My Adult Services Plan

First Name:	**Last Name**:	**Date of Birth**:	**Age**:
FACTS Case Number:	**Projected Release from Custody (ROC)**:	**Date Completed**:	

Section 1: Getting to Know Me

Required for all youth ages 14 and older who are on an I/DD waiver or waitlist. Youth or young adults who meet these criteria are not required to complete the 3059A.
(Attach additional pages or expand sections 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:
What help/support do I need right now?
Examples: clothing, visits, medical/mental health appointments, contacting my Guardian Ad Litem (GAL) etc.

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My Adult Services Plan

Section 2: Social Security, Payee, Guardian, and Waivers

Required for all youth ages 14 and older

Psychological Exams and Social Security ☐N/A

Date of last Psychological Exam:	Assessor:	IQ Results:
Date of next Psychological Exam, if applicable:	Assessor:	
Currently Receiving SSI/SSDI: ☐Yes ☐No	Date Applied to Adult SSI/SSDI:	Approved: ☐Yes ☐No
If denied, has an appeal been filed? ☐Yes ☐No	Date Appealed:	Results:

Case Manager Notes:

Payee ☐N/A

Does a payee for after release of custody need to be appointed? ☐Yes ☐No	If yes, has an application for a payee been completed? ☐Yes ☐No	Date applied:
Payee after ROC :	Phone:	
Relationship:	Email:	

Case Manager Notes:

Adult Guardian ☐N/A

Is there a statement from a designated professional (per K.S.A. 59-3064) stating that the individual lacks capacity **and** a guardian needs to be appointed? ☐Yes ☐No

Does a referral need to be sent to the Kansas Guardianship Program*? ☐Yes ☐No **please see PPM 10630*	Date referral packet sent to DCF Adult Protective Services:
Proposed Adult Guardian Name:	Phone:
Relationship:	Email:

Case Manager Notes:

Home and Community Based Services (HCBS) Waivers

Brain Injury (BI) ages 0-64 ☐N/A

Aging and Disability Rights Center (ADRC): 1-855-200-ADRC (2372)

Local ADRC:	Address:
Contact:	Phone/Email:
Date of Functional Eligibility Assessment:	Results:
Has a BI Program Eligibility Attestation been completed by a medical professional: ☐Yes ☐No	Date sent to ADRC:
Medical Professional:	Phone/Email:

Case Manager Notes:

Intellectual/Developmental Disability (I/DD) ages 5+ ☐N/A

Local CDDO:	Address:
CDDO Contact:	Phone/Email:
Date Applied for I/DD Waiver:	Results:

Does a crisis exception to the I/DD waiver need to be made ☐Yes ☐No

if yes, is there a task in their case plan that say they will transition to Adult Residential and Day Services? ☐Yes ☐No

Targeted Case Management Provider:	Address:
TCM Case Manager:	Phone/Email:
Medicaid MCO:	Number:
MCO Care Coordinator:	Phone/Email:

Case Manager Notes:

Physical Disability Waiver (PD) ages 16-64	☐**N/A**
Aging and Disability Rights Center (ADRC): 1-855-200-ADRC (2372)	
Local ADRC:	Address:
Contact:	Phone/Email:
Date of Functional Eligibility Assessment:	Results:
Case Manager Notes:	

Technology Assistance (TA) ages 0-21	☐**N/A**
Family Waiver Care: 785-296-9551 or email tawaiver@family-waiver-care.com	
Date MATLOC Assessment:	**Assessor:**
Results:	
Case Manager Notes:	

Tasks to add to case plan for Social Security, Payee, Adult Guardian, and Home and Community Based Services:
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Section 3: My Support Network

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**:
Relationship:	**Email**:
I see this person as much as I would like to: ☐Yes ☐No	I would like this person at my case planning meetings: ☐Yes ☐No
Name:	**Phone**:
Relationship:	**Email**:
I see this person as much as I would like to: ☐Yes ☐No	I would like this person at my case planning meetings: ☐Yes ☐No
Name:	**Phone**:
Relationship:	**Email**:
I see this person as much as I would like to: ☐Yes ☐No	I would like this person at my case planning meetings: ☐Yes ☐No
Name:	**Phone**:
Relationship:	**Email**:
I see this person as much as I would like to: ☐Yes ☐No	I would like this person at my case planning meetings: ☐Yes ☐No
Name:	**Phone**:
Relationship:	**Email**:
I see this person as much as I would like to: ☐Yes ☐No	I would like this person at my case planning meetings: ☐Yes ☐No
Name:	**Phone**:
Relationship:	**Email**:
I see this person as much as I would like to: ☐Yes ☐No	I would like this person at my case planning meetings: ☐Yes ☐No

Tasks to add to case plan to help build my support network *(family finding, set up visits/phone calls, refer to mentor/support program- examples: Big Brothers Big Sisters, Boys and Girls Club, etc.)*

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My Adult Services Plan

Section 4: 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?

Per DCF Policy, copies of third-party information may not be released without written permission from the originating source.

Vital Personal Documents	Current Document Status	Where is the document located?
An Official or Certified Copy of Birth Certificate	☐Have ☐Don't have ☐Date Applied:	
Social Security Card issued by SSA	☐Have ☐Don't have ☐Date Applied:	
Valid State-Issued Photo Identification	☐Have ☐Don't have ☐Date Applied:	
Valid State-Issued Permit	☐Have ☐Don't have ☐Date Applied:	
Valid State-Issued License	☐Have ☐Don't have ☐Date Applied:	
Educational History: *Copies of transcripts, report cards, names and addresses of schools attended, etc.*	☐Have ☐Don't have ☐Date Requested:	
Immunization Records	☐Have ☐Don't have ☐Date Requested:	
Medical History: *Including current medical treatment, current providers, and medications*	☐Have ☐Don't have ☐Date Requested:	
Copy of Medical and Genetic Information	☐Have ☐Don't have ☐Date Requested:	
Social History: *Including release of allowable records from time in custody*	☐Have ☐Don't have ☐Date Updated:	
Life Book	☐Have ☐Don't have ☐Date Updated:	
The documents below are needed as youth attains age 18.		
Copy of Consumer Credit Report	☐Have ☐Don't have ☐Date Applied:	
Medicaid Card/Health Insurance information	☐Have ☐Don't have ☐Date Applied:	
Voter Registration	☐Have ☐Don't have ☐Date Applied:	
DCF Custody Verification Letter	☐Have ☐Don't have ☐Date Requested:	
Tribal Enrollment Card/Tribal Documentation	☐N/A ☐Have ☐Don't have ☐Date Applied:	
Selective Service Registration	☐N/A ☐Have ☐Don't have ☐Date Applied:	
Citizenship/Immigration Documents	☐N/A ☐Have ☐Don't have ☐Date Applied:	
Healthcare Proxy or Medical Power of Attorney	☐N/A ☐Have ☐Don't have ☐Date Applied:	

Do you have a safe place to keep your important documents when you are released custody? ☐Yes ☐No

Tasks to add to case plan to take to obtain my identifying document(s): *(update life book, request social history, apply for birth certificate, Social Security Card, State ID/Driver's License, register for selective service, etc.)*

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Section 5: Life Skills

Required for all youth ages 14 and older

What skills have you already learned and what areas you would like to strengthen?

Case teams may attach a copy of an assessment completed within the last 6 months by a CDDO or other waiver service agency that addresses the youth or young adult's life skills. (The CLSA does NOT meet this requirement)

Self-Care/Hygiene:

(bathing, shaving, caring for your teeth, nail and hair care, use of deodorant and other hygiene products, selecting and putting on clothes, exercise, etc.)

Youth/Young Adult Input:

Worker/Supportive Adult(s) Assessment:

Laundry

(washing, drying, folding, stain removal, ironing, separating colors before washing, frequency of washing clothes and bedding, etc.)

Youth/Young Adult Input:

Worker/Supportive Adult(s) Assessment:

Healthy Living Environment:

(making bed, dusting, mopping, dishes, vacuuming, understanding household chemicals, using the A/C and heater, pet care, etc.)

Youth/Young Adult Input:

Worker/Supportive Adult(s) Assessment:

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Grocery Shopping
(buying ingredients for a recipe, understanding sales/coupons, making healthy meal choices within a budget, etc.)

Youth/Young Adult Input:

Worker/Supportive Adult(s) Assessment:

Cooking/Meal Preparation
(feeding oneself, preparing meals that do not require cooking, preparing meals with ingredients, basics of cooking, kitchen safety, using stove and other kitchen appliances, etc.)

Youth/Young Adult Input:

Worker/Supportive Adult(s) Assessment:

Communication Skills:
(understanding 1 and 2 step directions, asks simple questions, asking for help, knowing who to ask, active listening, etc.)

Youth/Young Adult Input:

Worker/Supportive Adult(s) Assessment:

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Accessing Community Resources/Public Transportation
(do you know who to ask for help with transportation, how to ride public transportation, obtain food, going to the doctor, etc.)

Youth/Young Adult Input:

Worker/Supportive Adult(s) Assessment:

Have you completed a Casey Life Skills Assessment (CLSA)? ☐ *Yes* **Date**: ☐ *No* ☐ *Unsure*

Section 6: Youth Advocacy

Required for all youth ages 14 and older
"Nothing About Us, Without Us!"

Kansas Youth Advisory Council & Regional Youth Advisory Council

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

KYAC Contact:

RYAC Contact:

Other Youth Advocacy Groups: *ex: Kansas Youth Empowerment Academy (KYEA), Youth Leaders in Kansas (YLinK), student groups, etc.*

My Adult Services Plan

Section 7: My Education Plan

Required for all youth ages 14 and older

Plans for your educational and career goals.

Current or Most Recent School Attended:	**Current Grade Level:**	**Highest grade completed**:

Vocational Supports: *Do you have any of the following? (check below)*

An Individualized Education Plan *(IEP)* ☐Yes ☐No ☐Unsure	**504 Plan** ☐Yes ☐No ☐Unsure
An Education Advocate ☐Yes ☐No ☐Unsure *If yes*, what is their name?	
Visual Impairment ☐Yes ☐No ☐Unsure	**Deaf or Hard of Hearing** ☐Yes ☐No ☐Unsure
Use of an Assistive Device for Learning ☐Yes ☐No ☐Unsure	**Other Disability** ☐Yes ☐No ☐Unsure

Specific IEP/504 Plan Accommodations:

Are you participating in Pre-ETS? ☐Yes ☐No ☐Unsure	*if no,* does a referral need to be made? ☐Yes ☐No

If you are under 16, please go to page 14.

I intend to complete my *(check below)*: ***(Ages 16 and older)***

☐**HS diploma at** *(name of school)*:	**Number of Credits Earned**:
☐**GED at** *(name of institution/program)*:	**Number of Tests Passed**:
☐**Obtain a Vocational Certificate at** *(name of school)*:	
☐**Post-secondary training/degree at** *(name of school)*:	

Highest Level of Education Completed *(check below all that apply)*: ***(Ages 16 and older)***

☐**HS diploma at** *(name of school)*:	
☐**GED at** *(name of institution/program)*:	
☐**College Credits** *(name of institution/program)*:	**Number of Credits Earned**:
☐**Technical Training** *(name of institution/program)*:	

I would like more information about the following:

☐A-OK Program	☐Tutoring	☐Tuition Waiver	☐First-Aid/CPR
☐Contacting My School Counselor	☐Applying for an Education Program	☐College Campus Tours	☐Military Enlistment
☐Choosing Classes	☐Applying for Scholarships	☐Feeling Alone on Campus	☐Bullying/Anti-Bullying
☐Credit Recovery	☐FAFSA Application	☐TRIO/Upward Bound	☐Sports/School Activities
☐Dual Credit Classes	☐Understanding Student Loans and Financial Aid	☐Pre-Employment Transition Services *(Pre-ETS)*	☐ KU Transition to Postsecondary Education
☐IEP/504 Plan	☐Test Preparation *(ACT/SAT)*	☐Educational Counseling	☐Kansas Kids at GEAR UP
☐Senate Bill 23 *(Graduation requirements for youth in foster care)* (*KS Statute #38-2285*)	☐Obtaining Education with a Disability *(Federal WIOA H.R 803 Section 422)*	☐Vocational Rehabilitation Services (VR)	☐ Other:

Tasks to add to case plan to address educational goals and needs:*(Enroll, submit applications, talk to an advisor, scholarships, placement exams meet with school counselor, pick elective classes, purchase materials, pay registration fees, explore post-secondary education programs etc.)*

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Section 8: My Health/Well-Being

Required for all youth ages 16 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 ☐ Healthy Blue ☐ 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:
My Other Provider is:	Phone:

Are you comfortable with the listed providers? ☐ Yes ☐ No

Do you find these services helpful? ☐ Yes ☐ No

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:
Medication:	Reason:	How often:
Medication:	Reason:	How often:
Medication:	Reason:	How often:
Medication:	Reason:	How often:
Medication:	Reason:	How often:

Do you have any concerns with the medications you are taking? ☐ Yes ☐ No

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.

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I would like more information on: *(check below)*		
☐Changing Doctors	☐Communicating with my Doctors	☐Sobriety Support
☐Scheduling Appointments	☐Applying for Medical Insurance	☐Physical Health
☐Filling Prescriptions	☐Substance Abuse Treatment	☐Domestic Violence Resources
☐Taking Medications as Prescribed	☐Mental/Emotional Health	☐Renewing Health Insurance
☐Healthy Relationships	☐Abstinence/Sexual Health	☐Weight Management
☐Obtaining/Using Birth Control	☐Tobacco/Vape Use and Quitting	☐Other:
☐Healthy Habits	☐Connecting to Community Resources	

Tasks to add to case plan for my health/well-being: *(scheduling appointments, refilling prescriptions, obtain medication, talking with doctor(s), changing providers, etc.)*

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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:

My Legal Driving Status: *(check all that apply)* ☐N/A

I currently have a: ☐ Valid Driver's License ☐ Valid Restricted Driving Permit ☐ Valid Learning Permit
☐ Expired License/Permit ☐ No Permit/License ☐ Suspended License ☐ Other:

If you have a License, when does it expire?

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:

Case manager notes:
Please explain the transportation plans for the youth/young adult for their transition into adulthood

Tasks to add to case plan to address my transportation goals: *(enroll in driver's education, referral to We Kan Drive, go to DMV, explore public transportation, walk through how to use medical card to request transportation, save for vehicle, explore auto insurance rates, etc.)*

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Section 9: My Employment/Financial Plan

Required for all youth ages 16 and older

My Current Employment Status *(Check all that apply)*: ☐Day School ☐ Full-Time ☐ Part-Time ☐ Volunteering ☐ Student ☐ Active Job Search ☐ Internship/Work Study ☐ Unable to Work ☐ No Work History ☐ Other:

If employed, where do you work?	**How long have you had your current job?**

What are some jobs or careers that interest you? *What level of education and/or experience do you need to obtain that job/career?*

Are you interested in any of the following programs:

☐DCF Vocational Rehabilitation (VR) Services	☐ DCF Pre-Employment Transition (Pre-ETS) Services	☐ KANSASWORKS Ticket to Work

Financial Awareness:

Are you interested in learning how to budget your money? ☐ Yes ☐ No ☐NA

Do you have a checking account? ☐ Yes ☐ No ☐NA	**Do you have a savings account?** ☐ Yes ☐ No ☐NA

If yes, who has access to your account(s)?

Would you like to open a checking/savings account? ☐ Yes ☐ No ☐NA

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 ☐NA

Do you know how to check your credit report? ☐ Yes ☐ No ☐NA

Please describe the young adult's financial plans for adulthood:

Tasks to add to case plan to address my employment and financial goals: *(Open checking/savings account, referral to Pre-ETS or Vocational Rehabilitation Services, create a budget, take budgeting classes, create resume, apply for jobs, interview prep, understanding taxes, etc.)*

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My Adult Services Plan

If you are under 17, please go to next section.

Section 10: My Housing Plan

Required for all youth ages 17 and older

I understand that DCF Independent Living does not provide placement/housing after release of custody ☐ Yes ☐ No

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: (*select all that apply)*

☐Relative(s)	☐Friend/Non-Relative	☐Current Placement	☐Unsure Where I will Live
☐Supportive Adult	☐Transitional Living Program	☐Shared Living	☐Other:
☐Adult Residential Community Setting	☐Sober Living/Halfway House	☐Apartment/House *If so, are you on the lease?* ☐*Yes* ☐*No*	

What area(s) of the state/country would I like to live?

Who I plan to live with: *(name, relationship, and address, if applicable)*:

Have you talked with them about household rules, financial expectations, etc.? ☐ Yes ☐ No

Do you need help talking about household expectations? ☐ Yes ☐ No

What is your plan if this housing option does not work out?

What steps have been taken to secure housing?

Applying for adult residential, touring adult residential/apartments, applying for low-income housing, purchased/obtained household items, signed housing related paperwork

Tasks to add to case plan to secure housing prior to release: *(search/apply for housing, apply for public housing, tour facility, secure household items, etc.)*

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If this section does not apply, please go to next section ☐N/A

Section 11: Legal

Required for all youth ages 14 and older who have current or pending charges and/or convictions.

Next Court Date:	**Type of Hearing:**
Current charges:	
Pending charges:	
Past convictions:	
Counties charges/convictions are from:	
Court Services Officer:	**Email/Phone:**
Probation Officer:	**Email/Phone:**
Attorney:	**Email/Phone:**
Do you know how to contact these people? ☐ Yes ☐ No	**When is your next meeting with your court services/probation officer?**
Court Orders:	
Court Fines and Fees Owed:	

What are your plans for completing court orders and paying fines?
(If no identified plan, please include tasks below to address creating a plan)

How do your current/past charges and court orders create barriers to your transition into adulthood?
What supports/resources can be explored to address these barriers?

Tasks to add to case plan to address current and pending charges and/or convictions: *(paying fines, community service hours, seeking out expungement resources, talk to GAL about charges/convictions impact on transition, etc.)*

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This Section to be Completed by Case Worker:

Summarize progress made since last transition plan meeting including narratives on progress towards obtaining adult social security, waiver services, guardianship, housing, and any other information needed for their transition into adulthood (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/Young Adult Signature: **Date:**
Case Manager feedback: *Concerns about youth's plan?* ☐*Yes* ☐*No* *Discussed concerns with youth/ team?* ☐*Yes* ☐*No* *(comments)*
CWCMP Case Manager Signature: **Date:**
DCF IL Coordinator feedback: *Concerns about youth's plan?* ☐*Yes* ☐*No* *Discussed concerns with youth/ team?* ☐*Yes* ☐*No* *(comments)*
DCF IL Coordinator Signature: **Date:**
Supportive Adult feedback: *Concerns about youth's plan?* ☐*Yes* ☐*No* *Discussed concerns with youth/ team?* ☐*Yes* ☐*No* *(comments)*
Youth or Young Adult Selected Supportive Adult Signature: **Date:**
Supportive Adult feedback: *Concerns about youth's plan?* ☐*Yes* ☐*No* *Discussed concerns with youth/ team?* ☐*Yes* ☐*No* *(comments)*
Youth or Young Adult Selected Supportive Adult Signature: **Date:**
Other Attendee Signature: **Date:**
Other Attendee Signature: **Date:**

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Resources	
Kansas Disability Rights Center (DRC): DRC has attorneys and advocates who provide free advocacy and legal services for Kansans with disabilities.	**Website:** www.drckansas.org **Phone:** 785-273-9661 **Address:** 214 SW 6th Ave Ste 100 Topeka, KS 66603
Social Security Administration (SSA): SSA administers retirement, disability, survivor, and family benefits, and enrolls individuals in Medicare.	**Website:** www.ssa.gov/agency/contact/ **Phone:** 1-800-772-1213
Kansas Guardianship Program: The Kansas Guardianship program is a volunteer-based model that provides guardianship or conservatorship services for vulnerable adults.	**Website:** www.ksgprog.org **Phone:** 785-587-8555 **Address:** 3248 Kimball Ave Manhattan, KS 66503
Kansas Department for Aging and Disability Services Home and Community Based Services (HCBS): HCBS provides oversight for a system of community-based supports and services for persons in Kansas with disabilities. Through this program, the state of Kansas is able to provide different services that allow those who need care to receive services in their homes or communities.	**Website:** www.kdads.ks.gov **Phone:** 785-368-6246 **Address:** 503 S. Kansas Ave Topeka, KS 66603 **Web Search:** KDADS HCBS Access Guide
Kansas Association of Centers for Independent Living: The Kansas Association of Centers for Independent Living (KACIL), is a member organization comprising eight (7) Centers for Independent Living (CILs) spanning the state. Centers provide services to people with all types of disabilities of all ages and all income levels through grant funded and fee for service programs.	**Website:** www.kacil.net/member-cil-directory **Phone:** 785-215-8048 **Address:** 214 SW 6th Ave Topeka, KS 66603
DCF Vocational Rehabilitation/Pre-ETS: Services for Kansans with disabilities to become gainfully employed and self-sufficient. PRE-ETS provides job exploration, counseling, and other services to help young people (16-21) prepare for employment and self-reliance.	**Website:**www.dcf.ks.gov/services/RS/Pages/Employment-Services.aspx