**Community Residential Program - Institutional Referral**

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| Referral to: |       | Date: |       |
| Street Address: |       |
| City: |       | State/Zip: |       /       |
| Phone #: |       |  | Fax #: |       |
|  |
| Referral from: |       |  | Staff Contact: |       |
| Phone #: |       | Email Address: |       |
|  |
| Participant Sex Assigned at Birth: Male **[ ]**  Female **[ ]**  Intersex **[ ]**   |
| Gender Identity: Male/Man **[ ]**  Female/Woman **[ ]**  TransMale/Man **[ ]**  TransFemale/TransWoman **[ ]**   |
| Gender Non-Binary/Gender Non-Conforming **[ ]**  Something Else        |
| Participant Name: |       | DOC #: |       |
| Release Date: |       |  |
| Current Offenses:  |       | Prior Offenses: |       |
|  |       |  |       |
|  |
| To what P&P District does this participant have post release supervision? |       |
| Are there any mental health needs? Yes [ ]  No [ ]  If yes, please explain:       |
| Are there any medical needs? Yes [ ]  No [ ]  If yes, please explain:       |
| Participant Special Needs: | 1) |       | 2) |       |
| (Medical, dietary, ADA): | 3) |       | 4) |       |
| Is the participant able to climb stairs? Yes [ ]  No [ ]  If the participant has any medical needs, please attach a statement from mental health and wellness and health services staff including diagnosis, medications, and any special needs that would need to be considered |
|  |
| How long has the participant been housed at current facility? |       |  |
| Is the participant currently employed? | Yes **[ ]**  | No **[ ]**  |
| Briefly describe the participant’s institutional behavior including institutional charges, behavior in the housing unit, etc.:       |
| What programs has the participant completed or currently attending?       |
| Are there any individuals with whom the participant should not have contact? Yes **[ ]**  No **[ ]**  If yes, please attach and submit a list of all persons with whom the participant should not have any contact. |
| Additional Comments:       |
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| [ ]  Yes [ ]  No | The participant has been notified that they will be responsible for all bills associated with medical care while at Insert Program Name. |

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| Participant’s Signature: |  | Date |       |
| \*CC: CRPReferrals@vadoc.virginia.gov; and the CRP site where the referrals are being sent. \*File material enclosed:All file material should be submitted as a complete package, e.g., *Pre/Post Sentence Report, a copy of a physical/TB test within last six months prior to release, and PSI/Criminal History information, Classification Report*, *Probation/Parole Conditions* |
| \*Contact the CRP with any questions. CRP contact information and mailing addresses; see Attachment 2, *Statewide Community Corrections Residential Programs*.  |