PATIENT I.D. DATA:
(name, DOC #, birthdate)

Department of Corrections
WASHINGTON STATE

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:

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DATE	FACILITY

Day:	Activity/Appointment:
Day:	Activity/Appointment:
Day:	Activity/Appointment:
Day:	Activity/Appointment:
Day:	Activity/Appointment:
Day:	Activity/Appointment:

APPOINTMENTS (after first week)

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.

MORNING	AFTERNOON	EVENING

OTHER

COPY – This page and preceding page(s) to participant

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Department of Corrections
WASHINGTON STATE

MISSION HOUSING/SKILL BUILDING UNIT CHECKLIST AND TRANSITION INFORMATION

DATE	FACILITY	EARLY RELEASE DATE (ERD)	MAX RELEASE DATE	PLANNED RELEASE DATE (PRD)

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:

Time: _____ Location: _____

Time: _____ Location: _____

Housing and personal needs (e.g., shopping needs):

ADDITIONAL INFORMATION RELATED TO TRANSITION

Additional appointments:

Date: _____ Time: _____ Location: _____

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DATE	FACILITY	EARLY RELEASE DATE (ERD)	MAX RELEASE DATE	PLANNED RELEASE DATE (PRD)

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