State of Illinois
Department of Children and Family Services

WAIVER OF LICENSING STANDARDS FOR FOSTER FAMILY HOMES
PART 402

SECTION BELOW TO BE COMPLETED BY LICENSING STAFF

Standard to be waived [# and letter(s)]:

Reason that the standard cannot be met:

Name(s) of foster parent(s):

Mailing Address:

Foster Home Provider ID #: Day Care Provider ID # (If applicable.):

License Capacity (Verify on LC-02.): Region foster home is located in:

Licensing Agency:

Mailing Address:

Licensing Representative: Phone #:

Date of last licensing monitoring visit: (Must be within 14 days.)

Visit completed by: (*Please attach licensing home visit record.)

Has the foster parent(s) ever been placed on hold? If so, why?:
(Please attach previous hold request and the subsequent hold release, if applicable.)

What is the age and health of the foster parent(s)? (Attach the most recent **CFS 602 Medical Examination Form**.):

Does the foster parent work? If so, number of hours per week and name of child(ren)'s caregiver during work hours:

Has the foster parent ever cared for this number of children? If so, please give a brief explanation:

Give a detailed explanation as to why you feel the foster parent is exceptional enough to manage this situation:

SECTION BELOW TO BE COMPLETED BY CASE MANAGEMENT STAFF

LIST ALL CHILDREN 0-18 YEARS OLD WHO LIVE IN THIS FOSTER HOME: (Include biological, foster and adoptive; note the child's relationship to foster parent below.)

Name	Sex	Date of Birth	Age	DCFS ID#	Relationship	Specialized	Placement Date

Are any children specialized? If so, list the child(ren)'s diagnosis/behavior(s) and what services is the child(ren) are receiving (diagnosis, counseling, medication, therapies, and so forth):

LEADS/SACWIS:

Please attach the current (within 14 days) LEADS/SACWIS for all adults and teenagers 13 and older residing in the foster home.

Are there any positive hits? Provide a written explanation for any positive hits:

SLEEPING ARRANGEMENTS:

List number of bedrooms for the children in the home:

List number of beds in each of the bedrooms:

List names of children matched with his or her bedroom:

SECTION BELOW TO BE COMPLETED BY CASE MANAGEMENT STAFF

FOSTER CHILD THIS REQUEST PERTAINS TO: (Attach One Copy for Each Child Seeking a Waiver.)

Name: DOB:

DCFS ID#: Traditional or Specialized:

Current Goal:

Potential placement date:

Mother's parental rights terminated? ☐ Yes ☐ No Father's parental rights terminated? ☐ Yes ☐ No

Case Manager: Phone #:

Agency:

Mailing Address:

If specialized, what is the child's diagnosis/behavior(s), and what services is the child receiving (diagnosis, counseling, medication, therapies, and so forth):

With whom is the child currently placed?

Specific reason for the child's removal:

Explain why the waiver is in the best interest of the foster child:

Explain the specific services your agency plans to provide to this foster home and child(ren) that will preserve this placement:

PLEASE PROVIDE THE FOLLOWING NAMES, COMPLETE MAILING ADDRESSES, and FAX NUMBERS:

Biological Parents (Mark N/A if all parental rights have been terminated.):

State's Attorney:

Guardian ad Litem:

SECTION BELOW TO BE COMPLETED BY STAFF WHO RECOMMENDED THE WAIVER

Case Management signatures must be secured for ALL children placed in the home, not just the waived child(ren).

Foster Parent(s) Name: **Provider ID#:** **Date:**

Case Management:

Typed Name Signature Agency's Name Child's Name

Case Management Supervisor:

Typed Name Signature Agency's Name Child's Name

Case Management:

Typed Name Signature Agency's Name Child's Name

Case Management Supervisor:

Typed Name Signature Agency's Name Child's Name

Licensing worker: _____
Typed Name Signature Date

Licensing supervisor: _____
Typed Name Signature Date

Program director: _____
Typed Name Signature Date

DEPUTY DIRECTOR OF CLINICAL SERVICES OR DESIGNEE:

Expanded capacity request is for one or more children receiving specialized services in the home, or there are more than 4 children under 6 years, or more than 2 children under 2 years in the home.

☐ Approve ☐ Deny

_____ _____
Signature of Deputy Director of Clinical Services or Designee Date

DIRECTOR or DESIGNEE:

Expanded capacity request for:

☐ unlicensed relative or fictive kin home

☐ Approve ☐ Deny

_____ _____
Signature of Director or Designee Date

DIRECTOR or Designee:

Request for a waiver of Licensing Rules for meeting the best interests of a youth in care.

☐ Approve ☐ Deny

_____ _____
Signature of Director or Designee Date