



**Arkansas Department of Human Services
Division of Children and Family Services
Request for After Care Support**

(Completed by FSW if youth is in care; Completed by Coordinator if youth has already exited care)

TO: _____(TYS Coordinator) Area: _____ Date: _____
FROM: _____(FSW) Phone: (_____) _____ - _____ County: _____

Youth's Name: _____ Birth Date: _____ Age: ____ Gender: ____
Case Name: _____ Client #: _____ Client ID: _____
SSN: _____ - _____ Email: _____ Phone: (_____) _____ - _____
Address: _____ City: _____ State: ____ Zip: _____ - _____
Name of Youth's Life Connection: _____
Address: _____ Phone: (_____) _____ - _____
City: _____ State: ____ Zip Code: _____ - _____

The above named youth is requesting After Care Support. In order to be eligible, the youth must meet the following requirements.

1. Youth must have been in foster care on his or her 18th birthday **OR** adopted **OR** placed in permanent guardianship, on or after his or her 16th birthday.
2. Youth must be between the ages of 18 and 21 and must request After Care **before** the age of 21.
3. Youth must have a budget and a plan that includes participation in education, employment, training, or treatment.

Please see POLICY VIII-C for guidance on how After Care Support can be used.

Case Assigned to Coordinator

Referring Supervisor's Name

Referring Supervisor's Signature

Date

Youth's Signature (Required)

Date

TYS Coordinator's Name

TYS Coordinator's Signature

Date