

Sample SCAAP Application External Screen Shots

State Criminal Alien Assistance Program - Microsoft Internet Explorer provided by U.S. Department of Justice

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**State Criminal Alien Assistance Program 2007-F0193-NY-AP**

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Applicant Information
OMB Number: 1121-0243
Expires: 02/29/2004

Application Number: **2007-F0193-NY-AP**
Welcome to the SCAAP on-line application process for Fiscal Year 2007.

Applicant/Organization Information

* Employer Identification Number: 65 - 6546546

* Type of Applicant: State

* Organizational Unit: Tester

* Legal Name (Legal Jurisdiction Name): Test

* Vendor Address 1: 1 test

Vendor Address 2:

* Vendor City: Buffalo

Vendor County:

* Vendor State: New York

* Vendor ZIP: 20009 4444 Need help for ZIP+4?

Please enter the CEO information for your jurisdiction below. Remember, this is the CEO of the level of government, not the implementing agency. (Note: Hit the TAB key to move between fields)

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Please enter the CEO information for your jurisdiction below. Remember, this is the CEO of the level of government, not the implementing agency. (Note: Hit the TAB key to move between fields)

CEO Of Your Jurisdiction: Governor, Cabinet-level State Official, County Administrator, County Judge, County Commissioner, Mayor, or City Manager

* Prefix: Dr.

Other Prefix:

* First Name: J

Middle Initial:

* Last Name: Husta

Suffix: Select a Suffix

Other Suffix:

* Title: Guy

* Phone: (555) 555 - 5555

Phone Ext:

Fax: () -

* Email: joe78@hotmail.com

* Address 1: 1 test

Address 2:

* City: Buffalo

County:

* State: New York

* Zip Code: 20009 - 4444

*- Indicates required field

Save Information

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Address: <http://oiprdcweb41u.ojp.usdoj.gov/gmsexternal/contactSCAAP.do>

OMB Number: 1121-0243
Expires: 02/29/2004

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Contact Information

Application Number: **2007-F0193-NY-AP**

Please enter the alternate contact information below. (Note: Hit the TAB key to move between fields)

*Prefix: Justice
Prefix Other:
*First Name: John
Middle Initial:
*Last Name: Smith
Suffix: Select a Suffix
Other Suffix:
*Title: Honorable
*Phone: (456) 644 - 6545
Phone Ext:
Fax: () -
*Email: h@r.com
*Address 1: 1 test
Address 2:
*City: Buffalo
County:
*State: New York
*Zip Code: 20009 - 4444

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Address: <http://oiprdcweb41u.ojp.usdoj.gov/gmsexternal/achBank.do>

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Financial Institution Information

Please provide the following financial institution information. All of this information is required to transfer funds to your jurisdiction's account electronically.

* Name of Institution:
* Address Line 1:
Address Line 2:
* City:
* State: Select a state:
* Zip:
* Bank Phone: - -
* ACH Coordinator Name:
* Routing Number:
* Account Title:
* Account Number:
* Account Type:
* Is this account Interest Bearing: N

* - Indicates required field

Save and Continue Cancel

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Inmate Information

Application Number: 2007-F0193-NY-AP

Inmate Information

How will inmate information be entered? ☒ Enter Data ☐ Upload File

Select All

Deselect All

0 Inmates Entered

X	Unique Inmate ID	Name (Last, First)	Date Incarcerated	Date Released
No Inmates				

Add

Delete Selected

Save Information

Done

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Facility Information Screen

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Correctional Officer Information:
(Use decimal values if needed to express full or partial full-time equivalents (FTE))

* Please report the maximum number of full-time correctional officers your facility(ies) employed during the reporting period:

* Please report the maximum number of part-time correctional officers your facility(ies) employed during the reporting period: (Please report as FTE's)

* Please report the maximum number of contracted full-time correctional officers your facility(ies) employed during the reporting period:

* Please report the maximum number of contracted part-time correctional officers your facility(ies) employed during the reporting period: (Please report as FTE's) ;

Total number of correctional officers your facility(ies) employed during the reporting period: (calculated from above)

* Please enter the total salary costs paid to all correctional officers during the reporting period. Do not use commas: \$

Facility(ies) Information

* Total bed count for correctional facility(ies):

* Total number of days for ALL inmates (legal aliens, illegal aliens, unknowns and U.S. citizens) housed in your facility(ies) for the reporting period (Do not report your capacity. BJA Requires an actual count of inmates housed during the reporting period):

* - Indicates required field

☐

[Save Information](#) [Clear](#)

Done Local intranet