CHILDREN WITH COMPLEX NEEDS TRANSITION PLAN AGREEMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHILDREN AND FAMILY SERVICES
SFN 1197 (4-2025)

Clear Fields

A Transition Plan Agreement is allowed per policy (624-05-12). In efforts to consider utilizing a Transition Plan Agreement, the child must be in a primary placement of a Qualified Residential Treatment Facility (QRTP) or a Psychiatric Residential Treatment Facility (PRTF), unless otherwise approved by the Department. After a Transition Plan Agreement is approved and in effect, monthly planning meetings are required to review and discuss additional treatment needs and further planning.

TRANSITION PLAN

Agency Requesting Transition Plan Agreement

☐ Human Service Zone: _____ ☐ Division of Juvenile Services (DJS)

☐ Tribal Nation (IV-E only): _____

Name of Custodial Agency Worker Completing the Form

DEMOGRAPHICS

Child's Name (First and Last)	Date of Birth
Current Placement	☐ QRTP ☐ PRTF
Foster Care Provider Name	Provider Number

Effective Dates of Agreement *(cannot exceed 90 days)*

From: To:

Provider Type	Transition Plan Daily Rate/Provider Daily Rate
☐ State Home ☐ Nexus PATH ☐ Tribal	☐ $33 (5-12 years) ☐ $36 (13+ years)
☐ Other: _____	☐ Nexus Path Rate $67/LOC rate with $50 to TFC provider

Is a bed amendment necessary?

☐ No ☐ Yes - Complete a SFN 1017 and discuss the need for an additional bed with the CFS Licensing Unit

EXPLANATION OF NEED FOR TRANSITION PLAN AGREEMENT

Specify information regarding the need of the child for additional support during the transition period including information regarding child's special medical, emotional, or behavioral needs.

EXPLANATION OF RESPONSIBILITY OF FOSTER CARE PROVIDER AND THE TFC AGENCY, IF APPLICABLE

Specify information regarding the responsibility of the foster care provider, and TFC agency, if applicable, to participate in treatment planning and programming, as well as responsibility to maintain contact with the child including home visits, onsite visits while in facility placement, etc.

It is agreed that all records kept by the Provider relating to this agreement shall remain confidential, except they shall be open for inspection by officials of the Department or their designated representatives if requested. This agreement does not constitute an employer-employee relationship, and the TPA may be terminated without cause by either party. It is further agreed if the foster care provider does not accept placement of the child upon discharge from the facility, they may be subject to repayment. The Transition Plan Agreement can also be terminated by DHHS, if the agreement is not being followed.

SIGNATURES

By signing this agreement, I attest that the Transition Plan Agreement is accurate and reflects my agreement to participate accordingly.

Provider Signature	Date
Custodial agency Worker Signature	Date
Nexus PATH Supervisor (if applicable)	Date
Field Service Specialist Signature	Date

PART 2: Monthly Transition Plan Agreement Update

Must be completed by the custodial agency worker, signed by the provider, and submitted to the CFS Field Service Specialist by the 1st working day of the following month in which the Transition Plan Agreement is in place. Reimbursement will be issued monthly.

This agreement is entered between the Department of Health and Human Services and

Foster Care Provider Name	Date of Anticipated Discharge
Provider Type ☐ State Home ☐ Nexus PATH ☐ Tribal ☐ Other _____	Date of Monthly Transitional Planning Meeting

Documentation of Home Visits: Record below the start and end dates for each visit that occurred during the month:

Child Name		Visit Start Date	Visit End Date
Visit Start Date	Visit End Date	Visit Start Date	Visit End Date
Visit Start Date	Visit End Date	Visit Start Date	Visit End Date

Documentation of Services and Supports Completed by the Provider Home

Detail the frequency and duration of services and supports offered to the child while placed in the facility. Summarize the dates of engagement made with the child through phone calls, family therapy, treatment planning, facility on-site visits, and trainings specific to meet the child's need upon discharge.

Documentation of Services and Supports Completed by the TFC Agency (If applicable)

Detail the frequency and duration of services and supports offered to the TFC provider and child while placed in the facility. Summarize the dates of engagement made through phone calls, treatment planning, facility onsite visits, and trainings specific to meet the child's need upon discharge.

Documentation of Services and Supports Completed by the Custodial Agency

Summarize the strengths of the transition plan agreement with the provider. What barriers or concerns do you have regarding the current discharge plan. What services and supports are being set up to assist in transition into the provider home.

It is further agreed that this agreement does not constitute an employer/employee relationship between the Department and Provider, that this agreement may be terminated by either party by giving 30-days' written notice, and that there are no other agreements, either oral or written, that impact this agreement.

SIGNATURE SECTION

By signing this agreement I attest that the Transition Plan Agreement details are true and correct.

Provider Signature	Date
Custodial Agency Worker Signature	Date
Nexus PATH Supervisor (if applicable)	Date
Field Service Specialist	Date

Routing: ☐ Child's File ☐ CFS FCSA Unit ☐ CFS Licensing Unit ☐ Nexus PATH (If applicable)