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| First Name: | Last Name: | Date of Birth: | Age: |
| FACTS Case Number: | Projected ROC: | Date Completed: | Gender: |

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| **Section 1: My Identifying Documents**  ***Review for all youth ages 14 and older***  *These important documents are critical for your transition to adulthood and are required for you to have before you leave care. What documents do you have and what do you still need before you leave care?* | | |
| **Vital Personal Documents** | **Current Document Status** | **Where is the document located?** |
| **Educational History:** *Copies of transcripts, report cards, names and addresses of schools attended, etc.* | Have Applied for Don’t have |  |
| **Social Security Card issued by SSA** | Have Applied for Don’t have |  |
| **Valid State-Issued License, Permit or**  **Photo Identification** | Have Applied for Don’t have |  |
| **An Official or Certified Copy of Birth Certificate** | Have Applied for Don’t have |  |
| **Immunization Records** | Have Applied for Don’t have |  |
| **Medical History:** *Including**current medical treatment, current providers and medications* | Have Applied for Don’t have |  |
| **Copy of Medical and Genetic Information** | Have Applied for Don’t have |  |
| **Social History**: *Including release of allowable records from time in custody* | Have Applied for Don’t have |  |
| **Life Book** | Have Applied for Don’t have |  |
| ***The documents below are needed as youth attains age 18.*** | | |
| **Copy of Consumer Credit Report** | Have Applied for Don’t have |  |
| **Medicaid Card/Health Insurance information** | Have Applied for Don’t have |  |
| **Tribal Enrollment Card/Tribal Documentation** | Have Applied for Don’t have |  |
| **Voter Registration** | Have Applied for Don’t have |  |
| **Selective Service Registration** | Have Applied for Don’t have |  |
| **Citizenship/Immigration Documents** | Have Applied for Don’t have |  |
| **Healthcare Proxy or Medical Power of Attorney** | Have Applied for Don’t have |  |
| **DCF Custody Verification Letter** | Have Applied for Don’t have |  |
| **Do you have a safe place to keep your important documents when released from custody?** Yes No  *Per DCF Policy, copies of third party information may not be released without written permission from the originating source.* | | |
| **Steps my case manager and I need to take to obtain my identifying document(s):** | | |
| **1.** | | |
| **2.** | | |
| **3.** | | |

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| **Section 2: Getting to Know You**  ***Required for all youth ages 14 and older (Attach additional pages as needed.)*** |
| **What I would like people to know about me:**  *Examples: interests/hobbies, what you like to do for fun, likes/dislikes, etc.* |
| **What I would like people to know about my culture and things that are important to me:**  *What holidays do you celebrate? Do you attend church? If so, which one? What other events or values are important to you?* |
| **My greatest strengths and talents are:**  *Examples: get along well with others, study hard in school, create art/music, express feelings in a healthy way, etc.* |
| **The top three things that I need most right now are:** |
| **I think that these things could change if:** |
| **When I am an adult, I want to be:** |
| **Some things that I would like to accomplish are:** *(list short-term and long-term goals)* |

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| **Section 3: Life Skills**  ***Required for all youth ages 14 and older***  *What skills have you already learned and what areas you would like to strengthen?* | | |
| **Specific Skill** | **Youth Assessment** | **Placement/Worker Assessment** |
| **Laundry** *(washing, drying, folding, stain removal, ironing, separating colors before washing, frequency of washing clothes and bedding, etc.):* | I feel confident in performing this skill.  I need support as I continue developing this skill.  I have limited experience and will need assistance in developing this skill. | Describe the youth’s level of competency: |
| **Grocery Shopping** *(understanding sales/coupons, making healthy meal choices within a budget, buying ingredients for a recipe, etc.):* | I feel confident in performing this skill.  I need support as I continue developing this skill.  I have limited experience and will need assistance in developing this skill. | Describe the youth’s level of competency: |
| **Cooking/Meal Preparation** *(preparing meals with multiple ingredients, basics of cooking, kitchen safety, etc.):* | I feel confident in performing this skill.  I need support as I continue developing this skill.  I have limited experience and will need assistance in developing this skill. | Describe the youth’s level of competency: |
| **Self-Care/Hygiene:** *(bathing, shaving, caring for your teeth, nail and hair care, use of deodorant and other hygiene products, exercise, healthy stress management, etc.)* | I feel confident in performing this skill.  I need support as I continue developing this skill.  I have limited experience and will need assistance in developing this skill. | Describe the youth’s level of competency: |
| **Communication Skills:** *(making appointments for keeping a schedule, setting up an e-mail, and communicating in a professional manner)* | I feel confident in performing this skill.  I need support as I continue developing this skill.  I have limited experience and will need assistance in developing this skill. | Describe the youth’s level of competency: |
| **Healthy Living Environment:** *(dusting, mopping, dishes, vacuuming, understanding household chemicals, using the A/C and heater, pet care, etc.)* | I feel confident in performing this skill.  I need support as I continue developing this skill.  I have limited experience and will need assistance in developing this skill. | Describe the youth’s level of competency: |
| **Money Management/Budgeting:** *(saving money, budgeting for bills and groceries, understanding the pros and cons of student/car loans, credit cards, payday loans, etc.)* | I feel confident in performing this skill.  I need support as I continue developing this skill.  I have limited experience and will need assistance in developing this skill. | Describe the youth’s level of competency: |
| **Accessing Community Resources/Public Transportation** *(bus/taxi services; emergency resources for food, clothing, and shelter; crisis/emergency services, etc.)* | I feel confident in performing this skill.  I need support as I continue developing this skill.  I have limited experience and will need assistance in developing this skill. | Describe the youth’s level of competency: |
| **Have you completed a Casey Life Skills Assessment (CLSA)?** *Yes No Unsure*  *(If yes, please attached most recent CLSA.)* | | |
| **Becoming an Adult** | | |
| **My thoughts about becoming an adult are:** | | |
| **Some things I would like to learn before I become an adult are:** | | |
| **Placement/Worker Assessment- specific suggested areas of life skill development include:** | | |

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| **Section 4: My Education Plan**  ***Required for all youth ages 14 and older***  *Plans for your educational and career goals.* | | | |
| Current Student Status: ***(Ages 14 and older)***  Current or Most Recent School Attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Highest grade completed: \_\_\_\_\_\_\_ | | | |
| **Vocational Supports:** *Do you have any of the following? (check below)* ***(Ages 14 and older)*** | | | |
| An Individualized Education Plan *(IEP)* *Yes No Unsure*  504 Plan *Yes No Unsure*  Visual/Hearing Impairment *Yes No Unsure*  Use of an Assistive Device for Learning *Yes No Unsure*  Other Disability *Yes No Unsure* | | | |
| **I intend to complete my** *(check below)*: ***(Ages 16 and older)*** | | | |
| HS diploma at *(name of school):\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  GED at *(name of school):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Testing completed: Yes No*  Obtain a Vocational Certificate at *(name of school):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  Post-secondary training/degree at *(name of school):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | |
| Highest Level of Education Completed: ***(Ages 16 and older)***  # of Credits Earned \_\_\_\_\_\_\_ HS Diploma (name of school) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  GED College Credits Technical Training | | | |
| **If enrolled in high school or GED, I have:** | | | |
| Completed ACT or SAT Entrance Exam  Completed a Kansas Kids @ Gear Up Application  Bought or Have Been Provided Materials/Books  Paid Registration Fees | | | |
| **I would like more information about the following:** | | | |
| A-OK Program | Gear Up | FAFSA Application | Tuition Waiver |
| Tutoring | First-Aid/CPR | IEP/504 Plan | Scholarships |
| Choosing my Classes | Dual Credit Classes | Credit Recovery | Bullying/Anti-Bullying |
| Feeling Alone on Campus | Sports/School Activities | Military Education | Educational Counseling |
| Help with Choosing Electives *(High School Level)* | Vocational Rehabilitation (VR) | Understanding Student Loans and Financial Aid | Pre-Employment Transition Services *(Pre-ETS)* |
| Contacting My School Counselor | Test Preparation *(ACT/SAT)* | College Campus Tours | Upward Bound |
| Applying for an Education Program | Senate Bill 23 *(Graduation requirements for youth experiencing foster care)* (*KS Statute #38-2285*) | Obtaining Education with a Disability *(Federal WIOA H.R 803 Section 422)* | Other: |
| **What I need to do to achieve my education goal(s) and what supports I have identified are needed to accomplish this:**  *(Enroll, submit FAFSA application, talk to an advisor, scholarships, meet with school counselor, pick my elective classes, etc.)* | | | |

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| **Section 5: Youth Advocacy**  ***Required for all youth ages 14 and older***  *Kansas is proud to have councils that support youth who have experienced foster care, to ensure that youth’s voices are heard for advocacy and to promote change within the child welfare system.*  **“Nothing About Us, Without Us!”** | | | | | |
| **Kansas Youth Advisory Council & Regional Youth Advisory Council:** *(check below)* | | | | | |
| I have been to a Regional Youth Advisory Council **(RYAC)** event: Yes No Unsure | | | | | |
| I have been to Kansas Youth Advisory Council **(KYAC)** event: Yes No Unsure | | | | | |
| I am interested in KYAC and /or RYAC: Yes No Unsure | | | | | |
| I would need help getting rides to KYAC and/or RYAC meetings: Yes No Unsure | | | | | |
| **Section 6: My Connections Plan**  ***Required for all youth ages 14 and older*** | | | | | |
| **Who could you call for issues related to money, job, transportation, school, housing, physical or emotional health? Who could you call for general/everyday support when you need it?** | | | | | |
| Name: | | | Phone: | | |
| Email: | | |
| I see him/her as much as I would like to: Yes No I would like him/her at my case planning meetings: Yes No | | | | | |
| Name: | | | Phone: | | |
| Email: | | |
| I see him/her as much as I would like to: Yes No I would like him/her at my case planning meetings: Yes No | | | | | |
| Name: | | | Phone: | | |
| Email: | | |
| I see him/her as much as I would like to: Yes No I would like him/her at my case planning meetings: Yes No | | | | | |
| Name: | | | Phone: | | |
| Email: | | |
| I see him/her as much as I would like to: Yes No I would like him/her at my case planning meetings: Yes No | | | | | |
| Name: | | | Email: | | |
| I see him/her as much as I would like to: Yes No I would like him/her at my case planning meetings: Yes No | | | | | |
| Name: | | | Phone: | | |
| Email: | | |
| I see him/her as much as I would like to: Yes No I would like him/her at my case planning meetings: Yes No | | | | | |
| **Mentor Supports:** | | | | | |
| I would like help finding a supportive adult/mentor:Yes No  I already have a mentor | | | | | |
| Would you or this mentor be interested in participating in YouThrive? Yes No Unsure | | | | | |
| ***If you already have a mentor, please list their name and contact information:*** | | | | | |
| **Section 7: My Health/Well-Being**  ***Required for all youth ages 15 and older***  *Taking care of yourself is important. Without health insurance, you could end up with large bills for having to see a doctor.* | | | | | |
| **My Medicaid or other health insurance provider is:** *(check below)* | | | | | |
| United Sunflower Aetna Other: | | | | | |
| *My Primary Care Doctor is:* | | | *Phone:* | | |
| *My OB/GYN Doctor is:* | | | *Phone:* | | |
| *My Eye Doctor is:* | | | *Phone:* | | |
| *My Mental Health Provider is:* | | | *Phone:* | | |
| *My Preferred Pharmacy is:* | | | *Phone:* | | |
| *My Dentist is:* | | | *Phone:* | | |
| *My Other Provider is:* | | | *Phone:* | | |
| *My Other Provider is:* | | | *Phone:* | | |
| **I know how to:** *(check below)* | | | | | |
| Schedule Appointments Fill Prescriptions Take Medications as Prescribed Obtain/Use Birth Control  Ask for Help Other: | | | | | |
| **I take the following medications***: (list all medications and the reason they are prescribed): or*  **I am not taking mediations** | | | | | |
| *Medication:* | | *Reason:* | | | *How often:* |
| *Medication:* | | *Reason:* | | | *How often:* |
| *Medication:* | | *Reason:* | | | *How often:* |
| *Medication:* | | *Reason:* | | | *How often:* |
| *Medication:* | | *Reason:* | | | *How often:* |
| Do you understand the short-term and/or long-term effects of the medications you are taking? Yes No | | | | | |
| Do you plan to continue taking your prescribed medications after being released from custody? Yes No  ***If No, please work with your case manager to set up an appointment for medical guidance from a professional.*** | | | | | |
| Are you receiving any HCBS waiver services or supports from a Community Developmental Disability Organization (CDDO)?  Yes No  If “Yes,” list service provider(s) names and contact information: | | | | | |
| **I would like more information on:** *(check below)* | | | | | |
| Changing Doctors | Communicating with my Doctors | | | Sobriety Support | |
| Scheduling Appointments | Applying for Medical Insurance | | | LGBTQI Supports | |
| Filling Prescriptions | Substance Abuse Treatment | | | Physical Health | |
| Taking Medications as Prescribed | Mental/Emotional Health | | | Domestic Violence Resources | |
| Healthy Relationships | Abstinence/Sexual Health | | | Renewing Health Insurance | |
| Obtaining/Using Birth Control | Tobacco Use/Quitting | | | Weight Management | |
| Healthy Habits | Connecting to Community Resources | | | Other: | |

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| **Section 8: My Employment/Financial Plan**  ***Required for all youth ages 16 and older*** | | |
| **My Current Employment Status** *(Check all that apply)*:  Full-Time Part-Time Volunteering Disabled Student  Active Job Search Unable to Work Internship/Work Study No Work History | | |
| **I would like more information about the following topics:** | | |
| Job/Career Fairs | Opening a Checking/Savings Account | Understanding My Credit |
| Interviewing *(dress for success)* | Completing Job Applications | Saving Money for My Future |
| Finding a Job with Criminal History | Creating a Resume/Cover Letter | Understanding Taxes and W-2s |
| Vocational Rehabilitation *(VR)* | Finding a Job | Job Corp |
| Jobs for America’s Graduates-Kansas *(JAG-K)* | Pre-Employment Transition Services *(Pre-ETS)* | Joining the Military *(Army, Air Force, Navy, Marines, Reserves)* |
| Credit Recovery Programs | Online Banking/Bill Pay | Job Shadowing |
| Applying for/Understanding Social Security Benefits *(SSI/SSDI)* | Obtaining Employment with a Disability | Other: |
| **Have you completed a career assessment such as ONET, My Next Move, OneStop, or another tool?***(check below)*  Yes No Unsure *If yes, when?*  What were the results?  Would you like to complete a career assessment, to see what jobs might interest you?Yes No Unsure | | |
| **What are some jobs or careers that interest you?** | | |
| **Financial Awareness:** | | |
| Do you have a checking account? Yes No Do you have a savings account? Yes No  If yes, who has access to your account(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Would you like to open a checking/savings account? Yes No  Who can help you set up a banking account? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Do you understand fees that are associated with a bank and/or debit card? Yes No  Do you have any credit cards or loans? Yes No Are you interested in financial literacy classes? Yes No | | |
| I have $\_\_\_\_\_\_ saved. My goal is to save $\_\_\_\_\_\_\_\_per\_\_\_\_\_\_\_\_(week/month) for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Where will you get the money from for your savings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Who will have access to the money that you are saving? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| The estimated cost of my housing plan is: $\_\_\_\_\_\_\_\_\_\_ per month semester year (*check one)*  Where will you get the money to pay for your housing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Who will have access to your money to pay bills? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Some things that I need to learn regarding money before I become an adult are:** | | |
| **Section 9: My Transportation Plan**  ***Required for all youth ages 16 and older*** | | |
| **I currently have the following transportation available to me** *(check all that apply)*: | | |
| Family/Friends Placement/Caseworker I have my own car I borrow a car  Paid Ride Service/Taxi Bike Walk Bus Other: | | |
| **I need transportation to:** *(check all that apply)* | | |
| School Employment Recreation Appointments Complete My Restricted License Other: | | |
| **If you own a vehicle:** | | |
| Who is it registered to? *(list all names on registration)* | | |
| When do the tags expire? | | |
| Insurance company name: | | |
| Insurance policy number: | | |
| Drivers listed on the policy: | | |
| When does the insurance expire? | | |
| When does your driver’s license expire*, if applicable?* | | |
| My understanding of car repair/upkeep is: *(oil change, gas, regular maintenance, etc.)* | | |
| I know how to keep my car in working order by: *(change a tire, pick the correct gas, change my oil etc.)*  I would like to learn how to perform regular car upkeep/repair: Yes No Unsure | | |
| **My Legal Driving Status: *Youth ages 16 and older*** | | |
| **I currently have a:** Valid Driver’s License Valid Restricted Driving Permit Valid Learning Permit  Expired License/Permit No Permit/License Suspended License Other:  **I am interested in getting my:** Driver’s License Restricted Driving Permit Learning Permit  Taking Drivers Education Completing Driving Hours Practicing the Permit Test Other: | | |
| What I see as a barrier to me obtaining my license is: | | |

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| **Section 10: My Housing Plan**  ***Required for all youth ages 17 and older*** | | | | | |
| **Where I currently live:** | | | | | |
| Foster Home Relative  Non-Relative Group Facility Shelter Detention Secure Care Other: | | | | | |
| **My options for housing, once I am released are:** (s*elect all that apply)* | | | | | |
| Apartment/House *If so, are you on the lease?* *Yes* *No* | Group Home | | Military Housing | | College Dorm |
| Supportive Adult | Friend/Non-Relative | | Current Placement | | Relative |
| Not Ready to Think About Housing Right Now | Sober Living/Halfway House | | Unsure of Where I Will Live | | Residential Community Setting |
| Homeless/Couch Surfing | No stable housing | | Homeless Shelter/Streets | | Domestic Violence Shelter |
| **If a stable housing plan is not in place, identify steps to take to help access housing supports to ensure your safety:** | | | | | |
| **I have completed the following to develop my housing plan:** | | | | | |
| Looked into housing rental ads | | Secured a co-signer, if needed | | Contacted specific housing | |
| Developed solid plans with potential roommates/family members | | I have budgeted and am able to pay my monthly expenses | | In person apt/house hunting | |
| Applied for affordable housing *(Section 8, HUD or income-based housing)* | | Secured deposits, if needed | | Other: | |
| I understand which utilities I will be responsible for and about how much they will cost me each month. Yes No Unsure  What utilities will you have to pay each month? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| What resources do you plan to use if you don’t have enough money to pay rent/bills? | | | | | |
| **I would like more information regarding:**  Locating Housing Applying/Budgeting for Housing Signing a Lease Affordable Housing Utility Deposits/Costs Other: | | | | | |
| **Who I plan to live with:** *(name, relationship and address, if applicable)* | | | | | |

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| **This Section to be Completed by Case Worker:**  *Summarize progress made since last transition plan meeting (required).*  *List any concerns that you have regarding the youth’s plan to transition into adulthood.*  **Each entry shall include the name of the staff member completing the update and the date.** |
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| **Transition Plan for Successful Adulthood: Participant Signatures & Date of Completion** | |
| *Youth feedback: Concerns about your plan? Yes No Discussed concerns with team? Yes No*  *(comments)*  ***Youth Signature/Date:*** | |
| *Case Manager feedback: Concerns about youth’s plan? Yes No Discussed concerns with team? Yes No*  *(comments)*    ***Case Manager Signature/Date:*** | |
| *DCF IL Coordinator feedback: Concerns about youth’s plan?**Yes No Discussed concerns with youth? Yes No*  *(comments)*  ***DCF IL Coordinator Signature/Date:*** | |
| *Supportive Adult feedback:* *Concerns about youth’s plan?**Yes No Discussed concerns with youth? Yes No*  *(comments)*    ***Youth-Selected Supportive Adult Signature/Date:*** | |
| *Supportive Adult feedback:* *Concerns about youth’s plan?**Yes No Discussed concerns with youth? Yes No*  *(comments)*    ***Youth-Selected Supportive Adult Signature/Date:*** | |
| **X** |  |
| **Other Attendee Signature** | **Date** |
| **X** |  |
| **Other Attendee Signature** | **Date** |
| **X** |  |
| **Other Attendee** **Signature** | **Date** |

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| **Section 11: Exit Plan**  **This section must be completed within 90 days prior to release from custody. If the exit plan is unable to be completed within 90 days prior to release of custody due to extenuating circumstances and exception has been granted per PPM 0100 the exit plan shall be completed as soon as possible and no later than 45 days after release from custody.**  **This plan is to be completed with the**  **Youth, Case Manager and DCF Independent Living Coordinator.**  Revisions must be made to ensure the youth’s transition plan reflects accurate post-release information.  Federal requirements are listed below and shall be addressed and finalized prior to release from custody. | | |
| **After release, my contact information will be as follows:** (Please fill in the information below.) | | |
| Address: | | |
| Email: | | |
| Phone: | | |
| Social Media: | | |
| **If this plan falls through, the address for my back up plan is:** (Please fill in the information below.) | | |
| Address: | | |
| Phone: | | |
| Alternate Email or Name of Social Media Contact who will know where you can be located: | | |
| Do you have any children? Yes No If yes, how many?  Are you currently expecting a child? Yes No If yes, how many?  ***If you have children or are expecting a child, what services are you receiving to assist you and your children?*** *(list below)* | | |
| **Check the box(s) for documents you have in your possession:** | | |
| State Photo Identification | Medical Card | Citizenship/Immigration Documents |
| Life book | Social Security Card (*not a copy*) | Driver’s License (*currently valid*) |
| Copy of Immunization Records | Educational Records | Diploma/GED |
| Letter Verifying Custody | Medical Power of Attorney, if requested | |
| Copy of the PPS 5340 Medical and Genetic Information for Child | | |
| Original or Certified Copy of Birth Certificate | | |
| If planning to finish your high school diploma or GED, have you enrolled in classes? Yes No N/A | | |
| If planning to attend college or other training program, have you enrolled in classes? Yes No N/A | | |
| If planning to work, are you employed? Yes No N/A | | |
| If employed, what is your employer’s name and address? | | |
| **List the name, address, and phone number of up to five people who would know how to contact you after release from the Secretary’s custody:**  (By providing emergency contact information, I agree to allow DCF to contact these individuals in efforts to locate me. I understand that DCF will not release any information about my case to these contacts.) | | |
| Name: | Phone number: | Address:  Email: |
| Name: | Phone number: | Address:  Email: |
| Name: | Phone number: | Address:  Email: |
| Name: | Phone number: | Address:  Email: |
| Name: | Phone number: | Address:  Email: |
| **National Youth in Transition Database (NYTD):**  *(Final Rule: Section 477of the Social Security Act)* | | |
| **The National Youth in Transition Database (NYTD) helps Kansas measure success in preparing youth for the transition from foster care to adult living by surveying youth at 17, 19, & 21 years of age.**  *You may be contacted at age 19 and 21 and asked to complete a survey by DCF Independent Living staff.*  If you have any NYTD questions, please email: [KS.NYTD@dcf.ks.gov](mailto:KS.NYTD@dcf.ks.gov) | | |
| **Medical Power of Attorney/Living Will:** *(Federal Reg. 475(1) F)*  *It is important that you choose a trusted adult, in case there is an emergency and you become unable to make medical decisions for yourself. Having a Medical Power of Attorney will protect you in emergency situations. This adult would make decisions for you only if you were seriously injured, critically ill, or became unable to speak regarding medical treatment. If you do not have a formal Medical Power of Attorney, then you risk having someone that you may not trust making these decisions for you.*  *When you select a trusted adult for this document, we can help you obtain the needed document.* | | |
| **Have you selected a trusted adult to make important decisions regarding emergency medical treatment? Yes No**  **Do you have documentation for your selected Medical Power of Attorney? Yes No Unsure** | | |
| **The person who I would like to list as my “Health Care Power of Attorney” is:** | | |
| Name: Phone: Email: | | |

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| **What services/supports are you interested in receiving from DCF, if eligible? Check all that apply:** | | | | |
| Aged Out Medical Card | Life Skills | | | Independent Living Subsidy |
| Employment Services | Case Management | | | Tuition Waiver |
| Access to Medical Services  Accessing Mental Health  Childcare Assistance  YouThrive Program Referral | Continuing Education Community Resources  Food Assistance Start Up Assistance  Other  Pre-ETS/Voc. Rehab Services  Crisis Care Information *(specific to the community that I plan to live in)* | | | |
| Completion of Secondary Education *(High School Diploma or GED)* | | | | |
| **DCF Independent Living Coordinator Contact Information:** | | | | |
| Name: | | Office Location: | | |
| Phone: | | Email: | | |
| Regional Group Email: | |  | | |
| **Exit Plan Participant Signatures & Date of Completion:** | | | | |
|  | | |  | |
| **Youth’s Signature** | | | **Date** | |
|  | | |  | |
|  | | |  | |
| **Case Manager’s Signature** | | | **Date** | |
|  | | |  | |
|  | | |  | |
| **DCF IL Coordinator or Designee’s Signature** | | | **Date** | |
|  | | |  | |
| **Send the Final PPS 3059 My Plan for Successful Adulthood forms along with the completed Exit Plan *(Section 11)* to the DCF Independent Living regional email for the region where the youth will be located or has requested services. All provider referrals shall have copies of the following attached as applicable: copies of the youth’s identifying documents, PPS 3050 series, confirmation the youth has been assisted with applying for Aged Out Medical *(if eligible),* and the last completed Casey Life Skills Assessment (CLSA).** | | | | |