

**COMMUNITY ALTERNATIVE CENTER
MANSFIELD MUNICIPAL COURT
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

Ordered # Days: _____

_____ **Court To Pay for CAC Program Costs** _____

_____ IDA Funds
_____ PIGG
_____ CCA 408
_____ Other

_____ **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 the hours of 9-4 pm M-F:
Malissa Higginbotham, Case Manager: 419-774-3557 or
Tom Trittschuh, Director: 419-295-2122 (Cell) or 774-3576 (Office)**

**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) = \$ _____