CFS 1800-S
Rev 1/2005

State of Illinois
Department of Children and Family Services

APPROVED SUBSIDY MAINTENANCE FORM

Foster Care (For Sub Guardian Cases)	**Adoption Assistance**	**Case Name**
Case ID: _____	**Case ID:** _____	**Last, First Mi:** _____

***** **CM-51 ENTRY** *****

Adoption Finalization/Guardianship Transfer Date: ___/___/____ Amendment Date: ___/___/___ Graduation Date: ___/___/____

Approved Subsidy Services: ☐ Adoption Assistance ☐ Subsidized Guardianship

☐ Ongoing Monthly Payment Amount: _____ ☐ Nonrecurring Expenses Amount: _____ ☐ Medicaid Card

				Start Date	End Date
☐ Therapeutic Day Care	☐ Part-Time	☐ Full-Time	Daily Rate: _____	___/___/____	___/___/____
☐ Day Care For Children Under Age 3	☐ Part-Time	☐ Full-Time	Daily Rate: _____	___/___/____	___/___/____

☐ Respite Care For DSCC Otherwise Eligible Child ☐ Director's Authorized Services

***** **CM-52 ENTRY** *****

☐ **Payment For Pre-Existing Conditions Not Payable Elsewhere At Medicaid-Eligible Rates**

				Start Date	End Date
☐ Counseling	Units: _____	Rate: _____	Frequency: _____	___/___/____	___/___/____
☐ Therapy	Units: _____	Rate: _____	Frequency: _____	___/___/____	___/___/____
☐ Other	Units: _____	Rate: _____	Frequency: _____	___/___/____	___/___/____
(Specify: _____)					
☐ Other	Units: _____	Rate: _____	Frequency: _____	___/___/____	___/___/____
(Specify: _____)					
☐ Other	(Specify: _____)				

***** **CM-53** ***** **(DIRECTOR'S AUTHORIZED SERVICES)**

Service: _____

Units: _____ Rate: _____ Frequency: _____ Start Date: ___/___/____ End Date: ___/___/____

Service: _____ Amount: _____

Service: _____ Amount: _____

_____ _____ ___/___/____

Print Name of Child's Assigned Permanency worker Worker's Signature DATE