

YOUTH-DEVELOPED DISCHARGE HEARING FORM

NAME:

DATE OF BIRTH:

I am under 21 and I want to stay in care.

Yes

No

I am already 21

My reasons for wanting to stay in care or leave care:

HOUSING PLAN/DAILY EXPENSES

Address where I will live:

Is there a lease to sign?

Yes

No

Monthly Housing Cost & Living Expenses:

I have a monthly budget.

Yes

No

My Back-Up Housing Plan:

My Concerns/Comments:

EDUCATION/VOCATIONAL TRAINING

My Current Educational/Vocational Level:

My Education Plan for the next 12 months:

My Long-Term Educational Goal:

My Financial Aid Documents Completed/Up-to-date:

Yes

No

My Concerns/Comments:

EMPLOYMENT/CAREER		
I need assistance finding employment.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contact Information for Current Employer <i>(Name, Address, Phone, E-mail, etc.)</i>		
My Monthly Income from Employment:		
My Long-Term Career Goal:		
My other Monthly Income (and source of that income...e.g. SSI, Social Security, trust account, individual incentive account (IDA), or other incentive account):		
I have checked with the probate court about any trust accounts in my name.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have an open bank account.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
My Concerns/Comments:		

HEALTH (all foster care youth are eligible to continue Ohio Medicaid through age 21)		
I have been signed up for health care through Ohio Medicare:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of Health Insurance Plan if not Ohio Medicaid:		
Contact Information for Primary Care Physician <i>(Name, Address, Phone, E-mail, etc.)</i>		
My last medical check-up was on:	Date: _____	
My last dental exam was on:	Date: _____	
My continued Health & Mental Health needs <i>(dental, therapy, substanceabuse, family planning, other medical needs, etc.)</i>		
Contact Information for my other Health Care Providers:		
My Concerns/Comments:		

CHILDREN (IF APPLICABLE)

Health Insurance Plan for Child(ren):

Contact Information for Child(ren)'s Primary Medical Provider:

Contact Information for Child Care Provider(s):

I have enough money to pay for Child Care: Yes No

I have applied for Child Care Subsidies: Yes No

Amount of TANF (welfare or public assistance) received for Child(ren):

Amount of Child Support received for Child(ren):

My Concerns/Comments:

LEGAL

I have concerns about my involvement with the Juvenile or Adult Justice system and need help getting my records expunged. Yes No

I still need support with my Immigration Status. Yes No

I need help with outstanding debts or credit score issues. Yes No I don't know

I need support with visitation with my siblings. Yes No

My Concerns/Comments:

OTHER CONCERNS

I NEED the following Important Documents *(please check all that apply)*:

- | | |
|---|--|
| <input type="checkbox"/> Social Security Card | <input type="checkbox"/> Birth Certificate |
| <input type="checkbox"/> State ID | <input type="checkbox"/> Driver's License |
| <input type="checkbox"/> Passport | <input type="checkbox"/> Immunization/Medical Records |
| <input type="checkbox"/> Education Records | <input type="checkbox"/> Health Insurance Card |
| <input type="checkbox"/> Court Documents | <input type="checkbox"/> Credit Report |
| <input type="checkbox"/> Bank Account/Savings Account | <input type="checkbox"/> Immigration Documents (if applicable) |
| <input type="checkbox"/> Registration for Selective Service (if male) | <input type="checkbox"/> Voter Registration |

MY KEY CONTACTS

Contact Information for Person/People I can call in an Emergency (*i.e. housing falls through, I get really hurt/sick, etc.*)

Additional Contacts (*please check and complete information for all that apply*):

	<u>Name</u>	<u>Address</u>	<u>Phone</u>	<u>Email/Social Ntwking</u>
<input type="checkbox"/>	Siblings			
<input type="checkbox"/>	Child Welfare			
<input type="checkbox"/>	Mental Health			
<input type="checkbox"/>	Physical Health and Disabilities			
<input type="checkbox"/>	Criminal Justice			
<input type="checkbox"/>	Alcohol/Drug Addiction Services			
<input type="checkbox"/>	Workforce Development			
<input type="checkbox"/>	Special Education (IEP)			
<input type="checkbox"/>	Supportive Housing			
<input type="checkbox"/>	Teen Parent Services			
<input type="checkbox"/>	Education/Financial Aid			

My Concerns/Comments:

I have participated in the development of this transition planning court form and believe the information in the form is accurate.

Youth Signature _____

Date _____

Case worker _____

Date _____

Other Signature _____

Date _____

Judge's Signature _____

Date _____