CONCHO VALLEY COMMUNITY CORRECTIONS FACILITY
Referral Form

Date: _____ Arrival Date: _____

CSO Name: _____ CSCD/ County: _____

CSO Phone #: _____ Judge Name/Jurist: _____

Cause #: _____ Supervision Level: _____

Defendant's Name: _____
(Last) *(First)* *(Middle)*

Age: _____ D.O.B.: _____ Race/Sex: _____/_____ Height _____

Weight _____ Hair _____ Eyes _____ POB _____

D.L. #: _____ State: _____ Expired or Suspended: Yes___No___

Social Security #: _____ FBI #: _____

Highest Education Completed: _____ Diploma or GED? Yes ____No ____ (circle which one)

Literate? Yes ____No____ English Speaking? Yes____ No ____

Current Offense: _____ Felony____ Misdemeanor____

SID # _____ Cause # _____ OID: _____

TRN # _____ TRS # _____ **PID #** _____

Deferred Adjudicated (Circle as appropriate)

Date of Offense: _____ Arrest Date _____ Weapon involved? Yes ____ No ____. If yes, please explain:

Sentence Date and Results: _____
_____

Incarceration Length: _____ days/months/years

Supervision Length: _____ days/months/years Expiration Date _____

Community Service Hours: _____

Prior Criminal History: _____

Assaultive History? Yes___ No___. If yes, please explain: _____
_____
_____

Charges Pending? Outstanding Warrants/ Traffic Tickets? Yes____ No____. If yes, please explain:_____

On Probation and/ or Parole for other Offense(s)? Yes___ No___. If yes, please include type of offense(s) and the name of jurisdiction(s): _____
_____
_____

Substance Abuse History: _____

_____

_____

Drug(s) of Choice: _____

Date and Results of Last Drug/ Alcohol Screening: _____

Note to Probation Officer: Should the defendant arrive at CCF under the influence of alcohol or show overt manifestations indicating use of other drugs, or our testing indicates recent drug use to the point where the client is visibly disoriented, the client may be denied entry to the CCF.

Reason for Referral: _____

_____

Prior Sanctions: _____

_____

Conditions of Probation **Not** Yet Completed. (Example, GED, Community Service, etc...)

_____

Please Check the following issues which **APPLY** to defendant's history:

_____ **IV Drug use**
_____ **Any drug use longer than 10 years**
_____ **Use of 3 or more substances in past 6 months**
_____ **More than Two (2) prior treatments for substance or other mental health diagnosis**
_____ **Age of first use less than 12 year of age**
_____ **Documented major head trauma**
_____ **More than 2 DWI's**
_____ **Identified emotional trauma**

Any History of Mental or Emotional Issues? _____ (Y/N)
If so, List medications the defendant currently taking AND diagnosis:

_____

_____

_____

Any History of Medical Issues? _____(Y/N)

Please list medications AND diagnosis:

_____

_____

_____

Employment

Employable? Yes ____ No____. If no, please explain

_____

_____

Currently Employed? Yes ____No____. If yes, Company Name and Job Duties:

_____

Defendant must bring drivers license and social security card with them to the facility.

Defendant's Work History: _____

_____

_____

Family Resources

Name/Address/Phone # of Nearest Relative of Defendant:

Name(s): _____

Address: _____

Phone #: _____

Comments: _____

_____

_____

_____

_____

Note: Defendants are required to complete a minimum of six (6) months of aftercare in their original jurisdiction upon discharge from the CCF.

COPIES OF THE FOLLOWING DOCUMENTS ARE <u>REQUIRED</u> ONCE PLACEMENT IS APPROVED

TRAS

Social Security Card

Drivers License/ID Card

H.S. Diploma/GED*

Alien Registration *(Green)* Card*

CJAD Approved Substance Abuse Screening (*SAQ, SASSI, etc.*
(ASI <u>and</u> SAE Required for TAIP Funding))

Prior Treatment Discharge Summaries

Prior Psychological Evaluations

Transfer/Transmittal Form

CCF Health Screening Form *(With Current TB Test Results)*

Placement With Incomplete Information Will <u>NOT</u> Be Permitted

Concho Valley Female CCF	Roy K. Robb Men's CCF

3398 McGill Boulevard
San Angelo, Texas 76905
325-655-7585/ Fax: 325-657-8485

3262 N. Hwy. 277
San Angelo, Texas 76905
325-486-1868 /Fax: 325-486-8609

RESIDENT PLACEMENT & GENERAL INFORMATION

1. Eligibility Criteria:
   A. Felony or misdemeanor cases.
   B. The defendant is not currently serving a term Community Supervision for a Title 5 offense (Texas Penal Code), and the defendant does not have an extensive history of Title 5 offenses.
   C. Court ordered by a Judge (placement and release) as a condition of Community Supervision either by direct placement or amended court order.
   D. The defendant does not have pending legal matters that may interfere with the CCF program.
   E. Defendants are required to complete a minimum of six (6) months of aftercare in their original jurisdiction upon discharge from the CCF.

2. Term of Placement:
   A. The term may not be more than 24 months.
   B. CCF program requires 6 months (minimum) to complete.
   C. Thirty day evaluation period.

3. Why Place a Defendant in the CCF?
   A. Alternative to prison.
   B. Alternative to jail term.
   C. Subsequent offense (while on term of Community Supervision).
   D. Result of Violation Report or Motion to Revoke.
   E. Alcohol use/ abuse.
   F. Drug use/ abuse.
   G. Behavioral problems.
   H. Technical violations.

4. Resident Categories Generally Not Acceptable in CCF Setting:
   A. Mentally low functioning.
   B. Schizophrenic.
   C. Severely handicapped.
   D. History of suicidal tendencies.
   E. Anti-social personality (Discuss with CCF personnel prior to entry)

5. Health Issues:
   A. Must not have a communicable disease.
   B. Recent (within last 30 days) results of TB skin test.
   C. Recent (within last 60 days) physical examination conducted by a licensed medical professional.
   D. Residents are not wards of the state and must be able to pay for medical treatment and medications.
   E. Residents who are taking psychotropic medication must be stable and enter the facility with no less than a 90-day supply of said medication.
   F. The CCF is not equipped to house pregnant residents. Please do not refer any pregnant defendants to the CCF. **A positive pregnancy during any phase of the program may be grounds for immediate discharge. Initial test will be performed upon entry.**

6. Pre-Placement Information Needed:
   A. Original judgment/ modification order.
   B. Offense reports (must be legible).
   C. P.S.I.
   D. Drug/ alcohol evaluations.
   E. Criminal history.
   F. Copy of chronological entry(s) stating the reason(s) as to why defendant is being placed at CCF.
   G. Full TRAS required on all cases unless direct court placement.
   H. Documentation of above mentioned TB test results and physical examination.

7. Major Elements of the CCF Program:
   A. Intake, orientation and assessment.
   B. Criminal Conduct and Substance Abuse Treatment (Wanberg/ Milkman).
   B. Intensive alcohol/ drug treatment (12 Step).
   C. Literacy/ GED.
   D. Employment skills/ job placement.
   E. AA/NA (in-house & community).
   F. Support group (alcohol-drug education).
   G. Group counseling.
   H. Community Service Restitution (CSR).
   I. Personal social adjustment/ life skills.
   J. Group counseling (alcohol & drug).
   K. Individual counseling.
   L. Family violence/ awareness.

8. Examples of Requested Conditions:

A. In lieu of incarceration, Defendant shall remain under custodial supervision in a Community Corrections Facility, obey all rules and regulations of such facility, and pay a percentage of your income to the facility for room and board. Defendant shall report within _____ days or on _____ , 2016, and Defendant shall reside at the Concho Valley Community Corrections Facility **Substance Abuse Treatment Facility(SATF) program or Court Residential Treatment Center (CRTC) program** at ***(address of either the Men's or Women's Facility goes here),*** in San Angelo, Texas, and remain there until satisfactorily discharged from said program by the facility Director. Defendant shall participate in all programs deemed appropriate, and shall neither voluntarily terminate participation in said programs nor voluntarily depart from the premises of said facility without the specific written permission of a duly authorized member of the facility.

B. Defendant shall submit to the following tests given by or under the direction of your Supervision Officer:(1) Breath analysis; (2) Urinalysis;

C. Defendant shall participate in Alcoholics Anonymous, Narcotics Anonymous, twice a week and/or other substance abuse groups/continuing aftercare programs as directed by your Supervision Officer. If necessary, Defendant shall submit to the Supervision Officer, written documentation/ receipts of such attendance at each required reporting.

D. Defendant shall surrender himself to the _____County Jail on or before _____, 201 __, by 2:00 o'clock P.M., or within 24 hours after the Community Supervision Officer notifies Defendant to surrender. Defendant shall remain in custody until transported by the _____County Sheriff's Department to the Concho Valley Community Corrections Facility.

NOTE: A copy of the original/ modification order placing the defendant in CCF should be on file with the Concho Valley CSCD CCF prior to the defendant's arrival.

9. Fees:

A. Code of Criminal Procedure, Article 42.12, Sec. 11, paragraph (12) requires a resident to pay a percentage of his income to the facility for transportation and room and board.

B. Resident's fees are currently $ 2.00 per hour worked.

C. The CCF requests that supervision fees be waived during the residents stay.

D. Resident's fees for Laundry are currently $ 25.00 per month

E Resident's fees for Transportation are currently $ 25.00 per month.

10. Release/ Retention Requirements:
    A. Prior to the release of a resident, the Residential Supervision Officer shall submit a completed evaluation report to the CCF and CSCD Directors for their review and subsequent approval. The Residential Supervision Officer
    shall submit a discharge summary to the resident's Community Supervision Officer one week prior to the resident's discharge. The Community Supervision Officer may use the discharge summary to notify the court of the upcoming discharge as well as indicator on how the resident performed while in the CCF. While progress reports are not sent out on a regular basis, the Courts and referring CSCD may request one at any time.
    B. For Release: A resident must have shown significant progress toward compliance with court-ordered conditions of Community Supervision as well as CCF general/ programmatic progress in order to be successfully discharged from the program.
    C. For Retention: A resident who fails to show progress while enrolled in the CCF program may be retained for a determined period exceeding the standard six month program, however, by law, the total stay of the resident shall not exceed 24 months.

NOTE: If the above-mentioned reports indicate that the resident has not made significant progress, the Court may choose to employ revocation proceedings.

12. General
    A. Although the residents wear institutional uniforms prior to the final phase, they should have a daily change of clothes for seven days. Some activities require shorts and tennis shoes.
    B. Due to storage limitations, personal items should be kept to a minimum.
    C. No personal TV's. Only "walkman" radios with earplugs are permitted in the later phases of the program.
    D. No personal musical instruments.

13. Contact Officers:
    A. Frank Tipton, Facility Director, 325-655-7585.
    B. Kim Skelton, Operations Manager Women's Facility, 325-655-7585.
    C. Tony Hill, Operations Manager Men's Facility, 325-486-1868

CONCHO VALLEY COMMUNITY CORRECTIONS FACILITY

List of Items to bring for FEMALES

5 pair of long pants
5 shirts with sleeves (no t-shirts with logos of drug or alcohol)
5 pair of socks
5 pair of underwear
2 pair of shoes, closed toe (1pair should be athletic shoes)
5 sleepwear sets, loose fitting, two-piece with sleeves, shorts or pant length
Resident must bring her Drivers License and Social Security Card for employment. Copies are not acceptable.

Razor, toothpaste, toothbrush, comb/brush, soap, deodorant, feminine hygiene products, and shaving cream

Polish must be removed from fingernails, and no artificial nails will be allowed. No glass containers or mirrors are allowed (including glass make-up bottles or mirrors on compacts) NO pillows allowed.

List of Items to bring for MALES

5 pair long pants
5 shirts with sleeves (no t-shirts with logos of drug or alcohol)
5 pair of socks
5 pair of underwear
2 pair of shoes, (1 pair should be athletic shoes)
Drivers License and Social Security Card

Razor, toothpaste, toothbrush, comb, soap, deodorant, shaving cream

Resident must bring his Drivers License and Social Security Card for employment. Copies are not acceptable

Tobacco Is NOT permitted in either facility!!

CCF Admission Health Screening Form

Today's Date: _____ Time: _____ am/pm Admission date: _____

Name:_____ SID #: _____

D.O.B._____ Age: _____ Sex: F_____ M_____ Race: _____

Blood Pressure: _____/_____ Temperature: _____ Pulse: _____ Respirations: _____

Drug Allergies: _____ Type of reaction: _____
Food Allergies: _____ Type of reaction: _____
Environmental Allergies (cedar, mold, etc.**): _____ Type of reaction: _____**

Current Weight: _____lbs. Height: _____ft. _____ in.
Recent unplanned weight loss: Yes ____ No ____ Recent unplanned weight gain: Yes ____ No ____
If the answer is yes how much weight in what length of time? _____

TB skin test to be administered and read within 7 calendar days prior to admission.

May be read after admission:

Current TB skin test:

Date given: _____ Date read: _____ Results: _____ mm.

If past history of previous positive TB skin test, give date _____ and results _____

TB Symptoms Screening Questionnaire Completed: Yes ___ No____ N/A ____ Date: _____
Symptomatic: Yes ____ No ____ if yes, referred for medical evaluation: _____

Chest x-ray results (only if applicable): Date: _____ Results: _____
Recommendations: _____

Medication History

List prescription drugs and over-the counter drugs currently being taken including herbal preparations, vitamins and other supplements:

Name of Medication	Dosage	Frequency/Instructions	Reason for Medication	Last Time Taken

Family Medical History
Does anyone in your family have a history of any of the following?

Health Problem	Yes	No	Who (mother, father, grandparent or sibling)	Health Problem	Yes	No	Who (mother, father, grandparent or sibling)
Alcoholism				Epilepsy / Seizures			
Arthritis				High Blood Pressure			
Cancer				Kidney Disease			
Bleeding Disorder				Mental Illness			
Diabetes				Mental Retardation			
Drug Addiction				Stroke			
Heart Disease				Thyroid Disease			

Medical History: (hospitalizations, surgery, injury, recent fall):

_____

_____

_____

_____

Last tetanus immunization: _____

Do you now have or have you ever been told that you have any of the following problems?

	Yes	No	Swelling of	Yes	No		Yes	No		Yes	No
Alcoholism			Ankles/Legs			Syphilis			Drug abuse		
Allergies			Gout			Gonorrhea			Seizures		
Anemia			Cancer			Herpes			Stroke		
Asthma			Diabetes			Trichomonas			Slurred Speech		
Bronchitis			Thyroid disease			Other STD's			Numbness		
Chronic Cough			Kidney disease			Broken bones			Paralysis		
Frequent colds			Kidney stones			Back problems			Dizziness		
Hay fever			Heartburn			Dentures			Fainting		
Shortness of breath			Nausea/ Vomiting			Hearing loss Left / Right Ear			Headaches Frequent / Severe		
Sinusitis			GI Ulcers			Hearing Aid			**Males Only**		
Emphysema			Hepatitis A, B or C			Eye glasses			Prostate problem		
Tuberculosis			Sickle Cell			Contact Lens			Prostate Surgery		
Pneumonia			Gallstones			Glaucoma			**Females Only**		
Wheezing			Arthritis			Cataracts			Pregnant		
Coughing up Blood			High Cholesterol			High Blood Pressure			Last Menstrual Cycle	Date	
Chest pain			Hernia			Hemorrhoids			Missed periods		
Heart disease			Varicose veins			Constipation			Last Pap Smear		
Heart Murmur			Leg Cramps			Diarrhea			Last Breast Exam		
Pacemaker			Vascular disease			Blood in stool			Post menopausal		

If you answered yes to any of the questions above, please explain:

_____

_____
_____
_____

Are there any other health problems not included in the list above?

____
_____
_____

Family physician's information if applicable (name, address, phone number)**:** _____
_____
_____

Dental Problems: (any current dental problems that require immediate attention):_____
_____

Mental illness current or past history: (any past history of suicide attempts or ideation) _____
Are you currently having any thoughts of harming yourself or others? _____
Have you ever received treatment for mental illness? Yes____ No____ When? _____ Where? _____
Are you currently receiving mental health services? _____ Last doctor's visit: _____
Attending Psychiatrist: _____ Telephone #: _____

Have you ever been diagnosed with any of the following?			**Please circle all that apply:**	
Depression	Schizophrenia	Compulsive disorder	Attention deficit disorder	Other_____
Anxiety disorder	Bipolar disorder	Eating disorder	Hyperactivity Disorder	_____
Panic attacks	Sleep disorder	Memory Loss	Mental Retardation	

Do you smoke or use other tobacco products? Yes_____ No _____
If the answer is yes, what type? _____
Length of time smoking/using: _____ Amount used daily _____
Have you ever attempted to stop smoking or using tobacco products? Yes ____ No ____ When?
_____
Comments:
_____

Alcohol and Drug Use/Abuse History: Inquire about the use of various types of alcohol (beer, wine, liquor), illicit drugs, inhalants, prescription drugs, over-the counter drugs of abuse, and any other drugs not mentioned.

Types of alcohol and drugs used:	**Mode of Use (IV, smoke, oral, etc)**	**Amount Used**	**Frequency of Use**	**Problems after stopping use**	**Last** date used

General Observations:

Behavior which includes state of consciousness, mental status, appearance, conduct, tremors and sweating.

_____

_____

_____

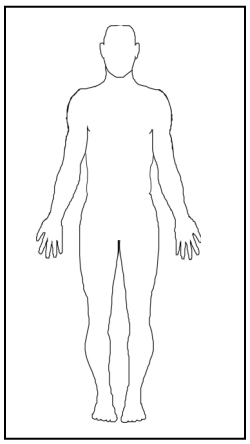
Body deformities, ease of movement, limited range of motion, assistive devices required:

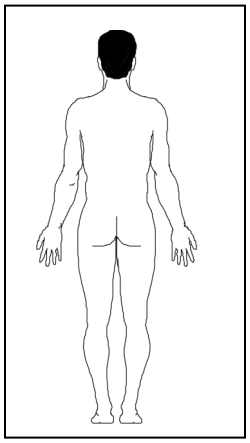
_____

_____

Condition of skin, including trauma markings, bruises, lesions, open sores, jaundice (yellow), skin rashes, infestations of the skin (lice, scabies, etc..) and needle marks or tracks or other indication of drug abuse:

_____





_____

_____

_____

Special skin markings (Tattoos, body piercing, etc.) _____

_____

_____

Codes for Body Outline: A - abrasion, B -bruises, C - cut, L - laceration, P - piercing, R - rash, T- tattoo S - scar, N - needle marks/ tracks, BR - burn, O - open sore, SU– sutures.

Regular Diet: Yes _____ No _____
Special Diet: _____
Cleared for Kitchen Duty: Yes _____ No _____

Activity Level: Total_____ Limited _____
Physical restrictions: _____
_____

Is there a medical reason a lower bed bunk is required? Yes_____ No_____
If Yes, Medical Diagnosis:
_____
_____
_____

Recommendations:

_____

_____

_____

Printed Name and Title (Physician, PA, FNP, RN, LVN, EMT-P)	**Signature and Title (Physician, PA, FNP, RN, LVN, EMT-P)**	**Date**

I verify that the information that I have provided regarding my past medical history and current medical problems are correct to the best of my knowledge, and I authorize this information to be released to the residential facility.

_____	_____	_____
Resident's Printed Name	**Resident's Signature**	**Date**