

90-DAY DISCHARGE PLAN REPORT

Michigan Department of Health and Human Services

Directions: The 90-Day Discharge meeting must be held at least 90 days prior to a youth exiting care, in order to develop a discharge plan. The youth must be involved at every aspect of developing the plan. It must be personalized to the individual youth at his or her own discretion. Participants may include CASA workers, foster parents, biological parents, relatives, therapists, the youth's friends, teachers, employers, or anyone the youth considers to be a supportive contact and wishes to invite. A copy of the completed plan is to be given to the youth at the end of the meeting and the original must be kept in the case file.

Youth Information			
Last Name:	First Name	Middle Initial	Case Number:
Birth Date:	Age:	Gender	County of Jurisdiction:
Address:	MDHHS Worker or Monitor Name:		
City, Zip:	Worker Phone:		
Phone:	Email:	Worker Email:	
Alternative Phone (cell, relative, etc.):	Tribal Worker Name:		
Legal Status:	Worker Phone:		
<input type="checkbox"/> Temporary Court Ward	Worker Email:		
<input type="checkbox"/> Permanent Court Ward	MDHHS Supervisor Name:		
<input type="checkbox"/> MCI Ward	Supervisor Phone:		
<input type="checkbox"/> Dual Ward	Supervisor Email:		
<input type="checkbox"/> Young Adult Voluntary Foster Care	PAFC Worker Name:		
Is the youth remaining in care beyond his/her 18 th birthday?	Worker Phone:		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Worker Email:		
If not, has the option of Young Adult Voluntary Foster Care (YAVFC) been discussed?	PAFC Supervisor Name:		
<input type="checkbox"/> Yes <input type="checkbox"/> No	CMH Worker Name:		
Date/Time Held:	CMH Worker Phone:		
Supervisor Phone:	Worker Email:		
Site Location:	GAL Name:		
Supervisor Email:	GAL Phone:		
Names of those present and roles:	GAL Email:		
Date of Next Meeting (if applicable):	Date Completed		

Independent Living Skills	
1. What IL skills and services did the youth participate in? (check all that apply)	
<input type="checkbox"/> Education	
<input type="checkbox"/> HS Graduation	
<input type="checkbox"/> GED Preparation	
<input type="checkbox"/> GED Testing	

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- College Preparation
- Career Testing
- Employment/Training
- Daily Living
 - Meal Planning/Cooking
 - Buying Groceries
 - Can Do Own 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. What additional IL skills and/or services does the youth need prior to discharge? (check all that apply)

- Education
- Employment/Training
- Daily Living
 - Meal Planning/Cooking
 - Buying Groceries
 - Can Do Own Laundry
 - Housekeeping
- Preventive Health Services
 - Personal Hygiene
 - Basic First Aid
- Parenting
- Budgeting/Financial Literacy
- Rental Responsibilities
- Housing Maintenance (minor repairs, exterior upkeep)
- Other (explain):

3. Who, and by what date, will be assisting the youth with these additional IL skills needed? (Please identify by name and title, and check all that apply)

- | | <u>Name and Title</u> | <u>Deadline</u> |
|--|-----------------------|-----------------|
| <input type="checkbox"/> MDHHS Staff: | | |
| <input type="checkbox"/> PAFC Staff: | | |
| <input type="checkbox"/> Foster Parents: | | |
| <input type="checkbox"/> Supportive Adult: | | |
| <input type="checkbox"/> Mentor | | |
| <input type="checkbox"/> MYOI Staff: | | |
| <input type="checkbox"/> CASA: | | |
| <input type="checkbox"/> Other (explain): | | |

Housing

1. Upon transitioning out of care, what is the youth's plan for housing?

- Own Apartment
 - Has the lease been signed? Yes No
 - If yes, when was it signed?
 - If no, is there a date/time set up to sign the lease?
 - Has the security deposit been made? Yes No
 - Are YIT Funds being used? Yes No
- Application Date?

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- Has the first/last month's rent been paid? Yes No
 - Are YIT Funds being used? Yes No Application Date?
- What is the plan to ensure ongoing rent is paid?

- College Dorm
 - Has all required paperwork been submitted? Yes No
 - Is campus housing available year-round? Yes No
- Remain in current foster home
- SIL/IL
- Relative
- Legal Guardianship
- Biological Family
- Supportive Adult (name):
 - Will the youth be provided with his/her own bedroom? Yes No
 - If no, where will he or she sleep?
- Friends
 - Will the youth be provided with his/her own bedroom? Yes No
 - If no, where will he or she sleep?
- Adult Foster Care
- Military Housing
- Other (explain):

2. Is youth aware of emergency shelters in the area? Yes No

3. Who, and by what date, will assist the youth with these final tasks?

	<u>Name and Title</u>	<u>Deadline</u>
<input type="checkbox"/> MDHHS Staff:		
<input type="checkbox"/> PAFC Staff:		
<input type="checkbox"/> Foster Parents:		
<input type="checkbox"/> Housing Agency:		
<input type="checkbox"/> MYOI Staff:		
<input type="checkbox"/> CASA:		
<input type="checkbox"/> Supportive Adult:		
<input type="checkbox"/> Other (explain):		

Education

1. Will the youth graduate from high school prior to transitioning out of foster care? Yes No
 - If no, does the youth have a plan for completing high school or a GED? Yes No
 - If yes, what is the plan?
 - If no, who will assist with making plan?
 - Adult Education? Yes No
2. The youth has been diagnosed with the following disabilities: None

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- | | | |
|---|---|--|
| <input type="checkbox"/> Mentally Impaired | <input type="checkbox"/> Specific Learning Disability | <input type="checkbox"/> Other Medically Diagnosed Condition |
| <input type="checkbox"/> Emotionally Impaired | <input type="checkbox"/> Visually Impaired | <input type="checkbox"/> Hearing Impaired |
| <input type="checkbox"/> Physically Disabled | <input type="checkbox"/> Speech and Language | <input type="checkbox"/> Not Yet Determined |

3. Is the youth currently in special education? Yes No
 • If yes, explain what services the youth will receive:

4. Does the youth have post secondary plans? Yes No
 • If yes, where:

5. Has the following information been provided to the youth?

	<u>Date Provided</u>	<u>Date Completed</u>
TIP	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ETV information	<input type="checkbox"/> Yes <input type="checkbox"/> No	
FAFSA information	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fostering Futures scholarship information		
Scholarship information	<input type="checkbox"/> Yes <input type="checkbox"/> No	

6. Does youth plan on attending trade school? Yes No

7. Who will be assisting the youth with post secondary planning?

	<u>Deadline</u>
<input type="checkbox"/> MDHHS Staff:	
<input type="checkbox"/> PAFC Staff:	
<input type="checkbox"/> Foster Parents:	
<input type="checkbox"/> Education Planner:	
<input type="checkbox"/> High School Counselor:	
<input type="checkbox"/> MYOI Staff:	
<input type="checkbox"/> CASA:	
<input type="checkbox"/> Supportive Adult:	
<input type="checkbox"/> Other (explain):	

Employment

1. Is the plan for the youth to be working? Full Time Part Time Contingent

2. Does the youth need to be referred to Michigan Rehabilitation Services? Yes No N/A
 • If yes, when was he/she referred?
 • If no, when will this be done and who will be assisting the youth or why N/A?

3. Is the youth currently working? Yes No
 • If yes, please identify the employer's name and address:

- Is the youth working with a community resource/employment agency? Yes No
- If yes: WIA/Michigan Works! Agency
- If no, who will be making the referral for the youth to begin participating with an agency and by what date?

	<u>Deadline</u>
<input type="checkbox"/> MDHHS Staff:	
<input type="checkbox"/> PAFC Staff:	
<input type="checkbox"/> Foster Parents:	
<input type="checkbox"/> Employment Agency:	
<input type="checkbox"/> AmeriCorp:	
<input type="checkbox"/> MYOI Staff:	
<input type="checkbox"/> Supportive Adult:	
<input type="checkbox"/> Other (explain):	

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4. If the youth loses, quits, or gets fired from a job, what is the back-up plan?

Transportation

1. What is the youth's plan for transportation?

- Public Transportation
- Bike
- Walking
- Other (explain):
- Has own vehicle
 - Does the youth have car insurance? Yes No
 - If yes, what is the youth's source of funds for insurance? (family, friends, job, etc.)
 - If no, how with the youth get insurance and pay for it?
- Plans to purchase own vehicle
 - What is the plan to pay for ongoing maintenance?

2. Does the youth have a driver's license? Yes No
- If no, does the youth need driver's Yes No
 - If yes, what is the plan and date for enrolling and paying for driver's education?
 - Who will be assisting the youth with transportation needs?

Name and Title

Deadline

- MDHHS Staff:
- PAFC Staff:
- Foster Parents:
- Community Agency:
- Supportive Adult:
- Youth:
- Other (explain):

Michigan Youth Opportunities Initiative (MYOI)

1. Is the youth a participant in MYOI? Yes No N/A

- If no, was the MYOI referral made at the meeting or why N/A?

2. Has the youth participated in financial literacy Yes No N/A

- If no, how will he/she be provided with financial training or why N/A?

3. Does the youth have one or more of the following?

- Checking account Savings account Individual Development Account (IDA)

Finances

1. Upon transitioning out of care, what is the youth's plan to financially support

2. 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?

3. For what services have applications been submitted? (check all that apply)

Submitted Receiving Monthly Amount

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- | | | |
|--|--------------------------|--------------------------|
| <input type="checkbox"/> Cash Assistance/Family Independence Program (FIP) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Child Day Care | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Employment | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Food Assistance Program (FAP)/Bridge Card | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foster Care Transitional Medicaid | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Independent Living Funds | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> RSDI/SSI | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Spousal Support/Child Support | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Tribal Trust Funds | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Trust Funds | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Other Medicaid | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Other (please explain): | <input type="checkbox"/> | <input type="checkbox"/> |

4. Who will assist the youth with applying for these services?

- | | <u>Name and Title</u> | <u>Deadline</u> |
|---|-----------------------|-----------------|
| <input type="checkbox"/> MDHHS Staff: | | |
| <input type="checkbox"/> PAFC Staff: | | |
| <input type="checkbox"/> Foster Parents: | | |
| <input type="checkbox"/> Employment Agency: | | |
| <input type="checkbox"/> Supportive Adult: | | |
| <input type="checkbox"/> Other (explain): | | |

Health / Medication

1. Does the youth have a primary physician? Yes No
 - If yes, identify the physician's name and phone number:
 - If no, where will the youth access

2. Does youth have any ongoing medical needs? Yes No
 - If yes, identify all conditions/needs:

3. Does the youth have a durable Power of Attorney for Health Care? Yes No N/A

4. Current medications (list all and

5. Where does the youth get their

6. How will the youth pay for the prescription(s)? Source of

7. How does the youth plan on renewing the prescriptions?

8. Who, and by what date, will assist the youth with the above Health/Medication needs?

- | | <u>Name and Title</u> | <u>Deadline</u> |
|---|-----------------------|-----------------|
| <input type="checkbox"/> MDHHS Staff: | | |
| <input type="checkbox"/> PAFC Staff: | | |
| <input type="checkbox"/> Foster Parents: | | |
| <input type="checkbox"/> Employment Agency: | | |
| <input type="checkbox"/> MYOI Staff: | | |
| <input type="checkbox"/> Supportive Adult: | | |
| <input type="checkbox"/> Other (explain): | | |

Dentist's Name & Phone

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Nearest Urgent Care or ER & Phone

Emotional / Mental Health

1. Has the youth stated a need for emotional support after transitioning? Yes No
- If yes, how will this be accomplished?

If the answer to #1 is no, skip to Substance Abuse Section.

2. Does the youth currently have emotional/mental health support? Yes No
- Community Mental Health
 - Private/contracted counselor
 - Clergy/Youth Pastor

If so, the youth will need to apply for FCTMA and locate a counselor or CMH.

3. Does the youth have a plan to meet his/her emotional/mental health needs? Yes No
- If yes, who will provide guidance and support?

Name and Title

Deadline

- MDHHS Staff:
- PAFC Staff:
- Foster Parents:
- Employment Agency:
- AmeriCorp:
- MYOI Staff:
- Supportive Adult:
- Other (explain):

Substance Abuse

1. Is substance abuse an identified need for the youth after he/she is discharged from foster care? Yes No
- If yes, are there identified funds to provide for services? Yes No
 - If no, what referrals have been made?

If the answer to #1 is no, skip to Social/Relational Section.

2. Is the youth receiving substance abuse counseling services? Yes No N/A
- If yes, identify the agency and counselor:
 - If no, specify the plan for the youth obtaining
 - Who will be assisting the youth?

3. Is the youth aware of substance abuse resources in the community where he/she will reside? Yes No N/A
- If no, specify the plan for the youth obtaining this information:
 - Who, and by what date, will be assisting the youth?

Social / Relational

1. Has the youth received information regarding Family Planning? Yes No
2. Has the youth received information regarding dating/domestic violence prevention? Yes No
3. Has the youth received information regarding lesbian, gay, bi-sexual, transgender, questioning (LGBTQ) issues? Yes No
4. Is the youth able to go to the church of his/her choice? Yes No
5. Is the youth aware of recreational facilities such as community centers, YMCA, YWCA, etc.? Yes No

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Parenting

1. Is the youth a teen parent, pregnant, or fathered any children? Yes No
- If yes, the number of children and their ages:
 - With whom are the children living? (Provide name and relationship to children)

If the answer to #1 is no, skip to Mentor/Supportive Adult Section.

2. 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, who is caring for the children?
3. Is CPS involved? Yes No N/A
- If yes, please identify the worker's name and phone number:
4. Is the youth, involved in a Teen Parenting Program? Yes No N/A
- If yes, please identify the agency:
 - If no, please identify available local programs:
 - Date of referral:

Mentor / Case Plan Team Member

1. Does the youth have an identified mentor/case plan team member? Yes No
- 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?
 - 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):

Supportive Adult / Support System

1. For discharge in the next three months, who will the youth call for support?
- Name and Phone Number:
 - Name and Phone Number:
 - Name and Phone Number:
2. Does the youth have a plan in the event of an emergency? Yes No
- If no, who, and by what date, will be assisting the youth to develop an emergency plan?

Name and title

Deadline

- MDHHS Staff:
- PAFC Staff:
- Foster Parent:
- Supportive Adult:
- Mentor:
- School Counselor/School Support person:
- MYOI Staff:
- Other (explain):

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Discharge Documents

1. Which of the following required documents been provided to the youth? (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Original Birth Certificate/Certified Copy | <input type="checkbox"/> Legal Information | <input type="checkbox"/> Social Security Card |
| <input type="checkbox"/> State/Driver's Identification Card | <input type="checkbox"/> Medical/Dental Records | <input type="checkbox"/> School Identification Card |
| <input type="checkbox"/> Psychological/Psychiatric Records | <input type="checkbox"/> Financial Records (IDA, Banking, etc) | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> Insurance Card (Medicaid) | <input type="checkbox"/> Car Title | <input type="checkbox"/> Family History/Life Book |
| <input type="checkbox"/> Tax Documents | <input type="checkbox"/> FAFSA Brochure | <input type="checkbox"/> List of Resources |
| <input type="checkbox"/> Placement history with permission of foster parents | <input type="checkbox"/> Selective Services Registration (Males) | <input type="checkbox"/> Education Records |
| <input type="checkbox"/> Copy of Plans (IL Agreement, etc.) | <input type="checkbox"/> Publication 858 | <input type="checkbox"/> Family Medical History |
| <input type="checkbox"/> Voter Registration Card (if 18+) | <input type="checkbox"/> Publication 161, Durable Power of Attorney | <input type="checkbox"/> YAVFC Fact Sheet |
| <input type="checkbox"/> Copy of 944/945 (Financial Aid Form) | | |

2. How will MDHHS provide all of the documents to the youth prior to release?

Additional Needs (not covered in other areas)

Identified Needs Prior to Discharge

- 1.
- 2.
- 3.

Plan to address each identified need:

Signatures

Youth Name	Youth Signature	Date
MDHHS FC Caseworker or Monitor Name	MDHHS FC Caseworker or Monitor Signature	Date
PAFC Caseworker Name	PAFC Caseworker Signature	Date
Facilitator Name (if applicable)	Facilitator Signature (if applicable)	Date
Supervisor Name (if applicable)	Supervisor Signature (if applicable)	Date

Youth Confidentiality Statement

I understand that sensitive and confidential information regarding my case (including, but no 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 Name	Signature	Date
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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	Role

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.