



Developmental Disabilities Administration (DDA)  
Residential Habilitation for Dependent Youth (RHDY)

**Planning for Youth Aged 18-21  
Receiving RHDY Services**

Plan Effective Date
End Date
ADSA ID Number

Youth's Legal Name		ADSA ID Number	
Youth's Residence		City	State Zip Code

Support	Name	Telephone Number (Home, Work, Cell)
Parent or Title 11 Guardian		
DCYF Case Worker		
Supported Decision Maker		
Emergency Contact		
Licensed or Certified Provider		
Doctor		
Dentist		
Specialist		
School IEP / 504 Contact's Name		
Representative Payee		

**Please include a copy of Transition Plan for Youth Exiting Care (DCYF 15-417).**

Significant Others (Family, Friends and Neighbors)	Relationship to You	Telephone Number (Home, Work, Cell)

Community agencies and formal supports (i.e., WISE, mental health provider, and/or ABA provider):

Distribution: Original – DDA Client File; Copies – Client, Licensed Provider, and DCYF

Informal community agencies (i.e., church / YMCA / recreation center):

Youth's vision for the future:

Youth questions, concerns, or requests:

Needs, concerns of DCYF and family: What worries you? What do you need?

Are there supports identified in the positive behavior support plan that are not sustainable or permissible in an adult community setting? Is assistance needed or requested to identify and implement a fade plan?

**Care Plan (Daily Routine, Night-time Schedules, Care Preferences)**

(Identify how the youth will be supported to work towards independence in the area of Advocacy, Personal Care, and Activities of Daily Living).

**Medical Appointments (Transportation, Decisions, Communication)**

Medical Consent form signed?  Yes  No

**Financial Plan**

(Identify how the youth will be supported to work toward independence in the area of money management)

**Other**

Legal Status including guardianship and/or power of attorney.

Washington Identification Card:  Yes  No

If no, please provide date by which this task will be completed:

Selective Service Registration (if applicable):  Yes  No

If no, please provide date by which this task will be completed:

Voter Registration:  Yes  No

If no, please provide date by which this task will be completed:

Social Security Card:  Yes  No

If no, please provide date by which this task will be completed:

Copy of Birth Certificate:  Yes  No

If no, please provide date by which this task will be completed:

<b>Future Planning</b>	
What habilitative goals have been identified to support transition into adult community settings?	
How will the youth be supported to make and maintain relationships, particularly after transitioning into adult community settings?	
In preparation for adult services, how will the youth, family, provider, and DDA work together to support the youth's vision of the future? This could be a series of meetings, Personal Centered Planning, or other my page plans.	
Is the youth participating in transition services through their school district? A vocational program? Please give details.	
Does the youth need assistance to access vocational services, such as DVR or school vocational resources?	
<b>Communication: What is the plan for staying involved in your youth's life?</b>	
Signature of Youth	Date
Signature of Title 11 Guardian (if applicable)	Date
Signature of Licensed or Certified Provider	Date

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