CFS 152A
3/2004

State of Illinois
Department of Children and Family Services

Children's Account Unit Assessment Form

Ward's Name: _____ DCFS ID Number: _____

Current Placement Name: _____

Address: _____

City, State, and Zip: _____

Permanency goal : ☐ SGH ☐ Adoption ☐ Return Home ☐ Independence

Is DCFS guardianship expected to end within 30 days? ☐ Yes ☐ No

Does the child have any special needs, currently or in the foreseeable future, that you believe could be met with allowable expenditures from the child's account? ☐ Yes ☐ No

IF YES, please provide a detailed explanation of the child's disability and cause for requesting use of these funds (attach additional pages if necessary).

_____

_____

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_____

Do you recommend allocation of the funds from the child's account to provide services or purchase items to meet these special needs? ☐ Yes ☐ No

IF YES, please complete and attach **Disbursement Request Form** and **Disability Related Services Report**.

_____ _____ (____)_____

Case worker Date Telephone

_____ _____

Supervisor Date

RETURN ALL FORMS TO:

Illinois Department of Children and Family Services
406 East Monroe Street, Mail Station 410
Springfield, IL 62701
or
FAX : 217-782-3882