6.24.2020

To. Peg Swan

My name is Jose Soto-Guzman # 535929 I am an Inmate at Jackson Correctional Institution at Black River Falls maam.
My Reason For writeing this letter is concerning This covid-19 Pandmic maam I as you already Know I have my Family reach out To you and again I am writeing about some more issues about my Health condition maam when it come's To my meds and my C.O.P.d and me also Being DiaBetic.
There are time's I'm afraid To take my insulin cause of my Dose I am always Have To Take cause my DiaBetis is hard To control at time's maam. also we ask about these covid-19 test and I am told soon so I asked H.S.U about testing again I sent you this copy of what I was told why say they test some one when aint no testing Been done I am concerned For my self and many in here when will Something Be Done when it's to late my time here is Short But I also was not Sentenced To a Death Sentence maam.
we matter as any other person when it come's To covid-19 and or health maam.
I will like To set a Phone call To speak about my health and How Thing's Be Done here maam.

Thank you
Jose Soto-Guzman

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 8/2018)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Adm. Code
Ch. DOC 316

é NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY ⇦

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
[illegible]	Jose	[illegible]
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
[illegible]	[illegible]	5/21/2020

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following:

- The Department of Corrections shall charge a copayment of $7.50 for a visit (face to face contact) initiated by a patient when a copayment is required.
- I will not be denied care if I am unable to pay the copayment.
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required.
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE

▶ Jose [illegible]

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE | DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received.

☐ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)

☐ PSYCHIATRIST ☐ INFORMATION

☒ OTHER: I will like To Have a Covid-19 Test Done Please and I will like To Reveiw my Records Time [illegible]

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

DATE RECEIVED: TO BE STAMPED BY HSU

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☐ Nursing Sick Call: ☐ Today ☐ Date (if not today):

☐ Scheduled to be seen in HSU ☐ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other:

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other:

☐ Refer for copies only: ☐ Refer for Health Care Record review appointment.

☐ Educational material attached (Specify): ☐ Other:

COMMENT / INFORMATION

Everyone will eventually get tested. We have to wait our turn. But the whole institution will be mass tested.
Will forward for file Review

PRINT STAFF NAME

K [illegible] Ralle WCY

DATE OF HSU RESPONSE

5/21/2020

DISTRIBUTION: Original – Patient Request Folder; Official Record – Business Office File; Copies (2) – Inmate Patient