



State of South Carolina

Department of Social Services

Policies and Guidelines: Child Welfare Services

Subject	601 Transition Planning
Authority	Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351); Patient Protection and Affordable Care Act (P.L. 111-148); S.C. Code Section 63-7-2700, <i>et seq.</i>
Standards	Guiding Principles and Standards (GPS) Practice Model
Application	Child Welfare Services Foster Care and Permanency staff, DSS Transition Services and Support staff, providers required to provide Independent Living Services
Purpose	
To outline policies and procedures for the preparation and full engagement of foster care youth and young adults in a transition planning process that promotes opportunities to obtain life skills for self-sufficiency, establishing enduring, supportive connections, and that leads to stability, independence, permanency and stability.	
Policy Statement	
The South Carolina Department of Social Services (DSS) provides transition planning supports and services to youth in DSS custody who are 14 years of age and older. A Transition Plan shall be developed for all youth in DSS custody 90 days immediately prior to turning age 17, 90 days immediately prior to turning age 18, and again 90 days immediately prior to turning the greater age of 19, 20, or 21 if the young adult is in the extended foster care program. The Transition Plan becomes the ongoing planning document for young adults ages 18-21 receiving Extension or Re-Establishment of Foster Care Services as a young adult. The Child and Adolescent Needs and Strengths (CANS) Independent Living (IL) Module is utilized throughout the transition planning process to evaluate the youth or young adult's strengths and needs and assess knowledge, skills, and abilities.	
Policy Administration	
The Division of Child Welfare Services' Office of Operations is the owner of this policy. The Operations Director, or designee, shall review this policy annually from the date published in the Child Welfare Services Policy Manual, or as needed due to changes in law or practice.	
Policy Guidelines	
A. Youth and Young Adult Rights for Transition Planning	Beginning at age 14, youth and young adults in foster care shall: 1. Be involved, in accordance with their age and development, in making major decisions that affect their Family Permanency Plan (FPP), permanency plan, and comprehensive transition plan; 2. Be prepared and encouraged to participate in all upcoming teaming meetings, hearings, and reviews; 3. Be able to discuss their views about the plans with the judge;

Subject: Transition Planning

	4. Be able to choose up to two additional members (not the youth's or young adult's case manager or foster parent) to participate in the case planning team; and Note: <i>One person selected may serve as the youth's or young adult's advisor, advocate, and with respect to the application of the reasonable and prudent parent standard to the youth or young adult.</i> 5. Receive copies of all summaries, recommendations, and legal and other documents, including annual credit reports, and unless the youth or young adult has been in foster care less than 6 months, prior to leaving foster care, a certified copy of his or her U.S. birth certificate, his or her social security card, health insurance information, medical records, driver's license or identification card issued in accordance with the requirements of Section 202 of the REAL ID Act of 2005, and any official documentation necessary to prove that the youth or young adult was previously in foster care.
B. Child and Adolescent Needs and Strengths Independent Living Module	1. The foster care or permanency case manager must initiate transition planning for all youth who are 14 or older who are in foster care to promote skill building and necessary foundations to enable self-sufficiency for a successful transition to adulthood. 2. The DSS case manager shall administer the Child and Adolescent Needs and Strengths (CANS) Independent Living (IL) Module to all youth in DSS custody 14 years of age or older prior to the initial Child and Family Team Meeting (CFTM). This is followed by participating members of the CFTM to support any portions of the transition goals, action steps, services, and supports. a. Initial CANS is completed within 48 hours following the 25-Day CFTM. b. Full Review of the CANS will be completed by Day 30 of the foster care line opening. c. CANS IL Module is updated, at a minimum, of every 90 days. d. Before any FPP revision. e. Before all CFTM's after the 25-Day CFTM. 3. The CANS assessment domains to be assessed for youth in custody 14 up to 17 years of age to begin transition planning include: a. Safe and Stable Housing; b. Financial Stability; c. Health and Personal Care; d. Education/Employment; e. Positive Connections; and f. Parenting/Caregiving.

Subject: Transition Planning

	4. Once the CANS IL Module is completed, the case manager shall: a. Share a copy and discuss the results with the youth and young adult by identifying areas of strengths and needs; b. Use the CANS IL Module results to develop service goals and activities that will be addressed in the youth's or young adult's Transition section of the FPP; c. Link a copy of the completed CANS IL Module in the youth's or young adult's CAPSS file; and d. Document the CANS IL Module in the National Youth in Transition Database (NYTD) CAPSS tab as a delivered non-funded service, "IL Assessment." 5. When the CANS IL module is completed or updated, the results must be reflected on the youth's or young adult's Transition Plan.
C. Transition Planning Process	1. The foster care or permanency case manager is responsible for regular review and updates to the goals and services of the plan during regular monthly, face-to-face, contacts and engagement. 2. The foster care or permanency case manager is responsible for high level monthly engagement during face-to-face visits to include the following: a. Reminder to the youth of their transition goals; b. A discussion with the youth about progress being made toward achieving those goals; c. A discussion with the youth to determine if they feel changes or updates are needed to the plan; and d. A discussion with the youth to determine if additional supports are necessary for the youth to achieve their goals. 3. The foster care or permanency case manager shall record and update NYTD services in CAPSS under the "NYTD" tab (at least monthly) to promote monthly recorded NYTD entries reflect services received and assistance provided to youth and young adults in support of transitional growth for independence, education, housing, life skills, employment, etc. a. A NYTD service requires action from the case manager or provider. b. Case managers shall communicate with youth, young adults, and care providers, at least once per month, utilizing DSS Form 30254: Monthly NYTD Tracking, and store copies in the case file. c. The case manager shall provide the care provider with access to DSS Booklet 30255: NYTD Services to understand the 14 NYTD categories for accurate data tracking. 4. The foster care or permanency case manager shall: a. Complete timely referrals for identified services; b. Regularly monitor the transition planning progression; and

Subject: Transition Planning

	c. Make reasonable efforts to promote the timely delivery of appropriate services. 5. The foster care or permanency case manager shall utilize the resources available under the Transition Services and Support unit within the Office of Child Welfare Operations. a. Complete DSS Form 30198 to access available funding for transitional services to support transitional growth in academic, post-secondary, employment, transportation, and housing. b. Complete DSS Form 37166 to access Education and Training Voucher (ETV) awards for youth pursuing post-secondary education. c. Life skill development opportunities and workshops. d. Youth advocacy and leadership development opportunities. 6. The foster care or permanency case manager teams with staff across the department as well as other agencies and external partners as applicable to promote assignment of appropriate staff, resources, and supports are readily available to assist in transitional growth. 7. The foster care or permanency case manager must review and assess progress, at minimum, annually, and routinely document case activities in CAPSS.
D. Formalizing the Transition Plan	1. The foster care or permanency case manager shall complete DSS Form 30206 with the youth or young adult to formalize the transition planning for youth 17 years of age or older identifying the services, resources, and supports needed to be successful. The Transition Plan is a document that: a. Describes transition goal(s); b. Describes activities that will assist in achieving those goals including programs and services provided by the agency and other services for transition age youth and young adults; c. Identifies the individuals assisting the youth or young adult to meet those goals; d. Indicates the planned activities completion date; and e. Evaluates progress toward reaching those goals. 2. DSS Form 30206 shall be completed with the youth 90 days immediately prior to turning age 17. The Transition Plan is reviewed and updated with the youth in the 90 days immediately prior to the youth turning age 18. The Transition Plan is then reviewed and updated in the 90 days immediately prior to the young adult turning the greater age of 19, 20, or 21. 3. The Transition Plan is guided by the youth or young adult and the results of the CANS IL Module strengths and needs categories associated with the FPP. The following areas are addressed in the Transition Plan, as applicable:

Subject: Transition Planning

	a. Life Skills; b. Social Skills; c. Permanency; d. Healthy and Supportive Relationships; e. Education; f. Employment; g. Essential Documents; h. Housing; i. Home Management Skills; j. Finances and Money Management; k. Credit Check; l. Transportation; m. Physical and mental health including information about the importance of designating a person to make health care treatment decisions if the young adult becomes unable to participate in such decisions and continuation of health insurance; n. Pregnant/Parenting; and o. Exit Trajectory (i.e., Reunification, Permanency, Extension of Foster Care, Aftercare, or no DSS continued partnership) p. Local Opportunities for Mentors. 4. Formalizing DSS Form 30206 must be personalized at the direction of the youth or young adult, be as detailed as they choose, include specific action steps with timeframes, and identify a support system to be held accountable for agreed upon action commitments and progression. 5. The foster care or permanency case manager shall coordinate participation from the following individuals: a. Young adult; b. Any supportive adults identified by the youth or young adult; c. Bridge Navigator; d. Transition Services and Support (TSS) Representative, Transitional Youth Advocate, TSS Team Lead, or TSS Program Coordinator, if applicable, to support transition into Extension of Foster Care; e. Placement Services Coordinator when there is a potential need for identifying a new licensed placement; f. Internal DSS representatives, if applicable, to identify additional support and services; and g. External community organizations, if applicable, to identify additional support and services. 6. The foster care or permanency case manager shall make reasonable efforts to: a. Assure there are more non-professionals than professionals;
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Subject: Transition Planning

	b. Assure all appropriate members of the youth's care team are present; c. Assure proper assessment of level of care and needs are being met; d. Elicit the full participation of the youth; and e. Provide multiple platforms for participation to include, but not be limited to, in-person meetings, virtual platforms (Microsoft Teams, Zoom, FaceTime), and conference telephone calls. 7. DSS Form 30206 is signed by all parties and copies are provided to the youth or young adult and other individuals involved in the development of the plan. 8. The signed DSS Form 30206 shall be saved in the youth's or young adult's case file, linked in CAPSS, and entered into CAPSS dictation with the code "Transition Plan" to capture completion of required tasks. 9. The Transition Plan is filed in accordance with DSS filing requirements for Family Court. 10. The completed DSS Form 30206 is required to access Chafee and/or ETV funded services. 11. The department or a contracted provider must conduct an administrative case review no less frequently than once every 6 months to review the young adult's Transition Plan and progress toward achieving goals that lead to a successful transition to adulthood. Additionally, every 12 months for the duration of the young adults stay in foster care, the Family Court shall continue to review in a permanency planning hearing the young adult's Transition Plan and progress toward achieving goals that lead to a successful transition to adulthood.
E. Impairments to Participating in Transition Planning and Formalizing the Plan	If a young person's physical, intellectual, emotional, or psychiatric impairment prevents participation in their own transition planning and/or transition plan meeting, the following shall occur: 1. The foster care or permanency case manager schedules a Transition Plan meeting, making diligent efforts to assure all appropriate members of the youth's care team are present, proper assessment of level of care and needs are being met, the youth's Transition Plan addresses all applicable items as set forth in subsection (D) above, and that a Family Court hearing will be held prior to the youth's 18th birthday wherein the department can receive a judicial determination whether, based upon physical, intellectual, emotional, or psychiatric impairment it is in the youth's best interest to remain in foster care beyond the youth's 18th birthday so that the department can assist the youth in making a safe and successful transition from the State's foster care system.

Subject: Transition Planning

	2. In the event DSS does not obtain a court order to extend foster care for an impaired young adult prior to the young adult's 18th birthday, the foster care or permanency case manager shall schedule a case consultation with agency counsel to evaluate alternatives. The department or a contracted provider must conduct an administrative case review no less frequently than once every 6 months to review the young adult's Transition Plan and progress toward engaging supportive services for the young adult. Additionally, every 12 months for the duration of the young adults stay in foster care, the Family Court shall continue to review in a permanency planning hearing the young adult's Transition Plan and progress being made to co-ordinate supportive services.
F. Interstate Compact on the Placement of Children	1. If a youth is placed in another state through the Interstate Compact on the Placement of Children (ICPC), DSS shall collaborate with the receiving state to ensure transition planning is occurring. 2. If the ICPC case manager is unable to complete the transition planning process as described, the DSS case manager remains responsible to work with the youth or young adult to develop a Transition Plan. 3. The foster care or permanency case manager is responsible for: a. Regularly monitoring the Transition Plan; b. Making reasonable efforts to provide timely and appropriate services; and c. Regularly reviewing and updating the goals and services of the identified Transition Plan.
G. Review	1. The foster care or permanency case manager must provide a copy of the Transition Plan to the following: a. Family Court at the initial hearing on the Voluntary Services and Support Agreement b. Family Court at the next scheduled Permanency Planning Hearing; c. Six-month Foster Care Review Board reviews for youth under the age of 18; d. Child and Family Team Meetings; and e. Six-month DSS administrative case review for young adults ages 18-21; f. Case consultations. 2. Any review conducted is to determine and make findings regarding whether: a. The plan is adequate to support the youth's successful transition to adulthood; b. DSS has made reasonable efforts to offer appropriate services pursuant to the plans; and c. DSS has involved the youth in the development of the plan.

Subject: Transition Planning

	3. The foster care or permanency case manager is responsible for updating the Transition Plan with the following information: a. Any progress in achieving the goals of the Transition Plan; b. Any barriers and plans to address the barriers; c. Any changes in the Transition Plan made by the youth; and d. Notification to service providers of changes to the Transition Plan.
H. Development of the Transition Plan for Young Adults Receiving Extension of or Re-Entry to Foster Care Services	1. The Transitional Youth Advocate (TYA) case manager of young adults receiving Extension or Re-Establishment of Foster Care Services shall utilize the CANS IL Module to evaluate the young adult's strengths and needs and assess knowledge, skills, and abilities. The TYA case manager uses the CANS IL Module to develop appropriate goals and activities in the young adult's Transition Plan. a. Within 30 days of opening the Extension of Foster Care line, the TYA case manager completes a full review of the CANS. b. At a minimum, TYA case manager updates the CANS IL Module IL every 90 days c. Before any 6-month administrative review (please see the Young Adult Transitional Teaming (YATT) policy). d. Before annual Permanency Planning Hearings in Family Court. 2. The TYA case manager shall review and update DSS Form 30206, at minimum, every six months. Transition Planning for these young adults is completed in the context of specified goals with timeframes to measure readiness. 3. The core IL domains, addressed by the case manager, must be personalized at the direction of the young adult and be as detailed as the young adult chooses. 4. It is acceptable to utilize the Transition Plan developed just prior to exiting custody for young adults that transition directly to Extension of Foster Care services, but the plan must be revised to reflect the young adult's current circumstances and needs. 5. The Transition Plan for young adults receiving Extension of Foster Care services shall be filed in accordance with DSS and Family Court guidelines. 6. The completed Transition Plan is required to access Chafee and/or ETV funded services. 7. The Transition Plan shall be reviewed and updated in the 90 days immediately prior to exiting foster care.
I. Transition Plan Amendment	1. DSS Form 37182: Transition Plan Amendment is utilized for former foster youth who at, or after, age: a. 14 achieved reunification and are receiving Chafee/ETV funded services;

Subject: Transition Planning

	b. 16 achieved permanency through adoption or legal guardianship, and are receiving Chafee/ETV funded services; c. 18 reached the age of majority while in DSS custody and is accessing aftercare services; d. 21 and receiving ETV funded services; and e. 18 and have not reached their 26th birthday receiving any services and support from DSS or a contract provider. 2. The Transition Services and Support Program Coordinator or contract provider shall utilize the information from the last known Transition Plan created while in DSS custody to inform the development of the amended transition plan. 3. At a minimum, DSS Form 37182 shall be updated annually to track goals and outcomes and provide service navigation that removes or mitigates identified barriers. 4. The Family Court does not review the cases of former foster care youth who are utilizing Aftercare services provided by DSS or a contracted private provider. 5. The TSS Program Coordinator must save and link DSS Form 37182 in CAPSS. 6. A copy of DSS Form 37182 shall be provided to the client by either the TSS Program Coordinator or the contracted private provider. Note: <i>Contracted private providers are required to provide all DSS referred clients with Transition Planning meetings and written summaries of meetings in accordance with DSS contract requirements.</i>
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Forms and Related Documents	DSS Form 30206: Transition Plan DSS Form 30198: John H. Chafee Foster Care Program for Successful Transition to Adulthood Funding Request DSS Form 37166: Education and Training Voucher Application DSS Form 37182: Transition Plan Amendment
Related Management Reports	CANS Report CAPSS Transition Plan Report: CAPSS – Report-Batch – Foster Care and Licensing – Case Management – Transition Plan – SF194-R01/R02/R03

Glossary	
Adolescent Teaming: an approach where young people are centered and supported by staff and partners as they prepare for their transition to adulthood. This approach emphasizes the importance of alignment, partnership, and integrated support for transition age youth. It demonstrates the continuum of care. It is everyone's responsibility including the community, care providers and family of origin to prepare and support youth into young adulthood and their departure from foster care.	

Subject: Transition Planning

Authentic Youth Engagement: Young people are valued as equal partners, respected as having significant input in co-developing case planning, transition planning, short- and long-term goals, advocacy, and leadership development.

Bridge Navigator: The TSS staff trained and assigned to facilitate Young Adult Transitional Teaming (YATT) meetings when a young adult reaches the age of 18. Bridge Navigators implement referrals, engagement, planning, and support to promote a young adult's continuum of care in life skills development, stability, safety, permanency, and well-being. Bridge Navigators must participate in the CFTMs for young adults age 17 and up to 17.5 years old. The Bridge Navigator may participate, as needed, in transition meetings and/or CFTM planning at ages 14-16 where they provide guidance and support.

Child and Adolescent Needs and Strengths (CANS): a multipurpose information integration tool which best exemplifies strength-based, culturally responsive, and family focused casework practice. The CANS produces the least stigma or label for the children, youth, and families served. It provides a collaborative communication means for understanding the treatment needs of youth and making decisions about care and services. The CANS assesses the needs of children and youth to assist with matching services to needs.

Child and Family Team Meeting (CFTM): a family-centered, trauma-informed, individualized, strengths-based, and culturally responsive meeting. The meetings are a goal oriented and problem-solving processes that brings together the Child and Family Team to make decisions about the safety, permanency, and well-being of a child through the development of an individualized Family Permanency Plan. CFTMs are planned ahead of time to provide more opportunity for meaningful participation by all members. Interpreter services and other accommodations are scheduled as needed.

Educational and Training Vouchers (ETV): Grants, funded by the federal government and administered by the states, awarded for youth or young adults who experienced foster care after age 14 and who are pursuing post-secondary education in an approved educational program. ETV awards of up to \$5000 per year to cover the unmet needs of the students cost of attendance at a post-secondary educational institution are available for up to five (5) years or until the young adult's 26th birthday, whichever comes first.

Extension of Foster Care (EFC) Services: Assistance provided to an eligible young adult who ages out of foster care at age 18, and who is between 18-21 years of age during service delivery, to obtain education, housing, employment, well-being, health services, and to establish permanent supportive relationships. The young adult receives a foster care board payment, paid through a foster parent, group home, or supervised independent living setting, unless the young adult is living independently. If the young adult is living independently all or a part of the foster care maintenance payment is paid directly to the young adult.

Family Permanency Plan (FPP): the sole case plan developed collaboratively with the family to describe the reasons for SCDSS involvement, and the actions and services required to change behaviors and eliminate safety concerns, reduce risks, and promote the safety, permanency, and well-being of the child and family

Placement and care responsibility: The authority conveyed through the court, through written authorization prior to the child's eighteenth birthday, or through a

Subject: Transition Planning

Voluntary Services and Support Agreement to provide supervision of the young adult and the young adult's placement.

Placement Services Coordinator: the employee responsible for identifying safe, stable, and appropriate licensed and/or contracted placement for young adults.

Supportive Adult: an individual who is at least 18, contributes to the well-being and personal development of a young adult and may provide emotional, educational, moral, and physical support to a young adult. Supportive adults can be in various roles including friend, mentor, sibling, family, caregiver, parent, and foster parent.

The John H. Chafee Foster Care Independence Program (Chafee): Provides funds to assist current and former foster care youth or young adults in achieving self-sufficiency. Funds assist youth or young adults in a wide variety of areas designed to support a successful transition to adulthood. Activities and programs include, but are not limited to, help with education, employment, financial management, housing, emotional support, and maintaining connections to caring adults.

The National Youth in Transition Database (NYTD): a national database that surveys youth about their thoughts and experiences related to foster care services and tracks the Chafee services that youth receive

Transition Plan: a case plan that is personalized, as detailed as the youth or young adult may elect, and that includes specific options on housing, health insurance, education, local opportunities for mentors, and for continuing support services, work force supports, and employment services . A Transition Plan also must include information about the importance of designating another individual to make health care treatment decisions on behalf of a young adult if the young adult becomes unable to participate in such decisions and the young adult does not have, or does not want, a relative who would otherwise be authorized to make such decision and provides the young adult with the option to execute a health care power of attorney or health care proxy.

Transitional Planning: ongoing process beginning at age 14, the goal of which is to develop a Transition Plan as defined in this policy, identifying skills, services, and supports needed in several life domains, to promote successful transition into adulthood.

Transition Plan Meeting: A meeting that is youth/young adult- centered, culturally responsive, goal-orientated, and problem-solving processes that bring together the youth/young adult and identified support transitional Team to support decisions about safety, permanency, and well-being through the development of an individualized permanency and Transition Plan. TPM are planned so that meaningful participation and preparation for all members is possible.

Transitional Youth Advocate: The TSS staff assigned primary responsibility for case management support, including engaging and preparing the young adult for permanency and a successful transition to adulthood by developing and implementing a Transition Plan, in collaboration with the young adult, private providers, supportive adults, and extended team members.

Transitional Supports and Services (TSS) Team Lead: the TSS staff assigned to support and manage Transitional Youth Advocates and Bridge Navigators and who promotes alignment with Regional Case Manager Team Supervisors and Managers regarding transition age youth. They are also trained team meeting facilitators

Subject: Transition Planning

Voluntary Services and Support Agreement/Voluntary Placement Agreement: a written agreement, binding on the young adult and DSS, which describes at a minimum, the legal status of the young adult, as well as the rights and obligations of the young adult and the department while the young adult is under the placement and care responsibility of the department.

Young Adult: a person aged 18 and no older than 26 years of age.