COMMUNITY ALTERNATIVE CENTER
REFERRAL FORM

Court: _____ Judge: _____

P.O. or Other Court Contact: _____ Date: _____

OFFENDER INFORMATION

_____(_____)
Last Name First Middle AKA

Home Address: _____
Street Apt # City State Zip Code

D.O.B.:_____ SS#_____

Phone Contact (s):_____-_____-_____ _____-_____-_____ _____-_____-_____

Case #: _____Offense: _____ Attorney: _____

Date / Length of Sentence: _____ Education Level: _____

Employment Status: _____Shift/Hrs. _____

Medical Issues (*list if any)*: _____

Additional Comments: _____

PROGRAM AUTHORIZATION

___ Judgment Entry Attached

Ordered # Days: _____

_____Court To Pay for CAC Program Costs

_____Offender to Pay CAC Program Costs

Work Release Conditions (if authorized by Court):

_____

Additional Court Comments:

_____

Fax form to: 419-774-3544
To Schedule: Call between hours of 9-4 pm M-F
Tom Trittschuh, Director @ 419-295-2122 (cell) or 419-774-3576 (Office)
or Ms. H, Case Manager @ 419-774-3557

Community Alternative Center
597 Park Ave. East
Mansfield, OH 44905

_____ Days @ $40.00 (Jail Time Only) = $_____
_____ Days @ $50.00 (Treatment) = $ _____
_____ $60 D/A Assessment (if necessary) = $

_____