

Sixth Judicial District Department of Correctional Services FORM 900M-21
SOTP MONTHLY REPORT

PLEASE PRINT

REPORTING MONTH:

Name:		
Address: New? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Change: _____ Reason for Change: _____		
Phone: New? <input type="checkbox"/> Yes <input type="checkbox"/> No	Living with: [List person(s)]: New? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Emergency Contact: (Name and Relationship)	Emergency Contact Phone Number:	If any of the above information is new, have you updated the SOR? <input type="checkbox"/> Yes <input type="checkbox"/> No

JOB STATUS: (circle one) Full-Time Part-Time Disabled Retired Seasonal Spot-Job Student Unemployed

Employer's Name:	Occupation:	
Address:	Phone:	
Supervisor:		
Work Hours: (days & times)		
Hourly Wage: \$	Check stub presented today? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your employer aware of your offense? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is this a change in employment/status? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Change: _____		
Reason for Change:		
If any of the above employment information has changed, have you updated the SOR? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Describe since last report any new developments in: your life, relationships, living situations, arrests, health problems, vehicles you own or drive, missed group or employment for any reason, change in medications, etc:

What action steps have you completed on your case plan since your last office visit?

What strategies have you used to manage risk factors?

Yes	No	Payment on Court Fines/Fees <input type="checkbox"/> Paid in Full	Yes	No	Engaged in sexual encounters with an adult partner?
Yes	No	Payment on Supervision Fee <input type="checkbox"/> Paid in Full	Yes	No	Access to the Internet?
Yes	No	Attended SOTP Treatment Group: <input type="checkbox"/> NA List Group:	Yes	No	Changes of Electronic Devices?
Yes	No	Attended Other Treatment Services: <input type="checkbox"/> NA List Agency/Group: _____ Change in medication: <input type="checkbox"/> _____	Yes	No	Changes to internet identifiers? Social Media, E-mail, etc..... Did you update the SOR <input type="checkbox"/> Yes <input type="checkbox"/> No
Yes	No	Have you been to the SOR for your reporting month? Reporting Months:	Yes	No	Masturbated using fantasies of your offense, a victim or child? Masturbation over the last 30 days: _____
Yes	No	Any new debts/loans	Yes	No	Use any sexually explicit materials?
Yes	No	ANY Contact with HRU/Law Enforcement Arrests/New Charges? If yes, please explain.	Yes	No	ANY violations of your probation/parole? If yes, please explain.
Yes	No	URGES to Use Alcohol or Drugs? If yes, please explain.	Yes	No	Unauthorized contact with victim? If yes, please explain
Yes	No	ACTUAL USE of alcohol or drugs? If yes, please describe	Yes	No	Unauthorized contact with minor? If yes, please explain

Using the following scale, how would you rate your life in general since your last report?
Really Bad 0 1 2 3 4 5 6 7 8 9 10 **Really Great**

What could make it better? _____

I HEREBY CERTIFY THAT THIS REPORT IS TRUE, ACCURATE, AND COMPLETE.

Signature: _____

Date: _____