### PROGRAM INFORMATION

<table>
<thead>
<tr>
<th>Requesting Agency</th>
<th>State Agency</th>
<th>City</th>
<th>Number of Offenders Needed</th>
<th>Request Date</th>
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</thead>
<tbody>
<tr>
<td>☐ Internal</td>
<td>☐ External</td>
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Contact Person: ___________________________ Telephone Number: ___________________________

Offender(s) Name, DOC ID# and Living Location:

Program Description:

Location: (Provide sufficient detail for emergency assistance)

Payment Terms: ___________________________ Program Work Hours: ___________________________

Projected Start Date: _________________________ Projected Completion Date: _____________________

### FACILITY INFORMATION

Facility/Program Name: ___________________________ Region (If applicable): ___________________________

Work Program Supervisor Name: ___________________________ Telephone Number: ___________________________

Note Agency Program Responsibilities:

### REQUESTING AGENCY OR ORGANIZATION INFORMATION

Transportation Provided By Requesting Agency

<table>
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<tr>
<th>☐ Yes</th>
<th>☐ No</th>
<th>Method of Transportation: (Indicate One)</th>
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<td>☐</td>
<td>☐ Van</td>
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<td>☐</td>
<td>☐ Pickup</td>
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<td>☐</td>
<td>☐ Bus</td>
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<td>☐ Other: (Specify)</td>
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Vehicle Capacity ___________________________

Tools, Supplies and Safety Equipment to be used:

Provisions for food and water:

Name(s) of Supervisor(s) who will provide safety instructions and oversee work:

Provisions for access to restrooms (Identify Type and Location)

Identify additional assistance being provided by requesting agency:

Requesting Agency Program Supervisor

Name: ___________________________ Telephone Number: ___________________________

### ACCOMMODATIONS PROVIDED BY MONTANA DEPARTMENT OF CORRECTIONS

(To be filled out jointly with Requesting Agency)

Size of Offender Work Force: ___________________________ Number of Correctional Staff Assigned: ___________________________

Special Needs (i.e., clothing, equipment): ___________________________

Mobile Communications (i.e., cellular phone, hand held radio): ___________________________

Food Service: ___________________________

Vehicles: ___________________________

Armory: ___________________________

Other: ___________________________
HEALTH AND SAFETY REVIEW
(Complete only if the administrator or Contract Placement Bureau Chief requests a safety and health review.)

I have evaluated the above referenced program, which has also been reviewed by certified personnel provided by the requesting entity. My decision regarding the program is as follows:

- Approved □
- Disapproved □

__________________________________________
Investigations Bureau Chief, or Designee

### PROGRAM RECOMMENDATION AND AUTHORIZATION

- Approved □
- Denied □

Reason for Denial (i.e., staff resources, etc.)

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Requesting Agency Representative</th>
<th>Date:</th>
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<tr>
<td>Signature:</td>
<td>Warden/Superintendent/Facility Administrator</td>
<td>Date:</td>
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<tr>
<td>Signature:</td>
<td>Contract Placement Bureau Chief (if necessary)</td>
<td>Date:</td>
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This form is filled out by the requesting party and submitted to staff designated to evaluate the offender work assignment. This form must be attached to the Community Work Program Screening Form.

This agreement shall be effective upon signature and shall remain in effect until the program completion date or until such time as either party terminates said agreement.