DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-2501 (Rev. 8/2011)

WISCONSIN
Wisconsin Statutes
§302.113 (9g)

PETITION TO MODIFY BIFURCATED SENTENCE

Geriatric/Extraordinary Health Condition

FACILITY NAME

OFFENDER NAME	DOC #	ES DATE	MAX DISCHARGE DATE	DATE OF BIRTH

I am an offender who is serving a bifurcated sentence imposed under §973.01, for a crime other than a Class B felony, or an offender serving a life sentence imposed under § 973.014. I am seeking modification of the following applicable sentence(s):

COUNTY OF CONVICTION	CASE NUMBER(S)	STATUTE NUMBER AND OFFENSE(S)	SENTENCE
			Confinement: ES:
			Confinement: ES:
			Confinement: ES:
			Confinement: ES:

If you wish to be represented by an attorney, it is your responsibility to obtain counsel. If you cannot afford to hire counsel, you must contact the state public defender for an indigence determination and appointment of counsel.

Check One ATTORNEY NAME ADDRESS TELEPHONE NUMBER

☐ I will be represented by counsel. _____

☐ I do not wish to be represented by counsel.

Check One

☐ I have not previously forwarded a petition for a sentence modification on the above court case(s) pursuant to §302.113 (9g).

☐ I have previously forwarded a petition for a sentence modification pursuant to §302.113 (9g).

☐ The program review committee denial was dated _____. It has been over one year since that denial.

☐ The sentencing court denial was dated _____. It has been over one year since that denial.

The petition is for an offender serving a bifurcated sentence, for a crime other than a Class B felony, and meets the following statutory requirements:

☐ I have an extraordinary health condition, as defined in § 302. 113 (9g) (a), and have attached two affidavits from physicians describing a current medical condition and diagnosis that an extraordinary health condition exists. At least one affidavit is from a physician currently treating the offender.

☐ I am 65 years of age or older and have served at least 5 years of the term of confinement, in prison, portion of the bifurcated sentence for a sentence imposed under §973.01 or have served at least 5 years in prison for a life sentence imposed under § 973.014 (1g) (a) or (2).

☐ I am 60 years of age or older and have served at least 10 years of the term of confinement, in prison, portion of the bifurcated sentence for a sentence imposed under §973.01 or have served at least 10 years in prison for a life sentence imposed under § 973.014 (1g) (a) or (2).

OFFENDER SIGNATURE	DATE SIGNED

FOR COMPLETION BY BOCM

☐ The petitioner does not meet the statutory requirements for modification of the bifurcated sentence.

☐ The petition packet is complete and the information above has been verified. The offender is statutorily eligible to petition.
A review has been scheduled for _____ .

OFFENDER CLASSIFICATION SPECIALIST SIGNATURE	DATE SIGNED

DISTRIBUTION: Original – Social Service File; Copy – DCC Agent; Copy - Offender

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-745 (Rev. 05/2013)

WISCONSIN
Wisconsin Statutes
Chapter 304
Administrative Code
PAC 1

RELEASE PLAN INFORMATION

INSTRUCTIONS TO SOCIAL WORKER:

Social Workers will provide this form to offenders who must complete it prior to being considered for any type of release from prison (i.e., all Parole Commission Interviews, Act 38 release considerations, or ES/MR).

TO	DOC NUMBER	FACILITY NAME	REENTRY ASSESSMENT DATE COMPLETED

HOUSING UNIT	SOCIAL WORKER NAME	AGENT NUMBER	ES DATE

TO BE COMPLETED BY OFFENDER (PLEASE PRINT ALL INFORMATION IN BLACK PEN)

In preparation for your forthcoming Parole Commission Interview and/or release, please fill out this form, which will help plan for your release. This information will be shared with your Social Worker, DCC Agent, and the Parole Commission (if applicable).

RETURN COMPLETED FORM TO THE SOCIAL WORKER NO LATER THAN

PROPOSED RESIDENCE PLAN

PRIMARY ADDRESS

PERSON'S NAME WITH WHOM YOU WILL LIVE	RELATIONSHIP TO YOU	IS THIS PERSON A VICTIM OF YOUR CRIME
		☐ Yes ☐ No

STREET ADDRESS	CITY	STATE	ZIP CODE

PRIMARY HOME PHONE NUMBER	PERSON'S CELL PHONE NUMBER	PERSON'S WORK PHONE NUMBER

ALTERNATE ADDRESS

PERSON'S NAME WITH WHOM YOU WILL LIVE	RELATIONSHIP TO YOU	IS THIS PERSON A VICTIM OF YOUR CRIME
		☐ Yes ☐ No

STREET ADDRESS	CITY	STATE	ZIP CODE

ALTERNATE HOME PHONE NUMBER	PERSON'S CELL PHONE NUMBER	PERSON'S WORK PHONE NUMBER

DO YOU NEED HOUSING ASSISTANCE	COUNTY OF YOUR RELEASE	CITY OF YOUR RELEASE
☐ Yes ☐ No		

EMPLOYMENT

WORK RELEASE

EMPLOYER NAME	YOUR JOB POSITION	YOUR PAY

SKILLS USED / LEARNED

HOW CAN YOU APPLY THESE SKILLS TO EMPLOYMENT IN THE COMMUNITY

INSTITUTION JOB(S)

LIST ALL JOBS

SKILLS USED / LEARNED

EMPLOYMENT UPON RELEASE

PROPOSED EMPLOYER NAME | PHONE NUMBER

STREET ADDRESS | CITY | STATE | ZIP CODE

FINANCIAL

REGULAR ACCOUNT AMOUNT	RELEASE ACCOUNT AMOUNT	SAVINGS ACCOUNT AMOUNT	RESTITUTION AMOUNT OWED	CHILD SUPPORT OWED
$	$	$	$	$

HAVE YOU RECEIVED SOCIAL SECURITY BENEFITS IN THE PAST

☐ Yes ☐ No If yes, list date(s):

ARE YOU ELIGIBLE FOR VETERANS' BENEFITS

☐ Yes ☐ No

HEALTH

DO YOU HAVE ANY CURRENT HEALTH ISSUES (medical, psychological, dental) THAT YOU BELIEVE NEEDS TO BE ADDRESSED IN YOUR RELEASE PLANNING? PLEASE DESCRIBE.

DO YOU HAVE MEDICAL APPLIANCES (wheelchair, artificial limbs, etc.) THAT NEED TO BE CONSIDERED IN YOUR RELEASE PLANNING? PLEASE DESCRIBE.

WHAT MEDICATIONS ARE YOU ON THAT YOU WILL NEED TO TAKE WITH YOU UPON RELEASE? (If you do not know, please check with health services.)

EDUCATION AND TREATMENT UPON RELEASE

EDUCATION / VOCATIONAL GOALS

DO YOU PLAN ON ATTENDING SCHOOL UPON RELEASE?

☐ Yes ☐ No If yes, where:

TREATMENT GOALS

ARE YOU INTERESTED IN ATTENDING TREATMENT PROGRAMS WHILE ON SUPERVISION?

☐ Yes ☐ No If yes, identify the type below:

☐ Anger Management ☐ AODA ☐ Domestic Violence ☐ Parenting/Family ☐ Sex Offender ☐ CGIP

☐ Other (list):

LIST LOCATION(S) OF SERVICE PROVIDER

TRANSPORTATION UPON RELEASE

IS SOMEONE PICKING YOU UP

☐ Yes ☐ No If yes, list their name:

DO YOU NEED A BUS TICKET

☐ Yes ☐ No

CLOTHING NEEDS UPON RELEASE

LIST NEEDED CLOTHES

VITAL DOCUMENTS / PROPER IDENTIFICATION

CHECK THE BOX(ES) FOR ALL DOCUMENTS THAT YOU HAVE

☐ Social Security Card ☐ Driver's License ☐ State Photo ID ☐ Birth Certificate

ADDITION INFORMATION

List other information you feel the Parole Commission or your DCC Agent should know about your institution programming, group participation, activities, individuals who may assist you when released, and alternate plans you may have, etc. **DO NOT ATTACH ANY DOCUMENTS TO THIS FORM.**

OFFENDER SIGNATURE	DATE SIGNED

SOCIAL WORKER STATEMENT

ADDRESS ISSUES OR CONCERNS REGARDING THE OFFENDER'S COMMENTS AND ANY CONDUCT REPORTS ACQUIRED SINCE LAST REVIEW

SOCIAL WORKER SIGNATURE	DATE SIGNED

DISTRIBUTION: Original – Social Service File, Left Side; Copy – DCC Agent via e-mail; Copy – Virtual Release Planning Folder; Copy - Offender

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-1163J (Rev. 8/2011)

WISCONSIN
Wisconsin Statutes
§ 302.113 (9g), 146.82 and 51.30
Federal Regulations
42 CFR Part 2 & 45 CFR Parts 160 & 164

AUTHORIZATION FOR DISCLOSURE OF DOCUMENTS RELATED TO PETITION TO MODIFY BIFURCATED SENTENCE

PRINT

OFFENDER NAME (Last, First)	DOC NUMBER	FACILITY NAME	
ADDRESS	**CITY**	**STATE**	**ZIP CODE**

STATEMENT OF AUTHORIZATION

By signing this form, I authorize the State of Wisconsin Department of Corrections to disclose a copy of the DOC-3612 Affidavit of Extraordinary Health Condition or equivalent affidavit, DOC-1208D Program Review Committee Action, ICCR200 Inmate Classification Report -Initial and ICCR204 Inmate Classification Report - Re-classification forms that contain protected health information to any or all of the following: sentencing court, District Attorney, my attorney, victims, and victim advocate from the DOC Office of Victim Services and Programs. Protected Health Information may include medical, dental, mental health and/or alcohol and drug abuse diagnostic/treatment information. This Authorization expires upon the termination of the proceedings under § 302.113 (9g), Wis. Stats.

I have read or had read to me this Authorization form. I have had an opportunity to ask questions. By signing this Authorization, I am confirming that it accurately reflects my wishes regarding disclosure of my protected health information included on various documents.

NOTICE OF LEGAL RIGHTS

Right to Receive Copy of This Authorization. I have a right to receive a copy of this Authorization after I sign it.

Right to Withdraw This Authorization. I have the right to revoke this Authorization at any time by completing a DOC-1163R Revocation of Authorization for Use/Disclosure of Protected Health Information (PHI). Revocation is effective when DOC receives the form, and is not effective regarding the uses/disclosures of PHI made prior to receipt of the DOC-1163R.

Re-disclosure. If a patient authorizes disclosure to an individual/agency not covered by laws that prohibit re-disclosure, the PHI may be re-disclosed by that individual/agency.

Right to Refuse to Sign This Authorization. DOC can not condition treatment or payment for treatment based on a patient's decision not to sign this form, except for research-related treatment and provision of health care solely for the purpose of creating PHI for disclosure to a third party.

SIGNATURE OF OFFENDER	DATE SIGNED

DISTRIBUTION: Original – Social Services File; Copy – Offender

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3612 (Rev. 8/2011)

WISCONSIN
Wisconsin Statutes
§ 302.113 (9g)

AFFIDAVIT OF EXTRAORDINARY HEALTH CONDITION

INSTRUCTIONS:

- A physician, licensed to practice in Wisconsin, shall complete and sign this Affidavit attesting to the fact that the named inmate patient is currently incarcerated in a Department of Corrections facility and has an *extraordinary health condition*, which is defined at Wis. Stats. § 302.113 (9g), as "a condition afflicting a person, such as advanced age, infirmity, or disability of the person or a need for medical treatment or services not available within a correctional institution."
- Physicians must sign this affidavit in the presence of a Notary Public.
- **See Guidelines on Next Page or Reverse Side**

PATIENT NAME (Last, First)	DOC NUMBER	DATE OF BIRTH	FACILITY NAME

I personally examined the above-named patient on: _____ .
Month Day Year

In my medical opinion, the above-named patient has an extraordinary health condition due to the reason(s) indicated below:

☐ **Advanced age**: years old and inability to care for oneself, see definitions on next/reverse side

☐ **Infirmity**: Describe medical conditions that have weakened the individual such that the person cannot care for oneself. See next page or reverse side for guidance.

☐ **Disability:** See next page or reverse side for definitions and conditions.

☐ **Need for medical treatment or services not available within a correctional facility**. Examples include need for an Alzheimer's unit or nursing assistant for activities of daily living. Explain below.

Note to physician: Sign only in the presence of a notary.

PHYSICIAN SIGNATURE	DATE SIGNED	PRINT NAME

NOTARY

State of Wisconsin
County of: _____

Subscribed and sworn to before me on: _____ .
Month Day Year

By:

_____
Name of Physician

_____
Signature of Notary Public

My commission ☐ Expires on _____
☐ is permanent

DISTRIBUTION: Original – Attach to Petition to Court. Copy - Medical Chart, Miscellaneous Section Copy - Patient

GUIDELINES FOR PHYSICIANS COMPLETING DOC-3612

"Infirmity" means a weakness, an abnormal, more or less disabling, condition of mind or body.

"Disability" means an impairment or defect of one or more organs or members.

Physicians must include symptoms, description of limitations in functioning, and prognosis.

The following list provides examples of extraordinary health conditions:

- Advanced age and problems with activities of daily living such that the person needs ongoing assistance with basic self care.such as feeding oneself, toileting, and personal hygiene.
- Significant cognitive problems due to Alzheimer's or other diseases that cause impairment in mental capacity. The person is unable to communicate coherently, cannot conduct their own self interests such as financial matters, or consistently recognize individuals they know.
- Significant/end of life medical conditions (e.g., heart disease, cancer, COPD) such that there is a strong likelihood the person will only live another 6-12 months or less.
- Quadriplegics with underlying medical problems.
- Medical condition is such that the individual's functioning is impaired enough to significantly restrict the individual's ability to do basic self care and activities of daily living (ADLs). The individual's overall activity is significantly impaired. Impairments of ADLs include but are not limited to the following: inability to feed oneself, inability to toilet or perform personal hygiene without assistance, inability to transfer from bed, chair or walk without assistance.