopy of this authorization to be as valid as the original. I have read and received a photocopy of this document if requested.

_____ _____
Participant Signature Date

_____ _____
Drug Accountability Program Staff Date