MANITOWOC COUNTY SHERIFF

Sheriff - Daniel L. Hartwig
Chief Deputy - Brian L. Nack

In Partnership with the Community. Dedicated to Your Safety.

Manitowoc County Electronic Monitoring Application

Huber Sergeant email: AmyMatthias@manitowoccountywi.gov Telephone: (920) 683-4945

Last Name: _____ First: _____ Middle: _____ DOB: _____

Manitowoc County residential address: (to include Apt# and Zip Code):_____

_____

- How long have I lived at the above location: _____ ☐ Rent ☐ Own
- Landline Phone Number_____
- Cell Phone Number_____
- Internet: YES NO
- Email: _____

List all the person(s) living with me (including shared custody children):

Name: Last, First, Middle: DOB: Relationship:

_____

_____

_____

_____

List (2) Emergency Contacts in event we cannot reach you:

1. Name: _____ Number: _____Relation: _____
2. Name: _____ Number: _____Relation: _____

Do you have any disabilities or special medical conditions? YES NO If "Yes" Explain:

_____

_____

Are you currently taking prescribed medication(s)? YES NO Names of Medication(s):

_____

_____

Any special family circumstances we should know about? YES NO If "Yes" Explain:

_____

_____

List any pets in the home (name, breed & size) _____

_____

List ALL Weapon(s) kept in the home:

_____

_____

Are you looking to transfer? ☐ YES ☐ NO

FROM: _____ TO: _____

Although a transfer maybe authorized by the court, both participating counties must approve before it is considered.

Appointments requesting outside of work: (this in no way guarantees approval of said appointments)

A	D	☐ Probation & Parole Appointment(s) Regularly scheduled appointment times: _____
A	D	☐ Treatment Program(s) Scheduled Appointment(s): _____ Type of Treatment Program: _____ Name & Location of Program: _____ Name & Contact# of Leader: _____
A	D	☐ Counseling Session(s) Scheduled Appointment(s): _____ Type of Counseling: _____ Name & Location of Facility: _____ Name & Contact# of Counselor: _____
A	D	☐ Medical Appointment(s) Scheduled Appointment(s): _____ Name & Location of Facility: _____ Name & Contact# of Physician: _____
A	D	☐ Laundry Laundry Facility Name & Location: _____ Day & Time requesting: _____
A	D	☐ Yard Work Day & Time requesting: _____
A	D	☐ Shopping Store & Location: _____ Day & Time requesting: _____
A	D	☐ Child Care (child(ren) information should be included in this application) Day & Time requesting: _____
A	D	☐ Banking Day & Time requesting: _____
A	D	☐ Church Service(s) Day & Time requesting: _____
A	D	☐ Other: _____ _____ _____ _____

SHERIFF OFFICE USE ONLY

APPROVED OR DENIED REQUESTS

Additional jail related information is located on our jail website at **manitowoccountywi.gov/jail**

Employment Information

Temp Agency employed through (if any) _____

Complete Address of Temp Agency: (to include Apt# and Zip Code)

_____

_____

Temp Agency Telephone# _____ Fax# _____

Name of Employer: _____

Position: _____ Length of Employment: _____

(Self-Employment Requires Proof: Injury Accident Insurance, Fed. Tax Number, WI Seller's Permit)

Complete Address of Employment: (to include Apt# and Zip Code)

_____

_____

Telephone Number: _____ Fax #: _____

Supervisor's Name: _____ Extension: _____

Supervisor's Email: _____

Does Your Supervisor Work on Site With You? YES NO

Does Your Employment Take You Outside of Manitowoc County? YES NO If "Yes" Explain

_____

Do I Have Childcare Privileges? YES NO

Will I Have Transportation That Meets Huber Requirements? YES NO

(i.e. Valid Driver, Vehicle Registration, Valid Insurance, Interlock System (if court ordered), etc.)

PERSON TRANSPORTING:_____

ADDRESS: _____

PHONE#: _____

DESCRIPTION OF VEHICLE: _____

LICENSE PLATE #: _____

INSURANCE COMPANY/EXPIRATION DATE: _____

PERSON TRANSPORTING:_____

ADDRESS: _____

PHONE#: _____

DESCRIPTION OF VEHICLE: _____

LICENSE PLATE #: _____

INSURANCE COMPANY/EXPIRATION DATE: _____

☐ Copies of the above transportation was received & approved by _____

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INMATE NAME: _____ TODAY'S DATE: _____

EMPLOYER Name & Address: _____

SUPERVISOR'S Printed Name: _____ Phone Number: _____

SUPERVISOR'S Email Address: _____

TEMP AGENCY Name: _____ Phone Number: _____

WORK ☐ **CHILDCARE** ☐ **OTHER** ☐ _____ **MONTH OF** _____

DAY OF MONTH	TIMES SCHEDULED TO WORK	DAY OF MONTH	TIMES SCHEDULED TO WORK
1		16	
2		17	
3		18	
4		19	
5		20	
6		21	
7		22	
8		23	
9		24	
10		25	
11		26	
12		27	
13		28	
14		29	
15		30	
		31	

If you have any questions or changes to the schedule, please call the Manitowoc County Jail Huber Division at 920-683-4944 or fax to 920-683-5169

Staff Use: Events scheduled by: _____

Criminal Information

What is/are my Current Charge(s)?

_____

_____

When did or does my sentence start? _____

Do I have any charges pending? YES NO If "Yes" Explain

_____

_____

Am I currently on Probation/Parole? YES NO If "Yes" Explain

Agent's Name: _____

List Charge(s) I am on Probation for?

_____

_____

Have I ever been convicted of a Domestic Violence Offense? YES NO If "Yes" Explain

Date of the Offense: _____

Do I currently live with the victim? YES NO

Have I ever been convicted of any Illegal Substance Charges? YES NO If "Yes" Explain

_____

_____

Are there any current/past Restraining Orders/Injunctions against me? YES NO If "Yes" Explain

_____

_____

Why should I be considered for the Electronic Monitoring Program?

_____

_____

_____

_____

_____

- ☐ I agree that the information provided on the application is true and accurate.
- ☐ Any false/misleading information may disqualify me from EMP & may result in disciplinary actions.
- ☐ Completion of this application **does not** guarantee my acceptance on this EM Program.

Inmate Signature: _____ Date: _____

EMP Officer Signature: _____ Date: _____

ELECTRONIC MONITORING INMATE RULES

Initial Below:

_____ 1. I understand EMP is an extension of the jail & participants are still Manitowoc County inmates.
_____ 2. I agree to reside in Manitowoc County at the approved residence on my application.
_____ 3. I will not change my address, or allow anyone to move into my residence without prior approval of EMP staff.
_____ 4. WCS & Manitowoc County Jail must always have a way to contact you. I agree to have a working cell phone with an activated voicemail. I, also, will not change my phone number without prior approval of EMP staff.
_____ 5. I may not have contact with, walk with, or visit with unauthorized people while away from home or have visitors at my home.
_____ 6. I will not inappropriately use emails, text, or video visitation while on this program.
_____ 7. I agree to submit my person, property, place of residence, vehicle, and any other belongings to search at any time, to include locker, etc., at my place of employment when requested by any Law Enforcement Officer or Manitowoc County Jail Staff. This includes entering my residence at any time, to inspect equipment and/or to see if I am complying with the rules of the program.
_____ 8. If I have any type of police contact (besides EMP officer), it is my responsibility to let the officer know I am a Manitowoc County EMP inmate. You must contact the jail at (920)683-4338 immediately, to leave a message for the Huber Sergeant with the nature of the police contact & the result of the contact (accident, citation, etc)
_____ 9. I will not communicate false information.
_____ 10. I agree to comply with all federal, state, local laws, and ordinances.
_____ 11. I understand that I cannot possess or use (consume, ingest, or take into my body) any drugs (legal or illegal).
_____ 12. I will keep EMP staff current (from my physician) any and all medications prescribed to me. Any further medication changes will need to be faxed/emailed to WCS staff by my physician immediately.
_____ 13. I will not use any non-prescription drugs containing alcohol or mood altering substances. This includes, but is not limited to, mouthwashes, cold/cough medications, etc.
_____ 14. I will comply with submitting random and scheduled drug and alcohol screenings at my expense.
_____ 15. I will call the Random Drug Test Line daily & report timely to complete test.
_____ 16. I understand that the EMP officer or Jail Sergeant may order me to the Manitowoc County jail at any time to submit the above screenings. Failure to report will result in immediate suspension from the program.
_____ 17. I will report for weekly drug screenings at the Manitowoc County Jail on Wednesday mornings between the hours of 8 a.m. and 10 a.m. for my **scheduled** screen time. If I cannot make my scheduled appointment, I will prearrange a time with the WCS staff & Manitowoc County Jail for my weekly screening. Approved transportation to/from these appointments are the inmates' responsibility.
_____ 18. I understand that I must inform the WCS staff & jail staff immediately of **any** changes in my work/ school schedule including but not limited to: illness, emergency, termination, or layoffs. Any changes or modifications of hours and/or days must be reported to WCS by my employer, school staff, etc., prior to that change being made. *I will need to fill out a Huber Work Site Log form if my place of employment varies. This form must be filled out prior to being scheduled workday.*
_____ 19. I understand that if I choose to change my work hours prior to WCS staff approval, I am subject to disciplinary action.
_____ 20. I may not deviate from my assigned route, stop at any unauthorized location (restaurant, gas station, etc), change my method of transportation, or leave my authorized destination without prior consent from jail staff.
_____ 21. I will not enter areas defined as off-limits, restricted, or areas identified as exclusion zones.
_____ 22. I understand that the Manitowoc County Jail is not responsible to provide me with food, clothing, shelter, medical, mental health or dental needs while I participate on the program.
_____ 23. I also understand that if the electricity is turned off in my residence (for any reason), I will notify WCS staff immediately.
_____ 24. I agree all monies I receive while an inmate of the county jail shall be sent or presented to the jail staff for distribution according to Wisconsin Statue 303.08, unless other approved arrangements are made. I agree to keep current with my payment agreement.

_____ 25. All scheduled time out **MUST** be preauthorized. I am allowed out a max of 72 hours per week to include my travel time. The maximum time out in any one day is 12 hours. Any variations to this rule must be preauthorized by the Manitowoc County Jail.

_____ 26. I understand I am allowed out 6 days in a row and under the 72 hour total. After 6 days out I must remain in my residence for one complete day.

_____ 27. I agree to request a preauthorized stop/appointment at least 72 hours (3 days) in advance of stop/appointment [bank, grocery shopping (if living alone)] unless it is an emergency situation.

_____ 28. I am subject to a body scan at any time I am asked to return to jail unless confined to a wheelchair or confirmed pregnant. It is my responsibility to notify staff or HSU if I believe I am pregnant before scan.

_____ 29. I have read, understand & agree to the tri-fold documents attached to this application (these 2 documents are to be kept for your reference)

****MANITOWOC COUNTY JAIL & WCS EMP RULES AND REGULATIONS****

FAILURE TO COMPLY WITH THE FOLLOWING RULES WILL RESULT IN REMOVAL FROM THE PROGRAM AND YOU WILL BE RETURNED TO JAIL. RULE VIOLATIONS MAY ALSO RESULT IN LOSS OF HUBER, ADDITIONAL CRIMINAL CHARGES, OR LOSS OF GOOD TIME!

Inmate Signature: _____ Date: _____

EMP Officer Signature: _____ Date: _____

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Huber Report-In / Medical Pre-Booking Information

Last Name:_____ First Name:_____ Middle Name:_____

DOB: ___/___/___ Report in Date:___/___/____ Phone #_____

Sentence Length:_____

Have you been in the Manitowoc County Jail in the last two years? Yes or No (circle one)

Primary Doctor: _____ Clinic: _____ Phone #: _____

State current medical diagnosis:

_____
_____
_____
_____
_____
_____

Do you have any allergies to Medication or Food? Yes or No (circle one)

Remarks if Yes_____

_____

List Current prescribed medications you are taking.

Medication Name	Strength	Dosage Instructions	Prescribed By.

Confidential information release authorization form attached Yes or No (circle one)

Information received by _____ Date_____

MANITOWOC COUNTY SHERIFF'S OFFICE

CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION

****COMPLETE**Individual Who Is Subject of Record:**

Name: _____

Address: _____

City, State, Zip Code: _____

Date of Birth: _____

Identifying Number: _____

Information May Be Released To:

Manitowoc County Sheriff's Office
Jail Health Services Unit
1025 South 9th Street
Manitowoc, WI 54220
Telephone: (920) 683-4340
Fax: (920) 683-4405

(Wisconsin Statutes Section 19.35 & 19.36 Federal Regulation 42 CFR Part 2)

****COMPLETE**Agency or Organization being Authorized to Release Information**

Name of Physician/ Agency : _____

Address: _____

City, State, Zip Code: _____

Telephone: _____

List Specific Records Authorized For Release to include dates, if applicable

Date of Visit: _____

Record, to include notes: _____

_____

Date of Visit: _____

Record, to include notes: _____

_____

Date of Visit: _____

Record, to include notes: _____

_____

PURPOSE OR NEED FOR RELEASE OF INFORMATION IS CONTINUATION OF CARE

I understand that I may revoke this authorization, in writing, at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration time I have indicated by initialing below. **(Initial & Sign Below)**

_____ Authorization expires as of _____. (Date)

(Initial)_____ Authorization expires 12 months from the date I sign this authorization.

_____ Authorization expires after the following action takes place: _____.

_____ Authorization expires upon change in custody status.

As evidenced by my signature below, I hereby authorize disclosure of records to the person(s) or agency(s) as specified above.

Signature of Individual who is Subject of Record: **(X)** _____ Date: _____

Signature of Other Person Legally Authorized to Consent to Disclosure: _____

Title or Relationship to Individual who is Subject of Record: _____ Date: _____

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FINANCIALS FOR

Name: _____

Address: _____

_____

Telephone (day): _____

Telephone (evening): _____

Telephone (cell): _____

Date of Birth: _____ Age: _____

Social Security #: _____

Marital Status: _____

Name of Spouse: _____

Number of Children/Dependents (& ages): _____

_____

EMPLOYMENT

I am currently employed: YES NO

If yes, Name of Employer: _____

Job Title: _____

If no, Name of last Employer: _____

Last day worked: _____

BENEFITS

I currently receive:

- ☐ Food Share/ Stamps
- ☐ Supplemental Security Income
- ☐ Legal Representation based to indigency
- ☐ Medical Assistance
- ☐ Relief funded under Wis. Stat. 59.53 (21)
- ☐ Relief funded under public assistance
- ☐ Veterans Benefits under Wis. Stat. 45.351 (1)
- ☐ Veterans Benefits under 38 USC 501-503
- ☐ Other means-tested public assistance:

  _____

My financial situation ☐ has ☐ has not changed since I became eligible for the program(s) checked above.

MONTHLY GROSS INCOME

Employment (salary, wages, bonus, tips) $ _____

Pensions/Retirement $ _____

Social Security/Disability $ _____

Unemployment Benefits $ _____

Child Support/Maintenance $ _____

Other Income: _____ $ _____

ASSETS

House- Value $ _____

Vehicle(s) - Value (Cars, Motorcycles,

Snowmobiles, RV, boats, etc) $ _____

Cash $ _____

Checking Account(s) $ _____

Savings Account(s) $ _____

Other Assets: _____ $ _____

EXPENSES

Do you:	Amount of expense:
☐ Rent	$ _____
☐ Own a home	$ _____
☐ Have Cable/satellite TV	$ _____
☐ Have a cell phone	$ _____
☐ Have internet service	$ _____
☐ Drink alcohol	$ _____
☐ Smoke	$ _____

I certify that the information provided is true. I understand a background investigation may be conducted. I authorize my employer and creditors release information to the Manitowoc County Sheriff's Office. I understand that as a prisoner in a jail, I shall cooperate with the county in seeking reimbursement for expenses incurred by the county while I am a prisoner. Failing to cooperate or intentionally refusing to cooperate may result in **not earning good time credit under Wis. Stat. 302.43.**

Signature _____ **Date** _____