Appendix to WRAP+ Policies and Procedures Manual
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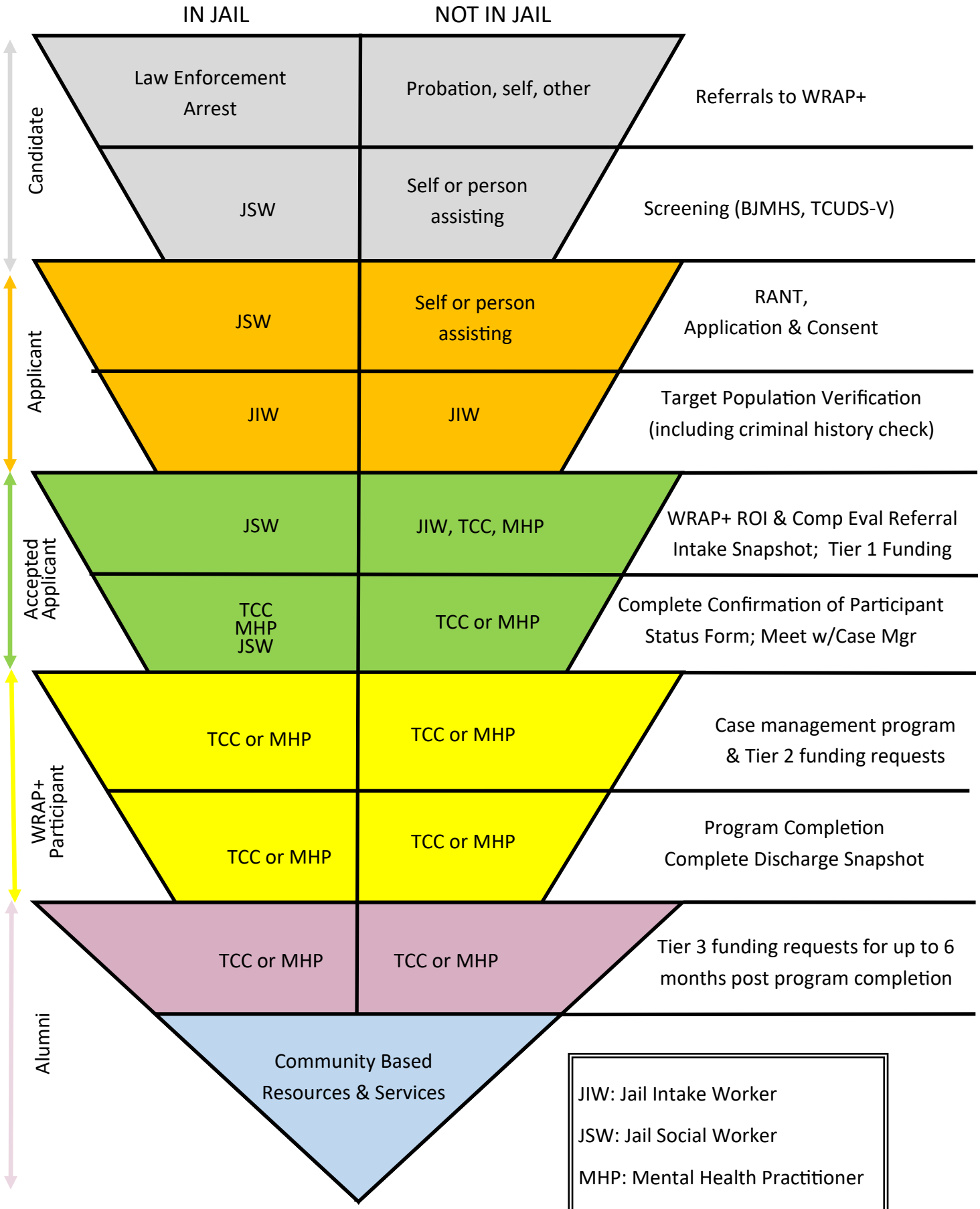
(Updated 1/6/24)

WRAP+ Program Flowchart

Updated 1/6/24



WRAP+ Excludable Offenses
Updated 8/22/23

An applicant will be excluded from participation in in WRAP+ if that individual has been charged with or convicted of any sex offense as defined by 34 USC § 20911(5)(A), or any offense relating to the sexual exploitation of children, or murder or assault with intent to commit murder. A charge or conviction for any of the following Minnesota crimes will exclude a candidate from participation in WRAP+.

MN Statute #	Title
609.185	Murder in the first degree
609.19	Murder in the second degree
609.221	Assault in the first degree
609.25*	Kidnapping
609.255*	False Imprisonment
609.294	Bestiality
609.322	Solicitation, inducement, and promotion of prostitution
609.324 Subd 1; 1a only	Other prostitution crimes; patrons, prostitutes, and individuals housing individuals engaged in prostitution; penalties
609.342	Criminal sexual conduct in the first degree
609.343	Criminal sexual conduct in the second degree
609.344	Criminal sexual conduct in the third degree
609.345	Criminal sexual conduct in the fourth degree
609.346	Criminal sexual conduct in the fifth degree
609.3453	Criminal sexual predatory conduct
609.352	Solicitation of children to engage in sexual conduct

*if committed against a minor by a person other than a parent or guardian

Juvenile Sex Offenses: If an applicant was convicted of one or more of the above offenses as a juvenile, the case will be referred to the Winona County Attorney's Office for consideration of eligibility. Any determination made by the Winona County Attorney's Office can be appealed to the WRAP+ Task Force.

RISK AND NEEDS TRIAGE FOR PROBLEM-SOLVING COURTS

Risk and Needs Triage (RANT®) is a highly secure, web-based tool designed to help judges and other criminal justice professionals place adult drug offenders into the appropriate treatment and supervision settings. By matching offenders to appropriate services, RANT helps optimally target resources for improved public safety and public health outcomes.

When courts correctly classify a participant as a low risk offender, rather than misplacing them in a high risk program, they could:

- **Save more than $11,000 per court participant**
- **Reduce the court burden, increase efficiency**
- **Support effective participant rehabilitation**

HOW IT WORKS

RANT instantly sorts offenders into one of four risk/needs quadrants, each with direct implications on the optimal level of criminal justice supervision and behavioral health care.

It can be administered by non-specialists in 15 minutes or less and instantly provides client reports in order to make real-time decisions.

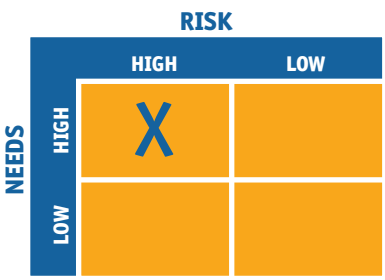
The following factors illustrate an individual who was classified as high risk and high need. Such individuals typically require a combination of services involving intensive treatment, close monitoring and accountability.

Risk factors:

- Early age of criminal activity onset
- Early age of substance use onset
- Deviant peer affiliations
- Prior failure in drug or alcohol rehabilitation
- Prior felony or serious misdemeanor convictions
- Unstable living arrangements

Needs factors:

- Physical addiction to drugs or alcohol



Expand Your Use with RANT®-Plus

RANT-Plus includes all the elements of the streamlined RANT, but with additional features:

- Jurisdiction-specific customization
- Data accumulation
- Aggregate data reporting
- Optional antisocial personality disorder module
- Case outcomes module
- Web conference training

RESEARCH & EVALUATION GROUP at PHMC

For more information or to purchase, please contact:

CourtTools@phmc.org
866.453.9262
phmcresearch.org/products

The Research & Evaluation Group at Public Health Management Corporation is dedicated to helping clients understand their communities, improve their programming, and deepen their impact on public health and education.

Brief Jail Mental Health Screen

Section 1

Name: _____ First MI Last	Detainee #: _____	Date: __ __/__ __/__ __ __ __	Time: _____ AM PM

Section 2

Questions	No	Yes	General Comments
1. Do you *currently* believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?			
2. Do you *currently* feel that other people know your thoughts and can read your mind?			
3. Have you *currently* lost or gained as much as two pounds a week for several weeks without even trying?			
4. Have you or your family or friends noticed that you are *currently* much more active than you usually are?			
5. Do you *currently* feel like you have to talk or move more slowly than you usually do?			
6. Have there *currently* been a few weeks when you felt like you were useless or sinful?			
7. Are you *currently* taking any medication prescribed for you by a physician for any emotional or mental health problems?			
8. Have you ever been in a hospital for emotional or mental health problems?			

Section 3 (Optional)

Officer's Comments/Impressions (check *all* that apply):

☐ Language barrier ☐ Under the influence of drugs/alcohol ☐ Non-cooperative

☐ Difficulty understanding questions ☐ Other, specify: _____

Referral Instructions: This detainee should be referred for further mental health evaluation if he/she answered:

- **YES to item 7; OR**
- **YES to item 8; OR**
- **YES to at least 2 of items 1 through 6; OR**
- **If you feel it is necessary for any other reason**

☐ Not Referred

☐ Referred on __ __/__ __/__ __ __ __ to _____

Person completing screen _____

INSTRUCTIONS ON REVERSE

INSTRUCTIONS FOR COMPLETING THE BRIEF JAIL MENTAL HEALTH SCREEN

GENERAL INFORMATION:

This Brief Jail Mental Health Screen (BJMHS) was developed by Policy Research Associates, Inc., with a grant from the National Institute of Justice. The BJMHS is an efficient mental health screen that will aid in the early identification of severe mental illnesses and other acute psychiatric problems during the intake process.

This screen should be administered by Correctional Officers during the jail's intake/booking process.

INSTRUCTIONS FOR SECTION 1:

NAME:	Enter detainees name — first, middle initial, and last
DETAINEE#:	Enter detainee number.
DATE:	Enter today's month, day, and year.
TIME:	Enter the current time and circle AM or PM.

INSTRUCTIONS FOR SECTION 2:

ITEMS 1-6:

Place a check mark in the appropriate column (for "NO" or "YES" response).

If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

ITEMS 7-8:

ITEM 7: This refers to any *prescribed* medication for any emotional or mental health problems.

ITEM 8: Include any stay of one night or longer. Do NOT include contact with an Emergency Room if it did not lead to an admission to the hospital

If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

General Comments Column:

As indicated above, if the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

All "YES" responses require a note in the General Comments section to document:

(1) Information about the detainee that the officer feels relevant and important
(2) Information specifically requested in question

If at any point during administration of the BJMHS the detainee experiences distress, he/she should follow the jails procedure for referral services.

INSTRUCTIONS FOR SECTION 3:

OFFICER'S COMMENTS: Check any one or more of the four problems listed if applicable to this screening. If any other problem(s) occurred, please check OTHER, and note what it was.

REFERRAL INSTRUCTIONS:

Any detainee answering YES to Item 7 or YES to Item 8 or YES to at least two of Items 1-6 should be referred for further mental health evaluation. If there is any other information or reason why the officer feels it is necessary for the detainee to have a mental health evaluation, the detainee should be referred. Please indicate whether or not the detainee was referred.

Client ID#	Today's Date	Facility ID#	Zip Code	Administration
|__|__|__|__|__|__|__|__|__|__|	|__|__|__|__|__|__|__|__|	|__|__|__|__|__|__|	|__|__|__|__|__|	|__|__|

TCU DRUG SCREEN 5

During the last 12 months (before being locked up, if applicable) –

		Yes	No
1.	Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	○	○
2.	Did you try to control or cut down on your drug use but were unable to do it?	○	○
3.	Did you spend a lot of time getting drugs, using them, or recovering from their use?	○	○
4.	Did you have a strong desire or urge to use drugs?	○	○
5.	Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?	○	○
6.	Did you continue using drugs even when it led to social or interpersonal problems?	○	○
7.	Did you spend less time at work, school, or with friends because of your drug use?	○	○
8.	Did you use drugs that put you or others in physical danger?	○	○
9.	Did you continue using drugs even when it was causing you physical or psychological problems?	○	○
10a.	Did you need to increase the amount of a drug you were taking so that you could get the same effects as before?	○	○
10b.	Did using the same amount of a drug lead to it having less of an effect as it did before?	○	○
11a.	Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	○	○
11b.	Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?	○	○

12. Which drug caused the most serious problem during the last 12 months? [CHOOSE ONE]

○ None
○ Alcohol
○ Cannaboids – Marijuana *(weed)*
○ Cannaboids – Hashish *(hash)*
○ Synthetic Marijuana *(K2/Spice)*
○ Natural Opioids – Heroin *(smack)*
○ Synthetic Opioids – Fentanyl/Iso
○ Stimulants – Powder Cocaine *(coke)*
○ Stimulants – Crack Cocaine *(rock)*
○ Stimulants – Amphetamines *(speed)*
○ Stimulants – Methamphetamine *(meth)*
○ Synthetic Cathinones *(Bath Salts)*
○ Club Drugs – MDMA/GHB/Rohypnol *(Ecstasy)*
○ Dissociative Drugs – Ketamine/PCP *(Special K)*
○ Hallucinogens – LSD/Mushrooms *(acid)*
○ Inhalants – Solvents *(paint thinner)*
○ Prescription Medications – Depressants
○ Prescription Medications – Stimulants
○ Prescription Medications – Opioid Pain Relievers
○ Other (specify) _____

Client ID#	Today's Date	Facility ID#	Zip Code	Administration
|__|__|__|__|__|__|__|__|__|__|	|__|__||__|__||__|__|	|__|__|__|__|__|__|	|__|__|__|__|__|	|__|__|

13. How often did you use each type of drug during the last 12 months?	Never	Only a few times	1-3 times per month	1-5 times per week	Daily
a. Alcohol	○	○	○	○	○
b. Cannaboids – Marijuana *(weed)*	○	○	○	○	○
c. Cannaboids – Hashish *(hash)*	○	○	○	○	○
d. Synthetic Marijuana *(K2/Spice)*	○	○	○	○	○
e. Natural Opioids – Heroin *(smack)*	○	○	○	○	○
f. Synthetic Opioids – Fentanyl/Iso	○	○	○	○	○
g. Stimulants – Powder cocaine *(coke)*	○	○	○	○	○
h. Stimulants – Crack Cocaine *(rock)*	○	○	○	○	○
i. Stimulants – Amphetamines *(speed)*	○	○	○	○	○
j. Stimulants – Methamphetamine *(meth)*	○	○	○	○	○
k. Synthetic Cathinones *(Bath Salts)*	○	○	○	○	○
l. Club Drugs – MDMA/GHB/Rohypnol *(Ecstasy)*	○	○	○	○	○
m. Dissociative Drugs – Ketamine/PCP *(Special K)*	○	○	○	○	○
n. Hallucinogens – LSD/Mushrooms *(acid)*	○	○	○	○	○
o. Inhalants – Solvents *(paint thinner)*	○	○	○	○	○
p. Prescription Medications – Depressants	○	○	○	○	○
q. Prescription Medications – Stimulants	○	○	○	○	○
r. Prescription Medications – Opioid Pain Relievers	○	○	○	○	○
s. Other (specify) _____	○	○	○	○	○

14. How many times before now have you ever been in a drug treatment program?
[DO NOT INCLUDE AA/NA/CA MEETINGS]

○ *Never* ○ *1 time* ○ *2 times* ○ *3 times* ○ *4 or more times*

15. How serious do you think your drug problems are?

○ *Not at all* ○ *Slightly* ○ *Moderately* ○ *Considerably* ○ *Extremely*

16. During the last 12 months, how often did you inject drugs with a needle?

○ *Never* ○ *Only a few times* ○ *1-3 times/month* ○ *1-5 times per week* ○ *Daily*

17. How important is it for you to get drug treatment now?

○ *Not at all* ○ *Slightly* ○ *Moderately* ○ *Considerably* ○ *Extremely*

WRAP+ Online Screening & Application Form

Sections 1-2 are required for all persons booked into the Winona County Jail. Others wishing to apply for the WRAP+ (Winona County Re-Entry Assistance Program) must also complete these screenings.

* Indicates required question

Personal Information (6 questions)

These questions can be pre-completed by jail personnel or a person assisting the applicant with these forms.

1. First Name *

2. Middle Name *
   If you have no middle name, type NMN (for "no middle name")

3. Last Name *

4. Date of Birth (MM/DD/YY) *

5. Gender Identification *

   Check all that apply.

   - [ ] Male
   - [ ] Female

6. Ever in Military? *

   Check all that apply.

   - [ ] Yes
   - [ ] No

7. Ethnicity

   Check all that apply.

   - [ ] Hispanic
   - [ ] Non-Hispanic
   - [ ] I don't know

8. Race *

   Check all that apply.

   - [ ] White
   - [ ] Black
   - [ ] American Indian or Alaskan Native
   - [ ] Asian or Pacific Islander
   - [ ] Multi-Racial

Skip to question 9

Brief Jail Mental Health Screen (8 questions)

Answer yes or no to each question. An answer of yes to question 7 or 8 or to two of the questions 1 through 6 qualifies an applicant for WRAP+.

9. DO NOT ANSWER: For Jail Staff Only

Mark only one oval.

- ◯ RTC - Click NEXT *Skip to question 66*

10. 1. Do you currently believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head? *

Mark only one oval.

- ◯ Yes
- ◯ No

11. 2. Do you currently feel that other people know your thoughts and can read your mind? *

Mark only one oval.

- ◯ Yes
- ◯ No

12. 3. Have you currently lost or gained as much as two pounds a week for several weeks without even trying? *

Mark only one oval.

- ◯ Yes
- ◯ No

13. 4. Have you or your family or friends noticed that you are currently much more active than you usually are? *

Mark only one oval.

- ◯ Yes
- ◯ No

14. 5. Do you currently feel like you have to talk or move more slowly than you usually do? *

Mark only one oval.

- ◯ Yes
- ◯ No

15. 6. Have there currently been a few weeks when you felt like you were useless or sinful? *

Mark only one oval.

- ◯ Yes
- ◯ No

16. 7. Are you currently taking any medication prescribed for you by a physician for any emotional or mental problems? *

Mark only one oval.

- Yes
- No

17. 8. Have you ever been in a hospital for emotional or mental health problems? *

Mark only one oval.

- Yes
- No

Drug Screen (13 questions)

TCU Drug Screen 5

Instructions
Please click the answer next to the response that best answers the question. A yes response to a question is assigned 1 point. A score of 2 or more indicates the need for further assessment.

18. DO NOT ANSWER: For Jail Staff Only

Mark only one oval.

- RTC - Press NEXT *Skip to question 9*

During the last 12 months (before being locked up, if applicable)

19. 1. Did you use larger amounts of drugs or use them for a longer time than you planned or intended? *

Mark only one oval.

- Yes
- No

20. 2. Did you try to control or cut down on your drug use but were unable to do it? *

Mark only one oval.

- Yes
- No

21. 3. Did you spend a lot of time getting drugs, using them, or recovering from their use? *

Mark only one oval.

- Yes
- No

22. 4. Did you have a strong desire or urge to use drugs? *

Mark only one oval.

- Yes
- No

23. 5. Did you get so high or sick from using drugs that it kept you from working, going to school or caring for children? *

Mark only one oval.

- Yes
- No

24. 6. Did you continue to use drugs even when it led to social or interpersonal problems? *

Mark only one oval.

- Yes
- No

25. 7. Did you spend less time at work, school, or with friends because of your drug use? *

Mark only one oval.

- Yes
- No

26. 8. Did you use drugs that put you or others in physical danger? *

Mark only one oval.

- Yes
- No

27. 9. Did you continue using drugs even when it was causing you physical or psychological problems? *

Mark only one oval.

- Yes
- No

28. 10a. Did you need to increase the amount of a drug you were taking so that you could get the same effects as before? *

Mark only one oval.

- Yes
- No

29. 10b. Did using the same amount of a drug lead to it having less of an effect as it did before? *

Mark only one oval.

- Yes
- No

30. 11a. Did you get sick or have withdrawal symptoms when you quit or missed taking a drug? *

Mark only one oval.

- Yes
- No

31. 11b. Did you ever keep taking drug to relieve or avoid getting sick or having withdrawal symptoms? *

Mark only one oval.

- ◯ Yes
- ◯ No

32. Do you want to complete the WRAP+ Application Forms? *

Mark only one oval.

- ◯ Yes *Skip to question 33*
- ◯ No *Skip to question 66*

Risk Screen (19 Questions)

Risk and Needs Triage - RANT; Persons needing assistance to complete this section should contact Katie Schild, Criminal Justice Social Worker at 507-457-6483 or kschild@co.winona.mn.us.

Instructions
Please click the answer next to the response that best answers the question. A score of 3 or more (male) or 4 or more (female) indicates a high risk. High Risk status is necessary to qualify for WRAP+.

33. DO NOT ANSWER: For Jail Staff Only

Mark only one oval.

- ◯ RTC - Press NEXT *Skip to question 18*

34. 1. Current Age *

_____

35. 2. Homeless during the past 12 months *
If incarcerated, the question pertains to the 12 months prior to incarceration

Mark only one oval.

- ◯ Yes
- ◯ No

36. 3. Number of address changes during the past 12 months *
If incarcerated, the question pertains to the 12 months prior to incarceration

Mark only one oval.

- ◯ Yes
- ◯ No

37. 4. Number of months in past 12 months engaged in regular employment for 20 or more hours per week *
If incarcerated, the question pertains to the 12 months prior to incarceration; If retired or disabled, type "not applicable."

_____

38. 5. Age of onset of criminal activity *

_____

39. 6. Number of prior diversion programs or de novo referrals *

40. 7. Number of prior deferred prosecution *

41. 8. Number of bench warrants for failure to appear in past 3 years *

42. 9. Number of prior felony convictions *

43. 10. Number of prior serious misdemeanor convictions *

44. 11. Number of other misdemeanor convictions *

45. 12. Age of onset of regular substance use *
Check "not applicable" if individual has not used alcohol, illicit or prescription drugs on a repetitive basis

46. 13. Number of prior substance abuse treatment episodes or attempts *

47. 14. Withdrawal syndrome in the past 12 months *
If incarcerated, the question pertains to the 12 months prior to incarceration
Mark only one oval.
- ◯ Yes
- ◯ No

48. 15. Binge use and loss of control in the past 12 months *
If incarcerated, the question pertains to the 12 months prior to incarceration
Mark only one oval.
- ◯ Yes
- ◯ No

49. 16. Cravings or compulsions in the past 12 months *
If incarcerated, the question pertains to the 12 months prior to incarceration
Mark only one oval.
- ◯ Yes
- ◯ No

50. 17. Chronic substance abuse-related medical condition *

Mark only one oval.

- Yes
- No

51. 18. Amount of time during the past 12 months spent interacting with other people who are engaged in criminal activity, including illicit drug use *

If incarcerated, the question pertains to the 12 months prior to incarceration

Mark only one oval.

- None
- A little
- Some
- Most
- Almost All

52. 19. Major Axis 1 mental health diagnosis *

If incarcerated, the question pertains to the 12 months prior to incarceration

Mark only one oval.

- Yes
- No

Areas of Need

WRAP+ can help you with many things. Use this section to indicate the areas of your life that you need help with.

53. I would like help with (check all that apply)

Check all that apply.

- [ ] Housing/rent
- [ ] Mental health services (including assessments)
- [ ] Employment
- [ ] Substance use services (including assessments)
- [ ] Health insurance
- [ ] Education
- [ ] Identification cards (including birth certificate)
- [ ] Veteran's benefits
- [ ] Medical health services
- [ ] Transportation (including getting driver's license)
- [ ] Food/clothing
- [ ] Income support (including applying for cash benefits or disability)

54. Describe anything that you need help with that is not listed above

55. Of the needs that you have listed, what two things are the most important things you need help with right now?

Residency & Justice System Involvement (4 questions)

To qualify for WRAP+, you must be a resident of Winona County, have some involvement with the justice system and not be excluded due to your past offenses or charges. The following questions cover these three areas.

56. Type of Offense

Certain offenses will disqualify an individual from participating in WRAP+. Please specify if you have been charged with or convicted of any of the following at any time.

Check all that apply.

- [ ] I have been charged with or convicted of murder.
- [ ] I have been charged with or convicted of assault with intent to commit murder.
- [ ] I have been charged with or convicted of criminal sexual conduct.
- [ ] I have not been charged with any of the above crimes.

57. Residency-Check all that apply

Check all that apply.

- [ ] I am a resident of Winona County.
- [ ] I am homeless and consider myself a resident of Winona County.
- [ ] I am not a current Winona County resident plan to become a resident of Winona County within the next three months.
- [ ] I am not a resident of Winona County and do not plan to become one.

58. Below are the types of justice system involvement that currently qualify an individual for participation. Please check all of the following situations that apply to you.

Check all that apply.

- [ ] I was arrested within the past year.
- [ ] I was charged with a crime within the past year (Does not include petty misdemeanors.)
- [ ] I have pending criminal charges. (Does not include petty misdemeanor.)
- [ ] I have served time in jail or prison within the past year.
- [ ] I am currently on probation or under court supervision.
- [ ] I was a suspect or potential victim for a law enforcement call for service within the past year.
- [ ] I was the subject of a welfare check by law enforcement within the past year
- [ ] I have been screened for civil commitment by Winona County within the past year.
- [ ] I was the subject of a child in need of protective services (CHIPS) investigation or was a party or participant in a CHIPS case within the past year.
- [ ] I am the protected party of a harassment restraining order, an order for protection or a domestic abuse no contact order OR am the person against whom one of those orders was issued.
- [ ] I am a participant in a treatment court or veteran's court or have been a participant within the past year.
- [ ] None of the above

59. If none of the above situations apply to you, explain your involvement with the criminal justice system. Otherwise, leave this question blank.

Contact Info & Consent to Participate

Your agreement to participate in WRAP+ is needed before any referrals can be made.

60. E-mail address

61. Phone number (list best one to reach you at)

62. Your Street Address or P.O. Box / City / State / Zip
If you are homeless and have no way to receive mail, type "homeless."

63. Best way to reach you
If you qualify for WRAP+, we need to be able to reach you using either the contact information (above) or another method. Describe the best way to reach you in the future. This can include the name and number of a friend, parent or other readily available contact person. If we cannot reach you, we cannot help you.

64. Do you agree to participate in WRAP+?

Mark only one oval.

- ◯ Yes
- ◯ No

65. By my typed signature below, I agree to participate in WRAP+. I give permission for WRAP+ staff to verify my eligibility for the program (including accessing my criminal history and/or most recent bail evaluation) and to use my answers (but not my name) for grant reporting purposes. I further agree to be referred to Hiawatha Valley Mental Health Center for a comprehensive evaluation (if I do not already have a valid comprehensive evaluation) and to be paired up with a Mental Health Practitioner (case manager).

Submit your answers

66. JAIL USE ONLY: Type comments below.

67. Click below to confirm that you have completed this questionnaire.

Check all that apply.

- ☐ I confirm that this questionnaire is complete.

WINONA COUNTY REENTRY ASSISTANCE PROGRAM+ COMBINED SCREENER & APPLICATION FORM

Revised 12/27/23

What is WRAP+? WRAP+ is a grant-funded reentry program that assists persons who have been involved with the criminal justice system to help them avoid further involvement in the criminal justice system. WRAP+ provides a **case manager** who can help people develop a plan and access resources and supports so they can live successfully in the community as well as **money** to pay for certain expenses that are a part of a person's case plan. Some of the common things that a re-entry program can assist people with include housing, health insurance, chemical dependency and mental health assessment and treatment, transportation and getting ID cards and birth certificates. Participation in WRAP+ is voluntary.

Your Name: _____
First Middle Last

Birthdate: _____/_____/_____ **Gender Identification:** ☐ Male ☐ Female **Ever in Military?** ☐Yes ☐No

Ethnicity: ☐ Hispanic ☐ Not Hispanic **Race**: ☐White ☐Black ☐Amer. Indian/Alaskan Native ☐Asian ☐Multi-Racial

NOTE: ALL PERSONS BEING BOOKED INTO THE JAIL MUST COMPLETE PAGES 1-2, REGARDLESS OF WHETHER THEY WANT TO APPLY FOR WRAP+.
Answers to the risk, drug and mental health screens will be used to determine eligibility for WRAP+, for WRAP+ data reporting requirements and (for incarcerated persons) to determine further medical needs.
Answers <u>WILL NOT BE USED</u> to generate additional charges or probation violations.

Mental Health Screen—Brief Jail Mental Health Screen

A score of 2 or more indicates the need for further assessment.

	QUESTIONS	NO	YES	Comments
1.	Do you *currently* believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?	○	○	
2.	Do you *currently* feel that other people know your thoughts and can read your mind?	○	○	
3.	Have you *currently* lost or gained as much as two pounds a week for several weeks without even trying?	○	○	
4.	Have you or your family or friends noticed that you are *currently* much more active than you usually are?	○	○	
5.	Do you *currently* feel like you have to talk or move more slowly than you usually do?	○	○	
6.	Have there *currently* been a few weeks when you felt like you were useless or sinful?	○	○	
7.	Are you *currently* taking any medication prescribed for you by a physician for any emotional or mental health problems?	○	○	
8.	Have you <u>*ever*</u> been in a hospital for emotional or mental health problems?	○	○	

Other important information (if any):

Total number of YES answers for 1-6:_____

Number of YES answers to 7 or 8:_____

To qualify for WRAP+, an application must have

- A YES to item 7; OR
- A YES to item 8; OR
- A YES to at least 2 of items 1 through 6

Drug Screen—Texas Christian University Drug Screen V—TCUDSV

A score of 2 or more indicates the need for further assessment.

	During the last 12 months (before being locked up, if applicable)	YES	NO
1.	Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	○	○
2.	Did you try to control or cut down on your drug use but were unable to do it?	○	○
3.	Did you spend a lot of time getting drugs, using them, or recovering from their use?	○	○
4.	Did you have a strong desire or urge to use drugs?	○	○
5.	Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?	○	○
6.	Did you continue using drugs even when it led to social or interpersonal problems?	○	○
7.	Did you spend less time at work, school, or with friends because of your drug use?	○	○
8.	Did you use drugs that put you or others in physical danger?	○	○
9.	Did you continue using drugs even when it was causing you physical or psychological problems?	○	○
10a.	Did you need to increase the amount of a drug you were taking so that you could get the same effects as before?	○	○
10b.	Did using the same amount of a drug lead to it having less of an effect as it did before?	○	○
11a.	Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	○	○
11b.	Did you ever keep taking a drug to relieve or avoid getting sick or having withdrawal symptoms?	○	○

Other important information (if any):

IF YOU WISH TO APPLY FOR WRAP+ SERVICES AND FUNDING, TURN THE PAGE AND CONTINUE. IF NOT, SIGN AND DATE BELOW

I do not wish to apply for WRAP+ at this time. I understand that I can re-apply at any time, but must complete the screening forms again.

Date:_____ Signature:_____

RISK ASSESSMENT (Risk and Needs Triage-RANT®)

Persons needing assistance to complete this section should contact Katie Schild, Criminal Justice Social Worker at 507-457-6483 or kschild@co.winona.mn.us.

1. Current Age _____

2. Homeless during the past 12 months? ☐ Yes ☐ No

3. Number of address changes during the past 12 months? _____

4. Number of months in past 12 months engaged in regular legal employment for 20 or more hours per week _____ or ☐ Not Applicable (if retired or disabled)

5. Age of onset of criminal activity _____

6. Number of prior diversion programs or de novo referrals _____

7. Number of prior deferred prosecutions _____

8. Number of bench warrants for failure to appear in past 3 years _____

9. Number of prior felony convictions _____

10. Number of prior serious misdemeanor convictions _____

11. Number of other misdemeanor convictions _____

12. Age of onset of regular substance use _____ ☐ Not Applicable (no substance use)

13. Number of prior substance abuse treatment episodes or attempts _____

14. Withdrawal syndrome in the past 12 months ☐ Yes ☐ No

15. Binge use and loss of control in the past 12 months ☐ Yes ☐ No

16. Cravings or compulsions in the past 12 months ☐ Yes ☐ No

17. Chronic substance abuse-related medical condition ☐ Yes ☐ No

18. Amount of time during the past 12 months spent interacting with other people who are engaged in criminal activity, including drug use: none / a little / some / most / almost all (pick one)

19. Major Axis I mental health diagnoses ☐ Yes ☐ No

WINONA COUNTY REENTRY ASSISTANCE PROGRAM+
COMBINED SCREENING & APPLICATION FORM
Revised 12/27/23

APPLICATION FOR WRAP+ (Page 1)

NAME: _____
First Middle Last

Mailing Address:_____
Street City State ZIP

Cell Phone: (_____)_____ **E-mail Address:**_____

Home phone:(_____)_____**Work phone**:(_____)_____ ext._____

Preferred method of contact (check one): □cell phone text or call □home phone □work phone □e-mail
DO NOT CONTACT ME at □cell phone □home phone □work phone □email (check all that apply).

TYPE OF ASSISTANCE NEEDED: Please tell us what kind of help you would like to receive from WRAP+. **Check all of the following that apply to you:**

☐ Housing/rent
☐ Mental health services (including assessments)
☐ Employment
☐ Substance use services (including assessments)
☐ Health insurance
☐ Education
☐ Identification cards (including birth certificate)
☐ Veteran's benefits
☐ Medical health services
☐ Transportation (including getting a driver's license).
☐ Income support (including applying for cash benefits or disability)
☐ Other—describe:_____
_____

Most important: What are the TWO most important things that you need help with right now?

_____

TYPE OF OFFENSE: Due to program restrictions, persons who have been charged with or convicted of certain crimes are not eligible to participate. **Please check all of the following that apply to you:**

☐ I have been charged with or convicted of murder.
☐ I have been charged with or convicted of assault with intent to commit murder or assault in the 1st degree.
☐ I have been charged with or convicted of criminal sexual conduct.
☐ I have not been charged with any of the above crimes.

APPLICATION FOR WRAP+ (Page 2)

NAME: _____
First Middle Last

RESIDENCY: Due to program restrictions and service availability, WRAP+ can only serve residents of Winona County. **Please check the one that best describes your situation:**

☐ I am a resident of Winona County and my permanent address is:

_____
Street address City State ZIP

☐ I am homeless and consider myself to be a resident of Winona County.
☐ I currently reside in another _____ County in _____ (Name of State) but plan to establish residency in Winona County by _____ (month/year).
☐ I am not a resident of Winona County and do not plan to become a resident of Winona County.
☐ Other-explain:_____

CRIMINAL JUSTICE INVOLVEMENT: WRAP+ serves individuals who have involvement with the criminal justice system at the time of application. **Please check all of the following that apply to you:**

☐ I was arrested within the past year.

☐ I was charged with any state or federal crime in any jurisdiction within the past year (NOTE: this does not include petty misdemeanors).

☐ I have pending criminal charges (NOTE: this does not include petty misdemeanors).

☐ I was an inmate in any state or federal custodial facility (such as jail or prison) or other comparable locked facility (such as a secure medical facility) within the past year.

☐ I am subject to terms of court supervision or probation from a criminal matter.

☐ I was the suspect or a potential victim for a law enforcement call for service within the past year.

☐ I was the subject of a welfare check by law enforcement within the last year..

☐ I was screened for civil commitment within the past year.

☐ I was the subject of a child in need of protective services (CHIPS) investigation or was a party or participating in a CHIPS court case within the past year.

☐ I am the protected party of a harassment restraining order, an order for protection or a domestic abuse no contact order OR am the person against whom one of those orders was issued.

☐ I am a participant in treatment court or veteran's court or have been a participant within the past year.

☐ Other involvement—please describe:_____

AGREEMENT TO PARTICIPATE: By my signature below, I agree to participate in WRAP+. I give permission for WRAP+ staff to determine my eligibility for the program (including accessing my criminal history and/or most recent bail evaluation) and to use my answers (but not my name) for grant reporting purposes. I further agree to be referred to Hiawatha Valley Mental Health Center for further evaluation and case management, if eligible.

_____ _____ _____
Signature Printed Name Date

WINONA COUNTY REENTRY ASSISTANCE PROGRAM PLUS

WINONA COUNTY REENTRY ASSISTANCE PROGRAM+
TARGET POPULATION VERIFICATION FORM

Revised 12/30/23

(to be completed by the Jail Intake Worker)

Applicant Name:_____

Mailing Address:_____

DOB:_____ **Age:**_____ **Gender ID: □ Male □ Female MNI:**_____

Phone: (_____)_____□ Cell □ Home **E-mail:**_____

Criteria	**Notes:**	**Yes**	**No**
Age Verification: Is applicant age 18 years or older?		◯	◯
Risk Level			
Risk Level: Is risk of recidivism medium to high? • RANT Score of High Risk	HR/HN HR/LN LR/HN LR/LN	◯	◯
Mental Illness or Co-occurring MI and Substance Abuse • BJMHS score of 2 on items 1-6 or YES to 7 or 8	BJMHS Q1-6 Score:_____ Question 7:_____ Question 8:_____	◯	◯
Drug: Not scored for WRAP+ eligibility • TCUDS-V score of 2-3 (mild)	TCUDS-V Score:_____		
Criminal Justice Involvement As of date of application, applicant was: 1. Arrested within past year 2. Charged with a crime within past year 3. Has pending criminal charges 4. Incarcerated within past year 5. On court supervision/probation 6. Suspect/victim in call for service within past year 7. Subject of welfare check w/in past year 8. Screened for civil commitment within past year 9. Subject of CHIPS investigation/case w/in past year 10. Projected party/subject of OFP/HRO w/in past year 11. Specialty court participant within past year 12. Other:_____	1. Date of arrest:_____ 2. Date of charge or file no.:_____ 3. Court file no:_____ 4. Date last incarcerated:_____ 5. Probation Officer:_____ 6. Date/location:_____ 7. Date/location:_____ 8. Date/location:_____ 9. Date/location:_____ 10. Date/location:_____ 11. Court:_____ 12. Notes:_____	◯	◯
Residency 1. Has a permanent in address in Winona County 2. Homeless & intends to stay in Winona County 3. Residing elsewhere, but plans to move w/in 3 mos	1. Check if applicable:_____ 2. Check if applicable:_____ 3. Check if applicable:_____	◯	◯
Voluntary Participation Did client complete and sign application?	Date signed:_____	◯	◯
Type of Offense (Must be non-violent) NO excludable criminal offenses or charges?	Answer YES if criminal history is clear; if no, specify offense_____	◯	◯
Client rejected: ☐ Refer for override: Yes No **Reason for rejection:**_____ **Notification provided to client:**_____	**Client accepted: ☐** **Client notified on** _____ **Referral to JSW or HVMHC (circle one) on** _____		

Target Population Verification done on_____ by _____

WINONA COUNTY REENTRY ASSISTANCE PROGRAM+
ELIGIBILITY AND APPEAL FORM
Revised 8/22/23
(to be provided to the applicant)

Applicant Name:_____

☐ You have been accepted to WRAP+!

Congratulations on your acceptance to the program! The next step in the intake process is the assessment stage, where you be able to obtain comprehensive evaluation (mental health assessment) and/or chemical dependency assessments at Hiawatha Valley Mental Health Center (unless you have recently had one or both). During this stage, you will meet with a case manager who can assist you in creating a plan that will allow you to access and receive resources and support and help you avoid further involvement with the criminal justice system.

Based upon your application, the person responsible for assisting you in the assessment stage is:

☐ Treatment Court Coordinator (active treatment court participant; not in jail)

☐ Jail Social Worker (accepted applicants who applied while in jail)

☐ Mental Health Practitioner (accepted applicant who is not in jail at time of application)

Your case manager will attempt to reach you using the contact information listed above. If your contact information has changed, please contact Trish Chandler, Jail Intake Worker at (507) 457-6539 or tchandler@co.winona.mn.us..

Congratulations again, and we look forward to working with you. -The WRAP+ Team

☐ You do not qualify for WRAP+ at this time.

The reason or reasons that you do not qualify for the program are listed below:

_____

Even though you have not been accepted to the program at this time, the door remains open for you to re-apply at any time. If you would like to complete a new application you may access one at www.winonacountycjcc.org/wrapplus or from Trish Chandler, Jail Intake Worker. You may also complete the appeal form (below) to have your eligibility decision reviewed by the WRAP+ Task Force.

☐ I would like to appeal to the WRAP+ Task Force to re-consider whether I qualify for WRAP+.

The reason or reasons that I believe that I qualify for the program are listed below:

_____

_____

_____ _____ _____

Signature Printed Name Date

If appealing, return this entire form to Trish Chandler, Jail Intake Worker at (507) 457-6539 or tchandler@co.winona.mn.us.

WINONA COUNTY REENTRY ASSISTANCE PROGRAM+
CONSENT AND RELEASE OF INFORMATION FORM

Revised 9/6/23

I,_____, D.O.B. _____, have agreed to receive services from the Winona County WRAP+ Program. I understand that signing this Consent and Release Form is a condition of my participation in the Winona County WRAP+ Program.

SECTION 1: ENTITIES/INDIVIDUALS WHO ARE AUTHORIZED TO EXCHANGE INFORMATION ABOUT ME

A. I authorize the below entities/individuals to disclose and exchange information

❑ **I AUTHORIZE ALL OF THE BELOW LISTED ENTITIES/INDIVIDUALS TO DISCLOSE AND EXCHANGE INFORMATION**

Law Enforcement
- ❑ Winona County Sheriff's Dept
- ❑ Winona Police Department
- ❑ Department of Public Safety
- ❑ Bureau of Criminal Apprehension
- ❑ _____

Court & Community Services/Corrections
- ❑ Winona County Court Administration
- ❑ Treatment Court of Winona County
- ❑ Winona Co. Jail Intake & Social Worker
- ❑ Minnesota Dept. of Corrections
- ❑ Winona County Health & Human Services
- ❑ WRAP+ Program Personnel
- ❑ Veteran's Treatment Court

Medical/Mental Health
- ❑ Advanced Correctional Healthcare
- ❑ Winona Health
- ❑ Hiawatha Valley Mental Health Center
- ❑ Counseling Associates
- ❑ Acumen Counseling Services, LLC
- ❑ Common Ground Treatment Services
- ❑ Ellie Family Services
- ❑ _____

Vocational/Financial
- ❑ Winona Workforce Center
- ❑ Social Security Administration
- ❑ Volunteer Services
- ❑ _____

Other
- ❑ Winona Community Hub
- ❑ Attorney:_____
- ❑

B. With the below entities/individuals

❑ **I AUTHORIZE ALL OF THE BELOW LISTED ENTITIES/INDIVIDUALS TO DISCLOSE AND EXCHANGE INFORMATION**

Law Enforcement
- ❑ Winona County Sheriff's Dept
- ❑ Winona Police Department
- ❑ Department of Public Safety
- ❑ Bureau of Criminal Apprehension
- ❑ _____

Court & Community Services/Corrections
- ❑ Winona County Court Administration
- ❑ Treatment Court of Winona County
- ❑ Winona Co. Jail Intake & Social Worker
- ❑ Minnesota Dept. of Corrections
- ❑ Winona County Health & Human Services
- ❑ WRAP+ Program Personnel
- ❑ Veteran's Treatment Court

Medical/Mental Health
- ❑ Advanced Correctional Healthcare
- ❑ Winona Health
- ❑ Hiawatha Valley Mental Health Center
- ❑ Counseling Associates
- ❑ Acumen Counseling Services, LLC
- ❑ Common Ground Treatment Services
- ❑ Ellie Family Services
- ❑ _____

Vocational/Financial
- ❑ Winona Workforce Center
- ❑ Social Security Administration
- ❑ Volunteer Services
- ❑ _____

Other
- ❑ Winona Community Hub
- ❑ Attorney:_____
- ❑

SECTION 2: INFORMATION TO BE EXCHANGED

⟹ ❑ **I AUTHORIZE RELEASE OF ALL OF THE INFORMATION LISTED BELOW**

❑ Admission/Intake
❑ Bail Evaluation Forms
❑ Behavioral Health Notes
❑ Charges/Criminal Complaints
❑ Chemical Health Programming Records
❑ Chemical Use Assessment/Recommendations
❑ Court Records
❑ Criminal Complaint
❑ Criminogenic Screening/Assessments (ex LS-CMI, ORAS-CSST)
❑ Mental Health Assessment/Recommendations (Comprehensive Evaluation)
❑ Discharge Summary
❑ Educational Records
❑ Emergency Room Records
❑ Other:_____

❑ Financial Status/Income Records
❑ Health Insurance Information
❑ Human Services Records
❑ Jail Admit/Discharge Records
❑ Laboratory Records/Tests
❑ Medical History/Physical Exam
❑ Medication Records
❑ PBT, Blood Test and Urinalysis Results
❑ Probation & Preesentence Investigation Reports
❑ Progress Notes/Case Notes
❑ Psychiatric Evaluation
❑ Psychological Testing/Evaluation
❑ Treatment/Community Support/Case Plans
❑ Other:_____

X I specifically authorize the release of records pertaining to alcohol abuse or test results, drug abuse or test results and mental health.

X I authorize representatives from the entities/individuals authorized in Section 1 to discuss the information disclosed above with each other.

SECTION 3: PURPOSE OF RELEASE

⟹ ❑ **I AUTHORIZE RELEASE OF INFORMATION FOR ALL PURPOSES LISTED BELOW**:

❑ To coordinate referrals and placement
❑ To coordinate services
❑ To continue evaluation or treatment
❑ To determine availability for funding
❑ research & analysis purposes (aggregate data)
❑ _____

SECTION 4: ACKNOWLEDGEMENT

I have been instructed as to what information will be released, the purpose and intended use of the released information, who will receive the information and any known consequences of this release. The information to be released is private, and any subsequent use and release is controlled under the Minnesota Government Data Practices Act (Minn. Stat. 1982 Chap. 13). I understand that State and Federal privacy laws protect my records. My records can be released only if I give my written permission or if the law allows it. If I refuse to sign or cancel this release, I may not be eligible to receive the service I am requesting. I may cancel this consent with written notice at any time, but that this written notice will not affect information about me that has already been requested or released. I understand that those who receive my records under this release may share it with others. I also understand that once the information is shared with others, it is no longer protected by this authorization. I have been informed of my right to refuse to release this information. I understand that I may revoke this consent upon written notice (not retroactive) and that the consent will automatically expire within one (1) year after the date of my signature. A photocopy of this release is as valid as the original and an electronic signature is as valid as an ink signature.

⟹ Participant's Signature _____ DATE _____

Printed Name:_____

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	**Gender**	**Date of Birth**	**Today's Date**	**Jail ID #**
Last _____ , First _____ M _____	☐ M ☐ F	__ __/ __ __/ __ __ mm dd yy	__ __/ __ __/ __ __ mm dd yy	**SSN#**

Name of Facility	**Name of Person Completing Form and Phone Number**	**Current Status**	**Date of Admission**	**Projected Release Date**
		☐ Pre-Trial Detainee ☐ Sentenced Inmate	__ __/ __ __/ __ __ mm dd yy	__ __/ __ __/ __ __ mm dd yy

Potential Needs in Community After Release	**Steps Taken by Jail Staff and Date(s)**	**Detainee's Final Plan & Contact Information for Referrals**
Mental Health Services ☐		
Psychotropic Medications ☐		
Housing ☐		
Substance Abuse Services ☐		
Health Care ☐		
Health Care Benefits ☐		
Income Support/Benefits ☐		
Food/Clothing ☐		
Transportation ☐		
Other ☐		

Full plan completed and discussed with detainee? ☐ Yes ☐ No Attachments? ☐ Yes ☐ No

If no, why?

Detainee refused ☐ Court released before plan completed ☐

Incomplete for other reasons ☐ Specify: _____

Detainee's Copy

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

Detainee's Name	Gender	Date of Birth	Today's Date	Jail ID #
Last , First M	☐ M ☐ F	__ __/ __ __/ __ __ mm dd yy	__ __/ __ __/ __ __ mm dd yy	SSN#

Name of Facility	Name of Person Completing Form and Phone Number	Current Status	Date of Admission	Projected Release Date
		☐ Pre-Trial Detainee ☐ Sentenced Inmate	__ __/ __ __/ __ __ mm dd yy	__ __/ __ __/ __ __ mm dd yy

Potential Needs in Community After Release	Steps Taken by Jail Staff and Date(s)	Detainee's Final Plan & Contact Information for Referrals
Mental Health Services ☐		
Psychotropic Medications ☐		
Housing ☐		
Substance Abuse Services ☐		
Health Care ☐		
Health Care Benefits ☐		
Income Support/Benefits ☐		
Food/Clothing ☐		
Transportation ☐		
Other ☐		

Full plan completed and discussed with detainee? ☐ Yes ☐ No Attachments? ☐ Yes ☐ No

If no, why?

Detainee refused ☐ Court released before plan completed ☐

Incomplete for other reasons ☐ Specify: _____

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

Detainee's Name	Gender	Date of Birth	Today's Date	Jail ID #
Last , First M	☐ M ☐ F	__ __/ __ __/ __ __ mm dd yy	__ __/ __ __/ __ __ mm dd yy	SSN#

Name of Facility	Name of Person Completing Form and Phone Number	Current Status	Date of Admission	Projected Release Date
		☐ Pre-Trial Detainee ☐ Sentenced Inmate	__ __/ __ __/ __ __ mm dd yy	__ __/ __ __/ __ __ mm dd yy

Potential Needs in Community After Release	Steps Taken by Jail Staff and Date(s)	Detainee's Final Plan & Contact Information for Referrals
Mental Health Services ☐		
Psychotropic Medications ☐		
Housing ☐		
Substance Abuse Services ☐		
Health Care ☐		
Health Care Benefits ☐		
Income Support/Benefits ☐		
Food/Clothing ☐		
Transportation ☐		
Other ☐		

Full plan completed and discussed with detainee? ☐ Yes ☐ No Attachments? ☐ Yes ☐ No

If no, why?

Detainee refused ☐ Court released before plan completed ☐

Incomplete for other reasons ☐ Specify: _____

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

Detainee's Name	Gender	Date of Birth	Today's Date	Jail ID #
Last , First M	☐ M ☐ F	__ __/ __ __/ __ __ mm dd yy	__ __/ __ __/ __ __ mm dd yy	SSN#

Name of Facility	Name of Person Completing Form and Phone Number	Current Status	Date of Admission	Projected Release Date
		☐ Pre-Trial Detainee ☐ Sentenced Inmate	__ __/ __ __/ __ __ mm dd yy	__ __/ __ __/ __ __ mm dd yy

Potential Needs in Community After Release	Steps Taken by Jail Staff and Date(s)	Detainee's Final Plan & Contact Information for Referrals
Mental Health Services ☐		
Psychotropic Medications ☐		
Housing ☐		
Substance Abuse Services ☐		
Health Care ☐		
Health Care Benefits ☐		
Income Support/Benefits ☐		
Food/Clothing ☐		
Transportation ☐		
Other ☐		

Full plan completed and discussed with detainee? ☐ Yes ☐ No Attachments? ☐ Yes ☐ No

If no, why?

Detainee refused ☐ Court released before plan completed ☐

Incomplete for other reasons ☐ Specify: _____

Facility Use

WINONA COUNTY REENTRY ASSISTANCE PROGRAM+ FUNDING REQUEST *(Revised 8/22/23)*

To be completed by the case manager. Use a separate form for each item Requests must be received by Thursday at noon and contain all necessary documentation to ensure payment the following week.

Client Name: _____ DOB:_____
First MI Last

Describe the reason your client needs the funds (i.e. rent, bus pass, ID card, work shoes, etc.)

_____

What other funding sources were considered/rejected and why:_____

_____

Amount needed:_____ **Payable to?:**_____

☐ Attached is documentation of the need for funding, i.e. copy of bill, copy of lease agreement, W-9 Form

Form of payment needed: ☐ Credit Card* ☐ Check ☐ Direct Deposit **Date Needed by**:_____
*Credit Card should be used only as a last resort. Please ensure that credit card payments are allowed by the vendor.

Transmit payment by?:
☐ I will pick it up. Contact me at _____when payment is ready.
☐ Mail it to:_____
☐ Pay online at:_____

Certification: I certify that I am the case manager for the client named above, that the funds requested above are necessary to meet the basic need of the client, that the expenditure is tied to the client's case plan and that other funding sources are not readily available for the expenditure requested. If approved, I agree to obtain a receipt for the funds signed by the client and return it to the WRAP+ Grant Manager.

Case Manager Signature:_____Date of Request:_____

Printed Name:_____ Title:_____

Admin Use Only:

☐ Rejected. Reason for rejection:_____
☐ Approved.

Funding Source	GL Code	Amount	Voucher (check) #	Date payment issued
JMHC	01-091-095-0000-6261			

Grant Manager Authorization:_____ Date:_____

Departmental Approval:_____ Date:_____

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

WINONA COUNTY REENTRY ASSISTANCE PROGRAM+ FUNDING RECEIPT

To be completed by case manager and signed by client.

Revised 8/22/23

I _____ received:
Client name – PLEASE PRINT

CHOOSE ONLY ONE BOX TO COMPLETE BELOW

FOR MONEY PAID ON BEHALF OF CLIENT	**FOR ITEMS RECEIVED BY CLIENT**
Amount paid (i.e. $600):_____	Item received (i.e. bike):_____
Purpose (i.e. rent):_____	Purpose (i.e. get to work):_____
_____	_____
When received (i.e. 1/1/19):_____	When received (i.e. 1/1/19):_____
Client agrees that the above money has been paid on his/her behalf and that the money paid is for rent, bills or other service that is not in violation of any probation terms or court orders.	Client agrees that he/she has received the above item and that he/she will not use the item to violate any probation terms or court orders. Client agrees that the items is received AS IS.

Client signature:_____ Date:_____

Case Manager signature:_____ Date:_____

Return completed form to Kalene Engel at kalene@engellawoffice.com

Position Description

TITLE: Mental Health Practitioner, Community Based Services

PROGRAM: Children's Community Based Services and Adult Community Based Services

JOB SUMMARY: This position entails 40 hours a week providing direct therapeutic, rehabilitative skills and/or Case Management services to children/adolescents and/or adults with functional skill deficits due to mental health needs. Services can be provided in the school, home, or other natural setting for the client and/or family. This position will involve meeting with the client individually, within the family, or in a group setting.

JOB RESPONSIBILITIES AND ESSENTIAL FUNCTIONS:

1. Provide direct client care based on requirements of the CTSS program, Targeted Case Management (TCM), ARMHS guidelines and agency service level standards.
2. Assure compliance with rules, regulations, licenses and/or certification standards for TCM, CTSS and/or ARMHS programming.
3. Attend all clinical supervision and client consultation meetings as required and based on qualifications.
4. Flexible work hours will be needed to meet the availability of the client which may include early mornings and later evenings. These hours may be flexed within the weekly schedule per approval of the director of the program.
5. Active team member of the agency Integrated Treatment Plan Team; participate in all treatment planning meetings focused on client centered care and treatment.
6. Works collaboratively with the client, the client's identified supports and all professionals to ensure quality of care.
7. Write and maintain daily progress notes based on client's progress and any other assessment's required for progress review. This includes keeping all documentation related to the client up to date, keeping notes and billing documents current and meeting or exceeding paperwork requirements.
8. Understands program requirements, state issued timelines, and agency expectations for client visits.
9. Attend conferences, in-services, and trainings related to assigned programs.
10. Must be able to pass a background check.
11. Possess a vehicle, valid driver license, and valid auto insurance.

PHYSICAL REQUIREMENTS FOR POSITION: Must be able to walk, sit, stand, crouch, twist, bend, reach overhead, maneuver stairs and stretch in a manner conducive to the execution of daily activities. Must be able to move around the office on a daily basis. While performing the duties of this job, the employee must communicate with others and exchange information. This is primarily a sedentary position (standing and/or sitting). Employee regularly operates a computer and other office equipment on a daily basis. Occasional bending and lifting of office materials up to 30 lbs.

NON-ESSENTIAL FUNCTIONS: Perform other duties as assigned by the Program Director.

EQUIPMENT USED: Computer, telephone/cell phone, office equipment, vehicle

JOB QUALIFICATIONS AND REQUIREMENTS:

1. Must meet minimum qualifications as a Mental Health Practitioner as outlined in MN Statutes 245, 462, Subdivision 17.
2. Worker Traits: Must possess a high level of human relation skills and an aptitude for effective decision making. Must possess good planning, organization and communication skills (oral and written) as well as problem solving skills. Independently motivated and responsible.
3. Must be able to maintain confidentiality.
4. Ability to work independently and as part of a team.
5. Must possess a vehicle, valid driver's license, and a willingness to travel as needed to client or organization locations throughout SE MN.

WORK ENVIRONMENT: Hiawatha Valley Mental Health Center is committed to providing a safe and inclusive work environment free from harassment, violence and discrimination. Our inclusive work environment represents many different backgrounds, cultures and viewpoints. The core values we live by include: integrity, respect, people focused, community focused, continuous improvement, compassion, partnership and collaboration, empowerment and financial stewardship. All Hiawatha Valley Mental Health Center owned facilities are smoke/drug free environments, with some exposure to excessive noise, dust and temperature. The employee is occasionally exposed to a variety of conditions at client sites.

SUPERVISED BY: Adult Community Based Director or Community Based Care Coordination Director

SUPERVISES: None

POSITION DESIGNATION: Non-Exempt, Full Time

This job description is subject to change at any time.

WINONA COUNTY
CLASSIFICATION DESCRIPTION

Classification: **Criminal Justice Social Worker**

Characteristics of Class:

Under direction of the Health and Human Services Director, an employee in this classification performs work in providing social work services on cases involving complex social problems and social treatment plans; performs responsible and difficult casework and performs related work as assigned. Work may be performed in a detention center setting.

Supervisory Controls:

An employee in this class performs the duties consistent with the policies of the Health and Human Services Department and other relevant statutory and regulatory requirements. Performance is reviewed through staff meetings and written reports.

Examples of Duties:

Any one position may not include all the duties listed, nor do the examples listed in their relative order of importance include all the duties, which may be found in positions of this class.

- Interviews clients at intake. Assists Detention Deputies during encounters with clients in a mental health crisis.
- Carries a caseload where a need for continuing social casework predominates. Conducts complex case evaluation for the purpose of assessing problems and determining appropriate types and methods of treatment.
- Prepares intensive long or short-term treatment plans.
- Identifies client's situations which require intensified service and brings to the attention of supervisor for help or referral.
- Provides direct services to individuals with emotional, physical, or socially handicapped individuals. Provides or assists in providing services to other cases involving difficult or complex social and financial problems.
- Interprets programs to clients, refers clients to appropriate community services.
- Interprets social and emotional factors to others involved in treatment of clients.
- Prepares social histories with emphasis on psycho-social factors.
- Provides preventive services. Provides casework services for rehabilitation.
- Interprets policies and regulations to clients.
- Prepares and maintains case records which meet federal, state and local guidelines. Documents findings and correspondence. Prepares regular and special reports.
- Works with in-jail healthcare providers to coordinate in-jail services.
- Participates on task force, committees or teams relevant to work activities. Participates in in-service training and other staff development activities to increase knowledge of social work processes and skill in application to individual cases.
- Any other duties as assigned.

Required Knowledge, Skills, and Abilities:

Any combination of training and experience providing the following knowledge, skills, and abilities.

For Full Performance:

- Knowledge of the principles and techniques of interviewing and recording in social work and the ability to apply them.
- Knowledge of substance use disorder and treatment.
- Knowledge of social casework objectives, principles, and methods.
- Knowledge of socio-economic factors which promote stable family life and understanding of the elements which affect family security.
- Knowledge of the principles of community organization.
- Knowledge of social welfare research methods.
- Knowledge of family systems and dynamics.
- Ability to effectively apply casework knowledge and skills.
- Ability to work constructively within an agency in the community setting and effectively utilize appropriate resources and services.
- Ability to work constructively in the development and coordination of community resources to meet special needs.
- Ability to prioritize caseloads.
- Ability to effectively assist clients with accessing community-based services to reduce jail recidivism.
- Ability to effectively use various computer software programs (i.e., Social Services Information Systems, electronic data management system).

For Pre-Employment:

- Ability to manage time productively.
- Ability to communicate effectively, both orally and in writing.
- Knowledge of individual and group behavior.
- Knowledge and skills in related adult protection services and investigation.
- Knowledge of physical and mental illness and their impact on personality.
- A bachelor's degree from an accredited four-year college or university with a major in social work, psychology, sociology or closely related field.

Or

- A bachelor’s degree from an accredited four-year college or university with a major in any field and one year of experience as a social worker in a public or private social services agency.
- Knowledge of computer software applications such as Microsoft Word and Microsoft Excel.
- Knowledge of English spelling, punctuation and grammar.
- Must pass a personal background investigation.
- Must possess and maintain a valid driver’s license.

Safety and Training Requirements

The County expects each individual employee to cooperate in every respect with the Safety Program so that the operations may be carried on in such a manner as to ensure the safety of all employees. The employee's responsibility is to be consistent with OSHA regulations, the Winona County Personnel Policies and Procedures Manual, the countywide safety rules, department safety rules, and specific job training.

Behavior Standard

Maintain a positive work atmosphere by acting and communicating in a manner so that you get along with customers, clients, co-workers and management.

_____ _____

Date Approved County Administrator

Physical, Mental and Environmental Requirements

Part I: Physical Requirements

Section A
The physical mobility requirements of this job are to spend:

5	hours a day sitting
1.5	hours a day standing
1.5	hours a day walking
	hours a day kneeling
	hours a day stooping
1	miles a day walked
	feet climbed using a ladder
	feet climbed on an incline
25	feet climbed using stairs

Section B
The physical effort requirements of this job are

# of pounds lifted	
10	pounds lifted waist high
	pounds lifted shoulder high
	pounds lifted above the head

pounds are...	
X	pounds are carried alone
	pounds are carried with someone else
15	distance weight must be carried (feet)
	pounds are pushed
	pounds are pulled
X	pounds are held

Section C
The physical dexterity requirements of this job are to operate:

X	a telephone
X	computer/electronic equipment
	hand tools
	electric tools
	manipulate small objects

Part II: Sensory Abilities

The checked items listed below are sensory requirements needed for this job. Items are critical, useful, or not required.

critical	useful	
X		See
	X	distinguish colors
X		hear or listen
	X	Taste
X		Smell
	X	Touch
X		speak

Part III: Mental Effort

The mental efforts required on a daily basis are:

X	reading	X	analyzing data
X	writing	X	searching for solutions
X	basic arithmetic	X	creating methodologies
X	mathematics	X	conducting research
	weighing and/or measuring	X	managing resources
X	visualizing conclusions		evaluating performance of others

Part IV: Work Environment

The elements of this job's work environment are:

5	hours a day spent working **under time pressure**
4	Hours a day spent working **rapidly**
95	% of time spent **indoors**
5	% of time spent **outdoors**
10	% of time spent **in an automotive vehicle**
80	% of time spent **at a desk, bench or window**
80	% of time spent **in an office or control room**

X	The condition of the air is **clean (controlled)**
X	The condition of the air is **normal/average**
X	The condition of the air is **dusty/dirty**
X	The condition of the air is **wet/humid**
X	The condition of the air is **affected by fumes, smoke etc.**

X	The noise level is **normal**
	The noise level is **loud, requiring ear protection**
X	The surface of the working environment is **level**
	The surface of the working environment is **sloping**
	The surface of the working environment is **uneven**
X	The surface of the working environment is **slippery**

Part V: Additional Comments:

WINONA COUNTY RE-ENTRY ASSISTANCE PROGRAM PLUS (WRAP+)

POSITION DESCRIPTION FOR GRANT MANAGER

Individuals in this position will be responsible for the overall programmatic and fiscal management of the program.

Examples of Programmatic Duties:

- Coordinate, attend and document all meetings of the WRAP+ Task Force
- Attend and document all meetings of the Planning Committees (Human Resources, Training, Policy, Data & Evaluation and Screening/Assessment)
- Attend and document all technical assistance provider meetings
- Create and distribute program forms and promotional literature.
- Maintain/update program policy guides/manuals/forms and funding guidelines
- Receive, review and approve requests for funding for recovery support services.
- Monitor the goals and objectives for program development, implementation and outcomes.
- Research and recommend strategies for improving the program.
- Maintain accurate records of all program activities.
- Ensure compliance with all federal, state and local rules and regulations, including any grant requirements.
- Serve as a spokesperson for the WRAP+ Program to the public, promoting the program both locally and in other jurisdictions

Examples of Fiscal Duties:

- Complete DOJ Financial Management Training
- Manage grant's fiscal operations in conjunction with the Winona County Finance Director.
- Organize and prepare required grant reports.
- Accurately record program expenditures and prepare expenditure reports as needed.
- Research, analyze and implement federal, state and local rules and regulations.
- Monitor compliance with grant restrictions and reporting.
- Establish efficiencies to create timelier information with less manual involvement.
- Make recommendations for corrections or budget transfers when needed.
- Compile and analyze program, grant and financial data.
- Maintain accurate records, including documentation of grant expenditures, and make them available for site visits or grant audits.

WRAP+ Data Collection Responsibility Chart
Updated 1/6/24

TASK FORCE & IMPLEMENTATION COMMITTEE	Source	Management Info System	Responsibility for Collecting	Reported
# of Task Force Meetings	Task Force Minutes	GM Spreadsheet	GM	Quarterly PMT; Process Evaluation
Attendance at Task Force Meetings by Group Represented	Task Force Minutes	GM Spreadsheet	GM	Quarterly PMT; Process Evaluation
Time (in hours) for Task Force Meetings	Task Force Minutes	GM Spreadsheet	GM	Quarterly FSR; Process Evaluation
# of Implementation Committee Meetings	Task Force Minutes	GM Spreadsheet	GM	Quarterly PMT; Process Evaluation
Attendance at Implementation Committee Meetings by Group Represented	Task Force Minutes	GM Spreadsheet	GM	Quarterly PMT; Process Evaluation
Time (in hours) for Implementation Committee Meetings	Task Force Minutes	GM Spreadsheet	GM	Quarterly FSR; Process Evaluation
TRAININGS	Source	Management Info System	Responsibility for Collecting	Reported
# of training sessions offered	Training attendance sheets	HVMHC Spreadsheet	HVMHC (CF), GM	Quarterly PMT; Process & Outcome Evals
Groups represented at trainings (by type)	Training attendance sheets	HVMHC Spreadsheet	HVMHC (CF), GM	Quarterly PMT; Process & Outcome Evals
# of people trained	Training attendance sheets	HVMHC Spreadsheet	HVMHC (CF), GM	Quarterly PMT; Process & Outcome Evals
Time (in hours) of training provided	Training attendance sheets	HVMHC Spreadsheet	HVMHC (CF), GM	Quarterly PMT & FSR Process & Outcome Evals
Training topic and presenter	Training flyers	N/A	HVMHC (CF), GM	Quarterly PMT; Process & Outcome Evals
% of trained persons who indicated that the training was helpful or would assist them in their job	Post training survey	HVMHC Spreadsheet	HVMHC (CF), GM	Process & Outcome Evals
TECHNICAL ASSISTANCE	Source	Management Info System	Responsibility for Collecting	Reported
Frequency of TA contacts	TA Minutes	N/A	GM	Quarterly PMT

				Process Evaluation
Type of TA Contact	TA Minutes	N/A	GM	Quarterly PMT Process Evaluation
Satisfaction level of TA Contacts	TA Minutes	N/A	GM	Quarterly PMT Process Evaluation
PARTICIPANT AND SERVICES (number of participants)	Source	Management Info System	Responsibility for Collecting	Reported
# of people eligible to participate in the program? (screened)(includes people booked into jail and those outside of jail who completed screening) CANDIDATE	Daily New Arrest Form or LETG and WRAP+ apps from non-jailed persons	JIW Spreadsheet	JIW	Quarterly PMT Outcome Evaluation
# of people who applied for admission to program APPLICANT	Applicatons	JIW Spreadsheet	JIW	Quarterly PMT Outcome Evaluation
# of people selected to participate (those who were chosen to participate but may or may not have actually enrolled)—ACCEPTED APPLICANT	Target Population Verification	JIW Spreadsheet	JIW	Quarterly PMT Outcome Evaluation
# of people who were admitted to the program during the reported period (receive services) WRAP+ PARTICIPANT	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of total participants (including NEW this quarter and existing)	GM Records	GM Spreadsheet	JIW	Quarterly PMT Outcome Evaluation
PARTICIPANT AND SERVICES (Risks/Needs Assessment)	Source	Management Info System	Responsibility for Collecting	Reported
# of people receiving risk assessment	MHP, JSW & TCC records	CL and Treatment Court Software; SSIS	MHP, JSW & TCC	Quarterly PMT Outcome Evaluation
# of people assessed at different levels (high/moderate/low)	MHP, JSW & TCC records	CL and Treatment Court Software; SSIS	MHP, JSW & TCC	Quarterly PMT Outcome Evaluation
PARTICIPANT AND SERVICES (Case Plans)	Source	Management Info System	Responsibility for Collecting	Reported
# of people receiving a case plan for the first time during reporting period	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
PARTICIPANT AND SERVICES (Mental Health Services)	Source	Management Info System	Responsibility for Collecting	Reported

# of people who received mental health **screen** this reporting period	WRAP+ Application	JIW Spreadsheet	JIW	Quarterly PMT Outcome Evaluation
# of people who underwent **clinical assessment** for MI or co-occurring this reporting period	MHP, JSW & TCC records	CL and Treatment Court Software; SSIS	MHP, JSW & TCC	Quarterly PMT Outcome Evaluation
# of people whose case plan included mental health services	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of people who **received** mental health services from a treatment provider	MHP & TCC records	CL and Treatment Court Software; SSIS	MHP & TCC	Quarterly PMT Outcome Evaluation
# of people who received mental health services for the first time this reporting period (new participants)	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of days between screening and clinical assessment	WRAP+ Application & Assessment	GM Spreadsheet	GM	Process & Outcome Evaluation
# of days between referral for treatment (clinical assessment) and start of treatment	Online referral (CL) & medical records	CL, SSIS, Treatment Court Software	MHP, TCC and JSW	Process & Outcome Evaluation
PARTICIPANT AND SERVICES (Substance Use Disorder Services)	Source	Management Info System	Responsibility for Collecting	Reported
# of people who received SUD **screen** this reporting period	WRAP+ Application	JIW Spreadsheet	JIW	Quarterly PMT Outcome Evaluation
# of people who underwent **clinical assessment** for SUD or co-occurring this reporting period	MHP, JSW & TCC records	CL and Treatment Court Software	MHP, JSW & TCC	Quarterly PMT Outcome Evaluation
# of people whose case plan included SUD services	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of people who **received** SUD services from a treatment provider	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of people who received mental health services for the first time this reporting period (new participants)	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of people enrolled in SUD treatment program for at least 90 days	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation

# of people enrolled in SUD treatment program for at least 90 days who were tested for substances during reporting period	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of people enrolled in SUD treatment program for at least 90 days who tested positive during the reporting period, regardless of the # of positive tests	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of days between screening and clinical assessment	WRAP+ Application & Assessment	GM Spreadsheet	GM	Process & Outcome Evaluation
# of days between referral for treatment (clinical assessment) and start of treatment	Online referral (CL) & medical records	CL, SSIS, Treatment Court Software	MHP, TCC and JSW	Process & Outcome Evaluation
PARTICIPANT AND SERVICES (Co-Occurring Disorder Services)	Source	Management Info System	Responsibility for Collecting	Reported
# of people whose case plan included co-occurring disorder services	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of people who **received** co-occurring disorder services from a treatment provider	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of people who received co-occurring disorder services for the first time this reporting period (new participants)	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
PARTICIPANT AND SERVICES (Employment Services)	Source	Management Info System	Responsibility for Collecting	Reported
# of people whose case plan included employment services or employment goal *specify standard services v. supportive services (for people with disabilities)	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of people who **received** employment services *specify standard services v. supportive services	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of people who received employment services for the first time (new participants) *specify standard services v. supportive services	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation

# of people receiving employment services who obtained employment this reporting period (report only once)	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of people receiving employment services who maintained employment for three or more months	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
PARTICIPANT AND SERVICES (Educational Services)	Source	Management Info System	Responsibility for Collecting	Reported
# of people whose case plan included educational services or educational goal	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of people who **received** educational services	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of people who received educational services for the first time (new participants)	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of people receiving educational services who earned a ___GED ___high school diploma ___vocational certificate ___higher education degree	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
PARTICIPANT AND SERVICES (Housing Services)	Source	Management Info System	Responsibility for Collecting	Reported
# of people whose case plan included housing services or housing goal *specify standard services v. supportive services (for people with disabilities)	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of people who **received** housing services *specify standard services v. supportive services	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of people who received housing services for the first time (new participants) *specify standard services v. supportive services	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation

# of people receiving educational services who achieved the following ___obtained housing (report only once) ___were housed for 3 or more months	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
PARTICIPANT AND SERVICES (Medication Assisted Treatment)	Source	Management Info System	Responsibility for Collecting	Reported
# of participants eligible for MAT during reporting period	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of participants who received MAT during reporting period	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
PARTICIPANT AND SERVICES (Program Completion)	Source	Management Info System	Responsibility for Collecting	Reported
# of participants who are no longer receiving services (left program during reporting period)	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of participants who successfully completed the program during program period *graduation from treatment court or completion of at least one pathway	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of participants who terminated due to (must select only 1 per participant) _____court or criminal involvement _____lack of engagement _____ absconding _____ relocating or case transfer _____ death or serious illness _____other reasons_____	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
PARTICIPANT AND SERVICES (Overall Progress in Program by Graduates)	Source	Management Info System	Responsibility for Collecting	Reported
-# of total graduates	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
-# of graduates who, during program participation ___received MH assessment ___received SUD assessment	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Outcome Evaluation

___established mental health treatment ___established SUD treatment ___maintained MH treatment for at least 90 days ___achieved at least 90 days sobriety ___improved housing situation ___improved employment situation ___obtained driver's license ___improved financial status ___reduced RANT score or LSCMI ___percent of case plan completed upon graduation				
Same as above, but differentiated by demographics: race, gender, sex, age	MHP, SW & TCC records	GM Spreadsheet	GM	Outcome Evaluation
Graduate reported improvement in overall functioning	Participant survey	GM Spreadsheet	GM	Outcome Evaluation
AFFORDABLE CARE ACT	Source	Management Info System	Responsibility for Collecting	Reported
# of new participants (new this reporting period) who entered program with any health care coverage at all	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of new participants who entered program with Medicaid coverage	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of participants who were eligible for health care coverage this reporting period	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of eligible participants who were eligible for Medicaid coverage	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of participants who were enrolled in any health care coverage during the reporting period	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of participants who were enrolled in Medicaid coverage during the reporting period	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation

# of participants EXITING the program this reporting period who were eligible for any health care coverage	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of participants EXITING the program this reporting period who were eligible for Medicaid coverage	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of participants EXITING the program this reporting period who were enrolled at exit in any health care coverage	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
# of participants EXITING the program this reporting period who were enrolled at exit in Medicaid coverage	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation
RECIDIVISM	Source	Management Info System	Responsibility for Collecting	Reported
# of program recidivating program participants who are still participating in the program	Jail records; court records; GM Records	LETG; MNCIS; GM Spreadsheet	JIW; GM	Quarterly PMT Outcome Evaluation
# of participants who received services in a community based program who were sent to jail during reporting period	Jail records; court records; GM Records	LETG; MNCIS; GM Spreadsheet	JIW; GM	Quarterly PMT Outcome Evaluation
# of participants who were sent to jail or prison during reporting period who were sent for _____administrative violations (no new offense) _____new offense or charge	Jail records; court records; GM Records	LETG; MNCIS; GM Spreadsheet	JIW; GM	Quarterly PMT Outcome Evaluation
# of total days in jail or prison for all participants during reporting period	Jail records; GM Records	LETG; GM Spreadsheet	JIW; GM	Quarterly PMT Outcome Evaluation
# of participants who underwent a pre-petition screen during reporting period	Social services records	SSIS	JSW	Outcome Evaluation
# of participants who received services in a community-based program who were sent to a hospital or inpatient mental health facility due to a mental health crisis during reporting period	MHP & TCC records	CL and Treatment Court Software	MHP & TCC	Quarterly PMT Outcome Evaluation

FUNDING	Source	Management Info System	Responsibility for Collecting	Reported
# of participants receiving Tier 1 Funding (Accepted Applicants)	GM Records; Finance Records	GM Quickbooks; Finance	GM	Outcome Evaluation
$$ amount of Tier 1 Funding for ___ Assessments ___ Monitoring Services	GM Records; Finance Records	GM Quickbooks; Finance	GM	Outcome Evaluation
# of participants receiving Tier 2 Funding (WRAP+ Participants)	GM Records; Finance Records	GM Quickbooks; Finance	GM	Outcome Evaluation
$$ amount of Tier 2 Funding for Recovery Support Services (by category)	GM Records; Finance Records	GM Quickbooks; Finance	GM	Outcome Evaluation
# of participants receiving Tier 3 Funding (Alumni)	GM Records; Finance Records	GM Quickbooks; Finance	GM	Outcome Evaluation
$$ amount of Tier 3 Funding for Recovery Support Services (by category)	GM Records; Finance Records	GM Quickbooks; Finance	GM	Outcome Evaluation

Abbreviations:
MHP=Mental Health Practitioner
CL=Care Logic
CF=Christy Ferrington
Finance Records: Winona County Finance Records
FSR-Financial Status Report
GM-Grant Manager
HVMHC=Hiawatha Valley Mental Health Center
JIW=Jail Intake Worker
JSW=Jail Social Worker
LETG=Law Enforcement Technology Group
MNCIS=Minnesota Court Information System
PMT = Performance Measure Report
SSIS=Social Services Information System
TCC=Treatment Court Coordinator

WRAP+ Client Intake & Discharge Data Summary (Revised 8/21/23)

Client Name:_____ **Birthdate:**_____

Case Manager:_____ **Intake Date:** _____ **Discharge Date:**_____

I-intake; D-discharge	Applies to Client
HOUSING SITUATION	
Incarcerated	
Homeless	
Temporary housing (includes inpatient)	
Living with family	
Renting	
Own home	
Unknown	
EMPLOYMENT	
Unemployed	
Seasonal/Part time	
Full time	
Other	
Unknown	
FINANCIAL	
No Income	
Social Security	
Government Subsidy (not SS)	
Disability Income (not SS)	
Family Assistance	
Job (full or part-time)	
Unknown	
IDENTIFICATION	
Valid ID?	
Social Security Card?	
Birth Certificate?	
Unknown	
DRIVER'S LICENSE STATUS	
Never had a driver's license	
Driver's license – not currently valid	
Valid driver's license	
Unknown	
TRANSPORTATION STATUS	
Walking/bicycling (self transportation)	
Public transportation (bus)	
Rely on private parties (friends/family)	
Has own vehicle	
Unknown	
COMMUNICATION STATUS	
Reliable method of communication?	
HEALTH INSURANCE	
No health insurance	
Medical Assistance	
Other subsidized insurance	
Private/employer provided insurance	
Unknown	
EDUCATION	
Less than high school diploma or GED	
GED or high school diploma	
Some college or tech school	
College or tech school graduate	
Unknown	

I-intake; D-discharge	Applies to Client
PHYSICAL HEALTH	
No established healthcare provider	
Healthcare provider – no visits in past year or not taking meds as prescribed	
Healthcare provider – sees regularly; taking meds as prescribed	
Unknown	
FAMILY/VISITATION STATUS	
No minor children or rights terminated	
Has minor children – no/very little contact	
Has minor children – non-custodian, regularly visits children	
Has minor children – is custodial parent	
Has adult children – little/no contact/relationship	
Has adult children – good relationship	
Unknown	
COURT/CRIMINAL JUSTICE/CHIPS	
Not compliant with probation/CJ Orders	
Compliant with probation/CJ Orders	
CHIPS Case – Not compliant	
CHIPS Case – Compliant	
Unknown	
MENTAL HEALTH ASSESSMENT (MHA)	
Has not received MHA (or MHA is no longer valid)	
Has received MHA-no treatment recommended	
Has received MHA-treatment recommended	
Unknown	
MENTAL HEALTH THERAPY (MH)	
Not receiving MH services	
Receiving MH services but poor attendance	
Receiving MH services with good attendance	
Completed MH Treatment	
Unknown	
MENTAL HEALTH MEDICATIONS	
Not currently prescribed medications	
Prescribed meds, not taking as prescribed	
Prescribed meds, taking as prescribed	
Unknown	
CHEMICAL HEALTH ASSESSMENT (CHA)	
Has not received CHA (or CHA is no longer valid)	
Has received CHA-no treatment recommended	
Has received CHA-treatment recommended	
Unknown	
CHEMICAL DEPENDENCY TREATMENT	
Not receiving CD Services	
Receiving CD services but poor attendance	
Receiving CD Services with good attendance	
Completed CD Treatment	
Unknown	

2021-2024 WRAP+ Data Collection Form
Complete at end of quarter for each WRAP+ Client (Rev. 9/6/23)

Client Name		**DOB:**	
Form Completed by:		**Date:**	
Year Being Reported:	**Circle one:** 2021	2022	2023 2024
Quarter Being Reported:	**Circle one:** Q1 (Jan-Mar) Q2 (Apr-Jun) Q3 (Jul-Sep) Q4 (Oct-Dec)		

Data Element	RESPONSE	#
RISK ASSESSMENT		
Received this quarter?	Trish	43A
Type of assessment?	Trish	
Assessed risk level?	Trish	43B
CASE MANAGEMENT		
Received this quarter?		
Received a case or transition plan for the 1st time this quarter?		48
MENTAL HEALTH SERVICES		
Assessed for services this quarter?		50A
Received services this quarter?		50B
Received for 1st time this quarter?		50C
Participant sent to hospital or inpatient due to MH crisis during reporting period?		74
SUBSTANCE USE DISORDER SERVICES		
Assessed for services this quarter?		51A
Received services this quarter?		51B
Received for 1st time this quarter?		51C
Enrolled at least 90 days in substance use disorder program?		54A
If yes, was person tested for use of alcohol or illicit substances?		54A
If tested, did person test positive on any test?		54B
CO-OCCURRING DISORDER SERVICES		
Assessed for services this quarter?		55A
Received services this quarter?		55B
If yes, what type? (Parallel, Sequential, Integrated?)		56
Received for 1st time this quarter?		55C
EMPLOYMENT SERVICES		
Assessed **as needing** services?		57A
If yes, standard or supportive?		57A
Received services this quarter?		57B
If yes, standard or supportive?		57B
If yes, obtained job?		58B
If yes, had job for 90 days+?		58C
Rec'd services for 1st time this Q?		57C
If yes, standard or supportive?		57C
EDUCATION SERVICES		
Assessed **as needing** services this Q?		59A
Received services this quarter?		59B
If yes, rec'd GED certificate?		60A
If yes, rec'd HS diploma?		60B
If yes, earned vocational cert?		60C
If yes, earned higher ed degree?		60D
Rec'd for 1st time this quarter?		59C

Data Element	RESPONSE	#
HOUSING SERVICES		
Assessed **as needing** services this quarter?		61A
If yes, standard or supportive?		61A
Received services this quarter?		61B
If yes, standard or supportive?		61B
How many obtained housing this Q?		62B
Were housed for 90+ days?		62C
Received for 1st time this quarter?		61C
If yes, standard or supportive?		61C
MEDICATION ASSISTED TREATMENT (MAT)		
Eligible for MAT this quarter?		66A
Received MAT this quarter?		66A
If yes, what type? (Methadone, Suboxone, Naltrexone/Vivitrol?)		65
PROGRAM COMPLETION		
Leave program during reporting period?		67.
Reason for leaving program?		
Successful completion		69.
Court/criminal involvement		70A.
Lack of engagement		70B.
Absconding		70C.
Relocating or case transfer		70D.
Death or serious illness		70E.
Other (specify)		70F.
RECIDIVISM (only complete if Yes to #67)		
Participant sent to jail/prison?		71
Reason: admin/technical violation?		72.
Reason: new charge		72
How many days in jail during reporting period?		73
HEALTH INSURANCE SERVICES		
Did person already have health ins?		ACA3
If yes, what type of coverage? (MA, etc)		ACA3
If no, was person eligible for insurance?		ACA3
If eligible, was person enrolled in health care coverage this quarter?		ACA3
If enrolled, what type of coverage?		ACA3
Insurance at program exit?		ACA3

Additional Data (new participants only)	Date	Score
Application Date		
When accepted to program (target popul)		
Completed Diagnostic Assessment		
Completed CD Assessment		
First mtg with CM? (or accepted into TC)		
Kalene Complete Below		
BJMHS Score		
TCUDSV Score		
Criminal Justice Involvement Score		
MN PAT Score		

Data Collection Guide for
WRAPRevised 1/6/24

NOTE: For questions relating to MENTAL HEALTH, SUBSTANCE USE and CO-OCCURING DISORDERS, if the person received services this quarter, you must answer YES to the question of whether they were **"assessed for"** services, even if they did not have a formal assessment this quarter. Only if a person did not RECEIVE or NEED those services, can you answer NO to the "assessed for" question. For questions relating to EMPLOYMENT, EDUCATION AND HOUSING, if a person received services this quarter, you must answer yes to the **"assessed as needing"** services. Otherwise, if a client did not NEED or RECEIVE those services, you can answer NO to the "assessed as needing service."

	PARTICIPANT NUMBERS
40A. Trish	How many people were eligible to participate in the program during the reporting period? *Eligible people include anyone who qualifies or meets the programs predefined requirements.* **For WRAP+, this is the number of ACCEPTED APPLICANTS.**
40B. Kalene	Of those eligible, how many were selected to participate in the program during the reporting period? *"Participants selected" includes those who were chosen to participate in the program but may or may not have actually enrolled.* **FOR WRAP+, this is the number of WRAP Participants (those accepted applicants who have signed a release of information and have completed an assessment.)**
40C. Kalene	Of those selected, how many NEW participants were admitted to the program during the reporting period? *Admissions are defined as new participants who receive services in the program. For the first reporting period that the grantee becomes operational, report all participants enrolled as new.*
40D. Kalene	During the reporting period, how many total people participated in the program? **(New participants and those already enrolled).**
	RISK ASSESSMENT
43.A. Trish	How many people received a risk assessment during the reporting period? (ORAS-CSST) *A risk and need assessment is an instrument to help identify risk factors and criminogenic needs that may lead an offender to reoffend. It pinpoints needed services to minimize those risks*.
43.B – 43.E Trish	Of those assessed, how many were assessed at the following levels: -Low risk/need; -high risk/need; -do not know/unsure **Risk: RANT - High Risk**
48.	How many participants received a transition or case plan for the first time during the reporting period? (For new participants, this should be a yes, as this is the first case plan through the WRAP+ program. Thus, for example, **participants who have a**

	CHIPS case plan prior to admission but are new participants to WRAP+ in the quarter being reported should have a YES to this question). *A case plan is designed to reduce criminogenic need and behavioral health need and to support reintegration of people into the community. Do not count those individuals who had minor revisions to the case plan. Only count those who were reassessed and, as a result, needed new or major revisions to their plan.*
	MENTAL HEALTH SERVICES
50.A.	During the reporting period, how many people were **assessed for** mental health services?
50.B.	Of those assessed, how many people received mental health services?
50.C	Out of those who received mental health services, how many received services for the first time during the reporting period (i.e. new participants) **Similar to Q48, this should be a YES for new participants to WRAP+, as all WRAP+ participants should be receiving some type of mental health services during the 1st quarter, even if it is only an assessment.**
74.	Was program participant who received services w/in a community-based program sent to a hospital or inpatient facility because of a mental health crisis during the reporting period?
	SUBSTANCE USE DISORDER SERVICES
51.A	During the reporting period, how many people were assessed for substance use disorder services?
51.B	Of those assessed, how many people received substance use disorder services?
51.C	Out of those who received substance use disorder services, how many received services for the first time during the reporting period (i.e. new participants)
54A. & B.	Of those enrolled in a substance use disorder treatment program for at least 90 days, please enter the number of participants who were tested and the number who tested positive for the presence of alcohol or illicit substances during the reporting period. (Only count each participant once, regardless of the number of tests) # of participants tested_____ # of participants testing positive_____
	CO-OCCURRING DISORDERS
55.A.	During the reporting period, how many people were assessed for co-occurring disorders?
55.B	Of those assessed, how many people received co-occurring disorder services?
55.C	Out of those who received co-occurring disorder services, how many received services for the first time during the reporting period?
56.	Which of the following co-occurring disorder treatment models do you follow? Sequential (one, then another); Parallel (concurrent); Integrated (providing both in the same setting)
	EMPLOYMENT SERVICES
57A.	During the reporting period, how many people were assessed **as needing** employment services? # needing standard services_____

	# needing supportive services _____ (like ORC) *Please separate those who receive standard employment services and those who receive supportive services. Supportive services are service provisions where people with disabilities are assisted with obtaining and maintaining employment.*
57B.	Of those assessed, how many people received employment services? # needing standard services_____ # needing supportive services_____
58.A-C	During the reporting period, how many participants who were directly provided with employment services accomplished the following: Not tracked_____ Obtained employment_____ (report this only once) Maintained employment for 3 or more months _____ *(Participants are considered to have maintained employment if they lost a job and found a new one w/in 30 days*).
57C.	Of those who received employment services, how many received them for the 1st time during the reporting period? # needing standard services_____ # needing supportive services_____
	EDUCATION SERVICES
59A.	During the reporting period, how many people were assessed **as needing** educational services?
59B.	During the reporting period, how many people received educational services?
60.A-E.	During reporting period, how many participants who were directly provided w/educational services achieved the following: Not tracked_____ Earned a GED certificate_____ Earned a high school diploma_____ Earned a vocational certificate_____ Earned a higher education degree____
59C.	Of those who received educational services, how many received services for the first time during the reporting period?
	HOUSING SERVICES
61.A.	During the reporting period, how many people were assessed **as needing housing** services? *Please separate those who receive standard housing services and those who receive supportive services. Supportive services are service provisions where people with disabilities are assisted with obtaining and maintaining housing*. Standard_____ Supportive_____
61.B	During the reporting period, how many people received housing services? Standard____ Supportive_____
62.	During the reporting period, how many participants who were directly provided with housing services achieved the following: Not Tracked:_____ Obtained housing_____ (report only once) Were housed for 90 days or more _____

61.C	Out of those who received housing services, how many received housing services for the 1st time during the reporting period. Standard_____ Supportive_____
	MEDICATION ASSISTED TREATMENT
65.	If your treatment program includes MAT, which of the following medications are you utilizing, regardless of BJA funding: Naltrexone___ Buprenophine or Naloxone (Suboxone)_____ Methadone_____
66A.	How many participants were deemed eligible for MAT (Medication Assisted Treatment) during the reporting period: ____
66A.	Participants receiving MAT____
	PROGRAM COMPLETION
67.	Did any participants leave the program?
69.	How many participants successfully completed the program during the reporting period?
70A-F.	How many did not complete and why? Due to court or criminal involvement (i.e. technical violation, arrest, conviction, revocation, reincarceration)____ Due to lack of engagement (no-shows and nonresponsive participants)_____ Due to absconding_____ Due to relocating or case transfer_____ Due to death or serious illness_____ Other/explain_____
	RECIDIVISM
71.	Were any participants who received services within a community-based program sent to jail or prison (e.g. as a sanction) during the reporting period? How many?
72.	Why were they sent to jail/prison? Administrative/technical violation_____ New charge ___
73.	How many days total did participants send in jail or prison during the reporting period?
	HEALTH INSURANCE
ACA3	Did person already have insurance when he/she entered the program?
ACA3	If yes, what kind? *Health care coverage includes both private health insurance and government health benefits. Examples include health insurance that is employment based, marketplace coverage/self-insured, Medicare, Medicaid, military health care or benefits from the Dept of Veterans Affairs.*

ACA3	If no insurance, was person eligible for health insurance?
ACA3	If no insurance and eligible, was person enrolled in health care coverage this quarter?
ACA3	If enrolled in coverage this quarter, what type of coverage?
ACA4	For those participants who exited the program, specify what type of insurance coverage they had, if any.
	NEW PARTICIPANT DATA
X1	On what date did applicant complete application for the program?
X1	What date was the person accepted into the program as an accepted applicant per the Target Population sheet?
X3	When did the applicant complete a diagnostic assessment?
X4	When did the applicant complete a chemical dependency assessment?
X5	When did the client first meet with a case manager? For those participants who are treatment court participants, please use the date of acceptance to treatment court.

WINONA COUNTY REENTRY ASSISTANCE PROGRAM+
CONFIRMATION OF PARTICIPANT STATUS ***(Revised 8/22/23)***
To be completed by the case manager. Internal Use Only.

Client Name: _____ DOB:_____
First Name/Last Name

NOTE: In order for an Accepted Applicant to become a Participant, the Accepted Applicant must sign a WRAP+ Release of Information AND must have a valid comprehensive mental health evaluation that recommends ARMHS (unless the Accepted Applicant is a Treatment Court Participant). Funding is available to Accepted Applicants to pay for a comprehensive mental health evaluation if there are no other funding sources for that assessment. To access funding, the Case Manager should complete a Funding Request Form.

☐ The above client has signed a WRAP+ Release of Information. Date signed:_____

☐ The above client has a valid comprehensive mental health evaluation. Details are provided below:

- **Date of Assessment:**_____ **Type of Assessment:**_____
- **Assessing Agency/Individual:**_____
- **Diagnosis:**_____
  _____
- **Treatment Recommendations:**_____
  _____

  ☐ ARMHS is one of the treatment recommendations (must be checked, unless Accepted Applicant is in treatment court).

Although a chemical dependency assessment is not required for an Accepted Applicant to become a Participant, data on CD assessments is being collected for grant reporting purposes. Please provide the following information on the most recent chemical dependency assessment completed by the above individual.

- **Date of Assessment:**_____ **Type of Assessment:**_____
- **Assessing Agency/Individual:**_____
- **Diagnosis:**_____
  _____
- **Treatment Recommendations:**_____
  _____

Case Manager Name:_____Date Completed/Updated:_____

Printed Name:_____ Title:_____

Please e-mail this form to Kalene Engel at kalene@engellawoffice.com when complete so that the change in status can be recorded and the Accepted Applicant's file can be transferred to the Participant folder. Kalene will transfer the folder from the Accepted Applicant to the Participant folder.

WINONA COUNTY REENTRY ASSISTANCE PROGRAM+ FUNDING REQUEST APPEAL FORM

Revised 9/6/23

Discretionary Funding Request
(to be completed by case manager only)

Name of client::_____ Length of time in WRAP+_____

Amount of funding already received:_____ Amount of funding requested:_____

Purpose for funding request (what is it for):_____

Other funding sources explored and results:_____

Rationale for request (how does this support individual's case plan):_____

_____

Case Manager:_____ Date:_____

Participant Appeal to Task Force
(to be completed by participant only)

☐ I would like to appeal to the WRAP+ Task Force to re-consider whether I should receive WRAP+ Funding.

Amount of funding already received:_____ Amount of funding requested:_____

Purpose for funding request (what is it for):_____

Other funding sources explored and results:_____

The reason or reasons that I believe that I should receive funding are listed below:

_____

_____

_____ _____ _____
Printed Name Signature Date

_____ _____
Phone Number E-mail address

Return completed form to Kalene Engel at kalene@engellawoffice.com

WINONA COUNTY REENTRY ASSISTANCE PROGRAM+ COMPREHENSIVE EVALUATION REFERRAL FORM

Revised 9/6/23

(to be completed by the person referring the Accepted Applicant for a Comprehensive Evaluation at HVMHC)

INFORMATION ABOUT PERSON BEING REFERRED

Full Name:_____

Mailing Address:_____

DOB:_____ **Age:**_____ **Gender ID: □ Male □ Female**

Phone: (_____)_____□ Cell □ Home **E-mail:**_____

Alternative Contact Name/Number: _____

Date Accepted to WRAP+_____ **Type of Insurance:**_____

INFORMATION ABOUT REFERRAL SOURCE

□ **Trish Chandler,** Jail Intake Worker, Phone: 507-457-6539, tchandler@co.winona.mn.us

□ **Trish Costello,** Mental Health Practitioner, Phone: 507-961-6509, trishc@hvmhc.org

□ **Carin Hyter,** Treatment Court Coordinator, Phone: 507-457-6434, chyter@co.winona.mn.us

□ **Sierra Schier,** Mental Health Practitioner, Phone: 507-961-6495, sierras@hvmhc.org

□ **Katie Schild,** Criminal Justice Social Worker, Phone: 507-457-6483, kschild@co.winona.mn.us

□ **Self-Referral: The person being referred is making his/her own arrangements for a CE.**

□ **Other:**_____

INFORMATION ABOUT PERSON RECEIVING REFERRAL

X Christy Ferrington, Adult Community Based Services Dir., Phone: 507-429-9885, ChristyF@hvmhc.org

X Kate Dieter, Adult Community Based Services Coord., Phone: 507-429-9885, kated@hvmhc.org

X Kalene Engel, WRAP+ Grant Manager, Phone: 507-453-3646, kalene@engellawoffice.com

□ **Kim Page,** Office Manager, Phone: 507-725-2022, kimp@hvmhc.org

□ **Barbara Von Cor,** Intake Coordinator, Phone: 507-474-9320, barbaravc@hvmhc.org

□ **Other:**_____

RELEASE OF INFORMATION ATTACHED

□ Accompanying this Referral Form is a valid Release of Information which authorizes HVMHC to provide information on the status of the Evaluation and the Evaluation itself to the Referral Source.

Date of Referral:_____ **Signed:**_____

WRAP+ Process for Getting Probation Agreements
Last revised 7.18.23

- Standard conditions of probation and pretrial: there are standard conditions that exist for anyone who is on probation or pretrial supervision (like remain law abiding, etc). Rena will send those to me and I will forward to you. Thus, if any of the WRAP+ Participants are on probation or pretrial, those conditions automatically apply.

- Probation or Pretrial Agreements: To get copies of any probation or pretrial agreements, at the time when you are completing the Confirmation of Participant Status for, send an email to Renee Rumpca (renee.rumpca@state.mn.us) with the WRAP+ ROI signed by the Participant asking if the person is on supervision and, if so, requesting copies of any supervision agreements. This should be done for all Participants, as they may not always accurately self report (or even know) if they are on supervision. By limiting this to Participants, we will limit the number of emails to which Renee has to respond, while still getting the information we need for case planning purposes.

- Example language is below:
  Attached is an ROI for XXXX, who is a participant in WRAP+. Could you please tell me if XXX is on supervision with your office? If so, could you please send me the supervision agreements and contact information for the supervising agent.

- Renee will respond to all emails, even if the person is not on supervision. If the person has a probation or pretrial agreement, she will email that to the requestor.

- Renee's responsive email will also cc: the assigned agent, so that they are aware of the participation in the program and the assigned caseworker.

- Rena noted that her office if very short staffed due to some vacancies and medical leaves, so it is possible that a different person will be assigned as the point person for the DOC in the future. However, for right now, it is Renee Rumpca.

Winona County Conditions of Probation for each Case Type
Last Updated 7/18/23

Felony conditions:

1. Follow all State and Federal criminal laws.
2. Contact your probation officer as directed.
3. Tell your probation officer within 72 hours if you have contact with law enforcement.
4. Tell your probation officer within 72 hours if you are charged with any new crime.
5. Tell your probation officer within 72 hours if you change your address, employment, or telephone number.
6. Cooperate with the search of your person, residence, vehicle, workplace, property, and things as directed by your probation officer.
7. Sign releases of information as directed.
8. Give a DNA sample when directed.
9. Do not use or possess any firearms, ammunition, or explosives.

Misdemeanor/Gross Misdemeanor conditions:

1. Follow all State and Federal criminal laws.
2. Contact your probation officer as directed.
3. Tell your probation officer within 72 hours if you have contact with law enforcement.
4. Tell your probation officer within 72 hours if you are charged with any new crime.
5. Tell your probation officer within 72 hours if you change your address, employment, or telephone number.
6. Cooperate with the search of your person, residence, vehicle, workplace, property, and things as directed by your probation officer.
7. Sign releases of information as directed.
8. Give a DNA sample when directed.
9. Do not use or possess any firearms, ammunition, or explosives if prohibited by law.

Pre-Trial Monitoring Program conditions:

General Conditions:

1. Contact DOC to set up an appointment immediately following court.
2. Sign all necessary releases of information and intake documents.
3. Keep agent informed of telephone, email address, physical/mailing address and workplace and notify Pre-Trial Agent of any changes within 48 hours.
4. Inform Pre-Trial Agent of police contact within 24 hours.
5. Complete any evaluations ordered by the Court and submit them to the Pre-Trial Agent.
6. Comply with all conditions as stated in the Order for Conditional Release issued by the Court. I acknowledge I have received a copy of the Order for Conditional Release.
7. Remain law abiding and obey all State and Federal laws and all local ordinances.
8. Report to Pre-Trial Agent as directed.

Special Conditions:

DWI cases:

1. Abstain from alcohol and controlled substances unless it is medication prescribed by a physician and taken in the dosages and amounts prescribed.
2. Submit to random testing.

Domestic cases:

1. Have no contact with the victim unless approved by the Court.
2. Comply with any HRO's, OFP's, or DANCO's in effect.

WINONA DISTRICT - PHONE NUMBERS (as of 7.27.23)

WINONA CONTRACT OFFICE
171 W 3RD STREET 5TH FLOOR
WINONA MN 55987
MAIN OFFICE NUMBER: (507) 205-6110
FAX NUMBER: (612) 473-5452

RENA` PATTERSON, SUPERVISOR	(507) 205-6109
RENEE RUMPCA	(507) 205-6108
KRIS SATHER	(507) 205-6107 Work Cell (507) 429-6001
KEVIN BURKE	(507) 205-6119
TERI HENDERSON	(507) 205-6106
BILL MOE	(507) 205-6118 Work Cell (507) 961-4022
MATT HUDSON	(507) 205-6105
MEGAN REICHEL	(507) 205-6114
KYLIE DAVISON - RJ	(507) 205-6117 Work Cell (507) 458-3090
KATIE ILLIES – RJ	(507) 205-6116 Work Cell (507) 205-1932
BERTINA ZAGER	(507) 205-6115

WINONA FELONY OFFICE
370 W. 2nd STREET STE 210
WINONA MN 55987
MAIN OFFICE NUMBER: (507) 205-6100
FAX NUMBER: (612) 473-5451

LOGAN JENSEN	507-703-0269
TAMI DRILL	507-450-5244
DAVID KOHRS	507-312-5673
KATHERINE MEINKE	(507) 730-2741
HUNTER MATZKE	(507) 703-0278
CRAIG WELSH	(507) 450-1295
NICOLE MYERS	(507) 205-6102
SUSAN BANNER-GOTTSCHALK	(507) 205-6103

HOUSTON CONTRACT OFFICE
306 S MARSHALL STREET STE 2400
CALEDONIA MN 55921
MAIN OFFICE NUMBER: (507) 500-5320
FAX NUMBER: (612) 473-5453

NICHOLE KLUG	(507) 703-0258
JENNIFER WURM	(507) 450-8895
DEANNA MCCABE	(507) 500-5710
NANCY WELSH	(507) 500-5325