OFFICE of the DISTRICT ATTORNEY
MIDDLE JUDICIAL CIRCUIT of GEORGIA
TRIPP FITZNER, DISTRICT ATTORNEY

MIDDLE JUDICIAL CIRCUIT EARLY INTERVENTION PROGRAM

FORM 5: INDIVIDUALIZED CASE PLAN

Case No: District Attorney File No:

Participant Name: DOB: Age:

Offense(s) Charged: _____

Assessment Date: Risk Assessment Score: ___ / 20

Risk Category:

- ☐ Low (0-5)
- ☐ Moderate (6-12)
- ☐ High (13-20)

Case Plan Completion Date: _____

Prepared By: Title: Date:

Reviewed By (Prosecutor): Approved:

- ☐ Yes
- ☐ No

SECTION 1: PARTICIPANT STRENGTHS & RISK FACTORS

Protective Factors (Strengths)

Based on the risk assessment, the following protective factors should be leveraged in case planning:

☐ **Employment/Income Stability**

- ☐ Currently employed
- ☐ Stable employment history
- ☐ Marketable skills

Description: _____

☐ **Family/Social Support**

- ☐ Strong family relationships
- ☐ Supportive partner/spouse
- ☐ Close ties to community
- ☐ Positive peer relationships

Description: _____

- [ ] **Housing Stability**
  - [ ] Owns home or has stable rental
  - [ ] Living situation is secure 12+ months

Description: _____

- [ ] **Education/Training**
  - [ ] High school diploma/GED
  - [ ] Post-secondary education/training
  - [ ] Vocational skills

Description: _____

- [ ] **Mental Health/Substance Use**
  - [ ] No substance abuse issues
  - [ ] Previously treated for mental health with good outcomes
  - [ ] Currently on stable psychiatric medications

Description: _____

- [ ] **Motivation**
  - [ ] Expressed genuine remorse
  - [ ] Motivated to avoid future criminal conduct
  - [ ] Responsive to supervision

Description: _____

- [ ] **Other Strengths:**

_____

_____

Identified Criminogenic Needs (Areas Requiring Intervention)

Based on the risk assessment, the following areas require targeted intervention:

- [ ] **Employment/Financial**
  - [ ] Unemployment or underemployment
  - [ ] Financial instability/poverty
  - [ ] Limited employment history

Barrier to employment: _____

- [ ] **Housing/Residential Stability**

- [ ] Unstable/temporary housing
- [ ] Frequent residential moves
- [ ] History of eviction
- [ ] Currently homeless

- [ ] **Substance Abuse**
  - [ ] Recent drug use (past 6 months)

  Frequency:
  - [ ] Occasional
  - [ ] Frequent
  - [ ] Daily

Type(s): _____

- [ ] No prior treatment
- [ ] Failed previous treatment
- [ ] Assessment results indicate need for intervention

- [ ] **Mental Health**
  - [ ] History of mental health treatment
  - [ ] Currently untreated mental health condition

Psychiatric diagnosis: _____

Currently on psychiatric medications: ___

- [ ] Non-compliance with mental health treatment history

- [ ] **Criminal History/Behavior Patterns**
  - [ ] Escalating criminal history
  - [ ] Prior failure to appear
  - [ ] Pattern of law violations

Age of first arrest: ___ (younger = higher risk factor) _____

Description of pattern: _____

- [ ] **Attitude/Accountability**
  - [ ] Minimization of offense
  - [ ] Blame-shifting/lack of responsibility
  - [ ] Disrespectful toward authority
  - [ ] Hostile demeanor
  - [ ] Poor insight into consequences

- [ ] **Family/Relationship Issues**
  - [ ] Family history of criminality
  - [ ] Domestic violence (as perpetrator or exposure)
  - [ ] Child custody/support issues
  - [ ] Parenting stress
  - [ ] Relationship conflicts
- [ ] **Education/Vocational**
  - [ ] No high school diploma/GED
  - [ ] Limited work history
  - [ ] No vocational training
  - [ ] Limited literacy/numeracy skills
- [ ] **Other Identified Needs:**

SECTION 2: RISK-BASED SUPERVISION LEVEL

Supervision Level Assignment

SELECT ONE:

- [ ] **LEVEL 1: LOW-INTENSITY SUPERVISION (For Low-Risk Participants: 0-5 Points)**
  - Monthly in-person visits with case manager (1 visit per month minimum)
  - Phone contact as needed
  - Case manager availability during business hours
  - No intensive monitoring required
  - Focus: Monitor compliance and support progress toward goals

  Recommended for: Low-risk offenders with stable employment, housing, no substance abuse issues, minimal criminal history.

- [ ] **LEVEL 2: MODERATE-INTENSITY SUPERVISION (For Moderate-Risk Participants: 6-12 Points)**
  - Bi-weekly in-person visits with case manager (2 times per month minimum)
  - Bi-weekly phone contact
  - Monthly compliance verification (employment treatment attendance)
  - Random home visits (optional based on conditions)
  - Case manager availability 24/5 (weekday business hours + emergency after-hours)
  - Focus: Monitor compliance coordinate services provide accountability

  Recommended for: Moderate-risk offenders with some employment instability, substance use history, or multiple identified needs.

☐ **LEVEL 3: HIGH-INTENSITY SUPERVISION (For High-Risk Participants: 13-20 Points)**

- Weekly in-person visits with case manager (minimum 1 per week)
- Weekly phone contact
- Regular employment/school/treatment verification (weekly or bi-weekly)
- Scheduled home visits (monthly minimum)
- Electronic monitoring (optional if approved by prosecutor/judge)
- Case manager availability 24/7 (with on-call backup)
- Focus: Intensive monitoring frequent accountability rapid response to violations

Recommended for: High-risk offenders with substance abuse issues, employment instability, mental health concerns, or pattern of non-compliance.

Case Manager Assignment

Primary Case Manager Name: Phone:

Office Address: _____

Office Hours: Emergency Contact:

Secondary Case Manager (backup): Phone:

SECTION 3: EMPLOYMENT/EDUCATION CONDITION

Employment Status and Plan

Current Employment Status:

- ☐ Employed full-time (35+ hours/week) at: ___
- ☐ Employed part-time (less than 35 hours/week) at: ___
- ☐ Unemployed
- ☐ Self-employed/Freelance: ___
- ☐ Student (full-time)
- ☐ Disabled/on disability
- ☐ Retired

IF EMPLOYED:

Maintain Current Employment:

- Participant will maintain current employment throughout program
- Minimum hours per week: ___ hours

Employer: Phone:

Supervisor: _____

Job duties: _____

Employment verification required:

- ☐ Monthly
- ☐ Quarterly
- ☐ As requested

Method:

- ☐ Pay stubs
- ☐ Employer letter
- ☐ Case manager employer contact

Contingency if Employment Ends:

If participant is laid off or fired, participant must:

1. Notify case manager within 24 hours
2. Begin job search immediately (apply for 3 jobs per week minimum)
3. Provide documentation of job applications to case manager
4. Document any barriers to employment (lack of transportation, health issues, etc.)

IF UNEMPLOYED:

Active Job Search Required:

- Participant will actively search for employment
- Minimum applications per week: ___ applications

Employment goal: Secure employment by: _____

Type of work sought: _____

Barriers to employment (transportation, childcare, health, criminal record): _____

Job Training/Placement Program (if applicable):

- ☐ Participant will enroll in job training program: ___

Provider: Contact:

Program start date: Expected completion:

Documentation Required:

- Weekly/bi-weekly: List of job applications with dates/employers
- Monthly: Written summary of job search activities
- Monthly: Updated resume if available

IF PURSUING EDUCATION:

High School Diploma/GED Program:

- ☐ Participant will enroll in GED preparation program

Program/Provider: Contact:

Start date: Expected completion:

Attendance requirement:

- ☐ 3x/week
- ☐ 4x/week
- ☐ Full-time

Verification: Attendance records submitted monthly to case manager

College/Vocational Program:

- ☐ Participant is/will be enrolled in higher education

School: Program:

Enrollment status:

- ☐ Full-time (12+ credit hours)
- ☐ Part-time

Expected graduation: _____

Minimum GPA to maintain: _____

Verification: Official transcripts at end of each term

Childcare/Transportation Barriers:

If participant identifies barriers to employment/education, note accommodation here:

SECTION 4: SUBSTANCE ABUSE SERVICES

Assessment of Substance Abuse Risk

Substance Abuse Identified:

- [ ] No substance abuse identified - NO SERVICES REQUIRED (skip this section)
- [ ] Substance abuse identified in assessment
- [ ] Current charge involves drugs/alcohol
- [ ] Prior substance-related conviction
- [ ] Test positive during program

Primary Substance(s): _____

Pattern of Use:

- [ ] Occasional
- [ ] Regular (weekly)
- [ ] Heavy (daily/near-daily)
- [ ] Unknown

IF SUBSTANCE ABUSE IDENTIFIED:

LEVEL 1: Substance Abuse Evaluation Only

- [ ] Participant will complete comprehensive substance abuse evaluation

Evaluator/Agency: Phone:

Address: _____

Evaluation appointment date: _____

Cost: Paid by

- [ ] Court
- [ ] Participant
- [ ] Insurance
- [ ] Sliding scale

- Participant must follow all evaluator recommendations (treatment counseling support groups etc.)
- Evaluation results to be provided to case manager within 2 weeks
- Next Step: Treatment level to be determined based on evaluation results

LEVEL 2: Outpatient Substance Abuse Treatment

- [ ] Participant WILL participate in outpatient substance abuse treatment

Provider/Agency: Phone:

Address: _____

Counselor/Therapist Name: _____

Type of Program:

- ☐ 12-Step (AA/NA)
- ☐ Cognitive-Behavioral
- ☐ Motivational Enhancement
- ☐ Other: ___

Frequency:

- ☐ Once weekly
- ☐ Twice weekly
- ☐ Other: ___

Expected duration: ___ months _____

Start date: Target completion:

Individual or group:

- ☐ Individual
- ☐ Group
- ☐ Both

Cost: Paid by

- ☐ Court
- ☐ Participant
- ☐ Insurance
- ☐ Sliding scale

Attendance Requirements:

- Participant must attend ALL scheduled sessions
- Participant must arrive on time
- Participant must actively participate
- Missing a session = potential strike (unless excused by case manager in advance)

Treatment Provider Coordination:

- Provider will submit attendance/progress reports to case manager:
  - ☐ Monthly
  - ☐ Bi-weekly
  - ☐ After each session
- Case manager will communicate with provider re: compliance/concerns

- Participant must sign release of information allowing provider to communicate with case manager

LEVEL 3: Intensive Treatment (IOP or Inpatient)

- ☐ Participant MAY be required to participate in intensive outpatient (IOP) or inpatient treatment if:
- Outpatient treatment is ineffective
- Participant has failed previous treatment
- Substance abuse is severe and daily use documented
- Participant expresses readiness for intensive treatment

If required:

Provider: _____

Program type:

- ☐ IOP (intensive outpatient daily)
- ☐ Inpatient/residential

Duration: _____

Start date (if applicable): _____

Cost: Paid by

- ☐ Court
- ☐ Participant
- ☐ Insurance
- ☐ Other: ___

Drug Testing Coordination

If Drug Testing is Required (See Early Intervention Agreement):

- Testing frequency:
  - ☐ Weekly
  - ☐ Bi-weekly
  - ☐ Monthly
  - ☐ Random
- Participant must notify case manager immediately of any positive result
- Positive result is a strike (1st strike etc.)
- Positive result will be reported to substance abuse treatment provider
- Treatment provider will adjust treatment plan as needed
- Case manager will assess need for increased treatment level

SECTION 5: MENTAL HEALTH SERVICES

Mental Health Assessment

Mental Health Condition Identified:

- [ ] No mental health condition identified - NO SERVICES REQUIRED (skip this section)
- [ ] History of mental health treatment
- [ ] Currently on psychiatric medications
- [ ] Mental health symptoms observed during assessment

Diagnosis noted: _____

Current Mental Health Status:

- [ ] Stable/managed
- [ ] Unstable/concerning
- [ ] Unknown

IF MENTAL HEALTH SERVICES RECOMMENDED:

Individual Mental Health Counseling:

- [ ] Participant will participate in individual mental health counseling

Mental Health Provider: Phone:

Therapist/Counselor Name: License:

Address: _____

Specialties/Experience: _____

Frequency:

- [ ] Weekly
- [ ] Bi-weekly
- [ ] Monthly
- [ ] As needed

Expected duration: ___ months _____

Start date: Target completion:

Focus areas:

- [ ] Depression
- [ ] Anxiety

- [ ] PTSD
- [ ] Bipolar disorder
- [ ] Other: ___

Cost: Paid by

- [ ] Court
- [ ] Participant
- [ ] Insurance
- [ ] Sliding scale

Psychiatric Medication Management:

- [ ] Participant is currently taking psychiatric medications

Prescribing Psychiatrist/Provider: Phone:

Medications: _____

Frequency of medication appointments:

- [ ] Monthly
- [ ] As needed
- [ ] Other: ___

Next appointment: _____

- Participant must take medications as prescribed
- Case manager will verify compliance during monthly visits
- Non-compliance with medication = potential strike

Hospitalization/Crisis Planning:

If participant has history of psychiatric hospitalization or suicidal ideation:

Emergency contact: Phone:

Crisis line number: _____

Hospital preference: _____

- [ ] Safety plan discussed with participant: Yes
- [ ] Safety plan discussed with participant: No
- [ ] Participant knows warning signs and what to do if crisis occurs: Yes
- [ ] Participant knows warning signs and what to do if crisis occurs: No

SECTION 6: SPECIAL SERVICES

Community Service Coordination (if required)

Community Service:

- ☐ Not required

OR:

- Total hours: ___ hours
- Deadline: ___
- Type of service: ___
- Organization: ___ Contact: ___
- Supervisor: ___ Phone: ___
- Schedule: ___
- Hours per week to complete: ___ hours/week
- Verification method: Work sheets signed by supervisor submitted monthly to case manager
- Barriers/accommodations: ___

Restitution Payment Plan (if required)

Restitution:

- ☐ Not required

OR:

- Total restitution owed: $___
- Monthly payment: $___ Starting: ___
- Deadline for full payment: ___

Payment method:

- ☐ Check
- ☐ Cash
- ☐ Direct debit
- ☐ Payroll deduction

Payable to: _____

Program Fees

Program Fees:

- ☐ Not required

OR:

- Monthly supervision fee: $___
- Court processing fee: $___

- Total fee obligation: $___
- Payment schedule: $___/month due by ___ of each month

Fee waiver/reduction available based on financial hardship.

SECTION 7: COMPLIANCE MONITORING SCHEDULE

Activity	Frequency	Method	Due Date
Case Manager Meeting			
Phone Check-in			
Drug Testing			
Employment Verification			
Treatment Attendance			
Community Service Verification			
Court Appearance			
Restitution Payment			

SECTION 8: PARTICIPANT ACKNOWLEDGMENT

I have reviewed this Case Plan with my case manager. I understand all conditions and requirements. I agree to comply with this plan. I understand that failure to comply may result in strikes and possible termination from the program.

_____

Participant Signature

Printed Name: Date:

Case Manager:

_____

Case Manager Signature

Printed Name: Title: Date:

Prosecutor Approval:

Prosecutor Signature

Printed Name: Title: Date:

END OF FORM 5