COLORADO
Department of Corrections
Division of Adult Parole

Interstate Compact Unit
940 N Broadway
Denver, CO 80203
303.763.2408
DOC_interstatetreatment@state.co.us

Revised November 2023

Form Must be Complete & Legible, or it will be returned
This document is required to complete the Application for Treatment.

NOTIFICATION OF OUT-OF-STATE OFFENDER PLACEMENT (C.R.S. 17-27.1-101)

Treatment Agency Information:

Agency Name:_____ DRS#:_____

Address:_____ Phone:_____-_____-_____

Email:_____

Staff Name:_____ Date:_____

Client Information:

Full Name_____ Phone:_____-_____-_____

Full Colorado Address:_____

DOB:____/____/_____ Place of Birth:_____ SSN:_____-_____-_____

Ethnicity:_____ Sex:_____ Ht:_____ Wt:_____ Eye Color:_____ Hair Color_____

Is the client a Colorado Resident? YES ☐ or NO ☐

Did the client live in Colorado more than 1 year before the offense was committed? YES ☐ or NO ☐

Is the client supervised by a Colorado Court, Probation, or Parole Officer? YES ☐ or NO ☐

Offense State Information:

State:_____ Offense Date:_____ Crime:_____ Case #:_____

Presentence:☐ Court:☐ Unsupervised Probation:☐ Supervised Probation:☐ Parole:☐

Length of Sentence/Supervision :_____ Deferred:☐ Diversion:☐ Misdemeanor:☐ Felony:☐

Agency supervising the offense:_____

Address:_____

Contact Person:_____Phone:_____-_____-_____

Notification of Client Discharge from Program

Date Closed:_____ Completed:☐ Absconded:☐ Terminated:☐

Explanation:_____

Staff Signature:_____ Date:_____

Form A