



State of Florida
Department of Children and Families

Charlie Crist
Governor

Robert A. Butterworth
Secretary

DATE: June 10, 2008

TO: Regional Directors

THROUGH: *George Sheldon*
George Sheldon, Assistant Secretary for Operations
David Fairbanks, Assistant Secretary for Programs
Michael Cusick, Florida Coalition for Children *MCS*

FROM: *Patricia Badland*
Patricia Badland, Director of Office of Family Safety

SUBJECT: 2008 - 2009 Independent Living Transitional Services Critical Checklists
Data Collection - Implementation Date: July 1, 2008

Last year, the Department of Children and Families, the Florida Coalition for Children (FCC), and the Independent Living Services Advisory Council worked together to gather baseline data to describe children in foster care and young adults formerly in foster care, who are eligible to receive independent living services.

Thanks to the many independent living and foster care case management staff that helped to conduct the unprecedented survey of youth in foster care and young adults who had aged out of foster care in the summer of 2007. This collaboration with the Independent Living Services Advisory Council and the FCC resulted in the collection of baseline data that will be used to inform our program planning and improve our service delivery system. Results of the 2007 survey have been compiled and can be located at:
<http://www.dcf.state.fl.us/inliving/>.

In order to continue this effort in 2008, the Department requested feedback about the checklist and has revised the tools for greater clarity and to ensure the ability to compare the data in future iterations. The collection of the information contained in the checklist will be on-going and instructions for the implementation of the new checklists are attached.

Conference calls have been scheduled for June 16, 2008 at 2 pm and June 30, 2008 at 10 am to address any outstanding issues of implementation and to answer questions. The conference call-in number is 1-888-808-6959 and the code is: 9222425.

If you have additional questions about the checklist project, please contact Catherine Heath, at 850-922-2425 or at Catherine_heath@dcf.state.fl.us.

Thank you for your on-going efforts to provide and improve services to youth in foster care and young adults formerly in foster care.

1317 Winewood Boulevard, Tallahassee, Florida 32399-0700

Mission: Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency

2008 - 2009 Independent Living Transitional Services Critical Checklist Data Collection
Implementation
June 10, 2008
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Attachments

cc: Circuit Administrators
Community-Based Care CEOs
Jane Soltis, Independent Living Services Advisory Council Chair
Glen Casel, Chief Executive Officer of Community-Based Care
(CBC) of Seminole County
Frank Platt, Office of Family Safety
Tracy Heller, Florida Coalition for Children

**Implementation of the Revised Independent Living
Transitional Services Critical Checklists
Effective: July 1, 2008**

Purpose

The purpose of collecting data through use of the Independent Living Services Critical Checklist is to:

- obtain information necessary to develop trends about service delivery successes and gaps
- provide local systems of care and policy makers with information about needed service improvements
- provide a means for establishing accountability to the children and young adults we serve as well as for the federal and state funds we receive to deliver independent living services.

Authority

409.1451 (6). F. S.

ACCOUNTABILITY.--The department shall develop outcome measures for the program and other performance measures in order to maintain oversight of the program. The department shall prepare a report on the outcome measures and the department's oversight activities and submit the report to the President of the Senate, the Speaker of the House of Representatives, and the committees with jurisdiction over issues relating to children and families in the Senate and the House of Representatives no later than January 31 of each year. The report must include:

- (a) An analysis of performance on the outcome measures developed under this section reported for each community-based care lead agency and compared with the performance of the department on the same measures.
- (b) A description of the department's oversight of the program, including, by lead agency, any programmatic or fiscal deficiencies found, corrective actions required, and current status of compliance.
- (c) Any rules adopted or proposed under this section since the last report. For the purposes of the first report, any rules adopted or proposed under this section must be included.

From the funds in Specific Appropriations 355, 357 and 361, the Department of Children and Family Services, in coordination with community-based care lead agencies, shall establish minimum standards for the Independent Living Transition Services Program (section 409.1451, Florida Statutes) for current and former foster youth. The department shall include these minimum standards in department contracts with community-based care lead agencies by July 1, 2007. These standards shall be consistent with, but by no means limited to, the standards contained in the Office of Program Policy and Analysis and Government Accountability (OPPAGA) Report Number 04-78. By July 1, 2007, the department, in coordination with community-based care lead agencies, shall also develop measures for assessing lead agency performance in meeting these minimum standards. The department shall begin monitoring lead agency performance in accordance with these requirements by Fiscal Year 2008-2009.

Tools for Implementation

- Independent Living Transitional Services Critical Checklist Ages 13-17 Part 1: Youth Survey
- Independent Living Transitional Services Critical Checklist Ages 13-17 Part 2: Case Worker Survey
- Independent Living Transitional Services Critical Checklist Ages 18 -22

When to Use the Checklists and Data Collection System

- Starting July 1, 2008, use the revised checklists on the following schedule –
 - Within forty-five (45) days after the youth's or young adult's birthday.
 - Youth who come into care and meet the eligibility requirements for independent living services must have a checklist completed forty-five (45) days after they entered foster care (placed in state custody).
 - Those community-based care lead agencies that have continued to implement the checklist during the interim period (since October 1, 2007) do not have to complete the checklist again on the new form.
 - Starting July 1, 2008, all community-based care lead agencies must use the revised checklists.
 - Checklists should be completed for youth and young adults when they are located even if it is after the forty-five (45) days.

The Department and the Florida Coalition for Children will work together to update the data collection system used by the majority of the CBCs last year. More information will be available in the next several weeks about changes to the system.

Community-based care lead agencies may continue to use their own or other data collections systems. However, those lead agencies that are not using the web-based collection tool coordinated by the Florida Coalition for Children must submit electronic survey data consistent with the specifications in the attached file layout. Data must be entered into the Florida Coalition for Children web-based collection tool or submitted to the Family Safety Program Office by the fifteenth of the month following the month in which the data was required to be collected. This information should be sent to

IL_Survey_Data@dcf.state.fl.us This email has been set up exclusively to receive this data.

Please email Catherine Heath at Catherine_heath@dcf.state.fl.us if your community-based care lead agency will be submitting data files.

Summary of Revisions Based on Input from Users

- Separate the tool into two separate documents for use with 13-17 year old youth and 18-22 year old young adults
- Have a separate checklist with questions for youth ages 13- 17 to complete
- Clarify the language on the tool(s) itself to ensure consistency in application (as opposed to have a separate instructions document)
- Ensure identifiers are included for cross matching of data
- Ensure CBCs are collecting the same data and using the same definitions
- Maintain similar format or structure of the July 2007 checklist to ensure capacity to compare in future iterations

- Ensure appropriate youth involvement and clarify expectations for youth involvement on the tools
- Ensure CBCs continue to have flexibility to implement individualized data collection systems
- Ensure DCF has the capacity to aggregate data from multiple CBC systems

Conference Calls

Conference calls have been scheduled for June 16, 2008 at 2 pm and June 30, 2008 at 10 am to address any outstanding issues of implementation and to answer questions. The conference call-in number is 1-888-808-6959 and the code is: 9222425.

For More Information

Please contact Catherine Heath at Catherine_Heath@dcf.state.fl.us, 850-922-2425.

Independent Living Transitional Services Critical Checklist
AGES: 13 through 17
Youth Survey

First Name: _____

Last Name _____

D.O.B.: ___/___/19___ **SSN:** _____-_____-_____

Caseworker: _____

Your Email Address: _____

Section 1: Background Information

1) Do you have a **written plan for participation in activities** that are appropriate for you?
This is your **“Teen Plan”** or **“Normalcy Plan.”**

Yes No Declined Services

2) Do you have an **open bank account** (does not include a master trust account)?

Yes No Declined Services

3) Do you deposit or withdraw money from your bank account at least once every 3 months, including using a debit card?

Yes No N/A

4) Are you pregnant?

Yes No N/A

5) Do you have children? How many?

Yes No Number: _____

6) Are your **children in your legal custody**?

Yes No N/A Some **How Many Are in Your Custody?** _____

7) Are you the **caregiver of your children**?

Yes No N/A Some **How Many?** _____

*****To Be Completed by the Youth*****

Independent Living Transitional Services Critical Checklist
AGES: 13 through 17
Youth Survey

8) Have you received a copy of the "Rights and Expectation for Children and Youth in Shelter or Foster Care?"

It looks like this and it is either wallet or full size.



Yes

No

9) Do you receive an allowance each month?

Yes

No

10) If you receive an allowance, how much do you receive each month?

\$1- \$20/ month

\$21- \$ \$ 40/ month

\$41- \$60/ month

\$61- \$80/ month

\$81- \$100/ month

More than \$100/ month

N/A

Section 2: Housing

1) Have you been formally evaluated for **Subsidized Independent Living? (Ages 16+)**

Yes

No

N/A

Section 3: Education

1) What is your Educational **Goal?** (Please check one.)

High School, Regular Diploma

High School, Special Diploma

GED Program

Associates Degree

Bachelor's Degree

Master's Program or Higher

Vocational

Military

Apprenticeship

No further education past age 16

Independent Living Transitional Services Critical Checklist
AGES: 13 through 17
Youth Survey

Section 4: Employment

1) Have you had an opportunity to **participate in job training** (paid or unpaid)?

- Yes No Declined Services

Section 5: Health

1) What health services have you received in the last year? (Check all that apply).

- Doctor Dentist
 Emergency Room Mental Health Provider
 Vision Services (Eye exam) Alcohol/ Substance abuse services
 Other: _____ None

Section 6: Department of Juvenile Justice or Corrections Involvement

[There are no questions for you to complete in this section.]

Section 7: Transportation

1) Do you have a **reliable means of transportation** to school, including the school bus?

- Yes No Not in School

2) Do you have a **reliable means of transportation** to work?

- Yes No Do Not Work

3) Have you successfully **completed a driver's education course?** (Age 15+)

- Yes No N/A Declined Services

4) If yes, what is your driver's license status? (Age 15+)

- Learners
 Regular
 Suspended/Revoked
 N/A

Independent Living Transitional Services Critical Checklist
AGES: 13 through 17
Youth Survey

5) and 6) What is your **primary** and **secondary** means of transportation to get around?

<p>5) PRIMARY: (Check One)</p> <p><input type="checkbox"/> Foster Parent</p> <p><input type="checkbox"/> Group Home Staff</p> <p><input type="checkbox"/> Public Transportation</p> <p><input type="checkbox"/> Own Car</p> <p><input type="checkbox"/> Friends</p> <p><input type="checkbox"/> Taxi</p> <p><input type="checkbox"/> Bike</p> <p><input type="checkbox"/> Walk</p> <p><input type="checkbox"/> Boyfriend/ Girlfriend</p> <p><input type="checkbox"/> Parent</p> <p><input type="checkbox"/> Caseworker/ IL Staff</p> <p><input type="checkbox"/> Church or Religious Official/ Member</p> <p><input type="checkbox"/> Other Family Member</p> <p><input type="checkbox"/> School Bus</p> <p><input type="checkbox"/> Therapist</p> <p><input type="checkbox"/> Other: _____</p>	<p>6) SECONDARY: (Check One)</p> <p><input type="checkbox"/> Foster Parent</p> <p><input type="checkbox"/> Group Home Staff</p> <p><input type="checkbox"/> Public Transportation</p> <p><input type="checkbox"/> Own Car</p> <p><input type="checkbox"/> Friends</p> <p><input type="checkbox"/> Taxi</p> <p><input type="checkbox"/> Bike</p> <p><input type="checkbox"/> Walk</p> <p><input type="checkbox"/> Boyfriend/ Girlfriend</p> <p><input type="checkbox"/> Parent</p> <p><input type="checkbox"/> Caseworker/ IL Staff</p> <p><input type="checkbox"/> Church or Religious Official/ Member</p> <p><input type="checkbox"/> Other Family Member</p> <p><input type="checkbox"/> School Bus</p> <p><input type="checkbox"/> Therapist</p> <p><input type="checkbox"/> Other: _____</p>
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Section 8: Case Plan, Aftercare, and Transitional Services

1) Were you involved in developing your case plan?

- Yes No Declined to Participate

2) Were you involved in developing your transition plan (Age 17)?

- Yes No N/A Declined to Participate

3) Are you connected to **adult mentors** in the community?

- Yes No Declined a Mentor

*****To Be Completed by the Youth*****

Independent Living Transitional Services Critical Checklist
AGES: 13 through 17
Youth Survey

4) and 5) Who do you **turn to for help?**

<p>4) FIRST:</p> <p><input type="checkbox"/> Relative</p> <p><input type="checkbox"/> Parent</p> <p><input type="checkbox"/> Foster Parent</p> <p><input type="checkbox"/> Mentor</p> <p><input type="checkbox"/> Friend Over 25</p> <p><input type="checkbox"/> Friend Under 25</p> <p><input type="checkbox"/> Teacher/ Coach</p> <p><input type="checkbox"/> GAL/ Attorney</p> <p><input type="checkbox"/> No One</p> <p><input type="checkbox"/> Boss</p> <p><input type="checkbox"/> Case Worker/ IL Staff</p> <p><input type="checkbox"/> Group Home Staff</p> <p><input type="checkbox"/> Friend</p> <p><input type="checkbox"/> Boyfriend/ Girlfriend/ Spouse</p> <p><input type="checkbox"/> Other Family Member</p> <p><input type="checkbox"/> Church or Religious Official/ Member</p> <p><input type="checkbox"/> Therapist</p> <p><input type="checkbox"/> Other: _____</p>	<p>5) SECOND:</p> <p><input type="checkbox"/> Relative</p> <p><input type="checkbox"/> Parent</p> <p><input type="checkbox"/> Foster Parent</p> <p><input type="checkbox"/> Mentor</p> <p><input type="checkbox"/> Friend Over 25</p> <p><input type="checkbox"/> Friend Under 25</p> <p><input type="checkbox"/> Teacher/ Coach</p> <p><input type="checkbox"/> GAL/ Attorney</p> <p><input type="checkbox"/> No One</p> <p><input type="checkbox"/> Boss</p> <p><input type="checkbox"/> Case Worker/ IL Staff</p> <p><input type="checkbox"/> Group Home Staff</p> <p><input type="checkbox"/> Friend</p> <p><input type="checkbox"/> Boyfriend/ Girlfriend/ Spouse</p> <p><input type="checkbox"/> Other Family Member</p> <p><input type="checkbox"/> Church or Religious Official/ Member</p> <p><input type="checkbox"/> Therapist</p> <p><input type="checkbox"/> Other: _____</p>
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Youth's Signature: _____ **Date:** _____

Dependency Caseworker's Signature: _____ **Date:** _____

*****To Be Completed by the Youth*****

Independent Living Transitional Services Critical Checklist
AGES: 13 through 17
Case Worker Survey

Youth's First Name: _____	
Youth's Last Name: _____	
D.O.B.: ___/___/19___	Age: _____
FSFN ID #: : _____	SSN: _____-_____-_____
Lead Agency: _____	
Caseworker: _____	CW Phone Number: _____
Youth's Email Address: _____	
Date Completed: _____	

Race/ Ethnicity of the Youth: (Select all the Apply)		
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African-American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> White
<input type="checkbox"/> Unknown	<input type="checkbox"/> Declined	<input type="checkbox"/> Hispanic or Latino Ethnicity
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		

<p>Obtaining data: Please complete this form along with the youth and a review of the file. "Evidence" can be obtained from other data sources; however the youth must be involved in the process. However, if the youth is unavailable, or is unsure of an answer, other sources may be used in order to obtain the data.</p> <p>Check ALL that APPLY:</p> <p><input type="checkbox"/> Unable to locate youth due to the youth currently being on runaway status. (Caseworker Checklist was completed using the data available from a file review).</p> <p><input type="checkbox"/> Youth is defined as a habitual runaway and services are unable to be delivered in a consistent manner.</p> <p><input type="checkbox"/> Youth is not participating in IL services because of a disability and is also unable to answer the questions.</p>

*****To Be Completed by the Case Worker and Youth*****

Independent Living Transitional Services Critical Checklist
AGES: 13 through 17
Case Worker Survey

Section 1: Background Information

- 1) Youth has **completed** a current and age appropriate standardized life skills assessment within the last 12 months?
- Yes No Declined Services
- 2) Youth has **received services** for areas identified by the life skills assessment as deficiencies.
- Yes No Partially
- N/A Declined Services Assessment was completed within the last 30 days;
Services are being developed.
- 3) Youth receives **Social Security Income (SSI)**?
- Yes No Applied for

Section 2: Housing

- 1) Youth Currently Residing in: **(Check one)**
- Foster Home
 Group Home
 Parent
 Relative, Licensed Foster Home
 DJJ
 Mental Health Facility
 Non-relative Licensed Home (Child Specific for Youth)
 Dorm
 Renting Housing
 Own Housing
 Assisted Living Facility
 Corrections Facility- Adult
 Subsidized IL
 Missing/ Runaway Status
 Out of State in Licensed Foster Home through ICPC
 Other: (Explain) _____

Section 3: Education

- 1) Youth, **as determined by their school**, is:
- At grade level
 Above Grade level
 Below Grade level
 Youth is not in school

*****To Be Completed by the Case Worker and Youth*****

Independent Living Transitional Services Critical Checklist
AGES: 13 through 17
Case Worker Survey

2) If the answer is "below grade level" or "youth is not in school" to item #1, is the youth **receiving remediation services identified to** improve his or her chances of performing at or above grade level or returning to school?

Yes No Declined Services

3) Youth has **passed their grade level FCAT.**

Yes No N/A

4) If no to item 3 above, the youth is **receiving tutoring/ other services identified to** improve his or her chances of passing their grade level FCAT?

Yes No
 N/A Declined Services

5) If no to passing their full grade level FCAT, the following sections were **passed:**

Reading Math
 Science Writing
 N/A

6) The youth **has an educational and career path** which has been developed into a **written plan.**

Yes No Declined Services

7) The youth's educational and career path has been **filed with the court.**

Yes No N/A

*****To Be Completed by the Case Worker and Youth*****

Independent Living Transitional Services Critical Checklist
AGES: 13 through 17
Case Worker Survey

8) **Current** Educational Status. (Please check one.)

- High School, ____th grade
- GED Program
- Community College
- University/ College
- Vocational/ Technical
- Apprenticeship
- Military
- Job Corp
- Not in School
- Graduate School
- Professional Certification
- Not in School
- Other: _____

9) **Highest completed** grade/education. (Please check one.)

- (____th)Grade
- 12th grade, Earned **Regular** Diploma
- 12th grade, Earned **Special** Diploma
- 12th grade, Earned **Certificate of Completion**
- GED Program, Earned Diploma
- Associate's Degree
- Vocational Degree
- Apprenticeship Degree

Section 4: Employment

1) Youth's current **Employment Status**:

- Full time (more than 35 hours a week, one or multiple jobs) without job supports
- Part Time (less than 35 hours a week, one or multiple jobs) without job supports
- Seasonal Job (holiday or school breaks)
- Volunteer
- Not employed
- Not employed due to disability
- Employed with job supports (full-time, part-time, and seasonal)

2) If employed, what is the **hourly wage**?

- | | |
|--|---|
| <input type="checkbox"/> Less Than Florida Minimum Wage + Tips / per hour | <input type="checkbox"/> Florida Minimum Wage/ per hour |
| <input type="checkbox"/> Above Minimum Wage to \$8.00/ per hour | <input type="checkbox"/> \$8.01 to \$10.00 per hour |
| <input type="checkbox"/> \$10.01 to \$12.00 per hour | <input type="checkbox"/> \$12.01 to \$14.00 per hour |
| <input type="checkbox"/> \$14.01 to \$16.00 per hour | <input type="checkbox"/> Over \$16.00 per hour |

*****To Be Completed by the Case Worker and Youth*****

Independent Living Transitional Services Critical Checklist
AGES: 13 through 17
Case Worker Survey

3) If employed, total number of **hours worked per week** on average (all jobs):

- | | |
|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Under 10 | <input type="checkbox"/> 11- 20 |
| <input type="checkbox"/> 21 to 30 | <input type="checkbox"/> 31 to 40 |
| <input type="checkbox"/> Over 40 | <input type="checkbox"/> N/A |

4) Youth has a job that offers **benefits such as health insurance, dental insurance, sick leave, paid vacation, and retirement plans such as a 401k** to them at their current employment status.

- | | | |
|----------------------------------|------------------------------|-------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Some |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A | |

5) If yes, please check type of benefits their job offers at their current employment status. (Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Health Insurance | <input type="checkbox"/> Dental/Vision |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Paid Vacation |
| <input type="checkbox"/> Education Support | <input type="checkbox"/> Sick Leave |
| <input type="checkbox"/> N/A | <input type="checkbox"/> None |
| <input type="checkbox"/> Don't Know | |

Section 5: Health

1) Medicaid Number of Youth: _____ or Does not have Medicaid

Section 6: Department of Juvenile Justice or Corrections Involvement

1) Youth has been **arrested in the past 12 months**.

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

2) If yes, number of times arrested in the last 12 months.

- | | | | |
|------------------------------|----------------------------|--------------------------------|---------------------------------------|
| <input type="checkbox"/> N/A | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6- 10 | <input type="checkbox"/> More than 10 |

*****To Be Completed by the Case Worker and Youth*****

Independent Living Transitional Services Critical Checklist
AGES: 13 through 17
Case Worker Survey

3) Youth is **currently on probation** or **under DJJ supervision**.

Yes No

4) Youth is **currently incarcerated**, or has **been incarcerated within the past 12 months**.

Yes No

Section 7: Transportation

[There are no questions for the case manager in this section.]

Section 8: Case Plan, Aftercare, and Transitional Services

1) Youth **has tasks in a case plan** filed with the court?

Yes No N/A due to disability

2) Case Plan Goal for the Youth (Check One).

- Reunification parent(s)
- Adoption
- Legal Guardianship
- Another Planned Permanent Living Arrangement
- Other: _____

3) Youth has signed their **independent living transition plan** and it has been filed with the court. **(17 only)**

Yes No Declined to Participate N/A

Youth's Signature: _____ **Date:** _____

Dependency Caseworker's Signature: _____ **Date:** _____

*****To Be Completed by the Case Worker and Youth*****

Independent Living Transitional Services Critical Checklist
AGES: 18 through 22

Adult's First Name: _____	
Adult's Last Name: _____	
D.O.B.: ___ ___ / ___ ___ / <u>1</u> <u>9</u> ___ ___	Age: _____
FSFN ID #: : _____	SSN: _____ - _____ - _____
Lead Agency: _____	
Caseworker: _____	CW Phone Number: _____
Adult's Email Address: _____	
Date Completed: _____	

Race/ Ethnicity of the Adult: (Select all the Apply)		
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African-American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> White
<input type="checkbox"/> Unknown	<input type="checkbox"/> Declined	<input type="checkbox"/> Hispanic or Latino Ethnicity
Gender: <input type="checkbox"/> Male		<input type="checkbox"/> Female

<p>Obtaining data: The checklist questions are worded with the intent that they be answered by the adult.</p> <p>Check all that apply:</p> <p><input type="checkbox"/> Unable to locate the adult (Only check this box if a good faith effort was conducted to complete a checklist on this young adult, but the agency was unable to locate the young adult. The caseworker should sign and date at the end of the checklist.) If the adult is located, please complete a new survey at that time.</p> <p><input type="checkbox"/> Adult is not participating in IL services because of a disability and is unable to answer questions.</p>
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Independent Living Transitional Services Critical Checklist
AGES: 18 through 22

Section 1: Background Information

1) Do you have an **open bank account**?

Yes No

2) Do you deposit or withdraw money from your bank account **at least once every 3 months**, including using a debit card?

Yes No N/A

3) Are you **married**?

Yes No

4) Are you pregnant?

Yes No N/A

5) Do you have children? How many?

Yes No Number: _____

6) Are your **children in your legal custody**?

Yes No N/A Some **How Many Are in Your Custody?** _____

7) Are you the **caregiver of your children**?

Yes No N/A Some **How Many?** _____

8) Do you receive **Social Security Income (SSI)**?

Yes No

Independent Living Transitional Services Critical Checklist
AGES: 18 through 22

Section 2: Housing

1) At the time of your 18th birthday, **what type of placement** were you in? (Please check one.)

- Foster Home
- Group Home
- Parent
- Relative, Licensed Foster Home
- DJJ
- Mental Health Facility
- Non-relative Licensed Home (Child Specific for Youth)
- Dorm
- Renting Housing
- Own Housing
- Assisted Living Facility
- Corrections Facility- Adult
- Subsidized IL
- Missing/ Runaway Status
- Out of State in Licensed Foster Home through ICPC
- Dormitory
- Other: (Explain) _____

2) What is your **current Housing/Living Arrangement?** (Please check one.)

- Foster Home
- Group Home
- Parent
- Relative
- DJJ
- Mental Health Facility
- Friend/ Non-relative
- Dorm
- Renting Apartment/ House
- Own Housing
- Assisted Living Facility
- Corrections Facility- Adult
- Residential Substance Abuse Treatment
- Homeless
- Other: (Explain) _____

3) Is your name on the lease or mortgage for your housing?

- Yes No N/A

4) How many times have you moved or changed your living arrangement in the past 12 months?

- None 1 2 3
- 4 5 6- 10 More than 10

Independent Living Transitional Services Critical Checklist
AGES: 18 through 22

5) Do you consider your **housing/living arrangement** safe?

Yes No N/A

6) Do you consider your **housing/living arrangement** stable?

Yes No N/A

7) Do you consider your **housing/living arrangement** affordable?

Yes No N/A

8) Is your housing/living arrangement **near stores and shopping**?

Yes No

9) Is your housing/living arrangement **near a bus stop**?

Yes No

10) Is your housing/living arrangement near your **school or educational program**?

Yes No N/A- Not in School

11) Is your housing/living arrangement near your **place of employment**?

Yes No N/A- Not employed

12) If the answer to any of the questions 5-11 are no, is there a plan developed to assist you in obtaining **housing** that is safe, stable, affordable, and is located near public transportation, work and/or school?

Yes No Declined Services

13) Have you spent at least one night **homeless** since leaving foster care in the last 12 months? *Homeless is defined as an individual who lacks a fixed, regular and adequate night time residence or someone whose primary nighttime residence is a shelter, an institution or a public or private place not designed for regular sleeping accommodations.*

Yes No Currently Homeless

14) How many **times** have you been homeless in the last 12 months?

None 1 2 3
 4 5 6- 10 More than 10

Independent Living Transitional Services Critical Checklist
AGES: 18 through 22

15) In the last 12 months, about how many **nights** were you homeless each time you were homeless?

- None 1 2 3
 4 5 6- 10 More than 10

16) In the last 12 months, where did you stay when you were homeless? (Answer all that apply):

- Homeless Shelter
 With Friends
 With Family
 On the Street
 With someone I did not know
 In my car
 Other: _____
 N/A

Section 3: Education

1) Are you currently **attending school or a vocational program?** (Please answer "Yes" if you are on break, summer vacation, transferring programs, or waiting for your school to start.)

- Yes No

2) If attending school, are you considered by your educational institution to be?

- At grade level
 Above Grade level
 Below Grade level
 N/A
 Unknown

3) Are you **receiving tutoring or other services?**

- Yes No
 N/A Not in School
 Declined Services

Independent Living Transitional Services Critical Checklist
AGES: 18 through 22

4) What type of school are you currently attending?

- High School, ___th grade
- GED Program **AT** Community College **or** Adult Education **or** Other
- Community College
- University/ College
- Vocational/ Technical
- Apprenticeship
- Military
- Job Corp
- Not in School
- Graduate School
- Professional Certification
- Not in School
- Other: _____

5) What is the **highest completed** grade/education that you have completed? (Please check one.)

- (___th)Grade
- 12th grade, Earned **Regular** Diploma
- 12th grade, Earned **Special** Diploma
- 12th grade, Earned **Certificate of Completion**
- GED Program, Earned Diploma
- Associate's Degree
- Bachelor's Degree
- Vocational
- Military
- Apprenticeship

6) What is your Current Educational **Goal?** (Please check one.)

- High School, **Regular** Diploma
- High School, **Special** Diploma
- High School, **Certificate of Completion**
- GED Program
- Associates Degree
- Bachelors Degree
- Master's Program or Higher
- Vocational
- Military
- Apprenticeship
- No further education

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Section 4: Employment

1) What is your current **Employment Status**?

- Full time (more than 35 hours a week, one or multiple jobs) without job supports
- Part Time (less than 35 hours a week, one or multiple jobs) without job supports
- Seasonal Job (holiday or school breaks)
- Volunteer
- Not employed
- Not employed due to disability
- Employed with job supports (full-time, part-time, and seasonal)

2) If employed, what is your **hourly wage**?

- Less Than **Florida Minimum Wage + Tips** / per hour Florida Minimum Wage/ per hour
- Above Minimum Wage to \$8.00/ per hour \$8.01 to \$10.00 per hour
- \$10.01 to \$12.00 per hour \$12.01 to \$14.00 per hour
- \$14.01 to \$16.00 per hour Over \$16.00 per hour

3) If employed, total number of **hours worked per week** on average (all jobs):

- Under 10 11- 20
- 21 to 30 31 to 40
- Over 40 N/A

4) Have you participated in **job training or internships (paid or unpaid)** in the last 12 months?

- Yes No

5) Have you had opportunities to **participate in job training** or internships (paid or unpaid) since leaving foster care?

- Yes No

6) If job training and internship opportunities (paid or unpaid) were made available now, would you participate?

- Yes No

7) Does your current job offer **benefits such as health insurance, dental insurance, sick leave, paid vacation, and retirement plans such as 401k** to you in your current position?

- Yes No Some
- Unknown N/A

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8) If yes, please check type of benefits your job offers to you in your current position. (Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Health Insurance | <input type="checkbox"/> Dental/Vision |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Paid Vacation |
| <input type="checkbox"/> Education Support | <input type="checkbox"/> Paid Sick Leave |
| <input type="checkbox"/> Discounted Prescription Drugs | <input type="checkbox"/> N/A |
| <input type="checkbox"/> None | <input type="checkbox"/> Don't Know |

9) If you are not currently employed, when was the last time that you held the same job for over 90 days?

- Within the last 3 months
- Within the last 6 months
- Within the last year
- More than one year ago
- Never

Section 5: Health

1) Do you have medical health insurance?

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Private |
| <input type="checkbox"/> Work Related | <input type="checkbox"/> No Medical Health Insurance |
| <input type="checkbox"/> Military | <input type="checkbox"/> School Health Insurance |

2) What is your Medicaid number?

_____ Don't Know N/A

3) Do you have mental health insurance?

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Private |
| <input type="checkbox"/> Work Related | <input type="checkbox"/> No Mental Health Insurance |
| <input type="checkbox"/> Military | <input type="checkbox"/> School Health Insurance |

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4) Do you have dental insurance?

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Private |
| <input type="checkbox"/> Work Related | <input type="checkbox"/> No Dental Insurance |
| <input type="checkbox"/> Military | <input type="checkbox"/> School Health Insurance |

5) Do you have vision insurance?

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Private |
| <input type="checkbox"/> Work Related | <input type="checkbox"/> No Vision Insurance |
| <input type="checkbox"/> Military | <input type="checkbox"/> School Health Insurance |

6) What health services have you received in the last year? **(Check all that apply).**

- | | |
|---|--|
| <input type="checkbox"/> Doctor | <input type="checkbox"/> Dentist |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Mental Health Provider |
| <input type="checkbox"/> Vision Services (Eye exam) | <input type="checkbox"/> Alcohol/ Substance abuse services |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> None |

Section 7: Department of Juvenile Justice or Corrections Involvement

1) Have you been **arrested in the past 12 months?**

- Yes No

2) **If yes, number of times in the last 12 months?**

- | | | | |
|------------------------------|----------------------------|--------------------------------|---------------------------------------|
| <input type="checkbox"/> N/A | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6- 10 | <input type="checkbox"/> More than 10 |

3) Are you on **currently on probation** or **under criminal court supervision.**

- Yes No

Independent Living Transitional Services Critical Checklist

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4) Are you **currently incarcerated**, or have you **been incarcerated within the last 12 months**?

- Yes No

Section 8: Transportation

1) Do you have a **reliable means of transportation to school**, including a school bus?

- Yes No Not in School

2) Do you have a **reliable means of transportation to work**?

- Yes No Do Not Work

3) Have you successfully **completed a driver's education course**?

- Yes No Declined Services

4) **What type** of driver's license do you currently have?

- Learners
 Regular
 Suspended/Revoked
 None

5) and 6) What is your **primary** and **secondary** means of transportation to get around?

<p>5) PRIMARY:</p> <p><input type="checkbox"/> Foster Parent <input type="checkbox"/> Group Home Staff <input type="checkbox"/> Public Transportation <input type="checkbox"/> Own Car <input type="checkbox"/> Friends <input type="checkbox"/> Taxi <input type="checkbox"/> Bike <input type="checkbox"/> Walk <input type="checkbox"/> Boyfriend/ Girlfriend/ Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Caseworker/ IL Staff <input type="checkbox"/> Church or Religious Official/ Member <input type="checkbox"/> Other Family Member <input type="checkbox"/> Therapist <input type="checkbox"/> Other: _____</p>	<p>6) SECONDARY:</p> <p><input type="checkbox"/> Foster Parent <input type="checkbox"/> Group Home Staff <input type="checkbox"/> Public Transportation <input type="checkbox"/> Own Car <input type="checkbox"/> Friends <input type="checkbox"/> Taxi <input type="checkbox"/> Bike <input type="checkbox"/> Walk <input type="checkbox"/> Boyfriend/ Girlfriend/ Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Caseworker/ IL Staff <input type="checkbox"/> Church or Religious Official/ Member <input type="checkbox"/> Other Family Member <input type="checkbox"/> Therapist <input type="checkbox"/> Other: _____</p>
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Independent Living Transitional Services Critical Checklist
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Section 8: Case Plan, Aftercare, and Transitional Services

1) Do you have **adult mentors** in the community?

- Yes No Declined a Mentor

2) and 3) Who do you **turn to for help first and second?**

<p>2) FIRST:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Relative <input type="checkbox"/> Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Mentor <input type="checkbox"/> Friend Over 25 <input type="checkbox"/> Friend Under 25 <input type="checkbox"/> Teacher/ Coach <input type="checkbox"/> GAL/ Attorney <input type="checkbox"/> No One <input type="checkbox"/> Boss <input type="checkbox"/> Case Worker/ IL Staff <input type="checkbox"/> Group Home Staff <input type="checkbox"/> Friend <input type="checkbox"/> Boyfriend/ Girlfriend/ Spouse <input type="checkbox"/> Other Family Member <input type="checkbox"/> Church or Religious Official/ Member <input type="checkbox"/> Therapist <input type="checkbox"/> Other: _____ 	<p>3) SECOND:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Relative <input type="checkbox"/> Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Mentor <input type="checkbox"/> Friend Over 25 <input type="checkbox"/> Friend Under 25 <input type="checkbox"/> Teacher/ Coach <input type="checkbox"/> GAL/ Attorney <input type="checkbox"/> No One <input type="checkbox"/> Boss <input type="checkbox"/> Case Worker/ IL Staff <input type="checkbox"/> Group Home Staff <input type="checkbox"/> Friend <input type="checkbox"/> Boyfriend/ Girlfriend/ Spouse <input type="checkbox"/> Other Family Member <input type="checkbox"/> Church or Religious Official/ Member <input type="checkbox"/> Therapist <input type="checkbox"/> Other: _____
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Adult's Signature: _____ **Date:** _____