Completion Report

# DRIVER SAFETY PLAN STATUS REPORT

Wisconsin Department of Transportation
s.343.16, 343.30(1q), or 343.305(10) Wis. Stats.
MV3631 10/2004

## General Information

| Name (Last, First, MI) | Birth Date | Sex | Driver License Number | State |
|---|---|---|---|---|
| SCHUETTE,SAMANTHA,MARY | [redacted] | F | [redacted] | WI |

| Address | City, State, ZIP Code | County of Residence | Area Code – Telephone |
|---|---|---|---|
| [redacted] | MADISON, WI 53711 | DANE | |

| Judge | Court Address (Street, City, ZIP Code) | Client Occupation |
|---|---|---|
| | | |

| Citation Number | Court Case Number | Non-UTC Number | Most Recent Conviction Date(s) |
|---|---|---|---|
| BC506698-3 | | | |

## Arrest Information

Arrest Date(s): 05-06-2021/WI

Blood Alcohol Level: .190

Arrested For:

- ☐ Controlled Substance and/or Other Impairing Drug:
- ☐ Implied Consent
- ☒ OWI - Operating While Intoxicated
- ☐ Repeat Offense
- ☐ OWI – Injury
- ☐ OWI – Great Bodily Harm
- ☐ OWI – Homicide

Total Lifetime OWI Arrests: 2

**Referred Information:** ☐ Court ☐ DOT ☒ Voluntary

## Assessment Finding Information

☒ Alcohol ☐ Other Drug(s) ☐ Controlled Substances

Final Diagnosis
Client completed 10 sessions with a prognosis of benefits from individual therapy. Client fully engaged in the therapeutic process and learned new coping and holistic strategies

## Driver Safety Plan Information - Program Recommendation

☐ Group Dynamics ☐ Multiple Offender Program Provider Name

☒ Outpatient Treatment — Regimen and Provider Name: tools for coping and self evaluation Choice #77777779

☐ Inpatient Treatment — Regimen and Provider Name:

☐ Victim Impact Panel

For any of the 6 choices below, please give provider name and explanation

☐ Medical Exam ☐ Psychiatric ☐ Detoxification ☐ Residential ☐ Day Treatment ☐ Other

Provider Name

Explanation
Client to follow recommendations of the provider.

| Plan Completion Date | Plan Extended Through – Total Assessment Period Cannot Exceed 16 Months |
|---|---|
| 05-15-2023 | |

| In Compliance Date(s) | Non-Compliance Date(s) |
|---|---|
| Plan | Assessment Interview |
| Assessment Fee | Plan |
| Treatment Fee | Assessment Fee |
| N/C Report Sent in Error | Treatment Fee |

(Provide date(s) only for the action(s) being taken for this report filing.)

Description, Prognosis or Comments
Completed, case closed.

## Assessment Facility/Assessor Information

| Agency | Name - Please Print | |
|---|---|---|
| Journey Mental Health Center - Clinical Assessment Unit | Quinton Wedig | 5-15-23 |
| Address: 25 Kessel Ct. Suite 200 / Area Code – Telephone: 608 280 2546 | Signature | Date: ~~06-09-2022~~ |
| City, State, ZIP Code: Madison WI 53711 | Title/Certification: BS, CSAC, CS-IT, IDP-AT | |

**Distribution**: 1 – Assessment; 2 – Plan Provider; 3 – DOT; 4 - Client