

**YOUTH IN TRANSITION ELIGIBILITY
VERIFICATION OF ADOPTION**
Michigan Department of Health and Human Services

To be completed by County making verification request:

Name: _____

DOB: _____ **County of Jurisdiction:** _____

To be completed by Education and Youth Services Staff:

_____ was a ward of the court/state after their 14th
Youth's Adoptive Name

birthday and was adopted. The adoption was finalized by the _____ County

Probate Court on _____

For the purpose of YIT eligibility, this form certifies that MDHHS possesses the following documentation regarding the above-named youth:

- Birth Certificate

- Court Order showing youth in care past their 14th birthday

- For youth currently 16/17, YIT was accessed prior to closure

Printed Name, Education and Youth Services Reviewer

Signature, Education and Youth Services Reviewer

Date

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.