

Instructions for Completing GAINS Jail Re-Entry Checklist

General Information

It is recommended that the form be completed in quadruplicate for all detainees identified with mental health service needs within 48 hours of arriving at the facility. The quadruplicate forms should be distributed as follows: top copy in detainee's file to give upon discharge, second copy to medical personnel, third copy to mental health personnel, and the fourth copy for use according to facility's procedures.

Detainee's Name:	Enter detainee's last name, first name, and middle initial
Gender:	Check Male (M) or Female (F)
Date of Birth:	Enter month, day, and year
Today's Date:	Enter month, day, and year
Jail ID#:	Enter Jail ID# associated with detainee
SSN#:	Enter detainee's Social Security Number
Name of Facility:	Enter name of jail
Name of Person Completing Form and Phone Number:	Print name of person completing form and unit phone number. If multiple people use this form, each person must print his/her identifying information on this form.
Current Status:	Check Sentenced Inmate or Pre-Trial Detainee
Projected Release Date:	Enter projected date of release (if known)

Instructions:

Potential Needs in Community after Release

Discuss each service *with detainee* to determine if there is a need to plan for this service prior to discharge. Check the appropriate boxes that correspond to the services identified as a need by the detainee. If the person completing the form identifies a need for which the detainee does not agree to receive planning, indicate this in the Steps Taken and Date(s) section (Ex: Detainee is homeless but does not agree to receive assistance with housing upon discharge).

Steps Taken by Jail Staff and Date(s)

Indicate the steps taken to set-up the identified services and the dates this was done. Notes in this section should reflect a continuous effort to plan for re-entry services throughout the detainee's stay in the facility. If multiple people complete this form, each person must identify the steps that she/he completes in this section with initials, as well as entering his/her name at the top of the form.

Example:

Detainee identifies Mental Health Services as a need:

9/1/03 L.T. Contacted Community Mental Health Services (MHS) to set-up appointment with intake coordinator upon release. Will contact closer to projected date of release.

9/25/03 S.P. Release date is firm for 10/3/03. Contacted MHS and made appointment for 10/3/03 at 1:00 p.m. MHS agreed to provide 1 bus token and jail will provide 1 token to assist with transportation.

10/2/03 L.T. Appointment confirmed at MHS for 10/3/03 at 1:00 p.m.

Detainee's Final Plan & Contact Information for Referrals

Identify final plan in terms of appointment times, next steps, and person to contact for each identified need.

Example:

1:00 p.m. appointment on 10/3/03 at MHS with intake coordinator: Julie Young. Phone: 333-1212; Address: 1234 Street, City, USA 11120.

Final Section

Full plan completed and discussed with detainee?	Check Yes or No
If no, why?	In this section, specify why the full plan was not completed or discussed with detainee by checking: ✓ Detainee refused; ✓ Court released before plan completed; ✓ Incomplete for other reasons—specify (e.g., provider was unable to be contacted)
Attachments?	Check Yes if attaching corresponding materials; Check No if not.

GAINS Re-Entry Checklist For Inmates Identified with Mental Health Service Needs

Detainee's Name _____ Last, First M		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth ____/____/____ mm dd yy	Today's Date ____/____/____ mm dd yy	Jail ID # _____ SSN#
Name of Facility	Name of Person Completing Form and Phone Number	Current Status <input type="checkbox"/> Pre-Trial Detainee <input type="checkbox"/> Sentenced Inmate		Date of Admission ____/____/____ mm dd yy	Projected Release Date ____/____/____ mm dd yy
<u>Potential Needs in Community After Release</u>		<u>Steps Taken by Jail Staff and Date(s)</u>		<u>Detainee's Final Plan & Contact Information for Referrals</u>	
Mental Health Services <input type="checkbox"/>		_____		_____	
Psychotropic Medications <input type="checkbox"/>		_____		_____	
Housing <input type="checkbox"/>		_____		_____	
Substance Abuse Services <input type="checkbox"/>		_____		_____	
Health Care <input type="checkbox"/>		_____		_____	
Health Care Benefits <input type="checkbox"/>		_____		_____	
Income Support/Benefits <input type="checkbox"/>		_____		_____	
Food/Clothing <input type="checkbox"/>		_____		_____	
Transportation <input type="checkbox"/>		_____		_____	
Other <input type="checkbox"/>		_____		_____	
Full plan completed and discussed with detainee? <input type="checkbox"/> Yes <input type="checkbox"/> No				Attachments? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, why?					
Detainee refused <input type="checkbox"/>		Court released before plan completed <input type="checkbox"/>			
Incomplete for other reasons <input type="checkbox"/>		Specify: _____			

Detainee's Copy

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Detainee's Name _____ Last, First M		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth ____/____/____ mm dd yy	Today's Date ____/____/____ mm dd yy	Jail ID # _____ SSN#
Name of Facility	Name of Person Completing Form and Phone Number	Current Status <input type="checkbox"/> Pre-Trial Detainee <input type="checkbox"/> Sentenced Inmate		Date of Admission ____/____/____ mm dd yy	Projected Release Date ____/____/____ mm dd yy
<u>Potential Needs in Community After Release</u>		<u>Steps Taken by Jail Staff and Date(s)</u>		<u>Detainee's Final Plan & Contact Information for Referrals</u>	
Mental Health Services <input type="checkbox"/>		_____		_____	
Psychotropic Medications <input type="checkbox"/>		_____		_____	
Housing <input type="checkbox"/>		_____		_____	
Substance Abuse Services <input type="checkbox"/>		_____		_____	
Health Care <input type="checkbox"/>		_____		_____	
Health Care Benefits <input type="checkbox"/>		_____		_____	
Income Support/Benefits <input type="checkbox"/>		_____		_____	
Food/Clothing <input type="checkbox"/>		_____		_____	
Transportation <input type="checkbox"/>		_____		_____	
Other <input type="checkbox"/>		_____		_____	
Full plan completed and discussed with detainee? <input type="checkbox"/> Yes <input type="checkbox"/> No				Attachments? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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Detainee refused <input type="checkbox"/>		Court released before plan completed <input type="checkbox"/>			
Incomplete for other reasons <input type="checkbox"/>		Specify: _____			

GAINS Re-Entry Checklist For Inmates Identified with Mental Health Service Needs

Detainee's Name _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Last First M </div>		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth ___/___/___ <div style="display: flex; justify-content: space-around; width: 100%;"> mm dd yy </div>	Today's Date ___/___/___ <div style="display: flex; justify-content: space-around; width: 100%;"> mm dd yy </div>	Jail ID # _____ SSN# _____
Name of Facility _____	Name of Person Completing Form and Phone Number _____	Current Status <input type="checkbox"/> Pre-Trial Detainee <input type="checkbox"/> Sentenced Inmate	Date of Admission ___/___/___ <div style="display: flex; justify-content: space-around; width: 100%;"> mm dd yy </div>	Projected Release Date ___/___/___ <div style="display: flex; justify-content: space-around; width: 100%;"> mm dd yy </div>	
<u>Potential Needs in Community After Release</u>	<u>Steps Taken by Jail Staff and Date(s)</u>		<u>Detainee's Final Plan & Contact Information for Referrals</u>		
Mental Health Services <input type="checkbox"/>	_____ _____ _____		_____ _____ _____		
Psychotropic Medications <input type="checkbox"/>	_____ _____ _____		_____ _____ _____		
Housing <input type="checkbox"/>	_____ _____ _____		_____ _____ _____		
Substance Abuse Services <input type="checkbox"/>	_____ _____ _____		_____ _____ _____		
Health Care <input type="checkbox"/>	_____ _____ _____		_____ _____ _____		
Health Care Benefits <input type="checkbox"/>	_____ _____ _____		_____ _____ _____		
Income Support/Benefits <input type="checkbox"/>	_____ _____ _____		_____ _____ _____		
Food/Clothing <input type="checkbox"/>	_____ _____ _____		_____ _____ _____		
Transportation <input type="checkbox"/>	_____ _____ _____		_____ _____ _____		
Other <input type="checkbox"/>	_____ _____ _____		_____ _____ _____		
Full plan completed and discussed with detainee? <input type="checkbox"/> Yes <input type="checkbox"/> No		Attachments? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, why? Detainee refused <input type="checkbox"/> Court released before plan completed <input type="checkbox"/> Incomplete for other reasons <input type="checkbox"/> Specify: _____	

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Name of Facility	Name of Person Completing Form and Phone Number	Current Status <input type="checkbox"/> Pre-Trial Detainee <input type="checkbox"/> Sentenced Inmate		Date of Admission ___/___/___ mm dd yy	Projected Release Date ___/___/___ mm dd yy
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Mental Health Services <input type="checkbox"/>		_____		_____	
Psychotropic Medications <input type="checkbox"/>		_____		_____	
Housing <input type="checkbox"/>		_____		_____	
Substance Abuse Services <input type="checkbox"/>		_____		_____	
Health Care <input type="checkbox"/>		_____		_____	
Health Care Benefits <input type="checkbox"/>		_____		_____	
Income Support/Benefits <input type="checkbox"/>		_____		_____	
Food/Clothing <input type="checkbox"/>		_____		_____	
Transportation <input type="checkbox"/>		_____		_____	
Other <input type="checkbox"/>		_____		_____	
Full plan completed and discussed with detainee? <input type="checkbox"/> Yes <input type="checkbox"/> No				Attachments? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, why?					
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Incomplete for other reasons <input type="checkbox"/>		Specify: _____			