	INDIANA DEPARTMENT OF CHILD SERVICES CHILD WELFARE MANUAL	
	Chapter 11: Older Youth Services	**Effective Date:** July 1, 2012
	Section 21: Collaborative Care (CC) Case Transfers	**Version:** 1

POLICY [NEW]

All youth under the care and supervision of the Department of Child Services (DCS) at the age of 17 years and six (6) months who plan to either voluntarily enter Collaborative Care (CC) or remain under a Child in Need of Services (CHINS) case and participate in CC, will have their case transferred to a Collaborative Care Case Manager (3CM) who will manage their cases until case closure. The 3CM and Family Case Manager (FCM) should engage the youth to determine the best path for the youth based on the youth's direction and voice. The youth may request to do one (1) of the following:

1. Remain under the care and supervision of DCS through the CHINS case;
2. Enter CC under the care and supervision of DCS; or
3. Request that his or her CHINS case be dismissed and enter into Voluntary Independent Living Services.

Continuity of care will continue when transferring a case from the FCM to the 3CM by conducting a transition meeting that includes the FCM, 3CM, the youth, and any other relevant persons.

The transition meeting can be held concurrently with the youth's IL/Transition Planning Meeting that occurs when the youth turns 17.5 years of age. See separate policy, 11.6 Independent Living - Transition Plan.

Code References

IC 31-28-5.8-7: Periodic Reviews by Court; Notice; Participation, Orders

PROCEDURE

The FCM will:

1. Invite a member of the Older Youth Initiatives Team (3CM Supervisor) to the Child and Family Team (CFT) Meeting to discuss the following for youth who are at least **17 years of age:
   a. National Youth in Transition Database (NYTD) survey,
   b. Permanency goal, and
   c. CC.

2. Arrange an additional CFT Meeting if the youth expresses interest in CC with a member of the Older Youth Initiatives Team three (3) months after the above listed CFT Meeting to cover the following:
   a. Confirm youth's interest in entering CC, and
   b. Prepare for case transfer.

3. Ensure all parties to the case (i.e., the youth's Court Appointed Special Advocate (CASA) or Guardian ad Litem (GAL)) are notified of the youth's interest in entering CC;

   Note: If youth does not want to enter CC at this point, the FCM will continue to offer CC, if appropriate, every six (6) months at the scheduled CFT Meetings. See separate policy, 11.6 Independent Living - Transition Plan, for additional details on the Transitional Planning Process.

4. Ensure all case information is entered into Management Gateway for Indiana's Kids (MaGIK) and up-to-date (see related information);
5. Document the following in the case file:
   a. Court reports (i.e., if the court hearing is within 10 business days of the transfer, the FCM would be responsible for this report, unless negotiated otherwise at the transition meeting),
   b. Notices, and
   c. The Independent Living/Transition Plan.

6. Schedule a transition CFT Meeting and invite all identified necessary participants (e.g. youth, informal supports, substitute caregivers or resource parents, and Older Youth Service Providers, etc.) within 15 calendar days of the case transfer (should occur as close to youth turning 17 and six (6) months old as possible);

   Note: Case transfer cannot occur prior to youth turning 17 and six (6) months old.

7. Document contacts in MaGIK that all parties were notified of the transition meeting; and
8. Notify the DCS Local Office Attorney and the youth's CASA or GAL of the case transfer, if applicable.

The FCM Supervisor will:

1. Ensure that the FCM continues to be responsible for attending all court hearings and monitoring the youth's safety and well-being until the case is transferred to a 3CM;
2. Assign the case to the 3CM Supervisor at the time of case transfer;
3. Ensure that the youth's pertinent information is up-to-date in MaGIK prior to the case transfer occurring;

   Note: If information is incomplete or missing after the case has been transferred, the FCM Supervisor shall work with the 3CM Supervisor and FCM to ensure that the FCM completes the data input.

4. Work with the Collaborative Care Case Manger Supervisor to ensure that any missing or incomplete information from the youth's electronic or hard copy is completed.

The 3CM Supervisor will:

1. Identify and assign the case to a 3CM in MaGIK within 48 hours of the case transfer meeting;
2. Ensure MaGIK has all pertinent information and is up-to-date upon case transfer;

Note: If information is incomplete or missing it is the 3CM Supervisor's responsibility to work with the FCM Supervisor to ensure that the youth's former FCM completes the data input/updates.

3. Ensure the 3CM receives the hard copy case file from the youth's FCM within 48 hours of the case transfer meeting.

The 3CM will:

1. Attend the transition meetings;
2. Thoroughly review the case file in MaGIK;
3. Thoroughly review the hard copy case file;
4. Ensure continuity of services, particularly those services that are related to the youth's physical and mental health and well-being including, but not limited to:
   a. Psychiatric treatment and care,
   b. Treatment and care for a chronic medical condition,
   c. Establishing a primary health care provider, dentist, ophthalmologist, gynecologist (if applicable), etc.,
   d. Therapeutic treatment and care, and
   e. Continuation of service referrals through DCS.

5. Ensure the youth does not lose contact with any siblings by adhering to the established visitation plan. If a visitation plan has not been created or is out of date, the 3CM will ensure that the visitation plan is completed;
6. Ensure that the youth does not lose contact with family members, and other informal supports due to the case transfer.

PRACTICE GUIDANCE

Preparing a Youth for Case Transfer

In any case transfer, ensuring a youth's safety is given the highest priority. The best way to ensure safety is to maintain consistency with services for the youth. At the IL/Transition Planning meeting, the youth and the 3CM may begin to identify formal and informal supports in his or her community. Immediately after transferring a case, a youth may need a higher level of support from the 3CM because he or she will be adjusting to his or her surroundings and may not have access to the same services, formal, and informal support systems as before.

Placement Disruption

When a case is transferred, the placement of the youth is not expected to be disrupted unless all parties agree that it would be in the best interest of the youth.

FORMS AND TOOLS

Independent Living/Transition Plan

RELATED INFORMATION

Transfer Meetings

If possible, transfer meetings may take place during the youth's IL/Transition Planning meeting. Both the FCM and 3CM (or a supervisor/delegate) should be present at the transfer meeting.

Examples of information that should be shared and discussed at the transfer meeting include, but are not limited to:

1. The youth's individual strengths and needs;
2. Needs that may arise in the near future, especially with the case transfer;
3. What supports are currently in place to support those needs;
4. What support will need to be in place after the case transfer;
5. Review and update the youth's IL/Transition plan;
6. Clarify expectations of what the next steps are for the case;
7. Formal and informal supports for the youth that will be utilized after case transfer;
8. Steps to address what could go wrong with any plans that are created; and
9. Visitation arrangements, as applicable.

Case File

Prior to transferring the hard case file or the case in MaGIK, the FCM is responsible for ensuring that all information is current and accurate. The originating county is not required to keep a copy of the case file. The data entry must be complete for each of the following:

1. Hearings;
2. Placements;
3. Services;
4. Visitation Plan (if applicable);
5. Case Plan;
6. IL/Transition Plan;
7. Demographic information;
8. Information entered in the NYTD (education, services, survey);
9. Contacts;
10. School information and other related education information (Individualized Education Plan);
11. Medicaid Number;
12. Health Information (medical and dental health issues, current treatment);
13. Indiana Support Enforcement Tracking System (ISETS) interface, if appropriate;
14. Court Reports;
15. Notices;
16. Mental Health Screen;
17. Medical Passport (including immunization records); and
18. Other information not included in the above list that is:
    a. Specific to the youth's individual circumstances; and
    b. Pertinent to the continuity of the youth's services and case.

Contacting Older Youth Initiatives Team

The CC Supervisor Map can be utilized to contact a member of the Older Youth Initiatives Team (3CM Supervisor).