Dakota County Community Corrections
Work Release Intake Form
Phone: 651-438-8258, Fax: 651-438-8379
Email: CCWKRLS@co.dakota.mn.us

All forms must be submitted to Work Release staff at least five business days before your scheduled jail report date

Full Name: _____ DOB: _____

Total jail days ordered: _____ Probation Officer: _____

Jail Report Date/Time: _____ Cell Phone#: ( ) _____

Transportation:

Designated Driver (or self) (Must have valid driver's license): _____

Phone: _____

DL#: _____

Year/Make/Model/Color of Vehicle: _____

License Plate#: _____

Treatment/School (Requires a court order):

Agency: _____

Address: _____

City:_____

Phone: _____

Counselor/Advisor: _____

Treatment/Class Schedule**:** _____

Employment

Company Name: _____

Address: _____ City_____ Zip Code_____

Supervisor(s): _____ Phone:_____

Job Title: _____Length of Employment: _____

Payday: _____Frequency: _____

Job Site Location(s) (if different from employer address): _____

_____

Regular Work Schedule: Days: _____Time:_____ to _____

Supervisor Signature_____ Date_____

*****PLEASE ATTACH YOUR MOST RECENT PAYCHECK STUB WITH THIS APPLICATION*****

Dakota County Community Corrections

Work Release Program Checklist

☐ Review the *Jail Work Release Program Handbook.* Contact Work Release staff if you have questions about program policies, procedures, or eligibility criteria.

☐ Complete the *Work Release Intake Form* and have your **employer** sign the bottom of the form. Also read and sign the *Work Release Agreement and the Dakota County Community Corrections Consent for Release of Information.*

☐ Return the *Work Release Intake Form,* the *Work Release Agreement,* and the *Dakota County Community Corrections Consent for Release of Information* along with a copy of two weeks worth of your most recent paychecks/check stubs. **Failure to return completed paperwork and documentation will result in a delay in your release for work.**

☐ When you report, enter the jail through the Inmate Release/Work Release Door. Once inside the lobby, press the button to alert staff you are reporting. Do not leave the lobby.

- You must bring with you at least **$75.00 in cash** (booking fee and first two days of work release fee). You are required to pay $25.00 for each additional day in jail. Credit cards are accepted with an additional fee.
- Fees are collected each night before the following day. Funds **must be** in your account prior to being released for work.
- The work release fee is collected and monitored by jail staff, NOT Work Release Program staff. If you are serving a jail sentence for a different county you will have additional costs. Please contact Jail Administration at (651) 438-4800 prior to your report date.

☐ All personal hygiene products must be purchased through the Dakota County Jail Canteen. Work Release inmates are allowed to bring 3 changes of clothes into the jail. You will not be allowed to go home to pick up clothes or other items.

☐ You will be responsible to arrange your own medical and dental care while on work release. All appointments must be approved and verified by Work Release staff. Some appointments may require a furlough from court. All prescribed medications should be turned in to the jail staff at booking in the original pharmacy container. Jail staff will distribute approved medications upon verification that the prescription is current.

☐ Please call the Dakota County Jail at **651-438-4800** with any further questions regarding your custody.

If you have any questions about the Work Release Program feel free to call the **Work Release Staff** at **651-438-8258.**

Dakota County Law Enforcement Center

Work Release Agreement

NAME_____ DOB_____
(Print)

I understand that participation in the Dakota County Work Release program is a privilege authorized by the Court. In order to keep this privilege, I agree that:

1) My behavior in jail can affect my work release status. I understand that the Work Release Unit is a minimum-security unit and that I must maintain a standard of behavior appropriate for such a unit. Deviations from that standard of behavior may result in my being placed in the Sentenced Unit and losing Work Release privileges.

2) I must be drug, including medical cannabis, and alcohol free when I report to the Law Enforcement Center to begin my Work Release sentence. I will not use alcohol, non-prescription mood-altering drugs, or medical cannabis, nor be under the influence while on Work Release. I will submit to random urinalysis or breath testing as requested by program staff. Failure to provide the sample or a test returned as positive may result in termination from the Work Release program.

3) I will provide my own transportation (driver must have valid driver's license.) I will go directly to and from work/school/appointments as approved by Work Release staff. I agree to account for my whereabouts while released from jail and to report any changes in location as directed by Work Release staff.

I hereby acknowledge that I have received a copy of the Jail Work Release Program Handbook. I understand the policies of the Work Release Program, and agree to abide by the rules and conditions, and understand failure to do so may result in disciplinary action.

_____ _____
Inmate Signature Date

DAKOTA COUNTY COMMUNITY CORRECTIONS - CONSENT FOR RELEASE OF INFORMATION

I, _____(client), (DOB:_____), authorize Dakota County Community Corrections (DCCC) to:

☐ Disclose to _____

☐ Obtain from _____

☒ Disclose, obtain, and exchange with the following individual(s) or entity (ies): _____

(Employer or Supervisor's name)

The following information about me listed below:

- the dates of admission/anticipated discharge;
- the attendance history and concerns;
- the type of service (counseling, CD treatment, etc.);
- the quarterly Progress Reports;
- the Discharge Summary upon completion; and
- the type of termination (satisfactory/unsatisfactory) for:
  - ☐ Chemical dependency/psychological or domestic abuse treatment records and evaluation
  - ☐ Medical history
  - ☐ Treatment information
  - ☐ Treatment discharge summary
  - ☒ Ongoing/Updated Reports
  - ☒ Other: Employment/contractors and/or education verification, treatment status and pertinent details

This information is needed to help DCCC provide efficient and successful supervision of me. I understand that I may authorize the release of all, some, or none of the above-mentioned information but if I fail to release the information it may have a negative effect on my probation status. I understand that I do not have to sign this Consent in order to receive health care benefits (treatment, payment, enrollment or eligibility) except for health care services necessary to create any assessment or report for disclosure to DCCC necessary for my conditions of probation/parole/supervision.

I understand what information about me will be disclosed or obtained from the above-mentioned individuals(s) or entities. I understand that DCCC may have records about me that it received from other organizations and that if these records have been used by DCCC and are filed in the records DCCC maintains about me and are of the type authorized to be released, these records may be released with the DCCC records.

I understand that my records are protected under State and Federal privacy laws and that these records cannot be disclosed without my written consent, unless otherwise authorized by law. I understand and consent to the re-disclosure by DCCC of the information used or disclosed by this Consent and understand that it will no longer be protected by Federal privacy laws prohibiting re-disclosure. I understand that DCCC cannot prevent re-disclosure of my information by the person/organization who receives my records under this Consent, and that the information may not be covered by state and federal privacy protections after it is released. By signing this Consent, I release DCCC from any and all liability resulting from a re-disclosure by the recipient.

I understand that I may revoke this consent in writing at any time; however, revocation will not pertain to data released or obtained prior to the County's receipt of my written revocation notice at one of the addresses listed below. Unless I revoke my consent sooner, my permission to allow the release of information about me will automatically expire one (1) year from the date I sign this release or when my probation ends, if sooner.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature if client is under 18 or under legal guardianship Date

Please forward to: _____
(Name/Title)

☐ **Judicial Center**	☐ **Western Service Center**	☐ **Northern Service Center**
1560 Highway 55	14955 Galaxie Avenue	1 Mendota Road West, Ste 510
Hastings, MN 55033	Apple Valley, MN 55124	West St. Paul, MN 55118
Fax: (651) 438-8340	Fax: (952) 891-7282	Fax: (651) 554-6070
Tel: (651) 438-8288	Tel: (952) 891-7200	Tel: (651) 554-6060