

AFTERCARE PLAN FOR PLC**PHILADELPHIA DEPARTMENT OF HUMAN SERVICES**

Agencies are expected to provide services in accordance with this plan and will report to DHS periodically on plan implementation.

Case Name:		DHS #:	Date of Completion:	
DHS Social Worker:		Telephone #: ()	Juvenile #:	
Provider Agency Name:			Agency Case #:	
Provider Agency Social Worker:			Telephone #: ()	
AFS Date:	Most Recent FSP Date:	Next FSP Review Due Date:	Next Court Date:	Planned Date of Discharge:

Identifying Information – List Children

SUF.	NAME	DOB	SUF	NAME	DOB

PLC Caregiver

Name	Relationship	Address	City, State	Zip Code	Telephone
					()
					()

Legal parents

Legal Mother's Name:	Address:	City, State	Zip Code	Telephone: ()
Legal Father's Name:	Address:	City, State	Zip Code	Telephone: ()

1. Describe the specific services the child and the PLC family have received to ensure a successful transition into the PLC family?

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Provider Agency:

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2. Describe how the child and new PLC family have been prepared to address child service issues and become independent of the child welfare system.

3. Describe how the family will sustain the transition progress that they have already made (described above in Questions #1 and 2). This description should correspond to the aftercare grid completed on pages 3-5.

Provider Agency:

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Applications for aftercare funding must address the following:

<i>LIFE DOMAINS/ISSUES</i>	<i>EXAMPLES OF POSSIBLE RESPONSES</i>	<i>PLAN FOR CHILD(REN) AND FAMILY (including specific services to address the life domains/ issues, timelines, and expected outcomes)</i>
<i>Safety.</i> Is everyone in the family safe? Are there dangers to individual family members? Is a family member dangerous to himself or others?	Casework Protective daycare Respite Informal family/community supports Professional services, i.e., counseling, medication management	
<i>Subsistence/Financial.</i> Is the current living arrangement adequate? What are the family's income sources? Have public benefits been explored or secured?	Housing advocacy/Cash assistance for housing (deposits, rent, repairs) ¹ Food, clothing Furniture, equipment Transportation	

¹ These services must be consistent with the Emergency Fund policies.
Aftercare Plan for PLC (85-392) Rev. 7-05

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<p><i>Emotional/Psychological</i> Does the family/child have behavioral health needs? Are there behavioral problems that impede normal interactions within the family or in the community?</p>	<p>Individual, family, group counseling Marital counseling Substance abuse treatment² Psychological testing/evaluation³ Other mental health services</p>	
<p><i>Medical.</i> Are health care needs met? Does the family need access to specialists?</p>	<p>Medicaid Public health benefits (e.g., visiting nurses) Employer health benefits for private health care</p>	

² These services are available through CBH-funded providers and may be provided at no cost.

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<i>Educational/Vocational.</i> Where and how will the child receive the educational services to which (s) he is entitled? For older wards, does the adolescent have access to vocational guidance and training? Does the parent need assistance in obtaining employment?	<i>For children/adolescents</i> Headstart/ Early Intervention/ Pre-K Local nursery/child care Regular schooling/special education GED/vocational training/college Work experience <i>For parents</i> Education/vocational training Vocational counseling/placement	
<i>Social.</i> Do family members have regular contact with extended family? With friends? Does the family have regular contact with others as a family?	Peer/self help activities Classes/recreation programs Churches and clubs Neighborhood friends	

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PARTICIPANTS IN AFTERCARE PLAN DEVELOPMENT			
Name	Relationship	Address	Telephone #

Signatures:

_____ Date: _____
Parent/Caregiver

_____ Date: _____
Child (if 14 or older)

_____ Date: _____
Parent/Caregiver

_____ Date: _____
Child (if 14 or older)

_____ Date: _____
Agency Social Worker

_____ Date: _____
Agency Supervisor

_____ Date: _____
Agency Administrator

Agency Administrator's Phone# _____

_____ Date: _____
DHS Social Worker

_____ Date: _____
DHS Supervisor

DHS Supervisor's Phone# _____