



STATE OF NEW YORK
DEPARTMENT OF CORRECTIONS
AND COMMUNITY SUPERVISION

**NOTICE OF DETERMINATION TO RELEASEE
REGARDING REQUEST FOR PARENTAL CONTACT
WITH BIOLOGICAL/ADOPTED MINOR CHILD(REN)**

To: _____ (Name) _____ (NYSID)

From: _____, _____ Area Office
(Bureau Chief)

Date: _____
(mm/dd/yy)

Following an investigation of your request dated _____ to have contact with your child(ren), please be advised that your request is being:

___ Approved regarding the child(ren): _____, _____, _____
(name[s]), *see* attached special condition.

___ Approved with modification regarding the child(ren): _____, _____,
_____ (name[s]), *see* attached special condition.

Please note that your conditions of supervision are subject to periodic review throughout your period of supervision and therefore, subject to adjustments or modifications in accord with case needs and/or new information received or obtained by the Department.

___ Disapproved for the following reason(s), *see* attached special condition:

If your request for parental contact has been denied, **you have the right to appeal** this decision to the Office of the Regional Director. Should you wish to review the documentation upon which the Department rendered its denial decision or to appeal from or discuss the decision of the Bureau Chief in a Parental Contact Conference meeting with the Regional Director, you must complete and mail your Notice of Appeal form to the Office of the Regional Director at the address provided below within **60 calendar days** of being served with this decision of the Bureau Chief.

If you do request a Parental Contact Conference, you will receive further notice regarding the date/time/location of such meeting. At the conference, you will be allowed to present witnesses or evidence on your behalf. If you desire, you may have an attorney accompany you at the conference. **If you do not request** a Parental Contact Conference, any documentation you wish to have considered by the Regional Director must be submitted to the address provided below within **30 calendar days** from the date you submitted your written request for review or appeal.

You will receive written notice of the final determination made by the Regional Director in your case.

ADDRESS: _____, Regional Director

