

VCRHYP Housing Program Plan of Care

Participant name: _____ Date of plan creation: _____

Which of the following things do you want to work on together?	
<p><input type="checkbox"/> Benefits & Financial Assistance (such as applying for food stamps, Reach Up, WIC, etc.)</p>	<p>Which of the following do you want to apply for? <input type="checkbox"/> 3SquaresVT (food stamps) <input type="checkbox"/> Reach Up <input type="checkbox"/> WIC <input type="checkbox"/> Subsidized housing <input type="checkbox"/> Other: _____</p> <p>Do you have everything you need to apply (application, documentation, identification, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I'm not sure.</p> <p>If no, what do you need in order to apply?</p>
<p><input type="checkbox"/> Education (such as staying or enrolling in high school, attending college or training programs, learning about financial aid, getting your GED)</p>	<p>What level of education do you want to complete? (e.g. high school diploma, GED, college degree, vocational certification, etc.)</p> <p>What are you interested in learning about?</p>
<p><input type="checkbox"/> Employment (such as applying for jobs, writing a resume, preparing for interviews, getting along with your boss/coworkers)</p>	<p>What type of work would you like to do?</p> <p>What work experience have you had?</p> <p>Do you have an up-to-date resume? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I'm not sure.</p>
<p><input type="checkbox"/> Health (such as applying for health insurance, finding a doctor or dentist, seeing a mental health or substance abuse counselor)</p>	<p>What health care providers are you already connected with?</p> <p>What types of health care do you want or need to connect with? (e.g. doctor, dentist, mental health counselor, substance abuse treatment, etc.)</p>
<p><input type="checkbox"/> Housing (such as finding housing, staying where you currently are, managing relationships with landlords/roommates/neighbors)</p>	<p>Can you or do you want to stay where you currently are? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I'm not sure.</p> <p>If yes or unsure: what supports do you need to stay there?</p> <p>If no: how soon do you need to find another place to stay?</p> <p>Where do you want to be living in 6 months?</p>

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<input type="checkbox"/> Legal (such as meeting requirements for probation/diversion/court, getting a suspended license reinstated, paying legal fees/fines, coordination with others providing you legal services like a lawyer, BARJ, drug court, etc.)	<p>What legal issues are you currently dealing with?</p> <p>Where are you in the process of resolving these legal issues?</p> <p>Who should we contact to get more information about these legal issues?</p>
<input type="checkbox"/> Life Skills (such as learning how to budget or prepare healthy meals)	<p>What skills are you interested in learning?</p>
<input type="checkbox"/> Parenting support (such as finding child care, learning parenting skills, getting the things you need for your child)	<p>How old is/are your child/children?</p> <p>What resources are you already connected with or accessing for parenting support?</p>
<input type="checkbox"/> Support (such as connecting with family, making new friends, accessing other programs or organizations)	<p>Who do you want to connect with for support?</p>
<input type="checkbox"/> Something else	<p>What do you want to work on together?</p>

Resources and Essential Documents			
Birth certificate:	<input type="checkbox"/> Have <input type="checkbox"/> Need	Job reference:	<input type="checkbox"/> Have <input type="checkbox"/> Need
Social security card:	<input type="checkbox"/> Have <input type="checkbox"/> Need	Housing reference:	<input type="checkbox"/> Have <input type="checkbox"/> Need
Photo ID:	<input type="checkbox"/> Have <input type="checkbox"/> Need	Personal reference:	<input type="checkbox"/> Have <input type="checkbox"/> Need
Medical records:	<input type="checkbox"/> Have <input type="checkbox"/> Need	High school transcripts:	<input type="checkbox"/> Have <input type="checkbox"/> Need
Phone/way to communicate:	<input type="checkbox"/> Have <input type="checkbox"/> Need	College transcripts:	<input type="checkbox"/> Have <input type="checkbox"/> Need

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Who are the people in your life and should we include them in our work together?			
<i>Relationship</i>	<i>Names</i>	<i>They are supportive</i>	<i>You want them included*</i>
Parents		<input type="checkbox"/>	<input type="checkbox"/>
Siblings		<input type="checkbox"/>	<input type="checkbox"/>
Other family members		<input type="checkbox"/>	<input type="checkbox"/>
Someone else who cares for me/is important to me/my family		<input type="checkbox"/>	<input type="checkbox"/>
Friends		<input type="checkbox"/>	<input type="checkbox"/>
Boy/girlfriend/dating partner		<input type="checkbox"/>	<input type="checkbox"/>
Online friendships		<input type="checkbox"/>	<input type="checkbox"/>
Teachers/adults at school		<input type="checkbox"/>	<input type="checkbox"/>
Other adults close to you		<input type="checkbox"/>	<input type="checkbox"/>
Spiritual community		<input type="checkbox"/>	<input type="checkbox"/>
Cultural/ethnic community		<input type="checkbox"/>	<input type="checkbox"/>
Work, clubs, teams, or groups		<input type="checkbox"/>	<input type="checkbox"/>

**complete Release of Information*

What other programs or providers are you connected with right now?			
<i>Name & where they work:</i>	<i>What do they help with?</i>	<i>How often do you see them?</i>	<i>Okay to contact them*</i>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

**complete Release of Information*

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GOAL #1

Based on what you want to work on together, what is one of your goals for the next six months?

What will your action plan be for this goal?

What steps will you take?	When or how often will you do them?
#1	
#2	
#3	

Who can support you with this action plan and what can they do to help?

Support person/ program/ organization	How can they help?	How will you connect/stay connected with them?
Your care worker		

What may be hard for you in achieving this goal and what will help you overcome these challenges?

Challenges	What can help you overcome them?

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GOAL #2

What is a second goal you want to work on during the next six months?

What will your action plan be for this goal?

What steps will you take?	When or how often will you do them?
#1	
#2	
#3	

Who can support you with this action plan and what can they do to help?

Support person/ program/ organization	How can they help?	How will you connect/stay connected with them?
Your care worker		

What may be hard for you in achieving this goal and what will help you overcome these challenges?

Challenges	What can help you overcome them?

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GOAL #3

What is a third goal you want to work on during the next six months?

What will your action plan be for this goal?

What steps will you take?	When or how often will you do them?
#1	
#2	
#3	

Who can support you with this action plan and what can they do to help?

Support person/ program/ organization	How can they help?	How will you connect/stay connected with them?
Your care worker		

What may be hard for you in achieving this goal and what will help you overcome these challenges?

Challenges	What can help you overcome them?

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Based on this plan, you and your care worker will meet at least:	<ul style="list-style-type: none"><input type="radio"/> Every day<input type="radio"/> _____ times a week<input type="radio"/> Every other week<input type="radio"/> Once a month<input type="radio"/> Other:
The times that work best to meet for you are:	

Youth signature

Date

Care worker signature

Date

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6-month Contact Information Update

Contact Information	
Home phone:	
Cell phone:	Is texting okay? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email:	
Mailing address:	
Other ways to contact you:	

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Take-Away Summary Page
For client to complete themselves

My Care Worker:	
Work Phone:	
Cell Phone:	Is texting okay? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email:	
Other:	

My goals:

- 1) _____
- 2) _____
- 3) _____

Next steps I will take:

- 1) _____
- 2) _____
- 3) _____

Based on my action plan, my care worker and I will meet at least:	<input type="radio"/> Every day <input type="radio"/> _____ times a week <input type="radio"/> Every other week <input type="radio"/> Once a month <input type="radio"/> Other:
If I have to miss a meeting, it is okay. I will let my care worker know and try to find another time. The best way for me to contact my care worker if this happens is:	
Next meeting dates:	