STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

JOHN A. WAGNER
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GOVERNOR

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[x] Federal Law or Regulation Change
[ ] Court Order
[ ] Clarification Requested by One or More Counties
[ ] Initiated by CDSS

October 14, 2010

ALL COUNTY LETTER NO. 10-45

TO: ALL COUNTY WELFARE DIRECTORS
ALL CHIEF PROBATION OFFICERS
ALL INDEPENDENT LIVING PROGRAM (ILP) MANAGERS
ALL ILP COORDINATORS

SUBJECT: NEW FEDERAL REQUIREMENT ADDED TO THE 90-DAY TRANSITION PLAN

REFERENCE: ALL COUNTY LETTER (ACL) NO. 09-87; PUBLIC LAW (P.L.) 111-148; P.L. 110-351; WELFARE AND INSTITUTIONS CODE (WIC) SECTION 391; WIC SECTION 16501.1(f) (16) (B); CALIFORNIA PROBATE CODE SECTION 4700-4701

The purpose of this letter is to inform all counties of the new federal mandate effective October 1, 2010. The Patient Protection and Affordable Care Act, P.L. 111-148, requires that all foster youth be provided with information about a “power of attorney for health care”, during the development of the 90-day Transition Plan.

The 90-day Transition Plan is developed with a foster youth during the 90-day period prior to the youth aging out of foster care. The 90-day Transition Plan is to specifically cover the following areas: housing, education, health insurance, mentors/continuing support services and workforce support/employment services, and now, informing youth about a power of attorney for health care. The 90-day Transition Plan requirement became effective January 1, 2010 and funding was provided for this mandate. For further information see ACL NO. 09-87.

The California Department of Social Services (CDSS) has updated the 90-day Transition Plan to help ensure the requirements of educating foster youth about the “power of attorney for health care” are fulfilled. An item has been added to the 90-day Transition Plan for youth to initial, verifying they have received the power of attorney information. Additionally, CDSS will be seeking to add this requirement to WIC

16501.1(f) (16) which describes what areas are to be covered in the 90-day Transition Plan.

A copy of the revised 90-day Transition Plan, form FC 1637, is attached. The word version of the revised 90-day Transition Plan will be sent via email to child welfare staff, ILP coordinators and probation contacts.

During the process of developing the 90-day Transition Plan with foster youth, social workers and probation officers are required to provide information to the foster youth that explains why and how to designate a "power of attorney for health care", also referred to as a "health care agent". A "health care agent" is an individual designated to make medical decisions on behalf of an adult if he/she is incapable of making decisions. If no health care agent is appointed, when an adult has a medical emergency in which he/she is not capable of communicating with hospital staff, the parent(s) or other relative would be asked to make decisions about medical treatment for the individual.

In explaining this to a foster youth, if he/she does not have, or does not want a relative to make emergency medical decisions on his/her behalf, at age 18 he/she can designate a trusted person to become a "health care agent". Explaining this during the 90-day transition planning will provide the foster youth with time to think about whether or not this is an appropriate choice, at age 18, and to discuss this with the person he/she may want to designate as a "health care agent". Providing youth with a sample of the Advanced Health Care Directive form during the 90-day transition planning may help to explain the process. The attached form is only one example of the form. Counties may select a different version of the form which can be found through internet searches or through various medical agencies. An Advanced Health Care Directive form will be provided to foster youth at age 18 along with the other important documents they receive as described in WIC 391. The CDSS will seek to add this form into the WIC 391 requirements.

If a foster youth decides to choose a "health care agent" at age 18, an Advanced Health Care Directive form must be completed. The form is to be signed either 1) in the presence of two non-relative witnesses or 2) in the presence of a notary public. The form contains many options around what type of medical decisions the power of attorney can make on behalf of the individual. When completing the form, the authority of the health care agent can be limited as to what type medical decisions the person can make, for example, making decisions about life support. This is explained on the instruction page included with the attached copy of the form. The completed form does not expire, but it can be revoked. The completed form should be kept in a safe place and the health care agent should also keep a copy. A copy of the form is as valid as the original form.

Foster youth may have questions regarding this information. It is important for the social worker or probation officer to explain this information to youth; however, the social worker or probation officer is not expected to provide legal or health care advice to the youth as this is a personal decision, nor to offer to assist the youth to complete the form. A foster youth may seek advice from his/her attorney, physician, mentor, trusted adult, or Court Appointed Special Advocate for this area.

The CDSS understands that most people are not familiar with the process of designating a power of attorney for healthcare and that this requirement will raise a lot of questions during implementation. The ILP Policy Unit will work to put together a resource document to provide further information; however, it is imperative to proceed immediately with implementation in order to meet the federal mandate. If you have any questions please email ILPPolicy@dss.ca.gov or call 916-651-7465.

Sincerely,

Original Document Signed By:

GREGORY E. ROSE,
Deputy Director,
Children and Family Services Division

Attachments

90-DAY TRANSITION PLAN

This form is for you to develop a plan when you are within 90 days of leaving foster care. This plan will focus on activities that you will complete during this time. This is as an agreement between you and those supporting you to work toward completing your transition plan. This should be developed with you in a transition conference setting, or group meeting, with those you want involved and who are helping you to successfully transition out of foster care.

Instructions To Youth: During the 90-day period before you leave foster care, you will make a transition plan that shows where you plan to live, receive additional support, work and/or go to school after you leave care and help keep family connections. The purpose of this plan is to help you take steps to successfully live on your own.

Instructions to Caregiver/other adults: If asked by the youth, you are also agreeing to assist the youth in the development of a 90-day transition plan that will help him/her to successfully transition out of foster care.

Instructions to Social Worker/Probation Officer: During the 90-day period prior to the youth exiting foster care, you are agreeing to assist the youth in developing a transition plan that will address his/her needs for housing, employment, education, mentors, continuing support services and health insurance.

Instructions for Family, Service Providers, CASA and others connected to and supporting the youth: If asked by the youth, you are also agreeing to assist the youth in the development of a 90-day transition plan that will help him/her to successfully transition out of foster care.

During the 90-day period prior to aging out of care:

This plan is to be completed within the 90 day period before you turn 18, 19, or graduate from high school, whichever event will coincide with his/her exit from foster care. If you emancipate from care before age 18, this plan should be completed within 90 days before your target emancipation date.

The sections on the next page must be completed to include your plan for education, employment, housing, mentoring, family connections, continuing support services and health insurance. The plan must be personal to you and as detailed as you can get. The plan must contain specific actions that you and others will take to help you prepare for leaving care.

***Note:** The last page of this form has an example grid that can give you ideas to help make your planning very concrete.

Copies to: Youth - Caregiver - Case File - ILP - Family - Others

YOUTH:	DOB:	AGE:	ETHNICITY:
CASE WORKER NAME:		CASE WORKER PHONE:	

90- DAY TRANSITION PLAN

Additional boxes can be inserted if needed

Education Plan:	To prepare, I or a supporting adult (name) will:	Recommended documents the youth will need
Employment Plan:	To prepare, I or a supporting adult (name) will:	Recommended documents the youth will need
Housing Plan:	To prepare, I or a supporting adult (name) will:	Recommended documents the youth will need
Mentoring & Continuing Support Services (e.e. mental health, health services) Plan:	To prepare, I or a supporting adult (name) will:	Recommended documents the youth will need
Family and Other Permanent Connections:	I plan to stay connected to family and other adults by:	Recommended documents the youth will need
Health Insurance Plan:	If not eligible for extended Medi-Cal, I plan to get health insurance through:	Agency, employer or other person providing health insurance:

Copies to: Youth - Caregiver - Case File - ILP - Family - Others

ACKNOWLEDGEMENTS:

I know that I must sign verification paperwork to continue my Medi-Cal health insurance benefits when I exit from foster care and again each year to receive Medi-Cal until my 21st birthday or until I have secured a different type of health insurance. I am also aware that when I move I must resubmit a verification form with my new address._____youth's initials

I have been told that when I am 18, I can choose a "power of attorney for health care" that can make medical choices for me if I am not able. When I turn 18, I will receive directions and a form that I can fill out if I want to choose a power of attorney for health care._____youth's initials

I know that 30 days prior to leaving foster care, I am eligible to apply for food stamps.__ youth's initials

I agree to meet with my caregiver and social worker/probation officer as needed to ensure sufficient progress towards my goals.

Target date for exiting foster care _____

By signing below, this means we will all work to complete the steps necessary to help the youth complete his/her transition plan.

Youth's signature	*Date*
Caregiver's signature	*Date*
Social Worker/Probation Officer signature	*Date*
Family Member signature	*Date*
Service Providers/Therapist signature	*Date*
CASA/Other Youth Advocates signature	*Date*

LEGISLATIVE & REGULATORY REFERENCES:

- Public Law (P.L.) 110-351, which states that a Transition Plan must be developed at the direction of the youth during the 90 day period prior to the youth aging out. The plan must contain specific options on housing, health insurance, education, local opportunities for mentors/continuing support services and workforce support/employment services. P.L. 111-148 requires providing foster youth with the information about a Power of Attorney for Health Care.

Copies to: Youth - Caregiver - Case File - ILP - Family - Others

90-DAY TRANSITION PLAN EXAMPLES

Education Goals:	**TimeLine**	**Recommended documents the youth will need**
I plan to attend….	FAFSA due: 01/01/2009 School application 01/15/2009 Scholarship app: 02/01/2009 Housing app: 03/01/2009 (Due dates of all document and application deadlines)	• Copy of School application • Copy of FAFSA application • Copy of Chafee grant application • Copy of Guardian Scholar application • Copy of High School transcripts
Employment Plan:	**I have Prepared by:**	**Recommended documents the youth will need**
I plan to get/have a job at…. 1. 2. 3. 4.	• Completing ILP Proficiency Certificate checklist • Completing job applications at:_____ • Having Social Security card available • Identifying people to provide reference	• Copy of resume • Copy of Permanent Residency card (if applicable) • List of people willing to provide reference
Housing Plan:	**I have prepared by:**	**Recommended documents the youth will need**
I plan to live with/in...	• Touring the facilities • Confirming deposit and move-in arrangements • Checking resources provided by housing facility	• Copy of housing application • Housing deposit verification • Completed cost of living budget
Family Connections:	**I plan to stay connected to family and other adults by:**	**Recommended documents the youth will need**
I feel closely connected to ...	• Having phone and in-person contact with….. • Making a plan to stay with ….during college dorm breaks • Having email addresses for…	• Contact list for family members

Copies to: Youth - Caregiver - Case File - ILP - Family - Others

Advance Health Care Directive Form Instructions

You have the right to give instructions about your own health care.

You also have the right to name someone else to make health care decisions for you.

The Advance Health Care Directive form lets you do one or both of these things. It also lets you write down your wishes about donation of organs and the selection of your primary physician. If you use the form, you may complete or change any part of it or all of it. You are free to use a different form.

INSTRUCTIONS

Part 1: Power of Attorney

Part 1 lets you:

- **name** another person as **agent** to make health care decisions for you if you are unable to make your own decisions. You can also have your agent make decisions for you right away, even if you are still able to make your own decisions.
- **also name** an **alternate agent** to act for you if your first choice is not willing, able or reasonably available to make decisions for you.

Your **agent** may not be:

- an operator or employee of a community care facility or a residential care facility where you are receiving care.
- your supervising health care provider (the doctor managing your care)
- an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Your **agent** may make all health care decisions for you, unless you limit the authority of your agent. You do not need to limit the authority of your agent.

If you want to limit the authority of your agent the form includes a place where you can limit the authority of your agent.

If you choose not to limit the authority of your agent, your agent will have the right to:

- Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- Choose or discharge health care providers (i.e. choose a doctor for you) and institutions.
- Agree or disagree to diagnostic tests, surgical procedures, and medication plans.
- Agree or disagree with providing, withholding, or withdrawal of artificial feeding and fluids and all other forms of health care, including cardiopulmonary resuscitation (CPR).
- After your death make anatomical gifts (donate organs/tissues), authorize an autopsy, and make decisions about what will be done with your body.

Part 2: Instructions for Health Care

You can give specific instructions about any aspect of your health care, whether or not you appoint an agent.

There are choices provided on the form to help you write down your wishes regarding providing, withholding or withdrawal of treatment to keep you alive.

You can also add to the choices you have made or write out any additional wishes.

You do not need to fill out part 2 of this form if you want to allow your agent to make any decisions about your health care that he/she believes best for you without adding your specific instructions.

Part 3: Donation of Organs

You can write down your wishes about donating your bodily organs and tissues following your death.

Part 4: Primary Physician

You can select a physician to have primary or main responsibility for your health care.

Part 5: Signature and Witnesses

After completing the form, **sign and date it** in the section provided.

The form must be signed **by two qualified witnesses** (see the statements of the witnesses included in the form) **or** acknowledged before a notary public. **A notary is not required if the form is signed by two witnesses. The wittnesses must sign the form on the same date it is signed by the person making the Advance Directive.**

See part 6 of the form if you are a patient in a skilled nursing facility.

Part 6: Special Witness Requirement

A Patient Advocate or Ombudsman must witness the form ***if you are a patient in a skilled nursing facility*** (a health care facility that provides skilled nursing care and supportive care to patients). See Part 6 of the form.

You have the right to change or revoke your Advance Health Care Directive at any time

If you have questions about completing the Advance Directive in the hospital, please ask to speak to a Chaplain or Social Worker.

We ask that you
complete this form in English
so your caregivers can understand your directions.

Advance Health Care Directive

Name_____

Date_____

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form also lets you write down your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or change all or any part of it. You are free to use a different form.

You have the right to change or revoke this advance health care directive at any time.

Part 1 — Power of Attorney for Health Care

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent:_____

Relationship_____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

ALTERNATE AGENT (Optional): If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as alternate agent:_____

Relationship_____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

SECOND ALTERNATE AGENT (optional): If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent: _____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

(1.2) AGENT'S AUTHORITY: My agent is authorized to 1) make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, 2) to choose a particular physician or health care facility, and 3) to receive or consent to the release of medical information and records, except as I state here:

_____

_____

(Add additional sheets if needed.)

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I initial the following line.

If I initial this line, my agent's authority to make health care decisions for me takes effect immediately. _____

(1.4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POST DEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named._____(initial here)

Part 2 — Instructions for Health Care

If you fill out this part of the form, you may strike out any wording you do not want.

(2.1) **END-OF-LIFE DECISIONS**: I direct my health care providers and others involved in my care to provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ a) Choice Not To Prolong
I do not want my life to be prolonged if the likely risks and burdens of treatment would outweigh the expected benefits, or if I become unconscious and, to a realistic degree of medical certainty, I will not regain consciousness, or if I have an incurable and irreversible condition that will result in my death in a relatively short time.
Or
☐ b) Choice To Prolong
I want my life to be prolonged as long as possible within the limits of generally accepted medical treatment standards.

(2.2) OTHER WISHES: If you have different or more specific instructions other than those marked above, such as: what you consider a reasonable quality of life, treatments you would consider burdensome or unacceptable, write them here.

_____

_____

_____

_____

_____

Add additional sheets if needed.)

Part 3 — Donation of Organs at Death (Optional)

(3.1) Upon my death (mark applicable box):

☐ I give any needed organs, tissues, or parts

☐ I give the following organs, tissues or parts only: _____

☐ I do not wish to donate organs, tissues or parts.

My gift is for the following purposes (strike out any of the following you do not want):
Transplant Therapy Research Education

Part 4 — Primary Physician (Optional)

(4.1) I designate the following physician as my primary physician:

Name of Physician: _____

Address: _____

_____

Telephone: _____

Part 5 — Signature

(5.1) EFFECT OF A COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign name: _____ Date: _____

(5.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly nor an employee of an operator of a residential care facility for the elderly.

FIRST WITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

SECOND WITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

(5.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate on his or her death under a will now existing or by operation of law.

Signature of Witness: _____

Signature of Witness: _____

Part 6 — Special Witness Requirement if in a Skilled Nursing Facility

(6.1) The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OF OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by section 4675 of the Probate Code:

Print Name: _____ Signature: _____

Address: _____ Date: _____

Certificate of Acknowledgement of Notary Public (Not required if signed by two witnesses)

State of California, County of _____ On this _____ day of _____ , _____, before me, the undersigned, a Notary Public in and for said State, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed it.

WITNESS my hand an official seal.

Seal

Signature _____