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| --- |
| SEMI-ANNUAL TRANSITION PLAN |
| FOR YOUTH AGE 14-15 |
| Michigan Department of Health and Human Services |
| Youth Name | Birth Date | Person ID |
|       |       |       |
| **Directions:** The Semi-Annual Transition Meeting must be held every 6 months beginning at the youth’s 14th birthday. The meeting must be held regardless of a youth’s maturity level or disability. The youth must be involved in all aspects of this meeting and the permanency plan. All areas of this plan must be thoroughly discussed with the youth. The youth must receive a copy of the completed plan at the end of the meeting. The original must be kept in the case file and a copy must be uploaded into MiSACWIS.**Youth Confidentiality Statement**I understand that sensitive and confidential information regarding my case (including, but not limited to treatment and records of substance abuse, mental health and/or medical issues) may be discussed at this meeting for purposes of case planning. I give my permission for this information to be discussed and understand that I can revoke my consent to these discussions and/or request the exclusion of individuals from certain conversations or can end my participation in this meeting. I also understand, that any new information regarding possible allegations of child abuse or neglect must be reported to Child Protective Services. |
| Print Youth Name | Signature | Date |
|       |  |       |
| **Team Member Confidentiality Statement**In accordance with the policies of Michigan Department of Health and Human Services (MDHHS) and any applicable provisions of the Michigan law, I understand that as a member of this Family Team Meeting (FTM) I will have access to confidential information about an individual’s or a family’s involvement with MDHHS. I understand that my access to this information is limited strictly to the information necessary to carry out my role as part of the family team. I will not share information received at a team meeting concerning a youth or family member with anyone including other family members, friends of the family or professionals who are not a part of the FTM. Any new information regarding possible allegations of child abuse or neglect must be reported to Child Protective Services. |
| Print Name | Signature | Date |
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| SEMI-ANNUAL TRANSITION PLAN |
| FOR YOUTH AGE 14-15 |
| Michigan Department of Health and Human Services |
| **YOUTH INFORMATION** |
| Last Name | First Name | Middle Initial | Birth Date | Age | Gender |
|       |       |       |       |      |       |
| Case ID | Person ID | County of Jurisdiction |
|       |       |       |
| Address | City | Zip Code |
|       |       |       |
| Phone | Email | Alternative Phone (cell, relative, etc.) |
|       |       |       |
| Legal Status |
| [ ]  Temporary Court Ward | [ ]  Permanent Court Ward | [ ]  MCI Ward | [ ]  Dual Ward |
| [ ]  Young Adult Voluntary Foster Care |
| Current Permanency Plan Goal |
|       |
| Was youth informed of the purpose of the meeting and told he/she could invite team members? | Meeting Date and Time |
| [ ]  Yes | [ ]  No |       |
| Meeting Location | Date of Next Meeting (if applicable) |
|       |       |
| MDHHS Worker or Monitor Name | MDHHS Worker Phone | MDHHS Worker Email |
|       |       |       |
| Tribal Worker Name | Tribal Worker Phone | Tribal Worker Email |
|       |       |       |
| MDHHS Supervisor Name | MDHHS Supervisor Phone | MDHHS Supervisor Email |
|       |       |       |
| PAFC Worker Name | PAFC Worker Phone | PAFC Worker Email |
|       |       |       |
| PAFC Supervisor Name | PAFC Supervisor Phone | PAFC Supervisor Email |
|       |       |       |
| CMH Worker Name | CMH Worker Phone | CMH Worker Email |
|       |       |       |
| GAL Name | GAL Phone | GAL Email |
|       |       |       |
| **INDEPENDENT LIVING SKILLS** |
| 1. | What areas of independent living skills are needed? (check all that apply) |
|  |  |  | **Date Completed** |
|  | [ ]  | Education |       |  |
|  | [ ]  | Employment/Training |       |  |
|  | [ ]  | Daily Living |       |  |
|  |  | [ ]  | Meal Planning/Cooking |       |  |
|  |  | [ ]  | Buying Groceries |       |  |
|  |  | [ ]  | Laundry |       |  |
|  |  | [ ]  | Housekeeping |       |  |
|  | [ ]  | Preventive Health Services |       |  |
|  |  | [ ]  | Personal Hygiene |       |  |
|  |  | [ ]  | Basic First Aid |       |  |
|  | [ ]  | Parenting |       |  |
|  | [ ]  | Budgeting/Financial Literacy |       |  |
|  | [ ]  | Rental Responsibilities |       |  |
|  | [ ]  | Housing Maintenance (minor repairs, exterior upkeep) |       |  |
|  | [ ]  | Other (explain): |       |       |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 2. | Is youth aware of how to access services in an emergency? | [ ]  Yes | [ ]  No |
|  | If no, who and by what date, will assist the youth with finding out what is available? |
|  |       |
| **HOUSING** |
| **Current Housing Status** |
| [ ]  Relative | [ ]  Unrelated Caregiver | [ ]  Psychiatric Hospital |
| [ ]  Foster Home | [ ]  Residential Facility | [ ]  Detention |
| [ ]  Legal Guardianship | [ ]  Medical Hospital | [ ]  Other (explain):  |
| **Emergency Shelters within a 30-mile radius (if ever needed)** |
| Name: |       |
| Address: |       |
| Phone: |       |
| Name: |       |
| Address: |       |
| Phone: |       |
| Name: |       |
| Address: |       |
| Phone: |       |
| **EDUCATION** |
| **Current Education Status** |
| 1. | Is the youth currently enrolled in and attending school? | [ ]  Yes | [ ]  No |
|  | If yes, where? |       |
|  | Number of current credits: |       |  | Number of credits needed to graduate: |       |
| 2. | Is the youth receiving special educations services? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | Does the youth have a current IEP? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If the youth does not have a current IEP, who will take the lead in advocating for this? |
|  |       |
| 3. | Will the youth obtain a high school diploma or GED prior to transition out of foster care? | [ ]  Yes | [ ]  No |
| 4. | Have post-secondary options been discussed? This includes providing information regarding what resources may be available, including Education and Training Voucher, Campus Based Support Programs and other resources, and the steps that will be needed to attend post-secondary programing. | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If no, specify the plan for the youth obtaining this information. |
|  |       |
|  | Who, and by what date, will assist the youth in completing this plan? (Identify by name and title) |
|  |       |
| **EMPLOYMENT** |
| 1. | Is the youth currently employed? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If yes: | [ ]  Full Time | [ ]  Part Time | [ ]  Contingent |
|  | Current Employer Name: |       |
|  | Phone Number |       |
| 2. | Does the youth have work or volunteer experience? | [ ]  Yes | [ ]  No |  |
|  | If yes, where? |       |
| 3. | Has youth been referred to the local Michigan Works! (MW!A) via Referral Form, DHS-348? | [ ]  Yes | [ ]  No |
|  | If yes, are services being received? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If no, who, and by what date, will follow up with MW!A? |       |
|  | If no, who, and by what date, will make a referral or why N/A? |       |

|  |  |  |  |
| --- | --- | --- | --- |
| 4. | Does the youth need to be referred to Michigan Rehabilitation Services? | [ ]  Yes | [ ]  No |
|  | If yes, when was he/she referred? |       |
| **TRANSPORTATION** |
| **Current Transportation Status** |
| [ ]  Public Transportation | [ ]  Bike | [ ]  Walking | [ ]  Foster Parent | [ ]  Friends |
| 1. | Has the youth taken driver’s education? | [ ]  Yes | [ ]  No |
|  | If no, specify the plan for the youth obtaining driver’s education (when he/she will be enrolled, where, YIT Payment). |
|  |       |
|  | Who, and by what date, will assist the youth with this task? (Identify by name and title) |
|  |       |
| 2. | Who will be assisting the youth with transportation goals, and in what way? (Identify by name and title) |
|  |       |
| **MICHIGAN YOUTH OPPORTUNITIES INITIATIVE (MYOI)** |
| 1. | Does the youth participate with MYOI? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If yes, are they currently active? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If no, has a referral been made? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If no, specify the plan for the youth obtaining a referral. |
|  |       |
|  | Who, and by what date, will assist the youth in completing this task? (Identify by name and title) |
|  |       |
| 2. | Has the youth participated in financial literacy training? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If yes, specify the dates of attendance: |       |
|  | If no, specify the plan for obtaining literacy training or why N/A. |
|  |       |
|  | Who, and by what date, will assist the youth with this task? (Identify by name and title) |
|  |       |
| 3. | If the youth is a participant of MYOI, do they have any of the following? (Check all that apply) |
|  | [ ]  Savings Account | [ ]  Individual Development Account (IDA) |
| **FINANCES** |
| 1. | Does the youth have a Savings Account open? | [ ]  Yes | [ ]  No |
| 2. | Does the youth know how to use a bank/credit union? | [ ]  Yes | [ ]  No |
|  | If no, specify the plan for the youth obtaining this information. |
|  |       |
|  | Who, and by what date, will assist the youth in completing this task? (Identify by name and title) |
|  |       |
| 3. | Has the youth developed and completed a sample monthly budget? | [ ]  Yes | [ ]  No |
|  | If yes, is it attached? | [ ]  Yes | [ ]  No |
|  | If no, specify the plan for the youth obtaining this information. |
|  |       |
|  | Who, and by what date, will assist the youth in completing these tasks? (Identify by name and title) |
|  |       |
| 4. | Does the youth understand the responsibility and use of a debit card? | [ ]  Yes | [ ]  No |
|  | If no, specify the plan for the youth obtaining this information. |
|  |       |
|  | Who, and by what date, will assist the youth in completing this task? (Identify by name and title) |
|  |       |

|  |  |  |  |
| --- | --- | --- | --- |
| 5. | Has a credit check been completed on the youth in the last 12 months? | [ ]  Yes | [ ]  No |
|  | If yes, what were the results? |       |
|  | If no, specify the plan for this to be completed prior to the youth’s discharge. |
|  |       |
|  | Who, and by what date, will complete this? |
|  |       |
| **HEALTH/MEDICATION** |
| 1. | Does the youth have Medicaid health coverage? | [ ]  Yes | [ ]  No |
|  | Which Medicaid Health Plan (MHP) is the youth enrolled in? |       |
|  | If no, specify the plan for the youth obtaining Medicaid health coverage. |
|  |       |
|  | Who, and by what date, will assist the youth in completing this plan? (Identify by name and title) |
|  |       |
| 2. | Does the youth have any other health coverage? | [ ]  Yes | [ ]  No |
| 3. | Does the youth or caregiver have a Mihealth card (Medicaid card)? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If no, specify the plan for the youth obtaining their Medicaid card or why N/A. |
|  |       |
|  | Who, and by what date, will assist the youth in completing this task? (Identify by name and title) |
|  |       |
| 4. | Has the youth received information regarding Family Planning? | [ ]  Yes | [ ]  No |
|  | If no, specify the plan for the youth obtaining this information. |
|  |       |
|  | Who, and by what date, will assist the youth in completing this task? (Identify by name and title) |
|  |       |
| 5. | Does the youth have a chronic health condition for which Supplemental Security Income (SSI) benefits should be applied? |
|  | [ ]  Yes | [ ]  No |
|  | If yes, who, and by what date, will assist with completing this task? (Identify by name and title) |
|  |       |
| 6. | Current Medications (list all and dosage): |
|  |       |
|  | Doctor’s Name and Phone Number: |       |
|  | Psychiatrist’s Name and Phone Number: |       |
|  | Dentist’s Name and Phone Number: |       |
|  | Nearest Urgent Care or ER and Phone Number: |       |
| **MENTAL HEALTH** |
| 1. | Does the youth have an identified mental health need? | [ ]  Yes | [ ]  No |
|  | If yes, does he/she have a referral for services? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If no, specify the plan for the youth obtaining a referral or why N/A. |
|  |       |
|  | Who, and by what date, will assist the youth in completing this task? (Identify by name and title) |
|  |       |
| 2. | Does the youth currently have mental health support? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If yes, | [ ]  Community Mental Health |
|  |  | [ ]  Private/contracted counselor |
|  |  | [ ]  Clergy/Youth Pastor |
|  |  | [ ]  Other (explain):  |  |

|  |  |
| --- | --- |
|  | If no, specify the plan for the youth obtaining support or why N/A. |
|  |       |
|  | Who, and by what date, will assist the youth in completing this task? (Identify by name and title) |
|  |       |
| 3. | Does the youth have a plan to meet his/her mental health needs? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If yes, explain: |       |
|  |       |
|  | Is this plan sustainable after the youth’s FC case closes? | [ ]  Yes | [ ]  No |  |
|  | If no, specify the plan for the youth this or why N/A. |
|  |       |
|  | Who, and by what date, will assist the youth in completing this task? (Identify by name and title) |
|  |       |
| 4. | Does the youth have a chronic mental health condition for which Supplemental Security Income (SSI) benefits should be applied? |
|  | [ ]  Yes | [ ]  No |
|  | If yes, who, and by what date, will assist with completing this task? (Identify by name and title) |
|  |       |
| 5. | Mental Health Provider and Phone Number |       |
|  | Emergency Mental Health Phone Number |       |
| **SUBSTANCE ABUSE** |
| 1. | Is substance abuse an identified need for the youth? | [ ]  Yes | [ ]  No | [ ]  N/A |
| 2. | Is the youth receiving substance abuse counseling services? | [ ]  Yes | [ ]  No |
|  | If yes, identify the agency and counselor |       |
|  | If no, specify the plan for the youth obtaining services. |
|  |       |
|  | Who, and by what date, will assist the youth in completing this task? (Identify by name and title) |
|  |       |
| 3. | Is the youth aware of substance abuse resources in the community where he/she resides? | [ ]  Yes | [ ]  No |
|  | If no, specify the plan for the youth obtaining this information. |
|  |       |
|  | Who, and by what date, will assist the youth in completing this task? (Identify by name and title) |
|  |       |
| **EMOTIONAL/SOCIAL SUPPORT** |
| 1. | Has the youth received information regarding preventing dating/domestic violence? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If no, specify the plan for the youth obtaining this information or why N/A. |
|  |       |
|  | Who, and by what date, will assist the youth in completing this task? (Identify by name and title) |
|  |       |
| 2. | Has the youth received information regarding LGBTQ supports? | [ ]  Yes | [ ]  No |  |
|  | If no, has the youth requested information? | [ ]  Yes | [ ]  No |  |
|  | Who, and by what date, will assist the youth in completing this task? (Identify by name and title) |
|  |       |
| 3. | Is the youth able to go to the church of his/her choice? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If no, specify the plan for the youth obtaining this information or why N/A. |
|  |       |
|  | Who, and by what date, will assist the youth in completing this task? (Identify by name and title) |
|  |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 4. | Is youth aware of recreational facilities, such as community centers, YMCA, YWCA? | [ ]  Yes | [ ]  No |  |
|  | If no, who, and by what date, will assist the with locating these? |
|  |       |
| **PARENTING** |
| 1. | Is the youth an expectant parent? | [ ]  Yes | [ ]  No |  |
|  | If yes, when is the due date: |       |
|  | Is the youth receiving prenatal care? | [ ]  Yes | [ ]  No |  |
|  | If no, who, and by what date, will assist the youth in completing this task? |
|  |       |
| 2. | Is the youth a parent? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If yes, the number of children and their ages: |       |
| **If the answers to #1 and #2 are No, skip to mentor section.** |
| 3. | Are the children residing with the youth? | [ ]  Yes | [ ]  No |  |
|  | If yes, is child care needed? | [ ]  Yes | [ ]  No |
|  | If yes, has a referral been made to the Child Care Coordinator? | [ ]  Yes | [ ]  No |  |
|  | Referral date and referral source: |       |
|  | If no, with whom are the children living? (Provide name and relationship to children) |
|  |       |
|  | What is the custody or parenting time plan? |
|  |       |
| 4. | Is CPS involved? | [ ]  Yes | [ ]  No |  |
|  | If yes, what is the worker’s name and phone number? |       |
| 5. | Is the youth involved in a Parenting Program? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If yes, list the agency: |       |
|  | If no, specify the plan for obtaining youth involvement or why N/A. |
|  |       |
|  | Who, and by what date, will assist the youth in completing this task? (Identify by name and title) |
|  |       |
| 6. | Is the youth receiving WIC? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If yes, what is the worker’s name, phone number and referral date? |
|  |       |
|  | If no, specify the plan for obtaining a referral or why N/A. |
|  |       |
|  | Who, and by what date, will assist the youth in completing this task? (Identify by name and title) |
|  |       |
| 7. | Is the youth participating with Early On? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If yes, what is the worker’s name, phone number and referral date? |
|  |       |
|  | If no, specify the plan for obtaining youth participation or why N/A. |
|  |       |
|  | Who, and by what date, will assist the youth in completing this task? (Identify by name and title) |
|  |       |
| 8. | Is the youth’s child(ren) receiving Infant Mental Health Services? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  | If yes, what is the worker’s name, phone number and referral date? |
|  |       |
|  | If no, specify the plan for obtaining these services or why N/A. |
|  |       |

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|  | Who, and by what date, will assist the youth in completing this task? (Identify by name and title) |
|  |       |
| **MENTOR/CASE PLAN TEAM MEMBERS** |
| 1. | Does the youth have an identified mentor? | [ ]  Yes | [ ]  No |  |
|  | If yes, who is the mentor for the youth? (Identify by name and title and check all that apply) |
|  | [ ]  Supportive adult: |       |
|  | [ ]  Teacher: |       |
|  | [ ]  Relative: |       |
|  | [ ]  Friend: |       |
|  | [ ] Other (explain): |       |
|  | If no, has the youth requested a mentor/case plan team member? | [ ]  Yes | [ ]  No |  |
|  | Who, and by what date, will assist with identifying a mentor/case plan team member? (Identify by name and title) |
|  |       |
| **SUPPORTIVE ADULT/SUPPORT SYSTEM** |
| Summarize the significant relationships and commitments made to the youth. |
| 1. | Name of Supportive Adult: |       |
|  | Relationship to Youth: |       |
|  | Address: |       |
|  | City, State and Zip Code: |       |
|  | Phone Number: |       |
|  | Email Address: |       |
|  | Type of Support Offered (advice, emergency housing, career guidance, place to go for holidays, help with finances): |
|  |       |
| 2. | Name of Supportive Adult: |       |
|  | Relationship to Youth: |       |
|  | Address: |       |
|  | City, State and Zip Code: |       |
|  | Phone Number: |       |
|  | Email Address: |       |
|  | Type of Support Offered (advice, emergency housing, career guidance, place to go for holidays, help with finances): |
|  |       |
| **YOUTH’S STRENGTHS (INCLUDING CULTURE, SPIRITUALITY, HOBBIES, INTERESTS)** |
|       |

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| **ADDITIONAL NEEDS (NOT COVERED IN OTHER AREAS)** |
|       |
| **ADDITIONAL NOTES** |
|       |
| **SIGNATURES** |
| By signing below, I am stating that I was present and participated in this meeting. At minimum, the case worker and youth must sign. If unavailable in person, participant can give verbal consent for someone to indicate he/she was present by phone. |
| Youth Name | Youth Signature | Date |
|       |  |       |
| Print Name | Signature | Date |
|       |  |       |
| Role |
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| Print Name | Signature | Date |
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| The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability. |