IN-CUSTODY SENTENCE TO SERVICE PROGRAM

Receive time off your ordered jail sentence and have your jail stay fee waived by participating on the In-Custody STS Program. Please complete the bottom portion of this form, the attached Health form, and the STS Contract Form. You can return these forms by mail, email, fax, or by turning it in to the Law Enforcement Center Lobby Work Release Box **at least 5 business days before your jail report date.**

WHAT IS THE SENTENCE TO SERVICE PROGRAM?

Sentence to Service is designed to be a direct benefit to the community using a crew approach to completing work projects. There are many types of jobs you may be working on as STS crew member. Projects may be completed for the State, County, Cities, Townships, or nonprofit community organizations within Dakota County.

ELIGIBILITY REQUIREMENTS

- Must be sentenced to 14 or more days in custody, without credit for time already served.
- Must not be applying for any other release program.
- Must have no current sex related offenses.
- Must have no felony level crimes of violence in the last 3 years.
- Must have no active warrants or holds.
- Must not have been terminated from STS or other jail programs within the past year.

If you are not eligible for the In-Custody STS Program, you may still be eligible for other in-custody programs. Please ask jail staff for more details upon reporting.

Applicants will be taken on a first come/first serve basis and you may be put on a waiting list. Credit will start accruing after the first day of participating on the STS crew.

Dakota County Community Corrections

SENTENCE TO SERVICE INTAKE FORM
1560 Highway 55
Hastings MN 55033
Email: ccsts@co.dakota.mn.us
PHONE: 651-438-8258, Option 1; FAX: 651-438-8379

ALL FORMS MUST BE SUBMITTED TO WR PROGRAM STAFF BY MAIL, EMAIL, FAX OR TURNED IN TO THE LEC LOBBY WORK RELEASE BOX AT LEAST 5 BUSINESS DAYS BEFORE YOUR REPORT DATE!!!

Full Name: _____ **DOB:** _____

Court File(s) #: 19-_____Offense:_____

Total jail days ordered: _____ Probation Officer: _____

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

SENTENCE TO SERVICE PROGRAM CONTRACT

Name: _____ DOB: _____

I understand the Court has granted me the option of participating on the Sentence to Service Program from the Dakota County Jail. As a program participant, I agree to the following provisions:

1. I understand that I may be eligible to earn a reduction credit off my jail time for participating in the STS Program. Should I be terminated from the program prior to my release, good time credit may be removed.

2. I understand that in order to remain eligible for the program, my behavior in the jail must warrant continued placement in the work release unit. Rules for Inmates and Work Release will remain in effect, and violation of these can result in program termination.

3. I understand that I am on custody status and that any absences from the work area, not authorized by program staff, will be treated as an Escape from Custody and prosecuted to the full extent of the law.

4. I will not use alcohol or nonprescription mood altering drugs, or be under the influence upon reporting; I will submit to random urinalysis and/or provide breath sample for drug testing as requested by program staff.

5. I understand that I am not an employee of Dakota County, or other governmental agency, and I am not entitled to wages or Worker's Compensation benefits. If injured while performing community work service, I must first use my personal health insurance. I further understand that claims for medical costs not covered by insurance may be submitted to the State of Minnesota in accordance with M.S. 3.739, Subd. 2 and 3.

6. Pursuant to M.S 3.739, Subd. 2 and 3, I agree to hold Dakota County Community Corrections, its employees, as well as persons or agencies which may provide me the opportunity to perform community work service, harmless of any claims known or unknown by me.

I certify that I have received a copy of the ***Work Release Program & In-custody STS Participant Manual,*** and understand the participant expectations, as well as the terms of this Contract and will abide by these rules and conditions.

_____ _____

Offender Signature Date

Health and Insurance Information: Consent for Release

The following information is subject to the Minnesota Data Practices Act and is considered private data per M.S. 13.04. Some of the information you provide will be used to determine program eligibility, or alert staff to potential hazards stemming from existing medical or physical conditions. In case of a medical emergency, the attending medical personnel will have information, or will readily access information necessary for treatment.

NAME: _____ DATE OF BIRTH: _____

COURT FILE NUMBER:

MEDICAL HEALTH INSURANCE CARRIER: **POLICY NUMBER:**

_____ _____

CLINIC, LOCATION: **MEDICAL RECORD NUMBER:**

_____ _____

PHYSICIAN: **PHONE NUMBER:**

_____ (____) _____ - _____

Do you have any physical condition that keeps you from doing any type of physical labor?

____No ____Yes (please explain)_____

_____

Current medication: ___None ___Yes (what)_____
_Allergies (to medication, bee stings, etc.) ____ No; ____ Yes (what)_____
_____

In case of emergency, contact: _____

Cell or home number:_____

Relationship: _____

The above information is true and correct to my knowledge. I am authorizing release of the above information to medical personnel in the event of my injury and treatment.

_____ _____
Offender Signature Date

_____ _____
Witness Date