Youth/Young Adult Name:_____ DOB:_____

North Carolina Department of Health and Human Services | Division of Social Services

PART A: TRANSITIONAL LIVING PLAN FOR YOUTH/YOUNG ADULTS IN FOSTER CARE

Instructions:	1. This form must be completed within 30 days following the youth's 14th birthday, or when the youth enters foster care, if age 14 or older; and updated every 90 days thereafter. 2. The Transition Plan (Part B) must be completed 90 days prior to the youth's 18th birthday. The youth must be informed of his/her option to continue in Foster Care 18 to 21 at this time. Note: If the youth opts to continue in Foster Care 18 to 21, the Transition Plan must be completed ***and*** the goals of the TLP (Section I.B) must be updated to reflect how the youth plans to meet eligibility requirements of the program.
Foster Care 18 to 21:	1. If the young adult opts to continue in Foster Care 18 to 21, the TLP (Section I – III) must be updated within 30 days of the young adult's 18th birthday, and every 90 days thereafter. 2. If the young adult is over age 18 and wishes to re-enter into Foster Care 18 to 21, the TLP (Sections I – III) of this form must be completed within 30 days of re-entry, and every 90 days thereafter. 3. The Transition Plan (Part C) must be completed 90 days prior to the young adult's 21st birthday, or planned exit from Foster Care 18 to 21.

I. TRANSITIONAL LIVING PLAN

Case Worker Name: _____ **Case Worker Phone Number:** (_____) _____

Parties to Case Plan:

Name: _____
Address: _____
Phone Number: _____
Email Address: _____

Name: _____
Address: _____
Phone Number: _____
Email Address: _____

Name: _____
Address: _____
Phone Number: _____
Email Address: _____

Name: _____
Address: _____
Phone Number: _____
Email Address: _____

A. YOUTH/YOUNG ADULT INFORMATION

Name: _____ Date of Birth: _____ Age:_____

Date of first admission to out-of-home care: _____Date of last admission to out-of-home care: _____

Estimated date of exit from foster care: _____ Date of Initial Plan: _____

Placement Type: _____ Date of Placement: _____

☐ Regular Foster Care ☐ Foster Care 18 to 21

If Foster Care 18 to 21, does placement continue to be approved? ☐ Yes ☐ No

Youth/Young Adult Name:________________________________ DOB:__________________

B. GOALS AND ACTIVITIES

Date of Plan: _______________

To be completed by youth/young adult and team:

Youth/Young Adult's strengths: *(include hobbies, interests, extracurricular, enrichment, cultural, and social activities)*				
Life Skills Assessment Completed? ☐ Yes ☐ No			Date Completed: __________	
Note: Items to consider when developing goals should include but are not limited to: educational and vocational training, personal support systems, independent living skills, safe and secure living arrangements upon exit from foster care, and any other specific items related to the youth/young adult's transition to self-sufficiency.				
Goal:	**Activities/Steps to achieve goal:**	**Responsible Parties:**	**Projected Completion Date:**	**Progress:**
				Date: _________ ☐ Met Goal ☐ Satisfactory Progress ☐ Needs more time / assistance ☐ Goal needs modification
				Date: _________ ☐ Met Goal ☐ Satisfactory Progress ☐ Needs more time / assistance ☐ Goal needs modification
				Date: _________ ☐ Met Goal ☐ Satisfactory Progress ☐ Needs more time / assistance ☐ Goal needs modification
				Date: _________ ☐ Met Goal ☐ Satisfactory Progress ☐ Needs more time / assistance ☐ Goal needs modification
				Date: _________ ☐ Met Goal ☐ Satisfactory Progress ☐ Needs more time / assistance ☐ Goal needs modification

Youth/Young Adult Name:_____ DOB:_____

C. SUPPORTIVE RELATIONSHIPS

Name:	Relationship to Youth/ Young Adult:	Address:	Email:	Telephone Number: ( )
Supports offered: *(housing, budgeting, healthcare, career/education planning, etc.)*				
Name:	Relationship to Youth/ Young Adult:	Address:	Email:	Telephone Number: ( )
Supports offered: *(housing, budgeting, healthcare, career/education planning, etc.)*				
Name:	Relationship to Youth/ Young Adult:	Address:	Email:	Telephone Number: ( )
Supports offered: *(housing, budgeting, healthcare, career/education planning, etc.)*				
Name:	Relationship to Youth Young Adult:	Address:	Email:	Telephone Number: ( )
Supports offered: *(housing, budgeting, healthcare, career/education planning, etc.)*				
What additional steps will be taken to establish meaningful adult relationships and supports for the youth/young adult?				

D. HOUSING

Current address: *(number and street, city, state, and ZIP code)*	Telephone or other contact information:
Where youth/young adult plans to live upon exit from foster care: *(number and street, city, state, and ZIP code)*	Telephone or other contact information:
What is the youth/young adult's back-up living arrangement if the above plan falls through? *(number and street, city, state, and ZIP code)*	Telephone or other contact information:

E. ADDITIONAL SERVICES NEEDED

Are any additional services needed to assist the youth/young adult with independent living skills, medical treatment, counseling, educational support, employment preparation and placement, and/or development of support networks? If yes, please list needed services below:		☐ Yes ☐ No
Service:	Who is responsible?	Has referral been made? ☐ Yes ☐ No Date:_____
Service:	Who is responsible?	Has referral been made? ☐ Yes ☐ No Date:_____
Service:	Who is responsible?	Has referral been made? ☐ Yes ☐ No Date: _____

II. ALTERNATE PLAN

In the event the above plan does not work out, an unexpected exit from Foster Care 18 to 21 occurs, or there is a sudden break in participation, what is the youth/young adult's back-up plan? *(please document a fully developed back-up plan that includes alternate plans for school and/or employment, resources that will be utilized, and any other information specific to these circumstances. This plan should be developed in partnership with the youth/young adult)*

Youth/Young Adult Name:_____ DOB:_____

III. FOSTER CARE 18 TO 21 SERVICES (only)

A. PROGRAM ELIGIBILITY

☐ High School Diploma / GED	Name of School: Address of School: Telephone Number:	Grade level: Anticipated graduation date:
☐ College / Vocational	Name of School: Address of School: Telephone Number: Type of Program:	Hours/Semester: Total credits earned:
☐ Program to remove barriers to employment	Name of Program: Address: Telephone Number:	Hours/week:
☐ Employment	Name of Employer: Address of Employer: Telephone Number:	Hours/week:
☐ Medical condition / disability	Condition Exempting Participation:	Documentation of condition in case record? ☐ Yes ☐ No

B. SKILL DEVELOPMENT

Educational/Vocational Assistance:	
Employment Assistance:	
Life Skills Training:	
Transitional Housing:	
Medical/Dental/Mental Health:	
Strengthening Personal Support Systems:	
Other:	
Identified Strengths:	
Identified Needs:	
Additional Services Requested:	

Youth/Young Adult Name:_____ DOB:_____

C. SIGNATURES

SIGNATURES	COMMENTS	DATE	I HAVE RECEIVED A COPY OF THIS PLAN
Youth/Young Adult			☐ Yes ☐ No
Care Provider			☐ Yes ☐ No
Care Provider			☐ Yes ☐ No
Parent (if applicable)			☐ Yes ☐ No
Parent (if applicable)			☐ Yes ☐ No
Social Worker			☐ Yes ☐ No
Social Work Supervisor			☐ Yes ☐ No
Service Provider			☐ Yes ☐ No
Service Provider			☐ Yes ☐ No
Other			☐ Yes ☐ No
Other			☐ Yes ☐ No