STATE OF WISCONSIN
Department of Children and Families
Division of Safety and Permanence

DSP Memo Series 2010 -14
December 8, 2010

Re: Independent Living Transition to Discharge Plan

To: Area Administrators/ Human Services Area Coordinators
Bureau Directors
Child Placing Agency Directors
Child Welfare Agency Directors
County Departments of Community Programs Directors
County Departments of Developmental Disabilities Services Directors
County Departments of Human Services Directors
County Departments of Social Services Directors
Indian Child Welfare Directors
Licensing Chiefs/Section Chiefs
Tribal Chairpersons/Human Services Facilitators

From: Cyrus A. Behroozi
Administrator

As youth transition to independence from out-of-home care, they need additional planning and support to prepare for a successful transition to adulthood. Transition planning improves long-term outcomes for the former youth in care.

The Fostering Connections to Success and Increasing Adoptions Act of 2008 enacted several requirements regarding children in out-of-home care (OHC), including a requirement for transition planning for children who are expected to age out of foster care. In response to the federal law, 2009 Wisconsin Act 79 enacted changes to s. 48.385, Wis Stats., requiring a plan for transition to independent living.

This plan must address the specific needs, goals and action steps for a successful transition from OHC to independent living and must be personalized at the direction of the child. These goals and activities, referred to as the Independent Living Transition to Discharge (ILTD) plan must detail specific options for, but not limited to: obtaining and securing housing; managing heath care needs; continuing education; attaching to mentoring or a supportive adult; employment services; workforce support and continuing necessary supportive services after leaving OHC.

In Wisconsin, once a youth becomes eligible for independent living services (see DSP Memo Series 2008 – 08), an Independent Living (IL) plan focusing on life skills development is created and reviewed or updated no less than every six months, consistent with Permanency Planning requirements set forth in ss. 48.38 and 938.38, Wis. Stat. At age 17 ½, the plan's focus for all youth must detail specific tasks requisite for the transition from foster care to independence (discharge). In order to meet the Federal requirements, the Independent Living Transition to Discharge (ILTD) plan must be 1) created as the youth directs, 2) signed by the youth (and others involved in the plan), and 3) documented in eWiSACWIS.

Refer to the eWiSACWIS Independent Living Quick Reference Guide for information on how to access and enter information on the youth's independent living page.

Document Summary

This memo and the attached policy describe the requirements for the Independent Living Transition to Discharge Plan and documentation.

REGIONAL OFFICE CONTACT: DCF Regional Administrator

CENTRAL OFFICE CONTACT: Youth Services Section Manager
Division of Safety and Permanence
Bureau of Youth Services
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MEMO WEB SITE: https://dcf.wisconsin.gov/cwportal/policy

Attachments: Appendix A

ILTD Plan Q&A

Independent Living Transition to Discharge Plan Policy
https://dcf.wisconsin.gov/files/cwportal/policy/pdf/ongoing-services-standards.pdf

Independent Living Transition to Discharge (ILTD) Plan DCF-F-2549
https://dcf.wisconsin.gov/forms

Independent Living Transition to Discharge Contact Information, DCF-F-2546
https://dcf.wisconsin.gov/forms

Independent Living Transition to Discharge Planning Checklist, DCF-F-2547
https://dcf.wisconsin.gov/forms

Independent Living Transition to Discharge (ILTD)Final Checklist, DCF-F-2548
https://dcf.wisconsin.gov/forms

APPENDIX A

To address the requirements of the ILTD plan, the following areas must be addressed (at minimum):

- **Obtaining and Securing Housing:** Has the youth secured an appropriate residence? If no, the agency must describe the actions needed to secure an appropriate residence and identify individuals who will assist the youth. Housing needs must also be considered for periods of time when the youth may be on break from college or other residential programs (such as the military, Job Corps, etc.), and should take into consideration housing options according to earnings. If the plan is for the youth to return to the biological family or an adult permanency resource, a comprehensive visitation plan for the 3 to 6 months prior to discharge should be developed. Options for the discharge to safe and stable housing, is expected to be available to the youth for at least the first 12 months after discharge. This priority does not apply to youth who are members of the military or job corps or full time students living in dormitories or youth who have voluntarily departed from the foster care placement without consent prior to exiting OHC at age 18 or later.

- **Source of Income:** Does the youth have a sufficient source of income upon discharge? If no, describe actions needed, the timeline, and who will assist the youth. This could include income from employment, Social Security benefits, trust funds and other potential available financial supports the youth may be eligible for. The development of a budget and savings (if not already done) shall occur as part of this planning.

- **Employment Services and Workforce Support:** Is the youth employed? If no, describe actions needed, the timeline and who will assist the youth: identify what sort of support is needed to assist in obtaining or maintaining employment over the next twelve months. Indicate any planned referrals/activities such as enrollment in Job Corps, referral to the Division of Vocational Rehabilitation (DVR), local job center, etc.

- **Management of Heath Care Needs:** Has the youth applied for private health insurance coverage or Badger Care Plus to cover the costs of preventative health care and identified physical, mental, dental health and prescription needs? If no, list the actions needed, the timeline, and who will assist the youth. Applications for Badger Care Plus for Youth Exiting Out-of-Home Care must be submitted in the 30-days prior to a youth exiting care at age 18 or later. Additional action items include selection of a provider, identification of where to go for services, and education about the importance of designating another individual to make health care treatment decisions on behalf of the youth if the youth becomes unable to participate in such decisions and the youth does not have, or does not want, a relative who would otherwise be authorized to make such decisions, whether a health care power of attorney, health care proxy or other similar document is recognized under state law (so the youth may elect an individual to make health care decisions for them in the event they are not able to, and how to execute such a document if the

adolescent wants to do so (Section 477(b)(3)(K) of the Fostering Connections and Increasing Adoptions Act).

- **Continuing Education:** Will the youth receive his/her high school diploma prior to discharge? If no, indicate the last grade completed and describe the actions needed, the timeline and who will assist the youth. Also explore the options for postsecondary education as well as an education plan to pursue a postsecondary degree, certificate, or license. Describe actions needed, the timeline and who will assist the youth.

- **Identification of Mentoring/Supportive Adult:** Have persons been identified who will provide supportive relationships after the age of 18 (at least three adult resources available upon the youth's discharge to provide emotional support/advice/guidance to the youth over time)? If no, what steps need to be taken to secure at least three individuals, and who will assist in identifying these individuals with the youth? This includes efforts to assist the youth to reestablish contacts with parents, former foster parents, or other persons significant to the youth.

- **Continuing Supportive Services After Leaving Care:** Has the youth been advised of services that will be available upon his/her discharge from foster care until he/she attains the age of 21? Have arrangements been made with those service providers for the needed support upon discharge? Have goods and services that will be provided by the agency IL program (e.g. room and board, education and training vouchers, utility payments, referral, driver's license, etc.) been identified as well as information on how to access IL, ETV or DCF Scholarship funding (and other opportunities as made available)? Have community resources for special or unique needs after the age of 18 been identified including referral to adult services, Division of Vocational Rehabilitation, SAIL, etc.? If no, describe the actions needed, the timeline and who will assist the youth.

- **Other important tasks related to the successful Independent Living Transition to Discharge planning:** Have arrangements been made for the youth to receive essential documents such as is outlined in DCF Memo Series 2007 – 14)? If no, describe the actions needed, the timeline and who will assist the youth. Identify any safety concerns related to the youth's discharge. Has a safety plan been developed? Describe concerns and actions needed to address concerns, the timeline, and who will assist the youth in developing a safety plan.

<u>Independent Living Transition to Discharge Plan Q&A</u>

1. **How exactly do I comply with the requirements to develop a 90-day IL transition plan?**
   a. The Independent Living Transition to Discharge (ILTD) plan (referred to as 90-day IL transition plan in Act 79) should be included as part of the Independent Living Plan. The transition plan's focus is on where the child will be living and working, as well as referrals necessary for a successful transition from out-of-home care to independent living after the age of 18. Case workers should start development of the plan at age 17 ½, and continue consulting with the child to complete the plan no later than 90 days prior to discharge. Completion (that is, development of the written plan), is not the end of the process. During the 90 days prior to the child leaving care the case worker and other significant adults must start implementation of the plan with the child, to fully address any and all transition needs.

2. **Does the court need to review the transition plan at 90 days?**
   a. No, no court review is specifically required of the transition plan. However, the plan does become part of the child's permanency plan.

3. **Why does the numbered memo say that the plan has to be developed and signed by the youth 90 days <u>prior</u> to the time he ages out of care when the statute states it is required to be developed <u>during</u> that period?**
   a. The statute reflects the minimum requirement set forth in the Fostering Connections Act. DCF and county agencies agree that is takes longer than 90 days to develop <u>and</u> implement a transition plan for a youth exiting out-of-home care and transitioning to independence.

4. **Can the social worker employed by a residential treatment center review the ILTD plan with the youth, or must it be the agency caseworker?**
   a. The ILTD plan is not a review. The ILTD plan must be developed, specifically addressing the areas listed in the Act 79 memo. This must begin by age 17 ½ and be completed no later than 90 days prior to discharge. If you have contracted with an agency to provide IL planning and transition services they could complete the ILTD with the youth, but it is ultimately the responsibility of the case worker to ensure the plan is appropriate and is attached to the permanency plan.

5. **Is the ILTD plan required under Ch. 938 as well?**
   a. Yes.

6. **Does an ILTD plan need to be developed for an 18 year-old who is going to age out in corrections? What about a case where an 18 year-old is in corrections but he will return to out-of-home care and age out within 90 days of leaving corrections? Will it be okay to complete his transition plan when he returns to out-of-home care (i.e. two months before he turns 18) and ages out?**
   a. An ILTD does not need to be completed for a youth whose case/placement is closed because he or she has gone to a secured detention facility. If that youth returns to an out-of-home care placement between the age of 17 ½ and 18, an ILTD plan would be completed immediately upon return to care.

7. **Are we expected to have a formal meeting to develop the plan? If so, who would be expected to attend/contribute?**
   a. It is likely to take more than one meeting to set goals and determine what is needed to meet the goals for a youth's successful transition. Due to the specific topics related to transition; it might be helpful to have others in the youth's life involved. Ask the youth who they would like to attend the meeting and who might be of help once they leave care. Case workers may also suggest individuals to attend the meeting.

8. **What should the plan look like and what should it include?**
    a. The "2009 WI Act 79: Federal Changes Act" Memo Series 2009-10, explains the required areas of focus. For example, the plan must address the plan for housing, such as, where is the youth going to live on the day he or she turns 18 (or when the order ends). If the youth will move to his or her apartment, the plan must include looking for a place, signing a lease, and other housing concerns to be addressed prior to age 18. In conjunction with this, how the youth is to be transported, who will do it or use of public transportation must be determined. If the plan is for the youth to return home, the parents must agree and a plan must be set forth which may include an extended home visit (e.g. 1-2 months) or trial reunification.

9. **Is the plan to be entered into eWiSACWIS?**
    a. The ILTD memo provides a template agencies must use when developing the plan, which identifies all required topics. Once developed, all goals, activities and services provided must also be entered into the services section of the Independent Living page in eWiSACWIS.

10. **Is there a tool available to assist in developing the transition plan?**
    a. Yes, tools have been created to assist in the development of ILTD plan, which are included in the ILTD memo.