



HEALTH SERVICES REENTRY PLAN

PARTICIPANT NAME Click here to enter text.	DOC NUMBER Click to enter #.	RELEASE DATE Click to enter date.
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RELEASE ADDRESS Click here to enter text.
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SPONSER NAME	SPONSER PHONE NUMBER
COMMUNITY CASE MANAGER/REENTRY NAVIGATOR NAME	CASE MANAGER/NAVIGATOR PHONE NUMBER

EMERGENCY PHONE NUMBERS

988 Lifeline – Call during a crisis or when in need of support. Translation services are available for over 240 languages.

Veteran’s Crisis Line: Call 988 then press 1 or text 838255

Idioma Español: Llame al 988 y luego presione 2

LGBTQI Crisis Line: Call 988 then press 3 or text PRIDE (77433)

American Indian and Alaskan Native: Call 988 then press 4

Crisis Counselor: Text HOME to 741741

Nicotine Cessation/Quitting Support Services: Call 1-800-784-8669 or text READY to 200400

Washington Recovery Helpline (24/7): 1-866-789-1511 (mental health, gambling, substance abuse)

Community Resource Needs in your area: Call 211

Other:

HEALTH INSURANCE

PROVIDER ONE NUMBER Click here to enter text.	
MANAGED CARE ORGANIZATION	PHONE NUMBER

Additional information:
Call Health Care Authority (HCA) for same-day access or if having issues at 1-800-562-3022.

PHYSICAL HEALTH

PRIMARY CARE PROVIDER (PCP)	PHONE NUMBER
PHARMACY	PHONE NUMBER

Additional information:

MENTAL HEALTH

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MENTAL HEALTH PROVIDER (MHP)	PHONE NUMBER
PHARMACY	PHONE NUMBER

Additional information:

Warning signs and symptoms I should reach out to my provider for support:

SUBSTANCE USE DISORDER

SUBSTANCE USE DISORDER PROVIDER (SUDP)	PHONE NUMBER
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Additional information:

Released on Medication Assisted Treatment: Choose an item.

BENEFITS/COMMUNITY RESOURCES

DSHS: The Community Services Office (CSO) may provide food assistance, cash assistance, housing and essential needs (HEN), and other benefits, if eligible.

To apply by phone call 1-877-501-2233.

For same-day service the closest CSO to your housing is at:

Additional information:

Social Security Administration (SSA): Call 1-800-772-1213 to schedule an appointment or access online at www.ssa.gov. SSA hours are Monday to Friday, 8:00 am to 7:00 pm.

The closest SSA office to your housing is:

DDA Contact:

Accountable Community of Health:

Tribal Resource Hub: 866-491-1683

Sex Offender Treatment:

Continuity of care information:

Vocational:

Education:

Financial Literacy:

ADA Accommodation Information:

Washington Talking Book & Braille Library (WTBBL): 206-615-0400

Department of Services for the Blind (DSB): 800-552-7103

<https://dsb.wa.gov/learn-about-our-services/request-more-information>

Office of the Deaf & Hard of Hearing (ODHH): 360-339-7382, Voice 800-422-7930

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Other:

TRANSPORTATION

Day of release:
After release (i.e., appointments):

EMPLOYEE NAME and TITLE Click here to enter text.	EMPLOYEE SIGNATURE	DATE Click to enter date.
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EMPLOYEE NAME and TITLE (if completing portion of document) Click here to enter text.	EMPLOYEE SIGNATURE	DATE Click to enter date.
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Distribution: **ORIGINAL** – Health Record **COPY** – Patient

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7-Day Plan After Release

Enter the 7 days after release and add any activities/appointments, locations, and transportation arrangements below.

Day:	Day:	Day:	Day:	Day:	Day:	Day:

Additional information:



PATIENT I.D. DATA:
(Name, DOC#, DOB)

Click to enter text

Click to enter text

Click to enter date

REENTRY NEEDS ASSESSMENT

DATE Click to enter date	FACILITY Select	UNIT (optional)	PRONOUNS	PREFERRED LANGUAGE
ADMISSION DATE Click to enter date	ERD/PRD Click to enter date	COUNTY OF ORIGIN Click here to enter text.	Do you have any challenges with understanding things in writing:	
<p>Benefits: <input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> TOAP referral <input type="checkbox"/> Veteran <input type="checkbox"/> American Indian/Alaska Native</p> <p><input type="checkbox"/> Health insurance – Preferred MCO:</p> <p><input type="checkbox"/> ACA complete or active: <input type="checkbox"/> Short form <input type="checkbox"/> Long form</p> <p>Do you have any questions about your insurance?</p> <p>Are you interested in an MCO warm hand off?</p> <p>Do you have a DPOA for healthcare – or are you in need?</p> <p>Are you interested in Tribal healthcare services?</p> <p>Are you a Veteran/have DD214/VA benefits:</p>				
<p>Physical Health:</p> <p>Current health concerns or chronic medical conditions:</p> <p>DME:</p> <p>Interested in primary care after release:</p> <p>Current pre- or post-release consults:</p> <p>Concerns related to medical care/follow up appointments/specialty care:</p> <p>Do you have a current HSR, if yes, explain:</p> <p>If eligible for DDCCS, patient is <input type="checkbox"/> declining <input type="checkbox"/> amenable to services. If amenable, DDCCS collaboration is underway: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If eligible for CCA: <input type="checkbox"/> Required exam completed <input type="checkbox"/> Required exam referred/pending</p> <p>If CLCC, have you been working with your case manager on a care plan at release? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If GAC, what are your treatment goals and barriers to achieving goals?</p> <p>Are you prescribed hormones? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you had a psychological evaluation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you been scheduled for surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>				
<p>Dental:</p> <p>Do you have current dental conditions/concerns?</p> <p>Interested in dental care after release/have a current provider:</p> <p>What are your needs or concerns related to dental:</p>				
<p>Mental Health Services: <input type="checkbox"/> RCS <input type="checkbox"/> Current involuntary antipsychotic order</p> <p>Diagnosis:</p> <p>History of MH care:</p> <p>Are you interested in follow-up mental health care or do you have a community provider?</p> <p>RCS referral appropriate/completed?</p> <p>Is patient interested in PACT or Path?</p>				
<p>Substance Use Services:</p> <p>Patient is interested in: <input type="checkbox"/> MAT/MOUD: <input type="checkbox"/> Pre-release <input type="checkbox"/> Post-release</p> <p><input type="checkbox"/> Narcan requested <input type="checkbox"/> SUD treatment referral post-release</p>				

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Click to enter text

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Click to enter date

REENTRY NEEDS ASSESSMENT

DATE Click to enter date	FACILITY Select	UNIT (optional)	PRONOUNS	PREFERRED LANGUAGE
<p>MOUD/MAUD summary: History of SUD Care: Treatment completed while incarcerated: Summary: Interested in recovery support groups or recover focused peer support:</p>				
<p>Release Medications: <input type="checkbox"/> Yes <input type="checkbox"/> No What is your plan for managing your medications after release? Medication list: Will any of your medications require refrigeration?</p>				
<p>DOC Housing Plan: Housing identified: <input type="checkbox"/> Yes <input type="checkbox"/> No Plan for housing/intent to use voucher? Special considerations for housing: Have you thought about adult family home or is there a need for residential care or caregiving of any kind?</p>				
<p>Partial Confinement: Are you planning to transfer for partial confinement? If yes, is the plan for GRE/electronic home monitoring, ABHS, or Reentry Center?</p>				
<p>SOTAP: <input type="checkbox"/> N/A <input type="checkbox"/> Current sex offense <input type="checkbox"/> Treatment while in custody <input type="checkbox"/> Treatment needs in community</p>				
<p>DOC Community Supervision: Will you have Community Supervision? Are you interested in meeting with your CCO prior to release?</p>				
<p>Basic Needs: <input type="checkbox"/> Food <input type="checkbox"/> Clothing <input type="checkbox"/> Transportation How do you plan to meet your needs after release? Do you know how to navigate the bus system? Do you need a referral for Medicaid transportation? What challenges might you face after release?</p>				
<p>Support: Who is in your support system? Are you interested in additional support referrals, ACH? Are you interested in formal Peer support referrals? Do you have vocational or education goals after release?</p>				
<p>Mini Mental Status Examination: Oriented: Thought Process: Observable Symptoms: Appearance/Behavior/Insight: Stage of Change:</p>				

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PATIENT I.D. DATA:
(Name, DOC#, DOB)

Click to enter text

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Click to enter date

REENTRY NEEDS ASSESSMENT

DATE Click to enter date	FACILITY Select	UNIT (optional)	PRONOUNS	PREFERRED LANGUAGE
Personal Strengths: What has helped you be successful in the past? Clinical summary:				
Individual's Identified Goals/Plan:				
What ROIs have been completed: <input type="checkbox"/> MCO: <input type="checkbox"/> CCO: <input type="checkbox"/> Reentry Navigator: <input type="checkbox"/> Community Provider: <input type="checkbox"/> Family: <input type="checkbox"/> Others:				
Primary Facilitator Notes: Meet for case management on: Primary facilitator to make referrals for:				
COMPLETED BY (typed name) Click here to enter text.			SIGNATURE	

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