ILLINOIS DEPARTMENT OF CHILDREN & FAMILY SERVICES
REQUEST FOR WAIVER/MODIFICATION
RELATED TO FILING AUDIT/FINANCIAL REPORTS

Provider Name: _____

Address: _____

FEIN: _____ Provider's Fiscal Year End: _____

Fiscal Year of Request: _____

Contact Person: _____

Phone #:_____ Fax #: _____

E-Mail Address: _____

Please identify the type of request by checking the appropriate category:

____ Partial waiver of reporting requirements

____ Modification of reporting requirements

____ Other

Explanation and Justification: _____

_____

_____

_____

_____ _____
Signature and Title (must be executive management or a Board member) Date

Fax request to: 708-210-2816
Or mail to: Office of Field Audits
15115 S. Dixie Highway
Harvey, IL 60426

____ Request approved

____ Request not approved

_____ _____
Deputy Director Date

A signed form indicating approval or denial of your request will be returned to the provider by mail within 30 business days after receipt of the request.