15th Judicial Circuit Community Corrections
Day Report Center and Home Incarceration
QUESTIONNAIRE

Instructions

Please complete this form as accurately and honestly as possible. Completion and submission of this form does not replace the intake interview, it is merely one portion of the process. Please provide as much information as possible on this form.

Bring valid identification, including driver's license and Social Security card to the intake interview.

Date: _____ Driver's License Number/State ID: _____

Last Name: _____ First Name: _____ Middle: _____

SSN: _____ Race: _____ Gender: ☐ Male ☐ Female

D.O.B _____ Height: _____ Weight: _____ Hair Color: _____

Eye Color: _____ Tattoos/Scars: _____

Place of Birth: _____

Are you a U.S. Citizen? ☐ Yes ☐ No

What is your native language? _____

Do you follow any specific cultural or religious traditions involving diet, appearance, clothing or special sacred activities? ☐ Yes ☐ No

_____

_____

Contact Information

Home: _____ Cell: _____ Other: _____

Address: _____

Mailing Address: _____

Housing Information

Living Status : _____ Own_____ Rent Other: _____ Length at residence: _____

Number of Occupants: _____

Persons living in residence and their relationship to you: _____

_____

_____

Former Addresses: _____

_____

Family Information

Marital Status: _____ Name of Spouse/Partner: _____

Dependents: _____

Custody Status: _____ Child Support: _____ Amount: _____

Emergency Contact: _____ Number: _____

Does anyone in your household have a criminal record? ☐ YES ☐ NO

If so please provide thier Name and Birth Date: _____

_____

Parents

Name: _____ Birth Date:_____ Age:_____

Address: _____

Telephone Number: _____ Occupation: _____

If Deceased, cause of death: _____ Date of Death: _____

Name: _____ Birth Date:_____ Age:_____

Address: _____

Telephone Number: _____ Occupation: _____

If Deceased, cause of death: _____ Date of Death: _____

Siblings

Name: _____ Birth Date:_____ Age:_____

Address: _____

Telephone Number: _____ Occupation: _____

Name: _____ Birth Date:_____ Age:_____

Address: _____

Telephone Number: _____ Occupation: _____

Name: _____ Birth Date:_____ Age:_____

Address: _____

Telephone Number: _____ Occupation: _____

Name: _____ Birth Date:_____ Age:_____

Address: _____

Telephone Number: _____ Occupation: _____

If Deceased, cause of death: _____ Date of Death: _____

Describe how well your family functioned. Was there physical and/or substance abuse?

Does anyone in your family, including spouse and close relatives have a criminal record?

Education

Highest level completed: _____ Diploma: _____ GED: _____ Year: _____
Name of Schools attended:

Name of School	Location	Dates and Grades Attended	Graduate (Y/N)

1. _____

2._____

3. _____

4._____

5._____

Employment

Are you disabled? ☐ Yes ☐ No
If yes, what is your disability, who is your physician, and when were you qualified for or awarded disability?
_____
_____

Disability/Retirement/Unemployment income: _____

Employment Status: _____
Longest full-time employment: _____

Current Employer: _____
Employer Address: _____
Telephone Number: _____
Name of Supervisor: _____

List work record beginning with your most recent job:

	Business	Position	Dates	Hours	Salary	Reason for Leaving
1.						
2.						
3.						
4.						
5.						
6.						
7.						

List name(s) and address(es) of union(s) in which you were or are a member, and include dates of membership:

_____

_____

_____

In the last year, or in the year before you were incarcerated, how many months have you been employed? _____

Military

Have you been in the Military Service? ☐ Yes ☐ No
Branch of Service: _____
Approximate Entry Date: _____
Approximate Discharge Date: _____
What rank did you achieve? _____
What duties did you have? _____
Did you have any particular problems, disciplinary or otherwise? ☐ Yes ☐ No
If yes, explain:

_____

_____

Where were you stationed? _____
What type of discharge did you receive? _____

Civic

Do you belong to any religious and/or civic organizations? ☐ Yes ☐ No

If yes, please list: _____

_____

How do you usually spend your free time, such as hobbies? _____

_____

_____

Health Information

Health Physical/Mental: _____

Medications: _____

_____

Health Insurance: ☐ Yes ☐ No Name of Provider:_____

Criminal History

____ No Criminal History

List any and all arrests and charges that may be on file anywhere. Include PENDING charges.

Offense	Location	Date of Offense	Disposition
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER IF NECESSARY.

How many prior dispositions (or convictions) did you have as a youth (under age of 18)? _____

How many prior adult convictions do you have? Felony _____ Misdemeanor_____

At what age were you first arrested or charged with a crime? _____

Were you ever arrested under the age of 16? ☐ Yes ☐ No

If yes, please explain: _____

_____

Were you ever incarcerated as a result of a conviction? ☐ Yes ☐ No

Were you ever punished for an institutional misconduct? ☐ No ☐ Yes How Many? _____

Have you had any behavior reports while in prison? ☐ No ☐ Yes How Many? _____

For what infraction(s)? _____

Have you ever had your probation or parole suspended or revoked while you were under any kind of prior community supervision? Have you ever had new charges laid while you were under any kind of prior community supervision?
If yes, describe the event. _____

HARRISON COUNTY HOME INCARCERATION FEES AND EXPENSES:

Supervison Fee $300.00 per month — Hook-up/Disconnect Fee: $50.00
Drug Screening Fees: $10.00 per decvice — $15.00 per Positive Laboratory Confirmation

Will you be able to afford the fees associated with Home Incarceration? YES ☐ NO ☐

VEHICLE INFORMATION

(Please include any leased & co-signed: cars, trucks, motorcycles, all terrain vehicles/4-wheelers, dirt bikes, side-by-sides)

How many vehicles do you own? _____

Please list **ALL** vehicles accessable to you:

	Color	Make	Model	Year	License Plate Number	Owner
1.						
2.						
3.						
4.						
5.						

WiFi Information: Do you have Wifi Internet access? Yes ☐ No ☐

WiFi Password: _____

SSID: _____

Network Name: _____

CURRENT OFFENCE INFORMATION:

Current Offense(s): _____

Offense Class: ☐ Felony
☐ Misdemeanor

_____

Judge: _____ Case Number:_____

Are you on Bond? _____ Offense Date: _____

Sentence Date: _____ Sentence Time: _____

Sentence Details:

Supervising Officer:_____

Prosecuting Attorney: _____

Attorney name/number: _____

Please give a detailed description of your residence, and driving directions to your residence.

Do you have any pets with aggressive, territorial, or anxious behaviors? ☐ YES ☐ NO
Please list description of animals:

Defendant's Version

Describe, in your own words, the events of the offense and your arrest.
You may also give a reason for your involvement in the crime.

Future Plans and Goals

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

HARRISON COUNTY COMMUNITY CORRECTIONS

220 Washington Avenue
Clarksburg, West Virginia 26301
FAX: 304-626-1085 PHONE: 304-624-8556

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION: CRIMINAL JUSTICE SYSTEM REFERRAL

I, _____, hereby consent to communication between the Harrison County Day Report Center and the following persons or agencies (check as appropriate):

☑ 1. Presiding Judge for the Circuit Court of Harrison County
☑ 2. Presiding Magistrate for the Magistrate Court of Harrison County
☑ 3. Prosecuting Attorney's Office for Harrison County
☑ 4. Defense Counsel
☑ 5. Supervising Probation Office for Harrison County.
☑ 6. Supervising Parole Office and, if required, Paroling Authority
☑ 7. Home Incarceration Office for Harrison County
☑ 8. Other Any Court Official from Harrison County

The purpose of and need for the disclosure is to inform the criminal justice agencies listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, drug test results, and

I understand that such information, where necessary, will be disclosed in open-court, which is a public forum, and I hereby authorize the same.

I understand that this consent will remain in effect for one year from the date of this contract or until I provide written notice to the agency withdrawing my consent.

I also understand that any disclosure made is bound by part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and that the recipients of this information may re-disclose it only in connection with their official duties.

_____ _____
DATE SIGNATURE OF CLIENT

_____
SIGNATURE OF DRC STAFF

AUTHORIZATION FOR THE RELEASE OF PROTECTED MEDICAL INFORMATION

PATIENT NAME:
DOB:
SOCIAL SECURITY #:

1. The following organization or health care provider is authorized to disclose the above-named individual's health information as described in this authorization form: ☐ Harrison County Community Corrections
   ☐ Harrison County Home Incarceration

2. The following person or organization (and agents, employees, and representatives of such person or organization) is authorized to receive and/or use the information:
   The Court, the Prosecuting Attorney's Office, my attorney, this Day Report Center, Harrison County Home Incarceration, and the Division of Justice and Community Services; and/or
   Other:

3. The description and amount of information to be disclosed is as follows:

   Any and all records, reports, summaries, notes, billing records and any other information regarding the examination, evaluation, care, and treatment (including alcohol and drug abuse treatment) of the above-named individual from**:**

   Dates of Service: _____

4. The information may be used or disclosed for the following purposes:

   For the purpose of pending criminal actions involving the above-named individual, including, but not limited to, disclosures in the course of judicial and administrative proceedings. These permitted disclosures include providing reports to the Court and officers of the Court regarding the above-named individual's compliance or noncompliance with Court Orders. Disclosures may also be made to the Justice and Community Services Division of W.V. Homeland Security to the extent that the Community Corrections Subcommittee of the Governor's Committee on Crime, Delinquency and Corrections may effectuate its obligations pursuant to W. Va. Code § 62-11C-3(b)(1) and other similar statutory authority.

5. I authorize the release of records pertaining to (please initial):

   _____ Behavioral or mental health services;

   _____ Treatment for alcohol and/or drug abuse;

_____Other:
(list):_____.

6. This authorization expires one year from the date of signature, if not otherwise indicated.

7. I understand that the requested health care information *may* be protected under HIPAA. For the purposes of this authorization, I hereby waive my rights under HIPAA and request that such information be released to the treating Day Report Center, the Justice and Community Services Division within the Department of Homeland Security, the ordering Court, and the prosecuting attorney's office or their authorized representatives, and any other party specified above, with the knowledge that these records may be reviewed subsequently by others as part of the day report programming and/or the accompanying judicial processes.

8. I understand that I may inspect and receive a copy of this authorization.

9. I understand that I will not be refused treatment simply because I do not sign this authorization, unless I have agreed to receive the treatment as part of a research project or in order to provide my information to a third party. Under those circumstances, I understand that my refusal to sign the authorization may result in a refusal to provide treatment.

10. I understand that I may revoke this authorization at any time in writing, except where action has already been taken in reliance upon this authorization. My revocation will not be effective until I submit a written request to revoke the authorization to the organization or provider who has been authorized to release my records pursuant to this authorization. I also further understand that my revocation will not circumvent the Court from ordering certain disclosures as they relate to my compliance with previous Orders of the Court.

11. This authorization does not permit any agent, employee or representative of _____ _____ to discuss records or medical treatment with any physician, hospital or clinic personnel without my prior written consent, but only permits and authorizes the release of copies of the complete medical file by such physician, hospital, pharmacy or clinic.

12. A photocopy of this authorization is to be used and considered as having the same effect as the original of said authorization.

Offender: _____ _____
Date

Witness: _____ _____
Date