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|  | Developmental Disabilities Administration (DDA)Residential Habilitation for Dependent Youth (RHDY)**Planning for Youth Aged 18-21Receiving RHDY Services** | Plan Effective Date |
| End Date |
| 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)** |
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| Community agencies and formal supports (i.e., WISE, mental health provider, and/or ABA provider): |

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

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| Youth’s vision for the future: |

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| Youth questions, concerns, or requests: |

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

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| 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? |

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| **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). |

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

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| 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) |

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| **Other** |
| Legal Status including guardianship and/or power of attorney. Washington Identification Card: **[ ]**  Yes **[ ]**  NoIf no, please provide date by which this task will be completed: Selective Service Registration (if applicable): **[ ]**  Yes **[ ]**  NoIf no, please provide date by which this task will be completed: Voter Registration: **[ ]**  Yes **[ ]**  NoIf no, please provide date by which this task will be completed: Social Security Card: **[ ]**  Yes **[ ]**  NoIf no, please provide date by which this task will be completed: Copy of Birth Certificate: **[ ]**  Yes **[ ]**  NoIf no, please provide date by which this task will be completed:  |
| **Future Planning** |
| 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? |
| **Communication: What is the plan for staying involved in your youth’s life?** |

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| Signature of Youth | Date |
| Signature of Title 11 Guardian (if applicable) | Date |
| Signature of Licensed or Certified Provider | Date |
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