THE GEORGIA STATE BOARD OF PARDONS AND PAROLES
Transitional Housing for Offender Reentry (THOR) Directory

FACILITY QUESTIONNAIRE 090629

Thank you for your interest in the THOR Directory of approved transitional housing for inmates, probationers and parolees. Review the THOR Directory Standards, available along with all other forms at www.pap.state.ga.us by clicking on "THOR Directory" then "Housing Provider Information", then complete this questionnaire, the Facility Authorization, and, only if applying to be listed as Structured Housing, the Consent for Criminal Record Check. Approval for the THOR Directory is based on receiving all pertinent documents (see the Standards) and verifying Standards compliance via a site visit with the Facility Director. If your facility is not GARR certified or DHR/ORS licensed, or currently an approved facility in the THOR Directory, your application must include a copy of your facility's policy and procedure manual, and all forms used to document client information.

Use the "Comment" lines in this questionnaire to explain answers or provide additional information that will be displayed in your facility profile in the Directory. Send the requested materials to george_braucht@pap.state.ga.us; fax to 404-651-7075; or mail to THOR Directory, State Board of Pardons and Paroles, Field Operations Division, Suite 458, E. Tower, Floyd Building; 2 MLK, Jr. Drive, S.E., Atlanta GA 30334-4909.

1. Questionnaire Completed Date: MMDDYYYY _____

2. Facility Name: _____

3. Facility Website: _____

4. Facility Type: Check only one. See THOR Directory Standards for definitions.

   a. Structured Housing: Programming is optional or not available. Signed Consent for Criminal Record Check and Facility Authorization forms are required. ☐

   b. Standard Recovery Residence: One or more hours of weekly substance abuse services or substance abuse counseling. Signed Facility Authorization form is required. ☐

   c. Intensive Recovery Residence: Five or more hours of weekly substance abuse counseling. Signed Facility Authorization form is required. ☐

   Comment: _____

5. Facility Tax Status: Proof is required during site visit. Check only one. For profit ☐ Not for profit ☐

   Comment: _____

6. Facility Proprietorship: Check all that apply. Proof is required during site visit. Own properties ☐ Lease properties ☐

   Comment: _____

7. Facility Housing Units are zoned _____ and the allowed capacity is _____

Comment: _____

8. Housing Location: If the facility office is at a housing location, list that location first. Enter one location per row.

Structure*: **A** = Apartment, **C** = Clinic/Hospital, **H** = House, **O** = Other, please explain.

Capacity**: Indicate the gender, **M** = Males, **F** = Females, **SO** = Sex Offender, and number of residents each location accommodates. For example, 4 MSO = four male sex offenders.

	Structure*	**Capacity****	**Street Address**	**City**	**County**	**Zip**	**Phone**
a.							
b.							
c.							
d.							
e.							
f.							
g.							
h.							
i.							

9. Facility Mailing Address: Check if same as Housing Location (a.) above and skip to next item ☐

Street City State Zip

_____

10. Office Location: If either box is checked, skip to next item.

Check if same as Housing Location (a.) above ☐

Check if same as Facility Mailing Address above and Mailing Address is not a PO box ☐

Street City State Zip

_____

11. Referral Contact:

First Name: _____ Last Name: _____

Check one or complete Other: Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other: _____

Job Title: _____

Phone: _____ Cell: _____ Fax: _____

Email: _____

12. Director: Check if same as Referral Contact above and skip to next item ☐

First Name: _____ Last Name: _____

Check one or complete Other: Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other: _____

Job Title: _____

Phone: _____ Cell: _____ Fax: _____

Email: _____

13. Questionnaire Completed By: Director ☐ Referral Contact ☐ or Other Staff (Name):

_____

14. Closest Parole Office: _____

15. Driving Directions to Facility: Check if attached ☐ _____

16. Facility Catchment Area: Check box or list Counties in which residence is required. Statewide ☐

Require residence in the following Counties: _____

17. First Step for Admission: Contact the referral contact ☐

See the facility's web page (note in Comments if referral/admission forms are available) ☐

Other: Explain in Comment ☐

Comment: _____

18. Faith-Based Activity Required? Yes ☐ No ☐

If yes, describe the religion and list required faith-based activities: _____

_____

19. Fees:

a. Required Admission Fee: $ _____

i) Minimum amount due at admission with balance of admission fee deferred until employed: $ _____

Comment: _____

b. Weekly Fee: $ _____

i) Can be deferred until employed ☐

Comment: _____

c. All Other Fees or Costs Not Covered by Admission and Weekly Fees: Enter "None" in Comment if applicable. Fee/cost list is attached ☐

Comment: _____

d. Housing Costs Subsidized: Yes ☐ No ☐

If yes, briefly explain how to access, for example, see facility web page, call referral contact, etc:

_____

20. Offenders Accepted

a. Gender: Check all that apply.

Male ☐

Female ☐

Female with Children ☐

Pregnant Female ☐

Comment: _____

b. Housing Status: Check all that apply.

Accept Homeless ☐

Accept not Homeless ☐

Comment: _____

c. Admission Allowed: Check all that apply.

Directly from Prison/Transition Center ☐
Directly from Probation/Parole Facility ☐
From Local Jail ☐
From the Community ☐

Comment: _____

d. Supervision Type Accepted: Check all that apply.

On Parole ☐
On Probation ☐
Not on Supervision ☐

Comment: _____

e. Ages Admitted: Check box or enter ages of primary residents that are accepted in Comment, e.g., 16+, 18+ or 21+.

No Age Restrictions ☐

Comment: _____

f. Accept persons with a Violent Offence: Check only one. Yes ☐ No ☐ Case by case ☐

Comment: _____

g. Accept Persons with a Sex Offense:

Yes, housing location is beyond 1,000 feet of a school, daycare center, church or bus stop, and acknowledgement letter from the Sheriff will be submitted before the site visit ☐
Case by case ☐
No ☐

Comment: _____

h. Accept Persons on Electronic Monitoring:

Yes: A dedicated phone can be available for each person on EM ☐ No ☐ Case by case ☐

Comment: _____

i. Accept Persons who are HIV Positive: Yes ☐ No ☐ Case by case ☐

Comment: _____

j. Accept Persons with an AIDS Diagnosis: Yes ☐ No ☐ Case by case ☐

Comment: _____

k. Accept Persons with a Handicap: Yes ☐ No ☐ Case by case ☐

Comment: _____

l. Accept Persons Who are Unable to Work: Yes ☐ No ☐ Case by case ☐

Comment: _____

m. Accept Persons Who have Mental Health Conditions: Yes ☐ No ☐ Case by case ☐

Comment: _____

n. Accept Persons Who have Chronic Physical Health Conditions: Yes ☐ No ☐ Case by case ☐

Comment: _____

21. Admission Process and Requirements

a. Written Application Required: Yes ☐ No ☐

Comment: _____

b. Submit Application Via: Check all that apply. Mail ☐ Fax ☐ Email ☐ In person ☐

Comment: _____

c. Interview Required Before Admission: Yes ☐ No ☐

Comment: _____

d. Interview May Be Conducted: Check only one. On Phone ☐ On Phone or Face to Face ☐ Face to Face ☐

Comment: _____

e. HIV Test Results Required: Yes ☐ No ☐

Comment: _____

f. Tuberculosis (TB) Test (PPD) Results Required: Yes ☐ No ☐

Comment: _____

g. Syphilis (RPR) Test Required: Yes ☐ No ☐

Comment: _____

h. Other Medical Tests Required: List tests or enter "None".

Comment: _____

i. Other Admission Requirements: List or enter "None".

Comment: _____

22. Program Length of Stay. If facility graduates may enter a subsequent program administered by the same organization, enter the program name in "Comment" and indicate its maximum length of stay, e.g. graduates may transfer to Next Step for a maximum of 12 months. Complete a separate questionnaire on the subsequent program if it is in a different location than the first program.

a. Minimum Initial Commitment: Short-Term = 3 Months or Less ☐ or Long-Term = 4+ months ☐

b. Average Length of Stay: Minimum _____ Maximum: _____

Comment: _____

23. Program Capacity: Enter a number for each or "0" if none.

Men _____

Women _____

Pregnant Women _____

Women with Children _____

Number of Children Facility Can Accommodate _____

Children's Minimum and Maximum Ages _____

Comment: _____

24. Smoking Allowed: Yes ☐ No ☐

Comment: _____

25. Employment Required:

Employment or volunteer work is required of all residents: Yes ☐ No ☐

Work for facility only, community-based employment not allowed: Yes ☐ No ☐

Comment: _____

26. Personal Vehicle Allowed: Yes ☐ No ☐

Comment: _____

27. Transportation Assistance Provided: Yes ☐ No ☐

Comment: _____

28. Proximity to Public Transportation: Check all that apply.

No Public Transportation ☐

Within a Mile of Bus Stop ☐

Within a Mile of Rail Station ☐

Comment: _____

29. Mail, Phone, or Personal Cell Phone Restrictions: If yes, explain and indicate the timeframe of the restrictions in Comment. Yes ☐ No ☐

Comment: _____

30. Visitors Allowed: Yes ☐ No ☐

Comment: _____

31. Passes Allowed: Yes ☐ No ☐

Comment: _____

32. Curfew: If yes, enter weekday and weekend curfew times in Comment. Yes ☐ No ☐

Comment: _____

33. Drug Testing: If yes, explain frequency in Comment. Yes ☐ No ☐

Comment: _____

34. Medication

a. Accept Individuals on Medications: Yes ☐ No ☐

Comment: _____

b. Medication Storage & Dispensing: Check all that apply.

By Resident ☐

By Medical Professional ☐

By Non-Medical Staff ☐

Comment: _____

c. Medication Log Maintained: Yes ☐ No ☐

Comment: _____

35. Facility Supervision

a. Facility Director: Full time ☐ Part time ☐

Comment: _____

b. On-Site Facility Manager: Check all that apply. Same as Facility Director ☐

Full Time ☐ Part Time ☐ None ☐

Comment: _____

c. Senior Resident (Resident Manager, Intern, etc.): Compensated ☐ Non-Compensated ☐ None ☐

Comment: _____

d. Daytime Supervision: Check all that apply. Staff ☐ Senior Resident ☐ Volunteer ☐

Comment: _____

e. Night Supervision: Check all that apply. Staff ☐ Senior Resident ☐ Volunteer ☐

Comment: _____

36. Certified/Licensed Staff: None ☐ or Some Certified ☐ All Certified ☐

Some Licensed ☐ All Licensed ☐

In Process of Certification/Licensure: Explain in Comment ☐

Comment: _____

37. Program Components:

a. Detoxification: Check only one. Not Available – Complete before admission ☐

On-Site ☐

Off-Site but Return to Facility at Night ☐

Off-Site and Stay Overnight ☐

Responsible Staff/Service Provider: _____

Comment: _____

b. 12 Step Meetings. Check all that apply or enter "Not available" in Comment.

Required # of Meeting per Week _____

Attendance is Optional for All Residents: Yes ☐ No ☐

Meetings Held: On-Site ☐ Off-Site ☐

Step Study ☐ Big Book Study ☐

Responsible Staff/Service Provider: _____

Comment: _____

c. Individual Counseling. Check all that apply or enter "Not available" in Comment.

Required # of Meeting per Week _____

Attendance is Optional for All Residents ☐

Meetings Held: On-Site ☐ Off-Site ☐

Responsible Staff/Service Provider: _____

Comment: _____

d. Group Counseling. Check all that apply or enter "Not available" in Comment.

Required # of Meeting per Week _____

Attendance is Optional for All Residents ☐

Meetings Held: On-Site ☐ Off-Site ☐

Responsible Staff/Service Provider: _____

Comment: _____

e. Psychoeducation/Substance Abuse Education - if occurs during the groups listed in "d. Group Counseling" above do not repeat the information here. Check all that apply or enter "Not available" in Comment.

Required # of Meeting per Week _____

Attendance is Optional for All Residents ☐

Meetings Held: On-Site ☐ Off-Site ☐

Responsible Staff/Service Provider: _____

Comment: _____

f. Education/GED Check all that apply or enter "Not available" in Comment.

Required # of Meeting per Week _____

Attendance is Optional for All Residents ☐

Meetings Held: On-Site ☐ Off-Site ☐

Responsible Staff/Service Provider: _____

Comment: _____

g. Other Program Component 1: Check all that apply and enter program title or "Not available" in Comment.

Required # of Meeting per Week _____

Attendance is Optional for All Residents ☐

Meetings Held: On-Site ☐ Off-Site ☐

Responsible Staff/Service Provider: _____

Comment: _____

h. Other Program Component 2: Check all that apply and enter program title or "Not available" in Comment.

Required # of Meeting per Week _____

Attendance is Optional for All Residents ☐

Meetings Held: On-Site ☐ Off-Site ☐

Responsible Staff/Service Provider: _____

Comment: _____

i. Other Groups or Programs Offered at the Facility. Enter "None" or Program Title(s).

Responsible Staff/Service Provider: _____

Comment: _____

38. Facility Accreditation/Certification/Licensure:

a. DHR/ORS: Yes ☐ No ☐ In process ☐ Comment: _____

b. GARR: Yes ☐ No ☐ In process ☐ Comment: _____

c. CARF: Yes ☐ No ☐ In process ☐ Comment: _____

d. JCAHO: Yes ☐ No ☐ In process ☐ Comment: _____

e. Other: Yes ☐ No ☐ In process ☐ Comment: _____

39. Facility Rules & Regulations.

a. Sign-In/Sign Out Required: Yes ☐ No ☐

Comment: _____

b. Behaviors that Cause Immediate Program Termination:

None, skip to next item ☐
Alcohol or Other Drug Use ☐
Curfew Violation ☐
Sex ☐
Violence or Threats ☐
Stealing ☐
Carrying a Weapon ☐
Other, explain in Comment ☐

Comment: _____

40. Additional Information: List other program information to be included in the Facility Profile or enter "None".

Comment: _____

41. Facility Condition

a. Physical Condition: Good ☐ Fair ☐ Poor ☐

Comment: _____

b. Facility Cleanliness: Good ☐ Fair ☐ Poor ☐

Comment: _____

c. Personal Furnishings Provided in Bedrooms: Yes ☐ No ☐

Comment: _____

42. Facility Staff and Supervising Officer (SO) Communications

a. Minimum of One Staff Communication Per Month with SO via: Fax ☐ Email ☐

Comment: _____

b. Staff Communicate with SO Before Program Resident Termination/Discharge: Yes ☐ No ☐

Comment: _____

c. Staff Communicate Positive Drug Test Results to SO Within 24 Hours via: Check all that apply.

Verbal ☐ Fax ☐ Email ☐

Comment: _____

43. Resident Charts Include the Following Forms Signed by the Resident. Note: Required for Intensive Recovery Residences and recommended for Standard Recovery Residences. Check all that are used.

Application/Intake Form ☐
Consent to Release Information ☐
Signed Resident Rights & Responsibilities ☐
Fee Statement ☐
Monthly Progress Note (by resident if possible) ☐
SO Communications (resident signature not required) ☐

Comment: _____

44. Individual Financial Record: Check all that apply.

Includes all Charges/Debits ☐
Includes all Payments/Credits ☐
None Maintained ☐

Comment: _____

45. Weekly Activity Schedule is Posted in Facility: Yes ☐ No ☐

Comment: _____

46. Policy and Procedures Manual and All Facility Forms Submitted to SBPP: Yes ☐ No ☐

Comment: _____

47. Other Information for the Facility Profile that All State Board of Pardons and Paroles and Department of Corrections' Staff Can Access: Enter "None" if applicable.

Comment: _____

_____

THE GEORGIA STATE BOARD OF PARDONS AND PAROLES
Field Operations Division

TRANSITIONAL HOUSING FOR OFFENDER REENTRY

THOR Directory Authorization

I. Please print:

A. Facility Legal Name: _____

B. Doing Business As (if different than A): _____

C. Facility Mailing Address: _____

_____

_____

D. *Facility Authorized Representative (AR): _____

E. AR's Title: _____

F. AR's Mailing Address (if different than C) _____

_____

_____

_____

G. AR's Phone: _____

H. AR's Email: _____

*An Authorized Representative is an individual who is legally authorized to sign contracts and other official documents on behalf of the organization or facility.

II. Authorization and Agreement

A. By my signature below, I hereby certify that I am an Authorized Representative of:

Facility Legal Name: _____

B. My signature also: Check one box

1. Authorizes ☐

2. Rescinds authorization for ☐

the State Board of Pardons and Paroles (SBPP) to include this facility in the Transitional Housing for Offender Reentry Directory.

C In addition, I will notify the Field Operations Division Director in writing whenever changes are made to the facility policy and procedure manual.

D. I also authorize the State Board of Pardons and Paroles to distribute via the internet and other electronic and paper-based media facility brochures, forms, photographs and other documents with unaltered content from what was received from the facility.

E. I acknowledge that I may rescind this authorization at any time via written notice to:

Field Operations Division Director
State Board of Pardons and Paroles
Balcony Level, East Tower, Floyd Building
2 Martin Luther King, Jr. Drive, SE
Atlanta GA 30334-4090.

_____
Authorized Representative's Printed Name

_____ _____
Authorized Representative's Signature Date

Georgia Bureau of Investigation
Georgia Crime Information Center

Criminal History Record Check Consent Form

I hereby authorize the State Board of Pardons and Paroles to receive any Georgia criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia.

_____
Full Name (print)

_____
Address

_____	_____	_____	_____
Sex	Race	Date of Birth	Social Security Number

_____
Signature

_____
Date

Special employment provisions (check if applicable):

- ☐ Employment with mentally disabled (Purpose code "M")
- ☐ Employment with elder care (Purpose code "N")
- ☐ Employment with children (Purpose codes "W")

One of the following must be checked:

- ☐ This authorization is valid for 90/180/_____ (circle one) days from date of signature.
- ☑ I, _____ give consent to the above named to perform periodic criminal history background checks for the duration of my employment with this company.