SUPPORTIVE TRANSITIONAL EMANCIPATION PROGRAM

TRANSITIONAL INDEPENDENT LIVING PLAN (STEP TILP) FOR 18 UP TO 21 YEARS OLD

PERSONAL DATA

START DATE OF PROGRAM: | COMPLETION DATE:

NAME: | SSN: | DATE OF BIRTH: | AGE: | GENDER: ☐M ☐F

COUNTY OF THE LAST HELD DEPENDENCY/WARDSHIP: | NAME OF LAST SOCIAL WORKER:

CURRENT ADDRESS: | CITY: | COUNTY: | STATE: | ZIP: | TELEPHONE:

MAILING ADDRESS IF DIFFERENT: | CITY: | COUNTY: | STATE: | ZIP: | OTHER TELEPHONE:

TRIBAL AFFILIATION: ☐ YES ☐ NO | IF YES, NAME OF TRIBE: | ETHNICITY: | LANGUAGE:

EMANCIPATED FROM: ☐ FOSTER CARE ☐ PROBATION ☐ RELATIVE CARE | EMANCIPATION DATE:

THE COUNTY WILL CHECK IN WITH ME:

☐ MONTHLY ☐ QUARTERLY ☐ EVERY 6 MONTHS ☐ ANNUALLY ☐ OTHER*(SPECIFY)*: _____

CURRENT IDENTIFICATION: ☐ CA ID CARD ☐ CA DRIVER'S LICENSE ☐ PASSPORT ☐ VISA | MY PRIMARY SERVICE PROVIDER IS:

EDUCATION

Completed schooling

Type of education I have completed:

☐ Up through 9th Grade ☐ Up through 10th Grade ☐ Up through 11th Grade ☐ Up through 12th Grade

☐ High School Diploma ☐ GED ☐ Vocational Education ☐ Community College

☐ 4 year College/University ☐ Other *(specify)*:_____

School Attended:_____

Course of Study:_____ Date Completed:_____

Current schooling

Type of education I am currently enrolled in:

☐ High School ☐ GED Courses ☐ Vocational Education ☐ Community College

☐ 4 year College/University ☐ Other *(specify)*:_____

School Attended:_____

Course of Study:_____ Projected Completion Date:_____

Proof of Enrollment *(attach)*: ☐ Report Card ☐ School Transcripts ☐ Proof of Registration

☐ Other *(specify)*:_____

Educational Goals

Grade Point Average: _____

During my time in STEP, my educational goals are:

1. _____

2. _____

3. _____

My plan to achieve these goals are:

1. _____
2. _____
3. _____

My educational Service Provider is:_____

They will help me achieve these goals by:

1. _____
2. _____
3. _____

Date projected to complete my educational goals:_____ Proof that I am achieving my education goals *(attach)*:

I have attached the following documents to verify the progress I've made toward my educational goals: _____

Financial Aid/Scholarship Information

I currently receive *(please mark all that apply)*:

☐ Financial Aid ☐ Scholarship ☐ Grant ☐ Other:_____

Please specify what is received:

1. _____
2. _____
3. _____

If I do not currently have Financial Aid/scholarship information and would like to obtain information about available options my Service Provider will help me achieve this by:

1. _____
2. _____
3. _____

Summer Plans

During the summer break, my plans are:

1. _____
2. _____
3. _____

Additional Information

Other information/interests that help me to achieve my educational goals *(ie. volunteer work, sport teams, etc.)*:

1. _____
2. _____
3. _____

EMPLOYMENT (Current Employment)

START DATE:	PLACE OF EMPLOYMENT:	
JOB TITLE:	JOB RESPONSIBILITIES:	
CURRENT WORK SCHEDULE:	HOURS i WORK PER WEEK: ☐ 1-10 ☐ 11-20 ☐ 21-30 ☐ 31-40	RATE OF PAY: $ per hour

SHIFT I WORK:

☐ Day ☐ Swing ☐ Evening ☐ Grave ☐ Other *(specify)*:

SUPERVISOR/CONTACT PERSON:	TELEPHONE:

PROOF OF EMPLOYMENT *(ATTACH)*:

Employment History

START DATE:	END DATE:	PLACE OF EMPLOYMENT:

JOB RESPONSIBILITIES:

START DATE:	END DATE:	PLACE OF EMPLOYMENT:

JOB RESPONSIBILITIES:

START DATE:	END DATE:	PLACE OF EMPLOYMENT:

JOB RESPONSIBILITIES:

Unpaid Work Experience *(Volunteer Work)*

START DATE:	END DATE:	PLACE OF EMPLOYMENT:

JOB RESPONSIBILITIES:

START DATE:	END DATE:	PLACE OF EMPLOYMENT:

JOB RESPONSIBILITIES:

START DATE:	END DATE:	PLACE OF EMPLOYMENT:

JOB RESPONSIBILITIES:

Employment Needs

To achieve my employment goals, I need assistance in the following areas:

1. _____
2. _____
3. _____

My employment Service Provider is:_____

My Service Provider will help me with these needs by:_____

1. _____
2. _____
3. _____

CAREER

Career Goal
My Career goals are:

1. _____
2. _____
3. _____

My plans to achieve these goals are:

1. _____
2. _____
3. _____

CAREER

Career Goal *(Continued)*

My career Service Provider Is:_____

My Service Provider will help me achieve my career goals by:

1. _____

2. _____

3. _____

I am achieving my career goals: ☐ YES ☐ NO

Supporting documentation:_____

HEALTH COVERAGE

I AM CURRENTLY ON MEDI-CAL:	I CURRENTLY HAVE HEALTH COVERAGE:	IF YES, MY SOURCE OF COVERAGE:
☐ YES ☐ NO	☐ YES ☐ NO	
I CURRENTLY HAVE DENTAL COVERAGE:	IF YES, MY SOURCE OF COVERAGE:	
☐ YES ☐ NO		
I CURRENTLY HAVE VISION COVERAGE:	IF YES, MY SOURCE OF COVERAGE:	
☐ YES ☐ NO		

If I do not have health, dental or vision coverage my Service Provider plans to help me obtain coverage by:_____

_____

I would like information on the following: ☐ Drug Rehabilitation ☐ Alcohol Rehabilitation ☐ Tobacco Cessatio
☐ None ☐ Other *(specify)*:_____

My health Service Provider is:_____

My Service Provider will assist me by:_____

Additional health needs:

1. _____

2. _____

3. _____

My Service Provider will assist me by:_____

HOUSING

My current living situation is *(check all that apply)*: ☐ With spouse ☐ With minor children
☐ Alone renting an apartment or house ☐ Transitional Housing ☐ Host Family ☐ With parent
☐ With roommate renting an apartment or house ☐ With relatives ☐ College Dorm ☐ Homeless
☐ Shelter ☐ Section 8 Vouchers ☐ Unsafe ☐ Temporary ☐ With friends
☐ Other (specify): _____
My current living situation is safe: ☐ YES ☐ NO

If NO, my Service Provider will help me gain a safe living environment by:_____

_____

I have changed residences during the previous 12 months because:_____

I am currently on the transitional housing waiting list: ☐ YES ☐ NO

I am currently on the Section 8 voucher waiting list: ☐ YES ☐ NO

My housing needs are:_____

_____

My housing Service Provider is: _____

My Service Provider will assist me by:_____

DRIVERS LICENSE

I hold a valid California Driver License: ☐ YES ☐ NO

If NO, please explain:_____

My plans to obtain one are:_____

My Service Provider will assist me by:_____

My Service Provider helping me obtain my driver's license is:_____

I currently have car insurance: ☐ YES ☐ NO

If NO, please explain:_____

My plans to obtain insurance are:_____

My Service Provider will assist me by:_____

SUPPORT NETWORK

I have a network of supportive adults to whom I can turn to in times of needs. They include:

Relationship	Name of Supportive Adult	Contact #
Mentor	NAME:	
Relative	NAME:	
STEP Provider	NAME:	
Social Worker	NAME:	
Friend	NAME:	
THP + Provider	NAME:	
ILP Staff	NAME:	
Former Foster Parent	NAME:	
Therapist	NAME:	
Other	NAME: RELATIONSHIP:	
Other	NAME: RELATIONSHIP:	
Other	NAME: RELATIONSHIP:	
Other	NAME RELATIONSHIP:	
Other	NAME: RELATIONSHIP:	
Other	NAME: RELATIONSHIP:	
Other	NAME: RELATIONSHIP:	

FINANCIAL

My sources of income include: ☐ Work ☐ STEP Payment ☐ SSI ☐ Trust Account ☐ CalWORKs

☐ Other (specify):_____

I currently have a: ☐ Checking Account ☐ Savings Account ☐ Neither

My plans to pay bills and manage money are: ☐ Open a Checking Account ☐ Open a Savings Account

☐ Money Order's ☐ Cashier's Checks ☐ Other *(specify)*:_____

Signing this contract means that we will all work to complete the steps necessary to help the participant meet his/her goals. The form shall be updated at least annually. The participant is responsible for informing the county whenever changes occur that affect payment of aid, including changes in address, living circumstances, educational/career/training programs. The participant understands that failure to follow the plan outlined herein may result in forfeiture of the STEP payments.

STEP PARTICIPANT	DATE
SERVICE PROVIDER	DATE
COUNTY REPRESENTATIVE	DATE

PERSONAL DATA FORM

These questions are for data collection purposes only.

Your answers do not affect your eligibility for STEP and you are not required to answer the questions in order to receive STEP.

1. Current Marital Status: ☐ Never Married ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

2. Number of children: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

3. Since I turned 18 years old I was incarcerated: ☐ YES ☐ NO

PERSONAL INFORMATION NOTICE

Pursuant to the Federal Privacy Act (P.L. 93-679) and the information Practices Act of 1977 (Civil Code Sections 1798, et. seq.), notice is hereby given for the request of personal information by this form. The requested personal information is voluntary. The principal purpose of the voluntary information is to facilitate the processing of this form. The failure to provide all or any part of the requested information may delay processing of this form. No disclosure of personal information will be made unless permissible under Article 6, Section 1798.17 of the IPA of 1977. Each individual has the right upon request and proper identification, to inspect all personal information in any record maintained on the individual by an identifying particular. Direct any inquiries on information maintenance to your IPA Forms Officer.