POLICY SOLUTIONS TO ADDRESS THE BARRIERS TO MEDICAID RE-ENROLLMENT FOR YOUTH AGING OUT OF FOSTER CARE

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# TABLE OF CONTENTS

**EXECUTIVE SUMMARY** ........................................................................................................... i-ii

**REPORT** ................................................................................................................................. 2-23

- Identified Issues ....................................................................................................................... 10-15
- Criteria ........................................................................................................................................ 16
- Solutions ..................................................................................................................................... 17-19
- Analysis ..................................................................................................................................... 20-22
- Recommendations .................................................................................................................... 23

**REFERENCES** .......................................................................................................................... 24-27

**APPENDICES** .......................................................................................................................... 28-49
EXECUTIVE SUMMARY

POLICY QUESTION

What are the Federal and State policy solutions to the barriers for youth re-enrolling into Medicaid once they have left care?

RECOMMENDATIONS (p. 23)

I recommend three solutions that the Children’s Bureau should consider to address the barriers of Medicaid re-enrollment for youth aging out of foster care.

The Children’s Bureau should:

- Support states in making the transitions onto Medicaid after foster care a seamless process.
- Encourage restructuring of the independent living programs.
- Study the possibility of a change in institutional mechanisms.

IDENTIFIED ISSUES (pp. 10-15)

Nationally about 30,000 of the half million youth in state custody will age out of care this year\(^1\). Youth aging out of care are at greater risk of unemployment, homelessness, dropping out of school, and unplanned parenthood\(^2\). These transition age youth report more health problems and mental health diagnoses, than their peers who have not been in the child welfare system\(^3\). Unfortunately many recently emancipated young adults do not have health insurance; this makes swift and appropriate interventions much harder to achieve.\(^4\)

I have identified four barriers to youth re-enrolling into Medicaid once they have left care. First, there is a lack of knowledge at the service delivery level, for both Medicaid enrollment staff as well as independent living coordinators. This is likely due to high turnover amongst staff in both divisions. Second, for youth that have aged out of care

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\(^1\) US Department of Health and Human Services, Administration for Children and Families, Children’s Bureau “The AFCARS Report 2009”.


there is a lack of knowledge of the Medicaid option. There is variability in how
independent living programs are delivered and some states and counties may not have
a set curriculum for teaching transition age youth about their benefits. Third, once youth
have left foster care they have shown a strong desire to disassociate with “the system”. Lastly, youth who have aged out of foster care lack healthy adult connections. These
are adults that many transition age youth can turn to help them understand their
insurance or how to make a doctor’s appointment. Former foster youth often do not
have a parent or other supportive adult they can turn to for help.

CRITERIA (p. 16)

I use the following criteria to analyze my solutions:

- Minimize costs for key stakeholders.
- Create collaborations among stakeholders.
- Assist states in their preparation for providing health insurance for all youth that
  age out of care until age 26.

POLICY SOLUTIONS (pp. 17-19)

The five policy solutions I evaluate are:

1. Support states in making the transition onto Medicaid after foster care a
   seamless process.
2. Encourage restructuring of the independent living programs.
3. Study the possibility of a change in institutional mechanisms.
4. Support collaborations with service providers outside of DSS.
5. Encourage states to develop websites that clearly communicate eligibility
   benefits for stakeholders.
REPORT:
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TO MEDICAID RE-ENROLLMENT FOR YOUTH
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REPORT:
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POLICY QUESTION

What are the Federal and State policy solutions to the barriers for youth re-enrolling into Medicaid once they have left care?

BACKGROUND

Profile of a Young Adult Leaving Care

Nationally about 30,000\(^5\) of the half million youth in state custody will age out of care this year. Aging out occurs when a youth becomes emancipated at age 18 (in some cases 16 or 17) and is no longer under the supervision of the state court system; meaning out of Child Protective Services (CPS) care.

Youth aging out of care are at greater risk of unemployment, homelessness, dropping out of school, and unplanned parenthood. These youth are more likely to commit crimes or be victimized than their peers who have not been in the state welfare system.\(^6\)

The average youth preparing to age out of care is likely to face the responsibilities of adulthood with little transition time or significant monetary support. Most youth that are on track to age out of foster care will wait in care for at least five years before being emancipated. Several studies have estimated that within two years of leaving care one in four youth will be incarcerated and over one fifth will spend some portion of time homeless. Education outcomes are more grim, with only about 3 percent earning college degrees, compared with 28 percent of their peers that were not in foster care.\(^7\) \(^8\)

\(^7\) Casey, J. (2007). Aging Out and On Their Own.
Many of these young adults report health problems and mental health diagnoses. More troubling is the fact that many recently emancipated young adults do not have health insurance; this makes swift and appropriate interventions much harder to achieve.

As of September 30, 2009, there were 423,773 children and youth in foster care. Within this population about 35,000 (or 9 percent of the total population) were 17 years old. About 12,000 (or three percent of the total population) were 18 years old. Less than two percent of the entire population in foster care is over the age of 18, meaning those that have signed themselves into care pass their emancipation date. The population of 19 and 20 year olds is about 6,000, showing that the overwhelming majority of youth do not stay in care past their eighteenth birthdays.

The Problem: Too Few Youths Leaving Foster Care are Enrolled in Medicaid

Young adults leaving foster care have greater medical needs than their counterparts that have not been in foster care. These transition age youth have numerous medical needs, but are not accessing the appropriate health care. Currently only 30 states have extended Medicaid to this vulnerable population.

Based on case worker experiences, one of the major problems articulated is that youth who have aged out of care do not have access to health care due to their lack of insurance.

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13 Ibid.
14 Interviews by author.
In various studies “between one-third and one-half of former foster youth...confirmed they experienced difficulties in accessing health care, with many citing lack of health insurance as a major reason, although not the only barrier”.\(^{15}\)

Resolving the issue of Medicaid enrollment is even more pressing with the passing of the Patient Protection and Affordable Care Act of 2010\(^{16}\). Under the current law, all states will be required to extend Medicaid to all youth that have aged out of foster care until they are 26\(^{17}\). This will be especially challenging for the 20 states that have not taken the option to extend coverage under the current Chaffee option. For these states, the identification and dissemination of best practices will be paramount.

**Policy History and Status**

The Children’s Bureau was created in 1912 and would become the agency responsible for the implementation of legislation aimed at protecting vulnerable youth. The Sheppard-Towner Act soon followed, which supplied funds for health services for mothers and children in the 1920s.\(^{18}\)

With President Roosevelt’s “war on poverty” and Congressional passage of the Social Security Act, made more funding and services available for poor families. In 1974, the Child Abuse Prevention and Treatment Act (CAPTA) was established and granted states authority through Child Protective Services divisions, as well as federal funding to the states.\(^{19}\)

The policies surrounding abused and neglected children began at the Federal level. When states were granted authority there was no single prescribed program or policy in place directing the provision of services. This system is further complicated in states that are county-administered\(^{20}\), such as North Carolina. County administered states have individual Departments of Social Services in each county, but are funded by the state. Each county sets its own policies and develops its own programs within the framework of Federal and State policies and laws.

Initially these laws were effective in protecting children and removing them from harmful situations, they also increased the foster care population tremendously. As a result, legislation including the Adoption Assistance and Child Welfare Act of 1980 and the 1993 Family Preservation and Support Act was passed. Policymakers hoped this would

\(^{16}\)------ (2010). Patient Protection and Affordable Care Act. p. 191
\(^{17}\) Ibid.
\(^{19}\) Ibid.
\(^{20}\) CA, CO, GA, MD, MN, NV, NY, ND, OH, PA, VA & WI.
“prevent unnecessary removals and... provide more preventions and early interventions services for struggling families”.

The most important legislation for youth aging out was passed in 1999. The John Chafee Foster Care Independence Program (CFCHIP), “offers assistance to help current and former foster care youths achieve self-sufficiency”. The funding is offered to states through grants allowing for programs on job training, education vouchers, financial management, and transportation. The program was created for the growing numbers of youth aging out of care. The funding level in 2009 was $140 million.

Another key legislative reform since the Chafee Program is the Fostering Connections Act of 2008. This legislation “reformed child welfare policy for the first time in more than ten years”. The policy made changes to create and facilitate permanency through improving outcomes in six key areas; one of which was older youth. Fostering Connections provides greater flexibility in funding for youth that have aged out of care or remain in care past their eighteenth birthday. Another critical component of this legislation was the "requirement that personal transition plans for youth aging out are developed within 90 days prior to youth exiting foster care".

An example of a transition plan can be found in Appendix A.

Summary of Practices across States

As a result of the Chafee Foster Care Independence Program each state has its own set of implementation tools and programs that best fit its population. For example in North Carolina, the program is called LINKS. The NC LINKS program aims to build “a network of services available to youth transitioning into self-sufficiency”. Consistent with the purpose of the funding through the Foster Care Independence Act, NC LINKS provides courses on obtaining employment, navigating housing, accessing public transportation and budget/financial management.

In South Carolina, many of the services and programs for youth aging out of care are provided through a contract with the Foster Parent Association, which is very active in the state. In conjunction with the Department of Social Services (DSS), the Foster Parent Association provides numerous trainings including training foster parents in Ansell Casey Life Skills assessments. (See Appendix B)

26 NC DSS. "NC Links". 2010.
27 Pridgen, Helen, South Carolina Department of Social Services State Supervisor Chafee
If these programs are completed successfully, youth are eligible for funding that can be used for: housing, transportation or education. Although many states have similar programs, not all young adults are enrolled in them. In one survey “less than half of the youth exiting care had received any transitional services”\textsuperscript{29}. The variability across counties is caused by many factors, but some experts have pointed to a motivated and passionate staff as well as increased collaboration at the county level\textsuperscript{30}.

A complete list of programs and services offered can be found in Appendix C.

Aging is not the only option for youth in foster care once they turn 18; another alternative is to voluntarily remain in care. In North Carolina this is called a Contractual Agreement for Residential Services (CARS)\textsuperscript{31}. In South Carolina youth apply to “after care services”\textsuperscript{32}. In most states this requires the young adult to meet certain requirements, such as full time vocational training, employment, education, and residency in a licensed foster care placement\textsuperscript{33}.

\textsuperscript{32}Pridgen, McLean-Titus, and Tester, 2011.
\textsuperscript{33}National Child Welfare Resource Center for Youth Development (2009).
LITERATURE REVIEW

Health Status and Delivery

The health status of youth in foster care is the most dire of all low-income youth. Foster care youth have been compared with their counterparts who qualify for Medicaid under the Aid to Families with Dependent Children (AFDC) program in several states. Their health outcomes are, in many instances, at least twofold worse than their counterparts that did not enter the foster care system. In one study “25% of foster care youth used mental health services, compared with 3% of AFDC children”. 34

The severity of these illnesses is also a cause for concern for policymakers and practitioners. Foster youth suffer at a higher rate than AFDC children from mental illnesses, depression, anxiety disorder, and ADHD35. The children in foster care are the most expensive of all youth in terms of health care expenditures. In California, foster care youth “represent less than 4% of the entire Medicaid-eligible population but accounted for over 50% of all mental health claims”36.

Although older youth in foster care suffer from mental illness in greater proportion than younger youth, they also struggle with physical health issues. In one study transition age youth were found to suffer from ulcers, respiratory disorders and chronic pain. In the same study older foster youth were shown to have a prevalence of cardiometabolic conditions at a rate of 22%37; this is above the national average of 10% of youth, ages 16 to 2138.

There are many factors that contribute to the poor health of foster care youth. These include the majority of the precipitating factors that would cause placement: poverty, lack of prenatal care, and parental substance abuse. There is also a lack of policy directing case managers and service providers to make health care provision a priority.39

38 -------- (2011). "What is Cardiometabolic Risk?"
Most troubling are the realities faced by older youth who will age out of care. Many of these youth have high needs, both developmentally and behaviorally, and have been placed in institutionalized or group care\textsuperscript{40}. As a result, they have become accustomed to highly structured care and may not have the necessary independent living skills to be successful after care\textsuperscript{41}. Older youth also account for the most mental health issues: 12-17 years olds accounted for 25\% of all foster youth with a mental illness diagnosis in a national study\textsuperscript{42}. With a large percentage of youth aging out on psychotherapeutic medications, there are concerns about how these medications will be acquired if the youth do not continue to re-enroll into Medicaid\textsuperscript{43}.

Although it is unclear nationally how much health care youth who have aged out require the anecdotal evidence points to minimal cost to the states. These costs represent youth who have managed to navigate an often complex system and are utilizing their health insurance.

\begin{table}
\centering
\begin{tabular}{|l|l|}
\hline
\textbf{STATE} & \textbf{AVERAGE PMPM COSTS} \\
\hline
California & $111.16 - $231.00 \\
Florida & $198.41 \\
Iowa & $306.57 \\
South Carolina & $350.00 \\
Texas & $227.85 \\
\hline
\end{tabular}
\caption{Comparison of Per Member Per Month Costs among States that Have Taken the Option}
\end{table}


\textsuperscript{41} Ibid.


\textsuperscript{43} McMillen et. al (2004) p.815.
DATA & METHODS

The Problem Statement

Youth aging out are not re-enrolling into Medicaid. This population has greater needs, specifically mental health diagnoses, than their peers who were not in care. Without basic health care needs being met, these youth will have poor outcomes in acquiring housing, education and employment necessary for successful independent living.

Question

- What are the barriers to youth re-enrolling into Medicaid once they have left care?
- What are possible recommendations for state and local governments that the Children’s Bureau should consider to increase Medicaid enrollment for youth who have aged out care?

Levels of Analysis

State: How can the policy and implementation be improved at the state level to ensure more youth re-enrolling into Medicaid?

- Among the states that have opted into the Medicaid waiver, what are the best practices? What is the variability within these states?

Federal: Is there a federal policy option that would improve implementation in the states to increase re-enrollment?

- Is the requirement that youth remain in foster care or other state approved out-of-home placement a barrier to Medicaid re-enrollment? If so, how can this requirement be changed?
- What are the costs to states if all youth who have aged out are eligible for Medicaid regardless of being signed into care? What states, if any, have provided coverage regardless of remaining in care?

Together with Catherine Heath, Federal Project Officer at the Children’s Bureau and with the input of Sanford School Mater’s Project committee members I created the following research strategy:

1) Examine research about Medicaid access for youth aging out of care and current policies.
2) Evaluate the extent to which current curricula of classes and programs for youth aging out emphasize Medicaid enrollment and benefits.

3) Conduct interviews with independent living coordinators at the service delivery level and with policy stakeholders at the state level.

4) Examine best practices of current programs that have produced positive outcomes in youth maintaining their Medicaid insurance. If possible, plan a site visit to these various programs or interview staff by phone.

5) Interview youth who have aged out of care to determine what, if any interventions would have helped them enroll into Medicaid.

The majority of my qualitative data is from the Child and Family Service Plan (CFSP)\(^44\) and the Child and Family Services Reviews Annual Progress and Service Report (APSR)\(^45\). These reports are produced by the states in conjunction with the Administration for Children and Families. They provide an extensive report of the services offered and performance measures. I am particularly interested in the survey results for participants in LINKS programs as their measure can be compared with similar data from other states.

There is little data on how much health care services youth that have aged out of care are utilizing. In North Carolina this data is currently being collected by Joy Stewart at the UNC School of Social Work. It should be complete at the end of 2011\(^46\). Nationally more data about health care needs and youth who are aging out is being gathered in the first round of the National Youth in Transition Database (NYTD) survey which begins collecting data on 17 year olds this year\(^47\).

I attempted to contact youth who have not been as “successful” in their transition to adulthood to obtain a more representative sample, but was unsuccessful.

Please see Appendix D for a complete list of my interview questions.

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\(^{45}\) Children’s Bureau. “Annual Progress and Service Report”


IDENTIFIED ISSUES

Through my research and interviews with key stakeholders I have identified four barriers to Medicaid re-enrollment and access to services.

Lack of knowledge of the Medicaid option and available services at the service delivery level

Both within the Medicaid enrollment office and at the independent living program level, there is a lack of knowledge of the Medicaid extension option, how to access services and who is eligible.

The only reason I enrolled into Medicaid was because I was pregnant. When I aged out I didn’t know where to go or what to do. ~ Former Foster Youth

One of the contributing factors to the lack of knowledge is high turnover rates among staff throughout social services. Child welfare case workers turnover rates are between 20 and 40 percent; such turnover requires significant time spent training new employees and attempting to regain the lost institutional knowledge48.

Youth need to have a stable worker. Having a constant presence in their life makes it easier for them to absorb the messages from someone they trust. Having a new worker every six months deters progress. ~ State Independent Living Coordinator

We found that a lot of Medicaid case workers were unaware of the policy so annually we try to send out a reminder email about the policy, but we know that is not catching everyone, there will be continued turnover in their offices as well. ~ State Independent Living Coordinator

Lack of knowledge of the Medicaid option and available services among youth who have aged out of care

There is variability among the states in the curricula and method that each state uses to deliver services under The Chafee Foster Care Independence Program, as mandated by the Federal government. For instance in North Carolina there is no curriculum for the LINKS classes in teaching youth what they are eligible for, how to make a doctor’s appointment\(^{49}\). When health issues are discussed, the conversation usually focuses on risky behaviors to avoid\(^{50}\). This varies among county staff implementing the independent living skills programs\(^{51}\).

\begin{quote}
I don’t have a curriculum for teaching about Medicaid. I rely heavily on when the youth attend the Real World [one day independent living simulation] and go to the Medicaid workshop. ~ County Independent Living Coordinator
\end{quote}

\begin{quote}
When I was in LINKS the discussion about Medicaid was very vague. We never reviewed paperwork. We never went over requirements. Most youth assumed that if someone isn’t taking care of it they’re not going to do it either. ~ Former Foster Youth
\end{quote}

Other states such as South Carolina have a defined curriculum they use for all youth planning to age out of care. In South Carolina all youth are required to work through the Casey Life Skills Assessments\(^{52}\) before they exit care. It is during this time that caseworkers identify the skills that the youth need to develop before leaving foster care, and incorporate those skills into their case plans. Furthermore, there are 46 active foster parent associations in South Carolina that train foster parents for older youth in the Casey Family assessments.\(^{53}\)

\begin{quote}
Through Fostering Connections we already have an exit interview and have to identify the transition plan. The Casey Life Skills offers a way to develop the treatment plan and manage the health and wellness of our exiting youth. ~ State Independent Living Coordinator
\end{quote}


\(^{50}\) Ibid.

\(^{51}\) Eberly, Jason, Alamance County Department of Social Services, LINKS Coordinator.

\(^{52}\) Casey Family Programs (2011). "Casey Life Skills."

\(^{53}\) Pridgen, Helen, McLean-Titus and Tester, 2011.
Desire to disassociate with “the system”

Youth have shown a desire to leave the system as soon as possible. For many older youth in foster care their experience has been less than ideal. The average length of stay for a teenager in foster care is 9.6 months\(^{54}\). Older youth are more likely to re-enter foster care: one study found that of 13-17 year olds 28% returned to care within a year of leaving\(^{55}\). Transition age youth are also more likely to experience multiple placements, with 18% having two or more placements\(^{56}\). They are also the most likely age group to change their living arrangement within the first six to twelve months in care\(^{57}\). All of these factors contribute to a desire to leave the system as soon as possible.

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I considered the CARS but I didn’t take it because I wanted to be out of DSS. After being in so long I didn’t want someone telling me what I could and couldn’t do. I thought that was what the CARS would be like and I didn’t want it to continue.

~ Former Foster Youth

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The average young person leaving care has a lot of distrust and discontent with the system. All they are focused on is disconnecting from DSS…they constantly think I have spent X amount of years in DSS, I want to return home where DSS can’t control me or when and how I see my family. ~ Advocate for Transition Age Youth

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Many youth want to be separated from DSS as soon possible. Many of the youth I’ve seen have a bad taste in their mouth from their experience. ~ Child Welfare Advocate

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The reapplication process does not happen. They have filled out forms for years and are tired of it. Youth don’t even want to apply for SNAP, knowing that it will save them money, because they dread going to the benefits office. ~ Advocate for Transition Age Youth

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\(^{54}\) US Department of Health and Human Services, Administration for Children and Families, Children’s Bureau “The AFCARS Report 2009”.


\(^{56}\) Ibid. p.5.

\(^{57}\) Ibid. p.5.
Often youth who do return for help and guidance are met with an overwhelmed caseworker. That caseworker often has to make difficult choices between a youth that left foster care when they reached 18 or a youth on their current caseload. For one independent living coordinator, his five foster care cases on top of his independent living program duties leave him feeling stretched thin. In the current state of budget deficits and cuts, this experience will be more likely.\(^58\)

The data shows that youth are exiting care at 18 and are choosing not to remain in care. In 2009, 18 year olds accounted for 10\% of all exits in foster care for a total of 26,416 youths exiting. For youths who chose to remain in care past their 18\textsuperscript{th} birthday, their likelihood of exiting care was significantly decreased: 19 and 20 year olds accounted for less than 3\% (6,050) of exits from foster care\(^59\). This is concerning because several studies show that remaining in care “increased the likelihood that young adults...would receive the medical, dental, and psychological care they perceived they needed”\(^60\).

\begin{figure}
\centering
\includegraphics[width=0.5\textwidth]{youth_exiting_foster_care.png}
\caption{Youth Exiting Foster Care}
\end{figure}

\(^{58}\) Eberly, 2011.

\(^{59}\) US Department of Health and Human Services, Administration for Children and Families “The AFCARS Report 2009”.

Lack of healthy adult connections

Many independent living programs stress the importance of healthy adult connections. This can come from many sources: aunts, uncles, grandparents, faith community leaders, teachers, caseworkers or foster parents\textsuperscript{61}. In North Carolina, the goal of the LINKS program is to identify five permanent connections using various strategies such as identifying relatives and incorporating them into that young person’s transition plan\textsuperscript{62}. Each plan is case specific and unique to that particular youth aging out of foster care\textsuperscript{63}.

When I think about my youth that are most motivated, a lot of their motivation comes from social support they receive at home. Many of them are motivated by their foster parents…The support piece is the key to being successful. I see the correlation of success with their network. ~ County Independent Living Coordinator

Part of my success was an active social worker. My independent living coordinator was also my caseworker so that made it easier... my social worker was my backbone in everything I did and helped me tremendously. ~Former Foster Youth

These healthy connections are likely to be the resources that youth rely on most once they have aged out of care. When a youth has a stable network they are likely to have someone to give them advice on where to access services, how to re-enroll into Medicaid and how to continue appropriate socialization into adulthood\textsuperscript{64}.

Too often, however, these youth do not have those type of connections and are intimidated by complex systems like Medicaid to obtain the rights which they are entitled. For instance, the average 18 year old has someone to call when they do not understand what a co-pay is or how their insurance works; youth who have aged out of care are forced to navigate life as an adult without these critical social supports.\textsuperscript{65}

\textsuperscript{61} NC DSS. "NC Links". 2010.
\textsuperscript{62} Britt and McConga, 2011.
\textsuperscript{63} Ibid.
\textsuperscript{64} Eberly, 2011.
CRITERIA

The following criteria are the standards by which I analyzed each potential solution. The analysis considers how well each solution to the barriers to Medicaid re-enrollment meets each criterion.

- Minimize costs for key stakeholders. The economic recession has constricted budgets of non-governmental organizations and government agencies at every level.

- Create collaborations among stakeholders. This will ensure the most fluid and effective service delivery.

- Assist states in their preparation for providing health insurance for all youth that age out of care until age 26. This Federal requirement is outlined in the Patient Protection and Affordable Care Act of 2010.
POLICY SOLUTIONS

I offer five policy solutions to reduce the barriers to Medicaid re-enrollment for youth aging out of care:

Solution I: Support states in making the transition onto Medicaid after foster care a seamless process.

- Youths will be enrolled into Medicaid while they are still in care and there would not be a requirement that the youth re-enroll for benefits.
- Youths will notify the appropriate office if their address changes.
- Youths will maintain the same Medicaid number if at all possible and will remain in the Medicaid system until their 21st birthday; in 2014, this will change to their 26th birthday.

Solution II: Encourage restructuring of the independent living programs.

- Establish a curriculum for independent living coordinators to teach youth about where to enroll, Medicaid benefits, how to set-up a doctor’s appointment and a schedule of how often they should be seeking routine check-ups.
- Develop evaluations for independent living programs and courses to identify gaps in youth knowledge, as well as topics that are difficult for transition age youth to understand.
- Require youth fill out their own forms. This creates more intervention and helps youth accept the responsibility for their own health insurance.
Solution III: Study the possibility of a change in institutional mechanisms.

- Change Medicaid form to ask the question: “Were you in foster care on your 18th birthday?”

- Have a designated caseworker at benefits office who is familiar with the policy and can verify the youths’ status as aged out of care. This designated caseworker will assist the youth in completing the form and enrolling into Medicaid.

- Mandate that during the exit interview for youth aging out of care they fill out their enrollment form, be able to identify their benefits, and demonstrate knowledge of how often they need to re-enroll.

- Develop an example of a completed form that youth can use to fill out the Medicaid form. This should be created with input from youth that have aged out of care.

- Collect data on the type and frequency of medical services are being utilized by youth aged out of care; this will help policy makers to better assess need.

Solution IV: Support collaborations with service providers outside of DSS.

- Develop contracts with the Department of Social Services and public/private partnerships to provide vital health care and case management services to youth transitioning into adulthood.

- An example of public/private partnerships in North Carolina is the Mélange Health Solutions, which contracts with DSS to provide a wide array of services from case management to primary care. Youth often find this system less intimidating because they do not view it as a part of “the system”.

- Appoint a working group from Medicaid enrollment and CPS to develop recommendations for improved service delivery for youth aging out of foster care.

- Develop joint trainings for independent living coordinators and Medicaid case managers to improve knowledge of populations served, policies and process currently in place.

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66 --------. (2011). “Mélange Health Solutions”.
67 Jones, 2011.
Solution V: Encourage states to develop websites that clearly communicate eligibility benefits for stakeholders.

- Websites should outline services and benefits available to youth in each particular state.

- Provide separate sections for youth, advocates and foster parents.

- Include a directory of location where youth can apply for benefits. The website would include checklists for what a youth needs when applying for Medicaid.

- Youth will be more likely to engage and seek out information through the internet than go to the Medicaid enrollment office, as it is less intimidating.
ANALYSIS

Solution I: Support states in making the transition onto Medicaid after foster care a seamless process.

Minimize costs: The costs to states and the federal government are likely to be high if all youth access health services on a consistent basis. However, data suggests that transition youth accessing these services are less likely to encounter other systems (justice system) or experiences negative outcomes (homelessness), which also come with great social and economic costs. 68

Create Collaborations: With this policy solution, there will be an initial collaboration with various divisions within each state level Department of Health and Human Services. Once the mechanisms are in place the collaborations will likely be inconsistent. One option to mitigate this would be to implement recurrent joint trainings among the different divisions.

Assists States: Making the transition a seamless process now will assist states in fulfilling their federal requirement to provide Medicaid for all former foster until age 26 by 2014, ahead of schedule. This option will also provide best practice guidance to the 20 states that have not extended Medicaid to youth that have aged out of foster care.

Solution II: Encourage restructuring of the independent living programs.

Minimize costs: When examining costs to service providers of restructuring the independent living programs, the expected impact would be minimal. Many states already have curriculums for finance or housing, creating a similar curriculum could be easily achieved. This would also be a good opportunity to engage youth that have aged out to determine the greatest need. Additionally, there are many resources online that individual independent living coordinators or states could use as models their program.

Create Collaborations: This policy solution would require collaboration between various stakeholders. It has the potential to work with non-profits, and academic researcher, as well as engage the youth voice. Businesses could be potential corporate sponsors. Additionally, health care providers would want their potential clients to be as educated as possible or familiar with their brand.

Assists States: If implemented, this could help enroll more youth aging out of foster care into Medicaid through educating more youth and allowing them to take ownership of their responsibilities once they leave care. Additionally this prepares states for the federal requirement that they provide Medicaid to all former foster youth until age 26.

68 Courtney et. al (2010).
Solution III: Study the possibility of a change in institutional mechanisms.

Minimize costs: This option is the most expensive. Collecting data and training designated caseworkers would be helpful in the long run, but with current budget crises it may be an uphill battle for policy stakeholders. There are also political costs to be considered: states run their own departments and may not welcome further mandates from the federal government. This option is to simply study the feasibility of these various mechanisms, but the political feasibility is an important piece of that analysis that should be noted.

Create Collaborations: Changing institutional mechanisms would create greater collaborations among the different divisions and increase efficiencies as well as information sharing. This could lead to the development of a system for verifying if an applicant was in foster care.

Assists States: Lastly, this option does assist states to overcome the barriers to Medicaid enrollment ahead of the 2014 federal requirement. By having stakeholders begin to think now about how to implement these policies, this option allows for greater planning and could generate best practices for other states.

Solution IV: Support collaborations with service providers outside of DSS.

Minimize costs: There is little information about the cost and benefits of contracting out services or the effectiveness of bringing a small operation like the Mélange clinic to scale. Trainings can be done cost effectively, but training all Medicaid caseworkers would likely be expensive.

Create Collaborations: This option would support collaborations at various levels: non-profit, business, policy stakeholders, etc. Cultivating new collaborations or building upon existing networks will help establish more service delivery systems so that providers can serve youth aging out of care more efficiently.

Assists States: With this option there is great deal of potential variation in how this would be implemented at the state and local level. It is hard to determine if these collaborations would help the states prepare for providing Medicaid for all youth aging of foster care until 26.
Solution V: Encourage states to develop websites that clearly communicate eligibility benefits for stakeholders.

**Minimize costs:** Minimal costs would be incurred for the website administrators. The costs would be centered on gathering the information which would likewise be minimal as much of the information already exists. Gathering the information and providing it to appropriate authorities, should not strain existing resources.

**Create Collaborations:** Collaboration would likely not be key in providing this information. The information would likely come from one organization, state agency, or non-profit providing for their particular state.

**Assists States:** This option has the potential to assist states in meeting their requirement ahead of schedule. Youth are more likely to use the internet as it is less intimidating than a Medicaid enrollment offices. This will encourage more youth to re-enrolling into Medicaid by equipping them with the appropriate information.
RECOMMENDATIONS

I recommend three solutions for the Children’s Bureau to address the barrier of Medicaid re-enrollment for youth aging out of foster care.

The Children’s Bureau should:

- Support states in making the transitions onto Medicaid after foster care a seamless process.
- Encourage restructuring of the independent living programs.
- Study the possibility of a change in institutional mechanisms.
REFERENCES


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Urban Institute (2008). Employment Outcome for Youth Who Age out of Foster Care Through Their Middle Twenties.


## APPENDICES

### Table of Contents

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A</td>
<td>Example Transition Plan</td>
<td>29-33</td>
</tr>
<tr>
<td>Appendix B</td>
<td>Casey Life Skills Learning Objectives for Health</td>
<td>34-36</td>
</tr>
<tr>
<td>Appendix C</td>
<td>List of Service for Youth Aging Out of Care by State</td>
<td>37-43</td>
</tr>
<tr>
<td>Appendix D</td>
<td>Interview Questions</td>
<td>44-46</td>
</tr>
<tr>
<td>Appendix E</td>
<td>Review of Literature and Online Resources</td>
<td>47-49</td>
</tr>
</tbody>
</table>
Appendix A

Example Transition plan

WHAT'S A TRANSITION PLAN?

A transition plan is an investment in the future – your future. It includes an overview of the skills, knowledge and resources you’ll need to prepare for life on your own as a young adult. FosterClub’s Transition Plan also provides a space to write down and keep track of all the resources that are available for you. In addition, the Plan reveals the secrets to setting clear goals custom designed for your life, along with step-by-step plans for achieving them.

The FosterClub Transition Toolkit puts you in the driver’s seat. It is designed by young adults recently transitioned from foster care for young people beginning the journey. They think of the Toolkit as your map to adult life on your own. You’re in charge. This Toolkit is your guide. It’s time to take a big step towards the adventure of your life!

The FosterClub Transition Toolkit is built around ten different domains (or topics). Each one will be part of your transition plan.

In this Toolkit, each of these domains is shown as a line on a subway map, see the next page. The “subway” map will give you a look at everything you’ll need to plan for on your way to successful life on your own.

What will success look like? That’s up to you to define!

69 FosterClub’s Transition Toolkit

Foster Club's Transition Toolkit: Self Care + Health.
## Transition Plan Overview Worksheet

### Youth Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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<tr>
<td>First Name and Initial</td>
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<tr>
<td>Last Name</td>
<td></td>
</tr>
<tr>
<td>Case Number</td>
<td></td>
</tr>
<tr>
<td>Independent Living Provider or Case Manager</td>
<td></td>
</tr>
<tr>
<td>Date Plan Completed</td>
<td>Six month follow-up due</td>
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<tr>
<td>Projected emancipation date</td>
<td></td>
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<tr>
<td>Birth date (mm/dd/yy)</td>
<td>Current age</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
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<tr>
<td>Male</td>
<td></td>
</tr>
<tr>
<td>Female</td>
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### Transition Domains

Indicate the domains included in this transition plan, along with the Readiness Score (optional).

<table>
<thead>
<tr>
<th>Completed domains</th>
<th>Date of 1st score</th>
<th>Date of 2nd score</th>
<th>Date of 3rd score</th>
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<tr>
<td>Finances &amp; Money Management</td>
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<td>Job &amp; Career</td>
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<td>Permanence</td>
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<td>Life Skills</td>
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<td>Transportation</td>
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<tr>
<td>Housing</td>
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</tr>
<tr>
<td>Self Care &amp; Health</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other (please list):</td>
<td></td>
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</table>

**Total Readiness Score:**

### Additional Plans

Have other community partners crafted a plan on behalf of the youth? □ Yes □ No

If Yes, consider including as part of this transition plan in order to reduce redundant planning and improve agency collaboration in serving the youth:

- Ansell-Casey Life Skills Plan (www.caseylifeskills.org)
- Individual Education Plan (IEP)
- Person Centered Plan
- Treatment Plan and Discharge Plan (D&A, Residential, Mental Health, etc.)
- Voc Rehab/IPE (Individual Plan for Employment)
- Development Disabilities Individual Support Plan (DD ISP)
- Temporary Assistance to Needy Families (TANF/JOBS)
- Workforce Investment Act (WIA)
- Other (please list):

### Transition Team

Attach additional sheets as necessary

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Phone Number</th>
<th>e-Mail</th>
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</table>

I participated in creating and approve of this Transition Plan. Youth’s Signature: 

Visit [www.fosteringconnections.org](http://www.fosteringconnections.org) for more federal and state information regarding the Fostering Connections to Success and Increased Adoptions Act.

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During the transition to adulthood, surprises about the costs of health and self care often take young people by surprise. Plan for a safe journey!

**Health Insurance**

Know what type of health insurance you have access to after you leave care. Find out what you need to do to maintain eligibility for health coverage. Research what it will cost if you have to pay for your own health care. List the Medical Insurance provider and the youth’s identification or client number.

**Health Care Provider**

List your most current doctor, even if you no longer have health insurance. Compile medical records if multiple doctors/providers have been used. Confirm that your immunizations are up-to-date. Complete a comprehensive exam before leaving foster care, if possible.

**Mental Health Insurance**

Know what type of health insurance you have access to after you leave care. Find out what you need to do to maintain eligibility for health coverage. Research what it will cost if you have to pay for your own health care. List the Medical Insurance provider and the youth’s identification or client number.

**Mental Health Care Provider**

List your most current doctor, even if you no longer have health insurance. Compile medical records if multiple doctors/providers have been used. Confirm that your immunizations are up-to-date.

**Dental**

Schedule a complete dental checkup and take care of any dental issues before leaving care. Have a plan for meeting future vision needs.

**Vision**

Arrange a comprehensive vision examination before leaving care. If possible, determine if coverage is available if the cost will be if you have to pay.

**Figure Out What You’ll Need**

Identify ongoing need for physical health, mental health and substance abuse services (arranged comprehensive screenings, provided physical, dental and vision examinations, along with developmental and mental health screenings).

**Prescriptions**

Make a list of current prescriptions. Find out if health insurance will continue to cover the cost and for how long. Determine what the prescriptions will cost if you have to pay for them on your own. Learn about the side effects of stopping prescriptions. Figure out how to keep prescriptions in a safe place.

**Health Support**

Identify supportive individuals who can help you stay healthy, including someone who would be willing to attend medical appointments and advise you in accessing resources.

**Health Education**

Prepare yourself with health education, including healthy sexual decision making, awareness of birth family’s physical and mental health history, prevention and transmission of sexually transmitted diseases, effects of trauma, substance abuse issues, constructive methods for coping with stress, addressing social and relational problems, anxiety, depression and other mental health issues.
# Self Care + Health

**WHAT I HAVE**

Looking for instructions? Download at www.fosterclub.org

<table>
<thead>
<tr>
<th>Current HEALTH insurance coverage (name of company/plan):</th>
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</table>

<table>
<thead>
<tr>
<th>VISION needs:</th>
<th>Prescriptions:</th>
</tr>
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</table>

| Health education: | | | | |
|-------------------| | | | |
| Substance abuse | Healthy relationships | Fitness | Other: |
| Coping with stress | Pregnancy prevention | First Aid | Other: |
| Nutrition | Prevention of STDs | Health self-advocacy | Other: |

**RESOURCES AVAILABLE TO ME**

Find ‘em at www.fosteringconnections.org

<table>
<thead>
<tr>
<th>Assistance type</th>
<th>Eligibility (what I need to qualify)</th>
<th>Who I contact (and how to apply)</th>
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Visit www.fosteringconnections.org for more federal and state information regarding the Fostering Connections to Success and Increased Adoptions Act.
# THIS IS MY PLAN
Get ideas about how to make a plan at www.fosterclub.org

<table>
<thead>
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<th>Short term (1 year) goals</th>
<th>Steps &amp; services (and who will help me)</th>
<th>Progress</th>
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Plan immediately after I leave foster care:

Long term goals (five years from now, my health, mental health, vision and dental goal is):

## READINESS SCALE
Needs work  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Prepared
Appendix B

Casey Life Skills Assessment for Health

Learning Goal 1: Knows how to stay healthy.

Expectations:

1. Identify three ways to prevent a cold or flu.
2. Explain how to prevent contagious diseases like measles, mumps, and chicken pox through vaccination and/or avoiding contamination.
3. Take care of self (e.g., gets enough sleep, protects eyes).
4. Attend regular doctor/dentist appointments (e.g., yearly).
5. Explain family health history.
6. Describe personal medical history.
7. Keep up to date medical records.
8. Explain how regular exercise can make one feel better and look better.
9. Exercise at least two to three times a week.

Learning Goal 2: Knows how to care for minor illness and simple injuries.

Expectations:

1. Describe symptoms of colds, flu, and other common health problems.
2. Demonstrate how to use a thermometer.
3. Select appropriate over-the-counter medications for pain, stomach upset, diarrhea, cold/allergy symptoms.
4. Explain how to treat cold and flu symptoms.
5. Demonstrate treating simple injuries like cuts, burns, bites, stings, and splinters.
6. Create a basic first aid kit.
7. Explain what to do when a fever doesn’t improve.

Learning Goal 3: Knows when and how to seek medical attention.

Expectations:

1. Describe how to know when an illness has not responded to over-the-counter medication or home remedies.
2. Explain what to do when an illness has not responded to over-the-counter medication or home remedies.
3. Explain how to tell if one should go to the emergency room or to a doctor.
4. Name three situations where you would go to a doctor.
5. Name three situations where you would go to the emergency room.

6. Explain the costs associated with doctors/dentists, clinics, and an emergency room.
7. Select the appropriate medical/dental resource for the problem needing attention.
8. Describe how to find a doctor and dentist (e.g., check yellow pages, check medical/dental societies, Health Insurance Company, family and friends).
9. Select a doctor and dentist for regular, ongoing care.
10. See a Doctor and Dentist regularly for well-being care (e.g., annually).
11. Describe the steps for making and keeping a medical/dental appointment.
12. Demonstrate making and changing a medical/dental appointment.
13. Explain what to do if someone ingests a poisonous substance.

Learning Goal 4: Knows and understands the importance of taking prescription drugs and over-the-counter medications as prescribed.

Expectations:

1. Explain the difference between prescription and over-the-counter medications.
2. Interpret instructions provided on prescription drugs and over-the-counter medications, including dose frequency, contraindications, warnings, recommended storage (e.g., safety cap use) and possible side effects.
3. Describe what happens when medication is used improperly.
4. Describe the possible effects of taking medications while pregnant.
5. Explain the difference between generic and brand name medications.

Learning Goal 5: Can state what medication or medical needs he/she requires.

Expectations:

1. Explain why it is important to know what medication one takes.
2. Tell what medications one takes.
3. Describe any medical needs (e.g., allergic to penicillin, asthma).

Learning Goal 6: Knows and understands the medical/dental resources available.

Expectations:

1. Describe types of medical insurance/ coverage available (e.g. Medicaid, employer health plans, student health plans, personal health plans).
2. Explain where and how to obtain one or more types of medical coverage.
3. Identify the common terms used in medical insurance (e.g., HMO, co-pay, deductible, referral, pre-existing condition).
Learning Goal 7: Knows how to maintain good emotional health.

Expectations:

1. Define and explain what stress is.
2. Identify situations which may cause conflict between people and lead to stress.
3. Identify source of conflict or fear in a stressful situation.
4. Identify three ways to reduce stress (e.g., exercise, deep breathing, simplify schedule).
5. Select a strategy to reduce stress and maintain good emotional health (e.g., exercise, deep breathing, simplify schedule, journal).
6. Evaluate effectiveness of strategy selected.
7. Describe the signs and symptoms of depression and other emotional health problems.
8. Describe where to go in the community to obtain help with depression and other emotional health problems.
Appendix C

List of Services for Transition Age Youth by state\textsuperscript{71}

YOUTH AGING OUT SURVEY
ISSUE: TRANSITION TO ADULT PROGRAMS

What services does your state provide to youth as they transition to adult programs?

Alaska
In Alaska, we have created four Independent Living Specialists one in each of the four regions to provide assistance for youth transitioning to adulthood. The ILS monitor the youth while in custody and assist the primary caseworker in determining what services the youth needs while in custody and then become the primary worker once the youth leaves state custody. While in custody, the ILS can provide aid in funding for tutoring and accompanies youth to the annual education conference held at one of the state universities. The ILS also works with the Youth Advisory Group (Facing Foster Care in Alaska) to provide support for youth to advocate for themselves and other foster youth. Youth also have the opportunity to participate in IL training on topics that will aid them in dealing with life on their own. Participants are given a gift card to encourage their participation in these training opportunities.

Arizona
Youth in Arizona may sign an agreement to voluntarily remain under the care and supervision of the Division of Children, Youth and Families (DCYF) while participating in a case plan of services, designed to assist them in making a successful transition to adulthood. Youth who choose to participate in continued care have access to a DCYF case manager who assists them initiate processes for transfer into adult service programs, i.e. adult behavioral health services.

Youth who do not wish to remain in care past age 18 are also assisted in enrolling in adult service programs by their DCYF case manager. Many areas of the state have protocols in place for determining eligibility for adult services (i.e. behavioral health) which are designed to ensure services do not lapse during the transition. These youth also have access to aftercare services through the Transitional Independent Living Program (TILP) where a case manager is assigned to develop an individualized service plan that may include assistance in negotiating the adult service system.

Colorado
• Chafee Foster Care Independence Program services (To include the YES! Academy) are provided through county departments of social/human services for transitioning youth/young adults up to age 21. Those services include mentoring, coaching, internships, employment prep and transportation. Services are provided to increase access skills to obtain medical/mental health care, housing and education.
• The YES! Academy provides a Chafee help desk for referrals and Ansel-Casey assessments and learning plans development assistance to Colorado’s rural counties and direct care services to eligible Chafee homeless youth.
• For Special Needs (Developmentally Delayed): Children enrolled in the CHRP waiver receive independent living skills through their individual plans. Some of these youth also receive services through Chafee. Adams County utilizes their CCB (Community Centered Board) to provide Chafee services. Counties are expected to work closely with CCBs to work on transitioning children into the adult system at 21 years of age.

\textsuperscript{71} \textit{-------} (2010). "Youth Aging Out Survey Issue: Transition to Adulthood Programs."
Connecticut
The Department has a Memorandum of Agreement in place with two State Agencies who work with adult populations - The Department of Mental Retardation and The Department of Mental Health and Addictive Services (DMHAS) to provide after service programs, including housing, case management and some financial assistance to youth who qualify for their programming and are aging out of our services. The Department is also working collaboratively with DMHAS and The Department of Social Services in designing, funding, establishing and monitoring a Supportive Housing Program that will include a designated number of apartments for youth between the ages of 18 to 24 who have aged out of the foster care system. The Department has a requirement that each youth 18 and over who are leaving our care must have a formal discharge conference six (6) months prior to their discharge. This meeting is to work with youth on issues surrounding their move towards adulthood and self-sufficiency. These include but are not limited to community and family connections, housing options, employment options, etc.

District of Columbia
Our agency has an MOA with the District’s DDS (Developmental Disability Services) to transition you into their system. It includes referrals being made 3 years prior to transition, an assignment of a DDS case manager who collaborates with the child welfare Social Worker and a smooth transition once the youth exits care.

Additionally, referrals are made to DMH (Department of Mental Health) and the Healthy Families Collaboratives for youth after care community supports.

Illinois
IDCFS have many services that are available to youth as they work toward independence and self-sufficiency. Here are the Divisions that work directly with the older adolescents:

- Office of Education and Transitional Services (OETS)
- Educational services for H.S./GED and Post Graduate
- Employment Education and Development
  i. Youth Employment Incentive Program
  ii. Youth In College
  iii. Scholarship Program
  iv. Life Skill Development (Ansell Casey)
  v. Youth Advisory Board
- Purchase of Service Independent/Transitional Living Agencies (Contracted by IDCFS to serve the Adolescent Older Population toward self sufficiency)
  (a) POS Agencies contract with IDCFS to provide direct services to youth in areas of
     1. Permanency
     2. Housing
     3. Education
     4. Vocation
     5. Life Skills
     6. Advocacy
     7. Self Sufficiency Development
     8. Personal Goals
     9. Family / Significant Other Positive Relations
- Office of Permanency & Placement
  (a) CANs (Child/Adolescent Needs Assessment)
  (b) CAYIT – Staffing with all pertinent persons to discuss permanency
- Office of Clinical Services
(a) Mental Health Services
(b) Special Needs Identification and Service provision

IDCFS has adult based CILA and Adult Guardianship if necessary. The agency will work with our DCFS Mental Health services in partnership with the Dept. of Human Services. Our DCFS Legal and Guardian Office will also help with the particulars for probate court. If the client qualifies, SSI (Policy 2002.16 SSI Special Needs Allowance) benefits through Maximus will also be accessed and re-determined for adult services. Public Aid services, such as TANF can also be of some assistance.

Indiana
- Youth that are 18 and “age out” of foster care are eligible for Chafee Independent Living Services
  i. Room and Board funding with case management up to $3000 until age 21.
  ii. Education and Training Vouchers up to $5000 per year until age 21 and if enrolled in school at age 21, funding is available through age 23.
  iii. Medicaid health coverage age 18 up to age 21.
  iv. Emancipation Goods and Services up to $1000 to help with start up items for those youth that are being placed in a group home.
- Youth that “age out” of foster care are eligible for Medicaid up to their 21st birthday
- Job Corps
- Work One
- Learn More Indiana—provides answers to questions and resources on education and career options
- State Student Assistance Commission of Indiana—offering assistance to college bound citizens with help in completing FAFSA, as well as providing information on various scholarships and grants
- Indiana INTERNnet—a matching program that links employers to students, colleges, and universities

Kansas
Youth receive transition services and planning prior to leaving care. Youth and social workers with foster care and Independent Living programs meet together to prepare a transition plan to include housing, employment, education and medical needs.

Maryland
Maryland provides After Care services as needed for youth who age out of care. Those services depend on need and the youth willingness to meet the service agreement. The services include but are not limited to: rent, security deposit, uniforms, medical assistance and cost to cover counseling, transportation cost for their car or insurance, food, personal items, furniture and more. Of course, it is our goal to plan with the youth to avoid some of the listed items using a timeline and budget. Educational costs are another option if the youth were enrolled in school prior to their 21st birthday and maintained satisfactory grades. The John H. Chafee, Educational Tuition Voucher (ETV) allows youth to receive funds up to their 23rd birthday if they meet the eligibility requirements.

Minnesota
Through our Chafee funding we provide funding to both counties (to serve youth ages 16+ who will age out of care) and community agencies (ages 18 to 21) to provide independent living skills training either in a group format or individually.
We also administer state funding via contracts with community agencies to serve both populations (youth in care and youth who have aged out of care) with intensive programs that promote independent living skill development.

As submitted earlier we also administer the Education and Training Voucher (ETV) program in Minnesota.

The Department of Human Services offers training to both foster parents and public social workers on building transition skills for youth who will be aging out of care.

We have also published a best practice manual for our county and grantees of community professionals who are working with these populations. See link to Best Practices Manual below:

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&ReadCount=Primary&AllowInterrupt=1&noSaveAs=1&dDocName=dhs_id_057255

In the very near future we will launch a transition website to assist youth and professionals with developing an independent living plan that will provide the user with local resources to match the identified needs. See beta site below:

http://216.81.233.83/MinnesotaBeta1/default.aspx?se=youth

**Montana**

All youth have access to contract staff and social workers to develop a transitional plan. Usually this includes assistance with higher education, living on their own, etc.

**Nebraska**

Nebraska provides services to transition to adulthood through Chafee, Education and Training Vouchers Programs, the Nebraska Former Ward Program and a Positive Youth Development Grant, through Family and Youth Services Bureau, designed to enhance leadership and community involvement skills.

**New Mexico**

NM has a Youth Services Bureau that includes eight Youth Services Consultants. The YSCs and caseworkers aid youth in foster care to develop life skills and to connect with education, employment, medical/mental health services, and other services to aid them in their transition to adulthood. We have the Adolescent & Adoption Resource Team (AART) that reviews cases of all transitioning youth with staff to ensure that transition issues are being addressed in a timely manner. The reviews occur every 60 days until the youth ages out.

**New York**

Most youth do not transition to adult “programs”, although prior to a youth leaving care a plan for services, education and housing is developed with the youth. If a youth is discharged prior to turning 18 (youth may remain in care until they turn 21 years of age), a period of trial discharge is arranged during which the youth may return to care if the need arises (6 months – see previous survey). Following that, supervision is required until the youth turns 21 – this involves offers of services and support. In addition to Chafee and state funded services, when a youth leaves care, Medicaid continues for one year, after which the youth is encouraged to apply for ongoing coverage through New York Family Health Plus Medicaid program. New York offers a housing subsidy (in addition to any Chafee funded room and board) mentioned in a previous survey response. Should a youth require residential or services programs, such as ongoing mental health treatment, the discharge plan address this.
Services that must be available to youth in as they transition include: financial, employment, education and housing training, counseling and assistance; life skills training; promoting the involvement of mentoring and caring adults – no one is discharged to “independent living” rather there must be an adult that has made the commitment to parent or act as a parent to the youth. In addition, should a youth require services such as mental health or substance abuse treatment, that is not within the purview of the county child welfare/social services department, the youth’s plan for services must specify how these services will be provided and by whom.

**North Dakota**
North Dakota’s Chafee Foster Care Independence Program provides services to foster youth/young adults through the age of 21. Those youth receiving the Education and Training Vouchers receive services until the age of 23. ND has a Chafee program in each of our 8 regions. The majority of youth participate in the program prior to aging out of foster care, and the IL Coordinator is involved in the youth’s Child and Family Team Meetings for at least a year prior to the youth’s discharge from care. The IL Coordinator participates in the youth’s transition planning process. Housing and employment are among the domains planned for. The youth’s individualized needs regarding mental health, addiction, and developmental disabilities are also assessed and planned for. Referrals to various agencies are completed as needed. Some youth do not wish to participate in Chafee programming at the time of their discharge, but may reconsider at any time prior to their 21st birthday. The IL Coordinators assist the young adult with meeting their housing, employment, and educational needs. While the official Child and Family Team Meetings end at the time of the youth’s discharge from care, the IL Coordinators attempt to continue the team process.

**Ohio**
Independent living services, based on the assessment required by Ohio Administrative Code, include but are not limited to: Daily living skills. Securing and maintaining a residence. Home management, shopping, Money management, Utilization of community services and systems, Accessing and utilizing transportation. Utilization of leisure time. Personal care, hygiene and safety. Pregnancy prevention and/or parenting skills, Time management, Enhancement of personal decision making and communication skills, Assistance in obtaining a high school diploma or GED, evaluating personal educational goals, and planning for post-secondary education and training, Planning for job and/or career development, Securing and maintaining employment. Planning for ongoing and emergency personal health care needs, building a positive self-image and self-esteem, development of positive adult relationships and support systems.

**Oklahoma**
Oklahoma has numerous services and resources to prepare and support each youth in transition to adulthood. Services include a life skills assessment and individualized, youth driven independent living/transition case plans; intensive educational support; a tutoring initiation; life skills instructions through conferences and seminars; career awareness and post-secondary preparation; and the Yes I Can Network that provides toll-free access to youth development funds and case management. Resources include preparation, supportive, and housing youth development funds; a tuition waiver for in-state public colleges and career technology center; gas cards to support employment, education, and sibling connections; phone cards to support sibling and other permanent connections; portfolios to maintain all essential documents; and, various life skills instruction books and curriculum.

**South Carolina**
The Foster Parent Association has a contractual agreement with the agency to provide household showers for youth who will be emancipating from the foster care system or who will be attending college. When a youth has been identified, the foster parent association plans a household shower to include current and former caseworkers, foster families, and other attendees identified by the youth. The association then purchases items from a wish list prepared by the youth, e.g. pots, pans, linens, sheets, silverware,
microwave, etc. which are necessary to establish housekeeping. This program continues to be extremely successful.

Being able to obtain and retain a job is critical in achieving self-sufficiency. The Family Independence and child welfare programs formed a partnership to ensure that foster youth have the opportunity to learn employment readiness and retention skills. The TANF program has experienced extraordinary success in preparing “welfare” families for employment. Employment skill development was identified as an area that needed improvement for foster youth leaving the system. Since a successful program already existed within our agency and could be utilized to teach these skills to foster youth, a logical partnership was developed. Each foster care youth is to be referred to the program 30 days prior to their 16th birthday and again six months prior to their planned exit from foster care. An individual assessment of each adolescent is to be completed to determine interests, aptitude, etc. This results in the development of an employment self-sufficiency plan. The two programs share costs for allowable services within their funding capacity. The program encompasses all adolescents regardless of their residence, i.e., foster, group homes, therapeutic placements, etc. Age of foster youth is the only eligibility criteria.

The Independent Living Program provides the following services to support youth in employment efforts:

- Transportation assistance to and from employment for up to 3 months
- Certification courses (first aid, life guard, etc.)
- Interview clothing
- Initial supply of work uniforms and footwear
- Time limited childcare (1 month)
- Car repair (if youth has a personal car)
- Job skills training classes, i.e., computer classes, etc.
- Summer job opportunities
- Job mentor
- Apprenticeship Programs as available (none available in current fiscal year)

Texas
In 1986, the Preparation for Adult Living (PAL) program, a component of the Transitional Living Services Program, was implemented to better address the needs of youth aging out of foster care to ensure older youth in substitute care are prepared for the transition from foster care to adulthood. Services provided to youth to in care and in support of their transition from care and after care include:

Life Skills Training in core areas such as money management, job preparedness, planning for the future. PAL staff, through a collaboration with public and private organizations, assist youth in identifying and developing support systems and housing for when they leave care.

Transitional Living Allowance (TLA) PAL services include transitional living allowances for those having aged out of care, up to $1000 per eligible youth. These funds pay for rent or assistance to help a young person move into an apartment. They cannot receive more than $500 at one time.

Aftercare Room and Board Assistance is based on need. This funding pays for living costs such as groceries or utilities.

Case Management is provided to assist with transition planning and help connect the youth to needed resources.
Support Services are provided to youth preparing to age out of care and are funded through purchased service dollars and supports from stakeholders such as local child welfare boards. Supports services can include high school and college items, counseling, tutoring, driver’s education, mentoring. Ansell-Casey Youth Life Skills Assessment is an evaluation of basic life skills. The instrument assesses youth abilities in different domains: communications, daily living, housing and money, work and study habits, social relationships, and self care.

Additional Transitional Living Services Program services provided to youth in preparation for transition to adult living include:
- Circles of Support (COS), based on the Family Group Decision Making model, are facilitated meetings with participants that a youth identifies as “caring adults” who make up their support system. COS participants can be a youth’s foster care provider, a teacher, relatives, church members, or mentors. These participants come together to review the young person’s transition plan, including strengths, goals and needs. Each participant identifies a personal way they can help support the youth’s transition from care and attainment of their goals. They then sign the Transition Plan to seal their agreements.
- Positive youth development and youth leadership development activities.
- Educational / Vocational Services to help a young person complete high school, obtain their GED, or prepare for advanced education such as college or vocational schools. Youth receive essential services such as mentoring, tutoring, transportation to potential colleges for visits, and help with filling out financial aid or scholarship applications.
- Uninterrupted Medicaid coverage (automatic renewal) for youth who age out of foster care at age 18 through the month of their 21st birthday, effective September 2005.

**Vermont**
- Vermont Student Assistance Corporation scholarship money.
- Vocational Rehabilitation.
- School to Work Program.
- Transition classes at the high school level.
- Transitional Living Program (Runaway and Homeless Youth Act)
- VT Dept. of Labor
- Youth Development Coordinators

**Virginia**
In Virginia, foster care youth can continue to receive services until age 21. Transitional services include housing, post-secondary education, employment, financial, counseling, etc.

**Wyoming**
Case management Workers often partner with the Adult Waiver group at the Division of Developmental Disabilities. In a few of our counties, the contract worker for the Chafee program also serves the Division of Developmental Disabilities.
Appendix D

Interview Questions: Former Foster Care Youth

1. Tell me your experience?

2. When did you age-out of care?

3. Did you consider signing a contractual agreement for residential services (CARS)?
   Was this option offered to you?

4. How did you prepare for independent living?

5. Where have you lived while in care?

6. Where have you lived since leaving care?

7. What was your health care coverage while you were in care?

8. Has your health care coverage changed since you left care?

9. Where can you go to access services?

10. If you could go back and do things differently, what would you do?

11. In your opinion, how can the system be changed to help assist young adults more in their transition process?

12. Is there anything else you would like to say in light of all that we have talked about?
Interview Questions: Independent Living Coordinators

1. What is the typical profile of a LINKS attendee?

2. Are these youth coming from group care, foster homes or therapeutic foster homes?

3. What factors do you believe keep someone from attending a LINKS meeting?

4. What subject do you believe is the hardest for students to grasp?

5. Do you have any interaction with the caregivers of youth attending LINKS classes?

6. In your opinion, how can the system be changed to help assist young adults more in their transition process?

7. Is there anything else you would like to say in light of all that we have talked about?
Interview Questions: Program Directors

1. In your words, could you tell me what does your program does?
2. What do you consider your programs emphasis?
3. What is the typical profile of the average participant in your program?
4. What skills do these participants need the most help in developing before they can live independently?
5. What are the requirements to stay in your program?
6. What is consequence for failing to meet those requirements?
7. How is transportation facilitated at your program?
8. Is a job or education requirement an either/or option?
9. Are the youth required to maintain health insurance?
10. Do you provide any health care services such as counseling?
11. What is the expectation of supervisor support?
12. What is the interaction with DSS?
13. Where do you see the greatest needs?
14. When you look at the system as whole, what areas do you think can be improved to produce better outcomes in housing?
15. In your opinion, how can the system be changed to help assist young adults more in their transition process?
16. Is there anything else you would like to say in light of all that we have talked about?
Appendix E

Review of Literature and Online Resources


------ (2008). Employment Outcome for Youth Who Age out of Foster Care Through Their Middle Twenties, Urban Institute.


McCalley, B. Iowa Youth Dream Team Planning Process. from www.dhs.state.ia.us/cppc/docs/IYDT%20Power%20Point.ppt


