Services Post-Majority Extended Support Form
DCF-2098
(5/2024 Rev.)

Youth's First Name:	Youth's Last Name:	DOB:	Age:	Case Link #:
Social Worker's Name:	Social Worker's Signature:	Area Office:		
Social Work Supervisor Name:		Social Worker Supervisors' Signature:		
Eligible for Department of Developmental Services/Department of Mental Health and Addiction Services (Yes or No):		DDS/DMHAS transition date:		

The request is for the following:

- ☐ Extended Foster Care (Youth is 21 through 23)-Commissioner level of approval
- ☐ Time Off Approved Programming Only (Ex. Medical / MH / SU Treatment / Maternity)-Up to 6 months
- ☐ Other

Justification for Request:

APPROVALS

Position:	Signature:	Date:	Notes
Program Supervisor			
Office Director			
Assistant Chief of Child Welfare			
Bureau Chief of Child Welfare:			
Chief Fiscal Officer:			
Deputy Commissioner of Operations:			
Commissioner:			

Approved until (specify date or conclusion of program)

505 Hudson Street
Hartford, CT 06106
Phone: 860-550-6300