

Arizona Department of Corrections Rehabilitation and Reentry

Transition Program Application and Agreement

SIGNATURE DATE (mm/dd/yyyy) STAFF VERIFICATION (Last, First, M.I.) (Please Print) EMPLOYEE IDENTIFICATION NUMBER	☐ Drug Transition Program ☐ Standard Transition Program		
submitting my name for participation in the Transition Program. I am agreeing to the following terms and conditions: 1. Upon release from ADCRR secure care, I shall, within two weeks of my release date, attend a Transitions Class by an ADCRR contracted vendor. 2. I shall be assessed for treatment and psycho-educational needs. 3. I shall attend the recommended groups and classes. 4. I shall sign a release of information that allows the treatment provider to share information with the appropriate ADCRR Staff. 5. Upon release from custody, I will contact my Supervising Officer or Duty Officer by personal visit within one (1) working day unless otherwise directed. 1 understand that this is only an application and that final approval for participation may or may not be granted. 1 understand that I must have an approved housing placement to participate. (This is not applicable to those in the Drug Transition Program) 1 understand that I must have an approved housing placement to participate. (This is not applicable to those in the Drug Transition Program) 1 understand that if I wish to continue services beyond the 90 days, I shall have to make individual arrangements with the provider regarding payment. 1 understand that fin wish to continue services beyond the 90 days, I shall have to make individual arrangements with the provider regarding payment. 1 understand that fin the Transition Class, appointment for assessment and/or scheduled groups or classes will result in sanction up to and including return to custody. 1 understand that if I am returned to custody due to a violation of my release terms that occurs before my CSBD, I will receive an administrative probable cause hearing. If cause is established, my CSBD will be forfeited and I shall not be eligible for release until my ERD. 1 understand that if I am returned to custody due to a violation of my release terms that occurs after my CSBD, I shall appear before the Board of Executive Clemency. Unless reinstated by the Board, I shall remain in custo	I,	, understand that, by	
contracted vendor. 2. I shall be assessed for treatment and psycho-educational needs. 3. I shall attend the recommended groups and classes. 4. I shall stign a release of information that allows the treatment provider to share information with the appropriate ADCRR Staff. 5. Upon release from custody, I will contact my Supervising Officer or Duty Officer by personal visit within one (1) working day unless otherwise directed. 1 understand that this is only an application and that final approval for participation may or may not be granted. 1 understand that I must have an approved housing placement to participate. (This is not applicable to those in the Drug Transition Program) 1 understand that any mandated services in this program will be paid for by ADCRR from a Legislatively created fund. 1 understand that if I wish to continue services beyond the 90 days, I shall have to make individual arrangements with the provider regarding payment. 1 understand that my Community Corrections Officer will have access to my attendance and participation records. 1 understand that failure to attend the Transition Class, appointment for assessment and/or scheduled groups or classes will result in sanction up to and including return to custody, due to a violation of my release terms that occurs before my CSBD, I will receive an administrative probable cause hearing. If cause is established, my CSBD will be forfeited and I shall not be eligible for release until my ERD. NMATE NAME (Last, First, M.I.) (Please Print) SIGNATURE DATE (mm/dd/yyyy) STAFF VERIFICATION (Last, First, M.I.) (Please Print)	,		
3. I shall attend the recommended groups and classes. 4. I shall sign a release of information that allows the treatment provider to share information with the appropriate ADCRR Staff. 5. Upon release from custody, I will contact my Supervising Officer or Duty Officer by personal visit within one (1) working day unless otherwise directed. I understand that this is only an application and that final approval for participation may or may not be granted. I understand that I may not receive the full 90 days of early release. I understand that I must have an approved housing placement to participate. (This is not applicable to those in the Drug Transition Program) I understand that any mandated services in this program will be paid for by ADCRR from a Legislatively created fund. I understand that if I wish to continue services beyond the 90 days, I shall have to make individual arrangements with the provider regarding payment. I understand that my Community Corrections Officer will have access to my attendance and participation records. I understand that failure to attend the Transition Class, appointment for assessment and/or scheduled groups or classes will result in sanction up to and including return to custody. I understand that if I am returned to custody due to a violation of my release terms that occurs before my CSBD, I will receive an administrative probable cause hearing. If cause is established, my CSBD will be forfeited and I shall not be eligible for release until my ERD. I understand that if I am returned to custody due to a violation of my release terms that occurs after my CSBD, I shall appear before the Board of Executive Clemency. Unless reinstated by the Board, I shall remain in custody until my CSED. INMATE NAME (Lest. First. M.I.) (Please Print) SIGNATURE DATE (mm/dd/)yyyy) EMPLOYEE IDENTIFICATION NUMBER	Upon release from ADCRR secure care, I shall, within two weeks of my release date, attend a Transitions Class by an ADCRR		
4. I shall sign a release of information that allows the treatment provider to share information with the appropriate ADCRR Staff. 5. Upon release from custody, I will contact my Supervising Officer or Duty Officer by personal visit within one (1) working day unless otherwise directed. I understand that this is only an application and that final approval for participation may or may not be granted. I understand that I must not receive the full 90 days of early release. I understand that I must have an approved housing placement to participate. (This is not applicable to those in the Drug Transition Program) I understand that any mandated services in this program will be paid for by ADCRR from a Legislatively created fund. I understand that if I wish to continue services beyond the 90 days, I shall have to make individual arrangements with the provider regarding payment. I understand that my Community Corrections Officer will have access to my attendance and participation records. I understand that failure to attend the Transition Class, appointment for assessment and/or scheduled groups or classes will result in sanction up to and including return to custody. I understand that if I am returned to custody due to a violation of my release terms that occurs before my CSBD, I will receive an administrative probable cause hearing. If cause is established, my CSBD will be forfeited and I shall not be eligible for release until my ERD. I understand that if I am returned to custody due to a violation of my release terms that occurs after my CSBD, I shall appear before the Board of Executive Clemency. Unless reinstated by the Board, I shall remain in custody until my CSED. INMATE NAME (Last. First. M.I.) (Please Print) ADCRR NUMBER SIGNATURE DATE (mm/dd/yyyy)	I shall be assessed for treatment and psycho-educational needs.		
5. Upon release from custody, I will contact my Supervising Officer or Duty Officer by personal visit within one (1) working day unless otherwise directed. I understand that this is only an application and that final approval for participation may or may not be granted. I understand that I may not receive the full 90 days of early release. I understand that I must have an approved housing placement to participate. (This is not applicable to those in the Drug Transition Program) I understand that any mandated services in this program will be paid for by ADCRR from a Legislatively created fund. I understand that if I wish to continue services beyond the 90 days, I shall have to make individual arrangements with the provider regarding payment. I understand that my Community Corrections Officer will have access to my attendance and participation records. I understand that failure to attend the Transition Class, appointment for assessment and/or scheduled groups or classes will result in sanction up to and including return to custody. I understand that if I am returned to custody due to a violation of my release terms that occurs before my CSBD, I will receive an administrative probable cause hearing. If cause is established, my CSBD will be forfeited and I shall not be eligible for release until my ERD. I understand that if I am returned to custody due to a violation of my release terms that occurs after my CSBD, I shall appear before the Board of Executive Clemency. Unless reinstated by the Board, I shall remain in custody until my CSED.	3. I shall attend the recommended groups and classes.		
unless otherwise directed. I understand that this is only an application and that final approval for participation may or may not be granted. I understand that I may not receive the full 90 days of early release. I understand that I must have an approved housing placement to participate. (This is not applicable to those in the Drug Transition Program) I understand that any mandated services in this program will be paid for by ADCRR from a Legislatively created fund. I understand that if I wish to continue services beyond the 90 days, I shall have to make individual arrangements with the provider regarding payment. I understand that my Community Corrections Officer will have access to my attendance and participation records. I understand that failure to attend the Transition Class, appointment for assessment and/or scheduled groups or classes will result in sanction up to and including return to custody. I understand that if I am returned to custody due to a violation of my release terms that occurs before my CSBD, I will receive an administrative probable cause hearing. If cause is established, my CSBD will be forfeited and I shall not be eligible for release until my ERD. I understand that if I am returned to custody due to a violation of my release terms that occurs after my CSBD, I shall appear before the Board of Executive Clemency. Unless reinstated by the Board, I shall remain in custody until my CSED. INMATE NAME (Last. First. M.I.) (Please Print) STAFF VERIFICATION (Last. First. M.I.) (Please Print) EMPLOYEE IDENTIFICATION NUMBER	4. I shall sign a release of information that allows the treatment provider to share information with the appropriate ADCRR Staff.		
I understand that I must have an approved housing placement to participate. (This is not applicable to those in the Drug Transition Program) I understand that I must have an approved housing placement to participate. (This is not applicable to those in the Drug Transition Program) I understand that any mandated services in this program will be paid for by ADCRR from a Legislatively created fund. I understand that if I wish to continue services beyond the 90 days, I shall have to make individual arrangements with the provider regarding payment. I understand that my Community Corrections Officer will have access to my attendance and participation records. I understand that failure to attend the Transition Class, appointment for assessment and/or scheduled groups or classes will result in sanction up to and including return to custody. I understand that if I am returned to custody due to a violation of my release terms that occurs before my CSBD, I will receive an administrative probable cause hearing. If cause is established, my CSBD will be forfeited and I shall not be eligible for release until my ERD. I understand that if I am returned to custody due to a violation of my release terms that occurs after my CSBD, I shall appear before the Board of Executive Clemency. Unless reinstated by the Board, I shall remain in custody until my CSED. INMATE NAME (Last, First, M.I.) (Please Print) ADCRR NUMBER SIGNATURE DATE (mm/dd/yyyy)			
I understand that I must have an approved housing placement to participate. (This is not applicable to those in the Drug Transition Program) I understand that any mandated services in this program will be paid for by ADCRR from a Legislatively created fund. I understand that if I wish to continue services beyond the 90 days, I shall have to make individual arrangements with the provider regarding payment. I understand that my Community Corrections Officer will have access to my attendance and participation records. I understand that failure to attend the Transition Class, appointment for assessment and/or scheduled groups or classes will result in sanction up to and including return to custody. I understand that if I am returned to custody due to a violation of my release terms that occurs before my CSBD, I will receive an administrative probable cause hearing. If cause is established, my CSBD will be forfeited and I shall not be eligible for release until my ERD. I understand that if I am returned to custody due to a violation of my release terms that occurs after my CSBD, I shall appear before the Board of Executive Clemency. Unless reinstated by the Board, I shall remain in custody until my CSED. INMATE NAME (Last. First. M.I.) (Please Print) ADCRR NUMBER SIGNATURE DATE (mm/dd/yyyy) EMPLOYEE IDENTIFICATION NUMBER	I understand that this is only an application and that final approval for participation may or may not be granted.		
I understand that any mandated services in this program will be paid for by ADCRR from a Legislatively created fund. I understand that if I wish to continue services beyond the 90 days, I shall have to make individual arrangements with the provider regarding payment. I understand that my Community Corrections Officer will have access to my attendance and participation records. I understand that failure to attend the Transition Class, appointment for assessment and/or scheduled groups or classes will result in sanction up to and including return to custody. I understand that if I am returned to custody due to a violation of my release terms that occurs before my CSBD, I will receive an administrative probable cause hearing. If cause is established, my CSBD will be forfeited and I shall not be eligible for release until my ERD. I understand that if I am returned to custody due to a violation of my release terms that occurs after my CSBD, I shall appear before the Board of Executive Clemency. Unless reinstated by the Board, I shall remain in custody until my CSED. INMATE NAME (Last, First, M.I.) (Please Print) ADCRR NUMBER SIGNATURE DATE (mm/dd/yyyy) EMPLOYEE IDENTIFICATION NUMBER	I understand that I may not receive the full 90 days of early release.		
I understand that if I wish to continue services beyond the 90 days, I shall have to make individual arrangements with the provider regarding payment. I understand that my Community Corrections Officer will have access to my attendance and participation records. I understand that failure to attend the Transition Class, appointment for assessment and/or scheduled groups or classes will result in sanction up to and including return to custody. I understand that if I am returned to custody due to a violation of my release terms that occurs before my CSBD, I will receive an administrative probable cause hearing. If cause is established, my CSBD will be forfeited and I shall not be eligible for release until my ERD. I understand that if I am returned to custody due to a violation of my release terms that occurs after my CSBD, I shall appear before the Board of Executive Clemency. Unless reinstated by the Board, I shall remain in custody until my CSED. INMATE NAME (Last, First, M.I.) (Please Print) ADCRR NUMBER SIGNATURE DATE (mm/dd/yyyy) EMPLOYEE IDENTIFICATION NUMBER			
I understand that my Community Corrections Officer will have access to my attendance and participation records. I understand that failure to attend the Transition Class, appointment for assessment and/or scheduled groups or classes will result in sanction up to and including return to custody. I understand that if I am returned to custody due to a violation of my release terms that occurs before my CSBD, I will receive an administrative probable cause hearing. If cause is established, my CSBD will be forfeited and I shall not be eligible for release until my ERD. I understand that if I am returned to custody due to a violation of my release terms that occurs after my CSBD, I shall appear before the Board of Executive Clemency. Unless reinstated by the Board, I shall remain in custody until my CSED. INMATE NAME (Last, First, M.I.) (Please Print) ADCRR NUMBER SIGNATURE DATE (mm/dd/yyyy) STAFF VERIFICATION (Last, First, M.I.) (Please Print) EMPLOYEE IDENTIFICATION NUMBER	I understand that any mandated services in this program will be paid for by ADCRR from a Legislatively created fund.		
I understand that failure to attend the Transition Class, appointment for assessment and/or scheduled groups or classes will result in sanction up to and including return to custody. I understand that if I am returned to custody due to a violation of my release terms that occurs before my CSBD, I will receive an administrative probable cause hearing. If cause is established, my CSBD will be forfeited and I shall not be eligible for release until my ERD. I understand that if I am returned to custody due to a violation of my release terms that occurs after my CSBD, I shall appear before the Board of Executive Clemency. Unless reinstated by the Board, I shall remain in custody until my CSED. INMATE NAME (Last, First, M.I.) (Please Print) ADCRR NUMBER SIGNATURE DATE (mm/dd/yyyy) EMPLOYEE IDENTIFICATION NUMBER			
I understand that if I am returned to custody due to a violation of my release terms that occurs before my CSBD, I will receive an administrative probable cause hearing. If cause is established, my CSBD will be forfeited and I shall not be eligible for release until my ERD. I understand that if I am returned to custody due to a violation of my release terms that occurs after my CSBD, I shall appear before the Board of Executive Clemency. Unless reinstated by the Board, I shall remain in custody until my CSED. INMATE NAME (Last, First, M.I.) (Please Print) ADCRR NUMBER SIGNATURE DATE (mm/dd/yyyy) EMPLOYEE IDENTIFICATION NUMBER	I understand that my Community Corrections Officer will have access to my attendance and participation records.		
administrative probable cause hearing. If cause is established, my CSBD will be forfeited and I shall not be eligible for release until my ERD. I understand that if I am returned to custody due to a violation of my release terms that occurs after my CSBD, I shall appear before the Board of Executive Clemency. Unless reinstated by the Board, I shall remain in custody until my CSED. INMATE NAME (Last, First, M.I.) (Please Print) ADCRR NUMBER DATE (mm/dd/yyyy) STAFF VERIFICATION (Last, First, M.I.) (Please Print) EMPLOYEE IDENTIFICATION NUMBER			
the Board of Executive Clemency. Unless reinstated by the Board, I shall remain in custody until my CSED. INMATE NAME (Last, First, M.I.) (Please Print) ADCRR NUMBER DATE (mm/dd/yyyy) STAFF VERIFICATION (Last, First, M.I.) (Please Print) EMPLOYEE IDENTIFICATION NUMBER	administrative probable cause hearing. If cause is established, my CSBD will be forfeited and I shall not be eligible for release until		
SIGNATURE DATE (mm/dd/yyyy) STAFF VERIFICATION (Last, First, M.I.) (Please Print) EMPLOYEE IDENTIFICATION NUMBER			
STAFF VERIFICATION (Last, First, M.I.) (Please Print) EMPLOYEE IDENTIFICATION NUMBER	INMATE NAME (Last, First, M.I.) (Please Print)	ADCRR NUMBER	
	SIGNATURE	DATE (mm/dd/yyyy)	
	STATE VEDICICATION (Lost First ML) (Place Print)	EMDLOVEE IDENTIFICATION NI IMPED	
SIGNATURE DATE (mm/dd/yyyy)	STALL VERTILITY (Last, First, M.I.) (Flease PTINT)	LIVII LOTEE IDENTIFICATION NOWIDER	
	SIGNATURE	DATE (mm/dd/yyyy)	

Distribution: Original - Master Record File Copy – Community Corrections File