CFS 1800-P
Rev 1/2005

State of Illinois
Department of Children and Family Services

ADOPTION/GUARDIANSHIP VERIFICATION OF ONGOING MONTHLY SUBSIDY PAYMENT AMOUNT

DATE: _____/_____/_____

CHILD ID: _____

CHILD NAME: _____

PROSPECTIVE ☐ ADOPTIVE PARENT(S) ☐ GUARDIAN(S)

NAME(S): _____

PROVIDER ID NUMBER: _____

PROPOSED ONGOING MONTHLY PAYMENT AMOUNT: $ _____

RETURN VERIFICATION TO

WORKER NAME: _____

PHONE: (_____) _____-_____ FAX: (_____) _____-_____

CENTRAL PAYMENT UNIT RESPONSE

☐ AGREE WITH AMOUNT ☐ DISAGREE WITH AMOUNT

IF **DISAGREE**, MAXIMUM AMOUNT AUTHORIZED: $_____

NAME_____ DATE:_____

PLEASE FAX FORM TO CPU AT 217-557-0639
IF QUESTIONS, PLEASE CONTACT CPU AT 1-800-525-0499