

MAINE DEPARTMENT OF CORRECTIONS

APPEAL (SCCP, FURLOUGH PROGRAM, COMMUNITY TRANSITION PROGRAM) FORM

Resident Name _____

MDOC # _____

TO: Deputy Commissioner, or designee, **ONLY** if an SCCP appeal or an appeal of a denial of approval for an initial furlough leave or withdrawal of approval for an initial furlough leave

OR

TO: Central Office Director of Classification, or designee, for all **OTHER** appeals

On _____, the following decision took place:
Date

SCCP

Community Transition Program

Furlough Program

☐ Denial of approval for SCCP

☐ Denial of approval for a community transition program release

☐ Denial of an initial furlough leave

☐ Withdrawal of approval for SCCP

☐ Withdrawal of approval for a community transition program release

☐ Withdrawal of approval for an initial furlough leave

☐ Removal from SCCP

☐ Termination of a community transition program release

☐ Denial of any Other Furlough

☐ Restriction or Suspension of community transition program privileges

☐ Termination of a Furlough

☐ Restriction or Suspension of Furlough privileges

Appeal must be postmarked within fifteen (15) days of when: the written explanation of the denial of approval was received by the resident; the resident was notified of the withdrawal of the approval; the removal from or termination of the program occurred; or the restriction or suspension decision was received by the resident, whichever is applicable.

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I wish to appeal for the following reasons: _____

Resident's Signature

Date

DECISION ON REVIEW OF APPEAL

☐ Approved ☐ Reversed ☐ Modified ☐ Remand for further review

If modified, describe modification: _____

If remanded for review, at what point: _____

Explanation for decision: _____

Printed Name

Date

Signature