~~587~~280 TRANSITION TO ADULTHOOD

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REFERENCES: A.R.S. § 36-551; A.R.S. § 36-550; A.R.S. § 36-501; A.A.C. R4-6-212~~;~~, IDEA Part B, Section 1415 (m)~~;~~ Section 504 of the Rehabilitation Act of 1973; AMPM 587; AMPM 520; AMPM 320-P

PURPOSE

This policy establishes the requirements for the Administrative Services Subcontractors (AdSS) to provide behavioral health services and supports to Members who are transitioning to adulthood by strengthening practice in the Integrated System of Care and promoting continuity of care through collaborative planning.

~~This policy applies to the Division's Administrative Services Subcontractors (AdSS). The purpose of this policy is to strengthen practice in the system of care and promote continuity of care through collaborative planning by:~~

~~1. Supporting individuals transitioning into early adulthood in ways that reinforce their recovery process.~~

~~2. Ensuring a smooth and seamless transition from the AHCCCS Children System of Care to the AHCCCS Adult System of Care.~~

~~3. Fostering an understanding that becoming a self-sufficient adult is a process that occurs over time and can extend beyond the age of 18.~~

DEFINITIONS

1. "Adult Recovery Team" or ~~(~~"ART"~~)~~ is a group of individuals that, following the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a M~~m~~ember's assessment, service planning, and service delivery. At a minimum, the team consists of the M~~m~~ember, M~~m~~ember's ~~h~~Health ~~c~~Care ~~d~~Decision ~~m~~Maker ~~(~~if applicable~~)~~, advocates ~~(~~if assigned~~)~~, and a qualified behavioral health representative. The team may also include the M~~m~~ember's family, physical health, behavioral health or social service ~~p~~Providers, other agencies serving the M~~m~~ember, professionals representing various areas of expertise related to

the M~~m~~member's needs, or other individuals identified by the M~~m~~member.

2. "Adult System of Care" or "ASOC" means a spectrum of effective community-based services and supports for adult Members and their families who live with, or who are at risk for, physical or behavioral health challenges. The ASOC is organized into a coordinated network, builds meaningful partnerships with families and Members, and addresses their cultural and linguistic needs in order to help them to function better at home, in school, work, in the community, and throughout life.

3. "Assessment" ~~– Behavioral Health"~~ means the ongoing collection and analysis of an individual's medical, psychological, psychiatric, and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the individual's service plan is designed to meet the individual's ~~(~~and family's~~)~~ current needs and long-term goals.

4. "Child and Family Team" or ~~("~~CFT"~~)~~ is a group of individuals that includes, at a minimum, the child and their family, or Health Care Decision Maker ~~health care decision maker~~. A behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare ~~p~~Providers, coaches, and community resource ~~p~~Providers, representatives from churches, temples, synagogues, mosques, or other places of worship/faith, agents from other service systems like the Arizona Department of Child Safety (DCS) or the Division. The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore, expand and contract as necessary to be successful on behalf of the child.

5. "Children's System of Care" or "CSOC" means a spectrum of effective community-based services and supports for children and their families who live with, or who are at risk for, physical or behavioral health challenges. The CSOC is organized into a coordinated network, builds meaningful partnerships with families and Members, and addresses their cultural and linguistic needs in order to help them to function better at home, in school, in the community, and throughout life.

6. "Health Care Decision Maker" or "HCDM" means an individual who is authorized to make health care treatment decisions for a Member. As applicable to the situation, this may include a parent of an unemancipated minor or an individual lawfully authorized to make health care treatment decisions as specified in A.R.S. §§ Title 14, Chapter 5, Article 2 or 3; or A.R.S. §§ 8514.05, 36-3221, 36-3231 or 36-3281.

7. "Integrated Systems of Care" or "ISOC" means the coordination of physical and behavioral health care within the AHCCCS health

care delivery system to ensure appropriate, adequate, and timely services for all Members.

8. "Member" means the same as "Client", a person receiving developmental disabilities services from the Division, as specified in A.R.S. § 36-551.

9. "Mental Disorder" means, as specified in A.R.S. § 36-501, a substantial disorder of the person's emotional processes, thought, cognition, or memory. Mental Disorder is distinguished from:

a. Conditions that are primarily those of drug abuse, alcoholism, or intellectual disability, unless, in addition to one or more of these conditions, the person has a Mental Disorder.

b. The declining mental abilities that directly accompany impending death.

c. Character and personality disorders characterized by lifelong deeply ingrained antisocial behavior patterns,

including sexual behaviors that are abnormal and prohibited by statute unless the behavior results from a Mental Disorder.

10. "Provider" means, for purposes of this policy, an agency or individual operating under a contract or service agreement to engage in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State.

11. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

12. "Seriously Mentally Ill~~ness~~" or "SMI" means, as specified in A.R.S. § 36-550, ~~is a designation~~ persons who as a result of a Mental Disorder exhibit emotional or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or

services of a long-term or indefinite duration. In these persons mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment, and recreation. ~~as specified in A.R.S. 36-550 and determined in an individual 18 years of age or older.~~

13. "Serious Mental Illness Evaluation" means ~~is~~ the process of analyzing current and past treatment information including assessment, treatment, other medical records, and documentation for purposes of making a determination as to an individual's Serious Mental Illness ~~serious mental illness~~ eligibility.

14. "Service Plan" means a complete written description of all covered health services and other informal supports which includes individualized goals, family support services, peer-and-recovery support, care coordination activities and

strategies to assist the M~~m~~ember in achieving an improved quality of life.

15. Transition Planning means an individualized, collaborative process that helps Members acquire skills to prepare for adulthood by:

    a. Providing services and supports that reinforce the Member's health and wellness.

    b. Ensuring a seamless transition from the Children System of Care to the Adult System of Care.

    c. Fostering an understanding that becoming a stable and productive adult is a process that occurs over time and can extend beyond the age of eighteen.

~~**BACKGROUND**~~

~~The psychological and social development of adolescents transitioning into young adulthood is challenged by the economic, demographic, and cultural shifts that have occurred over several generations. Sociologist researcher, Frank F. Furstenberg, Jr., as Network Chair of the Network on Transitions to Adulthood stated: "Traditionally, early adulthood has been a period when~~

~~young people acquire the skills they need to get jobs, to start families, and to contribute to their communities. But, because of the changing nature of families, the education system, and the workplace, the process has become more complex. This means that early adulthood has become a difficult period for some young people, especially those who are not going to college and lack the structure that school can provide to facilitate their development." While some individuals adapt well as they transition into the responsibilities of adulthood, others experience challenges such as those youth who have mental health concerns.~~

~~Between 2008 and 2017, the number of adults that experienced serious psychological distress in the last month increased among most age groups, with the largest increases seen among younger adults aged 18-25 (71%). Notably, rates of serious psychological distress increased by 78% among adults aged 20-21 during the time period. Meanwhile, there was a decline among adults aged 65 and older.~~

~~These findings were consistent across other measures, with the rate of adolescents and young adults experiencing depressive symptoms in the last year increasing by 52% and 63%, respectively, while rates remained stable~~

~~adults aged 26 and older.~~

~~As the transition to adulthood has become more challenging, youth with mental health needs struggle to achieve the hallmarks of adulthood such as finishing their education, entering the labor force, establishing an independent household, forming close relationships, and potentially getting married and becoming parents. While these may be considered the trademarks of adulthood from a societal viewpoint, some studies suggest that youth may conceptualize this transition in more "intangible, gradual, psychological, and individualistic terms." Top criteria endorsed by youth as necessary for a person to be considered an adult emphasized features of individualism such as accepting "responsibility for the consequences of your actions," deciding one's "own beliefs and values independently of parents or other influences," and establishing "a relationship with parents as an equal adult."~~

~~Oftentimes, youth who successfully transition to adulthood are those that acquire a set of skills and the maturational level to use these skills effectively.~~

~~Transition planning can emphasize interpersonal skill training through a~~

~~cognitive-behavioral approach to help youth develop positive social patterns, assume personal responsibility, learn problem-solving techniques, set goals, and acquire skills across various life domains.~~

~~With transition to adulthood occurring at later ages and over a longer span of time, many young people in their 20's may still require the support of their families. Involving families in the transition planning process and identifying the individual support needs of their children recognizes the diversity that is needed when accessing services and supports. Youth who have been enrolled in government programs due to family hardship, poverty, physical, or mental health challenges are often the least prepared to assume adult responsibilities.~~

~~For others, such as youth leaving foster care, they must acquire housing without the financial support of a family.~~

~~Eligibility for public programs, such as Medicaid, Social Security, and vocational rehabilitation, as well as housing and residential services, may engender planning for changes at the age of 18. Youth who have disabilities that significantly impact their ability to advocate on their own behalf may~~

~~require a responsible adult to apply for guardianship. Other youth may benefit from a referral to determine eligibility for services as an adult with a serious mental illness. Thus, it is the responsibility of the behavioral health system to ensure young adults are provided with the supports and services they need to acquire the capacities and skills necessary to navigate through this transitional period to adulthood.~~

~~**POLICY**~~

~~This policy addresses the recommended practice for transitioning youth from the AHCCCS Children System of Care to the AHCCCS Adult System of Care with a focus on the activities that will assist youth in acquiring the skills necessary for self-sufficiency and independence in adulthood. The AdSS shall follow the procedures specified in AdSS Medical Policy 520, which requires that transition planning begins when the youth reaches the age of 16, however, if the Child and Family Team (CFT) determines that planning should begin prior to the youth's 16th birthday, the team may proceed with transition planning earlier to allow more time for the youth to acquire the necessary life skills, while the team identifies the supports that will be needed. Age 16 is the latest this process should start. For youth who are age~~

~~16 and older at the time they enter the AHCCCS System of Care, planning must begin immediately. It is important that members of the CFT look at transition planning as not just a transition into the AHCCCS Adult System of Care, but also as a transition to adulthood.~~

A. REQUIREMENTS FOR MEMBERS TRANSITIONING TO ADULTHOOD

1. The AdSS shall require Providers to utilize the best practices outlined in this policy for assisting Members in transitioning to adulthood.
2. The AdSS shall require Providers to deliver clinical practice and behavioral health services that are:
   a. Individualized;
   b. Strengths-based; and
   c. Culturally sensitive.
3. The AdSS shall require Providers to begin transition planning when the Member reaches the age of 16.
4. The AdSS shall require Providers to begin Transition Planning prior the Member's 16th birthday if:

a. The Child and Family Team (CFT) determines that planning should begin in advance to identify needed supports; and

b. Allow more time for the Member to acquire the necessary life skills, while the team identifies the supports that are needed.

5. The AdSS shall require Providers to begin Transition Planning immediately for youth who are age 16 and older at the time they enter the Children's System of Care.

B~~A~~. TRANSITION TO ADULT BEHAVIORAL HEALTH SERVICES

~~SERIOUS MENTAL ILLNESS DETERMINATIONS~~

1. The AdSS shall require Providers to complete an evaluation and referral for a Serious Mental Illness (SMI) eligibility determination, at the age of 17.5 if:

a. It is determined that the Member has a qualifying SMI diagnosis; or

b. If a determination is requested by any member of the CFT, unless declined by the Responsible Person.

~~1. When the adolescent reaches the age of 17 and the CFT believes that the youth may meet eligibility criteria as an adult designated as having a Serious Mental Illness (SMI), the Contractor and their subcontracted providers must ensure the young adult receives an eligibility determination at the age of 17.5, as specified in AdSS Medical Policy 320-P.~~

~~2. If the youth is determined eligible, or likely to be determined eligible for services as a person with a SMI, the adult behavioral health services case manager is then contacted to join the CFT and participate in the transition planning process. After obtaining permission from the parent/guardian, it is the responsibility of the children's behavioral health service provider to contact and invite the adult behavioral health services case manager to upcoming planning meetings. When more than one behavioral health service provider is involved, the responsibility for collaboration lies with the provider who is directly responsible for behavioral health service planning and delivery.~~

~~3. If the young adult is not eligible for services as a person with a SMI, it is the responsibility of the children's behavioral health provider, through the CFT, to coordinate transition planning with the adult general mental health provider. Whenever possible, it is recommended that the young adult and their family be given the choice of whether to stay with the children's provider or transition to the adult behavioral health service provider. The importance of securing representation from the adult service provider in this process cannot be overstated, regardless of the person's identified behavioral health category assignment (SMI, General Mental Health, Substance Use). The children's behavioral health provider should be persistent in its efforts to make this occur.~~

2. The AdSS shall require the children's behavioral health Providers to contact and invite the adult behavioral health Provider to upcoming meetings if:

   a. The Member is determined eligible for services as a person with an SMI; and

b. The Responsible Person consents.

3. The AdSS shall require the adult behavioral health services case manager to join the CFT and participate in the Transition Planning process.

4. The AdSS shall require the Provider who is directly responsible for behavioral health service planning and delivery to ensure collaboration occurs when more than one behavioral health services Provider is involved in the Member's care.

5. The AdSS shall implement a process for ensuring collaboration and coordination of care between the CFT and the SMI Provider.

6. The AdSS shall require the children's behavioral health Provider to coordinate Transition Planning with the adult general mental health Provider four months prior to the transition when the young adult Member is not eligible for services as a person with a SMI.

7. The AdSS shall require the child and adult behavioral health Providers, when Transition Planning, to:

a. Coordinate service delivery;

b. Identify services that will be needed; and

c. Identify the methods for ensuring payment for those services to meet the individualized needs of the Member.

C~~B~~. REQUIREMENTS FOR INFORMATION SHARING PRACTICES~~,~~ AND ELIGIBLE SERVICE FUNDING~~, AND DATA SUBMISSION UPDATES~~

1. The AdSS shall require the CFT and adult behavioral health Providers to review and follow health record disclosure requirements specified in AdSS Medical Policy 940 p~~P~~rior to releasing treatment information~~, the CFT, including the adult service provider, will review and follow health record disclosure guidelines per AdSS Medical Policy 940~~.
2. The AdSS shall require Providers to assist the Member in seeking services that may be available under non-Medicaid funding if the Member is not Medicaid eligible as an adult. ~~The behavioral health provider will ensure that the behavioral health category~~

~~assignment is updated along with other demographic data consistent with the AHCCCS Technical Interface Guidelines.~~

D. TRANSITION PLANNING REQUIREMENTS

~~31.~~ The AdSS shall require Providers to obtain updated treatment documents that require signature when the Member turns 18 with:

a. The Member's signature; or

b. The Responsible Person's signature, if the Responsible Person is someone other than the Member and changed upon the Member turning 18. ~~Youth, upon turning age 18, will be required to sign documents that update their responsibilities with relation related to their behavioral health treatment as an adult. Some examples include a new consent to treatment and authorizations for sharing protected health information to ensure that the team members can continue as active participants in service planning.~~

2. The AdSS shall not require a ~~A~~ full Aassessment ~~is not required~~ at the time of transition from child to adult behavioral health services unless:
   a. Aan annual update is due; or
   b. Tthere have been significant changes to the Member's ~~young adult's~~ status that clinically indicates the need to update the Assessment. ~~or Individual Recovery Plan.~~
3. The AdSS shall require behavioral health Providers to orient the Member and their family to potential changes they may experience as part of the transition to the Adult System of Care to:
   a. Minimize any barriers that may hinder seamless service delivery; and
   b. Support the Member's and family's understanding of their changing roles and responsibilities.
4. The AdSS shall ensure that its subcontracted network of Providers:

a. Evaluate the need for a referral to a family support partner or peer mentor to assist the Member and family with transition to the Adult System of Care;

b. Complete crisis and safety planning prior to the Member's transition to the Adult System of Care as specified in 320-O; and

c. Notify the Member of the type of crisis services that will be available through the Adult System of Care and how to access crisis services when needed.

E. PERSONAL CHOICE

1. The AdSS shall require their subcontracted network of Providers support Members with:

a. Making informed decisions about their treatment, unless there is a Responsible Person other than Member;

b. Developing goals and identifying methods, services, and supports necessary to meet the needs of transitioning to adulthood;

c. Including supportive team members, their parents, and

any other identified natural supports;

d. Acquiring self-advocacy skills to assist them in learning how to speak and advocate on their own behalf as outlined in Division Medical Policy 584;

e. Providing information about how the behavioral health service delivery systems operate in accordance with the Arizona Vision and 12 Principles for Children's Service Delivery and nine guiding principles for recovery-oriented adult behavioral health services and systems;

f. Utilizing best practices to build community supports and pro-social activities for Members who have disclosed to the behavioral health service pProvider their self-identity as gay, lesbian, bisexual, or transgender;

g. Maintaining or building a support structure as the Member transition to adulthood; and

h. Aligning services with the family and Member's cultural beliefs about this time of life transition.

~~C. KEY PERSONS FOR COLLABORATION~~

~~1. Team Coordination:~~

~~When a young person reaches age 17 it is important to begin establishing team coordination between the child and adult service delivery systems. This coordination must be in place no later than four - six months prior to the youth turning age 18. In order to meet the individualized needs of the young adult on the day s/he turns 18 a coordinated effort is required to identify the behavioral health provider staff who will be coordinating service delivery, including the services that will be needed and the methods for ensuring payment for those services. This is especially critical if the behavioral health provider responsible for service planning and delivery is expected to change upon the youth's transition at the age of 18.~~

~~Orientation of the youth, their family and CFT to potential changes they may experience as part of this transition to the AHCCCS Adult System of Care will help minimize any barriers that may hinder seamless service delivery and support the youth's/family's understanding of their changing roles and~~

~~responsibilities. It might be helpful to engage the assistance of a liaison (e.g., family and/or peer mentor) from the adult system to act as an ambassador for the incoming young adult and their involved family and/or caregiver. As noted in the AMPM, Policy 220, the young adult, in conjunction with other involved family members, caregivers or guardian, may request to retain their current CFT until the youth turns 21.~~

~~Regardless of when the youth completes their transition into the AHCCCS Adult System of Care, the CFT will play an important role in preparing the Adult Recovery Team (ART) to become active partners in the treatment and service planning processes throughout this transitional period. Collaboration between the child and adult service provider for transition age youth is more easily facilitated when agencies are dually licensed to provide behavioral health service delivery to both children and adult populations.~~

~~2. Family involvement and culture must be considered at all times, especially as the youth prepares for adulthood. Although this~~

~~period in a young person's life is considered a time for establishing their independence through skill acquisition, many families and cultures are interdependent and may also require a supportive framework to prepare them for this transition. With the assistance of joint planning by the child and adult teams, families can be provided with an understanding of the increased responsibilities facing their young adult while reminding them that although their role as legal guardian may change, they still remain an integral part of their child's life as a young adult. It is also likely that the youth's home and living environment may not change when they turn 18 and are legally recognized as an adult.~~

~~During this transitional period the role that families assume upon their child turning 18 will vary based on:~~

~~a. Individual cultural influences,~~

~~b. The young adult's ability to assume the responsibilities of adulthood,~~

~~c. The young adult's preferences for continued family involvement, and~~

~~d. The needs of parents/caregivers as they adjust to upcoming changes in their level of responsibility.~~

~~3. Understanding each family's culture can assist teams in promoting successful transition by:~~

~~a. Informing families of appropriate family support programs available in the AHCCCS Adult System of Care,~~

~~b. Identifying a Family Mentor who is sensitive to their needs to act as a "Liaison" to the AHCCCS Adult System of Care,~~

~~c. Recognizing and acknowledging how their roles and relational patterns affect how they view their child's movement toward independence, and~~

~~d. Addressing the multiple needs of families that may exist as a result of complex relational dynamics or those who may be involved with one or more state agencies.~~

~~Some youth involved with DCS may express a desire to reunite with their family from whose care they were removed. In these~~

~~situations it is important for the CFT to discuss the potential benefits and challenges the youth may face.~~

~~D~~F. COLLABORATION WITH SYSTEM PARTNERS

1. The AdSS shall require their subcontracted network of Providers to coordinate with the following system partners to promote collaborative planning and seamless transitions:
   a. Schools
      i. Prepare Members and their parents in developing an understanding of what happens as Members transition from secondary education to adult life;
      ii. Collaborate with school staff to receive individualized plans and gather information to assist the behavioral health Provider with transition planning;
      iii. Collaborate with school staff to determine if the Member is eligible for a Transition Plan through the Individualized Education Plan (IEP); and

iv. Collaborate with the school to determine if the Member is eligible to participate in school-based work activities.

b. Department of Child Safety (DCS)

Work with the DCS Specialist to determine if Members in foster care may be eligible for services through the Young Adult Program (YAP) and Transitional Independent Living Program (TILP).

c. Department of Economic Security/Rehabilitation Services Administration (DES/RSA)

Discuss the appropriateness of a referral to DES/RSA under a Vocational Rehabilitation program with the CFT as early as age 14 or any time thereafter when the youth is ready to work.

2. The AdSS shall require behavioral health Providers to assist

Members and their families or caregivers in accessing or preparing necessary documentation, including:

~~Coordination among all involved system partners promotes collaborative planning and seamless transitions when eligibility requirements and service delivery programs potentially change upon the youth turning 18.~~

~~Child welfare, juvenile corrections, education, developmental disabilities, and vocational rehabilitation service delivery systems can provide access to resources specific to the young adult's needs within their program guidelines. For example, students in special education services may continue their schooling through the age of 22. Youth in foster care may be eligible for services through a program referred to as the Arizona Young Adult Program (AYAP) or Independent Living Program (ILP) through the Arizona Department of Child Safety (DCS).~~

~~System partners can also assist young adults and their families/caregivers in accessing or preparing necessary documentation, such as:~~

a.~~1.~~ Birth certificates~~.~~;

b.~~2.~~ Social security cards and social security disability benefit applications~~.~~;

c. Driver's license or State identification cards;

d~~3~~. Medical records including any eligibility determinations and evaluations ~~assessments.~~;

e~~4~~. ~~Individualized Education Program (~~IEP~~)~~ Plans~~.~~;

f~~5~~. Certificates of achievement, diplomas, General Education Development transcripts, and application forms for college~~.~~;

g~~6~~. Case plans for ~~youth~~ Members continuing in the foster care system~~.~~;

h~~7~~. Treatment plans~~.~~;

i. Selective Service registration;

j.~~8.~~ Documentation of completion of probation or parole conditions.~~;~~

k.~~9.~~ Guardianship applications.~~;~~

l~~10~~. Advance directives.~~;~~

m. Redeterminations of Division eligibility; and

n. Voter registration.

~~**E. NATURAL SUPPORT**~~

~~Maintaining or building a support structure will continue to be important as the youth transitions to adulthood and has access to new environments. This is especially relevant for young adults who have no family involvement. For some youth, developing or sustaining social relationships can be challenging. The child and adult teams can assist by giving consideration to the following areas when planning for transition:~~

1. ~~Identify what supports will be needed by the young adult to promote social interaction and relationships.~~
2. ~~Explore venues for socializing opportunities in the community.~~
3. ~~Determine what is needed to plan time for recreational activities.~~
4. ~~Identify any special interests the youth may have that could serve as the basis for a social relationship or friendship.~~

~~F. PERSONAL CHOICE~~

~~Although young adults are free to make their own decisions about treatment, medications, and services, they are generally aware that their relationships, needs, and supports may not feel different following their 18th birthday. They may require assurance that their parents are still welcomed as part of their support system, that they still have a team, rules still apply, and that information will be provided to assist them with making their own treatment decisions. However, some young adults may choose to limit their parent's involvement, so working with youth in the acquisition of self-determination skills will assist them in learning how to speak and advocate on their own behalf.~~

~~This may involve youth developing their own understanding of personal strengths and challenges along with the supports and services they may need. When planning for transition, teams may also need to provide information to young adults on how the behavioral health service delivery systems operate in accordance with the following:~~

1. ~~Arizona Vision and 12 Principles for Children's Service Delivery,~~ ~~and~~
2. ~~Nine Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems.~~

~~G. CLINICAL AND SERVICE PLANNING CONSIDERATIONS~~

~~The AdSS shall support clinical practice and behavioral health service delivery that is individualized, strengths-based, recovery-oriented, and culturally sensitive in meeting the needs of children, adults, and their families. Transitioning youth to adulthood involves a working partnership among team members between the children's behavioral health service system and the AHCCCS Adult System of Care. This partnership is built through respect and equality, and is based on the~~

~~expectation that all people are capable of positive change, growth, and leading a life of value. Individuals show a more positive response when there is a shared belief and collaborative effort in developing goals and identifying methods (services and supports) to meet their needs.~~

~~H. CRISIS AND SAFETY PLANNING~~

~~The team is responsible for ensuring that crisis and safety planning is completed prior to the youth's transition as specified in the AMPM, Policy 220. For some youth, determining potential risk factors related to their ability to make decisions about their own safety may also need to be addressed. Collaboration with the adult case manager and/or ART will ensure that the transitioning young adult is aware of the type of crisis services that will be available through the AHCCCS Adult System of Care and how to access them in their time of need.~~

G~~I~~. TRANSITION PLANNING ACTIVITIES

~~The length of time necessary for transition planning is relevant to the needs, maturational level, and the youth's ability to acquire the necessary skills to assume the responsibilities of adulthood. When planning for the young person's transition into adulthood and the adult~~

~~behavioral health system, a transition plan that includes an assessment of self-care and independent living skills, social skills, work and education plans, earning potential, and psychiatric stability must be incorporated into the Service Planning. Living arrangements, financial, and legal considerations are additional areas that require advance planning.~~

1. The AdSS shall require their network of behavioral health Providers to perform the following Transition Planning Activities:

a~~1~~. ~~Self-care and Independent Living Skills~~ Assess self-care and independent living skills need of each ~~young adult~~ Member;

~~As the youth approaches adulthood, the acquisition of daily living skills becomes increasingly important. Personal care and hygiene can include grooming tasks such as showering, shaving (if applicable), dressing, and getting a haircut. Learning phone skills, how to do laundry and shop for clothes, cleaning and maintaining one's personal living environment, use of public transportation or learning how to drive are other suggested~~

~~areas for transition planning. Acquisition of various health-related skills includes fitness activities such as an exercise program, nutrition education for planning meals, shopping for food, and learning basic cooking techniques. Planning around personal safety would address knowing their own phone number and address, who to contact in case of emergency, and awareness of how to protect themselves when out in the community.~~

b. Provide Members services and supports to meet their independent living skills needs;

2. ~~Social and Relational Skills~~

~~The young adult's successful transition toward self-sufficiency will be supported by their ability to get along with others, choose positive peer relationships, and cultivate sustainable friendships. This will involve learning how to avoid or respond to conflict when it arises and developing an understanding of personal space, boundaries, and intimacy. Some youth may require additional assistance with distinguishing between the different~~

~~types of interactions that would be appropriate when relating to strangers, friends, acquaintances, boy/girlfriend, family member, or colleague in a work environment. For example, teams may want to provide learning opportunities for youth to practice these discrimination skills in settings where they are most likely to encounter different types of people such as a grocery store, shopping mall, supported employment programs, etc. Planning for youth, who have already disclosed to the behavioral health service provider their self-identity as gay, lesbian, bisexual, or transgender, may include discussions about community supports and pro-social activities available to them for socialization. Adolescents who do not have someone who can role model the differing social skills applicable to friendship, dating, and intimate relationships may need extra support in learning healthy patterns of relating to others relevant to the type of attachment.~~

c~~3~~. ~~Vocational/Employment~~ Collaborate with other system partners to plan and prepare the Member for employment

or other vocational opportunities, through the following activities:

i. Utilizing career interest inventories or engaging in vocational assessment activities to identify potential career preferences, volunteer opportunities, or other meaningful activities;

ii. Identifying skill deficits and effective strategies to address these deficits;

iii. Determining training needs and providing opportunities for learning through practice in real world settings;

iv. Learning about school-to-work programs that may be available in the community and eligibility requirements;

v. Developing vocational skills such as building a resume, filling out job applications, interviewing

preparation, use of online job sites, etc.;

vi. Learning federal and state requirements for filing annual income tax returns; and

vii. Offering opportunities for work experience in the community, whether it is through employment, volunteering, or internship experience when the Member reaches the age of 14.

~~An important component of transitioning to adulthood includes vocational goals that lead to employment or other types of meaningful activity. While a job can provide financial support, personal fulfillment, and social opportunities, other activities such as an internship or volunteering in an area of special interest to the young adult can also provide personal satisfaction and an opportunity to engage socially with others. The CFT along with involved system partners work together to prepare the young adult for employment or other vocational endeavors. It is imperative that a representative from the adult behavioral health~~

~~system be involved in this planning to ensure that employment related goals are addressed before, during, and after the youth's transition to adulthood.~~

~~Service planning that addresses the youth's preparation for employment or other meaningful activity can include:~~

~~a. Utilizing interest inventories or engaging in vocational assessment activities to identify potential career preferences or volunteer opportunities,~~

~~b. Identifying skill deficits and effective strategies to address these deficits,~~

~~c. Determining training needs and providing opportunities for learning through practice in real world settings,~~

~~d. Learning about school-to-work programs that may be available in the community and eligibility requirements,~~

~~e. Developing vocational skills such as building a resume, filling out job applications, interviewing preparation, use of online job sites, and~~

~~f. Learning federal and state requirements for filing annual income tax returns.~~

~~Youth involved in school-based work activities (paid or non-paid) are able to "test the waters" of the work world, develop a work history, better understand their strengths and weaknesses, explore likes and dislikes, and begin to develop employment related skills necessary for their success in competitive work settings. School based work activities can start as early as middle school yet should begin no later than the youth's freshman year of high school. When youth reach the age of 14 they can be given work experience in the community, whether it is through a volunteer or internship experience. It is best for school and community-based work experience to be short term, so that youth can experience a variety of employment settings and perform different job duties in more than one vocation to assist them in identifying possible career choices. These work-related opportunities will assist teams in determining where the youth excels or struggles in each type of work~~

~~undertaken, the types of supports that might be needed, and what the best "job match" might be in terms of the youth's personal interests and skill level.~~

~~As youth narrow their career focus, it is useful to tour employment sites, job shadow, and interview employers and employees who work in the youth's chosen fields of interest. It may be necessary to plan for on-going support after a job has been obtained to assist the young adult in maintaining successful employment.~~

~~Identifying persons in the job setting who can provide natural support such as supervisors and co-workers, as well as employer related accommodations may be necessary to ensure that the young adult can continue to perform their job duties.~~

~~4. Vocational/Employment Considerations for Youth with Disabilities~~

~~For youth who have a disability, regardless of whether they are in Special Education, may be eligible for services through the Arizona Department of Economic Security/Rehabilitation Services Administration (DES/RSA) under a Vocational Rehabilitation (VR)~~

~~program when transitioning from school to work. The school can refer youth with a disability to the VR program as early as age 14 or at any time thereafter when they are ready to work with VR to address their career plans. Students with disabilities between the ages of 14 and 22 are able to participate in Pre-Employment Transition Services as potentially eligible students, meaning they do not have to be VR clients. Pre-Employment Transition Services are group based, general workshops covering five topic areas that may provide the information a youth needs to begin the career exploration process, develop skills for successful employment, and learn about post-secondary education opportunities. Planning for employment is done in conjunction with the youth's VR counselor through the development of an Individual Plan of Employment. Including the VR counselor in the school's IEP planning that might involve VR services is necessary since only VR personnel can make commitments for DES/RSA program services. Refer to DES/RSA for information on the VR process regarding~~

~~intake/eligibility, planning for employment, services, and program limitations.~~

~~5. Education~~

~~Collaboration between the CFT and the education system is helpful with preparing youth and their parents/caregivers in developing an understanding of what happens as young adults transition from secondary education to adult life. Asking the youth to share their individualized plans with the rest of the team may provide information to assist with transition planning. Individualized plans could include:~~

~~a. Education Career Action Plan (ECAP),~~

~~b. 504 Plan,~~

~~c. Transition Plan, and~~

~~d. Summary of Performance.~~

~~6. Individualized Plans~~

~~a. Educations Consideration for all Students:~~

~~i. Education Career Action Plan - In 2008 the ArizonaState Board of Education approved Education~~

~~and Career Action Plans for all Arizona students in grades 9-12. The ECAP is intended to develop the young adult's individual academic and career goals. An ECAP process portfolio has for attributes that should be documented, reviewed and updated, at minimum, annually; academic, career, postsecondary, and extracurricular.~~

~~ii. Transition Plan - While youth are in secondary education, Individuals with Disabilities Educational Act (IDEA) requires public schools to develop an individualized transition plan for each student with an IEP. The transition plan is the section of the IEP that is put in place no later than the student's 16th birthday. The purpose of the plan is to develop postsecondary goals and provide opportunities that will reasonably enable the student to meet those goals for transitioning to adult life. All of the~~

~~following components are required as part of the transition plan:~~

1) ~~Student invitation to all IEP meetings where transition topics are discussed.~~
2) ~~Age-appropriate transition assessments.~~
3) ~~Measurable Postsecondary Goals (MPGs) in the areas of:~~
   a) ~~Education/Training,~~
   b) ~~Employment, and~~
   c) ~~Independent living, (if needed).~~
4) ~~Annually updated MPGs.~~
5) ~~Instruction and services that align with the student's MPGs:~~
   a) ~~Coordinated set of transition activities,~~
   b) ~~Courses of study, and~~
   c) ~~Annual goals.~~

~~6) Outside agency participation with prior consent from the family or student that has reached the age of majority.~~

~~a) Summary of Performance (SOP). The SOP is required under the reauthorization of the IDEA Act of 2004. An SOP is completed for every young adult whose special education eligibility terminates due to graduation from high school with a regular diploma or due to exceeding the age eligibility for FAPE under State law. In Arizona, the student reaches the maximum age of eligibility upon completing the school year in which the student turns 22. A Public Education Agency must provide the youth with a summary of their academic achievement, functional performance, and~~

~~recommendations on how to assist in meeting the young adult's postsecondary goals. The SOP must be completed during the final year of a student's high school education.~~

~~7. Other Considerations~~

~~a. Transfer of Rights' Requirement for Public Education Agencies. Under Arizona State law, a child reaches the age of majority at 18. The right to make informed educational decisions transfers to the young adult at that time.~~

~~i. According to IDEA, "beginning not later than one year before the child reaches the age of majority under State law, a statement that the child has been informed of the child's rights under this title, if any, that will transfer to the child on reaching the age of majority under section 1415(m)" must be included in the student's IEP. This means that schools must inform all youth with disabilities on or before their~~

~~17th birthday that certain rights will automatically transfer to them upon turning age 18, and~~

~~ii. In order to prepare youth with disabilities for their transfer of rights, it is necessary for parents/caregivers to involve their child in educational decision-making processes early. The CFT or ART, in conjunction with the adult behavioral health provider, should assist the youth/parent/caregiver with this process.~~

~~b. A student with a disability between the age of 18 and 22, who has not been declared legally incompetent, and has the ability to give informed consent, may execute a Delegation of Right to Make Educational Decisions. The Delegation of Right allows the student to appoint their parent or agent to make educational decisions on their behalf. The student has the right to terminate the agreement at any time and assume their right to make decisions.~~

d.8. ~~Postsecondary Education Considerations~~When postsecondary education is the goal for the Member, assist the Member with the following:

i. Matching the Member's interests with the right school;

ii. Connecting the Member to the preferred schools, and assisting with applications for scholarships or other financial aid; and

iii. Connecting the Member with the Disability Resource Centers from their preferred postsecondary institutions if accommodations are needed.

~~When postsecondary education is the goal for young adults, transition planning may include preparatory work in a number of areas, including, but not limited to, matching the young adult's interests with the right school, connecting the youth to the preferred schools Disability~~

~~Resource Center if accommodations are needed, assisting with applications for scholarships or other financial aids, etc. The CFT should anticipate and help plan for such needs. If accommodations are needed, connect the youth with the Disability Resource Centers from their preferred postsecondary institutions, and~~

e~~9~~. ~~Medical/Physical Healthcare~~ Plan for medical and physical healthcare by assisting the Member with the following:

~~Planning can include assisting the youth with:~~

i~~a.~~ Transferring healthcare services from a pediatrician to an adult health care p~~P~~rovider, if pertinent;~~,~~

ii~~b.~~ Applying for medical and behavioral health care coverage, including how to select a health plan and a physician;~~,~~

iii~~c~~. Preparing an application for submission at age 18 to AHCCCS for ongoing Medicaid services;~~,~~

iv.~~d.~~ Obtaining personal and family medical history (e.g., copies of immunization records, major illnesses, surgical procedures);~~,~~

v~~e~~. Providing i~~I~~nformation to the Member on advance directives, as indicated in the Division Medical Policy 640;~~,~~

vi~~f~~. Identifying m~~M~~ethods and supports needed for managing healthcare appointments, keeping medical records, following treatment recommendations, and taking medication;~~,~~

vii~~g~~. Assessing the supports or training needed ~~How~~ to identify healthcare concerns, address questions during appointments, and consult with doctors regarding diagnosis, treatment, and prognosis;~~,~~ and

viii~~h~~. Assessing the supports or training needed for the Member to a~~A~~ssume~~ing~~ responsibility for understanding and managing the symptoms of their

mental illness and obtaining knowledge of the benefits, risks, and side effects of their medication.

f. Evaluate and plan for the Member's living arrangements to include:

i. Assessing the ability to live independently;

ii. Identifying the level of community supports needed;

iii. Identifying the least restrictive living arrangement options to meet the Member's assessed needs and personal preferences;

iv. If needed, assisting the Member with completing and filing applications for public housing or other subsidized housing programs;

v. Allowing Members to continue receiving treatment at a BHIF at the time they turn 18 if they continue to require treatment and give their consent; and

~~10. Living Arrangements~~

~~Where young adults will live upon turning age 18 could change based on their current housing situation (e.g., living at home with family, with a relative, in a behavioral health inpatient or residential facility, other out-of- home treatment setting), or whether they decide to choose housing on-site while pursuing their postsecondary education. Youth who do not have the support of their parents or extended family, or who may be under the care and custody of the child welfare system, may require intensive planning to evaluate their ability to live independently, identify the level of community supports needed, and match the type of living environment to their individual personality and preferences. Each situation will require planning that specifically uses the young adult's strengths in meeting their needs and addresses any personal safety concerns.~~

~~The most common types of living situations range from living independently in one's own apartment with or without roommates to a supported or supervised type of living~~

~~arrangement. If needed, the team may assist the young adult with completing and filing applications for public housing or other subsidized housing programs. Refer to Arizona 2-1-1 for further information on housing options, state and federally funded programs, and other areas for consideration when addressing housing needs. Youth living in a behavioral health inpatient facility at the time they turn age 18 can continue to receive residential services until the age of 22 if they were admitted to the facility before their 21st birthday and continue to require treatment.~~

vi. Allowing l~~L~~icensed residential agencies ~~may~~ to continue providing ~~to provide~~ behavioral health services to individuals aged 18 or older if the following conditions are met as specified in A.A.C. R9-10-318 (B):

1)~~a.~~ Person was admitted before their 18th birthday and is completing high school or a high school

equivalency diploma, or is participating in a job training program, is not 21 years of age or older;~~,~~ or

2)~~b.~~ Through the last day of the month of the person's 18th birthday.

g. Complete financial planning to include:

i. Reviewing and updating any federal and state financial forms to reflect the Members's change in status to avoid disruptions in healthcare or financial assistance services, including applying for food stamps, housing, or other emergency assistance;

ii. Assisting Members who are eligible for Social Security Income (SSI) benefits as a child with obtaining disability redetermination during the month preceding the month of their 18th birthday;

iii. Assisting the Member and their family or caregiver

with identifying any changes related to Social Security benefits, including opportunities for Social Security Work Incentives;

~~11. Financial~~

~~Assessing the financial support needed will include identifying how much money is required to support the young adult's living situation and how s/he will obtain it. This will include determining whether the income from employment will pay the bills or if Social Security Disability programs, food stamps, or other emergency assistance will cover the young adult's financial responsibilities.~~

~~Depending on the special needs of the young adult, arranging for a conservator or guardian may also be necessary.~~

~~Together, the team should review and update any federal and/or state financial forms to reflect the young adult's change in status to ensure there is no disruption in healthcare or financial assistance services. Youth who are eligible for Social Security~~

~~Income (SSI) benefits as a child will have a disability redetermination during the month preceding the month when they attain age 18. This determination will apply the same rules as those used for adults who are filing new applications for SSI benefits. The team can assist the young adult and their family/caregiver with identifying any changes related to Social Security benefits, including opportunities for Social Security Work Incentives.~~

~~Young adults who learn about financial matters prior to age 18 have a better opportunity to acquire the skills necessary for money management. Skill development can include:~~

iv~~a~~. Setting up a simple checking and/or savings account to learn how it can be used to pay bills, save money, and keep track of transactions, if needed;~~,~~

v~~b~~. Identifying weekly/monthly expenses that occur such as food, clothes, school supplies, and leisure activities and determining the monetary amount for

each area, if needed;~~,~~

vi~~c~~. Learning how to monitor spending and budget financial resources, if needed;~~,~~

vii~~d~~. Providing e~~E~~ducation on how credit cards work and differ from debit cards, including an understanding of finance charges and minimum monthly payments, if needed;~~,~~ and

viii~~e~~. Understanding the short and long-term consequences of poor financial planning (e.g., overdrawn account [NonSufficient Funds fee], personal credit rating, eligibility for home and/or car loans, potential job loss), if applicable.

~~12. Legal Considerations~~

h. ~~Transition planning that addresses~~ Address legal considerations ~~ideally begins~~ when the Member ~~youth~~ is 17.5 years of age to ensure the Member ~~young adult~~ has

the necessary legal protections upon reaching the age of majority~~.~~, including: ~~This can include the following:~~

~~a. Document Preparation~~

~~Some families/caregivers may decide to seek legal advice from an attorney who specializes in mental health, special needs and/or disability law in planning for when their child turns 18 if they believe legal protections are necessary. Parents, caregivers, or guardians may choose to draw up a will or update an existing one to ensure that adequate provisions have been outlined for supporting their child's continuing healthcare and financial stability. Other legal areas for consideration can include:~~

i. Guardianship;~~,~~

ii. Conservator;~~,~~

iii. Special needs trust;~~,~~ and

iv. Advance directives (e.g., living will, powers of attorney).

~~b. Legal Considerations for Youth with Disabilities~~

~~Persons with developmental disabilities, their families and caregivers may benefit from information about different options that are available when an adult with a disability needs the assistance of another person in a legally recognized fashion to help manage facets of their life. Refer to the Arizona Center for Disability Law's Legal Options Manual for access to information and forms. This publication also addresses tribal jurisdiction in relation to the guardianship process for individuals who live on a reservation. While this resource is focused on planning for individuals with disabilities, teams can utilize this information to gain a basic understanding of the legal rights of individuals as they approach the age of majority.~~

~~13. Transportation~~

~~A training program, whether a formal or informal one, may be useful in helping the young adult acquire the skills necessary for driving or when using public transportation. Planning can include assisting the youth with test preparation and acquiring a driver's permit. Use of a qualified instructor, family member, or other responsible adult can provide the youth with "behind the wheel" driving experience including how to read maps or manage roadside emergencies. If obtaining a driver's license is not feasible, skill training activities for using public transportation can include reviewing bus schedules, planning routes to get to a designated location on time, and learning how to determine the cost and best method of transportation for getting to and from work or scheduled appointments.~~

~~When transitioning to the adult behavioral health system,~~

i. Eeducate the family and Member ~~young adult~~ on the transportation options available through the adult service delivery system~~.~~ to support the Member's continued attendance at behavioral health treatment appointments;

and~~This will help support the young adult's continued attendance at behavioral health treatment appointments, as well as assist the team with~~

j. Identify ~~identifying~~ and plan~~ning~~ for other transportation needs that are not necessarily associated with accessing medical or behavioral health services.

~~14. Personal Identification~~

~~The team can assist the youth with acquiring a State issued identification card in situations where the young adult may not have met the requirements for a driver's license issued by the Arizona Motor Vehicle Division. An identification card is available to all ages (including infants); however, the youth may not possess an Arizona identification card and a valid driver's license at the same time.~~

~~15. Mandatory and Voluntary Registrations~~

~~Selective Service registration is required for almost all male U.S. and non-U.S. citizens who are 18 through 25 years of age and~~

~~residing in the United States. Registration can be completed at any U.S. Post Office and a Social Security Number is not needed. When a Social Security Number is obtained after registration is completed, it is the responsibility of the young adult male to inform the selective Service System.~~

~~Upon turning age 18 the young adult can register to vote. Online voter registration is available through Arizona's Office of the Secretary of State.~~

H~~J~~. TRAINING AND SUPERVISION RECOMMENDATIONS

~~1. The practice elements of this policy apply to the AdSS and subcontracted network and provider behavioral health staff who participate in assessment and service planning processes, provider case management and other clinical services, or who supervise staff that provide service delivery to adolescents, young adults, and their families.~~

12. The AdSS shall establish a process for ensuring the following:

    a. ~~Staff~~ Providers are trained and understand how to implement the practice elements outlined in this policy;

b. The AdSS' network and ~~provider~~ Provider agencies are notified of changes in policy and additional training is available if required; and

c. ~~Upon request from AHCCCS or the Division, the~~ The AdSS ~~shall~~ provides documentation demonstrating that all required network and ~~p~~Provider staff have been trained on this policy upon request from AHCCCS or the Division.

2~~3~~. The AdSS shall monitor their network and ~~provider~~ Provider agencies for incorporation of this policy into other supervision processes the network and ~~p~~Provider agencies have in place for direct care clinical staff, in alignment with A.A.C. R4-6-212, Clinical Supervision requirements.

~~K. DIVISION OVERSIGHT OF AdSS~~

~~The AdSS shall comply with the Division's oversight requirements to ensure compliance with this policy and associated policies, including but not limited to the following:~~

~~1. The Division's Annual Operational Review of compliance with standards for Transition Aged Youth (TAY) and related evidence-based programs, including but not limited to:~~

~~a. Policies/procedures to promote, and evidence of, adequate programming for TAY utilizing the Transition to Independence (TIP) Model, or other evidence-based programs for this population.~~

~~b. Policies/procedures to track numbers, and evidence of, staff currently trained in TIP evidence-based programs.~~

~~c. Policies/procedures to analyze, and evidence of, sufficiency of current First Episode Psychosis (FEP) programming for TAY (aged 18-24).~~

~~d. Evidence of the completing an analysis of the data in Sections J.(1)(a.)(b.)(c.) and any related plans for developing additional FEP programming for TAY.~~

~~2. Submit deliverable reports or other data, as required, including but not limited to Provider Network Development and~~

~~Management Plans demonstrating network adequacy and plans to promote specialty services described in this policy.~~

~~3. Participate in oversight meetings with the Division for the purpose of reviewing compliance and addressing any access to care concerns or other quality of care concerns.~~

~~4. Submit data demonstrating ongoing compliance monitoring of network and provider agencies through Behavioral Health Clinical Chart Reviews.~~

SUPPLEMENTAL INFORMATION

A. Transition to adulthood is a process that occurs over many years and varies depending on the individual. Involving families in the Transition Planning process and collaborating with the Member to identify the individual needs acknowledges the diversity that is needed when accessing services and supports.

B. Often, Members who successfully transition to adulthood are those that acquire a set of skills and the maturational level to use these skills effectively. Transition Planning can emphasize interpersonal skill training through a cognitive-behavioral approach to help youth develop

positive social patterns, assume personal responsibility, learn problem-solving techniques, set goals, and acquire skills across various life domains.

C. Planning for a Member's transition to adulthood involves a working partnership among team members in the Children's System of Care and the Adult System of Care.

D. Whenever possible, it is recommended that the young adult and their family be given the choice of whether to stay with the children's Provider or transition to the adult behavioral health service Provider. The importance of securing representation from the adult service Provider in this process cannot be overstated, regardless of the person's identified behavioral health category assignment (SMI, General Mental Health, Substance Use). The children's behavioral health Provider should be persistent in its efforts to make this occur.

E. Members, upon turning age 18, will be required to sign documents that update their responsibilities with relation related to their behavioral health treatment as an adult. Some examples include a new consent to treatment and authorizations for sharing protected health

information to ensure that the team members can continue as active participants in service planning.

F. Members who learn about financial matters prior to age 18 have a better opportunity to acquire the skills necessary for money management.

G. Some families/caregivers may decide to seek legal advice from an attorney who specializes in mental health, special needs and/or disability law in planning for when their child turns 18 if they believe legal protections are necessary. Parents, caregivers, or guardians may choose to draw up a will or update an existing one to ensure that adequate provisions have been outlined for supporting their child's continuing healthcare and financial stability.

H. Persons with developmental disabilities, their families and caregivers may benefit from information about different options that are available when an adult with a disability needs the assistance of another person in a legally recognized fashion to help manage facets of their life. Refer to the Disability Rights Arizona's Legal Options Manual for access to

information and forms. This publication also addresses tribal jurisdiction in relation to the guardianship process for individuals who live on a reservation. While this resource is focused on planning for individuals with disabilities, teams can utilize this information to gain a basic understanding of the legal rights of individuals as they approach the age of majority.

I. OTHER LEGAL CONSIDERATIONS

1. Transfer of Rights' Requirement for Public Education Agencies. Under Arizona State law, a child reaches the age of majority at 18. The right to make informed educational decisions transfers to the young adult at that time.

   a. According to IDEA, "beginning not later than one year before the child reaches the age of majority under State law, a statement that the child has been informed of the child's rights under this title, if any, that will transfer to the child on reaching the age of majority under section 1415(m)" must be included in the student's IEP. This

means that schools must inform all youth with disabilities on or before their 17th birthday that certain rights will automatically transfer to them upon turning age 18; and

b. In order to prepare youth with disabilities for their transfer of rights, it is necessary for parents/caregivers to involve their child in educational decision-making processes early. The CFT or ART, in conjunction with the adult behavioral health ~~p~~Provider, should assist the Member/parent/caregiver with this process.

~~2.~~ A student with a disability between the age of 18 and 22, who has not been declared legally incompetent, and has the ability to give informed consent, may execute a Delegation of Right to Make Educational Decisions. The Delegation of Right allows the student to appoint their parent or agent to make educational decisions on their behalf. The student has the right to terminate the agreement at any time and assume their right to make decisions.

J. For Housing options, refer to Arizona 2-1-1 for state and federally funded programs, and other areas for consideration when addressing housing needs.

Signature of Chief Medical Officer: