

Reentry Plan Self-Assessment Form OPS 165-1a-R (Rev. 12/2025)					
Last Name:		First Name:		DOB:	Projected Release Date:
SID #:		DOC #:		Medicaid #:	
Social Security # :		Gender:		Telephone #:	
Case Manager Name:		Current Job Assignment:		Current Educational level:	
I Refuse Reentry Services at this Time			Signature: _____		Date: _____
I understand that I can change my mind and request reentry services prior to my release.					
Have you received any assistance from a DPSCS Social Worker? <input type="radio"/> Yes <input type="radio"/> No If yes, who was your social worker?					
Do you need any ADA resources or specialized services that are equipped to serve individuals with disabilities? <input type="radio"/> Yes <input type="radio"/> No					
Have you ever worked for MCE? <input type="radio"/> Yes <input type="radio"/> No If yes, what was your assignment?					
Have you or your family member ever served in the military? <input type="radio"/> Yes <input type="radio"/> No					
Do you have a place to live when you are released? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure					
If 'yes', what is the address?		Street Number	Street Name	City	Zip code County
Name of person living at the address:			Person's Relationship to you:		
Responsibilities and Commitments					
Family Responsibilities	<input type="checkbox"/> Parenting <input type="checkbox"/> Child care <input type="checkbox"/> Aging Family Member <input type="checkbox"/> Other				
Financial Commitments	<input type="checkbox"/> Child Support <input type="checkbox"/> Wage Liens <input type="checkbox"/> Restitution <input type="checkbox"/> Legal Fees <input type="checkbox"/> MVA Fees and Fines				
Legal Obligations	<input type="checkbox"/> Parole <input type="checkbox"/> Pending Warrants <input type="checkbox"/> Pending Divorce <input type="checkbox"/> Custody or Probation Detainers Criminal Case Visitation				
Needed Supports and Areas for Growth					
Health and Wellness	<input type="checkbox"/> Medical Care <input type="checkbox"/> Mental Health Services <input type="checkbox"/> Narcotics Anonymous <input type="checkbox"/> Medicaid Enrollment <input type="checkbox"/> Substance Use Treatment <input type="checkbox"/> AI-ANON <input type="checkbox"/> Medical Equipment <input type="checkbox"/> Alcoholics Anonymous <input type="checkbox"/> Other				
Identification	<input type="checkbox"/> Birth Certificate <input type="checkbox"/> State ID <input type="checkbox"/> Social Security Card <input type="checkbox"/> Other <input type="checkbox"/> Voter Registration		Basic Needs	<input type="checkbox"/> Food <input type="checkbox"/> Telephone/Lifeline <input type="checkbox"/> Clothing <input type="checkbox"/> Toiletries <input type="checkbox"/> Transportation <input type="checkbox"/> Other	
Housing	<input type="checkbox"/> Transitional <input type="checkbox"/> Shelter <input type="checkbox"/> Sober Housing <input type="checkbox"/> Low Income Rental <input type="checkbox"/> Out of State Home Plan		Career Development	<input type="checkbox"/> College <input type="checkbox"/> Certification Programs <input type="checkbox"/> GED <input type="checkbox"/> Student Grants/Loans <input type="checkbox"/> Job Training <input type="checkbox"/> Digital Literacy	
Assistance	<input type="checkbox"/> SNAP <input type="checkbox"/> SSI <input type="checkbox"/> TCA/TDAP <input type="checkbox"/> Veteran Benefits <input type="checkbox"/> WIC <input type="checkbox"/> SSDI <input type="checkbox"/> OHEP <input type="checkbox"/> Child Support Enforcement				
Skills and Accomplishments					
Education, Training, and Certifications					
Certificates					
Treatment and Programming					

☐ I accept reentry services at this time. I understand that my signature on this form shows that I have started to plan for my return to the community with a Reentry Services Specialist. The specialist will use this information to help me plan for my release. I understand that I can ask for additional resources and I can change my mind about accepting services throughout my incarceration.

Signature: _____ Date: _____

By signing this form, I confirm that I have made the appropriate internal and external referrals.

Staff Name: _____ Staff Signature: _____

Date: _____