State of Illinois
Department of Children and Family Services

60+ SUBSIDY CHECKLIST

Instructions: This checklist, to be completed by the caseworker, is REQUIRED for each child when the pre-guardianship or pre-adoptive caregiver(s) is (are) age 60 and older. The completed checklist will be reviewed in detail at the Child and Family Team Meeting in conjunction with the assigned Adoption Liaison/Coordinator (this may be done in conference or by phone) along with the back-up caregiver (in person or by phone) and a determination made as to whether additional permanency planning is necessary. If additional permanency planning is required, the family will be referred to the Child Protection Mediation Program (in Cook County), Metropolitan Family Services Older Caregiver Program (in Cook County), or to additional planning or services. If no additional permanency planning is required, the assigned DCFS Adoption Liaison/Coordinator signs the completed checklist reflecting agreement with the planning, and the original checklist will be maintained in EACH individual child's file.

Child Information:

1. **Child name**:______________________________ Male ____ Female ____ D.O.B. ____________

2. **Child I.D.**:____

3. **Child's special needs**: (specify all)

   ____

   ____

4. **Child's contact with biological family**: (specify who, frequency)

   ____

   ____

5. **Services currently in place for the child**:____

   Counseling:____

   Occupational Therapy:____________________________________

   Physical Therapy:____

   Respite:____

   Other:____

6. **Names/ages of others in home and their relationship to the child**:

   ____

   ____

   ____

7. **Child centered collaterals**: e.g. who does the child identify as important to him/her (for children age 4 and older).____

   ____

   ____

8. **Hotline contacted in past 6 months**: No ____ If Yes, ____ Unfounded ____ Indicated ____

   Outcome:____

9. **Name of current GAL**:____

10. **Concerns the GAL has about caregiver or placement**:
____
____
____

11. **Date of last conversation with GAL**:____
(Must be within 6 months of date checklist is submitted for review.)

Placement Information:

12. **Current placement**:
Caregiver's Name:____________________________________ D.O.B.:______________
Caregiver's Name:____________________________________ D.O.B.:______________
Address:____
Phone:_____________________________

Licensed _____ Unlicensed _____ If unlicensed, ***Home Safety Checklist*** **(CFS 2025)**
completed in accordance with Administrative Procedure #25: _____
Date completed:_______________

Relative _____ Non-relative _____

Date of placement _______________

CANTS/LEADS: Date:___________ Results:________________________________

13. **Currently rent or own home**:_________________ How long:______________________

Caregiver Information:

14. **Informal Supports**: Who comes into home to assist/support caregiver/s:_________________
____
Reason for assistance:____
Frequency of Assistance:____
N/A:______________

15. **Formal Supports**: Other agency/ies involved in home or with caregiver/s
Agency name:____
How involved:____
N/A: ______________

16. **Department of Aging** services in place:________ or needed:_________ (1-800-252-8966)
For Caregiver/s:_________________ Other Family Member:______________________
Homemaker services:________________________
Meals on Wheels:___________________________
Transportation Assistance:____________________
Respite:__________________________________
Other:___________________________________

17. **Caregiver health status:**

Caregiver #1:____

Caregiver #2:____

18. **Received & reviewed the caregiver(s) medical evaluation form**: (Attach CFS 604)

Caregiver #1

Dated_______________ from (Dr./Clinic)____

Caregiver #2

Dated_______________ from (Dr./Clinic)____

19. **Household income**: **(not including child's stipend)**

Annual or monthly (Amount):____

How verified:____

Back-Up Caregiver Information:

20. **Back-up caregiver participated in conference**: Yes_____ No_____

In person __________________

By telephone _______________

21. **Back-up caregiver**:

Name(s):____

D.O.B.(s):____

Address:____

Phone:____

Relationship to child:____

Does child agree (children 4 and older):_______________________________________

22. **Date back-up caregiver identified**:____

23. **Back-up caregiver currently involved with child**: Yes _____ No _____

How:____

Frequency:____

24. **Caseworker reviewed back-up caregiver's future role/responsibilities for child**:

Date:____

Others present:____

Back-up caregiver is prepared to assume future role. Yes _____ No _____

25. **Caseworker reviewed circumstances that may require back-up caregiver to assume future care of the child**:_____

Date:____

Others present:____

Back-up prepared to assume future role:____

Signatures:

26 ____ __________________________

Placement/Permanency Caseworker (Print Name) Phone Number

Signature:____ Date:__________________

27 ____ __________________________

Placement/Permanency Supervisor (Print Name) Phone Number

Signature:____ Date:__________________

28. **Agency/DCFS Region, Site and Field**:____

I have reviewed answers to each of the above questions.

( ) I have concerns regarding

( ) the living arrangement (e.g. housing, finances, health, safety, etc.)

( ) the back-up plan

AND I will ask the caseworker to

- ***(in Cook County)* refer the family to the Child Protection Mediation Program or to Metropolitan Family Services - Older Caregiver Program;**
- ***(in all other counties)* confer with the supervisor for additional planning and/or services**

OR

I have reviewed answers to each of the above questions.

( ) I am satisfied that appropriate plans have been made for this child, including a back-up plan.

29 ____ __________________________

Adoption Liaison /Coordinator (Print Name) Phone Number

Signature:____ Date:__________________

30. **Adoption/Liaison Coordinator participated:** by phone _____ in person _____