Judicial Involved Transitions

The purpose of this chapter is to provide information about the Civil Transitions Program (CTP), Extraordinary Medical Placement (EMP), and Special Commitment Center (SCC) programs. This chapter addresses eligibility, service availability and provides a description of how clients in these circumstances are supported by these programs.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

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CIVIL TRANSITIONS PROGRAM

Background

The Trueblood Settlement establishes a plan for providing services to individuals involved in the criminal court system, as well as providing treatment to people when needed in a focused effort to reduce recidivism.

The Civil Transitions Program (CTP) program was established in 2023 as a response to the mandate in Engrossed Second Substitute Senate Bill 5440. Home and Community Living Administration (HCLA) developed a process for connecting individuals found not competent to stand trial and not restorable due to an intellectual or developmental disability, dementia, or traumatic brain injury to available wraparound services and supports in the community. When a referral is screened in, Home and Community Services (HCS) will offer services to individuals, even those who are not traditionally eligible based on functional and financial criteria. Clients may be in jail, the community, or a state hospital. Individuals may have an assigned Forensic Navigator through the Behavioral Health and Habilitation Administration (BHHA) to coordinate with the HCS case manager.

Referral Process for Civil Transitions Program

Individuals must be referred to HCLA from the BHHA. These individuals have been forensically evaluated and determined to be not competent to stand trial and not restorable due to the diagnosis of intellectual or development disability, dementia, or traumatic brain injury.

- BHHA sends referrals to HCLA. HCS processes referrals with diagnosis of dementia or traumatic brain injury. DDCS process referrals with intellectual or developmental disability. Referrals are triaged by the program manager or designee.
- If the client is active on services, the assigned case manager and supervisor will be notified of the CTP referral by email.
- The case manager will determine if the referral is related to or affecting current services that would warrant a significant change assessment and/or additional wrap-around services or a program change.
- If the client is in jail, the case manager will coordinate with current providers to determine if the client can return to the same residential facility or utilize the same in-home provider. The case manager will connect with the BHHA Forensic Navigator to determine if the client is eligible for any additional services as a Trueblood class member.
- If the referral is for an inactive or new client, the program manager or designee will email the referral to the regional designee and/or intake. The HCS case manager will then contact the client to offer Long Term Services and Support (LTSS). If the client is homeless or at risk of

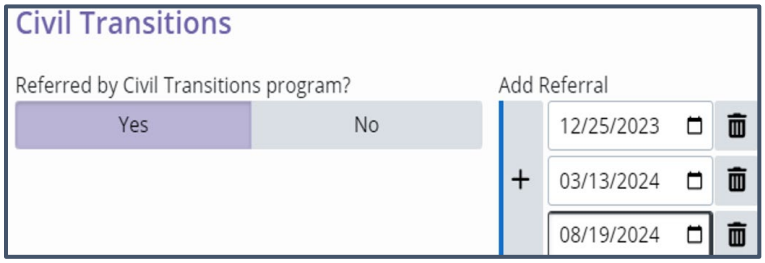
homelessness, supportive housing can be offered prior to the Client Assessment Reporting and Evaluation (CARE) assessment. Once the CARE assessment is completed:

  - If client is found to be financially and functionally eligible, HCS Case manager will continue with traditional services (MPC, CFC, COPES, RSW) and follow normal procedures.
  - *If the client is found not to be financially or functionally eligible, they may be eligible for a conditional service package.*

- The case manger will connect with the Forensic Navigator to determine if the client is eligible for any additional services as a Trueblood class member.

CARE Demographics Screen

The intake teamwill complete the CARE Demographics screen when processing the referral in CARE. If the individual is already on services, the Community Support Program Manager or designee will assist the case manager to complete the screen.



HCS Response Time Frames

Once a referral has been received by intake, follow the regular intake process see Chapter 3.

Housing Supports for CTP Clients

For individuals with an immediate need for housing, a referral for housing services may be submitted without a CARE assessment or Medicaid application being submitted. Case managers will contact the Housing Special Projects Program Manager. A supportive housing specialist will assist a client to connect with community resources, assist with housing search, transition and sustainability services, other benefits, as well as funding for motel stays. For more information see Chapter 6b for HCLA clients.

WHAT ARE CONDITIONAL SERVICES?

Conditional services are limited services developed for CTP clients that meet diagnostic criteria and are not functionally nor financially eligible. *These services are subject to available funds under the Civil Transitions Program*. Conditional services are offered only for in- home or interim settings while clients work to secure permanent housing.

How Will I Know if my Client Meets Criteria for Conditional Services?

After the HCS case manager has completed the CARE assessment and the client has been determined not functionally nor financially eligible, do not deny services or close the case. Contact the Community Support Program Manager or designee to assess for conditional services.

Conditional Service Packages

If the client meets functional eligibility for nursing facility level of care (NFLOC) under Community First Choice (CFC) but is not financially eligible, they may receive the following conditional services if included in their care plan:

- Personal Care
- Nurse Delegation
- Assisted Technology
- Personal Emergency Response System (PERS)
- Community Transition Service
- Supportive Housing
- WA Roads

If the client meets functional eligibility for Medicaid personal care (MPC) but is not financially eligible, they may receive the following conditional services if included in their plan of care:

- Personal Care
- Supportive Housing
- WA Roads

If the client is only financially eligible and not functionally eligible, they may receive the following conditional services:

- Supportive Housing
- WA Roads

If the client does not meet functional eligibility for CFC or MPC and is not financially eligible, they may receive the following conditional services:

- Supportive Housing
- WA Roads

Duration of CTP Conditional Services

Conditional services will only be authorized for six months regardless of whether a client is only functionally eligible, only financially eligible, or neither. The six-month timeframe will start on the first day of the service authorization. CTP cases will be case managed by HCS regional offices and not transferred to the AAA. Cases will be reviewed by the case manager at 90 days to determine if there

have been functional and/or financial changes that would allow for the conversion to traditional services. The client may then choose a residential setting.

Exception: For those at risk of homelessness, housing services will be reviewed at six months with the ability to re-authorize for up to two years

HOW TO DOCUMENT IN CARE

Service Episode Record

When writing service episode records (SER), the Civil Transitions Program (5440) code is to be used to document actions related to CTP referral information, service discussion and planning, and with Forensic Navigators.

Care Plan

For clients meeting the eligibility criteria for conditional services, the case manager will select Civil Transitions Program in the drop-down list under Client chosen program instead of MPC or CFC. *Only clients under Civil Transitions Program can utilize this drop down.*

Recipient Aid Categories (RACS) for CTP Services

Each RAC coincides with the Conditional services that the client is eligible to receive. CTP RACs require an override.

3491 - Civil Transitions Program not otherwise eligible (Only Financially Eligible and Neither Functionally nor Financially Eligible)
3492 - Civil Transitions Program Functionally eligible not financially eligible (NFLOC)
3493- Civil Transitions Program Functionally Eligible MPC not financially Eligible

Financial Eligibility

Collaboration with the Financial Eligibility & Policy Unit and designated Public Benefit Specialist (PBS) staff in each region will ensure timely and accurate determination of financial eligibility. Clients who are not financially eligible for other federal or state Apple Health coverage will be eligible for state-funded medical coverage for 6 months.

14-443

Select Civil Transitions Program on the 14-443 which triggers the public benefit specialist to communicate with the Financial Eligibility & Policy Unit to have the special state funded medical coverage turned on. There is no open coverage group in ACES so Provider One process, participation, letters, and time frames will all need to be manually constructed.

Assessment Data and Reporting

CTP clients will be tracked in CARE under the State Hospital Screen. This screen will be completed regardless of client eligibility outcome.

How to Complete the CARE State Hospital Screen

- Click the plus button to open an entry.
- Facility: Choose County Jail
- Place of Detention: This is a free text box. Write the name of the jail, Out of jail/PR, WSH, ESH
- Admit date and referral will be the same--which is the date the case manager receives the referral. Discharge Status: choose 'Active' if the assigned case manager is/will be assessing the client. Choose 'Inactive' if the case manager was unable to reach the client or they were not interested in service. If the client is discharged with services, the discharge date will be enabled. The discharge date is the date the individual's services began.
- Comment box: provide a short summary of the outcome of selections made.

EXTRAORDINARY MEDICAL PLACEMENT

WHAT IS EXTRAORDINARY MEDICAL PLACEMENT?

Extraordinary Medical Placement (EMP) is a Department of Corrections (DOC) program that enables incarcerated individuals who have been determined to meet specific criteria in RCW 9.94A.728 to be released before the end of their sentence to the community. The individual will remain under the supervision and authority of DOC. HCLA collaborates with the DOC EMP through an interagency agreement to assist those who are seeking long term care. DOC regulates if the client can reside in home with family or in a residential setting.

REFERRAL PROCESS FOR EMP

Referrals are initiated by DOC's Headquarters team and sent to the HCS Community Support Program Manager. After the referral is received and triaged, it is routed to the HCS Field Service Administrator (FSA) in the region where the incarcerated individual is located. The FSA will assign the client to a case manager and inform HCS Headquarters of said assignment. DOC Headquarters or their representative will submit the LTC Medicaid Application.

WHAT IS THE ROLE OF CASE MANAGERS IN EMP CASES?

Case managers will:

- Conduct an on-site assessment where the DOC incarcerated individual is located (including a prison or hospital setting) and provide them with information and choices regarding services and referrals. If the client refuses to participate inform HCS Headquarters Community Support Program Manager.
- Contact the prison in advance to coordinate and schedule the CARE assessment. *EMP assessments should occur within two weeks of the referral.* When coordinating the assessment, the HCS case manager should request that specific information be available at the time of assessment (for example: medication administration record, medical records, mental health records, etc.). Conduct the assessment with the client and a DOC staff person who can provide information on the offender's:
    - County of origin, or counties the client must avoid
    - Criminal history
    - Active restraining orders
    - Incarceration dates
    - Infraction and behavior history while incarcerated
    - Parole or supervision requirements that will be required once the offender is in the community (Judgement and Sentence, Conditions of Release and/or Stipulations)
    - The name and contact of the incarcerated individuals Community Corrections officer or Community Correction Specialist
    - Information on the individual's family, Power of Attorney or Guardian (if applicable)
    - Medical and mental Health diagnosis
    - Behaviors and triggers to behaviors
    - Any propensity to violence
    - Medication manager (does the individual follow medication regime)
    - Suicide risk, and
    - Strategies that work best with the client
- Include input from DOC Psychiatric Social Worker, Mental Health Counselor, Physician, Physician Assistance, Nurses, and or Psychologist who have been working with the incarcerated individual into the CARE assessment.
- Assist DOC to connect with the Public Benefit Specialist to ensure the client long-term care (LTC) Medicaid application processes timely.

DOCUMENTATION IN CARE

Behavior Screen

- Select Law breaking activity and list the index crime that brought the client to prison and other convictions. Provide pertinent details about the crime.
- If the client is a registered sex offender (RSO) select 'deliberate sexual violence' and provide the client's RSO level and convictions/offenses. Provide a victim profile, whenever possible (for example male, female, child, adult).
- Follow RSO process in Chapter 3.

Safety Screen

- Under legal issues choose parole and probation
- In the legal issues comment box add canned language for EMP clients.
- Client has been approved to be released under Department of Corrections Emergency Medical Placement due to their medical condition. The client is required to wear an ankle bracelet/GPS monitor in an approved placement by DOC for the remaining of their sentence which will expire (add month and date). Client will be supervised by a Community Corrections Specialist and monitored by an EMP Nurse.

TRANSITION PLANNING

The HCS Headquarters and DOC Headquarters teams work closely in transition planning. The HCS Headquarters team also works closely with and supports the HCS regional case manager throughout the assessment and transition planning processes. After the client has been found functionally eligible for long-term care services, HCS staff can begin to search for a community setting. If DOC staff are aware of potential residential transition options, they will coordinate with HCS case manager to send the CARE assessment to the potential providers. If the provider is interested in accepting the client, arrangements should be made by the Prison Social Worker for the potential provider to meet the incarcerated individual. The HCS case manager is to work with the residential care case manager (RCCM) assigned to the potential home to ensure that the home is a good fit for the client. Once a provider has accepted the client, the address of the facility is provided to DOC staff to investigate the home and explain EMP. If DOC accepts the facility, the Secretary of DOC must give final approval authorizing the EMP setting. There are instances where the EMP is denied.

Once the client has been approved for EMP, a transition date can be set. If the client needs equipment, DOC can work with the client to select a Manage Care Organization (MCO). Managed Care Organization have Justice Involved/Jail transition Coordinators that work with the incarcerated clients and can assist with coordination of their care needs.

Region	Name of Prisons
Region 1	Airway Heights Corrections Center (AHCC) Coyote Ridge Corrections Center (CRCC) Washington State Penitentiary (WSP)
Region 2	Monroe Correctional Complex (MCC)
Region 3	Stafford Creek Corrections Center Washington Corrections Center Washington Corrections Center for Women

SPECIAL COMMITMENT CENTER

WHAT IS THE SPECIAL COMMITMENT CENTER?

The Special Commitment Center (SCC) program provides specialized mental health treatment for civilly committed sex offenders who have completed their prison sentences. Each SCC resident has a constitutional right to an annual review hearing before the court of commitment to evaluate progress they've made in treatment. If the court finds the resident has made progress to the point that the resident can be safely managed in the community, the court may order the resident's conditional release to a Least Restrictive Alternative (LRA) community placement or the resident has the right to request to the court to be released unconditionally. Former residents no longer have SCC oversight.

WHAT IS HCS ROLE?

HCS facilitates community transitions for clients seeking long-term services and support when they are being unconditionally released from total confinement at the SCC or from SCC's community LRA housing facilities.

Referral Process

Referrals are submitted by the SCC's Psychiatric Social Workers or the Office of Public Defense (OPD) to the HCS Community Support Program Manager. The Community Support Program Manager meets with the referent to gather background information, proposed plan, and court time frames.

- In Region 3, referrals are emailed to Intake, SHDD Program Manager, and supervisor. Region 3 has a dedicated full-time equivalent (FTE) staff member for this work.
- In Regions 1 and 2, the referral is emailed to the FSA who then routes the referral to be processed and assigned to a case manager.

The HCS Community Support Program Manager will meet with the case manager to discuss the referral prior to the assessment.

WHAT IS ROLE OF THE HCS CASE MANAGER?

The HCS case manager is to coordinate with the SCC Social Worker and/or the OPD transitions specialist when setting up the assessment.
The assessment is to be conducted at the facility where the client resides and should include:

- Request annual evaluations/reviews
- Criminal history
- Sexual offense history, any violation while at the SCC
- Medical records
- Mental health records
- Behaviors and triggers

- Contact information for all Residential Community Treatment Team (RCTT)
- If the client is residing in LRA housing , the case manager will contact the Sex Offender Treatment Provider or community corrections specialist to gather information on the client progress while in the community.

DOCUMENTATION IN CARE

Safety Screen

- Select registered sex offender level (all individuals from SCC are level 3)
- Follow the RSO process that is in Chapter 3
- If the client is unconditionally released add in the legal comment box that the client will not be under DOC supervision.

Behavior Screen

- Select Deliberate sexual violence and document the RSO level and convictions/offenses. Provide victim profile (male, female, child, adult)
- Select Law breaking activity and list convictions. Provide pertinent details about the crime.

TRANSITION PLANNING

The transition process can be lengthy when transitioning a client from SCC total confinement or in LRA housing. The HCS Community Support Program Manager will work closely with the HCS case manager, SCC, and OPD transition specialist to navigate the process. Prior to being released unconditionally, clients in SCCs will complete evaluations and then attend the necessary court proceedings.

As the search for a facility begins, communication with the potential ongoing residential case manager is imperative. Case managers are to ensure the home is a good fit for any client who is a registered sex offender—meaning that the provider can meet the client's care needs while also considering the risk and safety of all who reside in or enter the facility. In many instances the OPD transition specialist will identify an adult family home (AFH) that may be interested in supporting the client. The HCS case manager needs to communicate with the potential AFH to provide them with the CARE assessment and ensure they are aware of the length of time transitioning clients in SCC may take.

After a facility has been selected, SCC or OPD can then provide a transition plan to the court. Once the client is approved for release, follow the process as usual.

ESCALATION PATH AND PROCESS

For Escalation Path Process Guidance see Chapter 9.

RESOURCES

Related WACs and RCWs

WAC 388-106-2000- 2050 Civil Transitions Program

RCW 9.94A.728: Release Prior to Expiration of Sentence

Acronyms

AAA	Area agencies on again
BHHA	Behavioral Health and Habilitation Administration
CARE	Client Assessment Reporting Evaluation
CFC	Community First Choice
COPES	Community Options Program Entry System
CTP	Civil Transitions Program
DDCS	Developmental Disabilities Community Services
DOC	Department of Corrections
EMP	Extraordinary Medical Placement
GPS	Global positioning system
HCLA	Home and Community Living Administration
HCS	Home and Community Services
LRA	Least restrictive alternative
LTSS	Long-term services and support
MCO	Managed Care Organizations
MPC	Medicaid Personal Care
NFLOC	Nursing facility level of care
OPD	Office of Public Defense
PBS	Public Benefits Specialist
PERS	Personal Emergency Response System
RAC	Recipient Aid Category
RSO	Registered Sex Offender
RSW	Residential Support Waiver
SCC	Special Commitment Center

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #

4/01/2026	Phyllis Moffatte-Clark	• Updated chapter links • Highlighed instructions for How do I know if my client meets criteria for Conditional Services. • Grammar and word clarification

APPENDIX

Conditional Services

Only Functionally Eligible (NFLOC)	Only Functionally Eligible (MPC)	Only Financially Eligible	Neither Functionally nor Financially Eligible
Conditional Services • Personal Care • Nurse Delegation • Assisted Technology • PERS • Community Transition Service • Supportive Housing • WA Roads	**Conditional Services** • Personal Care • Supportive Housing • WA Roads	**Conditional Services** Supportive Housing WA Roads	**Conditional Services** Supportive Housing WA Roads