Fostering Connections Plan for Older Youth

Children, Youth and Families Department

Instructions:

1. Page one (1) should be completed at the first case planning meeting at age sixteen and a half (16.5) or when the youth enters foster care if after age 16.5; **and** updated at every Fostering Connection planning meeting thereafter.
2. An update shall be completed, at minimum, every six (6) months, and in accordance with the age indicated on the top of each section contained within this plan, until the young person is no longer in care or participating in the Fostering Connections program.
3. An additional update, using the Fostering Connections Transition Plan, shall be completed ninety (90) days prior to the young person's eighteenth (18) birthday.

Plan Start Date (month, day, year): **Plan End Date** (month, day, year):

YOUTH INFORMATION		
First name and middle initial	Last name	FACTS Number:
Date of birth (month, day, year)	Current age	SOGIE
Permanency Plan: ☐ Reunification ☐ Adoption ☐ Guardianship with relative ☐ Guardianship with non-relative ☐ PPLA		

ACKNOWLEDGEMENT OF YOUTH BILL OF RIGHTS AND RESPONSIBILITIES	
I acknowledge that I have been given a copy of the Youth Bill of Rights and Responsibilities for young people in care. The document has been explained to me and I understand my rights. I understand that nothing in this acknowledgement shall limit the duties or discretion of CYFD or the court to act in my best interests regarding my Fostering Connections Transition Plan.	
Signature	Date (month, day, year)

WHAT I SHOULD HAVE IN MY POSSESSION BEFORE LEAVING CARE

This list shall be updated every six (6) months. All documents must be in my possession by the last court hearing before my eighteenth (18) birthday.

Document / Critical Information	**Date obtained by CYFD**	**Date document/information in youth's possession (initial and date)**
1. Photo ID Type: ☐ Learner's permit ☐ Driver's license ☐ State issued ID ☐ Passport		
2. Birth Certificate County and State of birth:		
3. Social Security Card		
4. Certificate of Indian Blood (CIB) and Tribal enrollment/membership info ☐ N/A Tribal affiliation:		
5. Medicaid or Medical Insurance Card		
6. Immigration Documentation, including SJIS application if applicable ☐ N/A		
7. Medical records Type: ☐ Mental health records - including latest treatment plan, discharge plan, etc. ☐ Physical health records - including immunizations, dental, annual physical, etc.		
8. Education records High school diploma obtained ☐ Yes ☐ No GED/HiSET certificate obtained ☐ Yes ☐ No Last school attended: Last grade completed: Document Type: ☐ GED test scores ☐ HiSET test scores ☐ diploma/certificate ☐ Updated IEP or 504 plan		
9. Crime Victims Reparation Commission (CVRC) application submitted ☐ Yes ☐ No		
10. Information regarding registering to vote at 18		
11. Information regarding registering for selective services at 18 (males only)		
12. Life Book, important pictures, etc.		
13. Foster Care Verification Letter (verifying emancipation from foster care)		
14. Information on the NYTD survey, if applicable ☐ N/A		
15. Information on eligibility and services available through Fostering Connections		

DISABILITY INFORMATION – IF APPLICABLE ☐ N/A		
Support/Service	**Date approved**	**Date information provided to youth (initial and date)**
Social Security Insurance/Disability Insurance ☐ Yes ☐ No		
DD Waiver application ☐ Yes ☐ No		
DD Planning Council – Office of Guardianship ☐ Yes ☐ No		

To be completed in partnership with youth and their support network at age sixteen (16) years and six (6) months.

FOSTERING CONNECTIONS PROGRAM NOTIFICATION	
The Fostering Connections program has been reviewed with the youth. ☐ Yes ☐ No	**Date of conversation:**

SUPPORTIVE RELATIONSHIPS AND COMMUNITY CONNECTIONS (Note: use separate sheet if additional space is needed)	
Circle of Safety and Support updated with youth. ☐ Yes ☐ No	**Date completed:**
Seneca Family Finding completed. ☐ Yes ☐ No ☐ N/A	**Date completed:**

Name of support person (all known family - including siblings, friends, and supportive adults)	**Relationship to youth**	**Complete address, email, and/or social media contact information**	**Phone number**	**Type of support this person provides** (advice, emergency housing, financial support, a place for holidays, etc.)
			( )	
			( )	
			( )	
			( )	
			( )	
			( )	
			( )	

Plan to maintain connections with parent(s) and sibling(s) (include other family members, if applicable):

HOUSING
Current Address (number and street, apartment/unit number, city, state, and ZIP code)
Type of Placement: ☐ Relative Home ☐ Fictive Kin Home ☐ Non-Relative Foster Home ☐ Treatment Foster Care ☐ Residential Treatment Center ☐ Other:
How does the youth feel about this placement?
Is the youth thinking about where they may want to live after 18? ☐ Yes ☐ No Describe:

EDUCATION				
Last grade completed	**Current grade**	**Current school**	**Expected graduation date** (month, year)	**Cumulative GPA**
Does youth have an IEP? ☐ Yes ☐ No ☐ N/A	**Date of last IEP** (month, day, year)		**Did youth attend IEP?** ☐ Yes ☐ No ☐ N/A	
Does the current IEP support the youth's needs and educational success? ☐ Yes ☐ No ☐ N/A Describe:				

CULTURAL AND PERSONAL IDENTITY		
How does the youth describe AND express their culture and identity?	**Supports/Activities in place that affirm identity:**	**Date began**

FINANCES AND EMPLOYMENT		
Credit report pulled (required annually) ☐ Yes ☐ No	**Date completed:**	**Date reviewed with youth:**
How is the youth being engaged in volunteer/civic engagement in their areas of interest?		
What opportunities are in place for the youth to earn money and learn budgeting skills?		
Does youth need referral to Dept. of Vocational Rehab? ☐ Yes ☐ No Describe:		**Date referred:**
Sources of income and monthly amounts (employment, Social Security, etc.):		
Bank account ☐ Yes ☐ No	**Name of bank/financial institution:**	**Type:** ☐ Checking ☐ Savings

DAILY LIVING SKILLS AND TRANSPORTATION	
Casey Life Skills Assessment (CLSA) completed? (complete every 18 months) ☐ Yes ☐ No	**Date Completed:**
Does youth have access to reliable transportation to participate in age-appropriate activities? ☐ Yes ☐ No Describe type of transportation:	
Attended Driver's Education? ☐ Yes ☐ No	**Date completed:**

PHYSICAL AND MENTAL HEALTH		
Has the CANS Assessment been completed? ☐ Yes ☐ No	**Date Completed:**	**Date results/recommendations reviewed with youth:**
Medical Insurance Information (name of carrier, type of insurance):	**Medical Insurance Policy/member Number:**	
Name of Care Coordinator:	**Contact information (phone/email):**	
PCP Information (name and contact information):	**Last Appointment** (month, day, year):	**Next Appointment** (month, day, year):
Current issues being addressed:		
Behavioral health provider (name and contact information):	**Last Appointment** (month, day, year):	**Next Appointment** (month, day, year):
Types of services/supports being provided:		
Does youth receive medication management services? ☐ Yes ☐ No	**Provider** (name and contact information): ☐ N/A	
Does youth understand purpose of ALL medication(s)? ☐ Yes ☐ No ☐ N/A Describe:		
Dental provider (name and contact information):	**Last Appointment** (month, day, year):	**Next Appointment** (month, day, year):
Does the youth have access to sexual and reproductive health resources, services, and information? ☐ Yes ☐ No Describe:		
How does the youth feel about their physical and mental health?		

PARENTHOOD	
Is the youth pregnant or parenting? ☐ Yes ☐ No	**Describe services and supports:**
Does youth have access to services and supports (including childcare)? ☐ Yes ☐ No	

To be completed in partnership between the youth and their support network:

What are the youth's greatest strengths?

SIX (6) MONTH GOALS (consider knowledge, skill needs identified in the CLSA)				
Life Domain	**Goal**	**Steps to achieve goal**	**Team member committed to support/assist**	**Date completed** (month, day, year)

SIGNATURES OF TEAM MEMBERS IN ATTENDANCE			
Team Member/ Relationship to youth (Youth always signs first)	**Signature**	**Printed name**	**Date/ Contact Number**
☐ **Youth declined to participate in plan meeting.** ☐ **Youth declined to sign plan.** ☐ **Youth was unable to participate.** Effort made to engage:			Supervisor Initial

To be completed in partnership with youth and their support network at age seventeen (17).

FOSTERING CONNECTIONS PROGRAM NOTIFICATION	
The Fostering Connections program has been reviewed with the youth. ☐ Yes ☐ No	**Date of conversation:**
Youth's thoughts/feelings about the Fostering Connections program:	

SUPPORTIVE RELATIONSHIPS AND COMMUNITY CONNECTIONS (Note: use separate sheet if additional space is needed)	
Circle of Safety and Support updated with youth. ☐ Yes ☐ No	**Date completed:**
Seneca Family Finding completed. ☐ Yes ☐ No ☐ N/A	**Date completed:**

Name of support person (all known family - including siblings, friends, and supportive adults)	**Relationship to youth**	**Complete address, email, and/or social media contact information**	**Phone number**	**Type of support this person provides** (advice, emergency housing, financial support, a place for holidays, etc.)
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			( )	
			( )	
Plan to maintain connections with parent(s) and sibling(s) (include other family members, if applicable):				

HOUSING
Current Address (number and street, apartment/unit number, city, state, and ZIP code)
Type of Placement: ☐ **Relative Home** ☐ **Fictive Kin Home** ☐ **Non-Relative Foster Home** ☐ **Treatment Foster Care** ☐ **Residential Treatment Center** ☐ **SIL Placement;** describe: **Other:**
How does the youth feel about this placement?
Where does the youth want to live after 18?

EDUCATION				
Last grade completed	**Current grade**	**Current school**	**Expected graduation date** (month, year)	**Cumulative GPA**
Does youth have an IEP? ☐ Yes ☐ No ☐ N/A	**Date of last IEP** (month, day, year)		**Did youth attend IEP?** ☐ Yes ☐ No ☐ N/A	
Does the current IEP support the youth's needs and educational success? ☐ Yes ☐ No ☐ N/A Describe:				

CULTURAL AND PERSONAL IDENTITY	
How does the youth describe AND express their culture and identity?	**Supports/Activities in place that affirm identity:**

FINANCES AND EMPLOYMENT			
Credit report pulled (required annually) ☐ Yes ☐ No	**Date completed:**	**Date reviewed with youth:**	
How is the youth being engaged in volunteer/civic engagement in their areas of interest?			
What opportunities are in place for the youth to earn money and learn budgeting skills?			
Does youth need referral to Dept. of Workforce Solutions? ☐ Yes ☐ No Describe:	**Date referred:**		
Does youth need referral to Dept. of Vocational Rehab? ☐ Yes ☐ No Describe:	**Date referred:**		
Sources of income and monthly amounts (employment, Social Security, etc.):			
Bank account ☐ Yes ☐ No	**Name of bank/financial institution:**	**Type:** ☐ Checking ☐ Savings	

DAILY LIVING SKILLS AND TRANSPORTATION		
Casey Life Skills Assessment (CLSA) completed? (complete every 18 months) ☐ Yes ☐ No	**Date Completed:**	
Does youth have access to reliable transportation to participate in age-appropriate activities? ☐ Yes ☐ No Describe type of transportation:		
Does youth have a driver's license? ☐ Yes ☐ No	**Date issued:**	

PHYSICAL AND MENTAL HEALTH		
Has the CANS Assessment been completed? ☐ Yes ☐ No	**Date Completed:**	**Date results/recommendations reviewed with youth:**
Medical Insurance Information (name of carrier, type of insurance):	**Medical Insurance Policy/member Number:**	
Name of Care Coordinator:	**Contact information (phone/email):**	
PCP Information (name and contact information):	**Last Appointment** (month, day, year):	**Next Appointment** (month, day, year):
Current issues being addressed:		
Behavioral health provider (name and contact information):	**Last Appointment** (month, day, year):	**Next Appointment** (month, day, year):
Types of services/supports being provided:		
Does youth receive medication management services? ☐ Yes ☐ No	**Provider** (name and contact information): ☐ N/A	
Does youth understand purpose of ALL medication(s)? ☐ Yes ☐ No ☐ N/A Describe:		
Dental provider (name and contact information):	**Last Appointment** (month, day, year):	**Next Appointment** (month, day, year):
Does the youth have access to sexual and reproductive health resources, services, and information? ☐ Yes ☐ No Describe:		
How does the youth feel about their physical and mental health?		
Does youth know how to schedule their own physical/behavioral health appointments? ☐ Yes ☐ No		

PARENTHOOD	
Is the youth pregnant or parenting? ☐ Yes ☐ No	**Describe services and supports:**
Does youth have access to services and supports (including childcare)? ☐ Yes ☐ No	

To be completed in partnership between the youth and their support network:

What are the youth's greatest strengths?

SIX (6) MONTH GOALS				
Life Domain	**Goal**	**Steps to achieve goal**	**Team member committed to support/assist**	**Date completed** (month, day, year)
Housing				
Education				
Finances + Employment				
Daily Life Skills + Transportation				
Cultural + Personal Identity				
Supportive Relationships + Community Connections				
Physical + Mental Health				
Parenthood				

SIGNATURES OF TEAM MEMBERS IN ATTENDANCE			
Team Member/ Relationship to youth (Youth always signs first)	**Signature**	**Printed name**	**Date/ Contact Number**

☐ **Youth declined to participate in plan meeting.** ☐ **Youth declined to sign plan.** ☐ **Youth was unable to participate.**
Effort made to engage:

Supervisor Initial

To be completed in partnership with youth and their support network at age seventeen (17) years and six (6) months.

FOSTERING CONNECTIONS PROGRAM NOTIFICATION		
The Fostering Connections program has been discussed in detail with the youth. ☐ Yes ☐ No	**Date of conversation:**	
Youth has had an opportunity to review the Voluntary Support and Services Agreement (VSSA). ☐ Yes ☐ No		
What questions does the youth have about the program?	**Currently, does the youth plan to opt into the Fostering Connections program upon turning 18 years old?** ☐ Yes ☐ No ☐ undecided	
What is the plan to get any remaining questions answered?		

SUPPORTIVE RELATIONSHIPS AND COMMUNITY CONNECTIONS (Note: use separate sheet if additional space is needed)	
Circle of Safety and Support updated with youth. ☐ Yes ☐ No	**Date completed:**
Seneca Family Finding completed. ☐ Yes ☐ No ☐ N/A	**Date completed:**

Name of support person (all known family - including siblings, friends, and supportive adults)	**Relationship to youth**	**Complete address, email, and/or social media contact information**	**Phone number**	**Type of support this person provides** (advice, emergency housing, financial support, a place for holidays, etc.)
			( )	
			( )	
			( )	
			( )	
			( )	
Plan to maintain connections with parent(s) and sibling(s) (include other family members, if applicable):				

HOUSING
Current Address (number and street, apartment/unit number, city, state, and ZIP code)
Type of Placement: ☐ **Relative Home** ☐ **Fictive Kin Home** ☐ **Non-Relative Foster Home** ☐ **Treatment Foster Care** ☐ **Residential Treatment Center** ☐ **SIL Placement;** describe: **Other:**
How does the youth feel about this placement?
Where does the youth want to live after 18?

EDUCATION				
Last grade completed	**Current grade**	**Current school**	**Expected graduation date** (month, year)	**Cumulative GPA**
Does youth have an IEP? ☐ Yes ☐ No ☐ N/A	**Date of last IEP** (month, day, year)		**Did youth attend IEP?** ☐ Yes ☐ No ☐ N/A	
Does the current IEP support the youth's needs and educational success? ☐ Yes ☐ No ☐ N/A Describe:				

CULTURAL AND PERSONAL IDENTITY	
How does the youth describe AND express their culture and identity?	**Supports/Activities in place that affirm identity:**

FINANCES AND EMPLOYMENT			
Credit report pulled (required annually) ☐ Yes ☐ No	**Date completed:**	**Date reviewed with youth:**	
How is the youth being engaged in volunteer/civic engagement in their areas of interest?			
What opportunities are in place for the youth to earn money and learn budgeting skills?			
Does youth need referral to Dept. of Workforce Solutions? ☐ Yes ☐ No Describe:	**Date referred:**		
Does youth need referral to Dept. of Vocational Rehab? ☐ Yes ☐ No Describe:	**Date referred:**		
Sources of income and monthly amounts (employment, Social Security, etc.):			
List all previous employment, dates of employment, and reasons for leaving (use separate sheet if needed):			
Bank account ☐ Yes ☐ No	**Name of bank/financial institution:**	**Type:** ☐ Checking ☐ Savings	

DAILY LIVING SKILLS AND TRANSPORTATION		
Casey Life Skills Assessment (CLSA) completed? (complete every 18 months) ☐ Yes ☐ No	**Date Completed:**	
Does youth have access to reliable transportation to participate in age-appropriate activities? ☐ Yes ☐ No Describe type of transportation:		
Does youth have a driver's license? ☐ Yes ☐ No	**Date issued:**	

PHYSICAL AND MENTAL HEALTH		
Has the CANS Assessment been completed? ☐ Yes ☐ No	**Date Completed:**	**Date results/recommendations reviewed with youth:**
Medical Insurance Information (name of carrier, type of insurance):	**Medical Insurance Policy/member Number:**	
Name of Care Coordinator:	**Contact information (phone/email):**	
PCP Information (name and contact information):	**Last Appointment** (month, day, year):	**Next Appointment** (month, day, year):
Current issues being addressed:		
Behavioral health provider (name and contact information):	**Last Appointment** (month, day, year):	**Next Appointment** (month, day, year):
Types of services/supports being provided:		
Does youth receive medication management services? ☐ Yes ☐ No	**Provider** (name and contact information): ☐ N/A	
Does youth understand purpose of ALL medication(s)? ☐ Yes ☐ No ☐ N/A Describe:		
Dental provider (name and contact information):	**Last Appointment** (month, day, year):	**Next Appointment** (month, day, year):
Does the youth have access to sexual and reproductive health resources, services, and information? ☐ Yes ☐ No Describe:		
How does the youth feel about their physical and mental health?		
Youth knows how to make own appointments ☐ Yes ☐ No If no, describe:	**Youth makes own medical/behavioral health appointments** ☐ Yes ☐ No	

PARENTHOOD	
Is the youth pregnant or parenting? ☐ Yes ☐ No	**Describe services and supports:**
Does youth have access to services and supports (including childcare)? ☐ Yes ☐ No	

To be completed in partnership between the youth and their support network:

What are the youth's greatest strengths?

SIX (6) MONTH GOALS				
Life Domain	**Goal**	**Steps to achieve goal**	**Team member committed to support/assist**	**Date completed** (month, day, year)
Housing				
Education				
Finances + Employment				
Daily Life Skills + Transportation				
Cultural + Personal Identity				
Supportive Relationships + Community Connections				
Physical + Mental Health				
Parenthood				

SIGNATURES OF TEAM MEMBERS IN ATTENDANCE			
Team Member/ Relationship to youth (Youth always signs first)	**Signature**	**Printed name**	**Date/ Contact Number**
☐ **Youth declined to participate in plan meeting.** ☐ **Youth declined to sign plan.** ☐ **Youth was unable to participate.** Effort made to engage:			Supervisor Initial

To be completed in partnership youth and their support network at age seventeen (17) years and nine (9) months.

Fostering Connections Transition Plan

HOPES AND DREAMS FOR FUTURE	FEARS AND CONCERNS ABOUT TURNING 18

FOSTERING CONNECTIONS PROGRAM NOTIFICATION	
The Fostering Connections program has been discussed in detail with the youth and all remaining questions have been answered ☐ Yes ☐ No	**Youth is eligible for Fostering Connections** ☐ Yes ☐ No
Youth has signed 'Intent to Sign' VSSA to enter Fostering Connections program on 18th birthday ☐ Yes ☐ No	**Date signed:**

QUALIFYING ACTIVITIES FOR FOSTERING CONNECTIONS PROGRAM

Review qualifying activities and determine which apply to the youth's current circumstances and for participation after 18th birthday. Mark all that apply

- ☐ Completing secondary education or a program leading to an equivalent credential
- ☐ Being enrolled in an institution that provides postsecondary or vocational education
- ☐ Participating in a program or activity designed to promote or eliminate barriers to employment
- ☐ Being employed for at least 80 hours per month
- ☐ Being unable to participate in the activities listed above due to a medical or behavioral health condition that limits my participation.

SUPPORTIVE RELATIONSHIPS AND COMMUNITY CONNECTIONS

(Note: use separate sheet if additional space is needed)

Circle of Safety and Support updated with youth ☐ Yes ☐ No	**Date completed:**	**Date of final review with youth:**	
Seneca Family Finding completed ☐ Yes ☐ No ☐ N/A	**Date completed:**		
Identified person(s) youth would like support (re)connecting with:	**Plan to support (re)connection:**		

Name of support person (all known family - including siblings, friends, and supportive adults)	**Relationship to youth**	**Complete address, email, and/or social media contact information**	**Phone number**	**Type of support this person provides** (advice, emergency housing, financial support, a place for holidays, etc.)
			( )	
			( )	
			( )	
			( )	

How will youth maintain connections with parent(s) and sibling(s) after the age of 18 (include other family members, if applicable)**:**

HOUSING

Current Address (number and street, apartment/unit number, city, state, and ZIP code)

Type of Placement: ☐ **Relative Home** ☐ **Fictive Kin Home** ☐ **Non-Relative Foster Home** ☐ **Treatment Foster Care** ☐ **Residential Treatment Center** ☐ **SIL Placement;** describe: ☐ **Other:**

How does youth feel about this placement?

Where/with whom does youth plan to live with upon turning 18?

POST-18 HOUSING SUPPORTS EXPLORED WITH YOUTH		DATE COMPLETED
TLP Programs		
Voucher Programs	☐ CYFD Supportive Housing ☐ FUP Voucher ☐ FYI Voucher ☐ Section 8	
Other		

Address for youth after 18th birthday (number and street, apartment/unit number, city, state, and ZIP code)**:**

How does youth feel about their identified post-18 housing plan?

POST 18 HOUSING ACTION ITEM(S)	TEAM MEMBER TO SUPPORT	TARGET COMPLETION DATE

EDUCATION		
Current school		**Anticipated graduation date** (month, year)
Program type		**Last grade completed**
Does youth have an IEP? ☐ Yes ☐ No	**Date of last IEP** (month, day, year)	**Did youth attend IEP?** ☐ Yes ☐ No ☐ N/A
Does the current IEP support the youth's needs and educational success? ☐ Yes ☐ No ☐ N/A Describe:		
Plan for education post 18th birthday is:		
We have discussed: ☐ How the Fostering Connections program can support me in completing my high school education and earn my diploma or GED. ☐ How the Fostering Connections program can support me in enrolling in and attending college or vocational program. ☐ How to obtain/complete applications for college, vocational programs, or other education programs I may be interested in.		

POST 18 EDUCATION ACTION ITEM(S)	TEAM MEMBER TO SUPPORT	TARGET COMPLETION DATE

CULTURAL AND PERSONAL IDENTITY	
How does the youth describe and express their culture and identity?	**Supports/Activities in place that affirm identity:**
Does youth feel their cultural and personal identity was supported while in care? ☐ Yes ☐ No Describe	

POST 18 CULTURE AND PERSONAL IDENTITY SUPPORT REQUESTED	TEAM MEMBER TO SUPPORT	TARGET COMPLETION DATE

FINANCES AND EMPLOYMENT		
Credit report pulled (required annually) ☐ Yes ☐ No	**Date completed:**	**Date reviewed with youth:**
Opportunities to earn income and strengthen budgeting skills while in care:	**Volunteer/civic engagement opportunities while in care:**	
Youth referred to Dept. of Vocational Rehab? ☐ Yes ☐ No ☐ N/A	**Important information about DVR participation:**	
Youth referred to Dept. of Workforce Solutions? ☐ Yes ☐ No ☐ N/A	**Important information about Dept. of Workforce Solutions participation:**	
Currently employed ☐ Part time ☐ Full time ☐ Not employed Hours per week	**Current employer** (name, complete address)	
List all previous employment, dates of employment, and reasons for leaving (use separate sheet if needed):		
Is youth participating in program to promote or remove barriers to employment? ☐ Yes ☐ No ☐ N/A Describe:		
Sources of income and monthly amounts (employment, Social Security, etc.):		
Bank account ☐ Yes ☐ No	**Name of bank/financial institution:**	**Type:** ☐ Checking ☐ Savings
Does youth feel they have the employment and financial skills needed for success and stability upon turning 18? ☐ Yes ☐ No Describe:		

POST 18 FINANCE AND EMPLOYMENT ACTION ITEM(S)	TEAM MEMBER TO SUPPORT	TARGET COMPLETION DATE

DAILY LIVING SKILLS AND TRANSPORTATION		
Access to reliable transportation? ☐ Yes ☐ No Describe:	**Completed Driver's Education?** ☐ Yes ☐ No	**Obtained Driver's License?** ☐ Yes ☐ No
Has own vehicle? ☐ Yes ☐ No	**Insurance coverage**	**Payment due dates**
Does youth feel their access to transportation will meet their needs upon turning 18? ☐ Yes ☐ No Describe:		
Date of last CLSA:	**Areas of strength:**	**Areas of needed development** (include in action items)**:**

POST 18 DAILY LIVING SKILLS AND TRANSPORTATION ACTION ITEM(S)	TEAM MEMBER TO SUPPORT	TARGET COMPLETION DATE

PHYSICAL AND MENTAL HEALTH		
Medical Insurance Information (name of carrier, type of insurance)**:**	**Medical Insurance Policy/member Number:**	
Name of Care Coordinator:	**Contact information (phone/email):**	
PCP Information (name and contact information)**:**	**Last Appointment** (month, day, year)**:**	**Next Appointment** (month, day, year)**:**
Current issues being addressed:		
Behavioral health provider (name and contact information)**:**	**Last Appointment** (month, day, year)**:**	**Next Appointment** (month, day, year)**:**
Types of services/supports being provided:		
Does youth receive medication management services? ☐ Yes ☐ No	**Provider** (name and contact information)**:** ☐ N/A	
Does youth understand purpose of ALL medication(s)? ☐ Yes ☐ No ☐ N/A Describe:		
Dental provider (name and contact information)**:**	**Last Appointment** (month, day, year)**:**	**Next Appointment** (month, day, year)**:**
Does the youth have access to sexual and reproductive health resources, services, and information? ☐ Yes ☐ No Describe:		
We have discussed: ☐ Ongoing medical coverage after 18th birthday, including steps to ensure continued coverage. ☐ Medical and dental history and how to contact offices for appointments. ☐ Mental and behavioral health history and recommendations for continued support, including how to contact offices for appointments. ☐ How to access emergency services if the need arises.		
How does youth feel about their current physical and mental health?		
What is the youth's plan for maintaining physical, mental, and behavioral health upon turning 18?		

POST 18 PHYSICAL AND MENTAL HEALTH ACTION ITEM(S)	TEAM MEMBER TO SUPPORT	TARGET COMPLETION DATE

PARENTING	
Is the youth pregnant or parenting? ☐ Yes ☐ No	**Describe**:
Does youth have access to resources, services, and supports? ☐ Yes ☐ No ☐ N/A	
Does youth have access to reliable, consistent childcare? ☐ Yes ☐ No ☐ N/A	

POST 18 PARENTHOOD ACTION ITEM(S)	TEAM MEMBER TO SUPPORT	TARGET COMPLETION DATE

To be completed in partnership between the youth and their support network:

What are the youth's greatest strengths moving into adulthood?

ACKNOWLEDGEMENTS AND SIGNATURES	
I, , have participated in the development of this transition plan and have been provided with the documents listed on page one. During my transition planning meeting, we discussed: ☐ the Fostering Connections program and services/supports available to me through the program. ☐ other services available should I chose not to opt into the Fostering Connections program upon turning 18. ☐ the federal National Youth in Transition Database (NYTD) survey and the importance of participating in the survey at 17, 19, and 21. ☐ the importance of having an Advanced Health Care Directive, which would designate another person to make health care treatment decision on my behalf in case I become incapacitated and unable to participate in such decisions. My Youth Attorney will help me set this up. ☐ the importance of having and keeping a secure mailing address for important documents. ☐ the importance of updating my mailing address, should it change, with benefits (SSI/SSA, SNAP, Housing) providers. ☐ how to access services I may be eligible for to support my transition to adulthood (SNAP benefits, TANF, childcare, etc.) ☐ other:	
Signature of youth:	**Date:**

SIGNATURES OF TEAM MEMBERS IN ATTENDANCE			
Team Member/ Relationship to youth	**Signature**	**Printed name**	**Date/ Contact Number**
☐ **Youth declined to participate in plan meeting.** ☐ **Youth declined to sign plan.** ☐ **Youth was unable to participate.** Active efforts made to engage:			Supervisor Initial