

**COMMUNITY ALTERNATIVE CENTER
WAYNE COUNTY SHERIFF DEPARTMENT (JAIL)
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: _____

___ **County Jail To Pay for CAC Program Costs**

___ **Offender to Pay CAC Program Costs**

Additional Court Comments:

Fax form to: **419-774-3544**

To Schedule: Tom Trittschuh, Director: **419-295-2122 (Cell)** or **419-774-3576 (Office)** or
Tara Garrett, Assistant Director: **419-774-3557 (Office)**

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

_____ **Days @ \$35.00 (Jail Time Only) = \$** _____

_____ **Days @ \$50.00 (D/A Treatment) = \$** _____

_____ **\$60 D/A Assessment (if necessary) = \$** _____
