STATE OF CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

ACP APPLICATION AND VOLUNTARY AGREEMENT

CDCR 2234 (07/12)

The Alternative Custody Program (ACP) is a voluntary program that promotes parenting, family reunification and the development of life skills while addressing treatment needs. The ACP allows inmates to be housed in a personal residence, a transitional care facility or a residential drug or treatment program instead of serving time in prison. I understand placement into the ACP is based upon meeting specific eligibility criteria and the California Department of Corrections and Rehabilitation has the authority for final placement approval based on bed availability and other factors. While participating in the ACP, I will be subject to applicable rules and regulations governing inmates pursuant to the California Code of Regulations (CCR), Title 15, Division 3. I understand I may be removed from the ACP and returned to prison to serve the remainder of my original sentence for any reason, with or without cause.

I. TO BE COMPLETED BY INMATE

I meet the criteria set forth in the CCR Title 15, section 3078.2 including the following: (Check all that apply)

☐ I am a female

(Select one)

☐ I have private medical insurance. **OR** ☐ I agree to apply for any county, state or federal medical coverage for which I may qualify.

I request to reside at the following location:	**Private Residence**
☐ My private residence is located at: (I understand my residence must have no aggressive animals, no weapons, unobstructed access by law enforcement and will be verified by a Parole Agent.)	**(Include street address, city, county and zip code)**
The contact person at the above address is:	
My relationship to the contact person is:	
The contact person's telephone number is:	
☐ Residential Drug or Treatment Program or Transitional Care Facility	

I understand that my signature on this document indicates my willingness to voluntarily participate in the ACP.

CDC NUMBER	INMATE NAME (PRINTED)	INMATE SIGNATURE	DATE SIGNED	HOUSING UNIT

II. FOR USE BY INSTITUTION COUNSELING STAFF

Does the participant have a qualifying disability requiring effective communication? ☐ Yes ☐ No

If yes, cite the source document and/or observation(s): _____

What type of accommodation/assistance was provided to achieve effective communication to the best of the inmate's ability?

COUNTY OF LAST LEGAL RESIDENCE	COUNTY OF COMMITMENT	INSTITUTION	EPRD

☐ INMATE ELIGIBLE	☐ INMATE INELIGIBLE	REASON, IF INELIGIBLE

CORRECTIONAL COUNSELOR NAME (PRINT)	CORRECTIONAL COUNSELOR SIGNATURE	DATE SIGNED	PHONE NUMBER

III. FOR USE BY ACP PROGRAM MANAGER

ACP PROGRAM NAME	ACP PROGRAM ADDRESS	PHONE NUMBER	ASSIGNED PAROLE UNIT

IV. FOR USE BY PAROLE UNIT

DISTRICT/UNIT	RECEIVING AGENT ASSIGNED TO INVESTIGATE	COMMENTS:

DATE ASSIGNED	DATE DUE	AGENT'S RECOMMENDATION Proposed residence meets criteria ☐ Yes ☐ No

PAROLE AGENT NAME (PRINT)	PAROLE AGENT SIGNATURE	DATE SIGNED

UNIT SUPERVISOR APPROVAL Concur with agent's recommendation ☐ Yes ☐ No	PHONE NUMBER	COMMENTS:

UNIT SUPERVISOR NAME (PRINT)	UNIT SUPERVISOR SIGNATURE	DATE SIGNED

UPON COMPLETION OF PRIVATE RESIDENCE VERIFICATION - RETURN THIS FORM TO THE SENDING INSTITUTION C&PR OFFICE

*EPRD means Earliest Possible Release Date

Distribution: Original to c-file; copy to inmate