Request for Services **Date: ___________________**

Please return to:
P.O Box 170130
San Francisco, CA 94117-0130

Name: _____________________________________ Date of Birth: _______________

Inmate ID #_____________________ Total Number of Incarcerations _____ Ethnicity____________

Please specify whether you are in a State Facility or Federal Facility: ________________________ Current Address (Facility)

____ ________________________________

____

City: State: Zip:

Preferred Communication method(s)
Letters ( ) JPAY ( ) CorrLinks ( ) Other:please explain____________________________________

Please specify your charge/s (i.e., Narcotic/substance related crime, rape, murder, armed robbery, etc.)
____

Sentence Handed Down: (i.e., Life / Life without / Death / Years / Months / etc) ________________
Time served to date: Number of Years ( ) Number of Months ( )

Total number of appeals filed? _______ # of appeals denied? _____ Paroles denied? _______
Name/s of Attorney/s who represented you at trial:
____Paid _______ or Public Defender________
Contact Information:
____

<u>Level of Educational:</u>

Elementary _____Middle School _____ High School _____College _____ Degree? _______

Skills, Talents (i.e. writing, teaching, music, medical, reading, Arts, etc.)
____

Are they any family members who visit and/or support you in any way (i.e., emotional, financial, periodic or ongoing visits, etc? (Yes) ____ (No) _____

Now we would like to ask if you were raised in a one family home or with two parents or by another or others:
One Parent: _____ Two Parents: ______ Family member: _____ Non-related Individual/s:
_______ Explain____# of siblings' _______

Is either parent deceased? _________________ Explain: _____________________________________

Are there any other family member/s incarcerated at this time? __________ If so, in the same facility? ___

Is/Was there any prior history of Drug/Alcohol involvement in your family or with you? _________________
Explain: ____

Have you ever been diagnosed with a Psychological and/or Medical Illness? Yes _____ No_____ Explain Below ____

Are you currently receiving Medical and/or Psychological/Psychiatric Treatment? Yes______ No________

If so, what type of treatment are you receiving if any: _______________________________________
Do you want to be involved in Rehabilitative/Therapeutic programs, educational and/or other activities?

Yes _____No _______ if no, why not? ____________________________

Have you requested such programs? Yes ___ No ___ If so, approved ( ) denied ( )

Please be very specific in this area; How can New Vision Organization, Inc. be of assistance to you (I.e., legal, vocational, religious, educational, medical, psychological, family/group/ individual support, etc) Explain:

____
____
____

Note* If you are requesting assistance with Aftercare Resources and you are due to be released within a few months of this application, please list a contact number where you can be reached upon your release. Due to the enormous mail received, we are not able to read all mail right away.**
Name of contact person and Alternative Phone # ____
Alternative Mailing Address: ____

My Signature below authorizes New Vision Organization to advocate and act on my behalf.

Your Signature: ____ Date: _________________________
NVO Advocate's Signature: __________________________________ Date Received: __________________

Any application incomplete or unable to be read will not be accepted

********* Please write on reverse side if you need additional space *********

FL inmates only send to A. Passaro, PO Box 82366, Tampa FL 33682

PLEASE NOTE: We encourage you to share as much as you are comfortable with; the more you share, the easier it will be for us to provide solutions tailored to your individual situation. However, please be aware that while we do our best to protect the privacy of each client, and while the risk of a subpoena for or a data breach of our records is minimal, we cannot legally guarantee complete confidentiality.