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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | BEHAVIORAL HEALTH ADMINISTRATION (BHA)  **Outpatient Competency Restoration Program (OCRP)**  **Transition Plan** | | | | | | | | |
| **Identifying Information** | | | | | | | | | |
| PERSON’S NAME | | | | | CAUSE NUMBER(S) | | | | |
| ORDERING COURT | | | | | DATE OF OCRP ORDER SIGNATURE | | | | |
| OCRP PROVIDER | | | | | DATE OF OCRP INTAKE | | | | |
| **Contact Information** | | | | | | | | | |
| Forensic Navigator | | | NAME(S) | | | | PHONE NUMBER(S) | | |
|  | | | |  | | |
| OCRP Provider | | |  | | | |  | | |
| FHARPS Provider | | |  | | | |  | | |
| FPATH Provider | | |  | | | |  | | |
| Behavioral Health Provider | | |  | | | |  | | |
| Substance Use Disorder Provider | | |  | | | |  | | |
| Defense Counsel | | |  | | | |  | | |
| Other Support(s) | | |  | | | |  | | |
| Housing Location | | | ADDRESS | | | | PHONE NUMBER | | |
| **Five (5) Day Schedule** | | | | | | | | | |
| Day 1  TIME / ACTIVITY / PROVIDER | | Day 2  TIME / ACTIVITY / PROVIDER | | Day 3  TIME / ACTIVITY / PROVIDER | | Day 4  TIME / ACTIVITY / PROVIDER | | | Day 5  TIME / ACTIVITY / PROVIDER |
|  | |  | |  | |  | | |  |
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| **Included in Five (5) Day Schedule** | | | | | | | | | |
| DSHS  Transportation  OCRP Intake  Medication appointment scheduled  SSI / SSDI  Support services (food / clothing / supplies)  Contact with providers (to include CPCs)  Phone  Housing  Behavioral health intake  Substance use disorder intake | | | | | | | | | |
| **Other Information** | | | | | | | | | |
| SAFETY CONCERNS, SPECIAL NEEDS, TECHNOLOGY NEEDS, LANGUAGE NEEDS, NATURAL SUPPORTS, HOBBIES) | | | | | | | | | |
| PERSON COMPLETING FORM | | | | | | | | DATE FORM COMPLETED | |