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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      |