



QUARTER 2

PIP 5.1.1

- 0801.4.3 Independent Living Agreement:** outlines the rules and responsibilities that a youth must agree to in order to live independently (outside of a licensed foster care placement) and permits the youth to directly receive funds for their living expenses in the same amount as the basic foster care payment.
- 0801.4.4 Independent Living (IL) Worker:** refers to the child welfare agency caseworker coordinating and/or providing services which are related to moving youth to self-sufficiency or furthering independence.
- 0801.4.5 Permanency Goal:** refers to the hierarchy of permanency goal options that ensures legal and emotional permanency for a child, which are in ascending order of priority, 1) Reunification, 2) Adoption, 3) Legal Guardianship, 4) Permanent Placement with a fit and willing relative, 5) Other Planned Permanent Living Arrangement.
- 0801.4.6 Independent Living (IL) Services:** Services that provide learning opportunities for youth to develop skill sets necessary to become productive, self-sufficient adults.
- 0801.4.7 Youth Plan for Independent Living (IL):** Refers to the document used to identify both long term goals and short term objectives and correlative services to prepare the youth for adulthood.

0801.5 Policy Requirements

0801.5.1 Youth Assignment Referral to Independent Living Program (ILP)

Youth in foster care who reach the age of 15 must be assigned to the IL program within 45 days of their birthday. When a youth is older than 15 upon entering foster care, they must be assigned to the IL program within 45 days of adjudication. The youth assignment/referral to the IL program must be completed in UNITY.

0801.5.2 Youth Engagement and Assessment

- A. Once a youth is referred for IL services, the IL worker will meet with the youth and the youth's caregiver face to face to explain the Independent Living Program (ILP), answer any questions they may have and conduct the Ansell Casey Life Skills Assessment (ACLSA).
- B. The ACLSA can be found online at:
http://www.caseylifeskills.org/pages/assess/assess_aclsa.htm.
- C. This assessment must be completed by the youth and also, when possible, their caretaker. Each jurisdiction/location has its own unique Organization ID for use on the ACLSA website.
- D. The ACLSA must be conducted within 45 days of the youth's referral to IL services.

0801.5.3 Youth Independent Living Planning

- E. The youth's plan for independent living services is developed in addition to their family case plan and permanency plan. The Youth Plan for IL includes preparation for transition to adulthood in the areas of education, employment, health management, life skills development, family and community connections, leadership development, enrichment activities and obtainment of personal documents. ILP activities are strategically selected to help the youth meet his/her goal(s) and include structured events and individual, youth-driven activities. Also to be considered in the planning process is the emotional permanency of the youth, in which they have a healthy and positive relationship with at least one caring adult in their life. When possible and appropriate, assist youth in identifying and developing healthy family connections and developing or maintaining their connections with siblings.

- Education – must be involved in a full time educational program; or be engaged full time in a combination of education and employment;
 - Grades – GPA of a 2.0 or higher;
 - Assessment of Skills – must show that living independently is viable and the youth must be able articulate/demonstrate necessary living skills as determined by the child welfare agency;
 - Behavior – demonstrates responsible behaviors and decision making.
 - Exceptions: Any exceptions to the above must be approved through the child welfare agency administration.
- B. The child welfare agency's IL worker responsibilities within the ILA include:
1. The IL worker, in conjunction with their supervisor, will evaluate the youth for appropriateness prior to entering into an ILA. An ILA must be in the youth's best interests and any safety concerns must be fully addressed. The IL worker will develop the written ILA with the youth that identifies:
 - Youth's educational program – start date, end date and goals;
 - Youth's responsibilities;
 - Budget – IL worker and youth will develop a monthly budget;
 - Requirements to maintain eligibility for ILA and consequences of non-compliance;
 - Target date for discharge and completion of goals;
 2. The child welfare agency IL worker, in conjunction with the supervisor, must approve the youth's living circumstances and setting;
 3. The IL worker will ensure ongoing supervision and guidance to the youth. The youth's well being, ILA compliance and overall progress will be monitored through regular contacts with the youth.
 - First month – 1 contact per week (2 contact at youth's residence);
 - After first month – A minimum of 2 contacts per month (1 contact at youth's residence);
 - Perform a 3 month and 6 month review with the youth and in conjunction with the IL supervisor, to determine suitability of ILA.
 4. The IL worker will assist the youth in finding the necessary resources to meet the youth's independent living needs.
 5. The ILA can be terminated by the IL worker if a youth is not in compliance with the ILA requirements. The IL worker must provide the youth a 30 day notification prior to the termination of the ILA.

0801.5.6 Voluntary Agreement

- A. A youth may be given the option to remain in foster care beyond the age of 18 under a voluntary agreement with the child welfare agency. This option is only allowable if a youth is enrolled in an authorized school or school district program and is actively working to complete their secondary schooling or equivalent training. The youth must be able to demonstrate they are making satisfactory progress in their schooling during the period of the voluntary agreement. The agreement will identify the maximum, reasonable timeframe for completion of such schooling.
- B. Termination of the voluntary agreement will occur under the following circumstances, including, but not limited to:
1. Mutual agreement between the youth and the child welfare agency to terminate the voluntary agreement.
 2. The youth is not enrolled in an authorized school or program.

3. The youth is not actively participating in school, i.e., poor attendance, truancy, incomplete school assignments/ projects, etc.
 4. The youth cannot demonstrate they are making satisfactory progress, i.e., failing grades.
 5. Youth enters runaway status or moves without prior approval of their IL worker.
 6. Receipt of a high school diploma.
 7. If a youth has received a Nevada High School Equivalency Certificate (GED), but is continuing to work towards a high school diploma, the case may remain open.
- C. Termination of the agreement will not be effective until 15 days after written notice of intent to terminate the agreement is provided to the youth.

0801.5.7 90-Day Transition Plan

- A. During the 90 day period prior to a youth leaving foster care at 18, the 90-Day Transition Plan section of the Youth Plan for IL must be completed with the youth. If the youth remains in foster care under a voluntary agreement, the IL worker will update the transition plan, at the youth's direction, during the 90 days immediately prior to the youth leaving foster care. The IL worker will meet with the youth to create this plan. The transition plan must be personalized at the direction of the youth and be as detailed as the youth chooses. The plan must include specific options regarding:
1. Housing;
 2. Health insurance;
 3. Education;
 4. Local opportunities for mentors and continuing support services;
 5. Work force supports and employment services;
 6. Health care power of attorney.
- B. **Health Care Power of Attorney:** At the 90-Day Transition Plan, the IL worker must educate the youth regarding the importance of designating someone to make health care treatment decisions on their behalf if the youth is unable to do so and does not have or want a relative who would otherwise be designated by law to do so.
1. This meeting and the youth's decision to execute or decline this option will be documented on the 90-Day Transition Plan.
 2. If the youth wants to execute a health care power of attorney, the IL worker will provide the youth the opportunity to do so upon the youth's attaining age 18 or legal emancipation.
 - The IL worker will maintain a copy of the health care power of attorney in the youth's case file. The IL worker will ensure the individual designated with the youth's health care power of attorney receives the appropriate documents.

0801.5.8 Case Closure

- A. Complete exit interview with youth 30 days prior to exit or no later than 30 days after exit.
- B. Ensure that youth has been given their original birth certificate, social security card, any medical or educational records they request as well as their aged out letter and court order closing the case. If unavailable, ensure the youth provides an address where their termination or wardship order and any other forms can be sent.
- C. Ensure referral and connection has been made with the Chafee/FAFFY after care provider.
- D. Ensure youth's application for aged out Medicaid has been submitted.
- E. Complete closing summary note in UNITY. Summary to include:

1. Discharge status;
2. Education status;
3. Employment status;
4. Financial status;
5. Mental health;
6. Criminal activity;
7. Substance abuse;
8. Family functioning;
9. Referrals.

0801.5.9 Exceptions to IL Services

- A. There are circumstances when a youth may be unable to participate in IL services, these circumstances may be temporary or ongoing. Such circumstances include:
 1. The youth is detained in a detention or correctional facility.
 2. The youth is in a psychiatric facility or residential treatment center.
 3. The youth is incapable of participating in IL services due to significant medical problems or severe developmental disability.
 4. The youth is in runaway status.
 5. The youth has demonstrated a general inability or unwillingness to comply with the requirements for independent living services.
- B. The IL worker will complete the section in the Youth Plan for IL form that documents the youth's exception for participating in IL services. The youth must sign the Youth Plan for IL unless the youth is physically incapable or on runaway status. If necessary, the youth's signature may be provided through the use of a facsimile machine.

0801.5.10 IL Service's Funding – Current & Former Foster Youth

The IL worker refers youth to outside IL providers through the "Independent Living Provider Referral" form (FPO 0801B).

- A. **Chafee Foster Care Independence Program:** The federally funded Chafee IL Program provides foster youth ages 15 to 18 and former foster youth between the ages of 18 up to 21 the additional resources required to transition to self-sufficiency/adulthood. Services that can be provided with Chafee funds include:
 1. For youth ages 15 to 18 –
 - Assistance to obtain a high school diploma;
 - Career exploration and vocational training;
 - Job placement and retention;
 - Training in daily living skills;
 - Training in budgeting and financial management skills;
 - Substance abuse prevention;
 - Preventive health activities (including smoking avoidance, nutrition education, and pregnancy prevention); and
 - Eligible financial assistance (class ring, cap & gown, senior pictures, college application fees, etc.).
 2. For former foster youth 18 up to 21 years of age –
(Appropriate support and services that complements the youth's own efforts to achieve self-sufficiency and recognize and accept their personal responsibility in making the transition from adolescence to adulthood)

- Services identified in subsection 1;
 - Prepare for and enter post secondary training and education institutions;
 - Personal and emotional support through mentors and the promotion of interactions with dedicated adults;
 - Housing assistance;
 - Counseling;
 - Employment;
 - Education;
 - Eligible financial assistance (transportation, utilities, driver's education, etc.)
- B. Financial Assistance to Former Foster Youth (FAFFY):**
1. FAFFY funds may be used to assist former Nevada foster youth ages 18 up to 21. In addition, FAFFY funds may be used for current foster youth, ages 17 and up, who are identified as certain to remain in foster care until a minimum of age 18. Based upon need, FAFFY funds may be used to provide goods and services, including, without limitation:
 - Room and board;
 - Housing assistance;
 - Job training;
 - Vocational services, including, without limitation, job placement assistance;
 - Educational assistance;
 - Medical insurance;
 - Services to reduce high-risk behaviors in the former foster youth; and
 - Mental health services
- C. Education and Training Vouchers (ETV):** The purpose of ETV is to provide financial assistance for post-secondary training and education to youth who have aged out of foster care or who have left foster care after age 16 for adoption.
- D. Access to Other Post-Foster Care Services and Resources:** In addition to child welfare agency-managed aftercare programs, the adult social services programs in the State (e.g., substance abuse or mental health treatment, services and supports for citizens with developmental disabilities) are available to youth who have aged out of foster care. These programs are available from a variety of public and private agencies in the community.
1. Each of these programs has different eligibility requirements based on the youth's needs and other factors. It is important to assist the youth in identifying and understanding how to access these post-foster care services and supports.
- E. Medicaid – "Independent Foster Care Adolescent" (IFCA):** As part of the 90-Day Transition Plan, the IL worker will discuss the process for the youth to continue their Medicaid eligibility upon exiting the foster care system. Once the youth's exits care, the following needs to occur:
1. The one page, *Aged-Out of Foster Care Medicaid Application* needs to be available.
 2. Submit application to the Dept of Welfare and Supportive Services (DWSS) along with any other required documentation.
 3. To maintain their Medicaid eligibility, ensure the youth understands they are required to report to DWSS any of the following:
 - Address change;
 - Moving to another state;

- Pregnancy;
- Birth of newborn;
- Third party insurance.

0801.5.11

Chafee NYTD: The National Youth in Transition Database (NYTD) will collect case-level information on youth in care including the services paid for or provided by the State agencies that administer the Chafee Foster Care Independence Program (CFCIP), as well as the outcome information on youth who are in or who have aged out of foster care. The initial three year period for data collection begins on 10/1/2010. Youth placed in a foster care setting, whose 17th birthday occurs between 10/1/2010 and 9/30/2011, and that have received IL services are the baseline population for the initial NYTD survey.

- A. NYTD requires collection and reporting of basic demographic data on youth receiving independent living services in 14 broad categories:
1. Independent living needs assessment;
 2. Academic support;
 3. Post-secondary educational support;
 4. Career preparation;
 5. Employment program or vocational training;
 6. Housing education and home management training;
 7. Budget and financial management;
 8. Health education and risk prevention;
 9. Family support and healthy marriage education;
 10. Mentoring;
 11. Supervised independent living;
 12. Room and board financial assistance;
 13. Education financial assistance;
 14. Other financial assistance.
- B. A baseline survey is conducted with youth in foster care at age 17 (within 45 days after their birthday). A follow up survey will be conducted with these youth at ages 19 and again at age 21 to collect and report information about the following youth outcomes:
1. Financial self-sufficiency;
 2. Experience with homelessness;
 3. Educational attainment;
 4. Positive connections with adults;
 5. High-risk behavior;
 6. Access to health insurance.
- C. Nevada will collect and report outcome information on a new cohort of youth every three years. All outcome information with the exception of demographics must be obtained directly from the youth and reflect the youth's provided response.
- D. More detailed information on NYTD is available in the FPO 0802 NYTD Policy.

0801.5.12 Timelines:

Table 0801.1: Youth Independent Living Program

Requirement	Deadline	Starting Date	Responsible Party	Actions to be Taken
Youth are referred to IL Services at age 15	Within 45 days	Upon youth's 15 th birthday or entering care if 15 or older	Permanency Worker & Supervisor	Completes referral for IL Services and sends to IL Supervisor

Assignment of IL Worker	Within 3 business days	Receipt of referral	IL Supervisor	Assigns an IL worker for youth
Acceptance of case	ASAP	Upon receipt of referral	IL Worker	Acceptance and review referral and contact permanency worker for further information as needed
Complete ACLSA	Within 45 days	Upon receipt of referral	IL Staff	Administer the ACLSA to youth and caregiver
Develop Youth Plan for Independent Living	Within 30 days	Upon completion of ACLSA	Designated Independent Living Case Worker (may be permanency worker in agencies not having separate IL Unit)	Indicate in UNITY on the ILP Program Enrollment Screen (CFS 112)
Completion of objective/task set in Youth Plan for IL	As determined on plan	Date of Plan	Youth with coordination by IL worker	Coordination of services for youth by IL worker
Documentation of contact must be made within 5 days of contact	5 days after contact	Date of contact	IL worker	Documentation in UNITY must be completed within 5 days of contact
Begin discussion regarding decision-making process for transition	Within 60 days after the youth's 17 th birthday	Youth's 17 th birthday	IL worker and/or permanency worker	Begin decision-making process for transition
90-Day Transition Plan	within the 90 day period prior to 18 th birthday	Youth at age 17½	IL worker and/or permanency worker	Development of the Transition Plan
Exit Interview	Within 30 days of exiting care	Exit Date	IL worker and/or permanency worker	Provide youth originals of birth certificate, social security card; provide proof of termination of wardship, Health Care Power of Attorney, Medicaid application and any other necessary assistance or documentation.
For mandated baseline cohorts, NYTD survey must be completed by the youth.	Within 45 day after identified youth's 17 th birthday	Identified youth's 17 th birthday	Independent Living Caseworker/Permanency worker	Indicate in UNITY on the ILP NYTD Screen

0801.5.13 Forms and Tools:

0801.5.14 Documentation:

- A. Document all ILP activities (e.g. youth activities, progress and plan updates). This includes ensuring that all documentation is provided to the youth's primary caseworker.
- B. Case File Documentation (paper): All forms required by this policy.

Table 0801.2: Case File Documentation for Policy 0801

File Location	Data Required
Dependent on agency policy	All hard copy documents

C. Electronic Documentation (UNITY): UNITY documentation from IL Policy and Practice requirements.

Table 0801.3: UNITY Documentation for Policy 0801

List the UNITY screen number	Data Required
IL Program Referral (CFS380)	Youth Referral for ILP Services
ILP Referral Assignment (CFS381)	Assignment of youth to IL Worker
Independent Living (CFS112)	IL Enrollment
IL Plan Approval (CFS112A)	Supervisor Approval of Youth Plan for IL
Case Note Text (CFS088)	IL Case Notes
Chafee Tracking (CFS112D)	IL Services Delivered

0801.5.10 Child Welfare Agency Supervisory Responsibility:

- A. Approval of Youth Plan for IL
- B. Approval of Exception to IL Services
- C. Oversight and approval of ILA
- D. Oversight and approval of Voluntary Agreement
- E. Approval of 90-Day Transition Plan
- F. Documentation of 90 day case staffing regarding IL services & outcomes
- G. Approval of case closure

0801.6 Child Welfare Agency Policy Compliance Requirements

0801.6.1 Development of Internal Policies:

- A. Child Welfare Agencies must meet the requirements of this policy.

0801.7 State Responsibilities

0801.7.1 Participants in Policy Development

- A. **DCFS FPO:** Jill Marano, Darlene Duncan, Dorothy Pomin
- B. **DCFS Rural:** Novia Anderson, Hallie Kirk, Cheryl Sharp, Cheri Kelly, Kandee Mortenson, Reesha Powell, Larry Robb, Gary Smith, Jessica Carstens, Phyllis Friend.
- C. **WCDSS:** Shannon McCoy, Valerie Welsh, Theresa Anderson
- D. **CCDFS:** Amy Jaffe, Debra Moulton, Judy Tudor, JoAnne Witter, Richard Demarko Brown,
- E. **External Stakeholders:** Sandy Baker, Family Resource Center of Northeastern Nevada; Joyce Buckingham, Ron Wood Family Resource Center; Naomi Cardy, Washoe Advocates for Youth Council Uplift Program (WAYCUP); Cynthia Carstairs, Children's Cabinet; Cheri Peterson, Fallon Paiute Shoshone Tribal Social Services; Clelia Pinza Garrity, NV Outreach Training Organization; Daria Mason-Davidson, Program Director, Child Focus; Cshampaigne Standridge, Nevada Life Youth Advisory Board and Foster and Adoptive Youth Together (FAAYT); Karen Stoll, FRIENDS Family Resource Center.

0801.7.2 Technical Assistance

A. Technical Assistance Received:

1. Facilitation of Independent Living Workgroup in the development of the State of Nevada Independent Living Practice, Procedure and Policy Manual. Face 2 Face Integrated Technologies through the Casey Family Programs.

B. Resources:

1. Face 2 Face Integrated Technologies. (2009). State of Nevada Independent Living Project Research Matrix.

0801.7.3 Policy Impacts:

A. State Plan Reference:

1. 90-Day Transition Plan,
2. Durable Power of Attorney for Healthcare Decisions

0801.8 Policy Cross Reference

- B. FPO 0202 Case Closure Policy
- C. FPO 0204 Case Planning Policy
- D. FPO 0802 NYTD Policy

0801.9 Attachments

- A. FPO 0801A - Youth Plan for Independent Living
- B. FPO 0801B - Independent Living Provider Referral
- C. FPO 0801C - Durable Power of Attorney for Healthcare Decisions

YOUTH PLAN FOR INDEPENDENT LIVING

<input type="checkbox"/> Initial or <input type="checkbox"/> Update Plan Meeting Date:		Next Plan Review Date:
Youth's Name:		Youth's Phone:
Youth's Email address:		Youth's DOB:
Youth's UNITY Person ID#:		Projected Exit Date:
UNITY Case #:		Worker's Phone:
CW Agency Worker:		<input type="checkbox"/> EXCEPTION TO IL SERVICES

PERSONAL DOCUMENTATION	ON FILE	WITH YOUTH	DATE REQUESTED	DATE RECEIVED
Social Security Card	<input type="checkbox"/>	<input type="checkbox"/>		
Birth Certificate	<input type="checkbox"/>	<input type="checkbox"/>		
Immunization Record	<input type="checkbox"/>	<input type="checkbox"/>		
Tribal Enrollment	<input type="checkbox"/>	<input type="checkbox"/>		
Medicaid Insurance Card (& Other Insurance Card)	<input type="checkbox"/>	<input type="checkbox"/>		
Drivers Identification or Permit/ License	<input type="checkbox"/>	<input type="checkbox"/>		
Proof of Residency or Citizenship	<input type="checkbox"/>	<input type="checkbox"/>		

PERMANENCY PLANNING

What does permanency mean to you?

Based on how you defined this, what is your plan to find permanency?

How can your team help you meet with your plan?

MENTOR

Do you have an adult you trust to go to when you need help and advice? Yes No

If yes, who is that person? What is their phone number? Contact information?
 Name: _____ Phone: _____
 Email Address: _____

Were they invited today to your planning meeting? Yes No

Is your team assisting you with identifying a mentor? Yes No

If not, how could they help you? _____

MEDICAL/DENTAL

My primary physician is: _____ Address: _____ Phone: _____

I currently have the following medical conditions:

My last physical exam was on:		Medications:	
My dentist/orthodontist is:		Address:	Phone:
The doctor's findings/results were:			
My last teeth cleaning was on:		Next appt is on:	
My eye doctor is:		Address:	Phone:
My last eye exam was on:		I <input type="checkbox"/> need or <input type="checkbox"/> have eyeglasses or contacts.	
Do you currently have any unresolved medical or dental issues? <input type="checkbox"/> YES <input type="checkbox"/> NO			
What are those?			

MENTAL HEALTH/EMOTIONAL WELLBEING

I am in individual therapy with:	Day/time:
I am in family therapy with:	Day/time:
I am in group therapy with:	Day/time:
My current diagnoses are: Diagnosed by:	When diagnosed:
<input type="checkbox"/> I am currently on psychotropic medication(s) for my wellbeing.	
Names of psychotropic medications I'm taking:	
If on psychotropic medication, I see Dr. _____	

FAMILY PLANNING, SEXUALITY AND SEX EDUCATION

My gender is: <input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> transgender <input type="checkbox"/> questioning /undecided	
My sexual orientation is: <input type="checkbox"/> heterosexual <input type="checkbox"/> bi-sexual <input type="checkbox"/> gay/lesbian <input type="checkbox"/> questioning /undecided	
I am sexually active. <input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:
I practice safe sex. <input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:
I have been tested for STDs. <input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:
I have been tested for HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:
I use birth control measures. <input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:
I have someone I can speak to about family planning, sexuality and sex education. <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	

PARENTING N/A

<input type="checkbox"/> I am an expectant parent. The due date is:	The father/mother is
My plan for this expectant child is (explain):	
<input type="checkbox"/> I have a child or children.	
Child's name:	Age:
Child's name:	Age:
Child's name:	Age:
My child or children reside with (explain):	
The plan for my child or children is (explain):	

SUBSTANCE USAGE

Check all that apply below:

- I have never used illegal substances.
- I am clean and sober now.
- I have used illegal substances in the past. What: _____
- I am currently using illegal substances. What: _____

I am currently in substance abuse treatment with:
 ~ Where (clinic/facility): _____

CRIMINAL JUSTICE INVOLVEMENT/HISTORY

Check all that apply below:

- I have never been involved in the criminal justice system.
- I am involved in the criminal justice system now.
- I have a juvenile record.
- I am on parole or probation. Name of P and P officer: _____ Phone: _____
- I was arrested/convicted/incarcerated in the past, but I am not involved in the criminal justice system now (explain): _____

ASSESSMENT OF BASIC LIVING SKILLS

I understand what the ANSELL CASEY Life Skills Assessment is: Yes No

I have scheduled an ANSELL CASEY assessment with: _____
 Date: _____ Time: _____

I completed the ANSELL-CASEY assessment on: _____ with: _____ Date: _____

I have participated in the following classes, workshops or training: _____

I am interested in participating in: _____

MONEY MANAGEMENT

I have a source of income Explain: _____

I have a budget. Explain: _____

I would like to learn how to budget better. Explain what help you would like: _____

<input type="checkbox"/> I have a savings account	Where: _____	The balance is	\$ _____
<input type="checkbox"/> I have a checking account	Where: _____	The balance is	\$ _____

TRANSPORTATION

Check all that apply:

- I don't drive yet, but would like to learn.
- I have taken driver's education. Where: _____
- I have a driver's permit. State: _____ Expires: _____
- I have a driver's license. State: _____ Expires: _____

<input type="checkbox"/> I have a vehicle. My vehicle is a (Make/Model/Year):	
<input type="checkbox"/> I have car insurance with (Company):	
I pay \$ <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annually	
<input type="checkbox"/> I drive someone else's car.	Who owns the car you drive?
<input type="checkbox"/> I use the public bus. <input type="checkbox"/> I receive bus passes. They are paid for by:	
<input type="checkbox"/> I walk. <input type="checkbox"/> I ride a bike.	
<input type="checkbox"/> Other transportation Explain:	

EDUCATIONAL STATUS	
Current School:	Grade Level:
Past School(s):	
Number of credits I have:	My current Grade Point Average (GPA) is:
Proficiency Exams Passed: <input type="checkbox"/> Math <input type="checkbox"/> Reading <input type="checkbox"/> Writing <input type="checkbox"/> Science	
I have an IEP <input type="checkbox"/> Yes <input type="checkbox"/> No	
~ If yes to IEP, what educational supports do you receive?	
I have a school transition plan <input type="checkbox"/> Yes <input type="checkbox"/> No	
My school transportation (check all that apply): <input type="checkbox"/> walk <input type="checkbox"/> get a ride <input type="checkbox"/> take the bus <input type="checkbox"/> drive	
Anticipated Graduation/GED Date:	OR: I have my <input type="checkbox"/> Diploma <input type="checkbox"/> GED
I graduated from (School):	Mo/Year graduated:

EXTRACURRICULAR / COMMUNITY ACTIVITIES / INTERESTS	
I participate in extracurricular activities <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	
I participate in community activities <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	
My interests are:	
My hobbies are:	
I may need assistance with (cost of equipment/activity, transportation, enrollment, etc.):	

YOUTH ADVISORY BOARD / COUNCIL	
Check all that apply:	
<input type="checkbox"/> I participate in a youth advisory board/council activities	
<input type="checkbox"/> I serve on a youth advisory board / council Explain:	
<input type="checkbox"/> I am interested in receiving information on a Youth Advisory Board / Council	

ADVANCED EDUCATION PLANNING	
Vocational school/training <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	
Trade Apprenticeship <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	
College / University: <input type="checkbox"/> Yes <input type="checkbox"/> No Where: Explain:	
I am aware of the scholarships available to me. <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	
I have filled out the FAFSA. <input type="checkbox"/> Yes <input type="checkbox"/> No	

If NO, I plan to complete it by (date): _____

I have filled out the ETV Application. Otto Huth Scholarship Millennium Other
 Explain:
 If not, I plan to complete them by (date): _____

WORK EXPERIENCE

Check all that apply:

I am working. Part time Full-time
 Where: _____ # of hours worked per week: _____
 Hourly wage: \$ _____

I am looking for work. Part time Full-time
 Type of work sought: _____
 I need help with finding a job. Explain: _____
 I am seeking volunteer work Where/type: _____

I have worked previously and quit Where / circumstances: _____

I have worked previously and was fired Where / circumstances: _____

I have worked previously and the job ended Where / circumstances: _____

Internship Apprenticeship Where/type of work: _____

Other related experience Explain: _____

I have challenges that may limit my ability to get a job. Explain: _____

CAREER PLANS

I am interested in pursuing a career in the following:

1.	2.	3.
----	----	----

I am interested in:
 Participating in an assessment to help me determine my career options Yes No Explain: _____

Job Corps DETR WIA Vocational Rehabilitation
 Military Yes No Branch: _____
 Explain: _____

YOUTH GOALS

ACLSA Domain: _____

Learning Goal: _____ Target Date: _____

Action Plan		
What activities or services will be done?	Responsible Party	Completion Date
1.		
2.		
3.		
4.		

Progress made: _____

ACLSA Domain:		
Learning Goal :		Target Date:
Action Plan		
What activities or services will be done?	Responsible Party	Completion Date
1.		
2.		
3.		
4.		
Progress made:		

ACLSA Domain:		
Learning Goal :		Target Date:
Action Plan		
What activities or services will be done?	Responsible Party	Completion Date
1.		
2.		
3.		
4.		
Progress made:		

ACLSA Domain:		
Learning Goal :		Target Date:
Action Plan		
What activities or services will be done?	Responsible Party	Completion Date
1.		
2.		
3.		
4.		
Progress made:		

I participated in the development of this plan and agree to the services and activities as written.			
Youth / date	Worker / date	Worker / date	Other / date
Other / date	Other / date	Other / date	Other / date

Exception to IL Services:

- The youth is detained in a detention or correctional facility.
- The youth is in a psychiatric facility or residential treatment center.
- The youth is incapable of participating in IL services due to significant medical problems or severe developmental disability.
- The youth is in runaway status.
- The youth has demonstrated a general inability or unwillingness to comply with the requirements for independent living services.

Youth Signature: _____ Date: _____

Date for future review for IL services referral: _____

Continued next page ⇒

90-Day Transition Plan

To meet federal law PL 110-351, the 90-Day Transition Plan must be completed within the 90 day period immediately prior to the youth 18th birthday. The transition plan must be personalized at the direction of the child, be as detailed as he/she chooses, and include specific options regarding housing, health insurance, education, local opportunities for mentors and continuing support services, work force supports and employment services.

90-DAY TRANSITION PLAN	Date:
Identify and explain each "Plan" section. Identify the preparation requirements and timeframes to meet each Plan. Identify documents required to carry out the Plan. Additional rows can be inserted if needed.	
MY HOUSING PLAN:	
Action steps needed to complete plan:	
Documents required to accomplish goal:	
Date completed or to be completed:	
MY EDUCATION PLAN:	
Action steps needed to complete plan:	
Documents required to accomplish goal:	
Date completed or to be completed:	
MY WORKFORCE & EMPLOYMENT SERVICES PLAN:	
Action steps needed to complete plan:	
Documents required to accomplish goal:	
Date completed or to be completed:	
MY PLAN TO ASSURE FAMILY & OTHER PERMANENT CONNECTIONS:	
Action steps needed to complete plan:	
Documents required to accomplish goal:	
Date completed or to be completed:	

MY MENTORING & CONTINUED SUPPORT SERVICES (i.e., mental health, health service) PLAN :

Action steps needed to complete plan:

Documents required to accomplish goal:

Date completed or to be completed:

MY HEALTH INSURANCE PLAN:

Action steps needed to complete plan:

Documents required to accomplish goal:

Date completed or to be completed:

OTHER PLANNING:

Obtain Credit Report:

Selective Service Registration:

Voter Registration:

Referral to FAFFY provider:

Referral to other community providers:

NYTD FOLLOW-UP POPULATION CONTACT & CONSENT FORM (for youth identified in the NYTD follow-up population):

Other:

Health Care Power of Attorney:

I choose NOT to complete a Health Care Power of Attorney.

Signature: _____ Date: _____

I, _____ (youth name) directed the development of my 90-Day Transitional Plan.

Youth / date	Worker / date	Worker / date	Other / date
Other / date	Other / date	Other / date	Other / date

INDEPENDENT LIVING PROVIDER REFERRAL

IL Provider:		Date:
Services Needed:		
Youth Name:	<input type="checkbox"/> Initial Referral	<input type="checkbox"/> Re-Referral
UNITY Case #	Referral Date:	
Next court date:	Youth's next CFT:	

Youth Phone:	Birth date:	Age:
School:	Grade:	
Best time to reach youth:	Youth e-mail:	

Referring Caseworker:	Caseworker Site/Office:
Caseworker's Phone :	Caseworker's Cell Phone:

Caregiver / Contact Name:	Caregiver / Contact Address:
Caregiver/ Contact Phone:	Cell/alternative Phone:
Email:	
Best time to reach Caregiver / Contact:	

Please identify adults significant to the youth for attendance at the Youth Plan for Independent Living meeting, as applicable.

Attorney:	Phone:
GAL:	Phone:
CASA:	Phone:
WIN Worker:	Phone:
Other:	Phone:
Other:	Phone:

Summary of Youth Functioning*:

*Please identify any special needs, areas requiring immediate attention, or any other areas that may affect IL services. For example: school credit deficiency, alcohol/substance abuse, legal/incarceration issues, pregnancy, hospitalization, medical, mental health, developmental delays, etc.

REFERRAL FOR INDEPENDENT LIVING SERVICES

Ansell-Casey Assessment

Initial Assessment OR Reassessment (check one)

Youth Plan for Independent Living

Initial Plan OR Update (check one)

Has the Child and Family team-planning meeting been scheduled?

yes – Date and Time Scheduled

no

Youth Advisory Council involvement requested? yes no

Life Skills Classes? yes no

If yes, please mark domain(s) below:

To be determined after independent living assessment meeting

Family Relationships & Home Life

Communication

Self Care

Daily Living

Social Relationships & Permanent Connections

Education & Study Skills

Work Life

Housing

Money Management

Career Planning

Other (provide information below)

Additional Information:

The following meets the requirements of a "Durable Power of Attorney for Health Care Decisions" provided for under NRS 162A:

DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. It creates a Durable Power of Attorney for Healthcare. Before executing this document, you should know these important facts:

1. This document gives the person you designate as your Agent the power to make health care decisions for you. This power is subject to any limitations or statement of your desires that you include in this document. The power to make health care decisions for you may include consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You may state in this document any types of treatment or placements that you do not desire.
2. The person you designate in this document has a duty to act consistent with your desires as stated in this document or otherwise made known or, if your desires are unknown, to act in your best interests.
3. Except as you otherwise specify in this document, the Power of the person you designate to make health care decisions for you may include the power to consent to your doctor not giving treatment or stopping treatment which would keep you alive.
4. Unless you specify a shorter period in this document, this Power will exist indefinitely from the date you execute this document and if you are unable to make health care decisions for yourself, this power will continue to exist until the time when you become able to make health care decisions for yourself.
5. Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped if you object.
6. You have the right to revoke the appointment of the person designated in this document to make health care decisions for you by notifying that person of the revocation orally or in writing.
7. You have the right to revoke the authority granted to the person designated in this document to make health care decisions for you by notifying the medical physician, hospital, or other provider of health care orally or in writing.
8. The person designated in this document to make health care decisions for you has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.
9. This document revokes any prior Durable Power of Attorney for Healthcare.
10. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

1. DESIGNATION OF HEALTHCARE AGENT

I, _____ (insert your name) do hereby designate and appoint:

Name: _____

Address: _____

Telephone Number: _____

as my Agent to make health care decisions for me as authorized in this document.

(Insert the name and address of the person you wish to designate as your Agent to make health care decisions for you. Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your agent: (1) your treating provider of health care; (2) an employee of your treating provider of health care; (3) an operator of a health care facility; or (4) an employee of an operator of a health care facility.)

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document, I intend to create a Durable Power of Attorney by appointing the person designated above to make health care decisions for me. This Power of Attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the agent named above full power, and authority: to make health care decisions for me before, or after my death, including consent, refusal of consent, or withdrawal of consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition; to request, review and receive any information, verbal or written, regarding my physical or mental health, including, without limitation, medical and hospital records; EXCEPT any power to enter into any arbitration agreements or execute any arbitration clauses in connection with admission to any health care facility including any skilled nursing facility; and subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISIONS AND LIMITATIONS

(Your agent is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your agent's authority to give consent for or other restrictions you wish to place on your agent's authority, you should list them in the space below. If you do not want any limitations, your agent will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this Durable Power of Attorney for healthcare, the authority of my agent is subject to the following special provisions and limitations:

5. DURATION

I understand that this Power of Attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this Power of Attorney expires, the authority I have granted my agent will continue to exist until the time when I become able to make health care decisions for myself.

(IF APPLICABLE)

I wish to have this Power of Attorney end on the following date: _____

6. STATEMENT OF DESIRES

(With respect to decisions to withhold or withdraw life-sustaining treatment, your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your agent has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interest. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space below.)

1. I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures. _____

2. If I am in a coma which my doctors have reasonable concluded is irreversible, I desire that life sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed). _____

3. If I have an incurable or terminal condition or illness and no reasonable hope of long-term recovery or survival, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, and sections 2 to 12, inclusive, if this subparagraph is initialed). _____

4. Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. I want to receive or continue receiving artificial nutrition and hydration by way of the gastro-intestinal tract after all other treatment is withheld _____

5. I do not desire treatment to be provided and/or continue if the burdens of the treatment outweigh the expected benefits. My agent is to consider relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life. _____

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Other or Additional Statements of Desires: _____

7. DESIGNATION OF ALTERNATE AGENT

(You are not required to designate any alternative agent but you may do so. Any alternative agent you designate will be able to make the same health care decisions as the agent designated in paragraph 1, page 2, in the event that he or she is unable or unwilling to act as your agent.. Also, if the agent designated in paragraph 1 is your spouse, his or her designation as your agent is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my agent is unable to make health care decision for me, then I designate the following persons to serve as my agent to make health care decisions for me as authorized in this document, such person to serve in the order listed below:

A. First Alternative Agent

Name: _____

Address: _____

Telephone Number: _____

B. Second Alternative Agent

Name: _____

Address: _____

Telephone Number: _____

8. PRIOR DESIGNATIONS REVOKED

I revoke any prior Durable Power of Attorney for Healthcare:

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY.)

I sign my name to this Durable Power of Attorney for Healthcare on: _____ (Date)

at _____, _____ (City) (State)

(Signature)

9. WAIVER OF CONFLICT OF INTEREST.

If my designated agent is my spouse or is one of my children, then I waive any conflict of interest in carrying out the provisions of this Durable Power of Attorney for Health Care that said spouse or child may have by reason of the fact that he or she may be a beneficiary of my estate.

10. CHALLENGES.

If the legality of any provision of this Durable Power of Attorney for Health Care is questioned by my physician, my agent or a third party, then my agent is authorized to commence an action for declaratory judgment as to the legality of the provision in question. The cost of any such action is to be paid from my estate. This Durable Power of Attorney for Health Care must be construed and interpreted in accordance with the laws of the State of Nevada.

11. NOMINATION OF GUARDIAN

If, after execution of this Durable Power of Attorney for Health Care, incompetency proceedings are initiated either for my estate or my person, I hereby nominate as my guardian or conservator for consideration by the court my agent herein named, in the order named.

12. RELEASE OF INFORMATION.

I agree to authorize and allow full release of information by any government agency, medical provider, business, creditor, or third party who may have information pertaining to my health care, to my agent named herein, pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended, and applicable regulations.

13. (THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO ARE PERSONALLY KNOWN TO YOU AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE, OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.)

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

(You may use acknowledgement before a notary public instead of statement of witnesses.)

State of Nevada)

County of _____)

: ss:

On this _____ day of _____, in the year _____,

before me, _____ (here insert name of

notary public) personally appeared _____ (here

insert name of principal) personally known to me (or proved to me on the basis of satisfactory

evidence) to be the person whose name is subscribed to this instrument, and acknowledged that

he or she executed it. I declare under penalty of perjury that the person whose name is ascribed to

this instrument appears to be of sound mind and under no duress, fraud or undue influence.

NOTARY SEAL

(Signature of Notary Public)

STATEMENT OF WITNESSES

(You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as the agent; (2) a provider of health care; (3) an employee of a provider of health care; (4) the operator of a health care facility; (5) an employee of an operator of a healthcare facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty that the principal is personally known to me, that the principal signed or acknowledged the Durable Power of Attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a provider of health care, an employee of a provider of health care, the operator of a community care facility, nor an employee of an operator of health care facility.

Witness #1:

Signature: _____

Print Name: _____

Residence Address: _____

Date: _____

Witness #2:

Signature: _____

Print Name: _____

Residence Address: _____

Date: _____

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing by operation of law.

Witness #1:

Signature: _____

Print Name: _____

Residence Address: _____

Date: _____

Witness #2:

Signature: _____

Print Name: _____

Residence Address: _____

Date: _____

COPIES: You should retain an executed copy of this document and give one to your agent. The Power of Attorney should be available so a copy may be given to your providers of health care.

State:	Nevada
Date Submitted:	3/28/2011
PIP:	
Quarterly Report:	X
Quarter:	Q1

Part C: Item-Specific and Quantitative Measurement Plan and Quarterly Status Report

Outcome/Systemic Factor:	SI	Item: 1										
Performance as Measured in Final Report	SI	Item: 1										
Performance as Measured at Baseline Source (date of 10/01)	The Prospective baseline will be developed using data from January 2011 to December 2011. The baseline will be reported in final quarterly status report after the December 2011 review, as applicable. Minimum of 2 applicable cases for this item at baseline.											
Renegotiated Improvement Goal	Improvement goal will be set using Method 2 (prospective formula from CFSR 700.5), and the overlap adjustment will be applied based on the number of quarters the baseline overlaps the PIP approval.											
Method of Measuring Improvement	Nevada item measures will be based on targeted case reviews using a modified version of the current CFSR case review tool to establish a baseline. Reviewers will review 62 cases during the January 2011 to December 2011 period, and the annual applicable cases required to be reviewed for item 1 is 29. The period under review will cover the 12 months prior to the date the case is reviewed and the sample will consist of 33% In-Home cases and 67% Foster care cases. In determination of the performance percentages the numerator is the number of applicable cases in three interim sites in which the indicator was determined a strength for the period. The denominator is the total number of applicable cases reviewed across three regional sites for the period. The baseline period for case reviews will be completed in December 2011. Case review results will be reported within 30 days of the review and rolled up for each review, each site as base data and also aggregated for a statewide percentage. The ongoing case review sample will consist of 62 cases review of annually, and the minimal applicable cases required to be reviewed for item 1 is 29. The sample will consist of 33% in-home and 67% foster care. During the evaluation p											
Renegotiated Improvement Goal												
Status (Enter the quarter end date and measurement for the reported quarter in cell below)	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12

Note: The baseline period for case reviews will be completed in December 2011

Outcome/Systemic Factor:	S2	Item:	3									
Performance as Measured in Final Report	58%											
Performance as Measured in Baseline Source Data Report	The Prospective baseline will be developed using data from January 2011-December 2011. The baseline will be reported in first quarterly status report after the December 2011 review is complete. Minimum of 62 applicable cases for this item is possible.											
Negotiated Improvement Goal	Improvement goal will be set using Method 2 Prospective Formula from CFR TB33 and the overlap adjustment will be applied based on the number of quarters the baseline overlaps the IIP approval.											
Method of Measuring Improvement	Nevada item measures will be based on a targeted case review using a modified version of the current CFR case review tool. To establish a baseline, reviews will review 62 cases during the January 2011 to December 31, 2011 period, and the minimal applicable cases required to be reviewed for item 3 is 4. The period under review will cover the 12 months prior to the date the case is reviewed and the sample will consist of 33% in-home cases and 67% Foster care cases. In determination of the performance percentages, the numerator is the number of applicable cases in three regional sites in which the indicator was determined a strength for the period. The denominator is the total number of applicable cases reviewed across three regional sites for the period. The baseline period for case reviews will be completed in December 2011. Case review results will be reported within 30 days of the review and rolled up for each review, each site as base data and also aggregated for a statewide percentage. The ongoing case reviews sample will consist of 62 cases reviewed annually, and the minimal applicable cases required to be reviewed for item 3 is 4. The sample will consist of 33% in-home and 67% Foster care. During the evaluation period.											
Renegotiated Improvement Goal												
Status (Enter the quarter and date and measurement for the reported quarter in cell below)	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
Note: The baseline period for case reviews will be completed in December 2011.												
Outcome/Systemic Factor:	S2	Item:	4									
Performance as Measured in Final Report	58%											
Performance as Measured in Baseline Source Data Report	The Prospective baseline will be developed using data from January 2011-December 2011. The baseline will be reported in first quarterly status report after the December 2011 review is complete. Minimum of 62 applicable cases for this item in baseline baseline is not yet established. This will occur January 2011- December 2011.											
Negotiated Improvement Goal	Improvement goal will be set using Method 2 Prospective Formula from CFR TB33 and the overlap adjustment will be applied based on the number of quarters the baseline overlaps the IIP approval.											
Method of Measuring Improvement	Nevada item measures will be based on a targeted case review using a modified version of the current CFR case review tool. To establish a baseline, reviews will review 62 cases during the January 2011 to December 31, 2011 period, and the minimal applicable cases required to be reviewed for item 4 is 62. The period under review will cover the 12 months prior to the date the case is reviewed and the sample will consist of 33% in-home cases and 67% Foster care cases. In determination of the performance percentages, the numerator is the number of applicable cases in three regional sites in which the indicator was determined a strength for the period. The denominator is the total number of applicable cases reviewed across three regional sites for the period. The baseline period for case reviews will be completed in December 2011. Case review results will be reported within 30 days of the review and rolled up for each review, each site as base data and also aggregated for a statewide percentage. The ongoing case reviews sample will consist of 62 cases reviewed annually, and the minimal applicable cases required to be reviewed for item 4 is 62. The sample will consist of 33% in-home and 67% Foster care. During the evaluation period.											
Renegotiated Improvement Goal												
Status (Enter the quarter and date and measurement for the reported quarter in cell below)	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
Note: The baseline period for case reviews will be completed in December 2011.												

Outcome/Systemic Factor: Performance as Measured in Final Report	P1 18%	Item: 7	The Prospective baseline will be developed using data from January, 2011 to December 2011. The baseline will be reported in first quarterly status report after the December 2011 reviews are complete. Minimum of 62 applicable cases for this item in baseline.									
Negotiated Improvement Goal	Improvement goal will be set using Method 2 Prospective Formula from CSR, Part 3, and the overlap adjustment will be applied based on the number of quarters the baseline overlaps the PIP approval.											
Method of Measuring Improvement	Nevada item measures will be based on a targeted case review using a modified version of the current CSR case review tool to establish a baseline. Reviews will review 62 cases during the January, 2011 to December 31, 2011 period, and the minimal applicable cases required to be reviewed for item 7 is 40. The period under review will cover the 12 months prior to the date the case is reviewed and 10% of home cases and 6% Foster Care cases. In determination of the performance percentages, the numerator is the number of applicable cases in three regional sites in which the indicator was determined a strength for the period. The denominator is the total number of applicable cases reviewed across three regional sites for the period. The baseline period for case reviews will be completed in December 2011. Case review results will be reported within 30 days of the review and rolled up for each review. Each site as base data and also aggregated for a statewide percentage. The ongoing case reviews sample will consist of 62 cases reviewed annually, and the minimal applicable cases required to be reviewed for item 7 is 40. The sample will consist of 33% of home and 6% Foster Care. During the evaluation in											
Renegotiated Improvement Goal	Note: The baseline period for case reviews will be completed in December 2011.											
Outcome/Systemic Factor: Performance as Measured in Final Report	P1 18%	Item: 10	The Prospective baseline will be developed using data from January, 2011 to December 2011. The baseline will be reported in first quarterly status report after the December 2011 reviews are complete. Minimum of 62 applicable cases for this item in baseline.									
Negotiated Improvement Goal	Improvement goal will be set using Method 2 Prospective Formula from CSR, Part 3, and the overlap adjustment will be applied based on the number of quarters the baseline overlaps the PIP approval.											
Method of Measuring Improvement	Nevada item measures will be based on a targeted case review using a modified version of the current CSR case review tool to establish a baseline. Reviews will review 62 cases during the January, 2011 to December 31, 2011 period, and the minimal applicable cases required to be reviewed for item 10 is 40. The period under review will cover the 12 months prior to the date the case is reviewed and 10% of home cases and 6% Foster Care cases. In determination of the performance percentages, the numerator is the number of applicable cases in three regional sites in which the indicator was determined a strength for the period. The denominator is the total number of applicable cases reviewed across three regional sites for the period. The baseline period for case reviews will be completed in December 2011. Case review results will be reported within 30 days of the review and rolled up for each review. Each site as base data and also aggregated for a statewide percentage. The ongoing case reviews sample will consist of 62 cases reviewed annually, and the minimal cases required to be reviewed for item 10 is 40. The sample will consist of 33% of home and 6% Foster Care. During the evaluation period, Nevada											
Renegotiated Improvement Goal	Note: The baseline period for case reviews will be completed in December 2011.											
Status (Enter the quarter end date and measurement for the reported quarter in cell below)	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
Status (Enter the quarter end date and measurement for the reported quarter in cell below)	2011	pending										

Outcome/Systemic Factor:	WBI	Item: 17										
Performance as Measured in Final Report	47%											
Performance as Measured at Baseline: Source Data: School	The Prospective baseline will be developed using data from January 2011 to December 2011. The baseline will be reported in first quarterly status report after the December 2011 reviews are complete. Minimum of 62 applicable cases for this item in baseline.											
Stipulated Improvement Goal	Improvement goal will be set using Method 2 Prospective Formula from FSR 10/93, and the overlap adjustment will be applied based on the number of quarters the baseline overlaps the FIP approval.											
Method of Measuring Improvement	Nevada data measures will be based on a target case: 62 cases during the January 2011 to December 31, 2011 period, and the minimal applicable cases required to be reviewed for item 17 is 62. The period under review will cover the 12 months prior to the date the case is reviewed and the sample will consist of 33% In-Home cases and 67% Foster Care cases. In determination of the performance percentages the numerator is the number of applicable cases in three regional sites in which the indicator was determined a strength for the period. The denominator is the total number of applicable cases reviewed across three regional sites for the period. The baseline period for case reviews will be completed in December 2011. Case review results will be reported within 30 days of the review and follow-up for each review. Each site as base data and also aggregated for a statewide percentage. The ongoing case reviews sample will consist of 62 cases reviewed annually, and the minimal applicable cases required to be reviewed for item 17 is 62. The sample will consist of 33% in-home and 67% foster care. During the evaluation											
Renegotiated Improvement Goal												
Status (Enter the quarter end date and measurement for the reported quarter in cell below)	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
Note: The baseline period for case reviews will be completed in December 2011.												
Outcome/Systemic Factor:	WBI	Item: 18										
Performance as Measured in Final Report	47%											
Performance as Measured at Baseline: Source Data: School	The Prospective baseline will be developed using data from January 2011 to December 2011. The baseline will be reported in first quarterly status report after the December 2011 reviews are complete. Minimum of 62 applicable cases for this item in baseline.											
Stipulated Improvement Goal	Improvement goal will be set using Method 2 Prospective Formula from FSR 10/93, and the overlap adjustment will be applied based on the number of quarters the baseline overlaps the FIP approval.											
Method of Measuring Improvement	Nevada data measures will be based on a target case review using a modified version of the current FSR case review tool. To establish a baseline, reviewers will review 62 cases during the January 2011 to December 31, 2011 period, and the minimal applicable cases required to be reviewed for item 18 is 57. The period under review will cover the 12 months prior to the date the case is reviewed and the sample will consist of 33% In-Home cases and 67% Foster Care cases. In determination of the performance percentages the numerator is the number of applicable cases in three regional sites in which the indicator was determined a strength for the period. The denominator is the total number of applicable cases reviewed across three regional sites for the period. The baseline period for case reviews will be completed in December 2011. Case review results will be reported within 30 days of the review and follow-up for each review. Each site as base data and also aggregated for a statewide percentage. The ongoing case reviews sample will consist of 62 cases reviewed annually, and the minimal applicable cases required to be reviewed for item 18 is 57. The sample will consist of 33% in-home and 67% foster care. During the evaluation											
Renegotiated Improvement Goal												
Status (Enter the quarter end date and measurement for the reported quarter in cell below)	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
Note: The baseline period for case reviews will be completed in December 2011.												

Outcome/Systemic Factor:	WBI	Item: 19										
Performance as Measured in Final Report	55%											
Performance as Measured at Baseline, Source Data Period	The Prospective baseline will be developed using data from January 2011-December 2011. The baseline will be reported in first quarterly status report after the December 2011 reviews are complete. Minimum of 62 applicable cases for this item in baseline.											
Negotiated Improvement Goal	Improvement goal will be set using Method 2 Prospective Formula from CFSK TBR3, and the overlap adjustment will be applied based on the number of quarters the baseline overlaps the PIP approval											
Method of Measuring Improvement	Nevada item measures will be based on a targeted case review using a modified version of the current CFSK case review tool. To establish a baseline, reviewers will review 62 cases during the January 2011 to December 31, 2011 period, and the minimal applicable cases required to be reviewed for item 19 is 62. The period under review will cover the 12 months prior to the date the case is reviewed and the sample will consist of 33% In-Home cases and 67% Foster Care cases. In determination of the performance percentages the numerator is the number of applicable cases in these regional sites in which the indicator was determined a strength for the period. The denominator is the total number of applicable cases reviewed across three regional sites for the period. The baseline period for case reviews will be completed in December 2011. Case review results will be reported within 30 days of the review and rolled up for each review. Each site as base data and also aggregated for a statewide percentage. The on-going case reviews sample will consist of 62 cases reviewed annually, and the minimal applicable cases required to be reviewed for item 19 is 62. The sample will consist of 33% in-home and 67% foster care. During the evaluation											
Renegotiated Improvement Goal												
Status (Enter the quarter end date and measurement for the reported quarter in cell below)	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
	2/28/11											
	pending											
Note: The baseline period for case reviews will be completed in December 2011.												
Outcome/Systemic Factor:	WBI	Item: 20										
Performance as Measured in Final Report	44%											
Performance as Measured at Baseline, Source Data Period	The Prospective baseline will be developed using data from January 2011-December 2011. The baseline will be reported in first quarterly status report after the December 2011 reviews are complete. Minimum of 62 applicable cases for this item in baseline.											
Negotiated Improvement Goal	Improvement goal will be set using Method 2 Prospective Formula from CFSK TBR3, and the overlap adjustment will be applied based on the number of quarters the baseline overlaps the PIP approval											
Method of Measuring Improvement	Nevada item measures will be based on a targeted case review using a modified version of the current CFSK case review tool. To establish a baseline, reviewers will review 62 cases during the January 2011 to December 31, 2011 period, and the minimal applicable cases required to be reviewed for item 20 is 50. The period under review will cover the 12 months prior to the date the case is reviewed and the sample will consist of 33% In-Home cases and 67% Foster Care cases. In determination of the performance percentages the numerator is the number of applicable cases in these regional sites in which the indicator was determined a strength for the period. The denominator is the total number of applicable cases reviewed across three regional sites for the period. The baseline period for case reviews will be completed in December 2011. Case review results will be reported within 30 days of the review and rolled up for each review. Each site as base data and also aggregated for a statewide percentage. The on-going case reviews sample will consist of 62 cases reviewed annually, and the minimal applicable cases required to be reviewed for item 20 is 50. The sample will consist of 33% in-home and 67% foster care. During the evaluation											
Renegotiated Improvement Goal												
Status (Enter the quarter end date and measurement for the reported quarter in cell below)	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
Note: The baseline period for case reviews will be completed in December 2011.												
Note												