Supervised Release

Individual Client Summary

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| **DEPARTMENT OF HEALTH SERVICES**Division of Care and Treatment ServicesF-02522 (10/2021) |  | **STATE OF WISCONSIN** |
| **SUPERVISED RELEASE** **INDIVIDUAL CLIENT SUMMARY** |
| Name – Client (Last, First, MI) | DHS Number | Staffing Date | Next Staffing Date |
| Client Name | DHS Number | Staffing Date | Enter Date |
| **INSTRUCTIONS**: Supervised Release Program contracted case managers are required to complete or update this form for every client on the Supervised Release Program. The form must be updated every six months, signed by the client and other team members, saved as an unchangeable format, and filed in the client file. |
| Client Community Re-Integration Team (CRT) Members |
| Staffing Attended By: | Title/Position |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Current CRT Members |
| Name – Case Manager | Start Date |
|  |  |
| Name – DOC Agent | Start Date |
|  |  |
| Name – Choose an item. | Start Date |
|  |  |
| Name – DHS Specialist | Start Date |
|  |  |
| **Past CRT Members with Dates in the Position** |
| Name | Position | Start Date | Finish Date |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |

| Community Supports (Auxiliary Team Members) |
| Entity | Name | Phone | Release of Information (ROI) | Date of ROI |
| DVR |  |  | Choose an item. |  |
| Street Address | City | State | Zip |
|  |  |  |  |
| Email Address |
|  |
|  |
| Entity | Name | Phone | Release of Information (ROI) | Date of ROI |
| Rep-Payee |  |  | Choose an item. |  |
| Street Address | City | State | Zip |
|  |  |  |  |
| Email Address |
|  |
|  |
| Entity | Name | Phone | Release of Information (ROI) | Date of ROI |
| Guardian |  |  | Choose an item. |  |
| Street Address | City | State | Zip |
|  |  |  |  |
| Email Address |
|  |
|  |
| Entity | Name | Phone | Release of Information (ROI) | Date of ROI |
|  |  |  | Choose an item. |  |
| Street Address | City | State | Zip |
|  |  |  |  |
| Email Address |
|  |
|  |
| Entity | Name | Phone | Release of Information (ROI) | Date of ROI |
|  |  |  | Choose an item. |  |
| Street Address | City | State | Zip |
|  |  |  |  |
| Email Address |
|  |
|  |
| Client Contacts Information |
| **Primary Emergency Contact Name** | Street Address | City | State | Zip |
|  |  |  |  |  |
| Phone | Relationship | Level | Status | Supervision | Date | Name – Approver |
|  |  | Select one. | Select one. | Select one. |  |  |
| Email Address |
|  |
| Notes: |
|  |
|  |
| **Secondary Emergency Contact** Name | Street Address | City | State | Zip |
|  |  |  |  |  |
| Phone | Relationship | Level | Status | Supervision | Date | Name – Approver |
|  |  | Select one. | Select one. | Select one. |  |  |
| Email Address |
|  |
| Notes: |
|  |
|  |
| Name | Street Address | City | State | Zip |
|  |  |  |  |  |
| Phone | Relationship | Level | Status | Supervision | Date | Name – Approver |
|  |  | Select one. | Select one. | Select one. |  |  |
| Email Address |
|  |
| Notes: |
|  |
|  |
| Name | Street Address | City | State | Zip |
|  |  |  |  |  |
| Phone | Relationship | Level | Status | Supervision | Date | Name – Approver |
|  |  | Select one. | Select one. | Select one. |  |  |
| Email Address |
|  |
| Notes: |
|  |
|  |
| Service Location and Activity Request Information Approved Service Location Information |
| Place | Street Address | City | State | Zip |
|  |  |  |  |  |
| Status | Date | Name – Approver | Email Address |
| Choose an item. |  |  |  |
| Notes: |
|  |
|  |
| Place | Street Address | City | State | Zip |
|  |  |  |  |  |
| Status | Date | Name – Approver | Email Address |
| Choose an item. |  |  |  |
| Notes: |
|  |
|  |
|  |
| Chronological Activity Request History **(oldest request first)** |
| Requests | Notes | Status | Date |
|  |  | Choose an item. |  |
| Requests | Notes | Status | Date |
|  |  | Choose an item. |  |
| Requests | Notes | Status | Date |
|  |  | Choose an item. |  |
| Requests | Notes | Status | Date |
|  |  | Choose an item. |  |
| Requests | Notes | Status | Date |
|  |  | Choose an item. |  |
| Client Details |
| Name | DHS Number | DOC Number | Date of Release |
| Client Name | DHS Number |  |  |
| Phone Number [ ]  Home [ ]  Cell | Phone Provider Name | DOC Supervision | Expiration Date |
|  |  | [ ] Yes [ ] No | Enter date or type N/A |
| Street Address | City | State | Zip |
|  |  |  |  |
| Bank Name | SSI/SSDI | How Much? | FoodShare | How Much? |
|  | Choose an item. |  | [ ]  Yes [ ]  No |  |
| Court Order Information |
| Is there a stipulation for when discharge can be petitioned? | Is there a search component to the SR order? |
| [ ]  Yes [ ]  No – Date: | [ ]  Yes [ ]  No – Details: |
| Court Order Notes: (Enter things of interest that are pertinent to make sure team members remember.) |
|  |
| Client Account Login Details |
|  | Login Name | Password | Reported to SORP |
| Cell Base Unit |  |  | NA |
| Email: |  |  |  | [ ] Yes [ ]  No  |
| Other:  |  |  |  | [ ] Yes [ ]  No |
| Other:  |  |  |  | [ ] Yes [ ]  No |
| Other:  |  |  |  | [ ] Yes [ ]  No |
|  |
| Vehicle Information |
| Make | Model | Vin # |
|  |  |  |
| Type | [ ]  2-door [ ]  4-door | Color | License Number |
|  | [ ]  Car [ ]  SUV [ ]  Truck [ ]  Van [ ]  Other (list): |  |  |
|  |
| Employment and Volunteer Information/History |
| Employer Name | Client Position Title | Employer Phone Number | Status |
|  |  |  | Choose an item. |
| Street Address | City | State | Zip |
|  |  |  |  |
|  |
| Employer Name | Client Position Title | Employer Phone Number | Status |
|  |  |  | Choose an item. |
| Street Address | City | State | Zip |
|  |  |  |  |
|  |
| Violation Summary |
| Date | Rule Number | Violation Description | Warning Type | Team Response |
|  |  |  | Choose an item. |  |
| Client Medical Information |
| Diagnosis | [ ]  DNR |
| Diagnosis Name | Status | Diagnosis Name | Status |
|  | Choose an item. |  | Choose an item. |
| Diagnosis Name | Status | Diagnosis Name | Status |
|  | Choose an item. |  | Choose an item. |
| Current Medication List **as of** Click here to enter a date. |
| [ ]  Client has a medication lockbox.[ ]  Client has signed lockbox access permission form. |
| Medication Name | Dose | Frequency/Times | Prescribing Doctor Name | Medication Purpose |
|  |  |  |  |  |
| Medication Name | Dose | Frequency/Times | Prescribing Doctor Name | Medication Purpose |
|  |  |  |  |  |
| Medication Name | Dose | Frequency/Times | Prescribing Doctor Name | Medication Purpose |
|  |  |  |  |  |
| Medication Allergies |
|  |
| Food Allergies |
|  |
| Pharmacy Information |
| Pharmacy Name | Street Address | City | State | Zip |
|  |  |  |  |  |
| Phone Number | Signed Release of Information  | Date |
|  | [ ]  Yes |  |
| Medical Equipment **(Check all that apply)** |
| [ ]  Glasses[ ]  Hearing Aids[ ]  Dentures Upper[ ]  Dentures Lower | [ ]  Dentures Partial[ ]  CPAP[ ]  Oxygen Equipment[ ]  Wheel Chair | [ ]  Walker[ ]  Cane[ ]  Shower Chair/Bench[ ]  Glucometer |
| [ ]  Other: |  |
| Medical Providers |
| Doctor Name | Street Address | City | State | Zip |
|  |  |  |  |  |
| Facility Name | Specialty | Release of Information (ROI) | Date of ROI |
|  |  | Choose an item. |  |
|  |
| Doctor Name | Street Address | City | State | Zip |
|  |  |  |  |  |
| Facility Name | Specialty | Release of Information (ROI) | Date of ROI |
|  |  | Choose an item. |  |
|  |
| Client Progress Summaries |
| Below you will find summaries in regards to this client’s current progress in treatment and supervision. This client does have a Case Management plan to assist the client with their transition to the community as well as (check all that apply):[ ] None [ ] Behavioral Support Plan (BSP) [ ]  SRSTC ATR [ ]  Community ATR [ ]  Treatment Plan Adjustment (TPA) |
| [ ]  Other:  |
| DOC Agent Update Summary |
| Agent update on supervision goals and progress:  |
|  |
| Case Manager Update Summary |
| Case Manager Plan updated for staffing: [ ]  Yes [ ]  No |
| Case Manager update on goals and progress:  |
|  |
| Sex Offender Treatment Update Summary |
| Summary of risk factors: |
|  |
| Client Risk and Responsivity (RNR) Summary |
|  |
| Summary of protective factors: |
|  |
| SOT update on treatment goals and progress:  |
|  |
| Supportive Living Services Update Summary  |
| SLS Care Plan updated for staffing: [ ]  Yes [ ]  No |
| Does the client currently receive supportive living services? [ ]  Yes [ ]  No |
| If no, is a referral for an assessment needed at this time? [ ]  Yes [ ]  No |
| If yes, what services are being provided? |
| [ ]  Medication Management[ ]  Medical Management[ ]  Financial Management[ ]  Grocery Shopping Assistance | [ ]  Hygiene[ ]  Environment[ ]  Cooking Meal Prep | [ ]  Other:  |
| Approved hours per week: Click here to enter hours. |
| Weekly Schedule |
| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| SLS update on goals and progress: |
|  |
| Case Plan SIGNATURE Page |
| Below are the signatures of the Community Re-Integration team and the client. By signing, the team and the client are agreeing that they have reviewed this Case Plan and that it summarizes the current progress of the client and the goals set within are appropriate. By signing, the client is agreeing that they will work towards these goals and be open to feedback and coaching by the team to help them achieve these goals. |
| **SIGNATURES** – Attendees |
| Team Role | Print Name | **SIGNATURE** | Date Signed |
| Client |  |  |  |
| Case Manager |  |  |  |
| DOC Agent |  |  |  |
| Choose an item. |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |