State of Illinois
Department of Children and Family Services

SUBSIDIZED GUARDIANSHIP AGREEMENT

The following agreement has been entered into by and between the Department of Children and Family Services, hereinafter called "the Department," and _____
Name of Guardian(s)

_____
Home Address

_____
Mailing Address (if different than above)

hereinafter called the "guardian(s)" for the purpose of facilitating the transfer of guardianship of

_____ _____ / _____ / _____
Child's Name Date of Birth

I. LEGAL BASE

Public Law 110-351 provides the authority for subsidized guardianship. Department Rules and Procedures 302.410, Subsidized Guardianship, govern the provision of subsidized guardianship by the Department.

II. GENERAL PROVISIONS

Following the transfer of guardianship**:**

1) This agreement may not be amended, or terminated except by mutual agreement in writing.

2) While payment may be increased based on changes in the needs of the child, payments will not be decreased based on changes in the needs of the child. All modifications/amendments to this agreement require documentation that the mental, emotional and/or physical condition or risk factors existed prior to the transfer of guardianship.

3) This agreement shall remain in place regardless of the place of residence of the guardian(s) and the child. However, if the guardian(s), who now reside in Illinois, move to another state in the future, the child may not receive a Medicaid card in that state. When a family moves out of state or currently resides out of state and that state will not provide Medicaid coverage for the child, Illinois will reimburse the guardian(s) at Illinois Medicaid reimbursement rates for eligible services. If the out-of-state medical provider participates in the Illinois Medicaid program, the provider will bill the Illinois Medicaid program for medical expenses.

Child's Name: _____

Guardian(s) Name: _____

Date: _____

4) This agreement cannot be transferred by the guardian(s) to any other party.

However, in the event of the death or incapacity of the guardian(s), the child remains eligible for assistance if the guardian(s) has designated a successor guardian(s) in this agreement (or any amendment to this agreement). Upon assuming care of the child, the successor guardian(s) must contact the DCFS Post Adoption staff in their region to request a home study, background checks and the development of a subsidy.

5) An ongoing monthly payment can be issued to only one custodial caretaker identified as payee in Section V b) of this agreement, and this person will be the designated authority for the purpose of service provision. In the event that there is a change in the custodial status of the child, the Department must be notified. If a change in payee is necessary, notification must be sent to the Department in writing with the supporting legal documentation attached.

III. OBLIGATIONS OF THE GUARDIAN(S)

The following are obligations of the guardian(s). Failure to comply with these obligations may result in termination of the Medicaid Card and the subsidy.

1) The Department is required to conduct reviews to confirm that the guardian(s) remains legally and financially responsible for the child, in part, to re-certify the child's eligibility for Medicaid benefits. Written notice will be sent annually to the guardian(s) along with a form that must be completed and returned to the Department.

2) The guardian(s) agrees to notify their DCFS Post Adoption Subsidy worker no later than 30 days after the following occurrences:

   a) When the child is no longer the legal responsibility of the guardian(s);
   b) When the guardian(s) no longer financially supports the child;
   c) When the child graduates from high school or equivalent;
   d) When there is a change of residential address or mailing address of the guardian(s) or the child;
   e) When the guardianship is vacated;
   f) When the child becomes an emancipated minor;
   g) When the child marries;
   h) When the child enlists in the military;
   i) When the mental or physical incapacity of the guardian(s) prevents the guardian(s) from discharging the responsibilities necessary to protect and care for the child;
   j) When the custodial status of the child changes;
   k) When the child dies;
   l) The subsidized guardians are also required to notify the Department no later than 30 days after the child completes their secondary education or a program leading to an equivalent credential if the guardianship was awarded before July 1, 2017, or the child was younger than 16 years of age when guardianship was awarded on or after July 1, 2017;

Child's Name: _____

Guardian(s) Name: _____

Date: _____

m) For children who were 16 years of age or older when the guardianship was transferred on or after July 1, 2017, the subsidy terminates at age 21. Between the ages of 18 and 21, the subsidy payments may stop and start based on the child's compliance with, and the guardian's confirmation of the requirements listed below (failure of the guardian to provide annual written confirmation will cause the subsidy payment to stop):

i) the child is completing secondary education or a program leading to an equivalent credential;

ii) the child is enrolled in an institution which provides post-secondary education or a vocational program;

iii) the child is participating in a training program or activity designed to promote, or remove barriers, to employment;

iv) is employed at least 80 hours per month; or

v) the child is incapable of doing any of the above due to a medical condition.

If the child later meets one of the requirements listed (i-v) above, the payment may be restarted following notification of the Department.

3) The guardian(s) designate the following person(s) as successor guardian(s) under this agreement. The successor guardian(s) have agreed in writing to assume care and custody of the child in event of the death or incapacity of the guardian(s):

Name: _____

Address: _____

Phone Numbers: _____

IV. OBLIGATIONS OF THE DEPARTMENT

The Department agrees to pay for services resulting from pre-existing, medical, emotional or mental health condition(s) that are documented in the CFS 1800 C-G at the rate that is customary and usual in the guardian's community, if not covered by the Medicaid card or other public resources.

This child may require services not currently being provided for pre-existing medical, emotional or mental health needs or risk factors. Such pre-existing conditions must be described in the CFS 1800–C–G to be eligible for assistance through the Subsidized Guardianship Program at a future date. Assistance cannot be granted for services for pre-existing conditions if the condition(s) is not listed on the CFS 1800–C–G.

History and Documentation:

In this section, documentation must be provided regarding why the child and all other siblings, if known, came into care, as well as all known mental health, medical, and substance abuse histories of the biological parents and immediate family. Include additional pages as necessary.

Documentation of the child's unique and routine medical, emotional or mental health conditions must be provided. The child's **SACWIS Health Passport must be included with the records** relating to the child's history of medical, emotional and/or mental health conditions. The records are considered part of this agreement. All of the child's pre-existing conditions must be identified, including what medical, emotional and mental health services the child is receiving and will continue to receive. Specify frequency, duration, the start date and anticipated end date. If there is no information to provide, state the reason.

Child's Name: _____

Guardian(s) Name: _____

Date: _____

Provide specific details for the following questions:

1) Why the child's case came into the system;

2) Does this child have siblings? Provide the following information regarding the existence of any other children known to be born to either birth parent by listing all known siblings or half siblings below:

1) Gender	DOB	Sib by Mother	Sib by Father	Full Sib	Sib in CWS
Reason in CWS and Outcome:					
2) Gender	DOB	Sib by Mother	Sib by Father	Full Sib	Sib in CWS
Reason in CWS and Outcome:					
3) Gender	DOB	Sib by Mother	Sib by Father	Full Sib	Sib in CWS
Reason in CWS and Outcome:					
4) Gender	DOB	Sib by Mother	Sib by Father	Full Sib	Sib in CWS
Reason in CWS and Outcome:					
5) Gender	DOB	Sib by Mother	Sib by Father	Full Sib	Sib in CWS
Reason in CWS and Outcome:					
6) Gender	DOB	Sib by Mother	Sib by Father	Full Sib	Sib in CWS
Reason in CWS and Outcome:					

Child's Name: _____

Guardian(s) Name: _____

Date: _____

3) Identify the specific reason(s) the child was unable to return to his/her birth family (Include issues and services not completed):

4) Provide dates of all placements, whether the provider was a relative caregiver or non-relative caregiver, residential placements etc. and reasons for moves (List in chronological order and provide specific reason for move as specified in case notes):

Placement Date	**Placement Type**	**Reason for Move**

Child's Name: _____

Guardian(s) Name: _____

Date: _____

5) Provide all major medical and mental health treatment history to date. Include all prescribed medication and hospitalization history. List all providers of medical and mental health services including diagnosis and dates of diagnoses, service type, service duration and frequency of treatment in chronological order:
DO NOT include routine medical /dental care in this Section. **The SACWIS Health Passport** must be included with this agreement. Attach copies of all diagnoses, assessments and related reports.

Provider	Diagnosis	Date of Diagnosis	Service Type	Service Duration	Frequency of Medication

Child's Name: _____

Guardian(s) Name: _____

Date: _____

6) Provide substance abuse history of the child and his/her immediate family, including birth parents, siblings and grandparents. Do not include identifying information.

7) Provide any genetic history, medical and mental health history or current conditions of the child's immediate family, including birth parents, siblings and grandparents. **Do not** include identifying information.

Child's Name: _____

Guardian(s) Name: _____

Date: _____

8) Provide information regarding any trauma this child may have been exposed to, i.e., domestic violence, physical abuse, sexual abuse, drug activity, weapons use, etc. Include information as to whether this child was a known victim, witness, or perpetrator of any form of abuse:

9) Provide information regarding any dependency or neglect experiences in which the child was a known victim:

Child's Name: _____

Guardian(s) Name: _____

Date: _____

10) Provide a description of any known separation and loss issues identified in the life of this child:

11) Provide a description of any known behavioral issues this child demonstrated in the past or the present by behavior and when it occurred:

Child's Name: _____

Guardian(s) Name: _____

Date: _____

12) Provide the following Educational information for this child: Schools attended and dates attended in chronological order, dates of any IEP's, IFSP's or 504 plans completed, dates and descriptions of assessments conducted and diagnoses provided regarding learning disorders, and special services provided by any of the schools attended:
(ATTACH CURRENT IEP, IFSP OR 504 PLANS)

School	Dates Attended	IEP/IFSP/504 Plan	Special Services

Child's Name: _____

Guardian(s) Name: _____

Date: _____

Other Educational/Learning Assessments or Information:

13) Provide a list of all pre-existing medical, emotional and mental health issues or risk factors NOT previously noted for which service needs may arise in the future:

Child's Name: _____

Guardian(s) Name: _____

Date: _____

14) List all of the documents that have been attached to this agreement including the name of the provider, type of service or report and date of service or report: **(THE CHILD'S SACWIS HEALTH PASSPORT MUST BE LISTED IN THIS SECTION)**

Provider	Type of Service or Report	Date of Service or Report

Child's Name: _____

Guardian(s) Name: _____

Date: _____

V. SERVICES PROVIDED UNDER THE AGREEMENT FOR ASSISTANCE

The Department shall provide assistance for the approved services as listed below upon the transfer of guardianship. **All Services provided, including those through IDCFS and the Illinois Medicaid, program are subject to periodic review and authorization throughout the duration of this agreement.**

a) Nonrecurring Expenses for Subsidized Guardianship

One-time only payment for expenses incurred during and related to the guardianship process. Eligible expenses include but are not limited to reasonable and necessary guardianship fees, court costs, attorney's fees, guardian *ad litem* fees, travel expenses related to pre-placement visits, health and psychological examinations and other costs associated with the transfer of guardianship of a special needs child subject to the maximum set by the Department of $2,000 per child. The non-recurring cost limit is $500 for cases of a subsequent guardianship after the death/incapacitation of a guardian in which the initial guardianship was established under the IDCFS Subsidized Guardianship Waiver. For attorney fees which may not be determined at the time this document is signed, provide the attorney's name and specify the amount that their fee cannot exceed as determined by the total amount of any other non-recurring costs listed here. **ALL NON-RECURRING COSTS INCLUDING ATTORNEY FEES MUST NOT EXCEED $2,000**

_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

Nonrecurring Expenses are approved for reimbursement through this agreement:

☐ **Yes** ☐ **No**

b) Monthly Cash Payment

The monthly cash payment shall not exceed the amount the child receives in the current foster family home.

Direct monthly payments to, _____ at the rate of
Name of Payee

$_____ per month.

The Department has approved monthly cash payments as a part of this agreement:

☐ **Yes** ☐ **No**

Child's Name: _____

Guardian(s) Name: _____

Date: _____

c) Medicaid Card

In no event can the Department make supplemental payments, pay for deductibles or make co-payments for medical services.

1) When the child and family live in Illinois, medical benefits are provided under Title XIX of the Social Security Act (Medicaid). Medicaid pays for eligible services not covered by medical insurance (if the child has been added to a medical insurance policy). If there is not a service provider who participates in the Illinois Medicaid program within 25 miles of the child's home, a non-participating provider may be used. Guardian(s) will be reimbursed for eligible services at the Illinois Medicaid rate.

2) When a family moves out of state and the new state will not provide Medicaid coverage, Illinois will reimburse the family at Illinois Medicaid reimbursement rates for eligible services.

3) In the event the family lives in another state and a medical provider participates in the Illinois Medicaid program, the provider will bill the Illinois Medicaid program for medical expenses.

A Medicaid Card is a part of this agreement:

☐ **Yes** ☐ **No**

d) Needs Not Payable Through Other Sources

1) Payment for medical, emotional and mental health services cannot be made until the Department has been notified that such services will begin, the Department has approved the requested services, and a contract (when applicable) with the identified vendor is in place.

2) The Department will pay the service provider directly or reimburse the family for Medicaid ineligible services relating to a pre-existing condition, which must be approved by the Department prior to providing services and at a rate negotiated and agreed to regardless of the state in which the child lives.

3) The Department will make direct payments at the Medicaid rate to providers not enrolled in Medicaid. Prior approval from the Department is required.

4) The Department will also make direct payments at the Medicaid rate to the provider or reimburse the family when services from a Medicaid enrolled provider are not available within a twenty-five mile radius of the family's home.

Child's Name: _____

Guardian(s) Name: _____

Date: _____

5) Current Services that will continue to be provided following the transfer of guardianship. Include only those services that are NOT payable through the medical card or other sources and that are allowable per subsidized guardianship rule and procedure **(Do not include provider name, rate or hours of service to be provided)**:

The Department has approved payment or reimbursement for the above services that are not payable through other sources for medical, emotional or mental health issues or disorders as a part of this agreement:

☐ **Yes** ☐ **No**

Child's Name: _____

Guardian(s) Name: _____

Date: _____

e) Therapeutic Day Care

Therapeutic day care provides services to children who cannot be served in traditional childcare settings or other childhood programs because of their inability to participate in such programs and because of the intensity of services they require as a result of their physical, mental or emotional disabilities.

Payment will be made for therapeutic day care only for those children who are determined to have a disability that requires special educational services through a current, Individual Education Plan (IEP), an Individual Family Services Plan (IFSP), or a 504 Educational Special Needs Plan updated on at least an annual basis, when such day care is not payable through another source. Local school districts are responsible for developing the Individual Education Plan or Individual Family Services Plan for students requiring special education services.

1) Payment may be made for specialized care that provides therapeutic intervention rather than only regular childcare services. The day care must include treatment of a disability or a disease as an integral part of the programming (i.e., speech, physical or occupational therapy; behavior modification; psychological or psychiatric services).

2) Approval of payment for therapeutic day care requires documentation as noted in the child's IEP, IFSP or 504 plan of the specific medical, emotional or mental health disability and the special training, licensing or credentialing of the individual providing the therapeutic daycare.

3) Payment for therapeutic day care cannot be made until the Department has been notified that such services will begin, has approved the requested service, and a contract with the identified vendor is in place (when applicable).

4) The Department's reimbursement will be limited to what is usual, customary, and reasonable in the community as determined by the Department.

The Department has approved payment or reimbursement for therapeutic day care as a part of this agreement:

☐ **Yes** ☐ **No**

f) Employment Related Day Care

Guardian(s) receiving assistance for a child under three years of age are eligible for payment of day care services for that child, if day care is required due to one of the following. (Check the appropriate box below).

☐ The guardian(s) is employed or participating in a training program that will lead to employment.

☐ A single guardian is employed or in a training program that will lead to employment or both parents in a two-parent guardianship home are working or in a training program that will lead to employment.

☐ One guardian works and the other parent is unable to care for the child due to a disability.

The Department has approved payment or reimbursement for employment-related day care as a part of this agreement:

☐ **Yes** ☐ **No**

Child's Name: _____

Guardian(s) Name: _____

Date: _____

VI. SOCIAL SERVICES

Social services, as provided under Title XX of the Social Security Act shall be available in accordance with the procedures of the state of residence. Illinois residents may apply at the local Department of Human Services office.

VII. REVIEW / ANNUAL NOTIFICATION

1) The Department will conduct reviews annually to determine whether the guardian(s) remains legally and financially responsible for the child.

2) Written notice will be sent annually to the guardians(s) along with a form that must be completed and returned to the Department. Failure of the guardian(s) to participate in the review process may result in termination of the Medicaid Card and the subsidy.

VIII. TERMINATION

Payments for subsidized guardianship assistance shall terminate when the Department has determined that any one of the following has occurred:

1) when the terms of the subsidized guardianship agreement are fulfilled;

2) the guardian has requested that the payment permanently stop;

3) the guardian is no longer financially supporting the child;

4) the child becomes an emancipated minor;

5) the child marries;

6) the child enlists in the military;

7) If the guardianship was finalized before July 1, 2017, or the child was under the age of 16 when the guardianship was finalized on or after July 1, 2017, assistance will terminate when:

   A) the child reaches age 18;

   B) a child 18 years of age graduates from high school or equivalent or reaches age 19, whichever occurs first; or

   C) a child who has a physical, mental or emotional disability associated with a condition or risk factor that existed prior to the finalization of the guardianship and that was documented prior to the youth's 18th birthday reaches age 21.

8) For children who were 16 years of age or older when the guardianship was awarded on or after July 1, 2017, the subsidized guardianship terminates at age 21. Between the ages of 18 and 21, the subsidized guardianship payments may stop and start based on the child's compliance with, and the guardian's confirmation of the requirements listed below (failure of the guardian to provide annual written confirmation will cause the subsidy payment to stop):

   A) the child is completing secondary education or a program leading to an equivalent credential;

Child's Name: _____

Guardian(s) Name: _____

Date: _____

B) the child is enrolled in an institution which provides post-secondary education or a vocational program;

C) the child is participating in a training program or activity designed to promote, or remove barriers to employment;

D) the child is employed at least 80 hours per month; or

E) the child is incapable of doing any of the above due to a medical condition.

9) the guardian dies;

10) the guardianship is vacated; or

11) the child dies.

IX. APPEAL

Guardian(s) may appeal the Department's decision to change or terminate assistance in accordance with 89 Ill. Adm. Code, Part 337, Service Appeal Process. Decisions that may be appealed include payments for services for the child for whom you are guardian or denial of a request for increased assistance to provide the child with additional services.

Decisions or actions made by the Department are appealed after the guardian(s) has received notice of the decision or action. Any written notices from the Department will provide specific information about the appeal rights of adoptive parents, guardians and foster parents.

To appeal a decision or action made by the Department, a written request for a service appeal is submitted to:

Administrative Hearings Unit
Department of Children and Family Services
406 E. Monroe, Station 15
Springfield, IL 62701
217-782-6655

X. AMENDMENTS

Upon notification by the guardian(s) of a change in the child's needs as set forth in Section IV, Obligations of the Department, amendments to the Agreement may be made at times other than at the review.

Following the guardianship transfer, the agreement may be amended, or terminated with the mutual agreement of the guardian(s). Amendments to the agreement must be completed on a CFS 1800–F, Amendment to Agreement for Assistance, and can only be completed by Subsidy Unit staff. An amendment to increase the ongoing monthly payment may be made only when authorized by the Post Adoption/Guardianship Services Review Committee (PAGSRC).

Amendments to designate or change successor guardian(s) must also be completed on the CFS 1800-F.

If it becomes necessary to change a subsidy that has been signed by all parties prior to finalization, a new agreement must be completed, approved and signed.

Child's Name: _____

Guardian(s) Name: _____

Date: _____

XI. EFFECTIVE DATE

This agreement is effective as of the date the transfer of guardianship of this child.

The guardian(s) acknowledges receipt of a copy of this agreement at the time of signing this agreement.

SIGNATURES:

_____ _____
Guardian Date

_____ _____
Guardian Date

The information contained in this application is complete to the best of my knowledge.

_____ _____
Signature of DCFS Adoption Supervisor/Coordinator Date

_____
Print Name of DCFS Adoption Supervisor/Coordinator

The information contained in this application is complete to the best of my knowledge.

_____
Signature of DCFS or POS Supervisor

_____
Name of DCFS or POS Supervisor

DCFS Office:

_____
Office Name

_____
Street Address

_____
City State ZIP Code

Worker Preparing the Form:

_____
Name Date

_____
Agency

_____
Worker's Supervisor