SECTION J - LIST OF ATTACHMENTS

J.1	PROGRAM DISCHARGE SUMMARY PROFILE
J.2	SAMPLE PROGRAM PLAN (PROBATION FORM 45)
J.3	RESERVED FOR FUTURE USE
J.4	MONTHLY TREATMENT REPORT (PROBATION FORM 46)
J.5	AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION (PROBATION FORMS 11B, 11E, and 11I; and PSA FORMS 6B, and 6D)
J.6	DAILY LOG
J.7	DAILY TRAVEL RECORD (PROBATION FORM 17)
J.8	INVOICE
J.9	TESTING LOGS (URINALYSIS, SWEAT PATCH, BREATHALYZER)
J.10	DEPARTMENT OF LABOR WAGE DETERMINATION (As required by the Service Contract Act, when applicable.)

Attachment J.1

Program Discharge Summary Profile[1]

1. Number of defendants[2] enrolled in program during the past 12 months? _____

2. Number of offenders[3] enrolled in program during the past 12 months? _____

3. Number of defendants successfully discharged from program during the past 12 month period? _____

4. Number of offenders successfully discharged from program during the past 12 month period? _____

5. Number of defendants unsuccessfully discharged during the past 12 month period? _____

6. Number of offenders unsuccessfully discharged during the past 12 month period? _____

7. Number of defendants that were discharged due to failure to attend as required during the past 12 month period? _____

8. Number of offenders that were discharged due to failure to attend as required during the past 12 month period? _____

9. Other types of discharge during the past 12 month period, please explain in short narrative paragraph below (e.g., number of defendants, number of offenders, and reason):_____
_____
_____
_____
_____
_____
_____

10. Average treatment duration per client over the past 12 month period? _____

11. Average frequency of treatment per client over the past 12 month period? _____

12. Average staff to client ratio over the past 12 month period? _____

---

[1]Shall include entire clientele (federal, state, and local). Shall not be limited to only federal probation and pretrial services referrals.

[2]Defendant - An individual who has been charged with a crime, but not yet convicted. These individuals may or may not have been under pretrial supervision.

[3]Offender - An individual who has been convicted of a crime. These individuals are typically serving a period of probation or other form of post-conviction supervision.

Attachment J.2

Prob. Form 45 Today's Date:

Client Identifying Information

Client:	PACTS#:
Address:	Pretrial/Post Conviction:
Officer:	Client Phone:
Officer Phone:	DOB:

Provider Information

Provider:
Provider Location:
Attn:
Location Address:

Phone:
Fax:

Procurement No:
Effective Date:
Termination Date:

Authorized Services

Your agency is authorized to provide the following services beginning on the plan effective date indicated above. Any services provided outside of those listed below and/or outside the Effective and Termination Dates of the Plan will not be authorized for payment.

Services Ordered

Project Code	Description Of Services	Phase	Frequency (Units)	Interval	Copay Amount (per unit)
2010	Individual Substance Abuse Counseling		1.0	Weekly	$0.00
2020	Group Substance Counseling		2.0	Monthly	$0.00

Instructions to Provider Regarding Client Needs and Goals of Treatment

_____ _____ _____

Officer: Referral Agent: Client:

PROB 46
(Rev. 06/10)

MONTHLY TREATMENT REPORT

This form must be completed and submitted with each monthly billing. Additional sheets may be used.

1. PROGRAM NAME:	1a. PROVIDER NAME:	2. DATE OF CURRENT TX PLAN (ATTACH REVISIONS):
3. CLIENT NAME:	3a. PACTS NO.	4. FOR PERIOD COVERING:

5. PHASE NO.	5a. TIME IN PHASE:	6. PRETRIAL CLIENT: ☐ Yes ☐ No	7. CLIENT EMPLOYED: ☐ Yes ☐ No ☐ Student ☐ Other

8. CONTACTS SINCE LAST REPORT

a. Date	b. Service (Name & No.)	c. Length of Contact	d. Comments (No Shows, Tardiness, Issues Addressed)	e. Copay (amount collected)

9. URINE TESTING RECORD

DATE COLLECTED	Scheduled		Sample Not Tested		Drug Use Admitted		COLLECTED BY	SPECIAL TESTS REQUESTED	TEST RESULTS (Positive/Negative)	Copay (amount collected)
	Yes	No	Insuf. Qty.	Stall	No	Yes (specify drug)				

10. COMMENTS REGARDING CLIENT'S TREATMENT PROGRESS

a. Describe the treatment goals addressed this month (☐ Met ☐ Not Met):

b. Describe any steps taken by the client this month toward these goals (☐ Positive ☐ Negative):

c. Describe any obstacles or setbacks the client encountered this month:

d. Describe one unique way the PO/PSO can assist/support the client in treatment over the next month:

e. If continued treatment is recommended, discuss the plan for next month (☐ Recommended ☐ Not Recommended):

f. Discuss your observations of the client's behavior and commitment to treatment (☐ Positive ☐ Negative):

g. Comments:

h. Overall Progress: ☐ Acceptable ☐ Unacceptable

SIGNATURE OF COUNSELOR	DATE

DISTRIBUTION: ORIGINAL CONTRACTOR

✎ PROB 11B
(Rev. 5/05)

UNITED STATES PROBATION SYSTEM
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
DRUG ABUSE PROGRAMS

I, _____ , the undersigned,
(Name of Client)

hereby authorize _____ to release confidential
(Name of Program)
information in its records, possession, or knowledge, of whatever nature may now exist or come to exist to the United States Probation Office of the _____ District of _____ .
(Name of Court) (State)

The confidential information to be released will include: date of entrance to program; attendance records; urine testing results; type, frequency and effectiveness of therapy (including psychotherapy notes); general adjustment to program rules; type and dosage of medication; response to treatment; test results (psychological, vocational, etc.); date of and reason for withdrawal from program; and prognosis.

The information which I now authorize for release is to be used in connection with my participation in the aforementioned program which has been made a condition of my _____ (pretrial release, post-trial release, probation, or parole).

I understand that the probation office may use the information hereby obtained only in connection with its official duties, including total or partial disclosure of such, to the District Court and/or United States Parole Commission when necessary for the purpose of discharging its supervisory duties over me.

I understand that this authorization is valid until my release from supervision, at which time this authorization to use or disclose this information expires. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contact at:

_____
(Name and Address of Program)

I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before I satisfy the condition of my supervision that requires me to participate in the program will be reported to the court. My revocation of authorization under such circumstances could be considered a violation of a condition of my post-conviction supervision.

_____ _____
(Signature of Parent or Guardian if Client is a Minor) (Signature of Client)

_____ _____
(Date Signed) (Date Signed)

_____ _____
(Name & Title of Witness) (Date Signed)

✎ PROB 11E
(Rev. 5/05)

UNITED STATES PROBATION SYSTEM
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT PROGRAMS

I, _____ , the undersigned,
(Name of Client)

hereby authorize _____ to release confidential
(Name of Program)
information in its records, possession, or knowledge of whatever nature may now exist or come to exist to the United States Probation Office of the _____ District of _____ .
(Name of Court) (State)

The confidential information to be released will include: date of entrance to program; attendance records; urine testing results; type, frequency and effectiveness of therapy (including psychotherapy notes); general adjustment to program rules; type and dosage of medication; response to treatment; test results (psychological, vocational, etc.); psychotherapy notes; date of and reason for withdrawal from program; and prognosis.

The information which I now authorize for release is to be used in connection with the preparation of a court-ordered report.

I understand that the probation office may use the information hereby obtained only in connection with its official duties, including total or partial disclosure of such, to the District Court.

I understand that this authorization is valid until I have been sentenced and my sentence is final, at which time this authorization to use or disclose this information expires. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contact at:

_____
(Name and Address of Program)

I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before the completion of the presentence investigation will be reported to the court.

_____ _____
(Signature of Parent or Guardian if Client is a Minor) (Signature of Client)

_____ _____
(Date Signed) (Date Signed)

_____ _____
(Name & Title of Witness) (Date Signed)

✎ PROB 11I
(Rev. 4/05)

UNITED STATES PROBATION SYSTEM
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
MENTAL HEALTH TREATMENT PROGRAMS

I, _____ , the undersigned,
(Name of Client)

hereby authorize _____ to release confidential
(Name of Program)

information in its possession to the United States Probation Office in the _____
(Name of Court)

The confidential information to be released will include: date of entrance to program; attendance records; drug detection test results; type, frequency, and effectiveness of therapy (including psychotherapy notes); general adjustment to program rules; type and dosage of medication; response to treatment; test results (e.g., psychological, psycho-physiological measurements, vocational, sex offense specific evaluations, clinical polygraphs); date of and reason for withdrawal or termination from program; diagnosis; and prognosis.

This information is to be used in connection with my participation in the above-mentioned program, which has been made a condition of my post-conviction supervision (including probation, parole, mandatory release, supervised release, or conditional release), and may be used by the probation officer for the purpose of keeping the probation officer informed concerning compliance with any condition or special condition of my supervision. I understand that this authorization is valid until my release from supervision, at which time this authorization to use or disclose this information expires. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contact at:

_____
(Name and Address of Program)

I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before I satisfy the condition of my supervision that requires me to participate in the program will be reported to the court. My revocation of authorization under such circumstances could be considered a violation of a condition of my post-conviction supervision.

_____ _____
(Signature of Parent or Guardian if Client is a Minor) (Signature of Client)

_____ _____
(Date Signed) (Date Signed)

_____ _____
(Name & Title of Witness) (Date Signed)

✎PS 6B
(Rev. 5/05)

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

(DRUG OR ALCOHOL ABUSE PROGRAMS)

I, _____ , the undersigned,
(Name of Client)

hereby authorize _____ to release confidential
(Name of Program)

information in its records, possession, or knowledge, of whatever nature may now exist or come to exist to the United States Pretrial Services or Probation Office for the _____ District of _____ .
(Name of Court) (State)

The confidential information to be released will include: date of entrance to program; attendance records; urine testing results; type, frequency and effectiveness of therapy (including psychotherapy notes); general adjustment to program rules; type and dosage of medication; response to treatment; test results (psychological, vocational, etc.); date of and reason for withdrawal from program; and prognosis.

The information which I now authorize for release is to be used in connection with my participation in the aforementioned program which has been made a condition of my pretrial release.

I understand that this authorization is valid until my release from supervision, at which time this authorization to use or disclose this information expires. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contact at:

_____
(Name and Address of Program)

I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before I satisfy the condition of my supervision that requires me to participate in the program will be reported to the court. My revocation of authorization under such circumstances could be considered a violation of a condition of my pretrial supervision.

_____ _____
(Signature of Parent or Guardian, if Client is a Minor) (Signature of Client)

_____ _____
(Date Signed) (Date Signed)

_____ _____
(Name & Title of Witness) (Date Signed)

✎PS 6D
(5/03)

UNITED STATES PRETRIAL SERVICES SYSTEM
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
MENTAL HEALTH TREATMENT PROGRAMS

I, _____ , the undersigned,
(Name of Client)

hereby authorize _____ to release confidential
(Name of Program)

information in its possession to the United States Pretrial Services Office in the _____ .
(Name of Court)

The confidential information to be released will include: date of entrance to program; attendance records; drug detection test results; type, frequency, and effectiveness of therapy; general adjustment to program rules; type and dosage of medication; response to treatment; test results (e.g., psychological, psycho-physiological measurements, vocational, sex offense specific evaluations); date of and reason for withdrawal or termination from program; diagnosis; and prognosis.

This information is to be used in connection with my participation in the above-mentioned program, which has been made a condition of my pretrial supervision, and may be used by the pretrial services officer for the purpose of keeping the pretrial services officer informed concerning compliance with any condition or special condition of my supervision. I understand that this authorization is valid until my release from supervision, at which time this authorization to use or disclose this information expires. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. Such information may also be made available to the probation office for the purpose of preparing a presentence report in accordance with federal law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contact at:

_____ .
(Name and Address of Program)

I understand that if I revoke this authorization to release confidential information, I will thereby revoke my authorization to further disclosure of such information. I also understand that revoking this authorization before I satisfy the condition of my supervision that requires me to participate in the program will be reported to the court. My revocation of authorization under such circumstances could be considered a violation of a condition of my pretrial supervision.

_____	_____
(Signature of Parent or Guardian if Client is a Minor)	(Signature of Client)
_____	_____
(Date Signed)	(Date Signed)
_____	_____
(Name & Title of Witness)	(Date Signed)

DAILY TREATMENT LOG

COMPLETE ONE FORM PER CLIENT PER MONTH

Client Name _____ **Month/Year** _____

Date	Client's Signature/Initials	Time In	Purpose of Visit	Co-Pay Collected	Time Out	Client's Initials	Vendor's Initials

✎PROB 17
(Rev. 2/93)

U.S. PROBATION AND PRETRIAL SERVICES TRAVEL LOG

DISTRICT:

DATE / OFFICER NAME	EXPENSE CODE	CONTACT CODES (P-Personal/C-Collateral)	PROBLEM CODES	DAILY TRAVEL RECORD
	A-Telephone B-Parking C-Other	H-Home C-Community PS-Presentence PR-Prerelease for Institution PT-Pretransfer SI-Special Investigation SS-Social Services for Institution OPO-Other Probation/Pretrial Services Officer PTS-Pretrial Services PTSD-Pretrial Services Diversion FWR-Furlough/Work Release	DA-Drug Abuse UA-Urine Collection PS- HS-Housing/Shelter O-Other AL-Alcohol MS-Monitoring/Surveillance EM-Employment FB-Financial/Budgeting FM-Family/Marital ET-Education/Training	

DESTINATION	ODOMETER READING	MILES TRAVELED	OTHER EXPENSES	CONTACT CODE	PROBLEM CODE	CASE NUMBER/NAME OF CASE	ACTIVITY AND PERSON CONTACTED
START							
TO							
TO							
TO							
TO							
TO							
TO							
TO							
TO							
TO							
TO							
TO							
TO							
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TO							
TO							
TO							
TO							
TO							
TO							

PER DIEM			TOTAL MILES TRAVELED	TOTAL OTHER EXPENSES	NUMBER OF MILES FROM HOME TO OFFICE	**SIGNATURE OF OFFICER**
TIME STARTED	TIME RETURNED	AMT. CLAIMED	AMOUNT CLAIMED FOR MILEAGE			

Date _____ Page _____ of _____

ADMINISTRATIVE OFFICE OF THE UNITED STATES COURTS
TREATMENT SERVICES INVOICE

(PART A)

1. Judicial District _____
2. Vendor _____
   a. Address: _____
   _____
   _____
   b. Telephone: _____
3. P.O./B.P.A.# _____
4. Service Delivery: From _____ To _____
5. Total # of Individuals Served: _____

Vendor's Certification: I certify that **all** expenditures and requests for reimbursement in this voucher are accurate and correct to the best of my knowledge and include only charges for services actually rendered to clients under the terms of the agreement and for which no other compensation has been received from sources other than the United States District Court.

_____
Authorized Administrator

6. Project Code	7. Quantity	8. Unit Price	9. Total Price

Date _____ Page _____ of _____

ADMINISTRATIVE OFFICE OF THE UNITED STATES COURTS
TREATMENT SERVICES INVOICE

(PART B)

Subtotal all costs for each client listed below:

1. Client Name	2. Client Number	3. Dates of Service	4. Service Rendered	5. Quantity (Units)	6. Unit Price	7. Cost

BREATHALYZER INSTRUMENT LOG

Vendor Name _____

Instrument Serial Number	Requirements for Calibration	Dates of Calibration	Date of Next Calibration	Signature of Person Conducting the Calibration

BREATHALYZER LOG

COMPLETE ONE FORM PER CLIENT PER MONTH

Client Name _____ **PACTS #** _____ **Month/Year**_____

Client's Signature/Initials	Collector's Initials	Reason Tested	Test Results	Refusal

Comments (please note any unusual occurrences):

SWEAT PATCH TESTING LOG

COMPLETE ONE FORM PER CLIENT PER MONTH
COMPLETE THE FIRST FIVE COLUMNS UPON APPLICATION, AND THE LAST FOUR UPON REMOVAL

Client Name _____ **PACTS #** _____ **Month/Year**_____

Application Date	Client's Signature/Initials	Chain of Custody Bar Code Number	Medications Taken	Collector's Initials	Removal Date	Client's Initials	Collector's Initials	Test Results/Date	Co-Pay Collected

Comments (please note any unusual occurrences):

URINALYSIS TESTING LOG

COMPLETE ONE FORM PER CLIENT PER MONTH

Client Name _____ **PACTS #** _____ **Month/Year**_____

Date Collected	Client's Signature/Initials	Bar Code Number	Special Tests	Medications Taken	Collector's Initials	Test Results/Date Received	Co-Pay Collected