

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 14 <sup>th</sup> birthday, or when the youth enters foster care, if age 14 or older; and updated every six months thereafter. 2. The Transition Plan (Part B) must be completed 90 days prior to the youth's 18 <sup>th</sup> 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 <u>and</u> 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 18 <sup>th</sup> birthday, 90 days from that date, and every three months 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, 90 days from that date, and every three months thereafter. 3. The Transition Plan (Part C) must be completed 90 days prior to the young adult's 21 <sup>st</sup> 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: _____ <input type="checkbox"/> Met Goal <input type="checkbox"/> Satisfactory Progress <input type="checkbox"/> Needs more time / assistance <input type="checkbox"/> Goal needs modification
				Date: _____ <input type="checkbox"/> Met Goal <input type="checkbox"/> Satisfactory Progress <input type="checkbox"/> Needs more time / assistance <input type="checkbox"/> Goal needs modification
				Date: _____ <input type="checkbox"/> Met Goal <input type="checkbox"/> Satisfactory Progress <input type="checkbox"/> Needs more time / assistance <input type="checkbox"/> Goal needs modification
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Youth/Young Adult Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**C. SUPPORTIVE RELATIONSHIPS**

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

**D. HOUSING**

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

Youth/Young Adult Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**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:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Service:	Who is responsible?	Has referral been made? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____
Service:	Who is responsible?	Has referral been made? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____
Service:	Who is responsible?	Has referral been made? <input type="checkbox"/> Yes <input type="checkbox"/> 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)*

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Youth/Young Adult Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**III. FOSTER CARE 18 TO 21 SERVICES (only)**

**A. PROGRAM ELIGIBILITY**

<input type="checkbox"/> High School Diploma / GED	Name of School: Address of School: Telephone Number:	Grade level:
		Anticipated graduation date:
<input type="checkbox"/> College / Vocational	Name of School: Address of School: Telephone Number: Type of Program:	Hours/Semester:
		Total credits earned:
<input type="checkbox"/> Program to remove barriers to employment	Name of Program: Address: Telephone Number:	Hours/week:
<input type="checkbox"/> Employment	Name of Employer: Address of Employer: Telephone Number:	Hours/week:
<input type="checkbox"/> Medical condition / disability	Condition Exempting Participation:	Documentation of condition in case record? <input type="checkbox"/> Yes <input type="checkbox"/> 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			<input type="checkbox"/> Yes <input type="checkbox"/> No
Care Provider			<input type="checkbox"/> Yes <input type="checkbox"/> No
Care Provider			<input type="checkbox"/> Yes <input type="checkbox"/> No
Parent (if applicable)			<input type="checkbox"/> Yes <input type="checkbox"/> No
Parent (if applicable)			<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Worker			<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Work Supervisor			<input type="checkbox"/> Yes <input type="checkbox"/> No
Service Provider			<input type="checkbox"/> Yes <input type="checkbox"/> No
Service Provider			<input type="checkbox"/> Yes <input type="checkbox"/> No
Other			<input type="checkbox"/> Yes <input type="checkbox"/> No
Other			<input type="checkbox"/> Yes <input type="checkbox"/> No