Transitional Housing for Offender Reentry (THOR) Directory

FACILITY QUESTIONNAIRE 130923

Thank you for your interest in the THOR Directory of approved transitional housing for inmates, probationers and parolees. Before submitting this Facility Questionnaire review the THOR Directory Standards, available along with all other forms at www.pap.georgia.gov by clicking on "Reentry", "THOR Directory," then "Housing Provider Information." 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, DCH 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 resident 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.ga.gov; 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: ____

   A statement like, "Parole Board approved in the THOR Directory" may be included in facility literature and/or on the facility webpage. If the facility is removed from the THOR Directory these statements will be removed immediately. ☐

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 (Federal tax number) ☐

Not for profit (IRS Letter) ☐

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: ____

Facility and all housing units meet all zoning, health, food service, fire, building, welfare, licensure and other city, county, state or federal ordinances or regulations ☐

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: ____

The Parole Board will be advised before changes occur in facility location, staff, contact information, operating procedures or policies, or other items in this facility questionnaire ☐

13. Questionnaire Completed By: Authorized Representative ☐ 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:

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20. Residents 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: Check box or enter age range of acceptable residents in Comment, e.g., 16+, 18-60, etc.

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. DCH: 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 (Probation or Parole) 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 (see Standards Appendix) ☐
- Signed Resident Rights & Responsibilities ☐
- Fee Statement ☐
- Monthly Progress Note (see Standards Appendix) ☐
- Supervising Officer 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: ____

____

____

____

____

____

____

____

State Board of
Pardons and Paroles

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 of the below)

1. Authorizes the State Board of Pardons and Paroles to include this facility in the Transitional Housing for Offender Reentry (THOR) Directory, an internet accessible list that displays the facility referral contact person's name, phone number, email address, facility website and city along with other details in the submitted Facility Questionnaire. .... ☐

2. Rescinds authorization to include this facility in the internet accessible THOR Directory and have removed from all facility literature and website any reference to being Parole Board approved because I am:
   a. closing the facility on _______________________ (insert date, if known) ... ☐
   b. voluntarily removing the facility from the THOR Directory due to:
   ____
   ____.... ☐
   c. other, please explain:____
   ____.... ☐

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

D. I also authorize the State Board of Pardons and Paroles to distribute via the internet and other electronic or paper-based media this facility's brochures, forms, photographs and other documents 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

Consent Form

I hereby authorize ____
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 withelder 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.