

Young Person Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**EMANCIPATION PLAN FOR 17-21 YEAR OLDS**

**For 17-year-olds, complete Part One and Two. For 18–21-year-olds with a planned exit different from Foster Care 18-21, complete Part Two only.**

Attach both a copy of the most recent Transitional Living Plan Part A and the Emancipation Plan to the court report for all court dates on or after a young person’s 17<sup>th</sup> birthday. All additional parts must be completed 90 days before a young person’s 18<sup>th</sup> birthday.

**PART ONE: 17 YEAR OLDS**

Has the Transitional Living Plan Part A been completed within the last 90 days?

Yes (if yes, proceed)       No

Complete the table below with the information needed for court.

<b>Information to Provide the Court:</b>	<b>Answer:</b>
What placement options does the young person have upon their 18 <sup>th</sup> birthday?	
Who are appropriate adults that can serve as resources for the young person?	
How may the young person maintain contact with sibling(s)? How can DSS assist this young person with maintaining contact with their sibling(s)?	
What educational, vocational, or job plan options does the young person have upon their 18 <sup>th</sup> birthday?	

List all Department of Social Services point of contacts for the young person.

LINKS Coordinator	Foster Care 18-21 Point of Contact	Social Work Supervisor	Medicaid
(Name)	(Name)	(Name)	(Name)
(Phone)	(Phone)	(Phone)	(Phone)
(Email)	(Email)	(Email)	(Email)

If the young person plans to reside out of county, provide all Department of Social Services point of contacts for the young person.

LINKS Coordinator	Foster Care 18-21 Point of Contact	Social Work Supervisor	Medicaid
(Name)	(Name)	(Name)	(Name)
(Phone)	(Phone)	(Phone)	(Phone)
(Email)	(Email)	(Email)	(Email)

Young Person Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Please select which documents the young person has in their possession.

Possessing these documents includes having them at home or in a location easily accessed. If the original documents are in the DSS office, it is because the young person has agreed to keep them there for the time being.

<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Social Security Card	<input type="checkbox"/> Driver's License/ID Card
<input type="checkbox"/> Health Insurance Information (Medicaid card)	<input type="checkbox"/> Educational records the young person requests	<input type="checkbox"/> Medical records the young person requests
Has the Foster Care 18-21 Program been explained?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the young person plan to participate in Foster Care 18-21?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If any of the above documents are missing or lost before the young person's 18 <sup>th</sup> birthday, who is responsible for assisting the young person in acquiring another original?		_____ (Name)
		_____ (Contact – Phone or Email)

Complete this section only if permanency will not be achieved at this or the next court hearing.

While this is the initial plan, additional information is needed to support the young person. Research shows engaging young people in more frequent, shorter meetings regarding their future yields more beneficial conversations and planning. Draft a timeline below of when the agency and the young person will discuss each of the following sections of Part Two of the Emancipation Plan. Part Two must be completed 90 days before the young person's 18<sup>th</sup> birthday.

<b>Part Two must be completed by</b>	
Housing	
Education	
Employment/Training Program	
Transportation	
Health Insurance	
Healthcare	
Income/Credit Report	
LINKS/Independent Living/Foster Care 18-21	

Young Person Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**PART TWO: 17-21 YEAR OLDS**

**HOUSING**

Current address: <i>(number and street, city, state, and ZIP code)</i>	Telephone or other contact information:
Where young person plans to live upon exit from Foster Care 18 to 21: <i>(number and street, city, state, and ZIP code)</i>	Telephone or other contact information:
What is the young person's back-up living arrangement if the above plan falls through? <i>(number and street, city, state, and ZIP code)</i>	Telephone or other contact information:

**HOUSING RESOURCES**

Family & Friends: <i>(Do you have a friend or family member you could stay with? List all possible connections)</i>	Contact Information: <i>(include address, telephone number, social media handles, email, for all listed)</i>
Local Program Supports: <i>(What housing programs exist in your current community?)</i>	Contact Information: <i>(include address, telephone number, website, social media handles, and email for all listed)</i>

Young Person Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**EDUCATION**

Current education program/school young person is attending:		Current grade level (if applicable):		Expected graduation date:	Current GPA:
Educational goal: <input type="checkbox"/> Certificate <input type="checkbox"/> HS Diploma <input type="checkbox"/> GED <input type="checkbox"/> Vocational Program <input type="checkbox"/> Two-Year College <input type="checkbox"/> Four-Year College <input type="checkbox"/> Other: _____					
Has young person received a High School Diploma or GED? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does young person plan to attend college or vocational program? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes: <input type="checkbox"/> Full time <input type="checkbox"/> Part time	Has young person completed PSAT/SAT/ACT? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable Date completed: Score:		
Does young person have an IEP/504 Plan? <input type="checkbox"/> Yes - IEP <input type="checkbox"/> Yes - 504 <input type="checkbox"/> No <input type="checkbox"/> Not applicable	Date of last IEP/504 Plan meeting:	If yes, is the young person involved with Vocational Rehabilitation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	Has the young person been provided a copy of their IEP/504 Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the young person been provided information on how to access student support services for their postsecondary education? <input type="checkbox"/> Yes ( <i>Ensure contact information for the special education point of contact is listed in resources.</i> ) <input type="checkbox"/> No					
<b>Complete only at time of permanence or if a young person plans to age out:</b> Based on the young person's exit from care, they would be eligible for the following postsecondary education support: <input type="checkbox"/> ETV <input type="checkbox"/> NC Reach (eligibility requirements can be found online through <a href="http://ncdhhs.gov">ncdhhs.gov</a> )					
List the supports the young person identifies that they need to further their education. More information about colleges, majors and financing can be found online at <a href="http://cfnc.org">cfnc.org</a> .					

**EDUCATION, CONT.**

College or Vocational program application submitted? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	Name of school(s) or program(s) applied and current status of the application:
Is the young person enrolled in a college or vocational program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	
If yes, <input type="checkbox"/> Full time <input type="checkbox"/> Part time	Name of school or program:
Area of study:	

Young Person Name:

DOB:

	Expected graduation date:	Current GPA:	Attached: <input type="checkbox"/> Schedule <input type="checkbox"/> Transcripts
--	---------------------------	--------------	---

**EDUCATIONAL RESOURCES**

Name:	Contact Information: <i>(include address, telephone number, website, and email, if applicable)</i>
Name:	Contact Information: <i>(include address, telephone number, website, and email, if applicable)</i>

Young Person Name: \_\_\_\_\_ DOB: \_\_\_\_\_

<b>EMPLOYMENT / TRAINING PROGRAM / VOLUNTEER</b>			
Has young person received information about WIOA through NCWorks? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	Does the young person have knowledge of how to complete an application for employment? <i>(If no, this should be a goal on the TLP)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the young person have an updated resume? <i>(If no, this should be a goal on the TLP)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the young person submitted any applications for employment or ever been employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
If no employment history, please explain any barriers the young person has that prevents them from employment:			
If the young person has a mental health or physical disability that significantly impacts their ability to function, has an application for Social Security Disability Benefits (SSDI) been submitted? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable			
Explain status:			
List applications submitted: <i>(optional; attach additional sheets if needed)</i>			
Is the young person currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and address of employer: <i>(number and street, city, state, and ZIP code)</i>	Full time (35+ hours/week): <input type="checkbox"/> Part time (34 or less hours/week): <input type="checkbox"/>	List average monthly income:
Has the young person maintained this employment for more than 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the young person been consistently employed over the last: <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> > 1 year		
Is the young person enrolled in a training program to limit or remove barriers to employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and address of program: <i>(number and street, city, state, and ZIP code)</i>	Hours per week:	
List any referrals that have been made in regards to employment and/or training and the current status of the referral: <i>(attach additional sheets if needed)</i>			
Does the young person have an internship? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and address of Internship: <i>(number and street, city, state, and ZIP code)</i>		
Does the young person volunteer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Volunteer location(s):	Hours:	
<b>EMPLOYMENT / TRAINING / VOLUNTEER RESOURCES</b>			
Name:	Contact Information: <i>(include address, telephone number, website, and email, if applicable)</i>		
Name:	Contact Information: <i>(include address, telephone number, website, and email, if applicable)</i>		

Young Person Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**TRANSPORTATION**

Will young person have access to consistent transportation upon discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does young person have his/her own car, truck, bicycle, or other form of transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a public bus line near where the young person will be residing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other means of transportation:
--	--	--	--------------------------------

**TRANSPORTATION RESOURCES**

Name:	Contact Information: <i>(include address, telephone number, website, and email, if applicable)</i>
Name:	Contact Information: <i>(include address, telephone number, website, and email, if applicable)</i>

Young Person Name: \_\_\_\_\_ DOB: \_\_\_\_\_

<b>HEALTH INSURANCE</b>		
Is the young person is eligible for the Extended Foster Care Medicaid Program as per the Affordable Care Act? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the young person received information and assistance regarding application procedures for Medicaid and other state/federal funded health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other private health insurance:  Insurer: _____  Policy number: _____
<b>HEALTH INSURANCE RESOURCES</b>		
Name:	Contact Information: <i>(include address, telephone number, website, and email, if applicable)</i>	
Name:	Contact Information: <i>(include address, telephone number, website, and email, if applicable)</i>	
<b>HEALTHCARE</b>		
Name of Medical Doctor:	Telephone Number: (     )	
Address: <i>(number and street, city, state, and ZIP code)</i>		
Name of Dentist:	Telephone Number: (     )	
Address: <i>(number and street, city, state, and ZIP code)</i>		
Name of Mental Health Provider:	Telephone Number: (     )	
Address: <i>(number and street, city, state, and ZIP code)</i>		
Name of Medication Provider:	Telephone Number: (     )	
Address: <i>(number and street, city, state, and ZIP code)</i>		
<b>REQUIRED:</b> Has the young person has received information on the importance of designating someone to make healthcare decisions on their behalf, if the young person is unable to do so and does not have or want a relative who would otherwise be so designated under NC law to make such decisions? <input type="checkbox"/> Yes <input type="checkbox"/> No The young person has been given information on how to designate a power of attorney or healthcare proxy. <input type="checkbox"/> Yes <input type="checkbox"/> No Five Wishes can be used to guide decisions. The Healthcare Power of Attorney document can be found at: <a href="https://www.sosnc.gov/documents/forms/advance_healthcare_directives/health_care_power_of_attorney.pdf">https://www.sosnc.gov/documents/forms/advance_healthcare_directives/health_care_power_of_attorney.pdf</a>		
<b>HEALTHCARE RESOURCES</b>		
Name:	Contact Information: <i>(include address, telephone number, website, and email, if applicable)</i>	
Name:	Contact Information: <i>(include address, telephone number, website, and email, if applicable)</i>	

Young Person Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**INCOME / CREDIT REPORT**

Will young person have income other than from employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list source(s) of income:	Amount of monthly supplemental income:
Has the child welfare agency conducted a credit report check for the young person from all three credit bureaus (Equifax, Transunion, and Experian)? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, date of last check: _____	Where there any issues on the young person's report? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, what were the issues?
How were the credit issues resolved?		If a credit report check has not been conducted, list the date the check will be completed: _____
<b>YOUNG PERSON:</b> You are entitled to a yearly credit report check from all three credit bureaus (Equifax, Transunion, and Experian) and a free credit report from <a href="http://annualcreditreport.com">annualcreditreport.com</a> . Additional information can be found at <a href="http://fostercreditcheck.org">fostercreditcheck.org</a> .		

**LINKS /INDEPENDENT LIVING/FOSTER CARE 18-21**

<b>YOUNG PERSON:</b> The LINKS program is available to you for services and resources until your 21 <sup>st</sup> birthday. Foster Care 18 to 21 services are also available to you up to your 21 <sup>st</sup> birthday. You can re-enter this program at any time. You can contact the LINKS Coordinator in your county of residence whether or not it is the same county in which you were in foster care. Your LINKS Coordinator is also known as your Chafee worker. <b>LINKS is North Carolina's Chafee Program. Your LINKS Coordinator is also known as your Chafee worker.</b>		
LINKS Coordinator:	Telephone Number: (     )	Email:
LINKS Supervisor:	Telephone Number: (     )	Email:
Name:	Contact Information: <i>(include address, telephone number, website, and email, if applicable)</i>	
Has Foster Care 18-21, including the re-entry policy, been explained to the young person? <input type="checkbox"/> Yes <input type="checkbox"/> No	Foster Care 18-21 Point of Contact Name:	
	Foster Care 18-21 Point of Contact Email:	
	Foster Care 18-21 Point of Contact Telephone Number:	
LINKS Coordinator:	Telephone Number: (     )	Email:
LINKS Supervisor:	Telephone Number: (     )	Email:
Name:	Contact Information: <i>(include address, telephone number, website, and email, if applicable)</i>	

Young Person Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**DOCUMENTS TO BE PROVIDED TO YOUNG PERSON AT DISCHARGE**

- Original or certified copy of birth certificate
- Original or certified copy of Social Security Card
- Copies of any legal documents that the young person might need for employment or benefits, including verification of eligibility for Extended Foster Care Medicaid, legal residency documentation, etc.
- Driver's license or identification card
- Copies of any credit reports and documentation related to issues resolved on the credit report.
- The original and signed copy of this document

**A. YOUNG PERSON'S CONTACT INFORMATION**

We would like to stay in touch with you. Please give us the name and contact information of people who will know how to contact you in the future.

---

---

**B. SIGNATURES**

---

Signature of Young person Date

---

Signature of Social Worker / LINKS Coordinator Date

---

Signature of Agency Director / Designee Date