APPLICATION FOR:
INTERMEDIATE PUNISHMENT - DUI
Fee due with application - $ 300
Criminal Complaint must be attached

Name: _____ Maiden Name/other _____

Address: _____
Street City State Zip Code

Telephone Number: _____ Date of Birth: _____

Social Security Number: _____ Email address_____

Case Number(s): _____ Date of Offense(s):_____

Attorney: ☐ Public Defender ☐ No Attorney ☐ Private Attorney: _____Phone_____

Employer: _____ Employer Address: _____

I plan to request work release while incarcerated at Blair County Prison ☐ Yes ☐ No

D.U.I. OFFENSE ☐1ST ☐2ND ☐3RD BAC_____ ☐Drugs ☐Refusal

$300. Due with application
$12-14. per day for electronic monitoring. Payment plan is available.

1st Offense		
.08-.099/Refusal of blood w/o warrant	**Not available. See Traditional Sentencing Brochure.**	
.10-.159/Minors	0 days jail	10 days monitoring
.16 or higher/Refusal of Breath/ Refusal of blood with warrant/Drugs	0 days jail	15 days monitoring
2nd Offense		
.08-.099/Refusal of blood w/o warrant	0 days jail	15 days monitoring
.10-.159/Minors	5 days jail	25 days monitoring
.16-.249	20 days jail	70 days monitoring
.25 or higher/Refusal of breath/Refusal of blood with warrant/Drugs	**Not available. Must apply for DUI Court.**	
3RD Offense		
08-.099/Refusal of blood w/o warrant	5 days jail	20 days monitoring
.10-.159/Minors	35 days jail	55 days monitoring
.16 or higher/Refusal of breath/ Refusal of blood with warrant/Drugs	**Not available. Must apply for DUI Court.**	

******** If you have more than 1 DUI for this sentencing, complete the following: ********

☐*Two 1st Offenses* ☐*Two 2nd Offenses* ☐*Two 3rd Offenses* ☐*Other* _____

BAC #1_____ or ☐*Drug/Refusal ……. BAC #2_____or* ☐*Drug/Refusal……. BAC #3_____or* ☐*Drug/Refusal*

To calculate the additional jail and monitoring days, use the above chart and add to the original offense.
To calculate the additional application cost, add $100 for each additional offense.

Continued on back

Electronic Monitoring is required as part of your sentence.
All Electronic Monitoring fees are collected by Blair County Adult Probation and Parole Office.

If you will be required to serve a period of imprisonment as part of your sentence and want to be considered for work release from the Blair County Prison, you must contact the Work Release Coordinator at (814) 693-3155 at least one week prior to going to Jail.

I verify that the statements made in the foregoing application are true and correct to the best of my knowledge, information and belief. I understand that false statements herein are made subject to the penalties of 18 PA C.S.A. SEC. 4909 relating to Unsworn Falsification to Authorities

_____ _____

DEFENDANT'S SIGNATURE DATE

Make check or money order payable to: **Blair Drug and Alcohol Partnerships**
Return this application with $300 to the Preliminary Conference or to address below.

Mail or bring application with fee to:
Blair Drug and Alcohol Partnerships
3001 Fairway Drive, Suite D, Altoona, PA 16602
(in Fairway Centre beside Pennsylvania Department of Environmental Protection – DEP)

BLAIR COUNTY DRUG AND ALCOHOL PROGRAM, INC CONFIDENTIALITY AUTHORIZATION TO RELEASE INFORMATION

Individual's Name: X _____

I hereby authorize: **Blair County Drug and Alcohol Program, Inc. 3001 Fairway Drive, Suite D, Altoona, PA 16602**
Name of Organization, Person, or Title

to release the following information to:

Blair County Adult Probation & Parole Office
Name of Organization, Person, or Title

At: **Blair County Court House, 423 Allegheny Street, Suite 330, Hollidaysburg, PA 16648 814-693-3190**
Address

The following information pertaining to MYSELF.

THE INFORMATION WHICH MAY BE RELEASED IS LIMITED STRICTLY TO THE FOLLOWING:

( ) PCPC Summary Sheet	(X) Attendance
( ) ASAM Summary Sheet	( ) Progress on objectives
( ) Psychosocial/diagnostic summary	( ) Legal System (type of program, summary of progress, Type/frequency of relapse and prognosis
( ) Emergency Contact	( ) Preliminary Diagnosis
( ) Physical Description	
( ) Liability Information	

Reason for the Disclosure: **Coordination of Services**

- **I understand the duration of this authorization is for no longer than one year unless I specify a date, event, or condition upon which it will expire sooner.**

  Specify date, event, or condition ONLY if consent expires sooner than 1 year; otherwise specify NA: _____

- **I understand that this authorization may be cancelled at any time by a verbal or written request unless I have been mandated into treatment as a result of a criminal proceeding. Information may have been previously released prior to the cancellation.**
- **I understand that I may refuse to sign this authorization; my refusal will not prevent me from receiving services; my refusal will prevent the treatment providers from sharing information that may be beneficial to my treatment.**
- **I have read and understand the intent of this authorization.**
- **I have been offered and ☐ accepted ☐ refused a copy of this form.**

X _____ _____
Individual's Signature Witness to Signature

X _____ _____
Date Date

A copy of the Authorization shall be deemed valid as original. ***To be valid, this Authorization must be signed and dated.***

PROHIBITION OF REDISCLOSURE: The information has been disclosed to you from records whose confidentiality is protected by State and Federal Law. Regulations prohibit you from making any further disclosures of this information except with the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general release of medical or other information is NOT sufficient for this purpose. Federal rules do not allow any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.