

# REINTEGRATION PROGRAM

## Application

*“The Mission of the Comanche Nation Reintegration Program is to empower the personal transformation of incarcerated, or formerly incarcerated individuals, by facilitating help for the resources and services needed to establish and maintain a healthy, productive, crime free, prosperous life.”*

Applicants must meet all eligibility requirements and provide the requested documents in order to be considered for assistance through the Comanche Nation Reintegration Program.



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**Comanche Nation Reintegration**  
**P.O. Box 908**  
**Lawton, OK 73502**  
**Phone: 580-360-0616**  
**Email: [reintegration@comanchenation.com](mailto:reintegration@comanchenation.com)**





**COMANCHE NATION REINTEGRATION**  
**APPLICATION/ASSESSMENT**

**LEGAL:**

Facility where you are currently incarcerated:

\_\_\_\_\_

Facility you were released/discharged from:

\_\_\_\_\_

Length of Incarceration: \_\_\_\_\_

Release date or projected release date (if not released): \_\_\_\_\_

Conviction (most recent if more than one): \_\_\_\_\_

City, County, and State of Conviction (most recent): \_\_\_\_\_

Do you have any pending court dates (please circle)?      YES      NO

Next court date (if applicable): \_\_\_\_\_

Are you on probation or parole (please circle)?      Probation      Parole

Probation/Parole Officer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Please tell us about your offense(s); explain in detail what led to your most recent incarceration/treatment:

\_\_\_\_\_

Please list the monthly amount of any fines, fees, or costs associated with your offense(s):

Probation:                      \$ \_\_\_\_\_                      DA Supervision:                      \$ \_\_\_\_\_

Restitution:                      \$ \_\_\_\_\_                      Court Fines/Costs:                      \$ \_\_\_\_\_

Other (please specify):                      \$ \_\_\_\_\_

Do you have a valid driver's license?                      YES                      NO

If not, what is the status of your driver's license? \_\_\_\_\_



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**MEDICAL, MENTAL HEALTH, & SUBSTANCE ABUSE**

Do you have any health/medical problems that you need assistance with? If yes, please explain:

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Do you need assistance with the purchase of medication? If yes, please explain:

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Have you ever been diagnosed with a mental illness? If yes, please explain:

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Are you currently receiving mental health services or counseling? If yes, please state provider:

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	Please circle	
Do you currently use alcohol?	YES	NO
Do you feel you have an addiction to alcohol?	YES	NO
Do you smoke or use tobacco?	YES	NO
Do you feel you have an addiction to tobacco?	YES	NO
Do you currently use any illegal substances/drugs?	YES	NO
Do you feel you have an addiction to any drugs?	YES	NO
Do you want treatment for any addiction you may have?	YES	NO

Additional comments: \_\_\_\_\_

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**EMPLOYMENT & EDUCATION**

What is your highest level of education? \_\_\_\_\_

Are you interested in seeking further education? If so, please explain:

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**COMANCHE NATION REINTEGRATION**  
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**EMPLOYMENT & EDUCATION CONTINUED:**

What type of work experience do you have? \_\_\_\_\_

Are you currently employed? \_\_\_\_\_

If yes, who is your employer? \_\_\_\_\_

What is your hourly wage? \_\_\_\_\_

Do you have reliable transportation? \_\_\_\_\_

**ADDITIONAL COMMENTS:**

Do you have any additional comments, questions, or concerns? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**By my signature, I affirm that the information in this application is correct to the best of my knowledge and belief. I understand that all services and funding are subject to the availability of funds and final approval of the departmental Director.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reintegration Staff

\_\_\_\_\_  
Date



**COMANCHE NATION REINTEGRATION**  
**APPLICATION/ASSESSMENT**

**RELEASE OF CONFIDENTIAL INFORMATION:**

If you do not provide a complete address, to include street, city and zip code, **notification of your inquiry will not be mailed.**

I, \_\_\_\_\_ authorize:  
(Print name)

**Comanche Nation Reintegration  
#10 SW D Avenue  
Lawton, OK 73501  
580-360-0616**

To release my confidential information to:

Name of person to receive information: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, & Zip Code: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Email: \_\_\_\_\_

- **Information may include but not limited to assessment results, the progress report, or certificate of completion.**
- **I understand that my records are protected under Federal and State Confidentiality Regulation (42: CFR) and cannot be released without my written consent.**
- **I understand that I may revoke this authorization, in writing at any time, except for actions that may have already taken place prior to the date on my written revocation.**
- **In any event, this consent expires automatically ninety (90) days after the termination of current services.**
- **I acknowledge the release of confidential information was fully explained to me and I consent.**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature



**COMANCHE NATION REINTEGRATION**  
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**AUTHORIZATION TO RELEASE INFORMATION:**

I, \_\_\_\_\_, **authorize** the release of my person and/or business-related information for eligibility requirements and/or program assistance to the named department/program listed below:

Name: Comanche Nation Reintegration  
Address: PO Box 908  
City: Lawton State: OK Zip: 73502

This request and authorization also apply to and or release of: (check all that apply)

- Tribal Related Records
- Employment Records
- Copies of Personal Information
- Education Records
- Financial Records
- Public Assistance Information
- Other: Please list any other items not specified above)

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I, \_\_\_\_\_, **do not authorize** the release of my personal and/or business-related information to and department, program, organization, and/or business of any kind.

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Signature

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Date