Massachusetts Department of Transitional Assistance

Final Transition Plan

(To be completed for each grantee)

TAO

Name **SSN**

Expected End Date of Time-Limited Benefits **Case SSN if different**

Part I

A. What efforts have you made since the last Transition Plan contact to seek training or find a job?

B. Are you currently working, performing Community Service or in a training activity?

❒ yes ❒ no If yes, check what applies to you.

❒ Employed ❒ Employment Training and Education program

❒ full time ❒ Community Service ❒ Employment Supports

❒ part time ❒ Full Employment Program (FEP)

If no, why not and when was the last time you worked? What type of work did you do? (full-time and part-time)

Have you attended training programs? ❒ yes ❒ no If yes, what were they and when?

C. Are you currently participating or would you like to participate in the Employment Ready activity or in another program which can lead to employment before the end of time-limited benefits? ❒ yes ❒ no

If yes, what is the program?

If no, why not?

D. What can you do at this time to increase your income and/or to find a job?

E. How will you support your family when your time-limited benefits end?

F. Are there health issues, including drug or alcohol use, that are interfering with your finding a job?

❒ yes ❒ no If yes, describe and include any treatment you are receiving.

I have reviewed all the months which I have used toward my 24 months of time-limited benefits and agree that I am currently in month 23 of my time-limited benefits and that if I receive assistance next month as a nonexempt client, my Transitional Assistance (TAFDC) benefits will end. I also understand that I may request an extension of my TAFDC benefits. I have also been given information about services which will be available to me if I do not request an extension. I have been given a *TAFDC Extensions Beyond the 24-Month Period* brochure.

❒ I disagree with the number of months.

❒ I wish to request an extension.

❒ I do not wish to request an extension.

Client Signature **Date**

Part II (To be completed by the Case Manager)

Check off items discussed with client.

☐	**Explained time-limited benefits rule and actual months used**
☐	**Provided and reviewed the *TAFDC Extensions Beyond the 24-Month Period* brochure**
☐	**Explained extension rules**
☐	**Explained transitional child care and transitional MassHealth and SNAP eligibility**
☐	**Explained available earned income credits and provided handout**
☐	**Explained Domestic Violence Waiver rules**

Comments

❒ **I have reviewed all sections of this plan.**

Case Manager Signature **Date**

Supervisor Signature **Date**