1.0 PURPOSE

To establish a uniform procedure within the Department of Public Safety (PSD) for designating the initial classification level and institutional placement for all newly committed prison inmates, in accordance with best practices.

2.0 SCOPE

This policy shall apply to all personnel involved with the RAD assessment process. To the extent any individual facility’s policy conflicts with the statewide policy, COR.18.03 shall control.

3.0 REFERENCES, DEFINITIONS AND FORMS

.1 References

a. Hawaii Revised Statutes (HRS), § 26-14.6, Department of Public Safety.

b. HRS § 353C-2, Director of Public Safety, Powers and Duties.

c. HRS § 353E, Statewide Integrated Sex Offender Treatment Program.


e. Department of Public Safety (PSD), Policy and Procedures (P & P), COR.11.01, Administrative Segregation and Disciplinary Segregation.


g. PSD, P & P, COR.18.07, Exception Case.


i. Department of Public Safety, Classification Coding Instructions Manual (Revised 2016).
.2 Definitions

a. ASUS – Adult Substance Abuse Survey (ASUS). A 64-item self-report survey designed to assess an individual's perceived alcohol and other drug use.

b. LSI-R – Level of Service Inventory – Revised (LSI-R). A predictive risk and needs scale that assesses an inmate's propensity for further unlawful and rule-violating behavior based upon criminal history and dynamic risk factors.

c. Pre-Sentence Investigation (PSI) Report – A report generated by the Adult Probation office that investigates the history of a convicted felon prior to sentencing to identify any extenuating factors that might decrease or increase the harshness of the sentence.

d. Prison Initial Classification Instrument – A tool used to determine the initial custody designation of a newly admitted, sentenced felon, for the sole purpose of identifying a housing assignment.

e. Prison Inmate – Any individual who is convicted of a crime and sentenced by the courts for a period of MORE THAN ONE (1) YEAR (this includes anyone that has been SENTENCED to a CONSECUTIVE term TOTTALLING more than one (1) year combined) and parole violators returned to custody.

f. Prison Reclassification Instrument – A tool used to record adjustments toward an inmate's custody designation that either follows the outcome of a misconduct(s) or involves new information received.

g. Reception, Assessment, Diagnostic (RAD) – A separate unit that temporarily houses all newly admitted, sentenced felons for evaluation to determine initial programming and custody designation, using tools such as the LSI-R, ASUS, PSI and any other relevant sources.

h. SOCLR – Sex Offender Custody Level Review.

i. SOTPA – Sex Offender Treatment Program Administrator.
.3 Forms
   a. PSD 0498 – Medical/Mental/Dental Health Intake Screening form (attached).
   
   b. PSD 8760 – Sex Offender Custody Level Review form (attached).
   
   c. PSD 8731 – Initial Prescriptive Plan form (IPP) (attached).
   
   d. PSD 8801 – Inmate Reentry Plan for the Department of Public Safety form (attached).

4.0 POLICY

It is the policy of the Department of Public Safety to provide a systematic and objective evaluation of prison inmates for their initial classification and appropriate facility placement. In order to accomplish this, the Reception, Assessment, and Diagnostic (RAD) Unit shall complete the IPP (PSD 8731), Reentry Plan (PSD 8801), and the Initial Classification Instrument, in order to designate an initial custody level, facility assignment, and program recommendations for the offender.

5.0 PROCEDURES

.1 Newly sentenced male prison inmates shall be initially assigned to the Reception Assessment and Diagnostic (RAD) Unit at Halawa Correctional Facility.

.2 Newly sentenced female prison inmates on Oahu shall be initially assigned to the RAD Unit at Women's Community Correctional Center (WCCC).

.3 Each inmate shall be assigned to the least restrictive environment required based on the risk the offender presents to the community and others within the correctional system.

.4 Inmates with a disability, in accordance with PSD, P&P, COR.14.27, Inmates with Disabilities shall be provided with all approved reasonable modifications, auxiliary aids or services, and removal of architectural, communication, or transportation barriers. Documentation of all such actions provided shall be

NOT-CONFIDENTIAL
written into the Initial Classification Instrument under Section 10. Medical/Physical Problem, and the IPP.

.5 Sentenced male inmates with "maximum" custody designations shall be housed at the Halawa Correctional Facility (HCF) maximum-security unit.

.6 Sentenced female inmates designated "maximum" shall be housed in the segregation unit at WCCC, due to the custody level requirements in accordance with PSD, P&P, COR.11.01, Administrative Segregation and Disciplinary Segregation.

.7 Inmates with pending charges listed under "Greatest" or "High" on the Severity of Offense Scale shall be assigned no lower than Medium custody to be reviewed once a judgment has been rendered.

.8 Each inmate shall have their RAD Assessment process completed to include a completed Initial Classification no later than 60 days from admission to the unit. A copy of the completed IPP "packet" shall be submitted to the Department's Inmate Classification Office.

.9 If documents are not received within the 60-day time frame allocated to the RAD Unit, inmates shall be given an initial classification of "medium" until documents are received, or other inmates indicates that another custody level designation is more appropriate.

.10 At a minimum, the following documentation is required in order to accomplish the initial classification, programming needs/recommendations, and facility assignment process:

a. A certified judgment of conviction, ordering imprisonment for the offense the inmate is currently serving; an "Order Pertaining to Bail" indicating pending charges; a written request for "safekeeping" from a Sheriff's Office or other sanctioned law enforcement agency.

b. A Pre-sentence Investigation Report (PSI) developed by the Adult Probation Division. Should the defendant waive PSI, other available documentation will be used in lieu of PSI (i.e. CJIS print out).

c. NCIC and CJIS reports or other verified information concerning the inmate's prior criminal history.

NOT-CONFIDENTIAL
d. Medical, mental and dental health evaluations that indicate findings and treatment needs on PSD 0498: Medical/Mental/Dental Health Intake Screening form.

Documents identifying any reasonable modifications, auxiliary aids or services, and removal of architectural, communication, and transportation barriers approved in accordance with PSD, P & P, COR.14.27.

e. Educational/vocational assessment.

f. Substance abuse history and treatment needs (LSI-R/ASUS).

g. Submission of a PSD 8760 form: Sex Offender Custody Level Review (SOCR) form to the Sex Offender Treatment Program Administrator (SOTPA).

h. Documentation that may identify separates, gang affiliations, etc.

i. Reentry Plan form PSD 8801 listing basic information about the offender's available resources within the community and indicating weak areas that should be addressed prior to the inmate's release.

.11 The Department Classification Officer will determine the actual facility placement in accordance with PSD, P&P, COR.18.04, Reclassification of Prison Inmates.

.12 The Wardens are responsible to administer the Inmate Classification and Facility Assignment of Prison Inmates policy and procedures.
APPROVAL RECOMMENDED:

[Signature]

Deputy Director for Corrections  

May 1, 2020

Date

APPROVED:

[Signature]

DIRECTOR

May 1, 2020

Date

NOT-CONFIDENTIAL
MEDICAL/DENTAL/MENTAL HEALTH INTAKE SCREENING

ADMISSION DATE: __________ FACILITY: __________ PRIOR ADM TO THIS FACILITY Y □ N □

NAME: ____________________________________________

SID: ___________________________ DOB: ___________ SEX: ________________

□ YES □ NO

☐ Does the arresting or transporting officer or other custodial agency report indications that
the inmate is a medical or mental health or suicide risk?

MEDICAL OBSERVATIONS:

☐ Are there observable signs of physical injuries? (Cuts, bruises, swollen or deformed areas)
☐ The inmate does not know what day it is and/or where he is. (If yes, ask about recent head injury.)
☐ Is there any sign of altered consciousness? (Not alert, non responsive to verbal commands, slow, slurred
or incoherent speech, excessive sleepiness.)
☐ Are there any signs of limitations in movement? (Limping can’t move a limb or joint, obvious physical
deformities or complaints of pain on movement.)
☐ Are there any signs of body parasites? (Lice, crabs, scabies, etc.)
☐ Are there observable signs of illness? (Blue lips, shortness of breath, hyperventilation, hacking
cough, flushed skin, rashes, orange/yellow skin or eyes, excessive sweating)
☐ Are there observable signs of intoxication or does the inmate appear to be under the
influence of drugs? (Smells like alcohol, staggers, shaky, anxious, slurred speech.)
☐ Are needle marks, "needle tracks", or a fresh tattoo visible?

QUESTIONS: (Ask inmate the Questions. Inmate may not self administer. No need to expand on yes answers health
care staff will obtain history based on a yes check mark)

☐ Do you have any allergies?
☐ Have you suffered a head injury within the last 48 hours?
☐ Have you ever had an infectious or communicable disease (e.g. Hepatitis C, TB)
☐ Do you currently have any symptoms of illness? (e.g. chronic cough, coughing up blood,
tiredness, weight loss or gain of two or more pounds per week, loss of appetite, fever, night sweats, shortness
of breath or fast breathing or any pain.) (Note all that apply)

☐ Are you under a doctor’s care?
☐ Are you currently taking any medications?
☐ Do you have any medical conditions that limit your movement?
☐ Do you have any diet restrictions?
☐ Have you had an organ removed or an organ transplant?
☐ Do you use any prosthetic device(s) to aid any physical limitations? (Including eyeglasses,
dentures, contact lens, hearing aid artificial eye(s), artificial limb(s).)
☐ Do you have any dental problems? (Toothaches, mouth sores or infections.)
☐ Have you ever been the victim of physical, psychological or sexual violence?
☐ Have you ever been enrolled in special education classes while in school?
☐ Have you recently been discharged from the Hawaii State Hospital?
☐ Have you ever suffered alcohol or drug withdrawal symptoms?
☐ Do you currently use any drugs or alcohol? (If so, what and when did you last use?)

FEMALES:

☐ Are you pregnant?
☐ Do you have any current gynecological problems?

PPD DATE: __________ DATE READ: __________ RESULTS: __________ X-ray Results: __________

☐ Nsg. Disposition: □ Same Day □ Sched. Appt. with Whom/Date: ____________ Refer.
☐ MH Emer. Contacted: ___________ Date/Time: ___________ □ Gen. Pop □ Other: __________

DOC 0498 (05/14) Page 1 of 4 CONFIDENTIAL
REVIEWED BY RN STAFF: _________________________ Date/Time _______
STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

VERBALIZED, OBSERVABLE OR OTHER DOCUMENTED SIGNS OF MH/SUICIDE RISK:

YES ☐ NO ☐

Any 3 positives to questions/observations #1 - #7 requires an SRE.
1. ☐ ☐ Strong feelings of remorse or shame?
2. ☐ ☐ Passive/withdrawn?
3. ☐ ☐ Is the nature of the crime high profile (media or celebrity status in community, etc.)?
4. ☐ ☐ Have you recently experienced a significant loss? (Relationship, death in family, job, etc.)?
5. ☐ ☐ Do you currently feel like you have to talk or move more slowly than you usually do?
6. ☐ ☐ Have there currently been a few weeks when you felt like you were useless or sinful?
7. ☐ ☐ Has a family member or close friend ever attempted or committed suicide?

Any one positive to questions/observations #8 - #13 (gray shade) requires an SRE.
8. ☐ ☐ Verbalizing hopelessness or extreme fear
9. ☐ ☐ Evidence of self-mutilation
10. ☐ ☐ If in jail or prison before was inmate ever placed on suicide or safety watch? (from OT alert)
11. ☐ ☐ In the past have you ever tried to hurt or kill yourself?
   When ______ Why ______ How ______?
   When ______ Why ______ How ______?
   When ______ Why ______ How ______?
12. ☐ ☐ Are you thinking about hurting or killing yourself now?
13. ☐ ☐ Question 1 page 1 (Arresting or Transporting Officer indicated Suicide Risk)

A positive response on any items #17 - #28 requires referral to the Mental Health Section.
14. ☐ ☐ Loud/noxious behavior?
15. ☐ ☐ Uncooperative behavior?
16. ☐ ☐ Aggressive behavior/Restless/over reacting?
17. ☐ ☐ Bizarre behavior, confused or incoherent?
18. ☐ ☐ Have you ever received mental health treatment in a correctional facility?
19. ☐ ☐ Are you receiving counseling from a mental health professional or treatment center?
20. ☐ ☐ Have you ever been hospitalized for an emotional or mental health condition?
21. ☐ ☐ Are you currently taking any medication for an emotional or mental health disorder?
22. ☐ ☐ Have you or your friends noticed that you are currently much more active than usual?
23. ☐ ☐ Do you hear things or see things others cannot see or hear?
24. ☐ ☐ Do you currently believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head? or other people know your thoughts and can read your mind?
25. ☐ ☐ Have you ever or are you currently thinking about harming another person?

The following questions are to be completed following a database search by the Intake Service Center.

26. ☐ ☐ Is the inmate a client of the Adult Mental Health Division? (ISC to check Data Base)
27. ☐ ☐ Has the inmate ever been on Conditional Release? (ISC to check CJIS or OT)
28. ☐ ☐ Has the inmate ever presented for a 704-404 Fitness Examination? (ISC to check CJIS or OT)

COMMENTS: ____________________________________________________________

_____________________________________________________________________
_____________________________________________________________________

Inmate’s Name __________________________ Signature ______________________ Date ______

ISC Disposition: ☐ Nurse Called: __________________________ Date/Time: ________ ☐ Med. Refer.  ☐ MH Refer
☐MH Emer. Called: __________________________ Date/Time: ________ ☐ Gen. Pop  ☐ Other _______

INTERVIEWER/TITLE __________________________ Date/Time ________
SEX OFFENDER CUSTODY LEVEL REVIEW

INMATE'S NAME: ____________________________

(Last) (First) (Middle Name or Initial)

INMATE'S ID: ____________________________

(SID # / SS #) DOB: ____________________________

(Date of Birth)

PED/EPH: ____________________________

(Parole Eligibility Date/Early Parole Hearing) TODAY'S DATE: ____________________________

1. The inmate is incarcerated at:
   □ Halawa Correctional Facility □ Other ____________________________
   Case Manager ____________________________

2. In which Circuit was the inmate sentenced?
   □ First, Oahu □ Third, Hawaii
   □ Second, Maui □ Fifth, Kauai

3. Is inmate currently incarcerated because of a conviction for sexual offense?
   □ Yes. CR# ____________________________ Charge:
   □ No. If not a sexual offense, on what charge is inmate convicted? CR# ____________________________ Charge:

4. If inmate is NOT convicted for a sexual offense, he/she may qualify as a sex offender because of a:
   □ Instant offense sexually motivated.
   □ Prior sex offense conviction as an adult.
   □ Prior sex charge as an adult.
   □ Prior sex charge as a juvenile.
   □ Other: ____________________________

5. Noteworthy factors include any history or incidents during incarceration of: (□ all that apply)
   □ Substance abuse, dirty UAs.
   □ Pornography in cell, seeks subscription to erotica.
   □ Violence/threats/attacks on ACO's, staff, or inmates.
   □ Health problems that hinder work.
   □ Poor performance on work details, firings, quitting.
   □ Deviant sexual behavior/proposition to staff or inmates.
   □ Non-compliance with programs, educational goals.
   □ Escapes (including attempts).
   □ Other: ____________________________

6. Does offender refuse to participate in SOTP or deny he/she needs further treatment?
   □ Yes □ No

7. Comments

SOTP Administrator's Recommendation
   □ Medium
   □ Minimum
   □ Community

SOTP Administrator's Signature

Date

*An Equal Opportunity Employer/Agency*
INITIAL PRESCRIPTIVE PLAN

FACE SHEET

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<tr>
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<td>SID:</td>
<td>SSN:</td>
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<td>Judge</td>
<td>Restitution</td>
<td>Max Term</td>
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Notifiers: If Yes, describe:

- Maximum Sentence (Longest)
- Mandatory Minimum Length
- Pre-Confinement Credits
Initial Prescriptive Plan
Name: 
Date: 
Page_____ 

CIRCLE ONE (verified):

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<th>TRADE SKILLS</th>
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Initial Prescriptive Plan

Name: 
Date: 
Page: 

Summary of Current Offense(s): 

Criminal History: 
Refer to attached CJIS printout.

I. ASSESSMENT RESULTS

A. **Medical:** Any medical condition which would preclude participation in programming?  
   No  Yes  
   Describe program/institutional restrictions:

B. **Any physical/mobility disabilities?**  
   No  Yes  
   Temporary  Permanent  
   Durable Medical Equipment Issued:

C. **ADA:** Accommodation/Modification Needed or Approved?  
   No  Yes  
   Specify Need (Example: sign language interpreter, large print, wheelchair access, modification to policies, practices, or procedures):

D. **Mental Health:** Any mental health condition which would preclude participating in programming?  
   No  Yes  
   Describe program/institutional restrictions:

E. **Educational:**  
   H.S. Diploma or GED?  
   No  Yes

   Initial TABE Assessment Results:  
   Reading  To Be Assessed  
   Math  To Be Assessed  
   Overall  To Be Assessed
F. **Sex Offender:** Any conviction for or history of sexual deviance?
   
   No                                               Yes

   If yes, describe needed assessment or treatment interventions:

G. **Family/Community Ties:**

H. **Institutional Behavior/Summary:** (List all misconducts, including those incurred as a jail inmate):

I. **Additional Comments:** (include information (past and present) that provides an overall historical assessment of the inmate)

Completed By: _________________________________    Date: ________________

RAD Case Manager
II. INITIAL TREATMENT PLAN

A. Problem: Substance Abuse
   Recommendations:  
      a. Treatment Level:
      b.

B. Problem: Education
   Recommendations:  
      a.
      b.

C. Problem: Social Skills/Criminal Behavior
   Recommendations:  
      a.
      b.

D. Problem: Marketable Job Skills
   Recommendations:  
      a.
      b. Available Workline

E. Problem: Other
   Recommendations:  
      a.

III. Program Intervention Summary:

A. Substance Abuse
B. Education:
C. Social Skills
D. Marketable Skills
I have read my Initial Treatment Plan and have received a copy.

_______________________________________ ____________________________
INMATE DATE

_______________________________________ ____________________________
CASE MANAGER DATE
NAME: ___________________________ SID#: ___________________________ DOB: ___________________________

JAIL INMATE REENTRY PLAN FOR THE DEPARTMENT OF PUBLIC SAFETY #: ____________

This form shall be completed with the inmate once housing has been assigned. It is to be updated whenever significant changes in information occur. Please PRINT legibly and attach all required documents to this form. Inmates are to be informed that they will be responsible for obtaining letters to confirm residence or employment and notify staff of any changes. Do not leave any blank spaces; if initially unknown, write "N/A" but the inmate will need to continue his/her efforts to fill in ALL BLANK SPACES. This and all subsequent forms are to become part of the offender's Institutional Record and filed accordingly.

Facility: ___________________________ Date: _____________ Custody Level: ___________________________

1. RESIDENCE

Things to consider when filling out this section:

- Is the residence and where it's located, appropriate?
- Are there geographical restrictions preventing you from living where you want?

The inmate is responsible for contacting the person (who will pay the rent/mortgage) at the place they want to live, or whom they will be asking for financial assistance, to obtain the information needed to complete this form. Facility staff will be responsible to assist the inmate in searching for appropriate housing prior to release by identifying resources that the inmate can research.

Name of Contact: ___________________________ Address: ___________________________

 (#Street/City, State, Zip Code) Phone: ___________________________

Relationship to you: ___________________________ Number of people that will live with you: ________________ Ages: ________________

Number of bedrooms/baths: __________ / __________ Will you be renting a room? Yes/No (circle one)

What will be your share of the rent and utilities: ________________ How long do you plan to live here? ________________

If you plan to stay less than six months, what is the reasoning? What are your alternatives? ___________________________

☐ Is a letter verifying residence attached? ☐ No changes to existing information.

2. EMPLOYMENT

Things to consider when filling out this section:

- Is there a job waiting for you upon release? If yes, fill out the sections below.
- If you lack specialized job skills, what type of job would interest you?

Assigned case managers are to assist in researching programs, work lines and classes available in the facility. Acquiring a skill set and saving your money prior to release is the first step towards avoiding returning to custody and being independent.

Name: ___________________________ Address: ___________________________ Phone: ___________________________

Contact person/Title: ___________________________ Job duties: ___________________________

Company Name: ___________________________ Address: ___________________________ Phone: ___________________________

Contact Person/Title: ___________________________ Starting Salary: ___________________________

Job duties: ___________________________ If you have nothing set up, what types of job or vocational training or schooling you are interested in: ___________________________

☐ Is a letter verifying employment attached? ☐ No changes to existing information.

3. PROGRAM PARTICIPATION

- List all programs you have completed and the date of completion;
- Attach all certificates of completion and/or achievement. Copies help with keeping track of your accomplishments.

PSD 8801 (1/20)
Indicate recommended programming you haven't completed to date or programs you are interested in attending:

__________________________

☐ Are letters/certificates verifying completion attached?  ☐ No changes to existing information.

4. FINANCIAL RESOURCES

Things to consider when filling out this section:

- Have all financial assets been listed (inmate account, outside bank accounts, trusts etc.)?
- Have all debts been listed (restitution, court fees, fines etc.)?
- How do you plan to support yourself upon release? Have you ever received financial assistance before? If yes, what type (RSDI, Food Stamps, etc.) and when?
- Are you interested in learning how to create and maintain a budget?

You will be charged rent wherever you choose to live, including any program you reside at. You will also be required to have in your spendable/restricted accounts, enough money to pay for documents you will require, but don’t already have in order to secure employment/go to school, etc. You are responsible for monitoring your own finances, in preparing to live on your own and reenter society. Restitution orders that are attached to any of your convictions will be automatically deducted from your account while you are incarcerated.

Current balances:

<table>
<thead>
<tr>
<th>Spendable account:</th>
<th>Restricted Account:</th>
<th>Personal:</th>
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</thead>
<tbody>
<tr>
<td>Restitution owed?</td>
<td>Court Fines?</td>
<td>CVCC?</td>
</tr>
</tbody>
</table>

☐ Business Office verification form attached

If you have less than $100 in all of your accounts combined, do you have a plan in order to avoid being homeless?

Do you plan to apply for financial assistance (e.g.: SSI, RSDI benefits, food stamps, etc.) or will family members provide financial assistance? Are you a beneficiary for a cash settlement or trust fund? (Circle all that apply)

☐ Is a letter verifying benefits attached?  ☐ No changes to existing information.

5. SPECIAL NEEDS/ASSISTANCE REQUIRED (check all that apply)

☐ Outside Identification (Driver's License, etc.)  ☐ Bus Pass/Taxi Voucher (outer island)  ☐ SNAP
☐ Birth Certificate  ☐ Social Security Card  ☐ Citizen [Yes/No]
☐ Divorce Decree  ☐ Wheelchair  ☐ Different Medical Plans
☐ Clean & Sober House  ☐ Handivan access  
☐ Cane/Walker  ☐ Hospice  
☐ SSN/R  ☐ Med Quest/Medicare/Medicaid  
☐ Interpreter (what language?)  ☐ Financial Assist (EBT/Food Stamps)

Other concerns:

☐ No changes to existing information.

6. TRANSPORTATION UPON RELEASE:

Do you have plans to be picked up? If yes, by whom?  Contact #
Relationship to you:

☐ No changes to existing information.

Inmate Name [PRINT & Sign]  Date  Assisted by (if applicable) [PRINT & Sign]  Date