

020-40M700 <H-ZC3300 <H-ZC00 0FFMS

Take home, read, fill out and bring back with you to your intake appointment.

Attached to this is a letter - please take the letter to your employer. Have them read and sign it. Bring the signed letter to your intake appointment.

**HOME DETENTION / ELECTRONIC MONITORING
CONTRACT**

WELLS COUNTY COMMUNITY CORRECTIONS

Home Detention/Electronic Monitoring Program Admittance

Guidelines

In order to qualify for admittance into the Home Detention/Electronic Monitoring program ***(hereinafter referred to as Home Detention/EM)***, you must meet certain guidelines for admission as follows:

- Must be reviewed by the Program Director for any violent or sex offender conviction before being placed on the program.
- Must have secure full-time employment. If not employed, we can work with offenders to gain employment.
- The employer of any offender on the program may be contacted and the offender may be checked on while at work.
- Must have transportation to and from check-ins.
- Must have installation fee and the first week's monitoring fee paid prior to installation of the monitoring equipment or as per sentencing court guidelines.
- Must have cell phone contact so that you can be reached.
- **All fees must be paid before an offender completes the program. If not paid in full upon completion, your probation may be revoked for failure to pay court cost, fines and/or fees.**

TO: Home Detention/Electronic Monitoring Applicant

FROM: Wells County Community Corrections Executive Director

The Wells County Home Detention/Electronic Monitoring Program, ***(hereinafter referred to as Home Detention/EM)***, was implemented in November 1990. The purpose of the program is to provide appropriate offenders the ability to maintain employment, while executing a sentence at home, which was imposed by the Court.

You should understand in advance that if you are admitted to the program, **you are still an inmate under the custody and control of the Wells County Community Corrections Department.** Failure to follow the rules of the program will result in your termination and referral back to the referring agency for further proceedings. The Court determines your release date. No early release will be approved by Wells County Community Corrections. Only a Court order will cause an early release. Do not ask the staff or the director to change your release date. They are not authorized to do so.

The Community Corrections Director expects you to cooperate fully with the staff members, as well as others, and to report to all required check-ins.

If you are accepted into the program, be prepared to give your very best effort. If you have any doubts about your intentions to do your best, you should not fill out the application.

Sincerely,

Blake Poindexter,
Executive Director

WELLS COUNTY COMMUNITY CORRECTIONS

General Rules and Regulations

Home Detention/Electronic Monitoring program (*hereinafter referred to as Home Detention/EM*) is a privilege. Participants are offenders serving a sentence in a special arrangement. Failure to observe the rules strictly may result in termination. If, in the judgment of the Community Corrections Officer, there is reason to believe a violation has occurred, participants will be terminated from the program and returned to the referring agency or returned to Court for a hearing.

PLEASE INITIAL ON THE LINE IN 'RED' AFTER YOU HAVE READ EACH RULE.

1. Electronic Monitoring Equipment:

An electronic GPS monitoring transmitter will be installed on your person so that your activities outside the home can be monitored. A daily fee of **\$14.50** will be charged for the use of the transmitter and **all** fees are to be paid prior to your release. This fee is subject to change at any time. You will be responsible for the care of your unit. If it is damaged, you will reimburse Wells County Community Corrections anywhere from **\$500.00** to **\$3,500.00** for the cost of the unit. Tampering with or destroying your monitoring equipment will result in termination from the program and a charge of Criminal Mischief.

CVBR (Cellular Video Breathalyzer Unit): If you fail to verify identification either visually or biometric measures (No obstructions) this will be considered a violation of the Home Detention Court order rule #8 (Pretrial) and #8 (Executed Home Detention Court Order). (You shall maintain all monitoring equipment as specified by the Community Corrections department supervising your Home Detention and comply with all rules and requirements of that agency.)

GPS: I understand I shall maintain charging of device as per Community Corrections Standards.

Participant Initials: _____

2. Financial:

Home Detention/EM charges shall be paid by money order or cashiers check made payable to the Wells County Community Corrections Office. We also take MasterCard/Visa for payments. There is a fee for this option.

There is a one-time installation fee of **\$50.00** along with a monitoring fee of **\$14.50** per day, which is subject to change at any time. Drug test are **\$25.00**. If an oral test is given instead of a urine test, the charge will be **\$45.00**. All fees are to be paid prior to your release from this Department.

WE WILL NOT BE YOUR CREDIT AGENCY!! THESE FEES ARE CONSIDERED THE SAME AS YOUR COURT COSTS AND FINES. FAILURE TO MAKE PAYMENTS AS ORDERED WILL RESULT IN A VIOLATION FILING.

You will have an intake appointment at the Wells County Community Corrections office. At that time, you must have a payment of **\$278.00** or **\$510.00** depending on the court, which is for installation and the first few weeks of fees or as described per your court order. At the next check in you will be expected to make **\$101.50** payment each week following intake.

If ordered by court to have a financial assessment done offender may be eligible for financial fee assistance.

Delinquent balances will be turned over to AAA Collections, our contracted Collection agency. If you are on probation or direct commit this will be considered a violation of the court order and you may face further revocation proceedings.

Participant Initials:_____

3. Medical:

You will be financially responsible for any medications, medical care, including dental care, while on the program. Medical appointments shall be arranged in advance with the Community Corrections Officer.

Over-the-counter medicines, as well as prescribed medications, shall be checked in with the Community Corrections Officer at intake and every check in thereafter. You will not be allowed to have in your possession an over-the-counter medication, nor prescribed medication, without the consent of the Staff of Community Correction. Any prescription medication found in your possession, without prior staff approval and that has not been reported, shall result in a referral back to the referring agency.

Any new prescriptions upon receiving from physician, you are to immediately inform Wells County Community Corrections at **(260) 824-6411**. At the direction of the staff it will be arranged for you to bring in the bottle and/or a copy of the prescription.

ALL MEDICATIONS WILL BE BROUGHT TO YOUR WEEKLY CHECK IN FOR VERIFICATION.

IF FOR ANY REASON YOU NEED TO BE HOSPITALIZED, IT IS YOUR RESPONSIBILITY TO LIST WELLS COUNTY COMMUNITY CORRECTIONS AS AN AGENCY OF CONTACT REGARDING YOUR CONDITION.

Participant Initials _____

4. Check-in:

You shall report each week, to the proper location, at the appointed time, as directed by the Wells County Corrections. You shall then: **(a)** provide a printed and legible schedule for the upcoming week **(b)** make weekly payments as set forth; **(c)** have the ankle transmitter inspected; and **(d)** turn in any documents that verify times away from home for the week that was just completed. All prescriptions shall be verified at this time. As mentioned in Rule # 3 above, **you must provide verification of your prescriptions (bottle and/or prescriptions) as directed by the staff of Wells County Community Corrections.**

Participant Initials:_____

5. Employment:

Your employer must have knowledge of the limitations placed upon you and you must expect that a Community Corrections Officer will check with your employer to verify schedules.

Home Detention/EM requires a set schedule of working hours; open-ended job assignments are acceptable upon review. **The only acceptable activities are limited to employment and Court ordered activities.**

You are required to get prior approval by Wells County Community Corrections before any changes of address, employment or telephone numbers. You are required to carry a working cell phone with you at all times.

You will be required to advise your employer to **submit copies of your time cards or time sheets** to Wells County Community Corrections either by **e-mail** or **fax (260) 824-6406**. It is required that these copies be submitted **every Monday**, unless another time has been allowed by the Director and should be for the prior week of work.

Providing false information, altering, or falsifying employment records or other documentation used for verification of your whereabouts, will result in your termination from the program with the potential of criminal charges being filed.

If, for any reason, your employment is temporarily terminated, you must return to your residence and immediately notify Wells County Community Corrections. For example, if you work outside and weather conditions prevent you from being able to work, you must return home.

Any schedule changes must be given to the on call officer Monday thru Friday between 8:00 AM and 4:30 pm, using the on-call# 260-824-6411. The only calls allowed after 4:30 PM and on weekends are for medical emergencies, work hours change or if you will be late coming home. Any calls for any other purpose will be reviewed for a violation of program rules.

If your employer requires mandatory **overtime**, you are to contact Wells County Community Corrections, as soon as possible.

You will not be allowed to change employment while participating in the program without prior approval from Wells County Community Corrections.

Attached to the back of this contract is a letter that you need to take to your employer and have them read and sign. You need to bring the signed letter with you to your intake appointment.

Participant Initials:_____

6. Verification of Daily Activities:

You will be punctual and accountable to Wells County Community Corrections for your whereabouts at

all times. You are to take the most **direct route** to and from any scheduled leaves from residence and **not to stop anywhere** while going to or from work, **unless permission has been granted in advance** by Wells County Community Corrections or in a genuine emergency, i.e., car trouble or accident. Travel time will be reasonable and based on the assumption that no stop has occurred. **ANY DEVIATION FROM YOUR WEEKLY SCHEDULED ACTIVITIES, EX: LEAVING WORK EARLY OR NOT GOING AT ALL, MUST BE COMMUNICATED TO WELLS COUNTY COMMUNITY CORRECTIONS STAFF BY CALLING (260)824-6411**

Grocery Shopping: If you are the only adult in the home, you may be granted up to an hour per week (plus travel time to shop for groceries at one store that sells groceries. Grocery shopping will be part of your permanent schedule.

Participant Initials: _____

7. Route of Travel:

As per your court order of Home Detention/EM, you are to take the most **direct route** to any approved leaves on your schedule by the Wells County Community Corrections Staff.

Participant Initials: _____

8. Phone Requirements:

You must maintain a working contact telephone number at all times, and you **MUST** have your voice mail activated on cell phones.

Participant Initials: _____

9. Conduct:

You are to obey all laws of the United States and the State of Indiana and behave well in society. You are expected to fully cooperate with the Community Corrections staff in their efforts to properly monitor your activity. Failure to do so could result in your being terminated from the program.

Participant Initials: _____

10. Drugs and Alcohol:

Any use of a mind-altering substance (drugs or alcohol), in any form or any amount, is strictly prohibited.

Any use of any product containing poppy seeds, all hemp products, including hemp seed oil, CBD oil and the Vicks Inhaler are also strictly prohibited. You **will not** have any alcoholic beverage on your

premises (opened, unopened, or any empty container unless otherwise stated in the Order of the Court or as authorized by the Executive Director of Wells County Community Corrections.

You shall agree to submit to a test for the presence of drugs or alcohol at any time and to pay for such testing, if required. If you fail to give a sample within a **four (4)** hour period after being asked to provide one, you will be charged **\$45.00** and an oral sample will be given. If a test returns twice as a diluted sample, it will be considered a positive test. You will be charged **\$25.00** for each drug test. Failure or refusal to submit to such testing or tampering with a test sample shall be considered the same as a positive test and you will be referred back to the referring agency or Court for a hearing. You may be given random alcohol screenings in order to determine the absence/presence of alcohol.

You shall **not** possess or be in possession of (possession includes your person, residence, property, vehicle, any vehicle you may occupy any designer or synthetic mood-altering drugs. Examples included but not limited to K2, Bath Salts, Spice, Ivory Wave, Ivory Coast, Rave On, Salvia Divinorum, etc.

As per Drug Testing Procedure Form offenders may be required to make a daily phone call to verify if they have a drug screen that day. Failure to abide by this requirement could range from sanctions to a violation of your court order of Home Detention/EM being filed.

Participant Initials: _____

11. Visits/Searches:

You shall be subject to a search of your person or belongings at any time while on the Home Detention/EM program 24 hours per day and seven days per week. If you are in possession of pets (dogs), they must be confined. You will be held liable for any incident that occurs during a home visit. However, no member of the opposite sex shall be authorized to conduct a strip search of you, and any strip searches will be conducted only according to staff policy. Two staff members will be present unless exigent circumstances warrant. This includes your person, residence, vehicle, any designated locker space or location at a place of employment where your personal belongings are kept, and any dwelling that you reside in. A K-9 unit can be used where it is deemed necessary by the Community Corrections Director or Field Officer.

Participant Initials: _____

12. Office Visits:

I agree to report to the Wells County Community Corrections Office when so ordered for the purpose of responding to matters related to the Home Detention/EM Program.

Participant Initials: _____

13. Residents/Co-Resident's Information Compliance:

I shall have prior approval of my residence by the Wells County Community Corrections Department. I will only reside in one residence at a time during my Home Detention/EM term. I will not change my residence without prior approval of the Wells County Community Corrections Department. In the event that I can no longer

maintain my residence, and I am unable to immediately secure another residence that is approved by the Wells County Community Corrections Department, I may be removed from the Home Detention/EM program.

I understand that all persons residing in my residence must be aware of my placement in the Home Detention/EM Program. They must be aware of my program requirements and agree to support my responsibilities during my Home Detention/EM period.

While the people with whom I reside are not solely responsible for me, they understand the consequences I must face if any violations occur in my program.

Each person residing in my residence or being a guest in my residence acknowledges and consents to search of any part of my residence pursuant to the rules of Home Detention/EM in Wells County,

Indiana, even if said co-resident or guest is using said part of my residence for sleeping or any other personal use. I further state that I will advise **ALL** co-residents and guests of the right of Community Corrections to search all parts of my residence, including parts of any residence used by said co-residents and guests, with or without law enforcement assistance at any time according to the rules of Home Detention/EM in Wells County, Indiana.

Participant Initials: _____

14. Vehicles:

It is understood that any vehicle driven by you shall be subject to search at any time by the Community Corrections staff. A K-9 unit can be used where it is deemed necessary by the Community Corrections Director or Field Officer. You shall be held accountable for any contraband found in the vehicle.

For the purposes of this rule, the following items will be considered contraband:

1. Any alcoholic beverage
2. Any alcoholic beverage container
3. Any type firearm (including a toy firearm)
4. Any type of fireworks
5. Any bow or arrow
6. Any type knives
7. Any controlled substance

Participant Initials: _____

15. Weapons:

You **shall not** possess or use any firearm, destructive device, or other dangerous weapon unless granted permission from the Wells County Community Corrections Executive Director.

Participant Initials: _____

16. No Contact Orders:

If a no contact order is issued, the offender is **NOT** allowed to have contact by the following means:

- A. Phone/Cell phone**
- B. Texting/Social Media (Internet)**
- C. In Person**
- D. Third Party individuals**
- E. Written**

Also, you are NOT allowed to go past the victim’s home, work or any other routine location Such as schools, churches etc.

Participant Initials:_____

17. Escape:

Being in an unauthorized place or leaving your residence or place of employment without authorization, will result in your being charged with the crime of escape [IC 35-38-2.5-6, IC 35-44-3-5].

If you have any questions or problems, contact the **Wells County Community Corrections Office** at **260-824-6411**. In the case of an **extreme emergency**, contact the **Wells County Sheriff’s Department** at **260-824-3426** and they will contact the Wells County Community Corrections Department on-call staff member.

I, the undersigned, hereby acknowledge that I have read and fully understand these rules and further agree to abide by them. I understand that my failure to comply may result either in termination and referral back to the referring agency or in a Court hearing. **I understand and agree that I will not hold Wells County Community Corrections or any employee liable for any injuries or illness I may suffer while I am a participant of the Home Detention/Electronic Monitoring Program, and I agree to indemnify and hold said agency and individuals harmless from claims for damages or injuries incurred by others resulting from my actions.**

I understand each of the rules above and have **indicated my understanding by placing my initials after reading each rule** where indicated. I agree to follow each of the rules above. I acknowledge that any failure to abide by the rules above may result in a Notice of Violation being filed with the Court or the Indiana Department of Correction; whichever is appropriate. If the Court or the Indiana Department of Correction finds that I am in violation of the rules, my placement within Community Corrections may be revoked and I may be ordered to serve my sentence in the Indiana Department of Correction.

Participant Initials _____

Additionally, a violation of any rule may result in an Administrative Hearing. If I am found in violation at the Administrative Hearing, I may be deprived of all or part of my "good time" credit. Violations may also be reported to the Wells County Prosecutor or other law enforcement and may result in my arrest and criminal prosecution. If I am on probation, I understand that a violation of the above rules may result in the Court revoking my probation and ordering me to serve all or part of any suspended sentence in the Indiana Department of Correction.

Participant Initials _____

Home Detention Participant Signature _____ Date _____

Home Detention Participant Name (Please Print) _____

If under 18, signature of parent or legal guardian: _____ Date _____

WCCCD Staff Signature: _____ Date _____

If Yes, why? _____

Have you ever had to serve jail time because of a conviction? Yes No

Do you have a record of assault/violence? ___ Yes ___ No

Ever punished for institutional misconduct? ___ Yes ___ No

Have you ever talked to anyone in the legal aspect regarding any type of sexual offense? ___ Yes ___ No

If Yes, what was the offense _____ List all prior misdemeanor and felony convictions: In the state of Indiana and/or any other state within your longevity (lifetime).

DATE	CHARGE	COUNTY	STATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EMPLOYMENT

Employment _____ Date Hired _____

Address of Employer _____

Work Hours _____ How long were you employed here?

(Check all that apply) ___ Employed ___ Unemployed ___ Full-Time ___ Part-Time
___ Student ___ Disabled How many hours a week do you work? ___ Gross earnings per

week \$ _____

Name of Supervisor _____ Work Phone _____ Ext. _____

Ever employed for more than 1 year at same job? ___ Yes ___ No

Ever fired from a job? ___ Yes ___ No

Why? _____

Do you work well with your supervisor and colleagues? Yes No

If No, why? _____

Personal:

With 5 being the best and 1 being the worst, how would you rate your financial well-being? _____

Are you receiving any form of financial assistance? **(Check all that Apply)**

Food Stamps SSI Disability Church Ministries

Connecting Center Foundations Other (List below)

How much are you receiving in total weekly/monthly? \$_____ Are you married? Yes No

If you are not married is there a significant other in your life? Yes No

Do they live with you? Yes No If Yes, what is their name? _____

Do you have any children living with you? Yes No If Yes, how many _____

Please list their names and ages below

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you required to pay support? Yes No Weekly/Monthly Amount: \$ _____

Is there anyone else living with you? Yes No What are their names and ages?

Do you have pets? Yes No If Yes, what is the breed and temperament of pet (i.e.

friendly, aggressive, anxious, ect. _____

Do you get along with your parents? ___ Yes ___ No Siblings? ___ Yes ___ No Has anyone in your immediate family ever been in trouble with the law? ___ Yes ___ No

Do you have many **real** friends? ___ Yes ___ No Who are they? _____

Have any of your **real** friends ever been in trouble with the law? ___ Yes ___ No If Yes, for how long? _____

Do you have friends who have never been in trouble with the law? ___ Yes ___ No If Yes, how long? _____

Have you ever had an alcohol problem? ___ Yes ___ No If Yes, how long? _____

Have you ever had a drug problem? ___ Yes ___ No If Yes, how long? _____

Have you ever gone through treatment for drugs or alcohol use? ___ Yes ___ No

If Yes, where? _____

Are you currently attending an AA/NA program? ___ Yes ___ No

If Yes, what days do you attend an AA/NA Program? Monday Tuesday

Wednesday Thursday Friday Saturday Sunday

What time? ___ A. M. ___ P. M. **till** ___ A M. ___ P. M. Where is this AA/NA program located? _____

(Check all that apply)

Have you ever experimented with the following?

K2 (Synthetic Marijuana) Acid/LSD Inhalants Marijuana Methadone

Pain Medications Opiates Heroin Methamphetamine/Stimulants

Cocaine Barbituarates/Sedatives/Tranquilizers

Have you used any drugs within the last 24 hours? ___ Yes ___ No Drugs used _____

Have you ever had a law violation because of drugs or alcohol? ____ Yes ____ No

Have there been problems in your relationships because of drugs or alcohol? ____ Yes ____ No

Has work/school suffered because of alcohol/drugs? ____ Yes ____ No

If Yes, how? _____

MEDICAL: (Check all that apply)

Do you have health insurance? ____ Yes ____ No What type of health insurance do you have?

Self-pay Group Insurance Medicaid Medicare Disability Other

Insurance Carrier _____

Does your insurance include prescription coverage? ____ Yes ____ No Do you pay for doctor

office appointments? ____ Yes ____ No Are you under Doctors care? ____ Yes ____ No

If Yes, why? _____

Are you pregnant? Yes No If yes, has your doctor restricted your activity? Yes No

Restrictions: _____ Pregnancy Due date: _____

Doctor _____ Hospital _____ Do you have any allergies, medical problems,

restrictions, or back problems? ____ Yes ____ No If Yes, what are your allergies, medical

problems, or back problems and restrictions? _____

Have the Courts or Probation ordered therapy or counseling? ____ Yes ____ No If Yes, where

will you be going for treatment? _____.

Not counting the effects from alcohol or other drug use, have you recently experienced any of the following? **(Check all that apply) Attach any relevant physician orders or restrictions to your contract.**

____ Serious depression ____ Trouble understanding, concentrating, or remembering

____ Anxiety or tension ____ Trouble controlling violent behavior

____ Hallucinations ____ Thoughts of suicide or attempted suicide

Have you seen a therapist? ___ Yes ___ No

Was there a psychological assessment done? ___ Yes ___ No

Was a diagnosis given? Yes No If yes, what was the diagnosis? _____

Have you been diagnosed with any of the following? *(Check all that apply)*

Chlamydia

Gonorrhea

Hepatitis A, B, C

HIV

Are you currently enrolled in a treatment program? ___ Yes ___ No

If Yes, what is the program name? _____.

Program Manager/Contact _____ Phone# _____

MEDICAL QUESTIONNAIRE (Attach any confirming documentation)

During the past thirty days, I have used the following drugs and/or medications:

Prescribed by Dr. _____

I. PRESCRIPTION:

	PRESCRIPTION DRUG	DOSE	FREQUENCY	DATE LAST USED
A.	_____	_____	_____	_____
B.	_____	_____	_____	_____
C.	_____	_____	_____	_____

II. OVER-THE-COUNTER MEDICATION:

	<u>MEDICATION</u>	<u>DOSE</u>	<u>FREQUENCY</u>	<u>DATE LAST USED</u>
A.	_____	_____	_____	_____
B.	_____	_____	_____	_____
C.	_____	_____	_____	_____

III. ILLEGAL DRUGS:

	<u>DRUG</u>	<u>DOSE</u>	<u>FREQUENCY</u>	<u>DATE LAST USED</u>
B.	_____	_____	_____	_____
C.	_____	_____	_____	_____

DRIVER'S LICENSE:

Do you have a valid driver's license? Yes No. Suspended? Yes No

If Yes, print your operator's license number _____ Expiration date _____

License plate number _____ Vehicle Model/Make _____

In case of emergency, notify:

Name _____ Relationship _____

Address: _____ City _____ State/Zip Code _____

Contact Phone: _____

On a scale of 1 to 5, with 5 being the fairest, how would you rate the fairness of your sentencing? _____ Comments: _____

We are allowed to come to your home any time day or night. We are allowed to do random searches of your home and property if we feel it is necessary. You will be scheduling all leaves from your residence. Any time you leave your home you will need to have a validation slip signed to prove where and how long you have been at that location.

Are you prepared to answer to the courts if you are not able to follow these rules? _____ Yes _____ No

Have you thoroughly read and understood the rules and regulations of the Home Detention/EM prgram?

___ Yes ___ No

Have all of your questions been reviewed and answered adequately by WCCCD staff and are the rules clearly understood by you prior to signing this contract? _____ Yes _____ No

Home Detention Participant Signature _____ Date _____

Home Detention Full Name (Print) _____

If under 18, signature of parent or legal guardian: _____ Date _____

WCCCD Staff Signature: _____ Date: _____

DRUG ADMISSION FORM

I hereby admit that I have used the following drug (s):

on the following date (s): _____

without proper medical authorization in the form of a valid prescription or physician’s instructions.

This admission of drug use is made voluntarily without threat or promise, and I understand that it can be used against me in a court of law.

“Do you solemnly swear that each and all of the facts contained in this instrument are the truth, the whole truth and nothing but the truth, so help you God.”

Signed: _____

Date: _____

WITNESS: _____

SIGNATURE: _____

Before me the undersigned, a Notary Public for Wells County, State of Indiana, personally appeared _____, and he is being first duly sworn by me upon his oath, says that the facts alleged in the foregoing instrument are true. Signed and sealed this ____ day of _____.

Notary Public _____

My commission expires: _____

CO-RESIDENT'S AGREEMENT

RESIDENTS ADDRESS: _____

I understand that all persons residing in my residence must be aware of my placement in the Home Detention/Electronic Monitoring Program. They must be aware of my program requirements and agree to support my responsibilities during my Home Detention/Electronic Monitoring period.

While the people with whom I reside are not directly responsible for me, they understand the consequences I must face if any violations occur in my program.

Each person residing in my residence or being a guest in my residence acknowledges and consents to search of any part of my residence pursuant to the rules of home Detention in Wells County, Indiana, even if said co-resident or guest is using said part of my residence for sleeping or any other personal use. I further state that I will advise ALL co-residents and guests of the right of Community Corrections to search all parts of my residence, including parts of any residence used by said co-residents and guests, with or without law enforcement assistance at any time according to the rules of Home Detention/EM in Wells County, Indiana

The following is a list of those persons living with me, and by their signature(s) below, they each acknowledge the right of Wells County Community Corrections, with or without law enforcement assistance to search all parts of my common residence pursuant to the rules of Home Detention/EM in Wells County, Indiana, with a court order and without consent of any co-residents or guests in said residence.

- | | | |
|--|-------------------------------|----------------------------------|
| 1. _____
(Co-Resident Printed Name) | _____
Relationship (Print) | _____
(Co-Resident Signature) |
| 2. _____
(Co-Resident Printed Name) | _____
Relationship (Print) | _____
(Co-Resident Signature) |
| 3. _____
(Co-Resident Printed Name) | _____
Relationship (Print) | _____
(Co-Resident Signature) |
| 4. _____
(Co-Resident Printed Name) | _____
Relationship (Print) | _____
(Co-Resident Signature) |
| 5. _____
(Co-Resident Printed Name) | _____
Relationship (Print) | _____
(Co-Resident Signature) |
| 6. _____
(Co-Resident Printed Name) | _____
Relationship (Print) | _____
(Co-Resident Signature) |
| 7. _____
(Co-Resident Printed Name) | _____
Relationship (Print) | _____
(Co-Resident Signature) |

Home Detention Participant Signature: _____ Date: _____

Memo

To: All Offenders

From: Blake Poindexter, Executive Director

RE: MEDICINE/PRESCRIPTIONS

Offenders **cannot** take prescription drugs and medications without a valid prescription. Offenders **cannot** take prescription drugs and medications except in the dosages stated in their prescription. Prescriptions that allow for offender usage of drugs on medications at the offender's discretion (ex: as needed) **must** state on the prescription the maximum number of pills or dosage the offender may take per day.

If **samples** are given, the Doctor must provide on legal prescription pad or letterhead the prescribed dosage with maximum daily amount and total quantity given.

Home Detention Participant Signature

Date

Home Detention Participant (Please Print)

Parent or Legal Guardian Signature (if required)

Date

WCCCD Staff Signature

Date

CC: File

OVER THE COUNTER PRODUCTS THAT CONTAIN ALCOHOL

This is a partial list of products that contain alcohol. While the percentage of alcohol may vary, it is necessary that you use only alcohol-free medicines. If you have any doubts if a product contains alcohol or not, you should consult with your local pharmacist or doctor.

REMEMBER – it is your responsibility to check.

<u>Antidiarrheals</u>	<u>Alcohol</u>	<u>Vitamins</u>	<u>Alcohol</u>	<u>Mouthwashes</u>	<u>Alcohol</u>
Corrective Mixture	1.5%	Ce-Vi-Sol Drops	5.0%	Act	7-8.0%
Corrective Mixture with Paregoric	2.0%	Ganatrex	15.0%	Astring-O-Sol	65.0%
DIA-quel	10.0%	Geralix Liquid	15.0%	Cepacol	14.0%
Donnagel	3.8%	Geriplex-FS Liquid	18.0%	Dr. Tichenor's	70.0%
Donnagel PG	5.0%	Geritol	12.0%	Flourigard	6.0%
Pabizol with Paregoric	9.6%	Geritonic	20.0%	Isodine Mouthwash Gargle	35.0%
Parelizir	18.0%	Gerizyme	18.0%	Listerine	26.0%
Parepectolin	.6%	Gevraban	18.0%	Listermint	12.0%
Percy Medicine	5.0%	SSS Tonic	12.0%	Mouthwash and Gargle	14.0%
Quintess	.99%	Zymalixir	1.5%	Odara	48.0%
		Zymasyrup	2.0%	Oral Pentacresol	30.0%
				Scope	18.0%
				Listerine breath strips	23.0%

<u>Cough-Cold-Allergy</u>	<u>Alcohol</u>	<u>Cough-Cold-Allergy</u>	<u>Alcohol</u>	<u>Cough-Cold-Allergy</u>	<u>Alcohol</u>
Actol Expectorant	12.5%	Daycare	10.0%	Novafed	7.5%
Alamine	5.0%	Demazin	8.5%	Novafed A	
Alamine C	5.0%	Dimacol	4.75%	Nyquil	25.0%
Alamine Expectorant	7.5%	Dimetapp	2.3%	Pediquil	5.0%
Ambenyl-D	9.5%	Demetane Decongestant	2.3%	Pertussin	8.5%
Ani-Tuss DM Expectorant	1.4%	Dr. Drake's	2.25%	Pinex	3.0%
Benadryl	14.0%	Dristan Cough	12.0%	Quelidrine	2.0%
Benadryl Decongestant	5.0%	Dristan Ultra	25.0%	Quiet Nite	25.0%
Benylin	5.0%	Endotussin-NN	4.0%	Robitussin	3.5%
Benylin DM	5.0%	Formula 44 Cough	10.0%	Robitussin AC	3.5%
Black Draught	5.0%	Formula 44D	20.0%	Robitussin CF	1.4%
Breacol	10.0%	2/G	3.5%	Robitussin DAC	1.4%
Cerose CM	2.5%	2/G DM	5.0%	Robitussin DM	1.4%
Cetro-Cerose	1.5%	GG-Cen	10.0%	Robitussin DM	1.4%
Cheracol	3.0%	GG-Tussin	3.5%	Robitussin PE	1.4%
Cheracol-D	5.0%	G-Tussin DM	1.4%	Romilar III	20.0%
Chloritrimeton Expectorant	1.0%	Halls	22.0%	Romilar CF	20.0%
Codimal DM	4.0%	Head & Chest	5.0%	Sudafed Cough Syrup	2.4%
Colrex	4.5%	Mercodol with Decapryn	5.0%	Terpin Hydrate with DM	40.0%
Colrex Expectorant	4.7%	Naldecon DX	5.0%	Tolu-Sed	10.0%
Contact Severe Cold	25.0%	Night Relief	25.0%	Tolu-Sed DM	10.0%
Contrex	20.0%	NN Cough Syrup	5.0%	Tonecol	7.0%
Consotus	10.0%	Nortussin	3.5%	Triaminic Expectorant	5.0%
Coryban-D	7.5%	Novahistine Cough	7.5%	Trind-DM	5.0%
Cotylenol	7.5%	Novahistine Cough & Cold	5.0%	Vicks Cough	5.0%
Cosanyl DM	6.0%	Novahistine DH	5.0%	Viromed Liquid	16.6%
Cotussis	20.0%	Novahistine DMX	10.0%	Wal-Act	5.0%
Creamcote #1, #2, #3, #4	10.0%	Novahistine Expectorant	7.5%		

Participant Initials:

Toothache – Cold Sore

<u>Cankersore</u>	<u>Alcohol</u>
Anbesol	70.0%
Anbesol Gel	70.0%
Betadine Mouthwash Gargle	8.8%
Blistor Klear	37.0%
Coldsore Lotion (DeWitt)	90.0%
Coldsore Lotion (Pfiffer)	85.0%
Dalidyne	61.0%
Dent's Toothache Drops	60.0%
Double Action Kit	60.0%
Gum-Zor	22.0%

Internal

<u>Pain Relievers</u>	<u>Alcohol</u>
SK-APAP Elixir	8.0%
Tempra Syrup and Drops	10.0%
Tylenol Liquid and Drops	7.0%
Tylenol Extra Strength Liquid and Drops	8.5%
Veladol	9.0%

<u>Laxative</u>	<u>Alcohol</u>
Gas-Evac	18.0%
Dr. Caldwell's Senna Laxative	4.5%
Fletcher's Castoria	3.5%
Senokot Syrup	7.0%

Antiemetic

	<u>Alcohol</u>
Jiffy	56.5%
Numzit	10.0%
Rid-A-Pain Dental Drops	20.0%
Rid-A-Pain Gel	7.5%
Teething Lotion	4.5%
Toothache Drops	20.0%

Iron Products

	<u>Alcohol</u>
Dramamine Liquid	5.0%
Fumaral Elixir	5.0%
Mol-Iron Liquid	4.75%
Niferex Elixir	10.0%

PRODUCTS THAT DO NOT CONTAIN ALCOHOL ARE LISTED BELOW. MOST CAPSULE AND TABLET FORMS ARE SAFE. ALWAYS CHECK WITH YOUR PHARMACIST.

Cough-Cold-Allergy

Actifed
Wal-Act
Drixoral
Delsym
Efficol Cough Whips
Mediquel
Ryna
Sudafed
Sudafed Plus
Wal-Phed
Triaminic DM
Wal-Minic DM
Triaminic Cold Syrup
Wal-Minic Cold Relief
Codimal Expectorant
Orthoxical
Coricidin
Triaminicol
Naldecon-DX Adult Liquid

Antidiarrheals

Kaopectate
Kaolin-Pectin
Rheaban
Dia-Eze
Pepto Bismol

Oral Products

Chlorasptic
Crest Mouth Wash
Ora-Relief
Proxigel

Home Detention Participant Signature _____ Date _____

Home Detention Participant Name (Please Print) _____

Parent or Legal Guardian Signature (if required) _____ Date _____

WCCCD Staff Signature _____ Date: _____

AUTHORIZATION TO RELEASE AND EXCHANGE INFORMATION

I authorize Wells County Community Corrections to obtain any information in your files pertaining to m employment, medical, education, credit, military records, and pre-sentence reports and/or any other reports that would disclose information concerning potential conduct for the Community Corrections Program for which I am being referred to, including but not limited to duration of employment, summary of contacts, academic achievement, attendance, disciplinary actions, and current status. I hereby direct you to release such information upon request of bearer. This release is executed with fu knowledge and understanding that the information obtained is for the official use of Wells County Community Corrections.

I hereby authorize Wells County Community Corrections to exchange information with any entity, person, or agency that is deemed appropriate, by Wells County Community Corrections, for enabling Wells County Community Corrections to provide more comprehensive services in my program of supervision.

I hereby release you, as the custodian of such records, and any school, college, university, or other education institution, hospital or other repository of medical records, credit bureau, lending institution, consumer reporting agency, or retail business establishment including its officers, employees, or relate personnel, both individually and collectively, from any and all liability for damages of whatever kind, which may at any time result to me, my heirs, family, or associates because of compliance with this authorization and request to release information, or any attempt.

This information is for the official use of Wells County Community Corrections and is valid as long as my file is active with Wells County Community Corrections or unless I request, in writing, that the Authorization to Release and Exchange Information be voided.

Program Participant’s Signature (full name)

Parent or Legal Guardian (if required)

Program Participant's Full Name (Please Print)

WCCCD Staff Signature

Program Participant’s Residential Street Address

City

State

Zip Code

Date of Authorization to Release Information



COUNSELING/TREATMENT RELEASE INFORMATION

Home Detention Participant Name _____
(Please Print)

NAME OF FACILITY _____
(Please Print)

LOCATION _____
Street Address City/Town Zip Code

Counseling/Treatment _____
(Please Print)

Name of Counselor/Therapist _____
(Please Print)

Counselor/Therapist Signature _____ Date _____

WCCCD Staff Signature _____ Date _____



Dear Employer:

As an employer of one of our clients, you should understand in advance the details and/or limitations of our program.

1. An employee is still an inmate under the custody and control of Wells County Community Corrections. Failure to follow rules of the program will result in termination and referral back to the courts for further proceedings.
2. Offenders are required to carry cell phones if they are required to change locations during their work hours.
3. Employees **must** submit weekly timecards showing time in and out, or they will **not** be able to report to work the following week. **Employers may fax timecards to 260-824-6406.**
4. A Community Correction Officer will be checking the employee's schedule and may make visits to your business. We would appreciate your cooperation.

I want to remind you that our program should not be looked at as a deterrent to the employee's job, but as an ability to maintain employment and the family unit.

Thank you,

Wells County Community Corrections

Employee's Name _____

Company Name _____

Company Address _____

Employer's Signature _____

Employer Phone _____ Employee Date of Hire _____