Special Management Unit: Tier III Program Over 2-Years 90-Day Quarterly Review Hearing Form

Current Date: ______________________

Date of Initial Assignment to Tier III: ______________________

Date of last 90-Day Mental Health Review: ______________________

Mandatory Release Date (MRD): ______________________

Within 12-months of Release: ____ YES or ____ NO

I. Offender: _______________________________ GDC#: _______________________________

II. In accordance with the Special Management Unit: Tier III Program SOP, the offender was assigned to Phase ______ following the last 90-Day Review (see Attachment 4).

III. In accordance with the Special Management Unit: Tier III Program SOP, the following were considered as part of the offender’s Over 2-Years 90-Day Quarterly Review:

   a. Length of time in Current Phase: ______________________________________________

   b. Perceived Risk of Release from SMU: __________________________________________

   c. Number, type, and frequency of disciplinary reports: __________________________

   d. Involvement in self-improvement activities: ______________________________________

   e. Behavior while in the SMU: __________________________________________________

   f. Offender’s 60-day or 90-day mental health evaluation: __________________________

   g. Progress on the Offender’s Management Plan: _________________________________

IV. Over 2-Years 90-Day Quarterly Review Panel Member Observations:

   a. Director, Fac Ops (or designee): ____________________________________________

RETENTION SCHEDULE: Upon completion, this form shall be placed in the offender’s institutional file.
b. Med Director (or designee): ______________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

c. MH Director (or designee): ______________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

d. Legal Services: _________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

V. The above-named offender has been given an Over 2-Years 90-Day Quarterly Review with the following recommendation given for his/her assignment:

☐ Remain in Current Phase
☐ Move to the Next Phase
☐ Return to Lower Phase
☐ Release/Transfer to Tier III STEP Program

Director, Fac Ops (or designee): ___________________________ Date: ______________

Med Director (or designee): ___________________________ Date: ______________

MH Director (or designee): ___________________________ Date: ______________

Legal Services: ___________________________ Date: ______________

VI. Offender’s Rebuttal:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Offender Signature ___________________________ Date

VII. Commissioner or Assistant Commissioner Review Date Received: ______________

I ☐ concur / ☐ disagree with the Over 2-Years 90-Day Quarterly Review Panel Recommendation and the following recommendation(s) has been made in this case:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Commissioner or Assistant Commissioner ___________________________ Date
VIII. Offender’s Acknowledgment of the Over 2-Years 90-Day Quarterly Review Recommendation

_______________________________________________

Signature/Date