



HEALING TO RE-ENTRY PROGRAM APPLICATION

Please print. All information needs to be legible. If you need any assistance filling out this document, please contact the HTR office.

All participants in the Healing to Re-Entry program. Must provide a copy of CDIB to apply.

Contact Information:

First Name: _____ MI: _____ Last Name: _____

Alias: _____ *N/A if doesn't apply* Sex: M/F: _____

Today's Date: _____ DOB: _____ Age: _____ SS: _____

Current Mailing Address: _____

Physical Address: _____ County: _____

Phone Number: Primary: _____ Alternate 1: _____ Alternate 2: _____

Email: _____

Tribal Enrollment:

Are you enrolled in a Federally recognized Tribe? YES | NO

If yes, which tribe: _____ Enrollment No.: _____

May we contact tribal enrollment to verify? YES | NO

Application Information:

1. Will you have stable housing upon your release? YES | NO

2. Will you have reliable transportation upon your release: YES | NO

If NO, what are your plans: _____

3. Do you have open Indian Child Welfare/ State Child Protection / State Adult Protection cases?

YES | NO

If YES, please explain: _____

4. Are you a Veteran? YES | NO Branch of Service: _____

Institutional Information:

Check all that applies.

Offense(s): ☐ Drug Related Crimes | ☐ Theft/Fraud | ☐ Violent Crimes | ☐ Sex Related Crimes

☐ Other: _____

Charges: _____

DOC#: _____

Facility/Correctional Center Name/Address: _____

County of Conviction: _____

Sentence: _____

Release Date: ____/____/____

Type of release: _____

Parole/Probation Information:

Length of Incarceration: _____ Parole Date: ____/____/____

Next Parole Hearing Date: ____/____/____

Probation Officer: _____ Phone No: _____

Office Address: _____

Sex Offense Information:

Conviction: _____

Date of Conviction: ____/____/____ Level of Offense: Tier 1 ☐ Tier 2 ☐ Tier 3 ☐

Date Sentence Completed: _____ Case# _____

Age of Victim(s): _____

Tribe/City/County/State of Conviction: _____

Confinement of Probationary Sentence: _____

Title 1 of the Adam Walsh Act known as the Sex Offender Registration and Notification Act (SORNA):

All sex offenders who reside, are employed, or are a student within the lands subject to tribal jurisdiction must register with the Sex Offender Registry Program. In these types of cases, sex offenders must register and keep the registration current.

Additionally, all sex offender convicted by the Tribes of a covered sex offense must register. In these types of cases, sex offenders must initially register with the Tribes regardless of the sex offender's actual or intended residency.

Each registered sex offender appears in person to keep registration current based on the level at which the person has been tiered. Tiering is as follows: 1) Tier 1 sex offenders appear once a year for 15 years; 2) Tier 2 sex offenders appear once every 180 days for 25 years, and 3) Tier 3 sex offenders appear once every 90 days for the life. The Tribes collaborate with US Marshalls, BIA Law Enforcement, and surrounding counties to enforce the Tribal Sex Offender Registration Act.

Please visit the Tribes sex offender registry at <https://catribes.nsopw.gov/>.

SORNA Tech Esteban Juarez can be reached @ 405-422-7456 | ej Suarez@cheyenneandrapaho-nsn.gov

SORNA Client Registration Date: ____/____/____ SORNA Tier: ☐ Tier 1 | ☐ Tier 2 | ☐ Tier 3

Probation/SORNA Officer: _____

Probation/SORNA Officer Phone Number: _____

Substance and Mental Health Information:

1. Were you under the influence of alcohol or drugs at the time of your offense? YES | NO
2. Are you seeking treatment or willing to seek treatment for your addiction(s)? YES | NO
3. Have you been in a sober-living or interested in sober living opportunities? YES | NO
4. Are you experiencing suicidal/homicidal thoughts? YES | NO
5. Are you under the influence of substances at the time of this application? YES | NO

Disclaimers:

1. At the application intake assessment appointment, please provide a detailed substance abuse history when asked by staff.
2. At the application intake assessment appointment, program staff will drug test you.
3. If accepted into the program, you will be expected to follow and complete an Individualized Care Plan.
4. If accepted into the program, you will be expected to follow and agree to program agreements.
5. The Healing to Re-Entry Program is federally funded and requires the program to meet and/or follow certain criteria/policies.

Program Client Rights:

1. The client has the right to request a program director at any time.
2. The client has the right to confidentiality.
3. The client has the right to refuse or question referrals.
4. The client has the right to advocacy.
5. The client has the right to question application acceptance or denial.
6. The client has the right to ask for copies of ICP or other program documents.
7. The client has the right to be respected and treated fairly.
8. The client has the right to request program involvement in legal matters.

I hereby make an application for reintegration services to the Cheyenne and Arapaho Re-entry program. I acknowledge that as an applicant for admission to the Healing to Re-Entry Program I have an affirmative duty to complete the application by responding to the questions herein truthfully, fully, and completely. I also acknowledge that my failure to complete the application by responding to the questions herein truthfully, fully and completely, will result in denial of the application for admission. Also any and all supporting documentation must accompany the application in order for it to be acknowledged as complete. No applications will be processed unless any and all available documentation is submitted.

Applicant Signature

Date

Program Director Signature

Date

Intake By: _____

Signature & Job Title

Time

Date

For Administrative Use Only:

Case Number: _____ **Case Status:** _____

Case Manager: _____

Age: _____ **Sex:** _____ **Date received:** _____

Currently Incarcerated: YES | NO **Previously Incarcerated:** YES | NO

Date of Application Submission: _____

Date of Application Intake Assessment Appointment: _____

Date of Program Director Application Approval: _____

Application Notes: _____

**Healing to Re-Entry Program Coordinator
Signature**

Date



Healing to Re-Entry

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