	INDIANA DEPARTMENT OF CHILD SERVICES **CHILD WELFARE POLICY**	
	Chapter 11: Older Youth Services	**Effective Date:** November 1, 2021
	Section 21: Collaborative Care (CC) Case Transfers	**Version:** 5

POLICY OVERVIEW

In order to support a youth's transition to successful adulthood, a youth's case is transferred to a Collaborative Care Case Manager (3CM) if the youth is 16 years of age or older with a Permanency Plan of Another Planned Permanency Living Arrangement (APPLA) and plans to either voluntarily enter Collaborative Care (CC) or remain under a Child in Need of Services (CHINS) case. During the youth's transfer, a Transition Plan for Successful Adulthood is developed to maintain the youth's services, which will help to ensure the youth's safety. The youth's essential connections are also identified during the transfer process, and there is a discussion about how to help the youth develop those connections.

PROCEDURE

The Indiana Department of Child Services (DCS) will engage the youth to determine the best path based on the youth's direction and voice. The youth may request to do one (1) of the following upon turning 18:

1. Remain under the care and supervision of DCS through the CHINS case;
2. Enter CC under the care and supervision of DCS; or
3. Request that the youth's CHINS case be dismissed and enter into Voluntary Older Youth Services (OYS).

   Note: Probation youth 18 years of age and over with an open Juvenile Delinquency (JD) case may be able to receive CC services (see policy 11.20 Youth Adjudicated as Juvenile Delinquents Accessing Collaborative Care).

Continuity of care will be ensured when transferring a case from the Family Case Manager (FCM) to the 3CM by conducting a transition Child and Family Team (CFT) Meeting that includes the FCM, 3CM, the youth, the youth's child representative(s), and any other relevant persons (see policy 5.07 Child and Family Team Meetings).

In addition to the transition CFT Meeting, there may be circumstances in which a case transfer meeting may need to be conducted with the FCM, 3CM, FCM Supervisor, and 3CM Supervisor. Examples of circumstances that would require a case transfer meeting include, but are not limited to:

1. Placement instability;
2. Safety concerns; and
3. High profile cases.

Case transfer meetings provide the opportunity to discuss effective case planning, address barriers to stepdown plans, and ensure a seamless case transition. The timing and/or necessity

of this case conference would be negotiated between the FCM Supervisor and 3CM Supervisor; however, it should not disrupt the general flow of the case transfer process.

For youth 16 years of age or older, the FCM will:

1. Staff the case with the FCM Supervisor to determine if the youth's Case Plan/Prevention Plan goal should change to APPLA and if the case should transfer to a 3CM;
2. Complete a CFT to ensure the team, including the Court Appointed Special Advocate (CASA)/Guardian ad Litem (GAL), supports and approves of the decision to change the Case Plan/Prevention Plan goal to APPLA prior to transferring the case to a 3CM (see policy 5.07 Child and Family Team Meetings);

   Note: Prior to selecting APPLA as a Case Plan/Prevention Plan goal and transitioning a youth at age 16, it is critical to ensure other viable Permanency Plan options (i.e., reunification, adoption, guardianship, or fit and willing relative placement) have been considered and actively pursued. Invite a 3CM or Independent Living Specialist to the CFT Meeting to provide information.

3. Request that the Regional Permanency Team (RPT), including a member of the Collaborative Care Team (see the Collaborative Care Supervisor Map for contact information) reviews and approves of the decision to change the Permanency Plan to APPLA. A Permanency Plan of APPLA must then be approved by the Regional Manager (RM) (see policy 8.51 Regional Permanency Teams);
4. Meet with the DCS Staff Attorney and, if appropriate, seek court approval of the Case Plan/Prevention Plan goal change;
5. Ensure case information is documented in the case management system and is current. This information includes, but is not limited to:
   a. Court hearings, reports, orders, and notices,

      Note: If the court hearing is within 30 calendar days of the transfer, the FCM is responsible for this report, unless negotiated otherwise at the transition meeting.

   b. Placements,
   c. Services,
   d. Visitation Plan (if applicable) (see policy 8.12 Developing the Visitation Plan),
   e. Case Plan/Prevention Plan (see policy 5.08 Developing the Case Plan),
   f. Transition Plan for Successful Adulthood (see policy 11.06 Transition Plan for Successful Adulthood),
   g. Demographic information,
   h. Information entered in the National Youth in Transition Database (NYTD) (see policy 11.17 National Youth in Transition Database [NYTD]),
   i. Contacts,
   j. Current contact information for the youth's parent, guardian, or custodian (if applicable),
   k. School information and other related education information (e.g., Individualized Education Program [IEP]),
   l. Medicaid number,
   m. Health information (e.g., medical and dental health issues and current treatment),
   n. Indiana Support Enforcement Tracking System (ISETS) interface, if appropriate,
   o. Mental health screen,
   p. Medical Passport (including immunization records),

q. A list of all of the youth's essential connections,
r. Other information not included in the above list that is:
   i. Specific to the youth's individual circumstances; and
   ii. Pertinent to the continuity of the youth's services and case.

6. Document the following in the hard copy case file:
   a. Court reports (e.g., if the court hearing is within 30 calendar days of the transfer, the FCM is responsible for this report, unless negotiated otherwise at the transition meeting),
   b. Court notices,
   c. The Transition Plan for Successful Adulthood,
   d. Completed Collaborative Care Case Transfer Checklist, and
   e. Completed Kinship Connection Diagram.

7. Schedule a transition CFT Meeting within 15 calendar days of the case transfer, and ensure all identified necessary participants are invited (e.g., youth, youth's child representatives, informal supports, substitute caregivers or resource parents, CASA/GAL, therapists, and OYS providers);
8. Document the notification of all parties in the case management system; and
9. Notify the DCS Staff Attorney and the youth's CASA/GAL of the case transfer, if applicable.

The FCM Supervisor will:

1. Ensure the FCM continues to attend all court hearings and monitor the youth's safety, stability, and well-being until the case is transferred to a 3CM;
2. Ensure the youth's pertinent information and the current contact information for the youth's parent, guardian, or custodian (if applicable) has been updated in the case management system prior to the case transfer; and
3. Work with the 3CM Supervisor and FCM to ensure that any missing or incomplete information from the youth's electronic or hard copy file is completed.

The 3CM Supervisor will:

1. Identify and assign the case to a 3CM in the case management system within 48 hours of the case transfer meeting;
2. Ensure the case management system has all pertinent information and is up to date upon case transfer; and

   Note: If information is incomplete or missing, it is the 3CM Supervisor's responsibility to work with the FCM Supervisor to ensure the youth's former FCM completes the data input/updates.

3. Ensure the 3CM receives the hard copy case file from the youth's FCM after the case transfer meeting.

The 3CM will:

1. Attend and co-facilitate the transition CFT Meeting;
2. Thoroughly review the case file in the case management system and the hard copy case file;
3. Ensure continuity of services, particularly those services that are related to the youth's physical and mental health and well-being including, but not limited to:

a. Psychiatric treatment and care,
b. Treatment and care for a chronic medical condition,
c. Establishing a primary health care provider, dentist, ophthalmologist, gynecologist (if applicable),
d. Therapeutic treatment and care,
e. Education, employment, and financial literacy, and
f. Continuation of service referrals through DCS.

4. Ensure the youth does not lose contact with any siblings by adhering to the established visitation plan. If a visitation plan has not been created or is out of date, the 3CM will ensure that the visitation plan is completed; and
5. Ensure that the youth does not lose contact with family members and other informal supports due to the case transfer.

RELEVANT INFORMATION

Definitions

N/A

Forms and Tools

- Collaborative Care Case Transfer Checklist (SF 56107)
- Collaborative Care Supervisor Map
- Kinship Connection Diagram
- Transition Plan for Successful Adulthood (SF 55166)

Related Policies

- 5.07 Child and Family Team Meetings
- 5.08 Developing the Case Plan/Prevention Plan
- 8.12 Developing the Visitation Plan
- 8.51 Regional Permanency Teams
- 11.06 Transition Plan for Successful Adulthood
- 11.17 National Youth in Transition Database (NYTD)
- 11.20 Youth Adjudicated as Juvenile Delinquents Accessing Collaborative Care (CC)

LEGAL REFERENCES

- IC 31-9-2-13: "Child"
- IC 31-28-5.8-7: Periodic reviews by court; notice; participation; orders