

**SERVICES POST-MAJORITY EXTENDED SUPPORT FORM**  
 DCF-2098  
 12/2025 (Rev.)

Youth's First Name:	Youth's Last Name:	DOB:	Age:	Child ID #:
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: <ul style="list-style-type: none"> <li><input type="checkbox"/> Extended Foster Care (Youth is 21 through 23)-Commissioner level of approval</li> <li><input type="checkbox"/> Time Off Approved Programming Only (Ex. Medical / MH / SU Treatment / Maternity)-Up to 6 months</li> <li><input type="checkbox"/> Other</li> </ul>				

**Justification for Request:**
**Approved until (specify date or conclusion of program):**
**APPROVALS**

Position:	Signature:	Date:	Notes
Program Supervisor			
Office Director			
Chief of Child Protective Services			
Deputy Commissioner of CPS			
Chief Fiscal Officer			
Commissioner			