State of Illinois
Department of Children and Family Services

ADOPTION ASSISTANCE ELIGIBILITY DETERMINATION

This form is to be completed by the child's assigned worker and reviewed by the supervisor.

I. Identifying Data

Name on Birth Certificate: _____ Birth date: _____
LAST FIRST MIDDLE

ID No.: _____ Race: _____ Gender: _____ S.S.#: _____

Date Child Came into Care: _____

Date of Placement with Caregiver: _____

Have parental rights been terminated? (Please check all that apply)

Mother: ☐ Yes ☐ No If "yes", How?	**Father:** ☐ Yes ☐ No If "yes", How?
☐ Involuntary Termination _____ Date	☐ Involuntary Termination _____ Date
☐ Voluntary Surrender _____ Date	☐ Voluntary Surrender _____ Date
☐ Specific Consent _____ Date	☐ Specific Consent _____ Date
☐ Death _____ Date	☐ Death _____ Date
☐ Expedited Adoption _____ Date	☐ Expedited Adoption _____ Date

II. Adoption Assistance Eligibility Factors (Please check all factors that apply)

1. a) Is the Department legally responsible for the child?

☐ Yes ☐ No County of Jurisdiction _____

If yes, enter initial legal date __/__/____ Juvenile Court Docket Number _____

WHEN NO, STOP AND USE THE CFS 1800–A–1, ADOPTION ASSISTANCE ELIGIBILITY FOR CHILDREN NOT UNDER THE LEGAL RESPONSIBILITY OF DCFS.

Child's Birth Name: _____

Adoptive Parents(s) Name: _____

Date: _____

AND

b) A court made a finding of probable cause to believe abuse, neglect, or dependency existed at a temporary custody or adjudicatory hearing.

☐ Yes ☐ No Date of hearing: ____/____/____ County: _____

OR

c) The parents voluntarily surrendered the child without a court finding of abuse, neglect, or dependency and the child was in the care and custody of the Department before July 1, 1998.

☐ Yes ☐ No

AND

d) The Department determined the child is likely to suffer further abuse or neglect or will not be adequately cared for if returned to the home of the parents.

☐ Yes ☐ No

2. Check all which qualify the child as a special needs child.

- ☐ Irreversible or non-correctable physical, mental or emotional disability;
- ☐ Physical, mental or emotional disability correctable through surgery, treatment or other specialized services;
- ☐ One (1) year of age or older;
- ☐ Member(s) of a sibling group being adopted together where at least one child meets one or more of the other criteria;
- ☐ Child being adopted by adoptive parents who have previously adopted, with adoption assistance, another child(ren) born of the same mother or father.

IF NONE OF THE BOXES IN #2 ABOVE ARE CHECKED, THE CHILD IS NOT ELIGIBLE FOR ADOPTION ASSISTANCE.

3. a) ☐ Efforts were made to place the child without a subsidy. Please check all that apply:

- ☐ Listing with an adoption exchange;
- ☐ Searching of adoptive placement resources;
- ☐ Checking waiting lists of adoptive parents;
- ☐ Asking if prospective adoptive parents are willing to adopt without a subsidy; as evidenced by a written statement;
- ☐ Other, please specify._____

b) ☐ Efforts to place the child without a subsidy were unsuccessful.

c) ☐ Efforts were **not** made to place child without a subsidy because it is against the best interests of the child since there is significant emotional attachment to prospective adoptive parents due to their being relatives, friends of the family, or developed while in their care as foster parents.

IF THE ANSWERS TO II. #1, (a) AND (b) or (c) AND (d) ARE YES, AND AT LEAST ONE BOX IS CHECKED IN #2 AND THE ANSWER TO #3 IS EITHER (A) AND (B) OR (C), THE CHILD IS ELIGIBLE FOR ADOPTION ASSISTANCE.

Child's Birth Name: _____

Adoptive Parents(s) Name: _____

Date: _____

4. The child is eligible for Adoption Assistance ☐ **Yes** ☐ **No**

Signature of Worker Completing the Form	Agency	/ / Date

Print Name of Worker Completing the Form

Signature of Supervisor	Agency	/ / Date

Print Name of Supervisor

Signature of DCFS Adoption Supervisor/Coordinator	Region	/ / Date

Print Name of DCFS Adoption Supervisor/Coordinator