Intent to participate Health Care Authority in the Reentry Demonstration Initiative

This Intent to Participate form expresses a carceral facility's commitment and intent to participate in the Reentry Demonstration Initiative (Reentry Initiative).

Under this initiative, participating facilities are responsible for:

- Meeting cohort milestones
- Ensuring that a client receives targeted pre-release services
- Adopting an electronic health record (EHR) that supports communication with community providers and Medicaid billing

Once the Health Care Authority (HCA) receives a facility's completed Intent to Participate form, we will release capacity building funding to the facility. We will work collaboratively with participating facilities to help complete their unique implementation plans and readiness assessments.

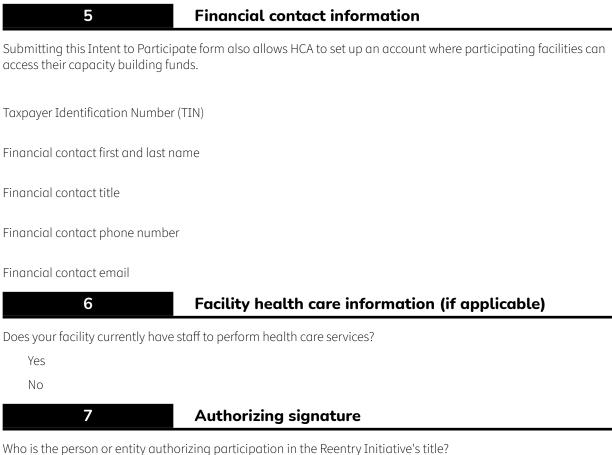
Please note: Once submitted, this document completes Milestone 1. For more information, read our overview.

Instructions

Fill out each section below (in this form) and provide an electronic signature. Then email to our team at **HCAReentryDemonstrationProject@hca.wa.gov** at your earliest convenience.

1 Facility information					
Legal name of the facility		Doing bus	siness as (if diffe	rent)	
Physical address					
Mailing address					
What city (cities), county (counties), jurisdiction	, or Native Am	nerican Tribe(s) does this faci	lity primarily serve?	
Maximum allowed capacity of individuals in fac	cility:				
Average daily population, as of March 2024:	1-49	50-249	250-1,000	More than 1,000	
Facility type:					
State prison					
City or county jail					
Tribal jail					
Vouth correctional facility including inveni	ile rehabilitati	on centers ar	nd iuvenile dete	ntion facilities	
Youth correctional facility, including juveni		on centers ar	·]	indentices	

2	Cohort selection
Which cohort will your facility go	
Cohort 1, go-live July 1, 202	
Cohort 2, go-live January 1	
Cohort 3, go-live July 1, 202	
Facilities that want to launch/geby June 1, 2024 .	o-live on July 1, 2025 , should submit their Intent to Participate form to HCA
3	Submitter's contact information
First and last name	
Title	
Phone number	
Email	
Name of facility director (or equ	ivalent)
Person or entity authorizing par	ticipation (if different than the director or equivalent)
4	IT Information (if applicable)
	an electronic health record (EHR) platform?
Yes	
No	
If yes, what is the name of the p	latform and the current version number (if known)?
Platform	Version number
IT contact first and last name	
IT contact title	
IT contact phone number	
IT contact email	



Authorizing signature

Date