Clear Form

Minnesota Department of **Human Services**

Voluntary Foster Care Agreement for Youth Ages 18 - 21 (Minnesota Statutes, Chapter 260C.451)

Purpose: This agreement is between the county social service agency and a youth who has requested to resume foster care benefits after age 18, and meets the required conditions.

THIS AGREEMENT IS BETWEEN _____ , an agency duly authorized
Agency

by the state of Minnesota to place children in out-of-home care, (hereinafter called the "agency"),

and _____ , residing at _____
Youth's name Youth's address

_____ , county of _____, Minnesota.

Placement

Youth: I agree to live in the foster care setting, which may be a supervised independent living setting authorized by the agency. I also agree that, in order to remain in foster care through the agency, I must be:

1. Completing a secondary education or a program leading to an equivalent credential
2. Enrolled in an institution that provides post-secondary or vocational education
3. Participating in a program or activity designed to promote or remove barriers to employment, or
4. Employed for at least 80 hours per month.

If I am incapable of doing any of the activities described above due to a documented medical condition, I agree to cooperate with the agency to document my condition on an ongoing basis.

Agency: The agency agrees to provide continued foster care services to you, whether you are placed in licensed foster care, residential care or in an authorized supervised independent living setting.

Planning

Youth: I agree to participate in development of the case plan, including an independent living plan (ILP) with the agency, attend all case plan reviews, and keep the agency informed about how to contact me at all times.

Agency: The agency agrees to develop a written plan, including an ILP with you, review the plan as required, provide notification of case plan reviews, and provide you with a copy of the plan.

Services

Youth: I agree to follow through with my responsibilities as outlined in the case plan and ILP, participate in identified services, be present at visits with my caseworker and keep the agency informed of my needs.

Agency: The agency agrees to provide foster care maintenance payments, case management, at least monthly face-to-face visits, and other services according to the plan(s). Maintenance is a monthly payment to support board, room, clothing and other expenses.

Permanent connections

Youth: I agree to visit and keep in touch with siblings, family and other important adults.

Agency: The agency will establish a plan with you, and make efforts to seek life-long permanent connections, which may include reunification or adult adoption.

Verification of eligibility condition(s)

Youth: I agree to provide and cooperate with establishing and maintaining verification(s) of my eligibility condition(s). I understand that the agency is required to verify my enrollment in school, employment, participation in a program to promote employment, or medical condition that affects my ability to work or go to school.

Agency: The agency agrees to provide foster care services and maintenance for you, as long as eligibility condition(s) and associated verification(s) are maintained.

Financial resources

Youth: I agree to use the financial supports provided for the purpose intended.

Agency: The agency agrees to notify you, if you are placed in an authorized supervised independent living setting and are directly receiving the foster care maintenance, or your caregiver, of the amount of the payment, and provide advance notice of any change in payment. Any notice of a payment change would include information about how to appeal.

Youth: You may object to having your credit reports requested by the agency. The agency must document your objection in the case file.

Agency: The agency also has responsibility to work with you to obtain credit reports from the three national consumer credit reporting agencies annually until discharged from foster care. Social workers must assist you in interpreting the report and resolving inaccuracies.

Medical insurance

Youth: I agree to apply for Medical Assistance, and provide information needed for continued eligibility.

Agency: The agency will bill health insurance or Medical Assistance for covered medical services. The agency will assist you in applying for Medical Assistance and understanding your coverage. You may be responsible for the cost of medical services not covered by your insurance.

Authorization for release of medical and educational records

Youth: I agree to sign the necessary releases for the agency and facility/foster home to have access to my education, medical and mental health records.

Agency: The agency will maintain data privacy of this information according to state and federal laws.

Termination of the agreement

Youth: I agree to terminate the agreement by notifying the agency of my desire to end this agreement.

Agency: The agency agrees to provide written notice to you if your voluntary placement agreement will be terminated. If your eligibility for continued foster care is not maintained, the agency agrees to offer a 90-day transition plan prior to your discharge. The written notice would include information about your right to a fair hearing and how to appeal the decision.

Signatures

I agree to the provisions contained in this voluntary foster care placement agreement. My and the agency representative's signature below is the agency's legal authority to resume foster care benefits.

SIGNATURE OF YOUTH	SIGNATURE OF AGENCY REPRESENTATIVE
DATE OF AGREEMENT	TITLE OF AGENCY REPRESENTATIVE

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກຂອງທ່ານຫຼືໂທຣ໌ຫາຕາມເລກໂທຣ໌ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông tin nầy miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB2-0001 (10-09)

ADA5 (12-12)

This information is available in accessible formats for individuals with disabilities by contacting your county worker. For other information on disability rights and protections to access human services programs, contact the agency's ADA coordinator.