MISSION HOUSING/SKILL BUILDING UNIT TRANSITION PLAN

DATE | FACILITY

CONTACT INFORMATION

Community Corrections Officer | Phone number

DDA Case Manager | Phone number

Mental Health Provider | Phone number

Substance Use Disorder Provider | Phone number

Pharmacy | Phone number

Sponsor/Family | Phone number

Other | Phone number

Emergency Contact | Phone number

COMMUNITY INFORMATION

Housing:

Primary Transportation To/From Appointments (excludes day of release):

Resources (local clothing and food banks close to housing):

Identified Goals (mental health and DDA):

Hobbies and Activities (to do once released):

7-DAY PLAN AFTER RELEASE

Enter date for the next 7 days after release and add activities/appointments, locations, and transportation arrangements (if made) below each.

Day: | Activity/Appointment:
### MISSION HOUSING/SKILL BUILDING UNIT TRANSITION PLAN

<table>
<thead>
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</table>

**APPOINTMENTS (after first week)**

<table>
<thead>
<tr>
<th>Day:</th>
<th>Activity/Appointment:</th>
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**MEDICATIONS**

Enter release medication information, including amount to take and time of day. Information should be obtained from the facility psychiatrist/primary therapist or community mental health provider.

<table>
<thead>
<tr>
<th>MORNING</th>
<th>AFTERNOON</th>
<th>EVENING</th>
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**OTHER**

COPY – This page and preceding page(s) to participant
### MISSION HOUSING/SKILL BUILDING UNIT
### CHECKLIST AND TRANSITION INFORMATION

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<tr>
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<th>MAX RELEASE DATE</th>
<th>PLANNED RELEASE DATE (PRD)</th>
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### TRANSITION TEAM MEMBER NAMES AND CONTACT INFORMATION

- **Classification Counselor**
  - Phone number
- **Skill Building Unit Counselor**
  - Phone number
- **Psychiatric Social Worker**
  - Phone number
- **Primary Therapist**
  - Phone number
- **Substance Use Disorder Provider**
  - Phone number
- **DDA Case Manager**
  - Phone number
- **Community Corrections Officer**
  - Phone number

### COMMUNITY INFORMATION

**Housing:** ____________________________  **ProviderOne number:** ________________

- Affordable Care Act (ACA) application complete ...........................................  ☐ Yes ☐ No ☐ N/A
- Transition Offender Assistance Program (TOAP) application complete .................................................................  ☐ Yes ☐ No ☐ N/A
- Supplemental Security Income (SSI) history within the last year ..........  ☐ Yes ☐ No ☐ N/A
- SSI appointment scheduled and/or SSI application packet completed  ☐ Yes ☐ No ☐ N/A

Additional information regarding finances, housing, federal/state assistance programs, and personal/household items:

Transportation after day of release/means of transportation to get to appointments:

If bus will be primary mode of transportation:
- **Bus route map given at release**..............................................  ☐ Yes ☐ No ☐ N/A
- **Individual knows how to use the bus**...........................................  ☐ Yes ☐ No ☐ N/A
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Identification card application submitted/received before release ...... ☐ Yes ☐ No ☐ N/A

Cell phone obtained ............................................................................................................................................................................................................................................................................................................................................ ☐ Yes ☐ No ☐ N/A

Other means of communication: ____________________________________________________________

DDA eligibility determined and services identified..................................... ☐ Yes ☐ No ☐ N/A

Symptoms likely to be signs of decompensation (see Discharge Summary or request from Primary Therapist):

Release medications: ☐ N/A

Durable medical equipment needed: ☐ N/A

Medical follow-up needed, including name of provider(s): ☐ N/A

Follow-up substance use disorder (SUD) treatment recommended... ☐ Yes ☐ No ☐ N/A

Released on medication for opioid use disorder (MOUD) treatment.. ☐ Yes ☐ No ☐ N/A

MOUD community provider / Referral: ☐ N/A

### DAY OF RELEASE PLAN

Transportation from facility: ________________________________

Appointments, if applicable:

<table>
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<th>Location</th>
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Housing and personal needs (e.g., shopping needs):

### ADDITIONAL INFORMATION RELATED TO TRANSITION

Additional appointments:

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<tr>
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State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.
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Date: ____________ Time: ____________ Location: ______________________________

Additional applicable information not yet included:

**COMPLETED BY**

Skill Building Unit Manager/Designee  Signature

Psychiatric Social Worker  Signature

Classification Counselor  Signature

Distribution:  **ORIGINAL** – Health Record  **COPY** – CCO, Imaging System