Transition Plan[1]					
Inmate Last Name:	First Name:			MI:	Gender M □ F □
DOC Number:	SSN#		DOB:		Today's Date:
Name of Facility:	Person Completing Form:				
Current Status:	Pretrial Detainee □		Sentenced Inmate □		
Date of Admission:	Expected Release Date:				

Risk Level, Treatment, and Criminogenic Needs			
Was the inmate's screen and assessment questionnaire reviewed?		Yes □	No □
Risk/Needs Assessment Score:	High □	Medium □	Low □

Interventions Needed					
Identification					
Social Security Card	Yes □	No □	Veteran Identification Card	Yes □	No □
Birth Certificate	Yes □	No □	Passport	Yes □	No □
Alien Registration Card	Yes □	No □	Valid State ID/Driver's License	Yes □	No □
Picture Identification	Yes □	No □	Military Discharge Papers	Yes □	No □
Certificate of Naturalization	Yes □	No □	High School Diploma/ GED Certificate	Yes □	No □
Are any identification documents in inmate's property?					
If yes, specify type of documentation:					
If no, explain how identification is being obtained:					
Benefit Eligibility					
Public Assistance	Yes □	No □	Food Stamps	Yes □	No □
Medicaid	Yes □	No □	SSI	Yes □	No □
SSD	Yes □	No □	Veteran	Yes □	No □
Transportation					
If known – Time of Release					
Will someone pick up the inmate?				Yes □	No □
If yes, who?					
If no, how will the inmate get home?					
Housing					

Address at Release:		Apt #:
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:
Residents in House:		

Does the inmate expect to be released to known housing?	Yes □	No □
Does the inmate expect to be released to a homeless shelter?	Yes □	No □
Type of housing assistance required:		
Medical/Mental Health/Dental		
Primary health care needed:	Yes □	No □
Medical specialist needed:	Yes □	No □
Mental health provider needed:	Yes □	No □
Medication needed:	Yes □	No □
Date of last full physical:		
Substance Abuse Counseling/Treatment		
Alcohol counseling/treatment needed:	Yes □	No □
Substance abuse counseling/treatment needed:	Yes □	No □
Level of care required:	Outpatient □	Residential □

Family				
Will have custody of children:	Yes □	No □	If yes, how many?	Ages: ___, ___, ___, ___, ___
Family counseling needed:	Yes □	No □		
Education				
Has GED	Yes □	No □	Has H.S. diploma	Yes □ / No □
Continuing education needed:	Yes □	No □		
Employment				
Job skills training needed:	Yes □	No □	Area of interest:	
Job placement needed:	Yes □	No □	Special skills:	

Financial Obligations			
Court:	Child Support:	Medical:	Civil:
Other:	Other:		

In-Jail Program Participation

Completion Information				Postrelease Referral
AA/NA	Yes □	No □	N/A □	Yes □
Anger Management	Yes □	No □	N/A □	Yes □
Cognitive Behavioral Change	Yes □	No □	N/A □	Yes □
Domestic Violence	Yes □	No □	N/A □	Yes □
Education	Yes □	No □	N/A □	Yes □
Employment Skills	Yes □	No □	N/A □	Yes □
Inmate Worker	Yes □	No □	N/A □	Yes □

Parenting	Yes □	No □	N/A □	Yes □
Religious Studies	Yes □	No □	N/A □	Yes □
Substance Abuse	Yes □	No □	N/A □	Yes □
Other:	Yes □	No □	N/A □	Yes □
Other:	Yes □	No □	N/A □	Yes □

Post-Release Community Referrals

Check each need and then fill out a separate referral for each need.

Aging & Disability Services □	Community Corrections □	Domestic Violence □	Drug or Alcohol Treatment □	Education □
Employment □	Coping Skills – Family/ Children □	Management of Financial Resources □	Food/ Clothing □	Health Care Benefits □
Housing □	Identification □	Income/Benefits/Entitlements □	Life Skills Training	Medical/Dental Care/ Local Health Clinic □
Mental Health Care □	Medication Assistance □	Rent Assistance □	Social Security □	Transportation □
Unemployment □	Vocational Training □			

1. Referral Type:

In-Custody: □	At Discharge: □	Post-Release: □

Agency Referred To:	Contact Phone:	Contact Person:	
Appointment Date/Time:	Location:	Referral Faxed/E-mailed: Yes □ No □	Fax # or E-mail Address

Reentry Accountability Plan:

My self-defeating behavior that blocks my success with this issue:

My behavioral goal to address my issue is:

My action plan to meet the above goal:	Target Completion Date:	Completion Date:

Staff action plan to meet the above goal:

Comments:

2. Referral Type:

In-Custody: □	At Discharge: □	Post-Release: □

Agency Referred To:	Contact Phone:	Contact Person:

Appointment Date/Time:	Location:	Referral Faxed/E-mailed: Yes □ No □	Fax # or E-mail Address
Reentry Accountability Plan:			
My self-defeating behavior/problem that block my success with this issue:			
My behavioral goal to address my problem is:			
My action plan to meet the above goal:		Target Completion Date:	Completion Date:
Staff action plan to meet the above goal:			
Comments:			
3. Referral Type:			
In-Custody: □	At Discharge: □	Post-Release: □	
Agency Referred To:	Contact Phone:	Contact Person:	
Appointment Date/Time:	Location:	Referral Faxed/E-mailed: Yes □ No □	Fax # or E-mail Address
Reentry Accountability Plan:			
My self-defeating behavior/problem that blocks my success with this issue:			
My behavioral goal to address my problem is:			
My action plan to meet the above goal:		Target Completion Date:	Completion Date:
Staff action plan to meet the above goal:			
Comments:			
4. Referral Type:			
In-Custody: □	At Discharge: □	Post-Release: □	
Agency Referred To:	Contact Phone:	Contact Person:	
Appointment Date/Time:	Location:	Referral Faxed/E-mailed: Yes □ No □	Fax # or E-mail Address
Reentry Accountability Plan:			
My self-defeating behavior/problem that blocks my success with this issue:			
My behavioral goal to address my problem is:			
My action plan to meet the above goal:		Target Completion Date:	Completion Date:
Staff action plan to meet the above goal:			
Comments:			

Completion of Plan					
Full plan completed and discussed with inmate?				Yes □	No □
If no, why?	Inmate refused □	Court release before plan completed □	Incomplete for other reasons □	Specify:	

Case Manager/Counselor Information	
Name of Case Manager/Counselor:	
Facility:	Inmate Housing Area:
Date Memorandum of Agreement Signed:	Date Discharge Plan Completed:
Case Manager/Counselor (signature):	Phone #:
Supervisor:	Phone #: E-mail Address:

Inmate Agreement	
I have participated in the completion of this transition plan, received a copy of this transition plan, emergency numbers for assistance in the community, and necessary psychiatric referrals (if necessary).	
Inmate's Name:	
Inmate's Signature:	Date:

[1] Transition plan adapted from the following plans: New York City Department of Corrections Rikers Island Discharge Enhance (RIDE) Plan; New York City Department of Corrections Discharge Planning Questionnaire; Davidson County, Tennessee, Sheriff's Office Re-Entry Release Plan; Washington, D.C., Department of Corrections Discharge Planning Form; Travis County, Texas, Inmate Discharge Plan; GAINS Re-Entry Checklist for Inmates Identified with Mental Health Service Needs; SAMHSA Sample Prison/Jail Substance Use Disorder Program Discharge Summary to Help with the Reentry Process; State of Missouri Department of Corrections; Douglas County, Kansas, LoCIRP reentry plan.