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| --- | --- | --- | --- |
| First Name: | Last Name: | Date of Birth: | Age: |
| FACTS Case Number: | Projected ROC: | Date Completed: | Pronouns: |
| **Section 1: Getting to Know Me**  *Required for all youth ages 14 and older who are on an I/DD waiver or waitlist. Youth or young adults who meet these criteria are not required to complete the 3059A.*  *(Attach additional pages or expand sections as needed)* | | | |
| **What I would like people to know about me:**  *Examples: interests/hobbies, what you like to do for fun, likes/dislikes, etc.* | | | |
| **What I would like people to know about my culture and things that are important to me:**  *What holidays do you celebrate? Do you attend church? If so, which one? What other events or values are important to you?* | | | |
| **My greatest strengths and talents are:**  *Examples: get along well with others, study hard in school, create art/music, express feelings in a healthy way, etc.* | | | |
| **The top three things that I need most right now are:**  *What help/support do I need right now?*  *Examples: clothing, visits, medical/mental health appointments, contacting my Guardian Ad Litem (GAL) etc.* | | | |

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| **Section 2: Social Security, Payee, Guardian, and Waivers**  ***Required for all youth ages 14 and older*** | | | | | | | | |
| **Psychological Exams and Social Security N/A** | | | | | | | | |
| Date of last Psychological Exam: | | Assessor: | | | | | | IQ Results: |
| Date of next Psychological Exam, if applicable: | | | | Assessor: | | | | |
| Currently Receiving SSI/SSDI: Yes No | | Date Applied to Adult SSI/SSDI: | | | | | | Approved: Yes No |
| If denied, has an appeal been filed? Yes No | | Date Appealed: | | | | | | Results: |
| **Case Manager Notes:** | | | | | | | | |
| **Payee N/A** | | | | | | | | |
| Does a payee for after release of custody need to be appointed? Yes No | If yes, has an application for a payee been completed? Yes No | | | | | | | Date applied: |
| Payee after ROC : | | | | | Phone: | | | |
| Relationship: | | | | | Email: | | | |
| **Case Manager Notes:** | | | | | | | | |
| **Adult Guardian N/A** | | | | | | | | |
| Is there a statement from a designated professional (per K.S.A. 59-3064) stating that the individual lacks capacity **and** a guardian needs to be appointed? Yes No | | | | | | | | |
| Does a referral need to be sent to the Kansas Guardianship Program\*? Yes No  *\*please see PPM 10630* | | | | | | Date referral packet sent to DCF Adult Protective Services: | | |
| Proposed Adult Guardian Name: | | | | | Phone: | | | |
| Relationship: | | | | | Email: | | | |
| **Case Manager Notes:** | | | | | | | | |
| **Home and Community Based Services (HCBS) Waivers** | | | | | | | | |
| **Brain Injury (BI) ages 0-64**  **N/A** | | | | | | | | |
| **Aging and Disability Rights Center (ADRC): 1-855-200-ADRC (2372)** | | | | | | | | |
| Local ADRC: | | | Address: | | | | | |
| Contact: | | | Phone/Email: | | | | | |
| Date of Functional Eligibility Assessment: | | | Results: | | | | | |
| Has a BI Program Eligibility Attestation been completed by a medical professional: Yes No | | | | | | | Date sent to ADRC: | |
| Medical Professional: | | | Phone/Email: | | | | | |
| **Case Manager Notes:** | | | | | | | | |
| **Intellectual/Developmental Disability (I/DD) ages 5+ N/A** | | | | | | | | |
| Local CDDO: | | | | | Address: | | | |
| CDDO Contact: | | | | | Phone/Email: | | | |
| Date Applied for I/DD Waiver: | | | | | Results: | | | |
| Does a crisis exception to the I/DD waiver need to be made Yes No  *if yes*, is there a task in their case plan that say they will transition to Adult Residential and Day Services? Yes No | | | | | | | | |
| Targeted Case Management Provider: | | | | | Address: | | | |
| TCM Case Manager: | | | | | Phone/Email: | | | |
| Medicaid MCO: | | | | | Number: | | | |
| MCO Care Coordinator: | | | | | Phone/Email: | | | |
| **Case Manager Notes:** | | | | | | | | |
| **Physical Disability Waiver (PD) ages 16-64 N/A** | | | | | | | | |
| **Aging and Disability Rights Center (ADRC): 1-855-200-ADRC (2372)** | | | | | | | | |
| Local ADRC: | | | Address: | | | | | |
| Contact: | | | Phone/Email: | | | | | |
| Date of Functional Eligibility Assessment: | | | Results: | | | | | |
| **Case Manager Notes:** | | | | | | | | |
| **Technology Assistance (TA) ages 0-21 N/A** | | | | | | | | |
| **Children's Resource Connection: 1-316-721-1945 or email crctaks@gmail.com** | | | | | | | | |
| **Date MATLOC Assessment:** | | | **Assessor:** | | | | | |
| **Results:** | | | | | | | | |
| **Case Manager Notes:** | | | | | | | | |
| **Tasks to add to case plan for Social Security, Payee, Adult Guardian, and Home and Community Based Services:** | | | | | | | | |
| **1.** | | | | | | | | |
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| **Section 3: My Support Network**  ***Required for all youth ages 14 and older*** | |
| *Who could you call for issues related to money, job, transportation, school, housing, physical or emotional health?*  *Who could you call for general/everyday support when you need it?* | |
| **Name**: | **Phone**: |
| **Relationship**: | **Email**: |
| I see this person as much as I would like to: Yes No I would like this person at my case planning meetings: Yes No | |
| **Name**: | **Phone**: |
| **Relationship**: | **Email**: |
| I see this person as much as I would like to: Yes No I would like this person at my case planning meetings: Yes No | |
| **Name**: | **Phone**: |
| **Relationship**: | **Email**: |
| I see this person as much as I would like to: Yes No I would like this person at my case planning meetings: Yes No | |
| **Name**: | **Phone**: |
| **Relationship**: | **Email**: |
| I see this person as much as I would like to: Yes No I would like this person at my case planning meetings: Yes No | |
| **Name**: | **Phone**: |
| **Relationship**: | **Email**: |
| I see this person as much as I would like to: Yes No I would like this person at my case planning meetings: Yes No | |
| **Name**: | **Phone**: |
| **Relationship**: | **Email**: |
| I see this person as much as I would like to: Yes No I would like this person at my case planning meetings: Yes No | |
| **Tasks to add to case plan to help build my support network** *(family finding, set up visits/phone calls, refer to mentor/support program- examples: Big Brothers Big Sisters, Boys and Girls Club, etc.)* | |
| **1.** | |
| **2.** | |
| **3.** | |

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| **Section 4: My Identifying Documents**  ***Review for all youth ages 14 and older***  *These important documents are critical for your transition to adulthood and are required for you to have before you leave care. What documents do you have and what do you still need before you leave care?*  *Per DCF Policy, copies of third-party information may not be released without written permission from the originating source.* | | |
| **Vital Personal Documents** | **Current Document Status** | **Where is the document located?** |
| **An Official or Certified Copy of Birth Certificate** | Have Don’t have Date Applied: |  |
| **Social Security Card issued by SSA** | Have Don’t have Date Applied: |  |
| **Valid State-Issued Photo Identification** | Have Don’t have Date Applied: |  |
| **Valid State-Issued Permit** | Have Don’t have Date Applied: |  |
| **Valid State-Issued License** | Have Don’t have Date Applied: |  |
| **Educational History:** *Copies of transcripts, report cards, names and addresses of schools attended, etc.* | Have Don’t have Date Requested: |  |
| **Immunization Records** | Have Don’t have Date Requested: |  |
| **Medical History:** *Including**current medical treatment, current providers, and medications* | Have Don’t have Date Requested: |  |
| **Copy of Medical and Genetic Information** | Have Don’t have Date Requested: |  |
| **Social History**: *Including release of allowable records from time in custody* | Have Don’t have Date Updated: |  |
| **Life Book** | Have Don’t have Date Updated: |  |
| ***The documents below are needed as youth attains age 18.*** | | |
| **Copy of Consumer Credit Report** | Have Don’t have Date Applied: |  |
| **Medicaid Card/Health Insurance information** | Have Don’t have Date Applied: |  |
| **Voter Registration** | Have Don’t have Date Applied: |  |
| **DCF Custody Verification Letter** | Have Don’t have Date Requested: |  |
| **Tribal Enrollment Card/Tribal Documentation** | N/A Have Don’t have Date Applied: |  |
| **Selective Service Registration** | N/A Have Don’t have Date Applied: |  |
| **Citizenship/Immigration Documents** | N/A Have Don’t have Date Applied: |  |
| **Healthcare Proxy or Medical Power of Attorney** | N/A Have Don’t have Date Applied: |  |
| **Do you have a safe place to keep your important documents when you are released custody?**  Yes No | | |
| **Tasks to add to case plan to take to obtain my identifying document(s):** *(update life book, request social history, apply for birth certificate, Social Security Card, State ID/Driver’s License, register for selective service, etc.)* | | |
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| **Section 5: Life Skills**  ***Required for all youth ages 14 and older***  *What skills have you already learned and what areas you would like to strengthen?* |
| *Case teams may attach a copy of an assessment completed within the last 6 months by a CDDO or other waiver service agency that addresses the youth or young adult’s life skills. (The CLSA does NOT meet this requirement)* |
| **Self-Care/Hygiene:**  *(bathing, shaving, caring for your teeth, nail and hair care, use of deodorant and other hygiene products, selecting and putting on clothes, exercise, etc.)* |
| **Youth/Young Adult Input:** |
| **Worker/Supportive Adult(s) Assessment:** |
| **Laundry**  *(washing, drying, folding, stain removal, ironing, separating colors before washing, frequency of washing clothes and bedding, etc.)* |
| **Youth/Young Adult Input:** |
| **Worker/Supportive Adult(s) Assessment:** |
| **Healthy Living Environment:**  *(making bed, dusting, mopping, dishes, vacuuming, understanding household chemicals, using the A/C and heater, pet care, etc.)* |
| **Youth/Young Adult Input:** |
| **Worker/Supportive Adult(s) Assessment:** |
| **Grocery Shopping**  *(buying ingredients for a recipe, understanding sales/coupons, making healthy meal choices within a budget, etc.)* |
| **Youth/Young Adult Input:** |
| **Worker/Supportive Adult(s) Assessment:** |
| **Cooking/Meal Preparation**  *(feeding oneself, preparing meals that do not require cooking, preparing meals with ingredients, basics of cooking, kitchen safety, using stove and other kitchen appliances, etc.)* |
| **Youth/Young Adult Input:** |
| **Worker/Supportive Adult(s) Assessment:** |
| **Communication Skills:**  *(understanding 1 and 2 step directions, asks simple questions, asking for help, knowing who to ask, active listening, etc.)* |
| **Youth/Young Adult Input:** |
| **Worker/Supportive Adult(s) Assessment:** |
| **Accessing Community Resources/Public Transportation**  *(do you know who to ask for help with transportation, how to ride public transportation, obtain food, going to the doctor, etc.)* |
| **Youth/Young Adult Input:** |
| **Worker/Supportive Adult(s) Assessment:** |
| **Have you completed a Casey Life Skills Assessment (CLSA)?**  *Yes* **Date**:  *No*  *Unsure* |
| **Section 6: Youth Advocacy**  ***Required for all youth ages 14 and older***  **“Nothing About Us, Without Us!”** |
| **Kansas Youth Advisory Council & Regional Youth Advisory Council** |
| I have been to a Regional Youth Advisory Council **(RYAC)** event: Yes No Unsure |
| I have been to Kansas Youth Advisory Council **(KYAC)** event: Yes No Unsure |
| I am interested in KYAC and /or RYAC: Yes No Unsure |
| I would need help getting rides to KYAC and/or RYAC meetings: Yes No Unsure |
| KYAC Contact: |
| RYAC Contact: |
| Other Youth Advocacy Groups: *ex: Kansas Youth Empowerment Academy (KYEA), Youth Leaders in Kansas (YLinK), student groups, etc.* |

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| **Section 7: My Education Plan**  ***Required for all youth ages 14 and older***  *Plans for your educational and career goals.* | | | | | | | | |
| **Current or Most Recent School Attended:** | | | | **Current Grade Level:** | | | | **Highest grade completed**: |
| **Vocational Supports:** *Do you have any of the following? (check below)* | | | | | | | | |
| **An Individualized Education Plan** *(IEP)* Yes No Unsure | | | | **504 Plan** Yes No Unsure | | | | |
| **An Education Advocate** Yes No Unsure *If yes*, what is their name? | | | | | | | | |
| **Visual Impairment** Yes No Unsure | | **Deaf or Hard of Hearing** Yes No Unsure | | | | | | |
| **Use of an Assistive Device for Learning** Yes No Unsure | | | | **Other Disability** Yes No Unsure | | | | |
| **Specific IEP/504 Plan Accommodations**: | | | | | | | | |
| **Are you participating in Pre-ETS?** Yes No Unsure | | | *if no,* does a referral need to be made? Yes No | | | | | |
| If you are under 16, please go to page 14. | | | | | | | | |
| **I intend to complete my** *(check below)*: ***(Ages 16 and older)*** | | | | | | | | |
| **HS diploma at** *(name of school)*: | | | | | **Number of Credits Earned**: | | | |
| **GED at** *(name of institution/program)*: | | | | | **Number of Tests Passed**: | | | |
| **Obtain a Vocational Certificate at** *(name of school)*: | | | | | | | | |
| **Post-secondary training/degree at** *(name of school)*: | | | | | | | | |
| **Highest Level of Education Completed** *(check below all that apply)*: ***(Ages 16 and older)*** | | | | | | | | |
| **HS diploma at** *(name of school)*: | | | | | | | | |
| **GED at** *(name of institution/program)*: | | | | | | | | |
| **College Credits** *(name of institution/program)*: | | | | | | **Number of Credits Earned**: | | |
| **Technical Training** *(name of institution/program)*: | | | | | | | | |
| **I would like more information about the following:** | | | | | | | | |
| A-OK Program | Tutoring | | Tuition Waiver | | | | First-Aid/CPR | |
| Contacting My School Counselor | Applying for an Education Program | | College Campus Tours | | | | Military Enlistment | |
| Choosing Classes | Applying for Scholarships | | Feeling Alone on Campus | | | | Bullying/Anti-Bullying | |
| Credit Recovery | FAFSA Application | | TRIO/Upward Bound | | | | Sports/School Activities | |
| Dual Credit Classes | Understanding Student Loans and Financial Aid | | Pre-Employment Transition Services *(Pre-ETS)* | | | | KU Transition to Postsecondary Education | |
| IEP/504 Plan | Test Preparation *(ACT/SAT)* | | Educational Counseling | | | | Kansas Kids at GEAR UP | |
| Senate Bill 23 *(Graduation requirements for youth in foster care)* (*KS Statute #38-2285*) | Obtaining Education with a Disability *(Federal WIOA H.R 803 Section 422)* | | Vocational Rehabilitation Services (VR) | | | | Other: | |
| **Tasks to add to case plan to address educational goals and needs:***(Enroll, submit applications, talk to an advisor, scholarships, placement exams meet with school counselor, pick elective classes, purchase materials, pay registration fees, explore post-secondary education programs etc.)* | | | | | | | | |
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| **Section 8: My Health/Well-Being**  ***Required for all youth ages 16 and older***  *Taking care of yourself is important. Without health insurance, you could end up with large bills for having to see a doctor.* | | | |
| **My Medicaid or other health insurance provider is:** *(check below)* | | | |
| United  Sunflower  Healthy Blue  Other: | | | |
| My Primary Care Doctor is: | | | Phone: |
| My OB/GYN Doctor is: | | | Phone: |
| My Eye Doctor is: | | | Phone: |
| My Mental Health Provider is: | | | Phone: |
| My Preferred Pharmacy is: | | | Phone: |
| My Dentist is: | | | Phone: |
| My Other Provider is: | | | Phone: |
| My Other Provider is: | | | Phone: |
| My Other Provider is: | | | Phone: |
| **Are you comfortable with the listed providers?**  Yes  No | | | |
| **Do you find these services helpful?**  Yes  No | | | |
| **I know how to:** *(check below)* | | | |
| Schedule Appointments  Fill Prescriptions  Take Medications as Prescribed  Obtain/Use Birth Control  Ask for Help  Other: | | | |
| **I take the following medications***: (list all medications and the reason they are prescribed): or*   **I am not taking mediations** | | | |
| Medication: | Reason: | How often: | |
| Medication: | Reason: | How often: | |
| Medication: | Reason: | How often: | |
| Medication: | Reason: | How often: | |
| Medication: | Reason: | How often: | |
| Medication: | Reason: | How often: | |
| Medication: | Reason: | How often: | |
| Medication: | Reason: | How often: | |
| Medication: | Reason: | How often: | |
| **Do you have any concerns with the medications you are taking?**  Yes  No | | | |
| **Do you understand the short-term and/or long-term effects of the medications you are taking?**  Yes  No | | | |
| **Do you plan to continue taking your prescribed medications after being released from custody?**  Yes  No  ***If No, please work with your case manager to set up an appointment for medical guidance from a professional.*** | | | |
| **I would like more information on:** *(check below)* | | | |
| Changing Doctors | Communicating with my Doctors | Sobriety Support | |
| Scheduling Appointments | Applying for Medical Insurance | LGBTQIA2S+ Supports | |
| Filling Prescriptions | Substance Abuse Treatment | Physical Health | |
| Taking Medications as Prescribed | Mental/Emotional Health | Domestic Violence Resources | |
| Healthy Relationships | Abstinence/Sexual Health | Renewing Health Insurance | |
| Obtaining/Using Birth Control | Tobacco/Vape Use and Quitting | Weight Management | |
| Healthy Habits | Connecting to Community Resources | Other: | |
| **Tasks to add to case plan for my health/well-being:** *(scheduling appointments, refilling prescriptions, obtain medication, talking with doctor(s), changing providers, etc.)* | | | |
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |
| **Section 9: My Transportation Plan**  ***Required for all youth ages 16 and older*** | | | |
| **I currently have the following transportation available to me** *(check all that apply)*: | | | |
| Family/Friends  Placement/Caseworker  I have my own car  I borrow a car  Paid Ride Service/Taxi  Bike  Walk  Bus  Other: | | | |
| **I need transportation to:** *(check all that apply)* | | | |
| School  Employment  Recreation  Appointments  Complete My Restricted License  Other: | | | |
| **My Legal Driving Status:** *(check all that apply)* N/A | | | |
| **I currently have a:**  Valid Driver’s License  Valid Restricted Driving Permit  Valid Learning Permit  Expired License/Permit  No Permit/License  Suspended License  Other: | | | |
| **If you have a License, when does it expire?** | | | |
| **I am interested in getting my:**  Driver’s License  Restricted Driving Permit  Learning Permit  Taking Drivers Education  Completing Driving Hours  Practicing the Permit Test  Other: | | | |
| **Case manager notes:**  *Please explain the transportation plans for the youth/young adult for their transition into adulthood* | | | |
| **Tasks to add to case plan to address my transportation goals:** *(enroll in driver’s education, referral to We Kan Drive, go to DMV, explore public transportation, walk through how to use medical card to request transportation, save for vehicle, explore auto insurance rates, etc.)* | | | |
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| **Section 9: My Employment/Financial Plan**  ***Required for all youth ages 16 and older*** | | | |
| **My Current Employment Status** *(Check all that apply)*: Day School  Full-Time  Part-Time  Volunteering  Student  Active Job Search  Internship/Work Study  Unable to Work  No Work History  Other: | | | |
| **If employed, where do you work?** | | **How long have you had your current job?** | |
| **What are some jobs or careers that interest you?** *What level of education and/or experience do you need to obtain that job/career?* | | | |
| **Are you interested in any of the following programs:** | | | |
| DCF Vocational Rehabilitation (VR) Services | DCF Pre-Employment Transition (Pre-ETS)Services | | KANSASWORKS Ticket to Work |
| **Financial Awareness:** | | | |
| **Are you interested in learning how to budget your money?**  Yes  No NA | | | |
| **Do you have a checking account?**  Yes  No NA | | **Do you have a savings account?**  Yes  No NA | |
| **If yes, who has access to your account(s)?** | | | |
| **Would you like to open a checking/savings account?**  Yes  No NA | | | |
| **Who can help you set up a banking account?** | | | |
| **Do you understand fees that are associated with a bank and/or debit card?**  Yes  No NA | | | |
| **Do you know how to check your credit report?**  Yes  No NA | | | |
| *Please describe the young adult's financial plans for adulthood:* | | | |
| **Tasks to add to case plan to address my employment and financial goals:** *(Open checking/savings account, referral to Pre-ETS or Vocational Rehabilitation Services, create a budget, take budgeting classes, create resume, apply for jobs, interview prep, understanding taxes, etc.)* | | | |
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| If you are under 17, please go to next section. | | | |
| **Section 10: My Housing Plan**  ***Required for all youth ages 17 and older*** | | | |
| **I understand that DCF Independent Living does not provide placement/housing after release of custody**  Yes  No | | | |
| **Where I currently live:** | | | |
| Foster Home Relative Non-Relative Group Facility Shelter Detention Secure Care Other: | | | |
| **My options for housing, once I am released are:** (s*elect all that apply)* | | | |
| Relative(s) | Friend/Non-Relative | Current Placement | Unsure Where I will Live |
| Supportive Adult | Transitional Living Program | Shared Living | Other: |
| Adult Residential Community Setting | Sober Living/Halfway House | Apartment/House *If so, are you on the lease?* *Yes* *No* |
| **What area(s) of the state/country would I like to live?** | | | |
| **Who I plan to live with:** *(name, relationship, and address, if applicable)*: | | | |
| **Have you talked with them about household rules, financial expectations, etc.?**  Yes  No | | | |
| **Do you need help talking about household expectations?**  Yes  No | | | |
| **What is your plan if this housing option does not work out?** | | | |
| **What steps have been taken to secure housing?**  *Applying for adult residential, touring adult residential/apartments, applying for low-income housing, purchased/obtained household items, signed housing related paperwork* | | | |
| **Tasks to add to case plan to secure housing prior to release:** *(search/apply for housing, apply for public housing, tour facility, secure household items, etc.)* | | | |
| **1.** | | | |
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| If this section does not apply, please go to next section N/A | | |
| **Section 11: Legal**  ***Required for all youth ages 14 and older who have current or pending charges and/or convictions.*** | | |
| **Next Court Date:** | **Type of Hearing:** | |
| **Current charges:** | | |
| **Pending charges:** | | |
| **Past convictions:** | | |
| **Counties charges/convictions are from:** | | |
| **Court Services Officer:** | **Email/Phone:** | |
| **Probation Officer:** | **Email/Phone:** | |
| **Attorney:** | **Email/Phone:** | |
| **Do you know how to contact these people?**  Yes  No | | **When is your next meeting with your court services/probation officer?** |
| **Court Orders:** | | |
| **Court Fines and Fees Owed:** | | |
| **What are your plans for completing court orders and paying fines?**  *(If no identified plan, please include tasks below to address creating a plan)* | | |
| **How do your current/past charges and court orders create barriers to your transition into adulthood?**  *What supports/resources can be explored to address these barriers?* | | |
| **Tasks to add to case plan to address current and pending charges and/or convictions:** *(paying fines, community service hours, seeking out expungement resources, talk to GAL about charges/convictions impact on transition, etc.)* | | |
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| **This Section to be Completed by Case Worker:**  *Summarize progress made since last transition plan meeting including narratives on progress towards obtaining adult social security, waiver services, guardianship, housing, and any other information needed for their transition into adulthood (required).*  *List any concerns that you have regarding the youth’s plan to transition into adulthood.*  **Each entry shall include the name of the staff member completing the update and the date.** |
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| **Transition Plan for Successful Adulthood: Participant Signatures & Date of Completion** | | | | | |
| *Youth feedback: Concerns about your plan?*  *Yes*  *No Discussed concerns with team?* *Yes*  *No*  *(comments)* | | | | | |
| **Youth/Young Adult Signature:** | **Date:** | | | | |
| *Case Manager feedback: Concerns about youth’s plan?* *Yes* *No Discussed concerns with youth/ team?* *Yes* *No*  *(comments)* | | | | | |
| **CWCMP Case Manager Signature:** | | **Date:** | | | |
| *DCF IL Coordinator feedback: Concerns about youth’s plan?* *Yes* *No Discussed concerns with youth/ team?* *Yes* *No*  *(comments)* | | | | | |
| **DCF IL Coordinator Signature:** | | | | **Date:** | |
| *Supportive Adult feedback:* *Concerns about youth’s plan?* *Yes* *No Discussed concerns with youth/ team?* *Yes* *No*  *(comments)* | | | | | |
| **Youth or Young Adult Selected Supportive Adult Signature:** | | | | | **Date:** |
| *Supportive Adult feedback:* *Concerns about youth’s plan?* *Yes* *No Discussed concerns with youth/ team?* *Yes* *No*  *(comments)* | | | | | |
| **Youth or Young Adult Selected Supportive Adult Signature:** | | | **Date:** | | |
| **Other Attendee Signature:** | | | **Date:** | | |
| **Other Attendee Signature:** | | | **Date:** | | |

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| **Resources** | |
| **Kansas Disability Rights Center (DRC):** DRC has attorneys and advocates who provide free advocacy and legal services for Kansans with disabilities. | **Website:** www.drckansas.org  **Phone:** 785-273-9661  **Address:** 214 SW 6th Ave Ste 100  Topeka, KS 66603 |
| **Social Security Administration (SSA):** SSA administers retirement, disability, survivor, and family benefits, and enrolls individuals in Medicare. | **Website:** www.ssa.gov/agency/contact/  **Phone:** 1-800-772-1213 |
| **Kansas Guardianship Program:** The Kansas Guardianship program is a volunteer-based model that provides guardianship or conservatorship services for vulnerable adults. | **Website:** www.ksgprog.org  **Phone:** 785-587-8555  **Address:** 3248 Kimball Ave  Manhattan, KS 66503 |
| **Kansas Department for Aging and Disability Services Home and Community Based Services (HCBS):** HCBS provides oversight for a system of community-based supports and services for persons in Kansas with disabilities. Through this program, the state of Kansas is able to provide different services that allow those who need care to receive services in their homes or communities. | **Website:** www.kdads.ks.gov  **Phone:** 785-368-6246  **Address:** 503 S. Kansas Ave  Topeka, KS 66603  **Web Search:** KDADS HCBS Access Guide |
| **Kansas Association of Centers for Independent Living:** The Kansas Association of Centers for Independent Living (KACIL), is a member organization comprising eight (7) Centers for Independent Living (CILs) spanning the state. Centers provide services to people with all types of disabilities of all ages and all income levels through grant funded and fee for service programs. | **Website:** www.kacil.net/member-cil-directory  **Phone:** 785-215-8048  **Address:** 214 SW 6th Ave  Topeka, KS 66603 |
| **DCF Vocational Rehabilitation/Pre-ETS:** Services for Kansans with disabilities to become gainfully employed and self-sufficient. PRE-ETS provides job exploration, counseling, and other services to help young people (16-21)  prepare for employment and self-reliance. | **Website:**www.dcf.ks.gov/services/RS/Pages/Employment-Services.aspx |