

YOUNG ADULT MONTHLY VISIT REPORT

Michigan Department of Human Services
Young Adult Voluntary Foster Care Program

To be used as a caseworker visit tool. This report should be used to guide discussion and identify needs. If a need is indicated, the caseworker must address the need by providing or referring to a service and document the action taken in the service plan.

| | | |
|--------------|----------------|-------------------|
| Youth's Name | Visit Location | Visit Date / / |
|--------------|----------------|-------------------|

Participants:

List any changes in the home/address, including who resides in home:

Assessment of home (sanitary concerns, safety or privacy issues, etc.)

Is there anything from the last visit that is still a concern? Please provide explanation.

Yes No

Top priorities for this visit:

1. _____

2. _____

3. _____

Does the youth need any of the following documents?

| | | | |
|---|--|---|---|
| <input type="checkbox"/> Birth Certificate | <input type="checkbox"/> Diploma/GED | <input type="checkbox"/> Driver's License | <input type="checkbox"/> Immunization Record |
| <input type="checkbox"/> Med Records/Info | <input type="checkbox"/> Dental Records | <input type="checkbox"/> Mental Health Info | <input type="checkbox"/> State ID Card |
| <input type="checkbox"/> Address History | <input type="checkbox"/> Contact Information | <input type="checkbox"/> School History | <input type="checkbox"/> Selective Service Card |
| <input type="checkbox"/> Social Security Card | <input type="checkbox"/> Health Insurance Card | | |
| <input type="checkbox"/> Other _____ | | | |

Education (enrollment status, performance, attendance, etc.):

Employment (employment status, reduction/change in hours, **review check stubs for the past 30 days**, discuss any issues/concerns, etc.):

Physical/Mental Health (concerns, appointments, treatment, follow-up care, therapy, status of SSI application etc):

Medication (dosage, physician, diagnosis, changes, etc.):

| | |
|--|--|
| Upcoming Appointments <input type="checkbox"/> Semi-Annual Transition Meeting: _____ <input type="checkbox"/> Next Home Visit: _____ <input type="checkbox"/> Upcoming Medical/Dental Appointments: _____ <input type="checkbox"/> Other: _____ | Communication <input type="checkbox"/> Update the following, if applicable: <input type="checkbox"/> Phone () - _____ <input type="checkbox"/> Email _____ <input type="checkbox"/> Text () - _____ |
|--|--|

| Follow-up activities identified during this visit | Person Responsible | Target Date |
|---|--------------------|-------------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |

| | |
|--|------|
| Youth's Signature | Date |
| Foster Care Provider Signature (if applicable) | Date |
| Case Worker Signature | Date |

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