

**Anoka County Community Corrections – Workhouse**

**WORK RELEASE ELIGIBILITY FORM**

The following information must be provided upon intake to the Workhouse and prior to approval for Work Release status. Work Release privileges allow a maximum of 50 hours per week outside the facility within 6 days unless the Court approves up to 60 hours per week.

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| Last Name | | | | | | | First Name | | | | | | Full Middle Name | | | | |
|  | | | | | | |  | | | | | |  | | | | |
| Are you employed by a temporary job service? | | | | | | | | | Yes | | | | | | No | | |
| Are you self-employed or a subcontractor? | | | | | | | | | Yes (If yes, must provide  self-employment criteria   information on page 2) | | | | | | No | | |
| Are you a full-time student? | | | | | | | | | Yes | | | | | | No | | |
| Does your job/worksite vary from company business address? | | | | | | | | | Yes | | | | | | No | | N/A |
| **Employer/Company or School Name** (**Work/school location may not be more than 50 miles from Workhouse.)** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Street Address | | | | | | City | | | | | State | | | Zip Code | | | |
|  | | | | | |  | | | | |  | | |  | | | |
| Company Telephone Number & Area Code | | | | | | Supervisor’s Name | | | | | Supervisor’s Telephone Number | | | | | | |
|  | | | | | |  | | | | |  | | | | | | |
| How long employed or student? | | | | Job title/description, or student of: | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | | | | |
| Describe work duties: | | | | | | | | | | | | | | | | | |
| Hourly salary | Check your regular pay day / pay schedule | | | | | | | Check your regular work/school days | | | | | | | | Work/school hours | |
| $ |  | | | | | | |  | | | | | | | | Start: | |
| Mon Tue Wed Thur Fri Sat Sun | | | | | | | Mon Tue Wed Thur Fri Sat Sun | | | | | | | | End: | |
| Weekly Bi-weekly Monthly | | | | | | | If your schedule varies, you must provide a weekly schedule prior to leaving the facility. | | | | | | | | | |
| **Employer/Company or School Name** (**Work/school location may not be more than 50 miles from Workhouse.)** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Street Address | | | | | | City | | | | | State | | | Zip Code | | | |
|  | | | | | |  | | | | |  | | |  | | | |
| Company Telephone Number & Area Code | | | | | | Supervisor’s Name | | | | | Supervisor’s Telephone Number | | | | | | |
|  | | | | | |  | | | | |  | | | | | | |
| How long employed or student? | | | | Job title/description, or student of: | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | | | | |
| Describe work duties: | | | | | | | | | | | | | | | | | |
| Hourly salary | Check your regular pay day / pay schedule | | | | | | | Check your regular work/school days | | | | | | | | Work/school hours | |
| $ |  | | | | | | |  | | | | | | | | Start: | |
| Mon Tue Wed Thur Fri Sat Sun | | | | | | | Mon Tue Wed Thur Fri Sat Sun | | | | | | | | End: | |
| Weekly Bi-weekly Monthly | | | | | | | If your schedule varies, you must provide a weekly schedule prior to leaving the facility. | | | | | | | | | |
| **Required Employment Documentation upon intake to the Workhouse (Check all documents provided.)** | | | | | | | | | | | | | | | | | |
| Paycheck stubs from the previous two pay periods, – AND – | | | | | | | | | | | | | | | | | |
| A letter from your employer on company letterhead indicating you are currently employed, your position or duties,  current work schedule, and location(s). | | | | | | | | | | | | | | | | | |
| **Required Self-Employment Documentation (Check all documents provided.)** | | | | | | | | | | | | | | | | | |
| If self-employed, you must provide **at least 3** of the following documents: | | | | | | | | | | | | | | | | | |
| Copy of Federal 1040 tax return from the previous tax year | | | | | | | | | | | | | | | | | |
| Copy of 1099 tax forms from the previous tax year | | | | | | | | | | | | | | | | | |
| Proof of liability insurance and/or worker’s comp insurance (if applicable) | | | | | | | | | | | | | | | | | |
| Written signed job contracts or work orders for each and every job | | | | | | | | | | | | | | | | | |
| Copies of required professional licenses for business | | | | | | | | | | | | | | | | | |
| Copies of current bank statements or business checks demonstrating business income | | | | | | | | | | | | | | | | | |
| **Transportation to/from work or school.**  A drivers’ license check will be completed to verify if the drivers’ license is active, prior to being approved to drive. | | | | | | | | | | | | | | | | | |
| Method of transportation to/from work or school: | | | | | | | | | | | | | | | | | |
| Using my own vehicle  Public transportation (bus/train) | | | | | | Getting rides from:  Other: | | | | | | Vehicle description: | | | | | |
| Travel time required **directly** to/from work or school site: | | | | | | | | | | | | | | | | | |
| **Vehicle Information:** You must provide a **current** and **valid** drivers’ license issued by your state of legal residence. | | | | | | | | | | | | | | | | | |
| State | | Drivers’ License Number | | | | | | | | | | | | | | | |
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| Vehicle Registration and Insurance must be current. A copy of current insurance is required.  If the vehicle is not registered in your name, a letter from the owner authorizing you to use their vehicle is required. | | | | | | | | | | | | | | | | | |
| Registered in (state) | | | License Plate Number | | | | | | | | | Valid through what month? | | | | | |
|  | | |  | | | | | | | | |  | | | | | |
| Vehicle Make / Model / Color | | | | | | | | | | | | | | | | | |
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| **Public Transportation (bus/train):** Provide detailed route to and from site (times, route/bus numbers, locations). | | | | | | | | | | | | | | | | | |
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| **Health Insurance:** Work Release status inmates are responsible for their own medical care.  Note: Medical Assistance and other government subsidized health benefits may be suspended during your incarceration. | | | | | | | | | | | | | | | | | |
| Do you have Health Insurance? | | | | | Yes | | No | | | Veterans (VA) benefits | | | | | Medical Assistance | | |
| Name of health insurance provider: | | | | | | | | | | | | | | | | | |
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| **FOR INTERNAL USE ONLY** | | | | | | | | | | | | | | | | | |
| Work Release status:  Approved  Denied Start Date: | | | | | | | | | | | | | | | | | |
| Notes: | | | | | | | | | | | | | | | | | |
| Staff signature: Date: | | | | | | | | | | | | | | | | | |