



CLIENT ENROLLMENT PACKET
 (Please complete in BLOCK Print)

Last name:	First name:	MI:
Address:		
City:	State:	Zip:
Email Address:		Home Phone:
Work Phone:	Cell phone/ Other:	
Preferred method of contact for non-urgent matters (circle one): HOME CELL EMAIL		
Date of Birth:	Age:	Birth City and State:
Marital status: Married Single Divorced Widowed Spouse Employed: Y N		
Social Security Number:		
Ethnicity: African Am / Asian / Hispanic / Mid. Eastern / Native Am. / White / Other		Sex: Male / Female
Height:	Weight:	Hair Color: Eye Color:
Distinguishing marks, scars or tattoos:		
Method of transportation while on EMP:		
Drivers License#	Suspended, Revoked, Restricted	
Vehicle License Plate#	Make, model, color and year of vehicle	Name of Auto Insurance:
How many dependents?	Have you ever served in the military? (Branch and dates)	

Emergency Contact

Last name:	First name:	Relationship:
Address:		Apt#:
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell phone/ Other:

Criminal Data/ Supervising Authority

Docket/Jail#:	Offense Description:	Penal Code:	
Length of Sentence (days):			
Sentencing Court:		Sentencing Judge:	
Judge phone#:	Judge Fax#:	Judge email:	
Attorney:	Phone:	Fax:	Email:
Probation Officer:	Phone:	Fax:	Email:

Employment/School #1 (leave blank if not applicable)

Employer/School name:		Contact phone:					
Address:		Apt. No.					
City:		State:			Zip Code:		
Contact Person:				Function/job title:			
Pay: \$		Hourly Weekly Monthly Annual					
Hours	Sun	Mon	Tue	Wed	Thu	Fri	Sat

Employment/School #2 (leave blank if not applicable)

Employer/School name:		Contact phone:					
Address:							
City:		State:			Zip Code:		
Contact Person:				Function/job title:			
Pay: \$		Hourly Weekly Monthly Annual					
Hours	Sun	Mon	Tue	Wed	Thu	Fri	Sat

Alternate Court mandated activities (i.e. AA/ DUI class/ DV class)

Activity:		Contact phone:					
Address:							
City:		State:			Zip Code:		
Contact Person:							
Hours	Sun	Mon	Tue	Wed	Thu	Fri	Sat

Questionnaire

When is your next scheduled court appearance?		
Who do you live with? (Parents, spouse, children, roommate, etc)		
Prior Convictions w/ Date:	Previous DUI: 1 2 3+ (circle)	
What is the highest level of education you have completed?		
Current medical and/or psychological conditions:		
Do you drink?	How frequently do you drink?	Age when you began drinking:
Do you consider yourself to have an alcohol problem?		
Last time you used illegal or non-prescribed drugs?	Age when you began using drugs:	
What is/was your drug of choice?		
Have you ever been treated for drug or alcohol abuse?		
Name of Program:	Length of treatment:	

LCA FMP#: _____

This information I have provided on this form is correct and up-to-date:

Client signature: _____ **Date:** _____

Case Manager assigned: _____ **Date:** _____

LCA STAFF USE ONLY:

TYPE OF EQUIPMENT:

RF/ CELL: _____
BEACON HMRU/ CELL BRACELET

GPS: _____
STOP/OMNILINK BRACELET BLUBOX/ BLUHOME/

CAM: _____
BASE STATION BRACELET WIRELESS

SCRAMx: _____
BASE STATION BRACELET

SUPERVISION FEE AGREEMENT

I, _____, understand that as a condition of my placement on LCA's Electronic Monitoring Program (EMP), I agree to make regular payments in the amount of \$_____ per day for my supervision fees and that I will adhere to the payment schedule listed below. I understand that my payments are to be paid so that I am always paid at least _____ weeks in advance. All payments must be made in the form of a money order, cashier's check, credit or debit card. **NO CASH OR PERSONAL CHECKS ARE ACCEPTED.**

Fee Summary:

Non-refundable consultation, court appearance, and/or travel fee: \$ _____
 + One Time Initial Enrollment and Administrative Fee: \$ _____
 + EM Supervision Fees (Sentence of _____ days x \$_____/day): \$ _____
= Total amount due: \$ _____

Equip. Deposit (refundable) \$ _____

PAYMENT DUE DATES

Due Date	Payment Amount	Due Date	Payment Amount	Due Date	Payment Amount

In signing below, I understand that if I fail to make a payment by the due date that an incident report will be submitted to the court and/or supervising agency. Sanctions for failure to make timely payments may include termination from the EMP*. If I am removed from EMP because of a court or county modification, I may request a refund of any overpayment balance. I understand that I must make payment prior to the due date listed by money order or cashier's check to avoid billing of my credit/debit card (if authorized below).

Client's Signature

Date

* California Penal Code Section 1203.016, states: A. (4) The participant shall agree that the correctional administrator in charge of the county correctional facility from which the participant was released may, without further order of the court, immediately retake the person into custody to serve the balance of his or her sentence if the electronic monitoring or supervising devices are unable for any reason to properly perform their function at the designated place of home detention, if the person fails to remain within the place of home detention as stipulated in the agreement, if the person willfully fails to pay fees to the provider of electronic home detention services, as stipulated in the agreement, subsequent to the written notification of the participant that the payment has not been received and that return to custody may result, or if the person for any other reason no longer meets the established criteria under this section. A copy of the agreement shall be delivered to the participant and a copy retained by the correctional administrator.

CREDIT CARD AUTHORIZATION

I agree to use the credit card listed below for: Today's payment
 Payments I authorize by phone
 Visa MasterCard Discover Auto payment of the amounts above (charged on the due date)

Card #: _____ Exp. Date: _____ CVV: _____

Billing Address: _____ State: _____ Zip Code: _____

Print Name that appears on credit card

Credit Card Holder's Signature

Date

Witnessing LCA Staff Signature

Date

***Please note that we cannot take a credit card over the phone and must have written consent from the credit card holder for new credit card charges.**

EQUIPMENT AND FEE GUARANTEE FORM

In consideration of LCA furnishing equipment and services to _____ (Client), the guarantor named below agrees to assume financial responsibility for the client's service fees and any costs to replace the equipment furnished.

Guarantor Name*		Social Security (Last 4 Digits)	
Address			
City	State	Zip	
Home phone		Cell Phone	

* Either Client or Third Party may provide guarantee. Juvenile clients must have parent or guardian provide guarantee.

I agree to ensure the following equipment is returned to LCA within two business days following termination of the Client:

<u>Program Equipment</u>	<u>Cost</u>	<u>Program Equipment</u>	<u>Cost</u>
<input type="checkbox"/> HMRU Base	\$1,500	<input type="checkbox"/> SCRAMx Bracelet	\$1,400
<input type="checkbox"/> HMRU Base (Cell)	\$1,500	<input type="checkbox"/> SCRAMx Base	\$700
<input type="checkbox"/> HMRU Transmitter	\$500	<input type="checkbox"/> SCRAMx Wireless	\$400
<input type="checkbox"/> GPS Bracelet	\$600	<input type="checkbox"/> Charging cords or cut straps	\$75
<input type="checkbox"/> GPS Home Units (BluBox, BluHome)	\$250 - \$450	<input type="checkbox"/> Phone cords/magnets	\$10

If the equipment is not returned as agreed, is damaged, lost, stolen, abandoned, or is for any other reason not returned in the condition it was given to me (without any regard for who caused the damage, loss, theft, or abandonment), I agree to pay LCA the full replacement value of the assigned equipment as indicated above. I also understand I may also be charged a late fee equal to the daily supervision fee for every calendar day the equipment is not returned. I further agree to be fully responsible for all program fees which are due at the time of program completion.

Guarantor Signature: _____ Date: _____

Alternative Contact Person (To be completed when Client is Guarantor): I designate the following contact person to return the monitoring equipment to LCA in the event that I am unable to do so. I hereby authorize LCA to access my premises for the sole purpose of recovering the equipment utilized.

Name of Contact	Phone	Cell
Address	City	State

Client Signature: _____ Date: _____

CREDIT CARD AUTHORIZATION

I agree to use the credit card listed below for the full replacement value of the assigned equipment as indicated above, should it not be returned within two business days after program completion or termination, plus any program fees still due. I further agree to an immediate charge of \$1.00 to my credit card. Visa MC Discover

Card Number: _____ Exp. Date: _____ CVV: _____

Billing address: _____ State: _____ Zip Code: _____

Print name that appears on credit card Credit Card Holder's Signature Date

Witnessing LCA Staff Signature Date

**LCA CLIENT SERVICES CONSENT FOR THE RELEASE
OF CONFIDENTIAL INFORMATION**

I understand that while I am participating in the Electronic Monitoring Program, I am in custody of the sentencing court and therefore am required to provide any verification asked of me.

I, _____ (client name), authorize LCA to obtain information from any agency or business that is providing services for me, including but not limited to: probation/parole agency, attorney, doctor, other medical provider, substance abuse programs, current school or work status, while I am under the supervision of LCA. In addition, these records may be accessed after I am no longer on the program, for statistical purposes.

I also authorize LCA to disclose to my supervising court, law enforcement, probation or parole agency, my attorney, and any service providers where I am currently receiving services information that is pertinent to my compliance on my monitoring program, including but not limited to: conviction history, current level of compliance on the electronic monitoring program, results of drug and alcohol testing and start and release dates.

I also understand that my records are protected and may not be shared with anyone outside of the parties listed above without my written consent, unless such information is subject to a court ordered subpoena.

Signature of Participant

Social Security Number

Date of Birth

Date signed

Signature of LCA Staff Member

Date

CO-RESIDENTS AGREEMENT

I understand that all persons residing in my home must be aware of my placement on the Electronic Monitoring Program. They must be aware of my program requirements and agree to support my responsibilities during my detention period.

The people with whom I reside are aware of the following conditions of my placement:

1. Random/surprise visits may be made to my home at any time and on any day of the week.
2. I am not allowed to consume any alcohol or drugs except medication specifically prescribed to me by a doctor.
3. If you are using equipment that requires a landline, the unit that is connected to the phone may not be unplugged, relocated, or tampered with.

While the people with whom I reside are not directly responsible for me, they understand the consequences I must face if any incidents occur during my program participation. All co-residents must sign in agreement with the rules of the electronic monitoring program. (Minors do not need to sign)

The following is a list of those persons living with me (including children):

Name: _____ Sex: M F DOB: _____

Signature: _____ Relationship: _____

Name: _____ Sex: M F DOB: _____

Signature: _____ Relationship: _____

Name: _____ Sex: M F DOB: _____

Signature: _____ Relationship: _____

Name: _____ Sex: M F DOB: _____

Signature: _____ Relationship: _____

Name: _____ Sex: M F DOB: _____

Signature: _____ Relationship: _____

I agree to notify LCA in the event of any change in those people residing with me during my placement in the Electronic Monitoring Program.

Client' Signature

Date

LCA Staff Signature

Date

HOME DETENTION CLIENTS ONLY

Electronic Monitoring Program Policies

In addition to the Electronic Monitoring Program (EMP) policies outlined in the EMP handbook, and/or the policies outlined in my SCRAMx Participation Agreement, I further understand and agree to abide by the following:

GENERAL POLICIES: (Please initial each line)

- ___ 1. I understand and agree that all information collected during my participation on the program may be turned over to anyone with legal right or need to know; this automatically includes all law enforcement agencies, courts and probation or parole agencies.
- ___ 2. I have been instructed how to install my equipment at home (if applicable) and use my equipment.
- ___ 3. If a home phone is not required for the equipment issued to me, I agree to have a cell phone or others means of contact throughout the program and return calls or emails the same day. I will notify my case manager if I change my contact number or method. If I do not have any means of contact, I agree to call my case manager every day to check in.
- ___ 4. If I have a medical emergency, I will contact LCA before I leave for the hospital or as soon as physically possible. If after business hours, I will leave a message on LCA's voicemail indicating the nature of the emergency with the name and address of the hospital or clinic. I will provide LCA with verification.
- ___ 5. If I am assigned a device that requires charging or downloading, I understand that failure to charge or download the device will result in a program incident. GPS bracelet require 2 consecutive hours of charging within a 24 hour period and may only be charged directly to power outlet. I will not charge while I'm sleeping.
- ___ 6. I agree to abide by any conditions listed on my court order, i.e. stay away orders, no alcohol clauses, etc.
- ___ 7. I agree to immediately notify LCA of any changes in my court status, probation status, parole status, voluntary status, address, telephone number, and/or employment.
- ___ 8. When I am contacted by LCA staff to report to the office for any equipment issue, maintenance check or equipment replacement, I agree to set up an appointment within one business day to promptly resolve the issue.
- ___ 9. I understand that all payments must be made on the date indicated in my supervision fee agreement and that failure to pay is a program incident that may result in termination from the program.

- ___ 10. I understand that I am financially responsible for all equipment issued to me. I agree to return the equipment in the same condition I received it or pay for its repair or replacement.
- ___ 11. I understand that if I am enrolled under the “Sliding Scale” at daily rate which is subject to income verification, I will furnish complete household information, including paystubs, tax returns or other documentation, within 10 business days of my enrollment date. Failure to furnish adequate income verification is grounds for termination from the program.
- ___ 12. I agree to also abide by the terms listed on the SCRAMx participation agreement, if Alcohol Monitoring applies.

HOME DETENTION SPECIFIC POLICIES:

- ___ 13. I will place the equipment telephone in an area of my home so that I can hear and answer the telephone at all times. I will not have any features on my equipment telephone line such as an answering machine, call waiting, caller ID, caller blocking, voicemail, etc.
- ___ 14. When traveling to and from approved activities such as work, school, court, medical and dental appointments, I will not make any unauthorized stops to stores, restaurants or homes of friends and relatives. Gas station stops are allowed as long as they are verified with a receipt.
- ___ 15. When scheduled to be home, I will remain within the walls of my residence, not outside on the porch, steps, yard or garage.
- ___ 16. I understand I may not work “under the table” for cash. If I have a last minute work schedule change, i.e. overtime, leaving work early, staying home from work or on-call, I will immediately call LCA and leave a message for my case manager and provide verification of the change by the next business day. I will not leave my office or job site for lunch or breaks.
- ___ 17. I will plan my schedule in advance and will adhere to it. If a change is required, I will request it at least one week in advance and wait for approval. No last minute schedule changes will be approved.
- ___ 18. I will answer the door immediately when an LCA staff person conducts an on-site visit. I agree to notify my case manager of any special circumstances regarding my residence, such as dogs in home or special entry instructions.
- ___ 19. I will not leave and return home during any scheduled activity without permission from my case manager, with the exception of my errand time. If I return home early due to illness or lack of work and agree to notify my case manager immediately.

- ____ 20. I agree to report to LCA for random drug testing as indicated on the "Random Drug Testing Procedures" form. A test can also be requested at any time, including during a field visit. Failure to show or refusal of a test will be reported to the supervising authority. If I miss a test I agree to report to the office the next day for testing. I understand I am responsible for the \$25.00 for each test administered.
- ____ 21. I agree to report to the LCA office in person once a month for a compliance meeting. At that time I will provide verification of employment hours, school, counseling, receipts and other activities, review my weekly activities and make applicable payments. Frequent rescheduling of office meetings is not allowed.
- ____ 22. I have received a copy of the Electronic Monitoring Program Client Handbook. I have read and understand all information contained in the handbook and am willing to comply with all rules and guidelines specified therein for the duration of my sentence on the program.

I understand that if I don't adhere to the above policies a written incident report will be sent to the supervising authority.

I also understand that any exemptions from the above stated policies must be submitted to LCA in written form directly from the supervising authority (i.e. court order from Judge or Probation).

Client Signature: _____ Date: _____

STAFF CONFIRMATION:

I have reviewed the policies above with the client and answered any questions regarding these policies.

Signature: _____ Date: _____

Name: _____

LCA STAFF USE ONLY

CLIENT MASTER SCHEDULE FORM

Client's Name: _____ Effective Date: _____
Program Start Date: _____ Program End Date: _____

Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

On-site Notes/ Instructions: _____

Additional Info.: _____

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

NOTES: **Activity Legend: W= work, S= school, C= child related, O= other (please indicate in additional info).**
Schedule should reflect travel time and be written in military time.