



DAUPHIN COUNTY PENNSYLVANIA WORK RELEASE

Matthew A. Miller, Director
919 Gibson Blvd. Steelton, Pa. 17113
Phone: 717-780-7002 Fax: 717-780-7371

Out of County – Direct Commitment Instructions

STEP #1: FILL OUT & SUBMIT the Out of County Cases Direct Commitment Application form to the Work Release Center (WRC) via email: jcoleman-cobb@dauphincounty.gov / mpeacock@dauphincounty.gov or via fax: 717-780-7371 as soon as possible **BUT at least 1 month prior to your sentencing date.**

STEP #2: Once the defendant receives pre-approval their attorney needs to contact Supervisor, Megan Peacock or 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 other County 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. **NOTE: The Dauphin County Work Release Center ONLY admits Direct Commitments (Walk-Ins) at 12:30pm on Tuesday’s & on Thursday’s.**

The WRC Supervisor or Coordinator will provide the attorney (along with the transfer order) the defendant’s report date, which will 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 for all the necessary transfer paperwork to be completed).

STEP #3: The defendant must complete a physical and TB/PPD (Tuberculosis) Test, within 90 days prior to their commitment date. They must have their physician complete the work release center’s **Health Assessment Form** and return it to the WRC via email: jcoleman-cobb@dauphincounty.gov / mpeacock@dauphincounty.gov or via fax: 717-780-7371 as soon as possible **BUT at least 2 weeks prior to your sentencing date.**

The health assessment can be completed at your primary care physician or an authorized health care provider such as:

Concentra (East Shore Locations)		Concentra (West Shore Locations)	
6301 Grayson Road Harrisburg, PA 17111 717-920-5910	4200 Union Deposit Road, Ste. G, H Harrisburg, PA 17111 717-558-6708	6108 Carlisle Pike Mechanicsburg, PA 17055 717-691-9560	4910 Ritter Road Mechanicsburg, PA 17055 717-795-1819
Medical Center Hours: Monday – Friday 8:00 a.m. - 5:00 p.m. (NOTE: TB/PPD Test are NOT Administered on Thursday’s)			
Prices: \$75.00 TB/PPD Test & \$124.00 Physical			
****Prices are Subject to Change****AND****Insurance May NOT be Accepted****			

STEP #4: Once the defendant is sentenced and given a date to self report they MUST contact Supervisor, Megan Peacock at 717-780-7028 / mpeacock@dauphincounty.gov or the Coordinator, Jennifer Coleman-Cobb at 717-780-6976 / jcoleman-cobb@dauphincounty.gov (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 Center, at least two weeks prior to your report date.

What the defendant can/cannot 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, as well as some other commonly abused prescription medications (**Including, but not limited to:** Gabapentin, Seroquel, & Wellbutrin). Bring no more than \$60 in cash. Tobacco products of any kind are strictly prohibited on Work Release property.

NOTE: Director approval is required to drive while in the Work Release Center, **DO NOT** report with your vehicle.

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 **12.30 pm**. 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 Supervisor, Megan at 717-780-7028 or Work Release Coordinator, Jennifer at 717-780-6976.

Out of County Cases

Direct Commitment Application

Dauphin County Work Release Center

Defendant Full Name: _____ Sex: Male Female

Defendant Phone: Cell: (____) _____ - _____ Home: (____) _____ - _____

Defendant Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Date of Birth: ____ / ____ / ____ **Social Security Number:** ____ - ____ - ____

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

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

Date of Sentencing: ____ / ____ / ____ **Report Date (To Be Determined):** ____ / ____ / ____

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): _____

Employer: _____ **Job Title/Position:** _____

Supervisor Name & Job Title: _____

Supervisor Email: _____ Phone: (____) _____ - _____ Ext. _____

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

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: _____ APPROVED by Warden on: _____ & Director on: _____

DENIED on: _____, Reason: _____

WRC:

PORTAL:

DQ:

DCP:

BACKGROUND:

L & I:

APO:

WARRANTS:

SECURITY DEPOSIT: \$ _____

DAUPHIN COUNTY WORK RELEASE CENTER HEALTH ASSESSMENT FORM

NOTE: This form must be completed, signed, & dated by a licensed medical provide.

Date of Assessment: _____

Patient Full Name: _____

Date of Birth: _____ SSN: _____

Insurance Information

Name of Health Insurance Co. _____ Policy#: _____
 Group No: _____ Are Referrals Needed for Care: Yes _____ No _____

MEDICAL HISTORY

Review of System – Specify (Y) Problem in Comment Section:

Y	N	System	Comment
		Headache	
		Seizures	
		Blackouts	
		DT's	
		Skin	
		Hearing	
		Ears	
		Vertigo	
		Vision	
		Speech	
		Dental	
		Chewing Problem	
		Swallowing	
		Joint Problems	
		Muscle	
		Ulcers	
		Gallbladder	
		Hepatitis & Type	
		Hemorrhoids	
		Thyroid	
		Diabetes	
		Allergies	
		Hay Fever	
		Asthma	
		Pneumonia	
		Heart Disease	
		Hypertension	
		Edema Swelling	

Y	N	System	Comment
		Anemia	
		Bleeding	
		Bruising	
		Arthritis	
		Gout	
		Back Pain	
		Kidney/bladder	
		Gonorrhea	
		Chlamydia	
		Syphilis	
		Herpes	
		Crabs/Lice	
		HIV/AIDS	
		Prostate	
		Hernia	
		Breast	
		Vaginal Discharge	
		Menarche Age	
		LMP / Duration	
		Cycle / Flow	
		Pregnancies	G: P:
		Miscarriages/Abortions	
		Pregnancy Complications	
		Mammogram Date:	
		Contraceptive Use/Type	
		UTI / Pelvic Infections	
		Pregnant Now?	
		Pregnant Test?	(+) (-)

Any Personal Medical Devices (assistive/diagnostic/etc.) Needed or Other Problems/Chronic Conditions:

Tuberculosis Testing (*MUST Have Test COMPLETED/Read With-in 90 Days of Report Date*):

Previous Testing: Yes: _____ No: _____ Results: _____ mm

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

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

Immunizations with Date of Last Vaccine/Dose (If Known):

COVID-19: _____ Flu: _____ Hepatitis B: _____ Rubella: _____

Pneumovax: _____ Tetanus: _____ (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: _____

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

N/A		Comments	N/A		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:

Currently on any PAIN Medication: Yes No **If Yes, Name & Dosage:** _____

Currently prescribed any BENZOS (Benzodiazepines): Yes No **If Yes, Name & Dosage:** _____

Currently on any ADHD Medication: Yes No **If Yes, Name & Dosage:** _____

Currently on ANY OTHER Medication: Yes No **If Yes, (List ALL Medication) Name, Dosage, & Duration On:**

★ **MEDICATION (includes but not limited to) NOT PERMITTED:** ADHD, Benzos, Narcotics, Gabapentin, Seroquel, & Wellbutrin ★

Any recommended follow-up care: Yes No **Any scheduled follow-up treatment:** Yes No

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

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

Signature: _____ **Specialty:** _____

Primary Care Physician: _____ Telephone: _____

Address: _____