EXHIBIT A-1

TRANSITIONAL INDEPENDENT LIVING PLAN (TILP)

State of California – Health and Human Services Agency California Department of Social Services

TRANSITIONAL INDEPENDENT LIVING PLAN & AGREEMENT

Youth: _____ Date of Birth: _____ Age: ____ Ethnicity: _____
Address: _____
Phone Number: _____ Text OK?: ☐ Email Address: _____

Instructions To Youth: The purpose of this agreement is to capture the goals you are agreeing to achieve over the next 6 months. It is a good organizing tool to help you stay focused and keep track of your progress toward accomplishing each goal. Your Social Worker/Probation Officer and caregiver will also have copies of this agreement and will help you achieve your goals.

Instructions to Caregiver: You are agreeing to assist the youth in the development of their ILP goals and to support the youth in completing the activities.

Instructions to Social Worker/Probation Officer: You are agreeing to assist the youth and the caregiver in completing this form, and develop Planned Services that will assist the youth in meeting his/her goals. Document the Planned Services and Delivered Services in CWS/CMS. Probation officers: use manual documentation procedures.

Service goals and activities to be addressed in the plan:
Goals are individualized based on your assessment and may include examples such as:

- develop a life-long connection to a supportive adult
- graduate from high school
- obtain a part-time job
- invest savings from part-time job
- develop community connections
- obtain a scholarship to attend college
- develop competency in the life skill of _____

Activities are individualized to help meet a specific goal. Example – if high school graduation is a goal, the youth directed activity might be to attend classes regularly with no tardies for the next 6 months.
For youth participating in ILP services, activities are reportable as ILP Delivered Services in CWS/CMS. The social worker shall select from one or more of the following ILP Service Types that an individualized completed activity fits in:

- Received ILP Needs Assessment
- ILP Mentoring
- ILP Education
- ILP Education Post Secondary
- ILP Education Financial Assistance
- ILP Career/Job Guidance
- ILP Employment/Vocational Training
- ILP Money Management
- ILP Consumer Skills
- ILP Health Care
- ILP Room and Board Financial Assistance
- ILP Transitional Housing, THP, THP Plus
- ILP Home Management
- ILP Time Management
- ILP Parenting Skills
- ILP Interpersonal/Social Skills
- ILP Financial Assistance Other
- ILP Transportation
- ILP Other (Stipends/Incentives)

☐ I understand that if I am employed as part of this plan, my earned income will be disregarded, as the purpose of my employment is to gain knowledge of needed work skills, habits and responsibilities to maintain employment. (WIC 11008.15)

☐ I understand that I can retain cash savings up to $10,000 under this plan in an insured savings account and any withdrawal requires the written approval of my social worker/probation officer and must be used for purposes directly related to my transitional goals. (WIC 11155.5)

☐ I understand that I will receive assistance to obtain my personal documents and information about financial aid for postsecondary education/training. (WIC 16001.9)

State of California – Health and Human Services Agency California Department of Social Services

Youth: _____ Date of Birth: _____ Age: _____
Case Worker Name: _____ Case Worker Phone: _____
Case Worker Email Address: _____
TILP 6-month timeline: _____ to _____.
Date Independent Living Needs Assessment completed: _____.

☐ Based on the assessment of my level of functioning, the following transitional goals and activities meet my current needs.
☐ I will participate in Independent Living Program (ILP) services to help meet my goals.

Goal	Activity	Responsible Parties	Planned Completion Date	Progress Date
Goal #1:				☐ Met Goal Date:_____ ☐ Satisfactory Progress. ☐ Needs more time/assistance. ☐ Goal needs modification.
Goal #2:				☐ Met Goal Date:_____ ☐ Satisfactory Progress. ☐ Needs more time/assistance. ☐ Goal needs modification.
Goal #3:				☐ Met Goal Date:_____ ☐ Satisfactory Progress. ☐ Needs more time/assistance. ☐ Goal needs modification.
Goal #4:				☐ Met Goal Date:_____ ☐ Satisfactory Progress. ☐ Needs more time/assistance. ☐ Goal needs modification.

Comments:

_____
_____
_____

Youth: _____ Date of Birth: _____ Age: _____
Case Worker Name: _____ Case Worker Phone: _____
Case Worker Email Address: _____

This Agreement will be updated on: _____ Update #: _____

Signing this agreement means we will all work to complete the steps necessary to help the youth reach his/her goals.

_____ _____
Youth's Signature *Date*

_____ _____
Caregiver's Signature *Date*

_____ _____
Social Worker/Probation Officer Signature *Date*

Voter Registration Info:
Secretary of State Voter Registration
www.sos.ca.gov/elections/voter-registration

Secretary of State Voter Information Contact
www.sos.ca.gov/elections/contact/email-elections-division

Secretary of State Voter Hotline
(800) 345-VOTE(8683)

Copies to: Youth
Caregiver
Case File
ILP

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY | CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

PLACEMENT AGENCY -- THP PLUS FOSTER CARE PROVIDER AGREEMENT
NONMINOR DEPENDENT PLACED BY AGENCY IN THP PLUS FOSTER CARE PROVIDER

NAME OF YOUNG ADULT	THP PLUS FC PROVIDER NAME
BIRTH DATE OF YOUNG ADULT	DATE PLACED WITH THP PLUS FC PROVIDER
CASE NUMBER	DATE FIRST ENTERED FOSTER CARE AS YOUNG ADULT

The Placement Agency will pay $ _____ per month in return for the above-named young adult's care and supervision as defined in Welfare and Institutions Code 11403.2 and other applicable law and regulations. First payment to be made within 45 days after placement with subsequent payments to be made monthly.

PLACEMENT AGENCY AGREES TO

1. The placing agency will obtain from the young adult all appropriate releases of information relevant to this placement in order to provide the THP PLUS Foster Care provider with knowledge of the background and needs of this young adult. This may include, based on the young adult's consent, a social work assessment, medical reports, educational assessment psychiatric/psychological evaluations, identification of special needs, and the young adult's TILP. This shall be made available to the provider within 14 days from date of placement.
2. Inform the provider, before placement, of this young adult's behaviors and proclivities that might be harmful to others.
3. Work with the provider in the development and progress of a transition plan. The county placing agency will notify and invite the provider to participate in any young adult and family team meetings to discuss the young adult's transition plan.
4. Work with provider staff toward successful completion of the young adult's needs and services plan, a positive placement outcome and timely permanency for the young adult.
5. Work together with the provider to develop and maintain positive relationships with the young adult's siblings, and other family members.
6. Maintain monthly contact with the young adult.
7. Continue paying for the young adult's care as long as the young adult remains in placement or in the temporary absence of the young adult, when the placing agency asks the provider to retain an open placement.
8. Provide the young adult with his or her Medi-Cal card or proof of other medical coverage.
9. Inform the provider of the county clothing allowance policy and provide the funding consistent with those policies.
11. Verify and remit/reconcile any underpayments within 45 days of provider notification of such underpayments.
12. Notify the provider within 12 months of suspected overpayments, in accordance with applicable laws and regulations.
13. Provide arrangements for educational travel to the young adult's secondary school of origin, as appropriate.
14. Provide a contact telephone number for emergencies and after business hours:

    Emergency # _____

THP PLUS FOSTER CARE PROVIDER AGREES TO

1. Provide this young adult with a transitional housing site that has been certified to care for the young adult's needs in accordance with applicable laws and regulations.
2. Conform to applicable approval standards regulations and all laws governing foster care.
3. Notify the placing agency within 24 hours of the provider having knowledge (unless there is a separate written agreement with the placing agency) by phone followed in writing of significant changes in the young adult's health, behavior or location as well as significant issues including suspected physical or psychological abuse, death, injury, unusual incidents, unusual absence of a young adult, placement issues, changes to work or school participation and all items required by approval standard regulations.
4. Work together with the placing agency to encourage the maintenance of permanent connections with the young adult's family members, and other significant adults, as indicated in the transition plan, and/or young adult and family teams whenever possible.
5. Use constructive alternative methods of harm reduction; not use corporal punishment; deprivation of meals, monetary allowances, threat of discharge or any degrading or humiliating punishment.
6. Respect and keep confidential information given about this young adult.
7. Work with the placing agency to develop and submit to them a transition plan that develops an understanding of the responsibilities, objectives and requirements of the agency in regard to the care of this young adult, including the information listed on the reverse side of this form, within 30 days of placement of the young adult. The transition plan shall be updated at least every six months.
8. Written progress reports on the transition plan progress shall be provided at least every six months or more frequently by mutual agreement.
9. Give placing agency 7 day notice of intent to discharge or move this young adult. Notify the placing agency of any intended move of this young adult between certified sites prior to the move. The provider has the authority to move a young adult in the case of imminent risk to the young adult or others in the household. The provider shall notify the placing agency within 24 hours of such move.
10. Provider social worker shall visit this young adult in private in their site at the frequency specified in the provider's plan of operation.
11. Provide state and federal agencies access to records as provided by state and federal law.
12. Follow any requirements associated with the county's clothing allowance policy and procedures.
13. Remit any overpayment in full to the county welfare department upon receipt of a notice of action or following the completion of due process.
14. Inform county upon discovery of any apparent overpayment.
15. Immediately notify the placing agency of any changes to the young adult's secondary educational travel plans (if appropriate).

Initial transition plan summary shall include:

A. Medical and Dental needs

B. Psychological/psychiatric issues identified

C. Staffing review summaries

D. Educational /employment assessment

E. Peer adjustment

F. Relationship to adults identified as potential permanent connection

G. Involvement in recreation programs

H. Behavior Problems impacting house rules

I. Educational and employment objectives (goals established for next 3 months)

J. Long-range goals including anticipated length of placement

K. Tasks planned to reach educational and employment objectives and goals as defined in the young adult's TILP and who will be performing these tasks, including agency service activity

L. Identification of unmet needs

M. Involvement of young adult in the transition program

Periodic update of transition plan shall include:

A. Current status of young adult's physical and psychological health as well as access to medical and dental exams

B. Reassessment of young adult's adjustment to the placements, transitional program, peers and school/work

C. Progress toward short-term objectives and long-range goals as defined in the young adult's TILP including tasks which have been performed to reach these objectives and goals

D. Reassessment of unmet needs and efforts made to meet these needs

E. Modification of transition plan, tasks to be performed and anticipated length of placement

F. Involvement of young adult in transition program

G. Plan to exit foster care to sustainable housing and incremental steps made towards independence.

By this signature I attest that I have read this agreement and agree to fulfill these requirements and I am authorized on behalf of my agency to sign this. The terms of this agreement shall remain in force until changed by mutual consent, in writing, of both parties.

YOUNG ADULTS'S PLACEMENT WORKER NAME PRINT:	SIGNATURE:		PHONE ( )
COUNTY AND NAME OF AGENCY	TITLE		DATE
THP+FC PROVIDER'S/REPRESENTATIVE'S NAME PRINT:	SIGNATURE:		PHONE ( )
NAME OF AGENCY	TITLE		DATE
AGENCY ADDRESS			

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

SIX-MONTH CERTIFICATION OF EXTENDED FOSTER CARE PARTICIPATION

Instructions: The purpose of this form is for the social worker/probation officer (SW/PO) to certify a nonminor's participation in extended foster care (EFC) activities and transmit it to the eligibility worker (EW).

Nonminor's name: _____ Case Number: _____ DOB: _____

I. Nonminor's transitional independent living plan (TILP) was updated on _____ (DATE). Nonminor's six-month plan to meet participation is:

☐ Primary participation activity in # _____ with backup plan in participation # _____.

☐ Combination of activities in participation # _____ and participation # _____.

☐ Incapable of doing activities in participation activity #1 through #4 due to a medical condition.

Participation Activities

1. *Complete secondary education/equivalent credential.*
2. *Enroll in post secondary/vocational education institution.*
3. *Participating in activity designed to promote or remove barriers to employment.*
4. *Employed at least 80 hours per month.*
5. *Incapable of doing any activities in number (1) to (4) due to medical condition.*

II. Certification

☐ **Nonminor dependent:** I certify the nonminor dependent is eligible for EFC based on the updated TILP for the next six-month period. Regular updates on participation will be verified and documented in the Child Welfare Services/Case Management System (CWS/CMS) Contact Notebooks and SW/PO court reports with the six-month case plan updates. Should the juvenile court terminate jurisdiction of the nonminor, I will notify the EW immmediately.

☐ **Ward of nonrelated legal guardian:** I certify the nonminor is eligible for EFC based on the updated TILP for the next six-month period. Regular updates on participation will be verified and documented in the Child Welfare Services/Case Management System (CWS/CMS) Contact Notebooks and the six-month case plan updates. Should the nonminor cease eligibility for EFC, I will notify the EW immediately.

SW/PO Name: _____

SW/PO Signature: _____ Date: _____

The SW/PO must send this Certification Form to the EW.

Received by:

EW Name: _____

EW Signature: _____ Date: _____

Copies must be kept in SW/PO and EW case files.

State of California – Health and Human Services Agency California Department of Social Services

MUTUAL AGREEMENT FOR EXTENDED FOSTER CARE

I have met with a county case worker (social worker or probation officer) to talk about voluntarily staying in foster care after turning 18 years old. I want to continue to stay in foster care after I turn 18 years old.

I am asking the county case worker for a foster care placement (such as a foster home, relative's home, foster family agency home, short-term residential therapeutic program (STRTP) or group home, transitional housing program, a supervised independent living placement or with my nonrelated legal guardian), as described in my Placement Agreement.

I understand that I am voluntarily staying in foster care as an adult. The benefits of staying in foster care include having safe and stable housing and having help from a county case worker to meet my needs and plan for my future.

INITIAL

— I agree to meet face to face with my county case worker at least once a month and update my permanency goals and my Transitional Independent Living Plan (TILP) at least once every six (6) months.

— I agree to do one or more of the following as described in my TILP to be eligible to stay in foster care:

1. Finish high school or get my California High School Equivalency Certificate (GED), or
2. Enroll in college, community college or a vocational education program, or
3. Participate in a program or activity to help me find and keep a job (for example: computer class, job search, job training, career counseling, volunteer work, etc.), or
4. Have a paid job and work at least 80 hours per month, or
5. I am unable to do any of the above due to a verified medical condition, including mental health conditions.

— I agree to work on completing the goals in my TILP, and to:

1. Talk to my county case worker at least once a month to report on my progress and any problems I am having in meeting the goals in my TILP.
2. Provide verification of my participation in one of the five eligibility conditions listed above.
3. Tell my county case worker as soon as possible, but no later than my monthly contact with my county case worker, about any changes in how I am meeting one of the five eligibility conditions listed above.
4. Tell my county case worker as soon as possible, but no later than my monthly contact with my county case worker, about any changes to my income (from work or any other source such as social security or disability benefits, grants and scholarships).
5. If I am in a county supervised placement such as a foster home, living with a relative, foster family agency home, in a short-term residential therapeutic program (STRTP) or group home, in transitional housing, or in a supervised independent living placement:

- I understand that the juvenile court will be supervising my case, and I agree to take part in six-month Review Hearings, either in person or by telephone, or communicate my needs with my attorney AND
- I understand that if I don't participate in my TILP that a court hearing may be set to possibly close my case.
- I understand that I will receive written notices of action (NOAs) and that I can appeal these actions.

6. If I am voluntarily living with my juvenile court appointed nonrelated legal guardian:
   - I understand that the county case worker will be supervising my case, and I agree to participate in updating my six-month TILP; AND
   - I understand that if I don't participate in one of the five eligibility activities as described in my TILP, the county agency may stop payments and recommend my case be closed. I understand that I will receive written NOAs and that I can appeal these actions.

— I agree to live in an appropriate approved or licensed foster care placement and agree to:

1. Tell my county case worker about any problems with my placement and work with my case worker to find solutions.
2. Make sure my county case worker always has a way to contact me, and tell my case worker within one week if my phone number, mailing address, or other contact information changes.
3. Tell my county case worker within 24 hours after I complete a planned move to a new placement, or move out of my current placement for any other reason.
4. I understand that if I leave my foster care placement, the foster care funding will be stopped until I am residing in another approved placement.

— I understand that if I leave extended foster care, I can petition the juvenile court for re-entry to foster care and receive assistance from the county agency with filing the petition if I am under the age limit.

— I understand that the following conditions would make me ineligible to remain in foster care:

- Active duty military service, or other military service if I cannot meet with my county case worker at least once a month.
- Incarceration (sentenced to confinement)

— The county agency agrees to:

1. Help me develop and achieve my goals for stable and permanent housing and independent living, as described in my TILP.
2. Review the goals in my TILP and update them at least every six months.
3. Help me find an appropriate approved or licensed placement (such as foster home, relative's home, short-term residential therapeutic program (STRTP) or group home, transitional housing program, or supervised independent living placement or remain with my nonrelated legal guardian).
4. Help me stay eligible for extended foster care by responding to any problems I have reported and help me find services and supports to meet my needs and maintain eligibility.
5. Help me develop a Shared Living Agreement, as needed, and help resolve any problems that arise with my placement.
6. Ensure that I have Medi-Cal or other health insurance, and help me get medical, dental, and/or mental health care as needed.

7. Tell me about any changes to my foster care benefits and give me information about the procedure to appeal a decision to either cut off or reduce my benefits.
8. Make sure I have contact information for my attorney, and information about upcoming juvenile court hearings, and how to participate in these hearings as applicable.

The undersigned agrees to foster care placement and supervision by the _____ County Agency.

Print Nonminor's Name:	Case Worker's Name:	Supervisor's Name:
Nonminor's Signature:	Case Worker's Signature:	Supervisor's Phone Number:
Nonminor's Contact Phone Number:	Case Worker's Phone Number:	Tribal Authority Name:
Date:	Date:	Tribal Authority Phone Number:

NOTE: If nonminor dependent (NMD) signs form prior to their 18th birthday, a new one must be signed after the NMD's 18th birthday.

Are You Registered to Vote? Access to voter information and registration can be found at the following links:

- Secretary of State Voter Registration
- Secretary of State Voter Information Contact

Secretary of State Voter Hotline: (800) 345-VOTE (8683)

State of California – Health and Human Services Agency California Department of Social Services

VOLUNTARY RE-ENTRY AGREEMENT FOR EXTENDED FOSTER CARE

I have met with a county case worker (social worker or probation officer) to talk about voluntarily re-entering foster care as an adult former foster youth who is under age 21. By signing this agreement, I understand I am voluntarily agreeing to re-enter foster care placement.

I agree to be placed in a supervised foster care setting (such as a foster home, relative's home, foster family agency home, short-term residential therapeutic program (STRTP) or group home, transitional housing program, a supervised independent living placement or with my juvenile court appointed nonrelated legal guardian), as described in my Placement Agreement under the placement and care responsibility of the _____County _____ department.

I understand that my Aid to Families with Dependent Children – Foster Care (AFDC-FC) benefits will begin to be paid as of the date I sign this agreement or the date I am placed in a supervised foster care setting, whichever is later.

I understand that I am responsible for completing, with assistance from my county case worker, the application for AFDC-FC payments and providing information and documentation about my status as a former dependent child or ward of the juvenile court, and my current income and assets, as required, as a child-only case.

I agree to participate with my county case worker in filing a petition in juvenile court so that the court may resume jurisdiction over my case by finding that it is in my best interests to re-enter foster care.

I agree to work collaboratively with my county case worker to develop my transitional independent living case plan and Transitional Independent Living Plan (TILP) within 60 days of signing this agreement.

I understand the benefits of re-entering foster care include having safe and stable housing and having help from a county case worker to meet my needs and plan for my future.

— I agree to meet face to face with my county case worker at least once a month and update my permanency goals and my TILP at least once every six months.

— I agree to immediately begin to do one or more of the following to be eligible to re-enter foster care:

1. Finish high school or get my California High School Equivalency Certificate (GED), or
2. Enroll in college, community college or a vocational education program, or
3. Participate in a program or activity to help me find and keep a job (for example: job search, job training, career counseling, etc.), or
4. Have a paid job and work at least 80 hours per month, or
5. I am unable to do any of the above due to a verified medical condition, including mental health conditions.

— I agree to work on completing the goals in my TILP, and to:

1. Talk to my county case worker at least once a month to report on my progress and any problems I am having in meeting the goals in my TILP.
2. Tell my case worker as soon as possible, but no later than my monthly contact with my county case worker, about any changes in how I am meeting one of the five eligibility conditions listed above.
3. Tell my county case worker as soon as possible, but no later than my monthly contact with my case worker, about any changes in my income (from work or any other source such as social security or disability benefits, grants and scholarships).
4. If I am in a county supervised placement such as a foster home, relative's home, foster family agency home, short-term residential therapeutic program (STRTP) or group home, transitional housing or a supervised independent living placement:
   - I understand that the juvenile court will be supervising my case, and I agree to take part in six month Review Hearings, either in person or by telephone, or communicate my needs with my attorney; AND
   - I understand that if I don't participate in my TILP that a court hearing may be set to possibly close my case. I understand that I will receive written notices of action (NOAs), and I can appeal these actions.
5. If I am voluntarily living with my previously juvenile court appointed nonrelated legal guardian:
   - I agree to voluntarily live with my previously juvenile court appointed nonrelated legal guardian and understand that the county case worker will be supervising my case and I agree to participate in updating my six month TILP; AND
   - I understand that if I don't participate in one of the five eligibility activities as described in my TILP, the county agency may stop payments and close my case. I understand that I will receive written notices of action (NOAs), and I can appeal these actions.

— I agree to live in an appropriate approved or licensed foster care placement and agree to:

1. Tell my county case worker about any problems with my placement and work with my case worker to find solutions.
2. Make sure my county case worker always has a way to contact me, and tell my case worker within one week if my phone number, mailing address, or other contact information changes.
3. Tell my county case worker within 24 hours after I complete a planned move to a new placement, or move out of my current placement for any other reason.
4. I understand that if I leave my foster care placement, the foster care funding will be stopped until I am residing in another approved placement.

— I understand that if I leave foster care, I can petition the juvenile court for re-entry to foster care and receive assistance from the county agency with filing the petition if I am under the age limit.

— I understand that the following conditions would make me ineligible to remain in foster care:
   - Active duty military service, or other military service if I cannot meet with my county case worker at least once a month.
   - Incarceration (sentenced to confinement)

— The county agency agrees to:

1. Help me develop and achieve my goals for stable and permanent housing and independent living, as described in my TILP.
2. Review the goals in my TILP and update them at least every six months.
3. Help me find an appropriate approved or licensed placement (foster home, relative's home, foster family agency home, short-term residential therapeutic program (STRTP) or group home, transitional housing program, or supervised independent living placement or remain with my nonrelated legal guardian).
4. Help me stay eligible for extended foster care by responding to any problems I have reported and help me find services and supports to meet my needs and maintain eligibility.
5. Help me develop a Shared Living Agreement, as needed, and help resolve any problems that arise with my placement.
6. Ensure that I have MediCal or other health insurance, and help me get medical, dental, and/or mental health care as needed.
7. Tell me about any changes to my foster care benefits and give me information about the procedure to appeal a decision to either cut off or reduce my benefits.
8. Make sure I have contact information for my attorney, and information about upcoming juvenile court hearings, and how to participate in these hearings as applicable.

The undersigned agrees to foster care placement and supervision by the _____ County Agency.

Print Nonminor's Name:	Case Worker's Name:	Supervisor's Name:
Nonminor's Signature:	Case Worker's Signature:	Supervisor's Phone Number:
Nonminor's Contact Phone Number:	Case Worker's Phone Number:	Tribal Authority Name:
Date:	Date:	Tribal Authority Phone Number:

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- Secretary of State Voter Registration
- Secretary of State Voter Information Contact

Secretary of State Voter Hotline: (800) 345-VOTE (8683)

COUNTY OF LOS ANGELES DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Non-Minor Dependent
2-Way Authorization For Sharing Information

I, _____hereby
Non-Minor Dependent

authorize Los Angeles County Department of Children and Family Services and

_____, at _____
Name of Provider Telephone

to exchange information.

The type of information to be disclosed: (please check all that apply)

- ☐ Evaluations
- ☐ Diagnosis (Including, Psychological or Substance Abuse)
- ☐ HIV/AIDS Diagnosis
- ☐ Treatment Plan
- ☐ Course of Treatment
- ☐ Medical/Hospital Records
- ☐ Psychological/Medical Test Results
- ☐ Mental Health Record Summary
- ☐ Psychotherapy Notes
- ☐ Psycho/Educational Assessment
- ☐ Developmental Assessment
- ☐ Other _____

The purpose of such disclosure: (please check all that apply)

- ☐ Ongoing Treatment
- ☐ Evaluation
- ☐ Coordination of Care
- ☐ Medical Care
- ☐ Consultation
- ☐ Legal issues
- ☐ Other _____

Exceptions:_____

The designated information about me ☐ may ☐ may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Los Angeles County Department of Children and Family Services and the above designated person ☐ may ☐ may not discuss by telephone the content of the information released.

This consent is in effect until_____. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already take place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by me during therapy sessions is confidential with certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

_____ _____

Date **Signature of Non-Minor Dependent or Personal Representative**

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION.

CSW Statement:

On _____ a copy of this authorization was given to the NMD to give to his/her provider. CSW's initials: _____

On _____ a copy of this authorization was faxed to the named provider by the CSW. CSW's initials: _____

DCFS Contact Information

CSW Name: _____

(Please print clearly)

Phone: _____

FAX: _____

COUNTY OF LOS ANGELES

PROBATION DEPARTMENT

Non-Minor Dependent
Two-Way Authorization for Sharing Information

I, _____
Name of Non-Minor Dependent

hereby authorize the exchange of information between Los Angeles County Probation Department and:

_____ at _____
Name of Person/Provider Phone Number

The type of information to be disclosed is as follows (check all that apply):

- ☐ Evaluations
- ☐ Diagnosis (Including, Psychological or Substance Abuse)
- ☐ HIV/AIDS Diagnosis
- ☐ Treatment Plan
- ☐ Course of Treatment
- ☐ Medical/Hospital Records
- ☐ Psychological/Medical Test Results
- ☐ Mental Health Record Summary
- ☐ Psychotherapy Notes
- ☐ Psycho/Educational Assessment
- ☐ Developmental Assessment
- ☐ Court Reports and Orders
- ☐ Other _____

The purpose of such disclosure is as follows (check all that apply):

- ☐ Ongoing Treatment
- ☐ Evaluation
- ☐ Coordination of Care
- ☐ Medical Care
- ☐ Consultation
- ☐ Legal issues
- ☐ Other _____

Exceptions: _____

The designated information about me ☐ may ☐ may not be transmitted by fax, electronic mail, or other electronic file transfer mechanisms. The Los Angeles County Probation Department and the provider designated above ☐ may ☐ may not discuss by telephone the content of the information released.

This consent is in effect for six months or until _____. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by me during therapy sessions is confidential with certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, as well as assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under HIPPA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

Date	Signature of Non-Minor Dependent or Personal Representative

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION.

DPO Statement:

A copy of this authorization was given to the NMD to given to his/her provider on the following date: _____

DPO's initials: _____

A copy of this authorization was given to the NMD sent electronically to his/her provider on the following date: _____

DPO's initials: _____

Probation Contact Information:

DPO Name:	
Phone:	
Email:	
Fax:	

PLACEMENT INFO & AUTHORIZATION FORM

NMD	Non-Minor Dependent:				
	Date of Birth:	Gender:	Child:		
	Cell Phone:	Email:			
AGENCY	Agency:		License #:		
	Contact Person:		Vendor #:		
	Proposed Address:		Telephone #:		
	City:		State:	Zip Code:	SPA:
	☐ Remote/Scattered ☐ Single /Staff ☐ Host Family				
	Staff Name:		Telephone #:		
	NMD is #: _____ on Bi-weekly referral log date _____				
	Agency Social Worker is: _____ # on caseload _____				
COUNTY STAFF	CSW/DPO Name:		Telephone #:		
	Office:		Address:		
	SCSW/DPO Name:		Telephone #:		
THPP-NMD COUNTY STAFF	Request to place NMD is approved				
	CPM/Designee Name:	Signature	Date:		
	Attached Documents are current: ☐ CCLD License/Facility Evaluation ☐ Certificate of Liability Insurance ☐ Certificate of Compliance Program Director/Designee Name: Signature:				
DATES	Received By DCFS/Probation:	Agency NMD Moved In On:	Agency Initals:		

CO-LEASING GUIDELINES

1) A Contractor may co-sign a lease with a Non-Minor Dependent (NMD) Participant as specified by the County Program Manager. The NMD Participant may not be permitted to solely sign a rental or lease agreement.

2) The Contractor shall oversee and maintain the lease agreements for the THPP-NMD Participants.

3) Prior to the NMD's housing placement, the Contractor shall obtain approval from the County CSW/DPO, to ensure the readiness of the NMD Participant.

4) The Contractor and the NMD Participant shall agree on the terms set forth by the Landlord prior to co-leasing a unit. In addition, the terms and/or details of the rental agreement should include the following:

    - The amount of rent due each month;
    - The due date of the rent each month;
    - The specified date requirement for paying the first and last month's rent prior to moving into the apartment unit;
    - The requirement for notification prior to the NMD terminating the lease agreement;
    - The term of the lease or the month-to-month payment requirements;
    - The specified upkeep and maintenance requirement of the rental unit;
    - The terms of the lease agreement which is inclusive of utility services, such as water, gas, electric, sanitation, cable service, etc.;
    - The specified number of maximum days/hours that a guest may stay with the NMD;
    - The responsibility for paying for damages should not come from the Participant's foster care allowance;
    - Any parking requiring and/or restrictions.

UNIT SHARING GUIDELINES

1) A Contractor may allow unit-sharing with a Non-Minor Dependent (NMD) Participant and a non-participant as specified by the County Program Manager. The NMD Participant may not unit-share with anyone under the age of 18 excluding children.

2) The Contractor shall ensure that the Non-Minor Dependent (NMD) Participant who is pregnant and/or parenting, identify as LGBTQ, or have physical disabilities, and/or managed mental health concerns are placed with an individual who is compatible.

3) The Contractor shall ensure that the NMD Participant's agreed upon apartment furnishings are kept upon transitioning from foster care.

4) The Contractor shall ensure that the NMD Participant who shares an apartment unit with a minor makes certain that the individuals are compatible with one another, is considerate of the minor's chronological age, sexual orientation and gender identity, as well as maintains the privacy of the Participant's orientation, unless otherwise disclosed.

5) The Contractor shall allow a NMD Participant to share a bedroom in a transitional housing unit with any of the following persons:

    a. Another participant as approved by the provider.

    b. A participant in Transitional Housing Program-Plus, as defined in subdivision(s) of Section 11400 of the WIC, as approved by the provider.

    c. A non-participant roommate as approved by the provider on a case-by-case basis, as specified by the department.

    d. The Participant's children.

    e. Any other person as specified by the County Program Manager.

6) The Contractor shall ensure that the NMD Participant receives the following items at the time of the initial placement:

    a. Grooming/hygiene supplies for NMD Participant and their infant;

    b. Clothing needs for NMD and his/her infant child(ren);

    c. Food supply; and,

    d. Information about expected utility costs.

7) The Contractor shall ensure, to the best of their ability, that the following terms are reviewed and monitored with the NMD Participant prior to apartment unit placement and noted in their case file:

a. That ongoing communication is recommended between cohabitants in order to resolve any concerns or disagreements;

b. That sharing of the common areas in the unit are made known and respected;

c. That the safety and cleanliness of the unit is maintained;

d. That personal space and personal property are to be respected by both individuals;

e. That there is adherence to any agreed apartment pet policies;

f. That guests, visitors, and opposite-sex invitees are respected by both individuals;

g. That the use of cigarette smoking and drug use are not acceptable; and,

h. That any unrelated children not on the rental agreement are not allowed.

8) The Contractor shall allow a minor Participant to share a bedroom in a transitional housing unit with any of the following persons:

a. Another Participant as approved by the Contractor.

b. A participant in Transitional Housing Program-Plus, as defined in subdivision (s) of section 11400 of the WIC, as approved by the Contractor.

c. The Participant's child(ren).

d. A non-participant roommate as approved by the provider on a case-by-case basis, as specified by the County.

e. Any other person as specified by the County.

f. Any adult who is not a participant, including participants in Transitional Housing Program-Plus, as defined in subdivision (s) of Section 11400 of the WIC, and who resides with a participant shall obtain a criminal record clearance or exemption in accordance with Section 1522.

EXHIBIT A-7

Therapeutic and Emotional Support Pet Guidelines

According to guidance provided by the California Mental Health Services Authority (CalMHSA), California law requires a landlord or other housing provider to waive a rule disallowing pets as a reasonable accommodation to a disabled tenant so they can live with a service or emotional support animal. However, the accommodation would not be considered reasonable if one of the following conditions exists: the animal poses a direct threat to other tenants; causes substantial physical harm to property; imposes an undue financial burden on the landlord; or fundamentally alters the nature of the services that the landlord provides.

The owner of the emotional support animal must provide a letter from a doctor or other medical professional stating that the owner has a disability and why the owner needs to live with an emotional support animal. The landlord or housing provider does not have the right to demand a copy of the tenant's medical records, specific diagnosis or permission to talk with the health care professional directly. However, this does not prohibit the landlord or housing provider from verifying that the letter came from a licensed practitioner.

The owner of the animal must also comply with state and local animal control laws and ensure that their pet is not a danger or nuisance to the community. Local animal control laws generally require an animal to be licensed, among other things.

MANDATORY ORIENTATION CHECKLIST EXHIBIT A-8

☐ THPP ☐ THPP NMD

AGENCY: _____ DATE: _____

PARTICIPANT: _____
PRINT

UNIT ADDRESS: _____
STREET APT# CITY ZIP

I UNDERSTAND AND RECEIVED COPIES OF EACH OF THE FOLLOWING:

1. ___ GRIEVANCE/COMPLAINT PROCEDURES
2. ___ AGENCY POLICIES
3. ___ AGENCY RULES
4. ___ FOSTER BILL OF RIGHTS
5. ___ LEGAL RIGHTS OF TEENS IN OUT-OF-HOME CARE
6. ___ PERSONAL RIGHTS
7. ___ AGENCY EXPECTATIONS
8. ___ LIST OF FURNITURE THAT I WILL TAKE WITH ME UPON TRANSITION
9. ___ ILP PARTICIPATION
10. ___ EMERGENCY PLAN INCLUDING EMERGENCY TELEPHONE NUMBERS
11. ___ NAME AND PHONE NUMBER(S) OF MY AGENCY'S SOCIAL WORKER, AND DIRECT CARE STAFF.
12. ___ OTHER: _____
13. ___ OTHER: _____

PARTICIPANT SIGNATURE: DATE:

CSW/DPO SIGNATURE: DATE:

Participant Unit/Furniture Inventory Exhibit A-9

Participant:	DOB:	Date:
Staff:	Agency:	
____Entry ____Quarterly ____Exit ____Other:		

Item	Minimum Requirements	Date	Condition	Total
		Enter the date and designation that applies: (P) Purchased (E) Expiration (R) Replaced (C) Completed (N/A) Not applicable	List and designate items that are (F) Fair or need to be (R) Replaced	Enter number of items
Name on mailbox				
Fire Extinguisher	One per unit. Include date of purchase or expiration			
Smoke Detector	In common area. Replace batteries in March and November			
Carbon Monoxide Detector	In common area. Replace batteries in March and November			
Circuit Breaker Box	In unit, each breaker must be labeled and unassigned breakers must be covered			
Emergency Ladder	One in each bedroom			
Telephone Service	Must have unlimited nationwide long distance			
Telephone				
Answering Machine or Voice Mail				
Internet Service	Must be operable at all times			
First Aid Kit	Must meet SOW requirements			
Emergency Radio				
Broom with Dust Pan				
Swifter				
Mop and Bucket				
Glass Cleaner				

Participant Unit/Furniture Inventory Exhibit A-9

Participant:	DOB:	Date:
Staff:	Agency:	
____Entry ____Quarterly ____Exit ____Other:		

Item	Minimum Requirements	Date	Condition	Total
All Purpose Cleaner	1 per Participant			
Paper Towels	2 rolls per Participant			
Dust Cloths	2 cloths per Participant			
LIVING ROOM (LR)				
Sofa	Seating for 4-6			
Center(Coffee) Table				
End Table				
Lighting				
Privacy Window Coverings				
DINING ROOM (or LR or Kitchen)				
Table				
Chairs	2 chairs per Participant			
Lighting				
Privacy Window Coverings				
KITCHEN				
Refrigerator				
Large Capacity Refrigerator	3 or more Participants			

Participant Unit/Furniture Inventory Exhibit A-9

Participant:	DOB:	Date:
Staff:	Agency:	
____Entry ____Quarterly ____Exit ____Other:		

Item	Minimum Requirements	Date	Condition	Total
Oven and Stove				
Lighting				
Privacy Window Coverings				
KITCHEN SUPPLIES				
Dishware	2 per Participant: plate, bowl			
Cups/Glasses	2 per Participant: cup, glass			
Silverware	2 per Participant: spoon, fork, knife			
Cooking Utensils				
Cutting Knives				
Cookware	Pots & Pans with lids			
Trash Can				
Dish Towels	2 per Participant			
Dish Cloths	2 per Participant			
Pot Holders	2 per Participant			
EACH BATHROOM				
Non-skid Mat				
Shower Curtain/Door				
Lighting				
Privacy Window Coverings				

Participant Unit/Furniture Inventory Exhibit A-9

Participant:	DOB:	Date:
Staff:	Agency:	
____Entry ____Quarterly ____Exit ____Other:		

Item	Minimum Requirements	Date	Condition	Total
EACH BEDROOM				
Smoke Detector				
Lighting				
Privacy Widow Coverings				
Emergency Ladder				
EACH PARTICIPANT				
Mailbox Key				
Parking				
Bed				
Mattress				
Box Spring				
Bed Frame				
Night Stand				
Dresser				
Lighting				
Personal Storage Space				
Mattress Pad/Cover				
Bed in a Bag or*				
*Fitted Sheet				
*Flat Sheet				
*Comforter/ Bedspread				

Participant Unit/Furniture Inventory Exhibit A-9

Participant:	DOB:	Date:
Staff:	Agency:	
____Entry ____Quarterly ____Exit ____Other:		

Item	Minimum Requirements	Date	Condition	Total
*Pillowcase				
Pillow				
Blanket				
Body Towel	2 per Participant			
Wash Cloth	2 per Participant			
Hand Towel	2 per Participant			
Toilet Paper	Consult with Participant before purchasing – 4 Rolls			
Sanitary Napkins/Tampons	Consult with Participant before purchasing – 1 Package			
Toothbrush	Consult with Participant before purchasing			
Toothpaste	Consult with Participant before purchasing			
Bath Soap/Wash	Consult with Participant before purchasing			
Deodorant	Consult with Participant before purchasing			
Hair Comb	Consult with Participant before purchasing			
Hair Brush	Consult with Participant before purchasing			
Laundry Soap	Consult with Participant before purchasing			
Laundry Basket	Consult with Participant before purchasing			
EACH INFANT/CHILD PLACED WITH PARTICIPANT				
Carrier/Car Seat	Consult with Participant before purchasing			
Crib/Bassinet/Bed	Consult with Participant before purchasing			
Mattress				
Mattress Pad/Cover				
Fitted Sheet				

Participant Unit/Furniture Inventory Exhibit A-9

Participant:	DOB:	Date:
Staff:	Agency:	
____Entry ____Quarterly ____Exit ____Other:		

Item	Minimum Requirements	Date	Condition	Total
Flat Sheet				
Blanket/Comforter				
Receiving Blanket	4 per Infant/Child			
Blanket Sleeper				
Diapers	Consult with Participant before purchasing – 36 Diapers			
Bibs	4 per Infant/Child			
Safety Gate(s)	Kitchen, bathroom, porch, etc. as needed			
Safety Latches	Drawers, Cabinets, Doors, Stove, Oven,			
Anchors	Furniture anchored to walls			
Socket Plugs	Safety covers for electrical outlets			
Toilet Covering	To prevent accidental drowning			
Medicine	Stored out of reach of all children			
Sharp Objects	Stored out of reach of all children			

Staff Signature_____ Date _____

Participant Signature _____ Date _____

PERSONAL RIGHTS

(a) Section 80072 and 86072, Personal Rights shall not apply to non-minor dependents.

(b) The licensee shall ensure that each non-minor dependent is accorded the personal rights specified in Welfare and Institutions Code section 16001.9 and the following personal rights:

(1) A non-minor dependent shall be free from corporal or unusual punishment; infliction of pain; humiliation; intimidation; ridicule; coercion; threat; physical, sexual, mental, or other abuse; or other actions of a punitive nature including, but not limited to, interference with the daily living functions of eating, sleeping, or toileting, or withholding of shelter, clothing, medication, or aids to physical functioning.

(2) To acquire, possess, maintain, and use adequate personal items. These shall include, but not be limited to, the non-minor dependent's own:

(A) Clothes.

(B) Toiletries and personal hygiene products.

(C) Belongings including furnishings, equipment, and supplies, for his or her personal living space in accordance with his or her interests, needs, and tastes.

(3) To acquire, possess, maintain, and use a personal vehicle for transportation.

(4) To select, obtain, and store food of his or her own choosing.

(5) To select, obtain, or decline medical, dental, vision, and mental health care and related services at his or her discretion.

(6) To have adequate privacy for visitors that include:

(A) Family members, unless prohibited by court order.

(B) The person or agency responsible for placing the non-minor dependent, such as a social worker or probation officer.

(C) Other visitors, unless prohibited by court order.

(7) To be informed by the licensee of the provisions of law regarding complaints, and information including, but not limited to, the address and telephone number of the licensing agency and about the confidentiality of complaints.

(8) To send and receive unopened mail, acquire, possess, maintain, and use a personal landline or cellular telephone to make and receive confidential telephone calls or a personal computer to send and receive unopened electronic communication, unless prohibited by court order.

(9) To leave or depart the THPP at any time at the discretion of the non-minor dependent.

(10) To have the independence appropriate to the status of a non-minor dependent as a legal adult, consistent with the Needs and Services Plan for the non-minor dependent or the Transitional Independent Living Plan for the non-minor dependent.

(11) To have dignity in his or her personal relationships with others in the THPP.

(A) To be free from unreasonable searches of person.

(12) To have private or personal information including, but not limited to, any medical condition or treatment, psychiatric diagnosis or treatment, history of abuse, educational records reflecting performance or behavior, progress at the THPP, and information relating to the biological family of the non-minor dependent maintained in confidence.

(A) There shall be no release of confidential information without the prior written consent of the non-minor dependent, and this information must only be released to the extent permitted by law. The licensee shall, with the consent of the non-minor dependent, only disclose relevant and necessary information about the non-minor dependent.

(13) To access information regarding available educational, training, and employment options of his or her choosing.

(14) To request assistance from THPP staff.

Welfare and Institutions Code section 16001.9, subsection (a) provides in part:

"(a) It is the policy of the state that all children in foster care shall have the following rights:

(1) To live in a safe, healthy, and comfortable home where he or she is treated with respect.

(2) To be free from physical, sexual, emotional, or other abuse, or corporal punishment.

(3) To receive adequate and healthy food, adequate clothing, and for youth in group homes, an allowance.

(4) To receive medical, dental, vision, and mental health services.

(5) To be free of the administration of medication or chemical substances, unless authorized by a physician.

(6) To contact family members, unless prohibited by court order, and social workers, attorneys, foster youth advocates and supporters, Court Appointed Special Advocates (CASAs), and probation officers.

(7) To visit and contact brothers and sisters, unless prohibited by court order.

(8) To contact the Community Care Licensing Division of the State Department of Social Services or the State Foster Care Ombudsperson regarding violations of rights, to speak to representatives of these offices confidentially, and to be free from threats or punishment for making complaints.

(9) To make and receive confidential telephone calls and send and receive unopened mail, unless prohibited by court order.

(10) To attend religious services and activities of his or her choice.

(11) To maintain an emancipation bank account and manage personal income, consistent with the child's age and developmental level, unless prohibited by the case plan.

(12) To not be locked in a room, building, or facility premises, unless placed in a community treatment facility.

(13) To attend school and participate in extracurricular, cultural, and personal enrichment activities, consistent with the child's age and developmental level with minimal disruptions to school attendance and educational stability.

(14) To work and develop job skills at an age-appropriate level, consistent with state law.

(15) To have social contacts with people outside of the foster care system, such as teachers, church members, mentors, and friends.

(16) To attend Independent Living Program classes and activities if he or she meets age requirements.

(17) To attend court hearings and speak to the judge.

(18) To have storage space for private use.

(19) To be involved in the development of his or her own case plan and plan for permanent placement.

(20) To review his or her own case plan and plan for permanent placement, if he or she is12 years of age or older and in a permanent placement, and to receive information about his or her out-of-home placement and case plan, including being told of changes to the plan.

(21) To be free from unreasonable searches of personal belongings.

(22) To confidentiality of all juvenile court records consistent with existing law.

(23) To have fair and equal access to all available services, placement, care, treatment, and benefits, and to not be subjected to discrimination or

harassment on the basis of actual or perceived race, ethnic group identification, ancestry, national origin, color, religion, sex, sexual orientation, gender identity, mental or physical disability, or HIV status.

(24) At 16 years of age or older, to have access to existing information regarding the educational options available, including, but not limited to, the coursework necessary for vocational and postsecondary educational programs, and information regarding financial aid for postsecondary education."

(c) In ensuring the rights of a non-minor dependent, the licensee is not required to permit or take any action that would infringe on the rights of others or impair the health and safety of the non-minor dependent or others in the THPP.

(1) The licensee is not prohibited from taking the following actions for the protection of the non-minor dependent or others in the THPP:

(A) Establishing house rules that include, but are not limited to, rules regarding visitation that shall apply to all visitors.

(B) Locking exterior doors and windows as long as the non-minor dependent can enter or exit the THPP.

(d) At the time of placement, the licensee shall ensure that the non-minor dependent is verbally notified of the rights specified in this section and provided with a written copy of these rights and information regarding agencies the non-minor dependent may contact concerning violations of these rights.

NOTE: Authority cited: Sections 1530, 1531, and 1559.110, Health and Safety Code; Sections16001.9 and 16522, Welfare and Institutions Code; Section 4 of Assembly Bill (AB) 12 (Chapter559, Statutes of 2010); and Section 21 of Assembly Bill (AB) 1695 (Chapter 653, Statutes of 2001). Reference: California Constitution, Article 1, Section 13; Sections 1501, 1501.1, 1502.7(b)(1), 1520, 1530.91, 1531, Health and Safety Code; Sections 361.2(j) - (j)(2), 369.5,727(a)(3), 827, and 16001.9, 16500, and 16522.1, Welfare and Institutions Code; Section 51, Civil Code; and Section 12921, Government Code

Participant:	DOB:	Date:
Staff:	Agency:	
____Entry ____Quarterly ____Exit ____Other:		

Minimum	Items/Outfits	Condition	Total
# of outfits or items		List and designate items that are Fair (F) or need to be Replaced (R)	Enter number of outfits or items
PARTICIPANT			
5-7	Casual Clothing		
3-5	Employment Clothing		
2-4	Sweater/Sweatshirt/Hoodie		
1-2	Jacket/Coat		
1-2	Belt		
1-2	Sneakers/Tennis or Casual Shoes		
1-2	Employment/Special Occasion Shoes		
4-6	T-shirt/Undershirt/Cami		
5-8	Underwear		
5-7	Bra		
5-8	Socks		
INFANTS			
Name:			
8	Onesie or Outfits		
1	Special Occasion Outfit		
1	Sweater and Cap Set		
1	Booties/Shoes		
8	Socks		
4-6	Undershirts		

Participant:	DOB:	Date:
Staff:	Agency:	
____Entry ____Quarterly ____Exit ____Other:		

Minimum	Items/Outfits	Condition	Total
1, as applicable	Swimsuit		
CHILDREN 2 YEARS & OLDER			
Name:			
12	Outfits		
2	Shoes		
2	Pajamas/Gowns		
1	Slippers		
2	Sweater/Sweatshirt/Hoodie		
1	Jacket/Coat		
1, as applicable	Swimsuit		

Participant Signature:	Date:

Staff Signature:	Date:

EXHIBIT A-11a
INTENTIONALLY LEFT BLANK

EXHIBIT A-12

MONTHLY FINES LOG

☐ THPP ☐ THPP-NMD

Agency: _____

Client Name:	Date of Birth:
Date of Entry:	Date of Termination:

Total Fines:	$
Total Credits:	$
Balance Due:	$

Date of Fine:	Fine:	Date of Credit:	Credits	Balance:	Reason for Fine/Outcome:
TOTALS:	$		$	$	
Participant Signature:					
Contractor Signature:					

Totals Fines Incurred by Client:	$
Total Fines Paid by Client	$
Balance Due by Client:	$

_____Payment plan attached

Revised: 7.26.18

Monthly Allowance Receipt

(THPP-NMD) Exhibit: A-13

Month and Year: _____

Agency: _____

Participant Name: _____

I received				**I understand that my allowance was deducted for**			
Allowance	**#**	**Date**	**Amount**	**Deduction**		**Amount**	**Initial**
my allowance this month	1			* Monthly deduction for fine totaled $___ due to (reason & date)	Non-Refundable		
					Refundable - will be deposited into my savings		
	2			Saving from allowance			
my infant supplement this month	1						
	2						
Total Allowance			$ -	Total Deduction		$ -	
Net Allowance						$ -	

* I understand this will be deducted each month from my allowance until it is paid in full.

I agree to create and follow my estimated monthly budget.

My Savings Ledger (Exhibit A-14) with the amount of _____ is correct.

Payment #1 Amount $_____ *Payment #2* Amount $_____

Participant Signature	Date	Participant Signature	Date
Agency Staff Signature	Date	Agency Staff Signature	Date

PARTICIPANT SAVINGS LEDGER EXHIBIT A-14

☐ THPP ☐ THPP-NMD

Agency: _____ Report Month: _____

Participant Information
Name
Date of Birth
Date of Entry
Date of Termination

Monthly Summary
Beginning Balance
Total Credits
Total Debits
Total Interest
Ending Balance

	Credits:			Debits:			
Date:	From Allowance	From Agency Saving	Self Contribution	Fine	Withdraw	Balance:	Interest: (0.05% APR)
Sub Total	$ -	$ -	$ -	$ -	$ -		
TOTALS	$ -			$ -		$ -	-
							$ -

PARTICIPANT SAVINGS LEDGER EXHIBIT A-14

☐ THPP ☐ THPP-NMD

Agency: _____ Report Month: _____

Participant Information
Name
Date of Birth
Date of Entry
Date of Termination

Monthly Summary
Beginning Balance
Total Credits
Total Debits
Total Interest
Ending Balance

Transaction Detail - Fine		
Date	Amount	Transaction Notes
		*payment deducted from "self-contributed" funds

Transaction Detail - Withdraw					
Date	Amount	Check#	Notes	Participant Signature	Contractor Signature

Final Transaction					
Date	Amount	Check#	Notes	Participant Signature	Contractor Signature
	$ -				

EXHIBIT A-15

Monthly Budget Categories

Goal: to assist the NMD with planning a budget that is inclusive of all of his/her income, and to encourage NMD to save money.

CONTRACTOR may use any template for the budget as long as these minimum categories and items are included

Income
Allowance
Infant Supplement
Employment
Financial Aid
Other

Transportation
Car Payment
Car Insurance
Car Registration
Car Fuel
Car Maintenance
Bus/Train/Taxi/Uber/Lift
Other

Food
Groceries
Fast Food
Restaurant
Coffee/Tea/Smoothies
Other

Personal Care
Clothing
Shoes
Toiletries
Hair Care
Medical
Prescriptions
Other

Savings
Allowance
Employment
Other

Housing
Cleaning Supplies
Toilet Paper
Towels/Bedding
Cable
Internet
Telephone
Maintenance/Repairs
Laundry
Other

Parenting
Clothing
Diapers/Baby Wipes
Toiletries
Formula/Food
Child Care
Other

Miscellaneous Expenses
Debt
Cell Phone
Recreation
Fines
Other

Monthly Balance
Income Subtotal
Expenses Subtotal
Total

Shared Agreement — Use of the Infant Supplement in Transitional Housing Placement Plus Foster Care (THPP-NMD)
(Sample Template)

This shared agreement is intended to help facilitate the discussion regarding the use of the Infant Supplement Payment in a THPP-NMD Program. This discussion should occur when placement in a THPP-NMD is being considered for a pregnant or parenting Non-Minor Dependent (NMD), and should occur in the context of a Child and Family Team (CFT) meeting, if available, or other collaborative team meeting. Completing the shared agreement in the context of a CFT can aid in a collaborative discussion that identifies the strengths and challenges of an NMD as it relates to their understanding of the financial implications regarding parenting. This agreement should be updated as necessary to reflect the changing needs of the NMD and the infant, and it is recommended that it is updated annually at a minimum. When an update is necessary a new agreement should be filled out and signed. Whether this template or another shared agreement template is used, the areas outlined must be in alignment with the allowable costs for the Infant Supplement as referenced in Federal Law 45 Code of Federal Regulations 1355.20 Title IV-E, Foster Care Maintenance Payments Program.

Food

This can include the costs of buying formula, milk, vitamin supplements and other age appropriate food for the infant/child.

Item	Estimated Cost	Provider	NMD

Clothing/Personal Incidentals

This can include any clothing related expenses, including diapers and wipes.

Item	Estimated Cost	Provider	NMD

Shelter/Furniture

This can include housing/shelter related expenses, including increased rent. This section should also detail the costs for age appropriate furniture, which can include cribs, toddler beds, changing tables, etc.

Item	Estimated Cost	Provider	NMD

Transportation

This can include reasonable travel expenses for a child's visitation with family or other caretakers. This can also include other travel related expenses including transportation costs necessary for obtaining supplies for the child and ensuring the child may remain in their school of origin.

Item	Estimated Cost	Provider	NMD

Child Care

This can include the costs of various child care options which provide daily supervision while the parent is working or attending school.

Item	Estimated Cost	Provider	NMD

Medical

This can include the various costs related to an infant/child's medical and dental needs. Some allowable examples are co-pays for medical visits and over the counter and prescription medications.

Item	Estimated Cost	provider	NMD

X_____

Non Minor Dependent DATE_____

X_____

Provider DATE_____

X_____

Social Worker/Support Person DATE_____

PARTICIPANT INFANT SUPPLEMENT SAVINGS LEDGER EXHIBIT A-16a

☐ THPP ☐ THPP-NMD

Agency: _____ Report Month: _____

Participant Information
Name
Date of Birth
Date of Entry
Date of Termination

Monthly Summary
Beginning Balance
Total Credits
Total Debits
Total Interest
Ending Balance

Date:	Credits: From Allowance	Credits: From Agency Saving	Credits: Self Contribution	Debits:	Debits: Withdraw	Balance:	Interest: (0.05% APR)
Sub Total	$ -	$ -	$ -	$ -	$ -		
TOTALS	$ -			$ -		$ -	-

Transaction Detail - Fine

PARTICIPANT INFANT SUPPLEMENT SAVINGS LEDGER EXHIBIT A-16a

☐ THPP ☐ THPP-NMD

Agency: _____ Report Month: _____

Participant Information
Name
Date of Birth
Date of Entry
Date of Termination

Monthly Summary
Beginning Balance
Total Credits
Total Debits
Total Interest
Ending Balance

Date	Amount	Transaction Notes

Transaction Detail - Withdraw					
Date	Amount	Check#	Notes	Participant Signature	Contractor Signature

Final Transaction					
Date	Amount	Check#	Notes	Participant Signature	Contractor Signature

PARTICIPANT'S MEDICATION LOG EXHIBIT A-17

THPP-NMD

AGENCY: _____

Please Print

MY NAME: _____

Please Print

TODAY'S DATE	TIME	AMOUNT I TOOK AT THIS TIME (SUCH AS, 2 TABLETS)	MEDICATION NAME	OVER THE COUNTER Yes	OVER THE COUNTER No	DR. NAME	MY INITIALS
/ /_	: AM/PM						
/ /_	: AM/PM						
/ /_	: AM/PM						
/ /_	: AM/PM						
/ /_	: AM/PM						
/ /_	: AM/PM						
/ /_	: AM/PM						
/ /_	: AM/PM						
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/ /_	: AM/PM						
/ /_	: AM/PM						

PARTICIPANT MUST TRACK EACH MEDICATION PRESCRIBED OR ANY OVER-THE-COUNTER MEDICATION USED.

Revised: 11.9.16

EXHIBIT A-18

MEDICATION DISPENSING LOG
THPP-NMD

AGENCY NAME: _____ DATE: _____

PARTICIPANT NAME: _____ CASE #: _____

NAME OF MEDICATION *	DR. NAME	DOSAGE (AMOUNT + TIMES PER DAY, e.g. 1 tablet 3x per day)	QUANTITY PRESCRIBED (e.g. 30 tablets)	PRESCRIBED START DATE	PRESCRIBED END DATE

List any problems/reactions you had to above medications: _____

List any medications that you are allergic to: _____

Revised: 11.9.16

Progress Report (A-20)

This report is to be used when completing initial, updated, quarterly, transition& termination reports. All reports are to be on agency letterhead, and prepared and signed by the assigned agency social worker, social work supervisor and client. Reports should be succinct and strength-based while accurately reflecting client's successes and challenges.

Agency may include additional categories; however, each report must include information in the following report categories.

Report Categories:

1. ***Demographics***: Include name, age, DOB, CSW/DPO, agency Social Worker, parenting status, placement date, projected or actual exit date, etc.
2. ***Report Summary***: provides a succinct overview of client's progress and challenges for the report type being completed for the reporting period.
    - Report Type *(Refer to "Reporting Requirements" in SOW for detailed instructions)*
        - *Initial Report*
            - This report provides a summary of the client's initial adjustment to placement. It is completed and submitted no later than 45 business days from client's initial placement date.
        - *Updated Report*
            - This report provides a summary of the client's progress for the requested time period. It is to be completed and submitted within five (5) business days of the request.
        - *Quarterly Report*
            - This report provides a summary of the client's progress for the prior three (3) months, and delineates goals for the upcoming quarter. It is required for any client who has been in the program for at least 45 days during the reporting period. Also, include Needs and Services Plan (NSP) goals and updates
        - *Transition Report*

- This report provides a summary of the client's transition planning, including client's competency in locating and accessing resources, his/ her housing plans, what agency has done (is doing) to assist client in securing housing, and any other pertinent information. It should also include the date(s) of transition meeting(s) and follow-up and achieved actions from meeting(s).

- *Termination Report*
  - This report provides a summary of the client's progress during his/her entire placement in agency's housing program. Report must be comprehensive and include information about client's housing destination at exit.

3. ***Case Management***: Include dates of CSW/DPO and agency Social Worker's visits, how long the visits were and where they occurred, and summary of agency case management services. Also indicate if there has been a change in the assigned CSW/DPO or agency Social Worker. Lastly, include how the agency has incorporated *#4-14* in client's case management sessions.
4. ***SOC 161 AB 12/EFC, TILP, NSP and case plan Goals***: Include SOC 161 AB 12/EFC, TILP, NSP, and case plan goals, and progress towards those goals. Also indicate if the goals have changed since the last report
5. ***Casey Life Skills Assessment (CLSA):*** Include how client is progressing in the CLSA areas, and identify CLSA areas where improvements are needed, and what agency is doing to assist client. Also, include how agency is confirming client's competency in areas where he/she rated him/herself at 75% or higher. Also, indicate any changes in ratings from initial and current CLSA, and how agency is addressing the changes.
6. ***Life Skills Training***: Include the name of life skills sessions attended during the reporting period, including how long each session was, if session was individual, group, hands-on or automated. For Termination Report list all categories client completed (see SOW "Participant Required Training" in SOW).
7. ***Education***: Include client's educational goal and how client is progressing towards his/her educational goals, particularly client's whose goals are to complete high school or attend a post-secondary institution. Include initial SOC 161 educational goal, if applicable.
8. ***Employment or Volunteer***: Include information about client's employment or volunteer activities; including where s/he is employed and/or volunteering, how long s/he has been working and/or volunteering at location, number of hours each week, etc. For clients whose goals are to eliminate barriers to employment,

agency must specify what the client is doing and how the agency is assisting him/her. Include initial SOC 161 employment goal, if applicable.

9. ***Pregnant and Parenting***: Include how client is progressing, including his/her understanding of child development, agency's assessment of parenting skills, etc. Also, include a copy of client's A-16. Clients who are not pregnant or parenting should also receive training in this category and agency should report on the training s/he has received.
10. ***Personal and Interpersonal Growth and Development***: Include information about client's Permanent Adult Connection (PAC) and the frequency of contact with PAC. If client does not have a PAC, include agency's efforts to connect client with a mentor. Also include information about client's progress with goal setting, self-esteem, communication, and participation in recreational activities.
11. ***Personal Care***: Include information about health care visits, including medical, dental, vision, substance abuse and/or mental health. Also include how client is progressing in maintaining relationships, personal items and overall appearance and self-care.
12. ***Finances/Money Management***: Include information on how client is managing his/her finances, sources of income, his/her progress with creating and maintaining a budget, if s/he has a personal savings and/or checking account, how much s/he has saved with agency. For parenting clients also include how s/he is managing infant supplement funds. Provide verifiable information regarding savings.
13. ***Food/Nutrition***: Include information about client's shopping, cooking and eating habits. Specifically addressing his/her competency with grocery shopping, understanding of the long-term impact of non-healthy food choices.
14. ***Household Management***: Include how client is abiding by the guest rules, maintaining the unit, interacting and getting along with unit mate(s) and neighbors. This is where agency should include information about therapeutic/emotional support pets and how the client is caring for the pet(s).
15. ***Noteworthy accomplishments***: Include anything positive about the client that agency wants to highlight. If client completed program, indicate what "completion" consists of for your agency.
16. ***Other***: Include anything that is pertinent to the reporting period that has not already been covered in the report.

All reports must be reviewed, approved and signed by Social Worker's (case manager) Social Work Supervisor.

EXHIBIT A-20

PROGRESS REPORT TO BE COMPLETED ON AGENCY LETTERHEAD

EXHIBIT A-21
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Participant:			DOB:	Date:
Age: :	Gender:	Phone:	Email:	
Address:			City:	Agency:
CSW/DPO:		Office:	Date of placement: :	

The THPP/THPP-NMD Advocacy Review process provides a participant the opportunity to share concerns, ask questions, and/or make recommendations regarding his/her experience in the program. Each request will be reviewed by the County Program Manager who oversees the THPP/THPP-NMD programs.

Please check each area that best describes your reason(s) for requesting an Advocacy Review:

__ Discharge	__ Allowance	__ Personal safety	__ Visitors	__ Internet	__ Staff interaction
__ Life Skills Training	__ Unit Safety (bed bugs, furniture, appliances, etc.)		_ Other (please list):		

Please share your concerns, questions and/or recommendations

Please share how you would like this situation to be resolved

Did you file a grievance with the agency?	If yes, enter date	__ No	__ N/A

Please share the outcome of agency grievance

__The following documents are attached:

Participant Signature:	Date:

You many send your Advocacy Review Request by mail, email or fax, to County Program Manager, THPP/THPP-NMD, 3530 Wilshire Boulevard, 4th Floor, Los Angeles, CA 90010 | Email: thpp@dcfs.lacounty.gov | Fax: (213) 637-0035 | Telephone: (213) 351-0123.

TO BE COMPLETED BY COUNTY PROGRAM MANAGER				
Date received:	__ DCFS	__ PROBATION	Staff Assigned:	Date:
Date participant contacted:	Date agency contacted:		__ Advocacy Review meeting not required	
__ Advocacy Review meeting required			Meeting date (within 7 business days):	

Advocacy Review Outcome	
__ Refer to YDS Youth Ombudsman	Date:

STATE OF CALIFORNIA — HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

PERSONNEL REPORT

INSTRUCTIONS: *This form is intended for keeping a current roster of all the facility personnel, other adults and licensees residing in the facility, including backup persons, volunteers and licensee if administrator/director. Show license/certificate number if applicable for specialized staff [e.g., Social Worker and other consultant(s)]. Show coverage for twenty-four hour supervision in residential facilities. Report any changes in personnel to the licensing agency as required by regulations. Send original to Licensing Agency and retain copy in facility file.*

NAME OF FACILITY	FACILITY TYPE	FACILITY NUMBER

PREPARED BY	DATE

A. **STAFF SUBJECT TO CRIMINAL BACKGROUND CHECK REQUIREMENTS:** The following staff members are subject to a criminal background check pursuant to Sections 1522, 1568.09, 1569.17 and 1596.871 of the Health and Safety Code. A California background clearance or a criminal record exemption shall be obtained prior to employment, residence or initial presence in the facility.

NAME	DATE EMPL'D	JOB TITLE	SPECIFY DAYS AND HOURS ON DUTY			SPECIFY DAYS AND HOURS ON DUTY			SPECIFY DAYS AND HOURS ON DUTY		
			DAYS	FROM	TO	DAYS	FROM	TO	DAYS	FROM	TO
Licensee/Administrator											

B. STAFF EXEMPT FROM CRIMINAL BACKGROUND CHECK REQUIREMENTS: The following are believed exempt from criminal background check requirements pursuant to Sections 1522, 1568.09, 1569.17 and 1596.871 of the Health and Safety Code. The licensee or designated representative shall sign below to verify that he or she believes the indicated persons are exempt from criminal background check requirements pursuant to statute.

Signature _____ Date _____

NAME	DATE EMPL'D	JOB TITLE	SPECIFY DAYS AND HOURS ON DUTY			SPECIFY DAYS AND HOURS ON DUTY			SPECIFY DAYS AND HOURS ON DUTY		
			DAYS	FROM	TO	DAYS	FROM	TO	DAYS	FROM	TO

EXHIBIT A-24
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EXHIBIT A-25
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THPP-NMD 2019-20 Annual Report

(From 7/1/2019 to 6/30/2020)

(Revised 7/16/19)

#	Agency	SPA	Total Served (a)+(b)	Youth Participation					Participation Activity (SOC 161 Primary)					By Referral Department		By Ethnicity							
				New Admit (a)	Continue from Previous Year (b)	Exited (c)	Active at Year End (d=a+b-c)	From Another County	Completing Secondary Education or Equivalent	Enrolled in Postsecondary or Vocational Education	Participating Employment Program or Activity to Remove Barriers	Employed for at least 80 hours per Month	Incapable Due to Medical Condition	DCFS	PROB	American Indian/ Alaska Native	Asian	Bi-Racial/ Multi-Racial	Black/African American	Hispanic/Latino	Hawaiian/ Pacific Islander	White/ Caucasian	Other
1			0			0	0																
2			0			0	0																
3			0			0	0																
4			0			0	0																
5			0			0	0																
6			0			0	0																
7			0			0	0																
8			0			0	0																
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24			0			0	0																
25			0			0	0																
26			0			0	0																
27			0			0	0																
TOTAL			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

THPP-NMD 2019-20 Annual Report
(From 7/1/2019 to 6/30/2020)

(Revised 7/16/19)

#	Agency	SPA	By Gender					Parenting Youth		Expecting Parents		# Parenting and Expecting	Employment & Education (Active at Year End)													
													Employment Status					Education Status								
			Male	Female	Transgender (M to F)	Transgender (F to M)	Gender Not Identified	Custodial	Non Custodial	Father	Mother		Employed (F/T)	Employed (P/T)	Un-Employed	Volunteer	In Program to Remove Barriers	Not Enrolled in Any Educational Program	Enrolled in High School/GED	Compited High School/GED	Enrolled in 2-Year College	Completed 2-Year College	Enrolled In 4-Year College	Completed 4-Year College	Enrolled Vocational Training	Completed Vocational Training
1																										
2																										
3																										
4																										
5																										
6																										
7																										
8																										
9																										
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24																										
25																										
26																										
27																										
TOTAL			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

THPP-NMD 2019-20 Annual Report

(From 7/1/2019 to 6/30/2020)

(Revised 7/16/19)

							Affordable Housing				Exit Destination														
							Participants will be placed in a SILP, transition in place or obtain affordable housing when exit.				Achieved Affordable/Stable Housing Goal				Not Achieved Affordable/Stable Housing Goal							Other Transition Housing		
#	Agency	SPA	Total Exited (e) + (f)	Planned (e)	Unplanned (f)	Average Lengh of Stay (Month)	Achieved	%	Meet Target? (75%)	10% Over the Previous Year?	SILP	Transition in Place	Own Housing	College Dorm	Incarcerated	Alcohol/Drug Treatment	Psychiatric Hospital	Homeless	Family	Unknown	Other	Another THP+FC	THP+	THP
1			0				0	#DIV/0!	#DIV/0!															
2			0				0	#DIV/0!	#DIV/0!															
3			0				0	#DIV/0!	#DIV/0!															
4			0				0	#DIV/0!	#DIV/0!															
5			0				0	#DIV/0!	#DIV/0!															
6			0				0	#DIV/0!	#DIV/0!															
7			0				0	#DIV/0!	#DIV/0!															
8			0				0	#DIV/0!	#DIV/0!															
9			0				0	#DIV/0!	#DIV/0!															
10			0				0	#DIV/0!	#DIV/0!															
11			0				0	#DIV/0!	#DIV/0!															
12			0				0	#DIV/0!	#DIV/0!															
13			0				0	#DIV/0!	#DIV/0!															
14			0				0	#DIV/0!	#DIV/0!															
15			0				0	#DIV/0!	#DIV/0!															
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17			0				0	#DIV/0!	#DIV/0!															
18			0				0	#DIV/0!	#DIV/0!															
19			0				0	#DIV/0!	#DIV/0!															
20			0				0	#DIV/0!	#DIV/0!															
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22			0				0	#DIV/0!	#DIV/0!															
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25			0				0	#DIV/0!	#DIV/0!															
26			0				0	#DIV/0!	#DIV/0!															
27			0				0	#DIV/0!	#DIV/0!															
TOTAL			0	0	0	N/A	0	#DIV/0!			0	0	0	0	0	0	0	0	0	0	0	0	0	0

THPP-NMD 2019-20 Annual Report

(From 7/1/2019 to 6/30/2020)

(Revised 7/16/19)

			Permanent Adult Connection				Participation Activity (at Exit)					Employment & Education (at Exit)															
			Participants will have a consistent relationship with their identified permanent adult connection upon exit from the program.				Met Initial Identified NMD Activity (SOC 161 Primary)					Employment Status						Education Status (Highest Level Achieved in Program)									
#	Agency	SPA	Achieved	%	Meet Target ? (75%)	10% Over the Previous Year?	Complete HSD/GED	Enrolled in college or vocational	Remove barriers to employment	Employed at least 80 hrs/month	Medical Condition	Employed (F/T)	Employed (P/T)	Un-Employed	Volunteer	In Program to Remove Barriers	More Than One Status	Exit Without High School Diploma/GED	Enrolled in High School/GED	Completed High School/GED	Enrolled in 2-Year College	Completed 2-Year College	Enrolled in 4-Year College	Completed 4-Year College	Enrolled Vocational Training	Completed Vocational Training	More Than One Status
1				#DIV/0!	#DIV/0!																						
2				#DIV/0!	#DIV/0!																						
3				#DIV/0!	#DIV/0!																						
4				#DIV/0!	#DIV/0!																						
5				#DIV/0!	#DIV/0!																						
6				#DIV/0!	#DIV/0!																						
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25				#DIV/0!	#DIV/0!																						
26				#DIV/0!	#DIV/0!																						
27				#DIV/0!	#DIV/0!																						
TOTAL			0	#DIV/0!			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

THPP-NMD Monthly Report

Agency ALL **Month of** 0 0

Demographic Information		Active (Month Basis)	New Entry	Transfer	Exited	Total Served	Demographic Information		Active (Month Basis)	New Entry	Transfer	Exited	Total Served
Participation Activity/ Condition (SOC161 Primary)	Completing HSD or GED	0	0	0	0	0	Gender	Male	0	0	0	0	0
	Enrolled College/Vocational	0	0	0	0	0		Female	0	0	0	0	0
	Work at least 80 hrs/month	0	0	0	0	0		Transgender (M to F)	0	0	0	0	0
	Remove Emplymnt Barriers	0	0	0	0	0		Transgender (F to M)	0	0	0	0	0
	Documented Med. Condition	0	0	0	0	0		Gender Not Identified	0	0	0	0	0
Referral Department	DCFS	0	0	0	0	0	Ethnicity	American Indian/Alaska	0	0	0	0	0
	Probation	0	0	0	0	0		Asian	0	0	0	0	0
Exit Type	Planned	N/A	N/A	0	0	N/A		Bi-Racial/Multi-Racial	0	0	0	0	0
	Unplanned	N/A	N/A	0	0	N/A		Black/African American	0	0	0	0	0
Exit Destination	SILP	N/A	N/A	0	0	N/A		Hispanic/Latin American	0	0	0	0	0
	Transition in Place	N/A	N/A	0	0	N/A		Hawaiian/Pac. Islander	0	0	0	0	0
	Own Housing	N/A	N/A	0	0	N/A		White/Caucacian	0	0	0	0	0
	College Dorm	N/A	N/A	0	0	N/A		Other	0	0	0	0	0
	Another THPP-NMD	N/A	N/A	0	0	N/A	Education	Not Enrolled in Any Ed.	0	0	0	0	0
	THP+	N/A	N/A	0	0	N/A		Enrolled in HSD/GED	0	0	0	0	0
	THP	N/A	N/A	0	0	N/A		Completed HSD/GED	0	0	0	0	0
	Incarcerated	N/A	N/A	0	0	N/A		Enrolled in 2-Yr College	0	0	0	0	0
	Alcohol/Drug Treatment	N/A	N/A	0	0	N/A		Completed 2-Yr College	0	0	0	0	0
	Psychiatric Hospital	N/A	N/A	0	0	N/A		Enrolled in 4-Yr College	0	0	0	0	0
	Homeless	N/A	N/A	0	0	N/A		Completed 4-Yr College	0	0	0	0	0
	Family	N/A	N/A	0	0	N/A		Enrolled in Vocational	0	0	0	0	0
	Unknown	N/A	N/A	0	0	N/A		Completed Vocational	0	0	0	0	0
	Other ( )	N/A	N/A	0	0	N/A	Employment	Employed Full-Time	0	0	0	0	0
Family Planning	Expectant Mother	0	0	0	0	0		Employed Part-Time	0	0	0	0	0
	Expectant Father	0	0	0	0	0		Un-Employed	0	0	0	0	0
	Parenting (Cusdtodial)	0	0	0	0	0		Volunteer	0	0	0	0	0
	Parenting (Non-Custodial)	0	0	0	0	0		Removing Barriers	0	0	0	0	0

revised: 7.26.18

EXHIBIT A-28
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ENTRY ASSESSMENT

☐THPP ☐THPP-NMD

Agency Name:	Date of Birth (MM/DD/YYYY):
Name:	Age:
Program Entry Date:	Expected Emancipation Date:

Do you: (Select All That Apply) ☐ Have a High School Diploma/GED: Name:	☐ Yes Graduation Date:	☐ No
☐Attend High School: Name:	☐ Yes	☐ No
I Expect To Graduate On: _____ If You Selected "Attend High School," What Are Your Plans After Graduation? (Check All That Apply) ☐ Attend College ☐ Obtain A Full-Time Job ☐ Attend Vocational School ☐ Join The Military ☐ Other _____		

(FOR NMDs ONLY) What is your AB 12 (SOC 161) goal? Please select all that apply		
Attend College/Vocational School At Least Half-Time: Name: _____	☐ Yes	☐ No
Attend an Apprentice Program: Name: _____	☐ Yes	☐ No
Have a Job Working At Least 80 Hours Per Month: Name: _____	☐ Yes	☐ No
Participate In A Program Or Activity Designed To Remove Barriers to Employment: Name: _____	☐ Yes	☐ No
Have A Medical/Mental Condition That Prevents You From Participating In One of the Above: Condition: _____	☐ Yes	☐ No

ENTRY ASSESSMENT

Permanent Adult Connection:			Relationship:
Phone:	Address:		
If you have other people that support you please list: Name:			Relationship:
Address:			
Email:	Length Of Time Known:	Verified: ☐ Yes	☐ No Date:
Name:			Relationship:
Address:			
Email:	Length Of Time Known:	Verified: ☐ Yes	☐ No Date:
Name:			Relationship:
Address:			
Email:	Length Of Time Known:	Verified: ☐ Yes	☐ No Date:

My Goals Are To: _____

_____

_____

_____

_____ _____

Participant Signature: Date: