| | INDIANA DEPARTMENT OF CHILD SERVICES<br>CHILD WELFARE POLICY | |
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| INDIANA DEPARTMENT OF CHILD SERVICES | **Chapter 11:** Older Youth Services | **Effective Date:** April 1, 2021 |
| | **Section 6:** Transition Plan for Successful Adulthood | **Version:** 9 |

## STATEMENTS OF PURPOSE

The Indiana Department of Child Services (DCS) will ensure a Transition Plan for Successful Adulthood (SF 55166) is developed, which identifies an Independent Living (IL) placement, for all youth in out-of-home placement beginning at 14 years of age and should continue until the youth leaves care. The plan shall be:

1. Youth-focused and developed with the assistance of DCS and members of the youth's Child and Family Team (CFT), including up to two (2) child representatives;
2. As detailed as the youth elects;
3. An outline of the Older Youth Services (OYS) the youth will receive (see policy 11.01 Older Youth Services);
4. Focused on short-term and long-term achievable and measurable goals;
5. Updated every six (6) months until the youth's case is closed; and
6. Given to the youth at each update (see the Transition Plan for Successful Adulthood [SF 55166] and Related Information for more information).

   **Note:** A Transitional Services Plan must be completed 90 days before the youth turns 18 years of age. See the Transitional Services Plan section of the Transition Plan for Successful Adulthood (SF 55166). If the youth enters out-of-home placement after 90 days before the youth's 18th birthday, a Transitional Services Plan will be developed within 60 days of the out-of-home placement.

Probation Officers are responsible for completing the Transition Plan (TP072117JDJS) for probation youth.

If DCS determines that the youth is unable to participate effectively in the development of the Transition Plan for Successful Adulthood (SF 55166) due to a physical, mental, emotional, or intellectual disability, DCS may excuse the youth from the planning process by documenting in the plan the reasons for the youth's inability to participate in the development of the plan.

If the youth refuses to participate in the development of the Transition Plan for Successful Adulthood (SF 55166), DCS must record the refusal and document efforts made to obtain the child's input or participation in the development of the Transition Plan for Successful Adulthood (SF 55166).

DCS will ensure a referral for OYS is completed for youth at the appropriate age, given the youth's placement (see policy 11.01 Older Youth Services).

**Note:** Review the Older Youth Services (OYS) Timeline for further guidance.

Code References

1. IC 21-12-6: Twenty-First Century Scholars Program; Tuition Grants
2. IC 31-25-2-21: Transitional services plan; participation by child representatives
3. IC 31-28-5.8-6: Updating case plans; transitional services plan; visitation with family case manager
4. IC 31-34-15-7: Consult with child; selection of child representatives; adviser
5. IC 31-34-21-7: Permanency hearing
6. 42 USC 675(5)(H): Transition Plan for Children Aging Out of Foster Care
7. 42 USC 677 John H. Chafee Foster Care Program for Successful Transition to Adulthood



## PROCEDURE

The Family Case Manager (FCM) will:

1. Convene a Transition Plan for Successful Adulthood meeting, which includes the youth, beginning at 14 years of age, to develop the Transition Plan for Successful Adulthood (SF 55166); and

   **Note:** The Transition Plan for Successful Adulthood (SF 55166) should be developed during a CFT Meeting or Case Plan Conference (see policies 5.07 Child and Family Team Meetings and 5.08 Developing the Case Plan). The FCM will review the composition of the current CFT with the youth prior to each meeting to determine the appropriateness of that team continuing as the youth's CFT. The youth's child representatives should be members of the CFT. If it is determined that the existing CFT should not serve this role, a new CFT will be developed with input from the youth regarding the team's membership.

2. Ensure that eligible youth in out-of-home placement as a "ward of another state" are receiving OYS as requested by the sending state of the Interstate Compact for the Placement of Children (ICPC) and a Transition Plan for Successful Adulthood (SF 55166) is prepared following the schedule outlined below and in the Older Youth Services (OYS) Timeline.
3. Provide the Indiana DCS Bill of Rights for Youth in Care and review the document with youth beginning at age 14.

The FCM or Collaborative Care Case Manager (3CM) will:

1. Hold follow-up meetings every six (6) months until case closure to review and update the Transition Plan for Successful Adulthood (SF 55166). See below for a list of required items to be discussed at each CFT Meeting and review the Older Youth Services (OYS) Timeline; and
2. Hold a Case Plan Conference with the youth if he or she is unable to or refuses to participate in the CFT process (see policy 5.08 Developing the Case Plan).

   **Note:** If unable to participate, document in the plan the reasons for the youth's inability to participate in the development of the plan. If the youth refuses to participate, document the efforts made to obtain the child's input or participation in the development of the plan.

**Transition Plan for Successful Adulthood Schedule**

At 14 years of age, the FCM will:

1. Assist the youth in applying for the 21st Century Scholars Program if the youth is not already enrolled (see policy 11.15 Post-Secondary Education);
2. Make a referral to Vocational Rehabilitation Services Vocational Rehabilitation Services for all youth with an Individualized Education Plan (IEP); and
3. Engage the CFT to develop the Transition Plan for Successful Adulthood (SF 55166). This initial plan shall:
   a. Address the youth's current level of independent living skills mastery,
   b. Identify independent living skills to work on,
   c. Set goals in identified areas of need, and
   d. Determine methods to achieve these goals.

   **Note:** The Transition Plan for Successful Adulthood (SF 55166) must be updated at least every six (6) months until case closure.

At 16 years of age, the FCM will:

1. Convene a Transition Plan for Successful Adulthood meeting to review the initial Transition Plan for Successful Adulthood (SF 55166) and update the goals as needed;

   **Note:** Beginning at 16 years of age, the youth must be provided all documents listed on the Transition Plan for Successful Adulthood (SF 55166), including the Foster Care Verification Letter (SF 56571), at the time of case closure. When the youth is 16 years of age, if the case has transitioned, a 3CM may take on the responsibilities of reviewing and updating the Transition Plan for Successful Adulthood (SF 55166).

2. Make a referral for OYS for youth placed in a DCS licensed foster home, unlicensed relative placements, or non-licensed court approved placements; and

   **Note:** If the youth has been referred to the Bureau of Developmental Disabilities (BDDS), a referral for OYS should be staffed with a member of the Older Youth Initiatives (OYI) Team to determine if a referral for OYS is appropriate.

3. Assist the youth in creating and/or updating a Successful Adulthood Lifebook.

At 17 years of age, the FCM or 3CM will:

1. Convene a Transition Plan for Successful Adulthood meeting to focus on goals to be achieved before the youth leaves out-of-home placement, including post-secondary options, employment, and housing;

   **Note:** Beginning at 16 years of age, the youth must be provided all documents listed on the Transition Plan for Successful Adulthood (SF 55166), including the Foster Care Verification Letter (SF 56571), at the time of case closure.

2. Invite a member of the OYI or CC Team to attend the Transition Plan for Successful Adulthood meeting to present information regarding Older Youth Services (OYS);
3. Provide the youth with information regarding post-secondary financial aid, including the Free Application for Federal Student Aid (FAFSA), federal aid such as Pell grants, the John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee Program) Education and Training Voucher (ETV) grant, and the Indiana Commission of

Higher Education's Division of Student Financial Aid. See policies 11.10 Education and Training Voucher Program and 11.15 Post-Secondary Education for further information; and

**Note:** This information may be provided earlier if the youth is applying to colleges before 17 years of age or is pursuing a High School Equivalency (HSE) Diploma.

4. Ensure that the youth and the caregiver have signed the Acknowledgement of Receipt of Information about Various Educational Programs (SF 55743). Give the youth and caregiver a copy and place the original in the child's case file and upload in the case management system.

At 17 years of age, a member of the OYI or CC Team will:

1. Attend the youth's Transition Plan for Successful Adulthood meeting/Case Plan Conference to present information regarding OYS; and

   **Note:** Beginning at 16 years of age, the youth must be provided all documents listed on the Transition Plan for Successful Adulthood (SF 55166), including the Foster Care Verification Letter (SF 56571), at the time of case closure.

2. Complete the National Youth in Transition Database (NYTD) Youth Outcomes Survey, as applicable (see policy 11.17 National Youth in Transition Database [NYTD]).

At age 17 years and six (6) months, the FCM or 3CM will:

1. Convene a Transition Plan for Successful Adulthood meeting to focus on preparing the youth for transitioning to CC (see policy 11.21 Collaborative Care Case Transfers) or transitioning out of out-of-home placement;
2. Continue to assist the youth in identifying his or her interests, possible career options, post-secondary education possibilities, and employment possibilities; and
3. Make a referral for OYS for a youth who will have his or her DCS case dismissed at age 18 if he or she is placed in a LCPA foster home, group home, residential facility, or at home on a THV.

   **Note:** Beginning at 16 years of age, the youth must be provided all documents listed on the Transition Plan for Successful Adulthood (SF 55166), including the Foster Care Verification Letter (SF 56571), at the time of case closure.

Ninety (90) days before the youth's 18th birthday, the FCM or 3CM will:

1. Convene a Transition Plan for Successful Adulthood meeting to complete the Transitional Services Plan portion of the Transition Plan for Successful Adulthood (SF 55166);

   **Note:** Beginning at 16 years of age, the youth must be provided all documents listed on the Transition Plan for Successful Adulthood (SF 55166), including the Foster Care Verification Letter (SF 56571), at the time of case closure.

2. Ensure the youth has received the Advance Directive packet (available on the Older Youth Initiatives website), is given the chance to watch the video explaining the packet, and is provided information and education regarding the importance of designating a health representative to make health decisions and the importance of executing a health

care power of attorney, health care proxy, or other similar document recognized under State law; and
3. Confirm the youth is enrolled in Medicaid.

**After the youth turns 18 years of age**, the FCM or 3CM will send the Medicaid Enrollment Unit (MEU) an e-mail to confirm the Medicaid case indicates the youth is a ward at the age of 18 so the youth is eligible for Medicaid for Former Indiana Foster Children (MA 15).

The FCM Supervisor or 3CM Supervisor will:
1. Ensure the FCM or 3CM has completed the appropriate sections of the Transition Plan for Successful Adulthood (SF 55166) are completed at the appropriate times, as outlined above;
2. Assist the FCM or 3CM in completing referrals as needed; and
3. Provide Clinical Supervision to the FCM or 3CM.

## PRACTICE GUIDANCE

### Legal Advice
The FCM/3CM cannot give legal advice. The FCM/3CM shall not be the health care legal representative for any youth known to DCS unless the FCM/3CM is given advance approval of this arrangement by the Regional Manager (RM) for FCM or the OYI Manager or designee for 3CMs.

### Child Representatives
Beginning at 14 years of age, FCMs should advise youth that they may select up to two (2) child representatives. The child representatives must be at least 18 years of age, members of the CFT, and may not be a foster parent or FCM. The youth may select one (1) of the child representatives to also be an adviser and, if necessary, advocate for age appropriate activities. Child representatives are subject to the approval of DCS, and they may be rejected if there is cause to believe that they would not act in the best interest of the child.

### Successful Adulthood Lifebook
At 14 years of age, at the CFT Meeting, each youth should begin developing a Successful Adulthood Lifebook. The Successful Adulthood Lifebook should provide information to help the youth become independent and should include space to store important documents as well as other personal items the youth may want to keep. The youth's FCM, therapist, resource parent, OYI Team member, or OYS provider may assist the youth, if necessary, in locating items for completing the Successful Adulthood Lifebook. There is no pre-set format for a Successful Adulthood Lifebook. The Successful Adulthood Lifebook should be individualized and tailored to fit the youth's needs. The Successful Adulthood Lifebook may contain, but is not limited to:
1. Photographs of the youth;
2. Photographs of persons and places that were significant in the youth's life prior to and while being placed in out-of-home placement;
3. Items related to school and extracurricular activities, (e.g., report cards, certificates, art work, awards, etc.);
4. Important documents the youth may need as he or she exits the foster care system (e.g., birth certificate, Social Security card, medical record, vaccination record, etc.); and
5. Short summaries of significant events that have occurred in the child's life.

**Note:** The Successful Adulthood Lifebook is the property of the youth and should remain with the youth through any placement changes.

**Permanency Plan of Reunification or Adoption**

In certain cases, a youth's permanency plan at age 16 years will be reunification or adoption with a concurrent plan of Another Planned Permanent Living Arrangement (APPLA). In these cases, a youth's Transition Plan for Successful Adulthood (SF 55166) may be focused on the skills the youth will need to live successfully at home with his or her parent or adoptive family. However, as the youth gets closer to 18 years of age, the team should ensure that the youth is prepared for potentially living on his or her own.

**Note:** APPLA is only an option for youth 16 years of age and older. DCS must document why every other permanency plan option is not in the best interest of the child, as well as, document continuous efforts to locate relatives of the youth.

## FORMS AND TOOLS

1. Acknowledgement of Receipt of Information about Various Educational Programs (SF 55743)
2. Advance Directives packet- Available on the Older Youth Initiatives website.
3. Foster Care Verification Letter (SF 56571)
4. Indiana DCS Bill of Rights for Youth in Care
5. Older Youth Services (OYS) Timeline
6. Transition Plan (TP072117JDJS)
7. Transition Plan for Successful Adulthood (SF 55166)

## RELATED INFORMATION

**Transition Plan for Successful Adulthood**

The Transition Plan for Successful Adulthood (SF 55166) and its Transitional Services Plan component is a comprehensive, written plan that is personalized for each youth and is to be used at each meeting with the youth and at the CFT Meeting to guide the transition planning process with the youth. The Transition Plan for Successful Adulthood (SF 55166) must include information and specific options relating to the following:

1. Education and training;
2. Employment services and work force supports;
3. IL placement;
4. Health care, including prevention and treatment services and referral information;
5. Health insurance availability and options;
6. Local opportunities for mentors and continuing support services, including development of lifelong adult relationships and informal continuing supports;
7. Identification and development of daily living and problem-solving skills;
8. Procedures available under Indiana law for, and the importance of advance directives;
9. Availability of local, state, and federal resources including financial assistance, relating to any parts of the plan described above; and
10. OYS, which may include any of the following kinds of services that are intended to prepare the youth for self-support and living arrangements that are self-sufficient and not subject to supervision by another individual or institution:
    a. Arrangements for the youth to participate in CC for a youth who is 17 and six (6) months of age or older, if appropriate,

b. Activities of daily living and social skills training,
c. Opportunities for social, cultural, recreational, or spiritual activities that are designed to expand life experiences in a manner appropriate to the youth's cultural heritage and needs and any other special needs, and
d. Matching of a youth on a voluntary basis with caring adults to act as mentors and assist the youth to establish lifelong connections with caring adults.

The Transitional Services Plan (90 days before the youth's 18th birthday) may include information and specific options relating any additional older youth service that is approved by the department and are appropriately tailored to the needs of the youth.

**Advance Directives**

"Advance directives" is a term that refers to spoken and written instructions about an individual's future medical care and treatment. By stating health care choices in an advance directive, this allows family members and physicians to understand the individual's wishes about medical care. Indiana law pays special attention to advance directives.

Advance directives are normally one (1) or more documents that list the individual's health care instructions. An advance directive may name a person of choice to make health care choices for when the individual is unable to make the choices. The individual may also use an advance directive to prevent certain people from making health care decisions on one's behalf. For more information go to the Indiana Department of Health or Older Youth Initiatives websites.

**Clinical Supervision**

Clinical Supervision is a process in which an individual with specific knowledge, expertise or skill provides support while overseeing and facilitation the learning of another individual.

> **Example**: The focus of clinical supervision for an FCM is on practice that directly impacts outcomes for families.