DHS
Georgia Department of Human Services

GRADUATED INDEPENDENCE PLAN

Youth Name:			Legal County:	Month Ending:
DOB:	Age:	Grade:	Special Education: ☐Yes ☐No	
DFCS CM Name:			Independent Living Coordinator Name:	

Placement Provider Name/Site :	
Person Completing Form:	Contact Information:

FREEDOMS
Weekdays (Include Curfews, Transportation and Other Expectations/Rules)
Weekends (Include Curfews, Transportation and Other Expectations/Rules)
Re-Occurring Events or Activities (Include Curfews, Transportation and Other Expectations/Rules)
Other (Include Curfews, Transportation and Other Expectations/Rules)

RESPONSIBILITIES
CONSEQUENCES
COMMENTS

SIGNATURES		
This section must be signed by ALL applicable parties before the plan is started.		
Youth	☐ I participated in the development of this plan. I agree to follow the responsibilities and I understand the consequences if I do not. I have received a copy of this plan.	Date
Foster Caregiver	☐ I agree with this plan.	Date
Parent (s)	☐I agree with the plan	Date
RBWO Provider Case Support Worker or HSP	☐ I have reviewed and concur with this plan.	Date
RBWO Provider Supervisor	☐ I have reviewed and concur with this plan.	
DFCS Case Manager	☐ I have reviewed and concur with this plan.	Date
DFCS Case Manager Supervisor	☐ I have reviewed and concur with this plan.	Date