

DEPARTMENT OF CHILDREN AND FAMILY SERVICES


Distribution: X & Z

Policy Guide 2012.07

**CFS 1800-U, 60+SUBSIDY CHECKLIST FORM; AND
CFS 486-G, SUBSIDIZED GUARDIANSHIP CONVERSION ASSESSMENT FORM**

DATE: June 19, 2012

TO: All DCFS and Private Agency Child Welfare Staff, and Supervisors and Rules and Procedures Bookholders

FROM: Richard H. Calica, Director 

EFFECTIVE: Immediately

I. PURPOSE

The purpose of this Policy Guide is to implement an Office of the Inspector General recommendation requiring caseworkers to complete the new **CFS 1800-U**, 60+ Subsidy Checklist form for each child when his/her prospective guardians or adoptive caregivers are age 60 and older.

This Policy Guide also issues the new **CFS 486-G**, Subsidized Guardianship Conversion Assessment form, which must be completed by the caseworker prior to submitting the guardianship subsidy packet to the Adoption Coordinator/Liaison for approval.

II. PRIMARY USERS

Primary users of this Policy Guide are Statewide Adoption Coordinators, Adoption Coordinators/Liaisons, their staff, and DCFS and Private Agency Child Welfare Staff, and Supervisors.

III. PROCEDURES

The completed **CFS 1800-U**, 60+ Subsidy Checklist form will be reviewed in detail at the Child and Family Team Meeting in conjunction with the assigned Adoption Liaison/Coordinator (in person or by phone), the prospective guardians or adoptive caregivers, and the back-up caregiver (in person or by phone). During the meeting, the Child and Family Team shall discuss the back-up caregiver's role and responsibilities for the child, confirmation that the back-up caregiver is prepared to assume their future role as the caregiver, and determine whether additional permanency planning is necessary. If



additional permanency planning is necessary, the family will be referred to the Child Protection Mediation Program (in Cook County), or to 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 **CFS 1800-U** reflecting agreement with the planning. The original signed **CFS 1800-U** shall be maintained in each child's file.

Caseworkers are also required to complete the **CFS 486-G**, Subsidized Guardianship Conversion Assessment form prior to submitting the Guardianship subsidy packet to the Adoption Coordinator/Liaison for approval. The information included in the **CFS 486-G** assists the worker and the agency in determining whether the prospective guardian(s) can meet the needs of the child. The **CFS 486-G** is an assessment tool that documents the family's preparation and also assists in identifying any possible issues or problems with the family's conversion from foster care to guardianship.

IV. ATTACHMENTS

CFS 1800-U, 60+Subsidy Checklist Form
CFS 486-G, Subsidized Guardianship Conversion Assessment Form

V. QUESTIONS

Questions about this Policy Guide may be directed to the Office of Child and Family Policy at 217-524-1983, by e-mail to OCFP – Mailbox or by fax to 217-557-0692. Persons or agencies not on Outlook may e-mail questions to cfpolicy@idcfs.state.il.us.

VI. FILING INSTRUCTIONS

Please file this Policy Guide immediately following Procedures 309.130, Placement Considerations.

60+ SUBSIDY CHECKLIST

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 back-up to assume future care of the child:** _____
 Date: _____
 Others present: _____
 Back-up prepared to assume future role: _____
26. Complete and attach **CFS 718, Authorization for Background Check** Date: _____
27. Process **CANTS 48, Request for LEADS/CANTS Check**, and attached the results.
 Date: _____

28. _____
Placement/Permanency Caseworker **PRINT NAME**

Signature: _____ Date: _____

Phone Number: _____

29. _____
Placement/Permanency Supervisor **PRINT NAME**

Signature: _____ Date: _____

Phone Number: _____

30. **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**

31. **Adoption Liaison /Coordinator**

PRINT NAME

Signature: _____

Date: _____

Phone Number: _____

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.

32. **Adoption Liaison /Coordinator**

PRINT NAME

Signature: _____

Date: _____

Phone Number: _____

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

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.

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State of Illinois
Department of Children and Family Services

SUBSIDIZED GUARDIANSHIP CONVERSION ASSESSMENT

Name of Family: _____

Address: _____

Telephone: _____

Date(s) of Contact: _____

Guardian Mother

Guardian Father

Birth Date: _____

Religion: _____

Education: _____

Occupation: _____

Employer: _____

Address: _____

Phone: _____

Children moving to Guardianship

	Name	DOB	Gender	Religion
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Other Child(ren)/Adults in Household

	Name	DOB	Gender	Religion	Relationship
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

SUBSIDIZED GUARDIANSHIP CONVERSION ASSESSMENT

Name of Family: _____

I. Child's Summary

A. History and Background

1. Child abuse/neglect history, including why any siblings came into the system, with details of their needs: _____
2. Placement history
 - (a) Number and type: _____
 - (b) Reason(s) for moves: _____
3. Medical/mental health history of both parents: _____
4. Medical/mental health of child: _____

B. Current Level of Functioning and Projection of Child's Possible Future Service Needs

Use the factors identified on the child's CFS 2017, Child Caregiver Matching Tool, or if the child is receiving specialized/treatment foster care, use the CFS 418, Levels of Care Assessment Form to provide a narrative description of the following:

1. Medical: _____
2. Mental Health: _____
3. Behavioral: _____
4. Emotional: _____
5. Developmental: _____
6. Educational: _____

C. Child's Attachment to Significant Others

1. Prospective Guardian
 - (a) Length of placement: _____
 - (b) Indicators of attachment: _____
2. Past caretakers
 - (a) Evaluation of relationship: _____
 - (b) Recommendation for continued involvement: _____
3. Biological family (including siblings)
 - (a) Evaluation of relationship: _____
 - (b) Recommendation for continued involvement: _____
 - Expressed desire of biological family: _____
 - Expressed preferences and feelings of the child: _____
 - Recommendation of Permanency Worker: _____
 - c) Religion and religious training: _____

4. Racial, Ethnic and/or Cultural Identity

Decisions made under the Interethnic Placement Act (IEPA). If race, culture, or national origin has been raised as a consideration in the placement or change of placement of the child whose needs are being assessed on this form, follow the procedures contained in Procedures 301, Placement and Visitation Services, Section 301.60(b)(4) and complete form CFS 2018, Interethnic Placement Act Assessment Form. Attach the completed CFS 2018 to the Individualized Assessment.

SUBSIDIZED GUARDIANSHIP CONVERSION ASSESSMENT

Name of Family: _____

D. Child's Understanding of Guardianship

1. Understanding of what Guardianship means: _____
2. Understanding of personal history: _____
3. Expressed desire of child: _____

E. Projected Eligibility for Guardianship Assistance

II. Family Summary

A. Description of Prospective Guardian(s)

1. Marital history and current status: _____
2. Health status: _____
Does the prospective Guardian(s) have any health or physical conditions that might prevent them from meeting the child's health and developmental needs over time? _____
3. Employment history and income of family: _____
4. Criminal history: _____
5. Plan of financial support for child: _____
6. Is the prospective guardian(s) able to communicate with the child in the child's primary language or mode of communication? _____

B. Guardian Assessment

1. Motivation to become Guardian
 - (a) Possible issues to consider or explore further (i.e. love/attachment, loyalty, obligation, penance/guilt, rescue, anger, infertility, religious beliefs): _____
2. Understanding of child's background and history: _____
3. Understanding of biological family's medical and mental health history: _____
4. Demonstrated ability to meet child's future needs
 - (a) Historical: _____
 - (b) Anticipated response to child's future needs: _____
 - (c) Responses to behavioral issues of child: _____
 - Management of children's problematic behaviors (i.e. sexual acting out, aggression, lying, stealing): _____
 - (d) Religious: _____
 - (e) Child's Strengths and abilities: _____
 - Fostering and encouraging child's talents and interests (eg. musical, athletic, academic, etc.): _____
 - _____ Communicating in child's primary means of communication (language other than English, sign language, etc.): _____
5. If a CFS 2018, IEPA Assessment Form has been completed: demonstrated capacity to meet child's racial, ethnic or cultural identity needs: _____
6. Understanding of child's grief, separation and loss issues: _____
7. Continued contact with child's significant others: _____
 - (a) Family's willingness for further contact: _____
 - (b) Family's plan to accomplish further contact: _____
8. Indicators of attachment to child: _____
9. Assessment of expectations for child: _____
10. Plan for sharing background information with child (describe): _____

SUBSIDIZED GUARDIANSHIP CONVERSION ASSESSMENT

Name of Family: _____

11. Plan for future adoption/guardianship and continued foster parenting (describe): _____
 - (a) Assessed effect on the child: _____
 - (b) Family's understanding of the differences between foster care, adoption and guardianship: _____
12. Child's integration into primary and extended family: _____
13. Child care plan: _____
14. Current and anticipated use of community resources: _____
15. Knowledge of post-guardianship services: _____
 - (a) Guardianship assistance: _____
 - (b) Guardianship preservation services: _____
 - (c) Contracted search services: _____
16. Plan for succession of guardianship due to incapacity or untimely death: _____
 - (a) Has a back-up caregiver been named? _____
 - (b) What is the back-up caregiver's current involvement with the family? _____
 - (c) Have discussions been held with the back-up caregiver regarding the actual process to change or transfer of guardianship? _____

C. Description of Other Children in Home

1. Understanding and acceptance of guardianship: _____
2. Quality of relationship to child(ren): _____

D. Required Collateral Contacts (Must have a minimum of 3 collateral contacts)

1. Teacher/School Personnel/Day Care Provider/0 to 3 provider (one is mandatory depend on child's age): _____
2. Licensing worker (Mandatory): _____
3. Medical professional or Service Provider: _____
4. Other person who has regular contact with the child: _____

SUBSIDIZED GUARDIANSHIP CONVERSION ASSESSMENT

Name of Family: _____

III. Recommendations

A. Summary of Family's Strengths

Ability to meet child's needs and provide permanency for child: _____

B. Capacity of child to benefit from permanency in this family: _____

C. Further Services or Training Needed: _____

1. Identification of problem areas: _____
2. Problem resolution and plan for services and/or training including timeline: _____

D. Recommendation Regarding Guardianship Conversion

Permanency Worker

Date Prepared

Supervisor

Date

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