REINTEGRATION /TRANSITION PLAN

Plan is formulated based on results of Assessments, Individual Service Plan (ISP) and the SAVRY instrument

ISP/Preliminary Release Plan:_____ (Date)

Final Release Plan:_____ (Date)

Name:_____ Client ID#_____

Release Type: Early / Full Term

Parent/Guardian:_____

Full Term Date:_____

Address:_____

Date of Commitment:_____

_____

Date of Birth: _____

Telephone Number:_____

Length of Stay: _____

Region:_____

Intake Age: _____

Parish:_____

Release Age: _____

Released To:_____

Initial Custody **Level:**_____

Release Custody Level: _____

Youth Care Release Stage: _____

Check Off for Facility Case Manager Only

	Y	NA
Crime Victim Notice		
Gang Notification		
Detainer		
DNA		
Sex Offender Registration		
897.1 (Vitter Bill)		

OFFENSE(S):

_____

_____

_____

Group Leader/Assistant Group Leader_____

Facility Case Manager_____

Non-secure Service Provider:_____

JUDGE(S): _____

_____

_____

PROBATION OFFICER:_____

Telephone number:_____

PROGRAMMING

Early Release Recommendation: Yes _____ No ____ Date: _____

Furlough/Escorted Leave: Yes ____ No____ How many successful _____ Not successful _____

Educational Level:_____

REMINDER: Non-secure care case manager and Secure care case manager shall verify that the youth's school records/report card was sent to the receiving school and that a copy was given to the youth and his parents/legal guardians.

REINTEGRATION /TRANSITION PLAN

Name: _____ Client ID#_____

The Reintegration plan should take into account the following areas:

- Education
- Acceptable interpersonal relationships
- Ability to obtain and maintain adequate housing
- Ability to manage resources
- Sufficient living skills to live independently
- Realistic goals and expectations
- Economic self sufficiency
- Faith Based Services
- Other

	(Preliminary Plan)		**(Final Plan)**	
PARENT(s) NOTIFIED of Reintegration Staffing:	Yes _____	No _____	Yes _____	No _____

NEED AREAS IDENTIFIED: (*Follow-up Services in the Community*)

NEED AREA #1 <u>Mental Health/Emotional Stability</u> Yes ___ NO ____ Date of Review: _____,_____,_____

(*List dates that plan was reviewed/ modified*)

Brief Narrative:_____

_____

_____

_____

_____

Name: _____ Client ID#_____

Contact Agency: _____ Phone Number: _____

Address: _____

_____

Appointment Scheduled: Yes _____ No _____ Date: _____ Time: _____

Agency Contact Person: _____

Responsible party to set up services(non-secure service provider or LSUMHTP at secure facility):

_____

REINTEGRATION/TRANSITION PLAN

Client Name_____ **Client ID#**_____

NEED AREA #2 Disruptive Behavior Problems Yes ___ NO ____ Date of Review: _____,_____,_____

(*List dates that plan was reviewed/ modified*)

Brief Narrative: _____

_____

_____

_____

_____

Name: _____ Client ID#_____

Contact Agency: _____ Phone Number: _____

Address: _____

_____

Appointment Scheduled: Yes _____ No _____ Date: _____ Time: _____

Agency Contact Person: _____ Responsible party to set up services: _____

NEED AREA #3 Family Yes ___ NO ____ Date of Plan:_____;_____;_____

Please indicate plans to reside with guardian or family member and any plans for family counseling or other family needs.

If youth will not be residing with guardian or family, please indicate why in narrative below and complete section on Placement Recommendation Other Than Home. (*List dates that plan was reviewed/ modified*)

Brief Narrative on Family:_____

_____

_____

_____

_____

Family Counseling Contact Agency: _____ Phone Number: _____

Address: _____

Appointment Scheduled: Yes _____ No _____ Date: _____ Time: _____

Agency Contact Person: _____ Responsible party to set up services: _____

REINTEGRATION/TRANSITION PLAN

Client Name_____ **Client ID#**_____

Need Area# 4 **Placement Needs Upon Release**

PLACEMENT RECOMMENDATION OTHER THAN HOME: Close proximity to Family/Guardian?

_____Specialized Foster Family Home _____Yes _____No

_____ Group Home

_____ Residential Facility

_____Supervised Apartment

_____Other(_____)

Visitation Plan- Is visitation between the youth and parent appropriate?

_____Yes _____No

Name of Placement:_____

Address:_____

Contact Person:_____

OJJ Staff or Non-secure Service Provider Responsible for Setting Up Placement:_____

NEED AREA # 5 **Peer/Social Skills and Supports** Yes ___ NO ____ Date of Review: _____,_____, _____

(supportive family and friends) (*List dates that plan was reviewed/ modified*)

Brief Narrative: _____

_____

_____

_____

_____

_____

Nam**e:**_____ Relation**:**_____
Address:_____
Tel#_____

Name:_____ Relation:_____
Address:_____
Tel#_____

Name:_____ Relation:_____
Address:_____
Te;#_____

REINTEGRATION/TRANSITION PLAN

Client Name_____ **Client ID#**_____

NEED AREA #6 Substance Abuse Yes ___ NO ____ Date of Review: _____,_____, _____

(*List dates that plan was reviewed/ modified*)

Brief Narrative:_____

_____

_____

_____

_____

_____

Contact Agency: _____ Phone Number: _____

Address: _____

_____

Appointment Scheduled: Yes _____ No _____ Date: _____ Time: _____

Agency Contact Person: _____ Responsible party to set up services: _____

Name: _____ Client ID#_____

Contact Agency: _____ Phone Number: _____

Address: _____

_____

Appointment Scheduled: Yes _____ No _____ Date: _____ Time: _____

Agency Contact Person: _____ Responsible party to set up services: _____

NEED AREA # 7 Community Yes ___ NO ____ Date of Review: _____,_____, _____

(organized or disorganized community, crime rate, urban or nonurban) (*List dates that plan was reviewed/ modified*)

Brief Narrative: _____

_____

_____

_____

REINTEGRATION/TRANSITION PLAN

Client Name_____ **Client ID#**_____

NEED AREA #8 Pro-Social Activity/Recreation Yes ___ NO ____ Date of Review: _____,_____,_____

(Positive Peer Groups or Activities) (*List dates that plan was reviewed/ modified*)

Brief Narrative:_____

_____

_____

_____

_____

_____

Contact Agency: _____ Phone Number: _____

Address: _____

_____

Appointment Scheduled: Yes _____ No _____ Date: _____ Time: _____

Agency Contact Person: _____ Responsible party to set up services: _____

REINTEGRATION/TRANSITION PLAN

Name:_____ Client ID#_____

NEED AREA # 9 Education/Vocational Yes ___ NO ____ Date of Review: _____,_____, _____

(*List dates that plan was reviewed/ modified*)

Education Specialist: When Assistance Is Needed:

Contact _____ **Tel.#** _____

A. School, Training and Vocational Environments needs:

Education Agency (School, Vocational College, Training Program)
Previous School _____
Address_____
Current Grade _____
Current Test Scores (TABE, Woodcock, etc.) Reading _____ Math _____ Language _____
Current Educational Program ☐ GED☐ Carnegie Units ☐ Pre-GED Skills Option☐Career Pathways
Currently enrolled in _____ vocational programming
Youth will be returning to *(School)* _____ in *(Parish)* _____
Contact *(Child Welfare and Attendance Officer)* _____ Tel # _____
For Assistance call (Guidance Counselor*)* _____ Tel # _____
Are Special Education Services Being Provided? Yes__ No___

IEP Date _____ Individual Evaluation Date _____ Exceptionality _____

Special Education Department for receiving Parish upon release
Contact _____ Title _____ E-mail _____
Parish _____ Tel. # _____ Fax _____
Address _____ City _____ State/Zip _____

Educational Tutoring Needs ☐ yes ☐no Specify*:* _____

Vocational Needs _____
_____
Job Training/Placement Needs ☐ yes ☐no *specify:* _____
_____

Contact _____ Title _____ E-mail _____
Parish _____ Tel. # _____ Fax _____
Address _____ City _____ State/Zip _____

Web Address _____ User IE _____ Password _____
Contact person _____Agency _____ ☐ Public ☐ Private
Address *(if available)* _____ City_____State/Zip _____

REINTEGRATION/TRANSITION PLAN

Client Name_____ **Client ID#**_____

B. Identification and Personal Resources

Do you have any of the following items?

1. ☐ yes ☐ no Social Security Card
2. ☐ yes ☐ no Driver's License
3. ☐ yes ☐ no State of Louisiana Picture I.D.
4. ☐ yes ☐ no Birth Certificate
5. ☐yes ☐no Immunization Record

Contact _____ Title _____ E-mail _____
Tel. # _____ Agency _____
Address _____ City _____ State/Zip _____

C. Possible Job Interest

☐ Carpenter Helper
☐ Cashier/Checker
☐ Buser (restaurant)
☐ Cook/Food Prep Worker/Waiter
☐ Hospital laundry worker
☐ Fast Food Crew Member
☐ Certified Nurses Aide
☐ Hotel/Motel Housekeeper
☐ Room Service Attendant
☐ Grounds Maintenance Worker
☐ Electrician Helper
☐ House Painter
☐ Commercial Cleaner
☐ General Laborer
☐ Warehouse Worker

Other:_____

Public or Private Job Assistance Website(s)

Web Address _____ User IE _____ Password _____
Contact person _____Agency _____ ☐ Public ☐ Private
Address *(if available)* _____ City_____State/Zip _____

Web Address _____ User IE _____ Password _____
Contact person _____Agency _____ ☐ Public ☐ Private
Address *(if available)* _____ City_____State/Zip _____

D. Post-Secondary Programming and Community Needs:Post-Secondary Education/Training

☐ Business College
☐ Community College
☐ College/University
☐ Employment
☐ Short Term Training/Certification
☐ On the Job Training
☐ Job Corps
☐ Trade School (Associate's Degree)
☐ Corporate Training Program
☐ Military
☐ Work Study
☐ Other _____

Address:_____
Address:_____
Address:_____

Possible Barriers to school re-entry or employment upon release: _____

_____
_____
_____
_____
_____

REINTEGRATION/TRANSITION PLAN

Client Name_____ **Client ID#**_____

Work Program: _____

Final Adjustment:

_____

_____

_____

Vocational Program: _____

Final Adjustment:

_____

_____

_____

Adjustment to other program areas:

_____

_____

_____

REINTEGRATION/TRANSITION PLAN

Client Name_____ **Client ID**_____

RELAPSE PREVENTION: **(To be completed as part of the final reintegration/transition plan)**

1. Risk factors are events situations or problems that may increase your likelihood of re-offending. Ongoing risk factors are those problems that are present in your life on a somewhat permanent basis. Therefore managing these risks on a daily basis is important. Examples might be family violence, drug and alcohol problems, negative friends, use of pornography, low self-image, etc.

   Please list your risk factors:

(1) _____

(2)_____

(3) _____

(4)_____

2. Negative consequences of your behavior are:

(1)_____

(2) _____

(3) _____

(4)_____

3. Coping responses for your top high risk situations/risk factors:

(1)_____

(2) _____

(3)_____

(4)_____

4. Names and telephone numbers of three individuals who will be knowledgeable about your reintegration plan and will play an important part in assisting you to make rational decisions:

Name: _____ Telephone Number:_____

Name:_____ Telephone Number:_____

Name:_____ Telephone Number:_____

REINTEGRATION/TRANSITION PLAN (RELAPSE PREVENTION, Page2)

Client Name_____ Client ID#_____

5. What are your biggest fears about transitioning?

_____

_____

_____

What pressures do you foresee having from:

a. Your family?_____

_____

_____

b. Your friends?_____

_____

_____

6. What recreational/faith based activities will you participate in following your return to the community?

a. _____

b. _____

c. _____

7. List goals you have for the next six months:

a._____

b._____

c._____

8. Goals for the next year:

a._____

b._____

c._____

9. Goals for the next two years:

a._____

b._____

c._____

REINTEGRATION/TRANSITION PLAN(Relapse Prevention Plan, Page 3)

Client Name_____ **Client ID#**_____

10. Are there other needs you have or important issues that you think you have not addressed in this plan?

COMMENTS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

REINTEGRATION/TRANSITION PLAN
Signature Page

Client Name_____ **Client ID#**_____

Youth's Signature and Date (*Preliminary*)	Youth's Signature and Date (*Final*)
Non-Secure Care Case Manager/Secure Care Case Manager/Supervisor Signature and Date (*Preliminary*)	Non-Secure Care Case Manager/Secure Care Case Manager/Supervisor Signature and Date (*Final*)
P & P Officer's Signature and Date (*Preliminary*)	P & P Officer's Signature and Date (*Final*)
P & P Supervisor's and Date (*Preliminary*)	P & P Supervisor's signature and Date (Final)
Education Staff/Education Specialist(Preliminary)	Education Staff/ Education Specialist (Final)
	Facility Director's Signature for 897.1 Youth (Final)

Other Participants' Signatures: _____
(Date)

_____
(Date)

_____
(Date)

Note: ALL Reintegration/Transition Plans for youth adjudicated under the La. Children's Code Article 897.1 must be reviewed and approved by the Director prior to submitting the plan to the courts. Plan must be submitted 6 months prior to release.

REVISED:

REINTEGRATION /TRANSITION PLAN
SUPPLEMENTAL

(*If supplemental sheet is needed, please attach before signature page*)

Client Name_____ Client ID#_____

Brief Narrative sections shall consist of:

- Service to address need (List service and service provider)
- How will services address youth's need
- Frequency of services
- Responsible Party to setup services
- Materials that may be needed for initial appointment

NEED AREA # _____ Date of Review: _____,_____, _____

(*List dates that plan was reviewed/ modified*)

Brief Narrative:

_____

_____

_____

_____

_____

_____

Contact Agency: _____ Phone Number: _____

Address: _____

_____

Appointment Scheduled: Yes _____ No _____ Date: _____ Time: _____

Agency Contact Person: _____ Responsible party to set up services: _____

NEED AREA #_____ Date of Review: _____, _____, _____

(*List dates that plan was reviewed/ modified*)

Brief Narrative:

_____

_____

_____

_____

_____

REINTEGRATION /TRANSITION PLAN

SUPPLEMENTAL

(*If supplemental sheet is needed, please attach before the signature page*)

Name: _____ Client ID#_____

Contact Agency: _____ Phone Number: _____

Address: _____

_____

Appointment Scheduled: Yes _____ No _____ Date: _____ Time: _____

Agency Contact Person: _____ Responsible party to set up services: _____

NEED AREA #_____ Date of Review: _____, _____, _____

(*List dates that plan was reviewed/ modified*)

Brief Narrative:_____

_____

_____

_____

_____

_____

Contact Agency: _____ Phone Number: _____

Address: _____

_____

Appointment Scheduled: Yes _____ No _____ Date: _____ Time: _____

Agency Contact Person: _____ Responsible party to set up services: _____