DAUPHIN COUNTY
PENNSYLVANIA
WORK RELEASE
Matthew A. Miller, Director
919 Gibson Blvd. Steelton, Pa. 17113
Phone: 780-7002 Fax: 558-9672

Out of County – Direct Commitment Instructions

Step One: Complete the attached Direct Commitment Application Form and return it to the Work Release Coordinator via fax (717-558-9672) or email to jcoleman-cobb@dauphinc.org as soon as possible or **at least 1 month prior to your sentencing date.**

Step Two: Once the defendant receives pre-approval their attorney needs to contact the Work Release Coordinator, Jennifer Coleman-Cobb to get the Order of the Court for Out of County Direct Commitments. This is a court order that needs to be signed "as is" by the sentencing Judge at the time of sentencing. If this order is not signed by the Judge as directed, the Dauphin County Work Release Center reserves the right to deny the defendant's transfer at any time. **Please Note: The defendant's report date MUST be on a Tuesday or Thursday and they MUST report to the Work Release Center by 9 am. The report date MUST be at least two weeks after the date of sentencing (to allow the Wardens of both counties and the Director of Work Release to authorize the transfer and complete the necessary transfer paperwork).**

Step Three: The defendant must complete a physical, to include a TB/PPD (Tuberculosis) Test, within 90 days prior to their commitment date. They must have their physician complete the attached Health Assessment Form and return it to the Work Release Coordinator via fax (717-558-9672) or email jcoleman-cobb@dauphinc.org as soon as possible or at least two weeks prior to their commitment date. The health assessment can be completed at your primary care physician or an authorized health care provider such as:

Concentra		Worknet	
4200 Union Deposit Rd	4910 Ritter Road	6301 Grayson Road	6108 Carlisle Pike
Harrisburg PA 17111	Mechanicsburg PA 17055	Harrisburg PA 17111	Mechanicsburg PA 17055
717-558-6708	717-795-1819	717-920-5910	717-691-9560
Cost: $37.50 TB Test/ $79.50 Physical (as of 09/2015)		**Cost** $15.00 TB Test/ $75.00 Physical (as of 09/2015)	
Hours: Mon – Fri 8a-8p, Weekends 9a-3p (HBG OFFICE)		Hours: Mon – Fri 8a-5p	

Step Four: Once the defendant is sentenced and given a date to self report they MUST contact the Work Release Coordinator, Jennifer Coleman-Cobb at 717-780-6976 or jcoleman-cobb@dauphinc.org (the defendant should call the same day they are sentenced). **ALL** paperwork to include the sentencing County's order, Dauphin County Transfer Order, and the defendants completed Health Assessment need to be forwarded to the Work Release Coordinator, at least two weeks prior to your report date.

What the defendant can/can not bring on their report date: a maximum of 5 changes of clothes, 3 pairs of shoes, toiletries (new & unopened), and a one week supply of groceries. You **CAN NOT** bring any beverages (powdered mixed or liquid) or products containing alcohol (mouthwash, cologne, & cough syrup). Narcotics prescribed by your doctor are not permitted to be taken at any time while in the Work Release Center. Bring no more than $50 in cash. Cell phones and tobacco products of any kind are strictly prohibited on Work Release property.

The defendant must report with a Security Deposit of $500 *(subject to change at any time)* to the gate of the Work Release Center at **9:00 am**. Upon arrival you will undergo an orientation process and you should inform your employer that you may not be able to attend work until the next business day. **Failure to report as directed or reporting under the influence of alcohol/drugs will result in your commitment to Dauphin County Prison pending transfer back to your sentencing county.**

If you have any further questions please contact the Work Release Coordinator, Jennifer at 717-780-6976.

Dauphin County Work Release Center

Direct Commitment Application

Out of County Cases

Defendant's Full Name: _____ Sex: ☐ Male ☐ Female

Defendants Home Phone: (____) _____-_____ **Cell Phone:** (____) _____-_____

Defendant's Address: _____ Apt. #_____

City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Date of Sentencing _____/_____/_____ **Commitment/Report Date** _____/_____/_____

Sentencing County: _____ Sentencing Judge: _____

Docket Number/Charge/Sentence: _____

Has the Judge Ordered any special conditions for Work Release Participation? ☐ Yes ☐ No

(If Yes, please supply those conditions): _____

Attorney Name: _____ Phone Number: (____) _____-_____

Employer Name: _____ **Job Title:** _____

Employer Address: _____ City: _____ State: ___ Zip: _____

Employer Phone Number: (_____) _____-_____ Ext. _____

Supervisor's Name/ Job Title: _____

Is Employer a Family Member: ☐ Yes ☐ No (If Yes, relationship): _____ Is Defendant the OWNER: ☐ Yes ☐ No

Rate of Pay: $_____ ☐ Per Hour ☐ Per Week ☐ Bi-Weekly ☐ Salary & Length of Employment: _____

Transportation to Employment: _____

Detailed Reason Requesting Transfer to Dauphin County: _____

_____

Were you ever in Work Release: ☐ Yes ☐ No (If Yes, When & Reason): _____

Are you current on Probation/Parole: ☐ Yes ☐ No (If Yes, County & why): _____

Below to be completed by Dauphin County Work Release Staff ONLY

Received Application on: _____ WR APPROVED by Warden on: _____ & Director on: _____

WR DENIED on: _____, Reason: _____

WRC –
DCP –
APO –

NCIC –
PORTAL –
WARRANTS –

DAUPHIN COUNTY WORK RELEASE CENTER

HEALTH ASSESSMENT FORM

NOTE: This form must be completed only by a licensed medical provider and must be placed in a sealed envelope addressed "ATTENTION MEDICAL PROVIDER"

Date of Assessment: _____

Patient Name: _____

Date of Birth: _____ **SSN:** _____

Insurance Information

Name of Health Insurance Co. _____ Policy#: _____

Group No: _____ Are Referrals Needed for Care: Yes_____ No_____

MEDICAL HISTORY AND PHYSICAL EXAM

Review of System – **Indicate problem in comment section:**

Y	N	System	Comment	Y	N	System	Comment
		Headache				Anemia	
		Seizures				Bleeding	
		Blackouts				Bruising	
		DT's				Arthritis	
		Skin				Gout	
		Hearing				Back Pain	
		Ears				Kidney/bladder	
		Vertigo				Gonorrhea	
		Vision				Chlamydia	
		Speech				Syphilis	
		Dental				Herpes	
		Chewing Problem				Crabs/Lice	
		Swallowing				HIV/AIDS	
		Joint Problems				Prostate	
		Muscle				Hernia	
		Ulcers				**Breast**	
		Gallbladder				**Vaginal Discharge**	
		Hepatitis & Type				**Menarche Age**	
		Hemorrhoids				**LMP / Duration**	
		Thyroid				**Cycle / Flow**	
		Diabetes				**Pregnancies**	**G:** **P:**
		Allergies				**Miscarriages/Abortions**	
		Hay Fever				**Pregnancy Complications**	
		Asthma				**Mammogram Date:**	
		Pneumonia				**Contraceptive Use/Type**	
		Heart Disease				**UTI / Pelvic Infections**	
		Hypertension				**Pregnant Now?**	
		Edema Swelling				**Pregnant Test?**	(+) (-)

Any other known/chronic conditions not listed above:

_____

_____

Tuberculosis Testing:

Previous Testing: Yes: _____ No: _____ Results: _____mm

Past Positives: Date: _____ Location: _____ (***Past Positives MUST be verified***)

Date PPD Planted	Nurses Initials	Date Read	Nurses Initials	Reaction 10mm or > = CXR	CXR Date	Results of CXR
				MM		

Immunizations with Date of Last Vaccine/Dose:

Tetanus: _____ Hepatitis B: _____ Rubella: _____

Pneumovax: _____ Flu: _____ (Other: _____ Date: _____)

Vital Signs at Time of Assessment:

Blood Pressure: _____ Temperature: _____ Pulse: _____

Respiration: _____ Height: _____ Weight: _____

Any Psychiatric, Mental Health and/or Intellectual Disabilities Concerns: Yes ☐ No ☐

If Yes, explain: _____

Currently on any medication: Yes ☐ No ☐ If yes, name of medication and dosage: _____

_____

Physical: Mark "N" if normal and "A" if abnormal in the box in front of the appropriate area and explain abnormalities.

		(Comments)			(Comments)
	Alert, oriented, co-op			Upper Ext.	
	Head, Scalp, face			Pulses	
	Eyes (EOMI, PERRLA)			Spine	
	Eyes (Sclera, Trauma)			Lower Ext.	
	Ears			Feet	
	Nose Lips, Gums, Teeth			GU System	
	Neck (masses, supple)			Lymph	
	Thorax			Skin	
	Lungs			Gait Balanced	
	Heart			HEARING	AD: AS: AU:
	Abdomen (GI)			VISION	OD: OS: OU:

Comments: _____

_____

Currently on any medication: Yes ☐ No ☐ If yes, name of medication and dosage: _____

_____

Any scheduled or recommended follow-up care or treatment: Yes ☐ No ☐

If Yes: Where: _____ Date: _____ Time: _____

Provider Name (*Printed*): _____ **License #:** _____

Signature: _____ **Specialty:** _____

Primary Care Physician: _____ Telephone: _____

Address: _____