GOVERNMENT OF THE DISTRICT OF COLUMBIA

Child and Family Services Agency

DC Child and Family Services Agency

Youth Aftercare Referral Packet

Youth Aftercare Referrals must include the following documents to complete the referral packet:

1. Youth Aftercare Referral Form
2. Signed Youth Aftercare Disclosure Form
3. Most recent Transition Plan
4. Most recent Court Report
5. Most recent Court Order

Any other pertinent document that will provide an accurate assessment of the youth's progress in preparing for transition (i.e. I.E.P, mental health evaluations, substance abuse treatment progress reports, educational/vocational reports)

(INCOMPLETE PACKETS WILL NOT BE ACCEPTED AND PROCESSED)

Youth Aftercare Referrals are due when the youth is 19 ½ years of age. Upon timely submission, the youth is assigned to one of CFSA Aftercare Providers (i.e. Healthy Families/Thriving Communities (HFTC) Collaborative or DC Court Appointed Special Advocates (CASA) when the youth is 20 years of age.

Aftercare Referrals must be submitted electronically to the CFSA Office of Youth Empowerment (OYE) at the following email address: cfsa.oye@dc.gov

For additional information regarding submission or for further assistance please contact OYE at (202) 727-7500.

What are Aftercare Services and how will this assist our Youth? Youth Aftercare consists of case management and supportive services provided to youth leading up, and for two calendars years following, their transition from the child welfare system. The services provided include but are not limited to housing assistance, employment/vocational information, guidance on assessing public services, and parenting support for those with dependent children. ***Please note: The Aftercare Provider is not responsible for full case management duties until the youth is 21 years of age, however they will support the transition process by attending meetings, reviewing tasks/outcomes of transition meetings, and providing referral resources. The Aftercare Provider is not the sole entity responsible for providing housing assistance to the youth; this is an effort that will be shared amongst the transition team. Please see the CFSA Aftercare Provider Administrative Issuance for additional information regarding Aftercare Provider services.***

Government of the District of Columbia Child and Family Services Agency
Youth Aftercare Project
REFERRAL FORM

Directions: Please complete this form in its entirety with the **most current information. Attach a Transition Plan, current court report and evaluation indicating the youth need for specific services (i.e. mental health, educational, etc. I**t is **MANDATORY** that the youth **sign the authorization to refer and disclose information form** as a condition to participate in the program. Your referral is not complete unless **ALL** the above information is attached.

Name of Youth: _____ FACES Client ID#:_____

DOB: _____ Date of Transition: _____

Current Placement Type:

- ❑ Foster Home ❑ ILP
- ❑ Group Home ❑ Other_____
- ❑ Incarceration/Detention Center; Anticipated Release Date/Offense:_____

Current Placement Address: _____

Home Number: _____ Cell Number: _____
Work Number: _____

Name of Agency/Administration_____
Social Worker: _____ Supervisor: _____
Office Phone #: _____ Office Phone#: _____

Cell Phone #: _____ Cell Phone #: _____

Email Address: _____ Email Address: _____

Is this youth eligible for DDS? □ Yes or No □ If the youth is eligible for DDS services, has the referral been submitted? □ Yes or No □

Education

Does the youth have one of the following?
❑ GED ❑ High School Diploma ❑Certificate of Completion
❑Vocational Certification (Name of Certification: _____)
Does the youth attend an educational program? □ Yes □No; If yes grade level_____

If Yes, Name/Address of School:_____

If Yes, Is this a Post-secondary setting? □ Yes □ No; If Yes year in school:_____

Anticipated Graduation Date?_____

Does youth receive or has the youth ever received Special Education Services?: □ Yes □No;

If yes, is a copy of the IEP attached to this referral? ❑ Yes ❑ No

Is the youth attending a Vocational Training Program? ❑Yes ❑No

If Yes, Name/Address of School: _____

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REFERRAL FORM

Employment

Is the youth currently employed? ❑Yes ❑ No; If yes ❑Part Time ❑Full Time

Name/Address of Employer: _____

Telephone Number of Employer: _____

Earnings Per Hour: _____

Office of Youth Empowerment

Is the youth receiving services through OYE? ❑ Yes ❑ No

What are they? _____

When did the last transition meeting occur? _____ When is the next meeting scheduled? _____

Who is the youth's assigned OYE Independent Living Specialist (Name/Phone)?

_____

Health

Date of Last Physical: _____ Where? _____

Does the youth have a diagnosed disability (i.e. Physical or Mental)? : ❑Yes ❑No

If yes, what is the youth's current diagnosis: _____

Medication/Dosage/: _____

Does the youth currently receive or potentially qualify for SSI? ❑Yes ❑No

Please identify youth's Health Care Providers (i.e. Community Support Worker, Therapist, Psychiatrists, Primary Doctor, etc.) and provide below:

	Title	**Name**	**Phone Number**
1.	_____/	_____ /	_____
2.	_____/	_____ /	_____
3.	_____/	_____ /	_____
4.	_____/	_____ /	_____
5.	_____/	_____ /	_____

Will the physical/mental health diagnosis affect the youth's ability to successfully transition?
No ❑ Yes❑ If yes how so? _____

Life Connections

Name/Addresses of Significant Persons in the Youth's life that they identify as a Life Connection. (Social Workers; please speak with your youth to obtain this information)

1. Name/Relationship to Youth: _____
   Address: _____
   Telephone#: _____

2. Name/Relationship to Youth:_____
   Address: _____
   Telephone#: _____

3. Name/Relationship to Youth: _____
   Address: _____
   Telephone#: _____

4. Name/Relationship to Youth: _____
   Address: _____
   Telephone #:_____

5. Name/Relationship to Youth:_____
   Address: _____
   Telephone #: _____

Pregnant/Parenting Youth

Is this a pregnant or parenting youth? □Yes □No

If yes, please list the name and ages of the children:

1. Name:_____ DOB:_____ Age:_____
2. Name:_____ DOB:_____ Age:_____
3. Name:_____ DOB:_____ Age:_____
4. Name:_____ DOB:_____ Age:_____

If pregnant, what is the estimated due date? _____

Are the children in the youth's care? □Yes or □No
If no, please provide explanation: _____

_____

_____

_____

Transition Supports

Identify the supports this Youth needs to successfully transition from care (Please check as many that apply):

- ❑ Educational/Vocational Training Support
- ❑ Employment
- ❑ Parenting Support (i.e. daycare voucher, child support, etc)
- ❑ Identification of additional Life Connections/Building relationships with Life Connections
- ❑ Housing
- ❑ Health (i.e. health insurance, medical supports/providers, SSI)
- ❑ Other_____
- ❑ Other_____

Do you have any specific concerns regarding this youth's transition from care?
Please explain: _____

_____

_____