

	DEPARTMENT OF PUBLIC SAFETY CORRECTIONS ADMINISTRATION POLICY AND PROCEDURES	EFFECTIVE DATE: April 7, 2020	POLICY NO.: COR.10.1G.10
		SUPERSEDES (Policy No. & Date): COR.10.1G.10 & 12/10/14	
SUBJECT: DURABLE MEDICAL EQUIPMENT		Page 1 of 12	

1.0 PURPOSE

The purpose of this policy is to ensure that durable medical equipment (DME) is supplied in a timely manner when required to assist in the retention or improvement of physical function or the health of the inmate would be adversely affected.

2.0 SCOPE

This policy and procedure applies to all correctional facilities and their assigned personnel. To the extent any individual facility's policy conflicts with the statewide policy, COR.10.1G.10 shall control.

3.0 REFERENCES, DEFINITIONS AND FORMS

.1 References

- a. Hawaii Revised Statutes (HRS), § 26-14.6, Department of Public Safety.
- b. HRS, § 353-2, Director of Public Safety, Powers and Duties.
- c. National Commission on Correctional Health Care, Standards for Health Services in Prisons and Jails. (2018)
- d. Title II of the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. §§ 12131-12134.
- e. 28 CFR Part 35, Americans with Disabilities Act of 1990, title II Regulations, Part 35, Nondiscrimination of the Basis of Disability in State and Local Government Services.
- f. Department of Public Safety (PSD), Policies and Procedures (P & P), COR.10.1A.02, Responsible Health Authority.

.2 Definitions

- a. Dental Appliance – A device to repair teeth or replace missing teeth, such as fillings, partial and full dentures, mouth guard.
- b. Disability - With respect to an individual, is a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such impairment; or being regarded as having such an impairment. The definition of "disability" shall be construed broadly in

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favor of expansive coverage, to the maximum extent permitted by the terms of the ADA.

1. Physical or mental impairment:
 - a) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems, such as: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, or endocrine.
 - b) Any mental or psychological disorder such as intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities.
 - c) The phrase physical or mental impairment includes, but is not limited to, such contagious and non-contagious diseases and conditions as orthopedic, visual, speech and hearing impairments; cerebral palsy; epilepsy; muscular dystrophy; multiple sclerosis; cancer; heart disease; diabetes; intellectual disability; emotional illness; specific learning disabilities; HIV disease (whether symptomatic or asymptomatic); tuberculosis; drug addiction, and alcoholism.
 - d) The phrase physical or mental impairment does *not* include homosexuality or bisexuality.
2. Major life activities: Shall include, but are not limited to; caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, reading, communicating, working, interacting with others, and operation of major bodily functions, such as the functions of the immune system, special sense organs and skin, normal cell growth, and digestive, genitourinary, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, and reproductive systems.
3. Substantially limits: Shall be construed broadly in favor of expansive coverage, to the maximum extent permitted by the terms of the ADA. "Substantially limits" is not meant to be a demanding standard. The determination of whether an impairment substantially limits a major life activity shall be made without considering corrective measures (e.g. medicine to treat disability, durable medical equipment to assist with

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mobility limitations), except for the beneficial effects of ordinary eyeglasses or contact lenses.

4. Has a record of such an impairment: Has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.
5. Is regarded as having an impairment:
 - a) This includes an inmate who:
 - i) Has a physical or mental impairment that does not substantially limit major life activities but that is treated by a public entity as constituting such a limitation;
 - ii) Has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or
 - iii) Has none of the impairments defined in paragraph 1 of this definition, but is treated by a public entity as having such an impairment.
6. The term disability does *not* include:
 - a) Pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders;
 - b) Compulsive gambling, kleptomania, or pyromania; and/or
 - c) Psychoactive substance use disorders resulting from current illegal use of drugs.
- c. Durable Medical Equipment (DME) - Any single or combination of an orthotic device, mechanical device, dental appliance or hearing aid needed to prevent or treat an illness, injury, condition, disease, or its symptoms, that reduces the effects of impairment and assists a patient in performing their activities of daily living.
- d. Basic Level DME – The level of DME that would be covered under the State of Hawaii Medicaid Program.

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- e. Health Care Payment Plan – A payment plan established between the patient and Health Care Services for indigent patients who are unable to cover the purchase price of DME that are not covered by the Department. Includes forms PSD 0477, Purchase Agreement and PSD0477-B, Furloughee Purchase Agreement.
- f. Hearing Aid – A small electronic device that fits in or behind the ear, worn by a partially deaf person, to amplify sound.
- g. Mechanical Device - A device consisting of a piece of machinery that has moving parts that perform some function, such as a wheelchair, patient lift, motorized wheelchair and similar motorized devices, Continuous Positive Airway Pressure (CPAP) machine, Biphasic Positive Airway Pressure (BIPAP) machine, alternating pressure mattress, oxygen, patient feeding pump, breast feeding pump, bariatric bed, intravenous (IV) pump, negative pressure wound therapy machine (wound vac).
- h. Medically Necessary – A DME that meets the following criteria; 1) is for the purposes of treating a medical condition, 2) is deemed the most appropriate, considering potential benefits and harms to the patient, 3) known to be effective in improving health conditions based on existing evidence, standards of care and/or expert opinion, and 4) is cost-effective for the medical condition being treated, compared to alternative health interventions. For the purposes of this paragraph, cost effective may not necessarily mean the lowest price.
- i. Orthotic Device - A device for the immobilization or stabilization of a body part to prevent deformity and protect against injury or assist with function, such as a cane, crutch, walker, sling, splint, brace, shoe insert, corrective eye glasses, transfer board, shower chair, specialized shoe(s), heel lifts.
- j. Responsible Health Authority – As defined in policy COR.10.1A.02 Responsible Health Authority.
- k. Responsible Physician – A designated Medical Doctor (MD) or Doctor of Osteopathic medicine (DO) who has the final authority at a given facility regarding clinical issues. The Physician II is the facility responsible physician.
- l. Special Utilization Review Panel (SURP) – A panel consisting of Providers including, at a minimum, the Medical Director and the Provider

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recommending the DME, who will determine if the DME is medically necessary and if the purchase is appropriate.

- m. Supporting Medical Supplies - Any supplies needed to use DME; such as batteries, stockings, hoses or tubing, CPAP or BIPAP masks, filters, tubing and distilled water, and cushions, or breast milk storage bags.

3. Forms

- a. PSD 0417, Refusal to Consent to Medical/Surgical/Dental Treatment/Medication (attached).
- b. PSD 0477, Purchase Agreement (attached).
- c. PSD 0477-B, Furlougee Purchase Agreement (attached).
- d. PSD 8773, Request for Accommodation/Modification (attached).
- e. Medical Request Form (attached).
- f. Medical Needs Memo (attached).

4.0 POLICY

- .1 DME shall be considered for use for patients with a disability, and if required under the ADA, made available to the patient with a disability.
- .2 State or contracted physicians and dentists may prescribe medically necessary clinically indicated DME when required to assist the retention or improvement of physical function or when the health of the patient would otherwise be adversely affected.
- .3 Provisions shall be made for a patient to purchase and maintain DME listed under 4.10 when ordered by a treating State or contracted physician or dentist.
- .4 Any patient may request DME during intake, the sick call process or by completing a Medical Request Memo or form PSD 8773 Request for Accommodation/Modification.
- .5 Only DME deemed medically necessary shall be considered for use in the facility.

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- .6 All DME shall be determined to be medically necessary by the Medical Director, SURP or onsite RHA.
- a. DME, with a purchase price of two hundred dollars (\$200) or more must be authorized as medically necessary by the Medical Director or SURP before being approved for purchase.
 - b. DME, with a purchase price of less than two hundred dollars (\$200) must be authorized as medically necessary by onsite RHA.
- .7 All DME are subject to search and shall be determined to not threaten the safety and security of the facility.
- .8 The Department will cover the purchase price of replacement basic level DME deemed medically necessary by the Medical Director or SURP and in accordance with section .10 below. This DME will be provided at no cost to the patient.
- .9 DME purchased for the patient shall not be replaced within a frequency period of less than five (5) years (even if the patient has been released from incarceration during that period) unless the patient's physical condition has changed necessitating a new DME or unless replacement is approved by the Medical Director or SURP under the ADA as a reasonable modification or auxiliary aid or service. If not approved, the DME replacement shall be the financial responsibility of the patient.
- .10 DME deemed medically necessary and covered at no cost to the patient includes:
- a. Mechanical Devices
 - Wheelchairs and lifts
 - Continuous Positive Airway Pressure (CPAP) machine
 - Biphasic Positive Airway Pressure (BIPAP) machine
 - Alternating pressure mattress
 - Oxygen
 - Bariatric bed
 - IV pump
 - Wound Vac
 - Patient feeding pumps
 - Breast feeding pumps

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b. Orthotic Devices

- Cane, crutches, walker
- Transfer board
- Shower chair

c. Hearing Aid

d. Other DME as deemed medically necessary by the Medical Director or SURP.

.11 The Department shall not be limited to the above if additional DME is required.

.12 DME other than those listed in .08 and .10 shall be the financial responsibility of the patient. The patient shall pay for all fees associated with the purchase, care, and maintenance of the device. These include:

- Corrective eye glasses
- Slings, splints, braces
- Shoe inserts, specialized shoes, heel lifts
- Motorized wheelchairs or similar motorized devices
- Partial or full dentures, mouth guards

.13 For patients determined to be indigent, DME listed above in section 4.12 may be purchased by the patient through the Health Care Payment Plan.

a. The following conditions apply:

- All more cost effective alternatives to the DME have been considered.
- The patient is determined to be indigent; and therefore, unable to pay for the cost of the DME in advance.
- The patient has a mandatory minimum sentence or parole date with sufficient remaining incarceration time to allow for the potential repayment of the cost of the DME.

b. The patient must sign form PSD 0477 Purchase Agreement establishing a payment plan allowing any funds above a ten dollar (\$10.00) minimum balance in their account, be withdrawn from their account until the DME cost is paid in full.

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- c. If on furlough, the patient must sign form PSD 0477-B Furloughee Purchase Agreement establishing a payment plan.
 - d. Patients refusing to sign form PSD 0477 Purchase Agreement or form PSD 0477-B Furloughee Purchase Agreement shall not be provided with the DME.
- .14 Medically recommended DME that cost two hundred dollars or more (\$200+) shall require authorization as a medically necessary device by the Medical Director or SURP prior to purchase.
 - .15 Medically recommended DME that cost less than two hundred dollars (<= \$199) shall require authorization as a medically necessary device by the onsite RHA prior to purchase.
 - .16 All outstanding medical cost obligations owed by the patient shall be deducted from the patient's account prior to the release of any account balance to the patient.
 - .17 Any DME deliberately damaged by the patient, if replaced, shall be replaced at the expense of the patient.
 - .18 Any DME deliberately misused, in a manner not medically recommended and/or is deemed a fundamental alteration or undue financial or administrative burden, may not be authorized for use in the facility and may be confiscated.
 - .19 The Department shall furnish appropriate auxiliary aids and services, including certain DMEs (e.g. hearing aids), where medically necessary to afford qualified inmates with disabilities an equal opportunity to participate in, and enjoy the benefits of, its services, programs, or activities in accordance with PSD, P & P, COR.14.30, Communication Access.
 - .20 The Department shall make reasonable modifications to its policies, practices, or procedures, including providing certain DMEs (e.g. wheelchairs), to qualified individuals with disabilities in accordance with PSD, P & P, COR.14.27, Inmates with Disabilities. For DMEs provided as a reasonable modification to individuals with disabilities, the Department may impose legitimate safety requirements for the safe operation of its services, programs, and activities so long as these safety requirements are based on actual risks.
 - .21 The Department may refuse to provide an auxiliary aid or service or a reasonable modification only if it fundamentally alters the nature of the program, service, or

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activity or constitutes an undue financial or administrative burden. For DMEs requested as a reasonable modification, the Department may also refuse to provide such DMEs when the DME constitutes a direct threat to the health or safety of others. In determining whether it poses a direct threat, the Department must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures or the provision of auxiliary aids or services will mitigate the risk.

5.0 PROCEDURES

- .1 During intake, a physician or onsite RHA shall determine the medical necessity of the patient's DME. If deemed not medically necessary, it will be removed, recorded and managed as an item of the patient's property.
- .2 Staff shall notify the Health Care Section (HCS) immediately when a device is to be confiscated.
- .3 When a patient requests DME through the sick call process, Health Care staff shall review the nursing protocol for any patient requesting DME through the sick call process. If not covered by the nursing protocol, the patient shall be referred to the facility physician or dentist, who shall determine whether or not the requested device is medically necessary.
- .4 When a patient requests a DME through form PSD 8773 Request for Accommodation/Modification in accordance with COR.14.27 Inmates with Disabilities policy, Health Care staff shall inform the patient to submit the form in the appropriate box/area.
- .5 When Health Care staff receive form PSD 8773 Request for Accommodation/Modification from the Facility ADA Coordinator, Health Care staff shall:
 - a. Review the request.
 - b. Complete Section II. Health Care Administration, confirming whether or not a qualifying disability exists related to the accommodation/modification request.

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- c. If the request is for a DME, staff shall follow the procedures within this policy and forward the completed form to the Facility ADA Coordinator along with an issued Medical Needs Memo.
- d. If the request is for a non-DME accommodation/modification, staff shall sign and forward the completed form to the Facility ADA Coordinator.
- .6 Recommended DME, under \$200, shall be referred to the onsite RHA for review and determination of being medically necessary.
- .7 If the onsite RHA determines that the DME is not medically necessary, and shall not be allowed in the facility, the referring physician or dentist may appeal the decision by requesting a review by the SURP for final determination.
- .8 Recommended DME, costing \$200 or more, shall be referred to the Medical Director for review and determination of being medically necessary.
- .9 If the Medical Director determines that the DME may not be medically necessary, the Medical Director shall refer the DME for review to the SURP for final determination.
- .10 If the SURP determines that the DME is not medically necessary, the decision will be final, and the DME shall not be authorized for use in the facility and shall not be authorized for purchase.
- .11 If an inmate is dissatisfied with their DME or any component of the DME process, they may file a grievance in accordance with the COR.12.02, Inmate Grievance Program.
- .12 If the SURP determines that the DME is medically necessary, the DME is authorized for use in the facility and may be purchased.
- .13 When a Health Care Payment Plan is utilized for authorized purchases by indigent patients with insufficient funds, staff shall ensure that the patient signs PSD 0477 Purchase Agreement to authorize the withdrawal of funds to pay for the DME.
- .14 The facility shall withdraw funds from the patient's account whenever there is more than ten dollars (\$10) in the account.

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- .15 If the withdrawal is made during the fiscal year in which the DME was purchased, a joint voucher will be used to transfer funds from the patient's account to the facility's HCS operating fund.
- .16 If the withdrawal is made after completion of the fiscal year in which the DME was purchased, the funds shall be made out to the Director of Finance and transferred to the state general fund.
- .17 Furloughed patients who are employed, must cover, up front, at least one-half the purchase price and all applicable fees of the DME, at the time of the initial examination and measurement.
- .18 The furloughed patient shall establish a payment plan and sign form PSD 0477-B Furlougee Purchase Agreement. Payment shall be made to the HCS by cashier's check, facility check or money order.
- .19 If a patient refuses the purchase of a physician's or dentist's recommended medically necessary DME, staff shall ensure that the patient signs form PSD 0417, Refusal to Consent to Medical/Dental Treatment/Medications.
- .20 All DME purchased shall be documented as a progress note in the patient's record.
- .21 All DME approved shall be documented in the patient's medical record.

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DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

REFUSAL TO CONSENT TO MEDICAL/SURGICAL/DENTAL TREATMENT/MEDICATION

NAME: _____ SID: _____ DOB: _____

FACILITY: _____ DATE: _____ TIME: _____

I, the undersigned patient, refuse the following treatment and/or medication: _____

(Describe Treatment and/or Medication)

The risk of refusing treatment or medication has been explained to me and I accept the risk involved. I release the State, the Department, the facility administration and personnel, the Health Care Division administration and medical personnel from any responsibility or liability for any unfavorable reaction, outcome, or any untoward results due to this refusal on my part to accept treatment or medication.

(Signature of Patient)

(Date)

I, the undersigned, have explained to the above named patient the risk involved in refusing treatment or medication recommended for the patient's continued good health and I witness the patient's refusal of the recommended treatment or medication

(Print Name)

(Signature & Title)

(Date)

A referral has been made to a provider: YES NO

I have reviewed this case and if necessary have further counseled this patient on the risk of refusing treatment or medication.

(Print Name of Provider)

(Signature & Title)

(Date)

** If the patient refuses treatment and/or medication and refuses to sign this consent, please have refusal witnessed by another correctional employee.*

I have witnessed the above named patient refuse the recommended treatment or medication and I have also witnessed the patient's refusal to sign this consent form.

(Print Name & Title)

(Signature & Title)

(Date)

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

PURCHASE AGREEMENT

(Print Inmate's Name)

(SID)

(DOB)

(List Item(s) to be Purchased)

- _____
(Initial) 1. I have been informed that the items I wish to purchase are not covered benefits under my health plan. I understand that by agreeing to purchase the item(s) listed above. I am responsible for the cost of the item(s) and that I am buying the item(s) from a private business and not from the Department of Public Safety.
- _____
(Initial) 2. I understand by agreeing to purchase the item(s), and I must have sufficient funds in my account to pay for the full cost of the requested item(s), and the entire amount will be deducted from my account.
- _____
(initial) 3. The Health Care Division (HCD) has a reimbursement payment plan available if I do not have sufficient money in my account to pay for the entire cost of the prosthesis. If I agree to the payment plan, the HCD will purchase the items (s) from the private business so I can have it right away. I will then be obligated to the terms of the payment plan until the entire cost of the item has been repaid.
- _____
(initial) 4. I understand I have the right to refuse the recommended item(s) listed above and participation in the payment plan.
- _____
(Initial) 5. If I agree to the payment plan, I understand that whenever there are funds in my account in excess of ten dollars (\$10.00), the excess amount will be withdrawn until the cost of the requested item(s) is paid in full.
- _____
(Initial) 6. I understand that if I agree to the payment plan and I am released from jail or prison before I have finished paying for the items(s), any funds remaining in my inmate account will be applied to my debt. I understand that if I ever return to jail or prison, I will be obligated to pay any outstanding balance owed the Health Care Division for the purchase of the requested item(s) as soon as funds are deposited into my account, for any reason, from any source.
- _____
(Initial) 7. I understand that the purchase of the item(s) listed above is non-refundable once the order is placed. An item(s) may be substituted for an item of equal value if the vendor's regulations allow for exchanges.

I refuse the payment plan and I do not wish to purchase the item(s) listed above at this time. _____
(Initial)

I consent to the purchase of the item(s) listed at the top of the page and authorize the amount of \$ _____ to be deducted in full or by the reimbursement payment plan if I have insufficient funds in my account at this time. _____
(Initial)

(Inmate Signature)

(Date)

(Staff Signature/Title)

(Date)

Item(s) ordered on _____ from _____.

Item(s) received on _____ Issued to inmate on _____
(Pt Initial)

Original sent to fiscal on _____

Copy to inmate & medical record

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

FURLOUGHEE PURCHASE AGREEMENT

If my funds are insufficient to cover the cost of the requested item(s), I understand that a cashier's check or money order amounting to half the cost of the requested item(s) shall be paid to the Department to purchase the following:

List Item(s)

A minimum of \$_____ shall be paid at regular intervals every _____ until the cost of the item(s) is paid in full.

Furlougee's Signature

Date

Nurse Signature

Date

Copy: Fiscal Office
 Medical Record
 Inmate



DEPARTMENT OF PUBLIC SAFETY

REQUEST FOR ACCOMMODATION/MODIFICATION

(for wheelchairs, canes, walkers, etc., submit a Medical Request Form)



I. REQUEST

Inmate Name: *(please print)* _____ **SID#:** _____

Facility & Housing Unit: _____

Auxiliary Aid or Service/Modification Requested/Needed: *(Answer the following questions)*

1. What auxiliary aid or service/modification do you think you need?

2. Why do you think this will help you? _____

Inmate Signature _____ **Date** _____

If Request was verbal: *(check)*
Print name of Individual who wrote request: _____

Facility ADA Coordinator Signature _____ **Date** _____

Forward to:

II. HEALTH CARE ADMINISTRATION

A disability exists relating to the above request (check one): Yes No

Comments: _____

Submit Medical Request Memo

Completed By: _____ Date: _____
(Print Name) (Signature)

Forwarded to Facility ADA Coordinator

cc: Facility ADA Coordinator, Statewide ADA Corrections Coordinator

MEDICAL REQUEST

Name: _____ SID # _____

Facility/Housing: _____ Concern: _____

Inmate Signature: _____ Date: _____

Date Received: _____ () Seen by Nurse in Sick Call () Appointment Made w/ _____

Comments: _____

Health Care Staff Signature: _____ Date: _____

Original: Medical Record Canary: To Inmate (w/ Response) Pink: Patient (Keep Copy Before Sending)

MEDICAL NEEDS MEMO

Facility: _____

Date: _____

TO: _____

FROM: _____
(Signature/Title of Provider)

Inmate _____
(Print Inmate's Name)

Housed in _____

DURATION: _____ Days; _____ Weeks; _____ Months; _____ Indefinitely

*Health Status Classification Report required if there is a significant change in health status.

Original: UTM/ACO/Work Supervisor
Canary: Medical Record
Pink: Inmate

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