

**APPLICATION MUST BE COMPLETED IN ENTIRETY AND LEGIBLE**

**Section 1**

FACILITY:	APPLICANT NAME/DIN:	LOG #:
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Have you participated in the FRP before? \_\_\_ YES \_\_\_ NO  
 What facility? \_\_\_\_\_ Previous denial?  YES  NO

Are you married? \_\_\_ YES \_\_\_ NO Please list date of marriage \_\_\_\_\_

**Section 2** List the names of family members with whom you would like to have an FRP visit. All visitors must be eligible to participate in accordance with Department Directive #4500.

NAME(S) of VISITOR(S)	ADDRESS, INCLUDING STATE AND ZIP CODE	RELATIONSHIP	AGE

Document verification must be completed and returned. Mail the packet to:

Name: \_\_\_\_\_

Email Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Best time to call: \_\_\_\_\_

Reasonable Accommodation request attached? \_\_\_ Yes \_\_\_ No

I HAVE READ AND UNDERSTAND ALL OF THE PROVISIONS OF DEPARTMENT DIRECTIVE #4500.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**Section 3** BASIC INELIGIBILITY FRP ORC completes. Use with Form #4500 G.  
 Date completed: \_\_\_\_\_ Eligible: \_\_\_ Ineligible: \_\_\_ If ineligible, complete Section 6.

**Section 4** PROGRAM REVIEW (ORC completes.) Inmate is/has:  
 COMMENTS:

In general population? ___ YES ___ NO		If NO: ___ CMC ___ RPV ___ VIOLATION:	
Where:			
Temporary Release Eligible? <input type="checkbox"/> YES <input type="checkbox"/> NO		Applicant has applied for and is	
<input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED			
Victim(s) include: <input type="checkbox"/> CHILD <input type="checkbox"/> ELDERLY	History of Domestic Violence: <input type="checkbox"/> YES <input type="checkbox"/> NO		
Anti-Aggression Program: Applied: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> WLT <input type="checkbox"/> REF <input type="checkbox"/> PPA DATE COMPLETED: _____			
Substance Abuse Treatment: Applied: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> WLT <input type="checkbox"/> REF <input type="checkbox"/> PPA DATE COMPLETED: _____			
Sex Offender Treatment: Applied: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> WLT <input type="checkbox"/> REF <input type="checkbox"/> PPA DATE COMPLETED: _____			
Participates in: ___ AA	___ NA	___ AVP	___ AVP II
From ___ to ___	From ___ to ___	Completed on _____	Completed on _____
Other voluntary programs:			
Recommendation: <input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED REASON: _____			

Signature: PRINT \_\_\_\_\_

SIGN \_\_\_\_\_ Date: \_\_\_\_\_

OFFENDER REHABILITATION COORDINATOR

**FAMILY REUNION PROGRAM (FRP) APPLICATION**

FORM 4201E (12/15)

**Section 5 SECURITY** Inmate is/has:

___ Currently under NO disciplinary restrictions		___ Currently under disciplinary restriction		___ Has pending tickets: T1__ T2__ T3__	
___ Outstanding warrants	___ SHU	___ KEEPLOCK	___ CELL CONFINEMENT	___ Considered ESCAPE RISK	___ OTHER: _____
___ Incurred a Penal Law conviction for a crime committed during his/her incarceration:					
Recommendation: <input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED					
REASON:					

Signature: PRINT \_\_\_\_\_

SIGN \_\_\_\_\_ RANK \_\_\_\_\_ Date: \_\_\_\_\_

**Section 6 FRP ORC** Inmate has: # FRP visits: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ # of Cancellations: \_\_\_\_\_

___ Ineligible due to disciplinary status	___ Has disciplinary sanctions in effect	___ Requires Special Review	___ has FRP violation in effect
___ <b>does not meet general population status requirements</b>		___ Current ___ Previous Order of Protection(s) for:	
___ due to ___ Instant Offense or ___ disciplinary must complete: ___ ASAT ___ Anti-Aggression ___ SOCTP			
___ due to ___ refusal or ___ negative removal must complete: ___ ASAT ___ Anti-Aggression ___ SOCTP ___ Academic ___ Vocational			
Recommendation: <input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED			
REASON:			
			May reapply:

Signature: PRINT \_\_\_\_\_

SIGN \_\_\_\_\_ Date: \_\_\_\_\_

**Section 7 REQUIRES:**

MEDICAL CLEARANCE  OFFICE OF MENTAL HEALTH REPORT  PHOTO

**Section 8 SUPERINTENDENT/DESIGNEE**

NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_

Recommendation: <input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED
REASON:

Additional Comments:

\_\_\_\_\_  
 \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_