

**DEPARTMENT OF HUMAN SERVICES
APPLICATION AND AGREEMENT OF RESPONSIBILITY FOR CONTINUED CARE
VOLUNTARY EXTENDED CARE AGREEMENT (V9)**

DATE: _____

Part I

I hereby make application to the Department of Human Services for continued care and support beyond my 18th birthday.

Name: _____ **Birthdate:** _____

Address: _____

Part II

The terms of this agreement are as follows:

I understand that this contract will be terminated if I marry or do not follow through with the terms of this agreement.

I understand that either the Department of Human Services or I may terminate this voluntary agreement by a ten day notice in writing. If this agreement is terminated, I understand that I have a 90 day period within which to renegotiate this agreement under terms that are mutually agreed upon between myself and my caseworker. I also understand that I have the right to request a meeting with my caseworker and their supervisor to discuss any decision to terminate, or change the terms of my agreement.

I understand that the Department of Human Services will not be financially responsible for any damages that I am responsible for, nor will the Department of Human Services provide legal counsel for me if I am involved in a legal situation after the age of 18.

I understand that the Department of Human Services will not be financially responsible for any contracts that I enter into after the age of 18.

Youth's Signature: _____

Department of Human Services Caseworker: _____

Department of Human Services Supervisor: _____