

## Drug and Alcohol Restrictive Intermediate Punishment (Levels 3 and 4) Dedicated Form

*Information provided by you is utilized in assessing the success and impact of D&A RIP sentences. It is very important that you submit this form with complete and accurate information each time an offender is admitted into your program. This is the only way that our research will be all-inclusive and provide a true picture of D&A RIP in Pennsylvania. Data may be used in policy formulation and evaluation, funding strategies, etc.*

<b>Last Name:</b>	<b>Suffix (i.e. Jr.)</b>	<b>First Name:</b>	<b>Middle Initial:</b>
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<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Date of Birth</b> (mm-dd-year)	<b>Race/Ethnicity:</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native American. <input type="checkbox"/> Hispanic <input type="checkbox"/> Other	
<b>State ID Number</b>	<b>Social Security Number</b>	<b>Guideline Sentencing Form Number</b>	<b>Police Photo ID Number</b>
<b>County</b>	<b>Date Placed in Program</b> (mm-dd-year)	<b>Date of Sentencing</b> (mm-dd-year)	<b>Date submitted to PCCD</b> (mm-year)
<b>Judge's Name</b>		<b>Agency</b>	

1. Was a weapon present during the current offense?  Yes  No
2. Was there a plea bargain to D&A RIP?  Yes  No
3. Number of time the offender changed residences in the past 12 months  None  1 to 2  3 to 5  6 or more
4. Offender is currently living with (mark all that apply) 
 Spouse  Significant other  Child(ren)  
 Friend  Alone  
 Other (specify) \_\_\_\_\_
5. Is the offender a parent?  Yes  No Number of Children \_\_\_\_\_
6. Does the offender have custody of children?  Yes  No
7. Does the offender report domestic violence in the home? (Includes as a victim, witness or perpetrator)  Yes  No
8. Is there any known substance abuse in the offender's immediate family?  Yes  No
9. Is the offender's domestic partner currently under criminal justice supervision?  Yes  No
10. What is the status of the children?  Delinquency  Dependency  Not Applicable
11. How many months was the offender employed in the last year?  None  1 to 3  4 to 7  8 or more
12. How many jobs has the offender held in the past five years?  None  1 to 3  4 to 7  8 or more
13. What is the highest level of education completed by the offender? 
 Not high school graduate  Two year or technical degree  
 High school graduate/GED  Four-year degree (B.A., B.S.)  
 Some college  Post graduate degree
14. Has the offender had additional training? (list) \_\_\_\_\_

15. How many times has the offender undergone treatment for the following: (mark all that apply and number of times in treatment)

Treatment Type	Utilized (√)	Number of Times
1. Outpatient (Non-Intensive)		
2. Intensive Outpatient		
3. Partial Hospitalization		
4. Halfway House		
5. Medically Monitored Inpatient Hospital Detox		
6. Medically Managed Inpatient Hospital/Residential		
7. Medically Managed Inpatient Detox (Non-Hospital)		
8. Medical Monitored Short-Term Residential		
9. Medically Monitored Long-Term Residential		

16. What substances has the offender abused? (Place an \* by the preferred substance(s))

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Alcohol       | <input type="checkbox"/> Hallucinogens     | <input type="checkbox"/> Other Opiates/Synthetics |
| <input type="checkbox"/> Amphetamines  | <input type="checkbox"/> Heroin            | <input type="checkbox"/> Over-the-Counter         |
| <input type="checkbox"/> Barbiturates  | <input type="checkbox"/> Inhalants         | <input type="checkbox"/> Stimulants               |
| <input type="checkbox"/> Cocaine/Crack | <input type="checkbox"/> Marijuana/Hashish | <input type="checkbox"/> Tranquilizers            |
|  |  | <input type="checkbox"/> Other                    |

17. Note the PCPC recommended levels of care:

PCPC Levels of Care	PCPC Recommended (√)	Client Placement (√)
1. Outpatient (Non-Intensive)		
2. Intensive Outpatient		
3. Partial Hospitalization		
4. Halfway House		
5. Medically Monitored Inpatient Hospital Detox		
6. Medically Managed Inpatient Hospital/Residential		
7. Medically Managed Inpatient Detox (Non-Hospital)		
8. Medical Monitored Short-Term Residential		
9. Medically Monitored Long-Term Residential		

18. If PCPC was not followed, please state why.

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19. What other restrictive criminal justice sanctions were included in the sentence?

- House Arrest     Electronic Monitoring     None     Other: \_\_\_\_\_

20. \_\_\_\_\_  
Name of person completing form

\_\_\_\_\_  
Phone Number

Internal Use Only	
ID: D _____	Entered _____