DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 2/2019)

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
Juarez	Henry	10009
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
Oshkosh	SBU ESI	9-1-2020

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- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.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

▶

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: Dr. peters / Dr. Lawie

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

I have called to postpone tylenol is not Helping the pains / aches, soreness is extreme in hips, legs, calfs, muscles, Im up at night cant sleep alot. the Nurse said she was notify you

DATE RECEIVED: TO BE STAMPED BY HSU
REC'D SEP 03 2020

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:

COMMENTS / INFORMATION Provider referral ordered.

PRINT STAFF NAME D. Henning RN

DATE OF HSU RESPONSE 9/3/2020

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

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 2/2019)

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
Zwirch	Harry	120034
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
GBCI	SCH ESL	9-4-2020

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 ▶

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: Dr. Peters / Dr. Lawie

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

I was told you'd be seeing me. I have covid 19 I'm in extreme pain Tylenol, Ibuprofen Don't help what: Hurt my Hips, legs calfs ankles feet, Abdomen Ribs temp 336

DATE RECEIVED: TO BE STAMPED BY HSU

REC'D SEP 06 2020

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:

COMMENTS / INFORMATION

appt pending w/ acp

PRINT STAFF NAME

S. Staeven RN

DATE OF HSU RESPONSE

9/6/20

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