6. All records, reports or other documents relating to any client shall be handled in strictest confidence. This standard shall not, however, exclude the sharing of vital treatment information, or other materials, records, and the like, which may through withholding, jeopardize the client's health or well-being.

8:63–6.4 Center activity reports and schedule of events

(a) The center shall maintain an ongoing record of activities and events including speaking engagements, meetings and daily activities.

(b) A daily schedule of events shall be posted in a conspicuous place.

8:63–6.5 Evaluation procedures

In conjunction with the Division, the center shall implement a system of evaluating its programs and services, and to make such facts, statistics and results of such evaluation available to the Division.

8:63–6.6 Financial accountability

(a) The center shall develop, and shall assign a person to administer the following fiscal policies and procedures:

1. The recording, handling and disposition of all incoming moneys, donations and so forth, including the granting of receipts.

2. The budgeting and allocation of funds, including maintenance of appropriate ledgers and securement of receipted bills for cash payments or expenditures.

3. The annual reporting of all assets liabilities, accounts receivable, payable and so forth.

(b) The Division shall have the right to review and examine the fiscal records of any center, and may require, as a matter of routine, that annual reporting be submitted on State forms.

8:63–6.7 Fund raising procedures

(a) The center shall maintain current records of all gifts, grants and donations of money, supplies, equipment, negotiable instruments and so forth.

(b) Receipts should be issued as a matter of policy.

(c) Furthermore, the center shall review and conform to all tax rules and regulations pertaining to fund raising activities, including applications for tax exempt status.

8:63–6.8 Application for grants or financial assistance

A copy of each application for Federal, State, county, municipal and private funding shall be concurrently submitted to the Division for review.

APPENDIX A THROUGH C

(RESERVED)

Repealed by R.1997 d.272, effective July 7, 1997.
See: 29 N.J.R. 860(a), 29 N.J.R. 2830(a).

APPENDIX D

Ambulatory induction should be attempted only with patients without major psychological, psychiatric or physical complications. If such complications exist, induction must be anticipated to be difficult and patients should be referred for inpatient induction to the New Jersey Neuro–Psychiatric Institute.

The same applies to patients who develop unexpected difficulties while on ambulatory induction.

New Jersey State Department of Health

Division of Narcotic and Drug Abuse Control

Name of Facility _____ Date _____

AGREEMENT *

* In the case of a minor, written consent (parent, guardian, or next of kin) must be obtained on form MM–2.

My full name is _____ (please print). I was born on _____ (Month) _____ (Day) _____ (Year) and my present age is _____.

I request to be placed on methadone maintenance for the treatment of my addiction to heroin.

This type of treatment has been explained to me in detail. I understand that methadone maintenance does not effect a cure, that methadone itself is a narcotic, and in order to help me, must be taken under strict medical supervision. The clinic, under medical supervision, will take full responsibility for providing me with the necessary daily maintenance dose and help me in any possible way with my efforts to rehabilitate myself and to resume my role in society.

I furthermore understand that this treatment program operates under certain rules and regulations, that strict compliance with these rules will be expected of me and that failure to adhere to these rules and regulations may lead to my removal from the program.

Specifically, I promise:

A. To submit to and cooperate with a careful screening procedure, to include physical examination, X-ray studies, laboratory studies and such other diagnostic procedures as deemed necessary by the clinic staff. Acceptance into the program will depend on results of this screening.

B. If accepted for maintenance, I must first undergo a build-up or "loading" phase as long as deemed necessary, but generally expected to last from 15 to 18 days.

During this time, I promise to adhere to the following conditions:

1. During the induction phase, I must enter the clinic from 8:00 A.M. to 4:00 P.M. daily, to include Saturdays, Sundays and Holidays. There can be no exceptions from this rule. During my daily stay at the facility I promise to be polite, cooperative and to obey directions given to me by members of the clinic staff.

2. I firmly promise to abstain from driving any type of motor vehicle during my induction and I will deposit my driver's license at the facility for safe-keeping until completion of "loading". After conclusion of my induction, my driver's license will be returned to me and I may resume driving.

3. During inductions, I pledge to abstain from working with power tools or any other type of dangerous machines, and to avoid any type of activities where full alertness and wakefulness is necessary to prevent physical danger.

4. During induction, I promise to observe a voluntary curfew, returning home immediately after clinic hours and staying home until the next morning. I understand that the clinic may check up on my observing this rule.

5. I agree to give a daily urine specimen to the clinic under strictly controlled conditions to be determined by the facility.

6. During induction and thereafter, I will carry an identification card, given to me by the clinic, at all times. The card will identify me as a methadone maintenance patient in the State program, thereby affording me protection pertaining to my use of this drug. It will also be important in medical emergencies and enable a hospital or physician to get important information pertaining to my maintenance schedule.

7. If, during the induction phase, major complications arise which, in the opinion of the clinic staff, require that the balance of my induction phase be conducted on an inpatient basis, I agree to enter the New Jersey Neuro–Psychiatric Institute or some inpatient facility as determined by the clinic, to complete induction.

After conclusion of my induction phase, I will be expected to lead a socially and legally acceptable life and to assume responsibilities in society. I understand that I will have to continue daily visits to the clinic at a certain time to receive my medication and give a daily urine specimen. I will be expected to inform the clinic about any medical problems and about any medication I might be taking, such as aspirin, headache pills, sleeping pills and so forth.

I will make myself available to talk with the social worker or other clinic personnel whenever this is deemed necessary and to cooperate with them.

I have read this agreement carefully, understand its content, and promise to adhere to it.

_____
(signature)
_____
_____
_____
(address)
_____
(telephone number)

_____
(witness *)
_____
(date)

* Witness must be a professional member of the clinic staff.

New Jersey State Department of Health
Division of Narcotic and Drug Abuse Control

Name of Facility _____ Date _____

CONSENT OF PARENT OR GUARDIAN

I, _____ (please print full name), ____ years of age, hereby declare under oath that I am the (parent, guardian, next of kin) of _____ who is ____ years of age and a minor, that I have carefully read and understand the agreement that _____ (full name) has signed in order to be placed on methadone maintenance for the treatment of his drug addiction and I am in agreement with his request. This consent can only be revoked in writing.

_____
(signature)
_____
_____
_____
(address)
_____
(telephone number)

_____
(witness *)
_____
(date)

* Witness must be a professional member of the clinic staff.

APPENDIX D

Methadone Maintenance Monthly Report for the Month of _____(month)____(year)

Clinic _____

Name of Patient _____ Sex F M

Address _____

Methadone Dosage _____

Additional Medication _____

1. Has the patient been working, going to school, or engaged in any other type of socially acceptable activity this month?

Yes No If no, please explain:

2. Has the patient had any medical problems this month?

Yes No If yes, please explain:

3. Has the patient had any legal problems this month?

Yes No If yes, please explain:

4. Remarks or comments:

Report completed by: _____
(signature)

Please send completed report to Hans W. Freymuth, M.D., Coordinator, State Methadone Maintenance Program, State of New Jersey Department of Health, P.O. Box, 1540, Trenton, New Jersey, 08625, not later than the fifth of each following month.

NEW JERSEY ADMINISTRATIVE CODE

DSR-3
MAR-71

NEW JERSEY STATE DEPARTMENT OF HEALTH
DIVISION OF NARCOTIC AND DRUG ABUSE CONTROL

TREATMENT FACILITY REPORT
OF CONTROLLED DANGEROUS SUBSTANCE (CDS) ABUSER

For Registry Use

PLEASE PRINT OR TYPE — SEE REVERSE SIDE FOR INSTRUCTIONS

1 LAST NAME | 2 FIRST | 3 MIDDLE

4 PRESENT ADDRESS — STREET — CITY — COUNTY — STATE

5 DATE OF BIRTH MO ☐☐ DAY ☐☐ YR. ☐☐ | 6 PLACE OF BIRTH | 7 SOCIAL SECURITY NO ☐☐☐ ☐☐ ☐☐☐☐ NONE ☐

8 SEX 1 ☐ MALE 2 ☐ FEMALE | 9 RACE 1 ☐ WHITE 2 ☐ BLACK 3 ☐ PUERTO RICAN 4 ☐ OTHER | 10 MAIDEN NAME

11 DRUG OR CDS OF PRINCIPAL ABUSE — NO PRINCIPAL DRUG OR CDS ☐ — UNKNOWN ☐ — DATE STARTED USING MO ☐☐ YR ☐☐

12 EMPLOYMENT (TIME: FULL / PART)
1 ☐ PERMANENT ☐ ☐
1 ☐ TEMPORARY ☐ ☐
2 ☐ UNEMPLOYED ☐ ☐
3 ☐ ENROLLED STUDENT ☐ ☐
4 ☐ UNKNOWN ☐ ☐

13 CDS OF 1ST ABUSE

13A DATE OF 1ST ABUSE MO ☐☐ YR. ☐☐

12A EDUCATION - HIGHEST GRADE COMPLETED ☐☐

14 RELIGION
1 ☐ CATHOLIC
2 ☐ PROTESTANT
3 ☐ JEWISH
4 ☐ OTHER
5 ☐ NONE
6 ☐ UNKNOWN

15 TREATMENT — PRIOR NO. OF TIMES (IN PATIENT / OUT PATIENT)

	IN PATIENT	OUT PATIENT
PHYCHIATRIC	____	____
CHEMO THERAPY	____	____
THERAPEUTIC COMMUNITY	____	____
DETOXICATION ONLY	____	____
OTHER (SPECIFY ____)	____	____
NONE	☐	
UNKNOWN	☐	

15A PLANNED AT THIS FACILITY

	IN PATIENT	OUT PATIENT
PHYCHIATRIC	1 ☐	2 ☐
CHEMO-THERAPY	1 ☐	2 ☐
THERAPEUTIC COMMUNITY	1 ☐	2 ☐
DETOXICATION ONLY	1 ☐	2 ☐
OTHER (SPECIFY ____)	1 ☐	2 ☐

16 OTHER PRESENT MEDICAL CONDITIONS
☐ HEPATITIS
☐ T B
☐ V D
☐ OTHER INFECTION
☐ OBSTETRICAL PROBLEMS
☐ COMPLICATING PSYCHIATRIC
☐ NUTRITIONAL PROBLEMS
☐ UNKNOWN
☐ OTHER (SPECIFY)

17 LIVING WITH
1 ☐ PARENTS OR OTHER RELATIVES
2 ☐ SPOUSE
3 ☐ PARENTS OR OTHER RELATIVES AND SPOUSE
4 ☐ FRIENDS
5 ☐ ALONE
6 ☐ UNKNOWN

18 CURRENT LEGAL INVOLVEMENT
1 ☐ NON-PUNITIVE CUSTODY (CIVIL COMMITMENT, MENTAL HEALTH, ETC.)
2 ☐ PUNITIVE CUSTODY (JAIL, REFORMATORY, ETC.)
3 ☐ NONE
4 ☐ UNKNOWN
☐ CHARGES PENDING
☐ PAROLE
☐ PROBATION

19 PRIOR LEGAL INVOLVEMENT
ARRESTED FOR CDS OFFENSE
1. ☐ YES 2. ☐ NO 3. ☐ UNKNOWN
19A.
ARRESTED FOR OTHER OFFENSE
1. ☐ YES 2. ☐ NO 3. ☐ UNKNOWN

20 FOR HOSPITAL EMERGENCY ROOM ONLY

REASON	RESULTS
☐ OVERDOSE	1 ☐ DIED
☐ BAD TRIP	2 ☐ RELEASED
☐ ACCIDENT	3 ☐ DISCHARGED AGAINST ADVICE
☐ OTHER MEDICAL	4 ☐ ADMITTED TO HOSPITAL
☐ WITHDRAWAL	5 ☐ REFERRED TO DRUG TREATMENT FACILITY
☐ UNKNOWN	6 ☐ REFERRED TO PRIVATE PHYSICIAN

21 SOCIO-ECONOMIC STATUS OF FAMILY

A. AREA RAISED	B. ECONOMIC LEVEL OF FAMILY	C. HIGHEST EDUCATIONAL LEVEL OF FAMILY (PARENT FIGURE)
1 ☐ RURAL	1 ☐ POOR	1 ☐ GRAMMAR
2 ☐ SUBURBAN	2 ☐ BELOW AVERAGE	2 ☐ HIGH SCHOOL
3 ☐ URBAN	3 ☐ AVERAGE	3 ☐ COLLEGE
4 ☐ UNKNOWN	4 ☐ ABOVE AVERAGE	4 ☐ GRADUATE
	5 ☐ UNKNOWN	5 ☐ UNKNOWN

REPORTED BY NAME AND TITLE IN HOSPITALS AND INSTITUTIONS ONLY PHYSICIANS REPORT | 22 DATE OF REPORT

ADDRESS OF PRACTITIONER OR NAME OF INSTITUTION | SIGNATURE

FOR REGISTRY USE ONLY ☐ Y ☐ N

M7414

New Jersey State Department of Health
Division of Narcotic and Drug Abuse Control
P.O. Box 1540
Trenton, New Jersey 08625

Application For Certificate Of Approval
For Narcotic and Drug Abuse Control Treatment Center

R6E-
Aug-71

INSTRUCTIONS

1. Please type or print
2. Complete in triplicate. Submit original and one copy.
3. Answer all applicable questions.
4. Submit a separate application for each Center to be approved.

SECTION A GENERAL

1. Name and address of applicant

2. Mailing address of applicant

3. Name and title of person in charge of center

Telephone No.

4. Certificate requested for (check one or more). See item 4 of instructions. See page 2 of procedures for definition of each.

- ☐ Residential, Drug Free
- ☐ Residential, Chemo-Therapy
- ☐ Non-Residential, Drug Free
- ☐ Non-Residential, Chemo-Therapy
- ☐ Counselling and Referral
- ☐ Other, including Pilot and Research Programs. Specify _____

SECTION B SPONSORSHIP

1. Name and principal address of the organization or entity responsible for the operation of the center.

2. Character of applicant organization

- ☐ Government Agency
- ☐ Proprietorship
- ☐ Corporation
- ☐ Other (specify) _____
- ☐ Partnership

3. List names and addresses of all officers and members of the board of directors of the agency. (Attach all sheets and mark "B-3" in upper right hand corner).

IF NONE, CHECK HERE ☐

4. Is organization controlled by other than your own governing board?

☐ YES ☐ NO

If "yes", attach the name and principal address of the controlling organization and the names and addresses of all officers and members of the board of directors. (Attach all sheets and mark "B-4" in upper right hand corner).

5. If the applicant is other than individually owned, complete the following appropriate section:

A-GOVERNMENT AGENCY

Identify department, division and bureau administratively responsible for the center:

_____

_____

B-UNINCORPORATED ASSOCIATION

Date Established _____

C-PARTNERSHIP

Date of Formation _____

List names and address of partners if not listed above. (Attach all sheets and mark "B-5c" in upper right hand corner).

D-CORPORATION

Date Incorporated _____

State where incorporated _____

CHECK TYPE: ☐ Business ☐ Non-Profit

If other than a New Jersey Corporation, list date of qualification to operate in New Jersey _____

List registered agent and address

_____

_____

_____

_____

SECTION C - TREATMENT PROGRAM

1. Submit a summary of your organization's goals and treatment philosophy. (Attach and mark all sheets "C-1" in upper right hand corner).

2. Describe the geographic, social and economic community that the program serves. (Attach and mark all sheets "C-2" in upper right hand corner).

3. Is this program regulated or operated in conjunction with other public or private agencies? ☐Yes ☐No

If "yes" identify and briefly describe the relationship with each. (Attach and mark all sheets "C-3" in upper right hand corner.

4.a. Give a brief narrative description of each program including the following items that apply. (Attach and mark all sheets "C-4a" in upper right hand corner).

1. types of therapy
2. criteria for client selection
3. requirements for participation (in each program)
4. number of clients served, by age and sex
5. source of referral
6. use of other community service in the administration of the program
7. are fees charged? amounts?

b. Include a sample schedule of daily activities for each program. (Attach and mark all sheets "C-4b" in upper right hand corner).

c. Are clients used for programs or activities outside of the center? ☐Yes ☐No

If "yes" briefly describe the type of activities. (Attach and mark all sheets "C-4c" in upper right hand corner).

SECTION D - OTHER

1. Complete enclosed "Personnel Report."

2. Submit copy of current annual budget and most recent financial statement.

3. Complete enclosed""Funding Report."

4. Specify any current or pending legal action involving applicant. (Attach and mark all sheets "D-4" in upper right hand corner)

5. Designate approximate date when center will be ready for certification inspection:

_____

I _____ (Name) hereby certify that I am the _____ (Title) of _____ (Center); that I am authorized to make this application on behalf of the applicant; that I have read the foregoing application for certificate of approval and that the facts stated therein are true.

Date _____ SIGNATURE _____

FOR STATE USE ONLY

Approved Yes	Approved No	Name	Title	Date

DAF
Aug-71

NEW JERSEY STATE DEPARTMENT OF HEALTH
DIVISION OF NARCOTIC AND DRUG ABUSE CONTROL
P.O. BOX 1540
TRENTON, NEW JERSEY 08625

PERSONNEL REPORT FOR YEAR_____

Name of Center_____

Address_____
Street Municipality Zip Code

TYPE OR PRINT

NAME (Include part time, consultants and volunteers)	POSITION TITLE	AVERAGE NUMBER OF HOURS WORKED PER WEEK	AVERAGE WEEKLY SALARY

R&E
Aug-71

NEW JERSEY STATE DEPARTMENT OF HEALTH
DIVISION OF NARCOTIC AND DRUG ABUSE CONTROL
P.O. BOX 1540
TRENTON, NEW JERSEY 08625

FUNDING REPORT FOR YEAR _____

Name of Center _____

Address _____
Street Municipality Zip Code

PLEASE SHOW SOURCE OF ALL FUNDS

TYPE OR PRINT

SOURCE OF FUNDS	AMOUNT
TOTAL FUNDS	