**Independent Living Transition to Discharge (ILTD) Plan**

**Use of form:** Planning for a youth’s transition to discharge and independent living must begin six months prior to a youth’s 18th birthday with activities completed in the 90 days prior to discharge. The plan must include the specific options for transitioning from out-of-home care to self-sufficiency listed below. All planning and services provided must be documented on the Independent Living (IL) page in eWiSACWIS. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Today’s Date        (mm/dd/yyyy) | | | | | | | | | | | | | | |
| Youth Full Name | | | | | | | | | | | | | | Birthdate (mm/dd/yyyy) |
| Current Age | Date Youth Entered Foster Care        (mm/dd/yyyy) | | | Date of Youth’s Anticipated Discharge        (mm/dd/yyyy) | | | | | | | | | | Anticipated Age at Discharge |
| Current Permanency Goal | | | | | | | | | | | | | | |
| Concurrent Permanency Goal | | | | | | | | | | | | | | |
| Youth Current Address | | | | | | | | | | | | Youth Current Telephone Number | | |
| Current Email Address (optional) | | | | | | | | | | | | | | |
| **Eligibility for Extension of Out-of-Home Care** | | | | | | | | | | | | | | |
| Yes  No Does the youth have an IEP?  Yes  No Is the youth expected to graduate before age 19?  Yes  No Will the youth be a full-time student at a secondary school or its vocational or technical equivalent after age 18?  The youth  eligible to continue care up to graduation or age 21 whichever occurs first. | | | | | | | | | | | | | | |
| Youth has been made aware of options for remaining in care.  Yes  No Date:       (mm/dd/yyyy)  Youth Chooses to:  Remain in care under court order  Remain in care under a voluntary agreement  Discharge from care. Anticipated Transition to Discharge HearingDate:       (mm/dd/yyyy) | | | | | | | | | | | | | | |
| **Subsequent Eligibility for Extension of Out-of-Home Care** | | | | | | | | | | | | | | |
| Yes  No Does the youth have an IEP?  Yes  No Will the youth be a full-time student at a secondary school or its vocational or technical equivalent after age 18?  The youth eligible to continue care up to graduation or age 21 whichever occurs first. | | | | | | | | | | | | | | |
| **Housing** | | | | | | | | | | | | | | |
| Goal: Safe and secure living environment upon leaving care. | | | | | | | | | | | | | | |
| Anticipated location youth will transition to | | | | | | | | | | | | | | |
| Address Youth Will Transition To | | | | | | | | | | | | | | |
| Housing Resource (if applicable) | | | | | | | | | Telephone Number at Housing Resource | | | | | |
| Description of Activities to Achieve Goal | | | | | | | | | | | | | | |
| Helper Full Name | | | | | | | | | | | | | | |
| Date to be Completed (mm/dd/yyyy) | | | Goal achieved?  Yes  No | | | | | | | | Date Goal Achieved (mm/dd/yyyy) | | | |
| **Alternate location** youth will transition to | | | | | | | | | | | | | | |
| Address Youth Will Transition To | | | | | | | | | | | | | | |
| Housing Resource (if applicable) | | | | | | | | | Telephone Number at Housing Resource | | | | | |
| Description of Activities to Achieve Goal | | | | | | | | | | | | | | |
| Helper Full Name | | | | | | | | | | | | | | |
| Date to be Completed (mm/dd/yyyy) | | | Goal achieved?  Yes  No | | | | | | | | Date Goal Achieved (mm/dd/yyyy) | | | |
| **Health** | | | | | | | | | | | | | | |
| Goal 1:Obtainment of private insurance or Badger Care Plus (Youth Exiting Out-of-Home Care): | | | | | | | | | | | | | | |
| Description of Activities to Achieve Goal | | | | | | | | | | | | | | |
| Helper Full Name | | | | | | | | | | | | | | |
| Date to be Completed (mm/dd/yyyy) | | | Goal achieved?  Yes  No | | | | | | | | Date Goal Achieved (mm/dd/yyyy) | | | |
| Goal 2:Educate youth regarding the importance of designating another individual to make health care treatment decisions on his / her behalf. | | | | | | | | | | | | | | |
| Description of Activities to Achieve Goal | | | | | | | | | | | | | | |
| Helper Full Name | | | | | | | | | | | | | | |
| Date to be Completed (mm/dd/yyyy) | | | Goal achieved?  Yes  No | | | | | | | | Date Goal Achieved (mm/dd/yyyy) | | | |
| **Education (secondary / post-secondary)** | | | | | | | | | | | | | | |
| Goal 1: Completion of high school (GED / HSED). | | | | | | | | | | | | | | |
| Description of Activities to Achieve Goal | | | | | | | | | | | | | | |
| Helper Full Name | | | | | | | | | | | | | | |
| Anticipated Date of High School Diploma or GED / HSED (mm/dd/yyyy) | | | | | | | | Goal achieved?  Yes  No | | | | | Date Goal Achieved (mm/dd/yyyy) | |
| Goal 2: Exploration / enrollment in post-secondary education program. | | | | | | | | | | | | | | |
| Description of Activities to Achieve Goal | | | | | | | | | | | | | | |
| Helper Full Name | | | | | | | | | | | | | | |
| Anticipated Date of Post-secondary Enrollment (mm/dd/yyyy) | | | | | | | | Goal achieved?  Yes  No | | | | | Date Goal Achieved (mm/dd/yyyy) | |
| (If N/A provide explanation) | | | | | | | | | | | | | | |
| Goal 3: Financial Assistance Explored and / or Obtained | | | | | | | | | | | | | | |
| Description of Activities to Achieve Goal | | | | | | | | | | | | | | |
| Helper Full Name | | | | | | | | | | | | | | |
| Date to be Completed (mm/dd/yyyy) | | Goal achieved?  Yes  No | | | | | | | | Date Goal Achieved (mm/dd/yyyy) | | | | |
| **Mentors and / or Other Supportive Adults Identified** | | | | | | | | | | | | | | |
| Goal: Explore and identify opportunities for mentoring and adult support after leaving foster care. Identify at least three individuals. | | | | | | | | | | | | | | |
| Description of Activities to Achieve Goal | | | | | | | | | | | | | | |
| Helper Full Name | | | | | | | | | | | | | | |
| Date to be Completed (mm/dd/yyyy) | | Goal achieved?  Yes  No | | | | | | | | Date Goal Achieved (mm/dd/yyyy) | | | | |
| Supportive adults, other than helping professionals, who are available and willing to work with the youth as he / she transitions toward and through his / her discharge to self-sufficiency and beyond. | | | | | | | | | | | | | | |
| Full Name | | | Relationship | | | | | | | | Contact Information | | | |
|  | | |  | | | | | | | |  | | | |
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|  | | |  | | | | | | | |  | | | |
| **Opportunities for Continuing Support Services** | | | | | | | | | | | | | | |
| Goal: Explore and identify continued support available through agency IL program. | | | | | | | | | | | | | | |
| Date to be Completed (mm/dd/yyyy) | | | | | | | | | | | | | | |
| Description of Activities to Achieve Goal | | | | | | | | | | | | | | |
| Helper Full Name | | | | | | | | | | | | | | |
| Date to be Completed (mm/dd/yyyy) | | Goal achieved?  Yes  No | | | | | | | | Date Goal Achieved (mm/dd/yyyy) | | | | |
| **Income** | | | | | | | | | | | | | | |
| Goal: Source of income identified and obtained. | | | | | | | | | | | | | | |
| Description of Activities to Achieve Goal | | | | | | | | | | | | | | |
| Helper Full Name | | | | | | | | | | | | | | |
| Date to be Completed (mm/dd/yyyy) | | Goal achieved?  Yes  No | | | | | | | | Date Goal Achieved (mm/dd/yyyy) | | | | |
| Indicate youth’s source of income at discharge for Out of Home Care (OHC) | | | | | | | | | | | | | | |
| **Employment Services and Workforce Support** | | | | | | | | | | | | | | |
| Goal: Youth has employment or is connected to employment services and support. | | | | | | | | | | | | | | |
| Description of Activities to Achieve Goal | | | | | | | | | | | | | | |
| Helper Full Name | | | | | | | | | | | | | | |
| Date to be Completed       (mm/dd/yyyy) | | Goal achieved?  Yes  No | | | | | | | | Date Goal Achieved (mm/dd/yyyy) | | | | |
| **Essential Documents Secured and Provided to Youth** | | | | | | | | | | | | | | |
| Goal: Youth receives all the documents needed for successful transition to independence prior to the transition date. | | | | | | | | | | | | | | |
| Required | | | | | | | | | | | | | | |
| Original birth certificate and information on how to obtain a duplicate | | | | | | | | | | | | | | |
| State ID card or driver’s license and information on how to obtain a duplicate | | | | | | | | | | | | | | |
| Medical card | | | | | | | | | | | | | | |
| Social security card and information on how to obtain a duplicate | | | | | | | | | | | | | | |
| Health records (e.g., medications, illnesses, diagnoses, immunizations, hospitalizations, surgeries, referrals, family medical history) | | | | | | | | | | | | | | |
| Education records (e.g., schools attended, transcripts, IEP, certificates, diplomas, degrees earned) | | | | | | | | | | | | | | |
| Documentation of immigrations, citizenship, or naturalization, if appropriate | | | | | | | | | | | | | | |
| Death certificate if parent is deceased | | | | | | | | | | | | | | |
| Proof of tribal registration and membership, if appropriate | | | | | | | | | | | | | | |
| Copy of ILTD plan | | | | | | | | | | | | | | |
| Selective Service card (required for males only; must register at age 18) | | | | | | | | | | | | | | |
| Annual credit report and efforts made by the agency to amend any inaccuracies in the report. | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | |
| Placement history, if appropriate | | | | | | | | | | | | | | |
| Copy of permanency plan, if appropriate | | | | | | | | | | | | | | |
| Change of address card | | | | | | | | | | | | | | |
| Employment Information | | | | | | | | | | | | | | |
| National Youth in Transition Database (NYTD) information provided | | | | | | | | | | | | | | |
| **Other Areas of Focus** | | | | | | | | | | | | | | |
| Goal:Youth’s own identified needs and concerns. | | | | | | | | | | | | | | |
| Description of Activities to Achieve Goal | | | | | | | | | | | | | | |
| Helper Full Name | | | | | | | | | | | | | | |
| Dates to be completed (mm/dd/yyyy) | | | | | Date of follow-up appointment following discharge (mm/dd/yyyy) | | | | | | | | | |
| Indicate desired method of contact following discharge | | | | | | | | | | | | | | |
| **SIGNATURES** | | | | | | | | | | | | | | |
|  | | | | | |  | | | | | | | | |
| Youth | | | | | |  | | | | | | | | |
|  | | | | | |  |  | | | | | | | |
| Caseworker | | | | | |  | Title | | | | | | | |
|  | | | | | |  |  | | | | | | | |
| Independent Living Coordinator | | | | | |  | Title | | | | | | | |
|  | | | | | |  |  | | | | | | | |
| Other | | | | | |  | Title | | | | | | | |
|  | | | | | |  |  | | | | | | | |
| Other | | | | | |  | Title | | | | | | | |
| **NOTE:** A copy of this plan, created in collaboration with the youth, should be provided to the youth 90 days before leaving care and at the time the youth leaves care with any updates. | | | | | | | | | | | | | | |