Application Packet

Initial Foster Family Home License:

Relative Caregivers

Revised: October 2017

FOSTER FAMILY HOME LICENSE APPLICATION FOR RELATIVE CAREGIVERS

(Si usted prefiere esta aplicación en Español por favor solicítela a su trabajador)

Part 402, Licensing Standards for Foster Family Homes, which is available on the DCFS Website at http://www.illinois.gov/dcfs/aboutus/notices/Pages/pr_policy_rules.aspx, provides a detailed description of the requirements for becoming licensed as a foster family home. Many of the requirements for becoming licensed can be waived, however the requirement to get fingerprinted cannot be waived.

Also enclosed are the forms that must be completed to apply for a foster home license.

- Application Form (CFS 597R) - - - This is the actual application form.

- Authorization for Background Check for Foster Care and Adoption (CFS 718-A) - - - Everyone living in the home who is age 13 or older must complete and sign a CFS 718-A form to authorize a background check of the following records: the Illinois Child Abuse/Neglect Registry, the Illinois Sex Offender Registry, the Illinois Criminal History Records, and the FBI, when needed. (Related children who have been placed in the home do not need to complete a CFS 718-A or get fingerprinted.)

- Medical Report(s) On All Members of the Household - - - It is the applicant(s)' responsibility to schedule and insure that a medical examination is completed for every member of the household (both adults and children). A **CFS 600, Certification of Child Health Examination,** must be completed for each child in the home; a **CFS 604, Medical Evaluation of an Adult in a Foster or Adoptive Home,** must be completed for each adult in the home. (Note: If you have a school medical report on a child and that report is less than one year old, the report of that examination may be attached to the application instead of the CFS 600.)

Steps in the License Application Process

1. **Complete and Sign the Application Form (CFS 597R)**

   License applicants should read the instructions on page 4 of the Application form, fill in the requested information, answer all questions completely, and sign and date the application form.

2. **Make Arrangements to Be Fingerprinted**

   Every person living in the home who is age 18 and older must:
   - complete and sign a CFS 718-A (Authorization for Background Check for Foster Care and Adoption) form; and
   - call **1-866-361-9944** to make arrangements to be fingerprinted.

   The person being fingerprinted must bring their valid government identification card.

   After the fingerprinting is completed, the fingerprint technician will give the individual a receipt to verify that he or she was fingerprinted.

3. **Attach ALL Fingerprint Receipts to Application Form and Mail to Licensing**

   The CFS 718-A and every receipt must be attached to the application (CFS 597R). in order for the licensing worker to know that everyone who needs to be fingerprinted has been fingerprinted so the licensing worker can then process the application.

CFS 597 R
Rev 9/2012

State of Illinois
Department of Children and Family Services

Complete in duplicate.
Retain one copy for your file.

APPLICATION FOR FOSTER FAMILY HOME LICENSE FOR RELATIVE CAREGIVERS

DO NOT WRITE IN THIS SPACE – AGENCY USE ONLY

Region/Site/Field
Responsible for License ________________________

Date Received ____________

Date Entered ____________

County No. __________

Supervising Agency No. ____________

☐ DCFS Regional Office ____________ Field Office ____________

☐ Licensed Child Welfare Agency

Name ____________________

Street Address ____________________

City ____________ Zip ________

Telephone No. ____________________

PLEASE READ INSTRUCTIONS ON THE BACK BEFORE COMPLETING THIS APPLICATION

I. APPLICANT INFORMATION:

Name of Applicants: A. ________________________ ________________________
Last Name First Name Middle — Social Security Number or ITIN Number

B. ________________________ ________________________
Last Name First Name Middle — Social Security Number or ITIN Number

Address ____
No. and Street — City, State and Zip — County

Mailing
Address ____
No. and Street — City, State and Zip — County

Home
Telephone ________________________
Area Code — Number

Work or Cell Number
Applicant A ________________________
Area Code — Number

Work or Cell Number
Applicant B ________________________
Area Code — Number

Email Address
Applicant A________________________

Email Address
Applicant B________________________

Does Applicant A and/or B speak a language other than English? ☐ No ☐ Yes If yes indicate:

Applicant A's Language: ________________________

Applicant A's Proficiency: Bilingual ________ Fluent ________ Conversational ________

Applicant B's Language: ________________________

Applicant B's Proficiency: Bilingual ________ Fluent ________ Conversational ________

II. CURRENT AND PREVIOUS LICENSES

1. Have you ever been convicted for other than a minor traffic violations? ☐ No ☐ Yes

   If yes, explain ____________________

2. Are you currently licensed for child care in Illinois? ☐ No ☐ Yes

   If yes, give type of license(s) and license(s) No(s) ____________________

   Name on license(s) ____________________

   Address on license(s) ____________________

3. Have you ever been licensed for child care outside Illinois? ☐ No ☐ Yes

   If yes, give type of license(s) and the license(s) No(s) ____________________

   Name on license(s) ____________________

   Address on license(s) ____________________

4. If you are not currently licensed for child care, complete the question below:

   Have you ever applied for a child care license? ☐ No ☐ Yes

   Was license issued? ☐ No ☐ Yes

   Name on license ____________________

   Address on license ____________________

III. HOME—Check any boxes that apply

Do You ☐ Own ☐ Rent

☐ Apartment ☐ Mobile Home ☐ House ☐ Other (Specify) ____________________

Do you have landlord approval to care for related children? ☐ Yes ☐ No

Water supply ☐ City ☐ Other (Specify) ____________________

Directions for reaching your home: ____________________

____

IV. MARITAL STATUS—Check One Box

☐ Married ____________________ (Date)

☐ Civil Union ____________________ (Date)

☐ Single

☐ Divorced

☐ Widowed

☐ Legally Separated

V. MEMBERS OF HOUSEHOLD (include Children, Relatives, Others)

NAME	RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY or ITIN NUMBER	RELIGION
Applicant A:				
Applicant B:				

VI. CURRENT EMPLOYMENT

	Name of Firm	Address	Title or Position	Working Hours
Applicant A				_____ to _____
Applicant B				_____ to _____

IF APPLICANT(S) WORK OUTSIDE OF HOME, DESCRIBE CHILD CARE PLANS: ____________________________________

____

____

____

____

____

____

VII. REFERENCES: Persons unrelated to you who know how you care for children

1. Name ________________________________ Phone ________________________________
   Address ________________________________ City ________________ Zip Code____________
2. Name________________________________ Phone ________________________________
   Address ________________________________ City ________________ Zip Code____________
3. Name ________________________________ Phone ________________________________
   Address ________________________________ City ________________ Zip Code____________

IF EITHER APPLICANT HAS BEEN AN ILLINOIS RESIDENT FOR LESS THAN FIVE YEARS, INCLUDE TWO REFERENCES FROM THE PREVIOUS RESIDENCE STATE:

4. Name________________________________ Phone ________________________________
   Address ________________________________ City ________________ Zip Code____________
5. Name ________________________________ Phone ________________________________
   Address ________________________________ City ________________ Zip Code____________

VIII. CERTIFICATION

I (WE), the undersigned, hereby apply for license to operate a foster family home under the Child Care Act of 1969 as amended. I (WE) declare that, I(WE):

1. Have received a copy of the standards for foster family homes, have read them and are familiar with them.
2. Will be subject to and cooperate with the supervising agency in the licensing process to determine my/our compliance with licensing standards.
3. Will be subject to supervision in terms of conformance with minimum standards upon issuance of a license.
4. Affirm that the information provided above is true. I(WE) understand that making materially false statements in order to obtain a license or permit constitutes a Class A misdemeanor and that I(WE) may be prosecuted for such misconduct.

SIGNATURE(S)

____ ____________________

Applicant A DATE

____ ____________________

Applicant B DATE

INSTRUCTIONS FOR APPLICATION FOR FAMILY HOME LICENSE

Name of Applicant(s)
Enter the name(s) of the person(s) who are applying to be licensed as foster parent(s). Enter the social security or individual taxpayer identification (ITIN) number of each person listed in the spaces provided.

Address
Enter the complete address of the home's actual location.

Mailing Address
Use ONLY when the mailing address is different from the actual location of the home.

Telephone Number
Enter the area code and phone number of the home and work telephone if applicable.

All applicants should verify the statements above and sign.

If there is one applicant, he/she must sign the form. If there are joint/married applicants, both must sign.

DCFS is an equal opportunity employer, and prohibits unlawful discrimination in all of its programs and/or services.

CFS 506-F
Rev. 11/2014

State of Illinois
Department of Children and Family Services

FOSTER FAMILY HOME INFORMATION

I. NAME: Applicant A ______________________________
(Last) (First) (Middle)

Applicant B ______________________________
(Last) (First) (Middle)

ADDRESS: ______________________________
(Street or Rural Route)

____
(City) (Zip Code) (County) (Telephone)

How long have you been a resident of Illinois? Applicant A: ________ (Months) (Years) Applicant B: ________ (Months) (Years)

II. HOME—Check any boxes that apply

DO YOU ☐ OWN ☐ RENT LANDLORD APPROVAL TO CARE FOR UNRELATED CHILDREN ☐ YES ☐ NO
☐ APARTMENT ☐ MOBILE HOME ☐ HOUSE ☐ OTHER ________

WATER SUPPLY ☐ CITY ☐ OTHER (Specify) ________

DIRECTIONS FOR REACHING YOUR HOME: ______________________________

____

III. MARITAL STATUS—Check One Box

☐ MARRIED ________ (Date)

☐ CIVIL UNION ________ (Date)

☐ SINGLE ☐ WIDOWED
☐ DIVORCED ☐ LEGALLY SEPARATED

PROVIDER ID# ________
Licensing Rep. ________
R/S/F ________

IV. MEMBERS OF HOUSEHOLD
(include Children, Relatives, Others)

NAME	RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY OR ITIN NUMBER	RELIGION
Applicant A:				
Applicant B:				
Other Adult/Child:				
Other Adult/Child:				
Other Adult/Child:				
Other Adult/Child:				
Other Adult/Child:				

Language(s) Spoken ______________________________

V. CURRENT EMPLOYMENT

	Name of Firm	Address	Title or Position	Working Hours	Years Employed
Applicant A				_____ to _____	
Applicant B				_____ to _____	

Approximate Annual Income of Total Household, Regardless of Sources: ______________________________

____

IF APPLICANT(S) WORK OUTSIDE OF HOME, DESCRIBE CHILD CARE PLANS: ______________________________

____

____

____

VI. DESCRIBE YOUR EXPERIENCE WITH CHILDREN OTHER THAN YOUR OWN. THESE MAY INCLUDE CARE OF RELATIVE'S CHILDREN, TEACHING SUNDAY SCHOOL, WORK WITH SCOUTS OR OTHER GROUPS, ETC.

____

____

____

____

WHY DO YOU WANT TO PROVIDE CHILD CARE? ____

____

____

STATE THE AGE RANGE, SEX, AND NUMBER OF CHILDREN YOU WOULD LIKE TO HAVE IN YOUR HOME:

____

____

____

VII. REFERENCES: **You must list at least three (3) persons unrelated to you who know how you care for children**

1. Name ________________________________ Phone ________________________________

   Address ______________________________ City ______________ Zip Code ______________

2. Name ________________________________ Phone ________________________________

   Address ______________________________ City ______________ Zip Code ______________

3. Name ________________________________ Phone ________________________________

   Address ______________________________ City ______________ Zip Code ______________

IF EITHER APPLICANT HAS BEEN AN ILLINOIS RESIDENT FOR LESS THAN FIVE YEARS, INCLUDE TWO REFERENCES FROM THE PREVIOUS RESIDENCE STATE:

4. Name ____ Phone ____________________

   Address ____________________ City ________________ State ______ Zip Code ________

5. Name ____ Phone ____________________

   Address ____________________ City ________________ State ______ Zip Code ________

I/WE CERTIFY THAT THE ABOVE INFORMATION IS TRUE. I/WE UNDERSTAND THAT MAKING MATERIALLY FALSE STATEMENTS IN ORDER TO OBTAIN A LICENSE OR PERMIT CONSTITUTES A CLASS A MISDEMEANOR AND THAT I/WE MAY BE PROSECUTED FOR SUCH MISCONDUCT.

______________________________ Signature (Applicant A)

______________________________ Signature (Applicant B)

Date ______________________________

CFS 604
Rev. 09/2003

STATE OF ILLINOIS
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
Medical Evaluation of an Adult in a Foster or Adoptive Home

Form Distribution
- Licensing worker/supervisor
- Kept in a sealed envelop in the licensing file and marked **"CONFIDENTIAL"**

Name of Person Examined: ____ Date: ____________________

Date of Birth: ________________ How long have you been treating this patient? ______________________________

This form will aid the Department in determining the physical wellness and capabilities of adults in foster or adoptive homes who are or may be caring for children. Please complete the following summary of health problems, conditions, and medication use that may affect the adult's ability to maintain alertness, endurance, and performance of tasks and responsibilities associated with caring for up to six children, ages 0 to 18 now and for the foreseeable future (five to ten years). If you have any medical or health questions or concerns, please call the Department of Children and Family Services at 312-814-5693.

☐ I am available to discuss further health concerns

Concerns or questions about confidentiality issues may be address to:

____ ________________________

Name Phone

I. HISTORY

1. Check any health problems:

☐ Heart Problems
☐ Lung Problems
☐ Diabetes
☐ High Blood Pressure
☐ Asthma
☐ Kidney Disease
☐ Arthritis
☐ Obesity
☐ Poor Ambulation
☐ Weak/Frail
☐ Vision
☐ Hearing
☐ Depression
☐ Sleep Disorder
☐ Confusion
☐ Dementia
☐ Epilepsy/Seizures
☐ Strokes/Paralysis
☐ Tremors
☐ Hepatitis
☐ Allergies

Explain ***all*** medical condition(s) checked and any other chronic conditions:

____

____

____

2. Are there any condition(s) that are progressive in nature? Yes ☐ No ☐
If yes, explain: ____

____

3. Is there a terminal illness that could interfere with this person's ability to care for a child in the next ___5 years, ___10 years __15 years? If yes, explain: ____

____

4. Medication(s): ____

____

____

Are there any physical limitations as a result of medication(s)? Yes ☐ No ☐
If yes, explain: ____

____

4. Illness/Injuries, Operations or Hospitalizations during the last 5 years:

Illness/Injury	Operation	Hospitalization	Date	Outcome

5. Health Habits
Is there a history of substances used by the applicant and what degree of impairment exists, if any, from the substance use?

Alcohol ☐ ______________________________ Drugs ☐ ______________________________
Tobacco ☐ ______________________________ Other ☐ ______________________________

6. Date ________ Result of Tuberculin Test (initial exam only): ______________________________

7. Date ________ Result of Chest X-Ray (if necessary): ______________________________

II. PHYSICAL EXAMINATION

Summary of abnormal physical findings that would affect caring for a child:

____
____
____
____
____
____

III. PHYSICAL CAPABILITIES

In your medical opinion could your patient physically be able to:

1. Lift a child:
   Under 6 months Yes ☐ No ☐
   6 months to 3 years Yes ☐ No ☐

2. Walk/maneuver 50-100 feet without major difficulties: Yes ☐ No ☐

3. Bend/stoop, kneel, reach: Yes ☐ No ☐

4. Is an assistive device needed to walk, bend/stoop, kneel, or reach? Yes ☐ No ☐
   If Yes, what type? ______________________________

5. Are there any medical conditions which limit this person's physical ability to care for a medically complex child which may include the ability to:

Lift from a bed to chair, etc.	Yes ☐	No ☐	Don't Know ☐
Frequent Feedings	Yes ☐	No ☐	Don't Know ☐
Frequent Suctions	Yes ☐	No ☐	Don't Know ☐
Frequent Monitoring	Yes ☐	No ☐	Don't Know ☐
Frequent Medication	Yes ☐	No ☐	Don't Know ☐
Frequent Nebulizations	Yes ☐	No ☐	Don't Know ☐
Frequent Treatments	Yes ☐	No ☐	Don't Know ☐

Are any limiting conditions temporary? Yes ☐ No ☐
If yes, which condition(s): ______________________________
For each condition, how long will the limitation exist? ______________________________
I certify that this individual is found free from symptoms of communicable disease.
Yes ☐ No ☐ If No, explain: ______________________________
____
I certify that the individual has no physical or cognitive limitations that would prevent her/him from parenting.
Yes ☐ No ☐ If No, explain: ______________________________
____
Physician's Signature: ______________________________ Date: ______________
State License Number: ______________________________
Address: ______________________________
Telephone: ______________________________

CFS 604
Rev. 09/2003

STATE OF ILLINOIS
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
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☐ I am available to discuss further health concerns

Concerns or questions about confidentiality issues may be address to:

______________________________ ______________

Name Phone

I. HISTORY

1. Check any health problems:

☐ Heart Problems ☐ Lung Problems ☐ Diabetes ☐ High Blood Pressure ☐ Asthma ☐ Kidney Disease

☐ Arthritis ☐ Obesity ☐ Poor Ambulation ☐ Weak/Frail ☐ Vision ☐ Hearing

☐ Depression ☐ Sleep Disorder ☐ Confusion ☐ Dementia ☐ Epilepsy/Seizures ☐ Strokes/Paralysis

☐ Tremors ☐ Hepatitis ☐ Allergies

Explain ***all*** medical condition(s) checked and any other chronic conditions:

____

____

____

2. Are there any condition(s) that are progressive in nature? Yes ☐ No ☐
If yes, explain: ______________________________

____

3. Is there a terminal illness that could interfere with this person's ability to care for a child in the next ___5 years, ___10 years __15 years? If yes, explain: ______________________________

____

4. Medication(s): ______________________________

____

____

Are there any physical limitations as a result of medication(s)? Yes ☐ No ☐
If yes, explain: ______________________________

____

4. Illness/Injuries, Operations or Hospitalizations during the last 5 years:

Illness/Injury	Operation	Hospitalization	Date	Outcome

5. Health Habits

Is there a history of substances used by the applicant and what degree of impairment exists, if any, from the substance use?

Alcohol ☐ ______________________________ Drugs ☐ ___________________________

Tobacco ☐ ______________________________ Other ☐ ___________________________

6. Date ________ Result of Tuberculin Test (initial exam only): ____

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II. PHYSICAL EXAMINATION

Summary of abnormal physical findings that would affect caring for a child:

____

____

____

____

____

____

III. PHYSICAL CAPABILITIES

In your medical opinion could your patient physically be able to:

1. Lift a child:
   Under 6 months Yes ☐ No ☐
   6 months to 3 years Yes ☐ No ☐

2. Walk/maneuver 50-100 feet without major difficulties: Yes ☐ No ☐

3. Bend/stoop, kneel, reach: Yes ☐ No ☐

4. Is an assistive device needed to walk, bend/stoop, kneel, or reach? Yes ☐ No ☐
   If Yes, what type? ____

5. Are there any medical conditions which limit this person's physical ability to care for a medically complex child which may include the ability to:

Lift from a bed to chair, etc.	Yes ☐	No ☐	Don't Know ☐
Frequent Feedings	Yes ☐	No ☐	Don't Know ☐
Frequent Suctions	Yes ☐	No ☐	Don't Know ☐
Frequent Monitoring	Yes ☐	No ☐	Don't Know ☐
Frequent Medication	Yes ☐	No ☐	Don't Know ☐
Frequent Nebulizations	Yes ☐	No ☐	Don't Know ☐
Frequent Treatments	Yes ☐	No ☐	Don't Know ☐

Are any limiting conditions temporary? Yes ☐ No ☐

If yes, which condition(s): ____

For each condition, how long will the limitation exist? ______________________________________

I certify that this individual is found free from symptoms of communicable disease.

Yes ☐ No ☐ If No, explain: ____

____

I certify that the individual has no physical or cognitive limitations that would prevent her/him from parenting.

Yes ☐ No ☐ If No, explain: ____

____

Physician's Signature: ______________________________ Date: ____________________

State License Number: ____

Address: ____

Telephone: ____

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 11/2013

Student's Name Last First Middle	**Birth Date** Month/Day/Year	**Sex**	**Race/Ethnicity**	**School /Grade Level/ID#**
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT** (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

																			Code:
Date																			P = Pass
Age/ Grade																			F = Fail
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	U = Unable to test
Vision																			R = Referred
Hearing																			G/C = Glasses/Contacts

Student's Name			**Birth Date**	**Sex**	**School**	**Grade Level/ ID #**
Last	First	Middle	Month/Day/ Year			

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			**MEDICATION** (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? Child wakes during the night coughing?	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**		
Bone/Joint problem/injury/scoliosis?	Yes No				

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed** ☐ **Test performed** ☐
Skin Test: Date Read / / **Result: Positive** ☐ **Negative** ☐ **mm** ______________
Blood Test: Date Reported / / **Result: Positive** ☐ **Negative** ☐ **Value** ______________

LAB TESTS (**Recommended**)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g.Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified,please attach explanation.)

PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** (for one year) **Yes** ☐ **No** ☐ **Limited** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 11/2013

Student's Name Last / First / Middle	**Birth Date** Month/Day/Year	**Sex**	**Race/Ethnicity**	**School /Grade Level/ID#**
Address / Street / City / Zip Code	Parent/Guardian / Telephone # Home / Work			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	**1** MO DA YR	**2** MO DA YR	**3** MO DA YR	**4** MO DA YR	**5** MO DA YR	**6** MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT** (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																			**Code:**
Age/ Grade																			P = Pass
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	F = Fail U = Unable to test
Vision																			R = Referred G/C =
Hearing																			Glasses/Contacts

Student's Name Last First Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID #

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? Child wakes during the night coughing?	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor ______ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**		
Bone/Joint problem/injury/scoliosis?	Yes No				

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed** ☐ **Test performed** ☐
Skin Test: Date Read / / **Result: Positive** ☐ **Negative** ☐ **mm** _______________
Blood Test: Date Reported / / **Result: Positive** ☐ **Negative** ☐ **Value** _______________

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g.Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

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EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified,please attach explanation.)
PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** (for one year) **Yes** ☐ **No** ☐ **Limited** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 11/2013

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT** (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	Measles	Rubella	Mumps			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

																			Code:
Date																			
Age/ Grade																			P = Pass
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	F = Fail U = Unable to test
Vision																			R = Referred G/C =
Hearing																			Glasses/Contacts

Student's Name			Birth Date	Sex	School	Grade Level/ ID #
Last	First	Middle	Month/Day/ Year			

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			**MEDICATION** (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? Child wakes during the night coughing?	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor ______ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**		
Bone/Joint problem/injury/scoliosis?	Yes No				

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA

HEAD CIRCUMFERENCE **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
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LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g.Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

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Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified,please attach explanation.)
PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** (for one year) **Yes** ☐ **No** ☐ **Limited** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
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Rev 11/2013

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

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Tdap; **Td** or Pediatric **DT** (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
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Signature **Title** **Date**

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Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN																			
Date																			**Code:** P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts
Age/ Grade																			
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	
Vision																			
Hearing																			

Student's Name Last / First / Middle	**Birth Date** Month/Day/ Year	**Sex**	**School**	**Grade Level/ ID #**

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			**MEDICATION** (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? Child wakes during the night coughing?	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
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Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor ______ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**		
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PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA

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Skin Test: Date Read / / **Result: Positive** ☐ **Negative** ☐ **mm** _______________
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LAB TESTS (**Recommended**)	Date	Results		Date	Results
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Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
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DIETARY Needs/Restrictions

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Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified,please attach explanation.)
PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** (for one year) **Yes** ☐ **No** ☐ **Limited** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)

Illinois Department of Children and Family Services

AUTHORIZATION FOR BACKGROUND CHECK for Foster Care & Adoption

READ INSTRUCTIONS ON REVERSE SIDE AND PRINT ALL INFORMATION

1

CHECK ONE BOX IN EACH COLUMN IN THE APPLICABLE ROW A or B:

	Category of Facility	Specific Type of Application	Person in the Home
A	Foster Care	☐ Initial ☐ Renewal ☐ Relative ☐ Traditional ☐ ICPC	☐ Applicant ☐ Member of Household (ages 13 to 17)* *Parent/Guardian signature required ☐ Member of Household (age 18 and over) ☐ Ward
B	Adoption	☐ Adopt Only Home ☐ Unlicensed Relative in Illinois ☐ Unlicensed Relative Out of State	☐ For Placement Purposes ☐ For Adoption Purposes

2

PERSONAL INFORMATION (Please see additions instructions on the back page)

Last Name/First Name/Middle Initial

______________________ ______________ __

Social Security or ITIN Number __ __ __ - __ __ - __ __ __ __

Maiden and/or Any Names Formerly Used (Last/First/Middle Initial)

____

____

I am or will be transporting foster children ☐ Yes ☐ No

If this statement is yes, list your Drivers License number here:

__ __ __ __ - __ __ __ __ - __ __ __ __

Is this an Illinois Drivers License Number? ☐ Yes ☐ No

CURRENT ADDRESS, TELEPHONE (when applicable):

Street/Apt.#:________________________________

City:______________________ State: __ __

Zip Code: __ __ __ __ __ County: ______________

Home Telephone (__ __ __) __ __ __ - __ __ __ __

Cell Phone (__ __ __) __ __ __ - __ __ __ __

List all previous addresses for the past five (5) years, including those outside of Illinois. (Street/Apt.#/City/County/State/Zip Code) — Dates From/To

______________________ __________

______________________ __________

______________________ __________

______________________ __________

______________________ __________

Have you lived outside of Illinois in the past 3 years? ☐ Yes ☐ No

Date of Birth (Month/Date/Year)	Age	Place of Birth (City and State)	Citizenship (Country)	Gender	Height Ft. In.	Weight (lbs.)	Hair (color)	Eye (color)
____-____-______			☐ USA ☐ Other Specify	☐M ☐ F				

Race (Check all that apply)

☐ Native American/Alaskan (Indian or Eskimo) ☐ Black/African American ☐ White ☐ Declined to Identify
☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Unknown ☐ Could not be Verified

Ethnicity (see codes on Page 2)

3

AUTHORIZATION /CERTIFICATION

Have you ever been indicated as perpetrator in a child abuse/neglect investigation? ☐ Yes ☐ No

Have you ever been convicted of a criminal offense, other than a minor traffic violation? ☐ Yes ☐ No

I certify that I have read and understood the Authorization/Certification box on the back page of this form.

SIGNATURE ______________________________ DATE______________________

Parent/Guardian Signature (if applicable)______________________________ **DATE**______________

4

TO BE COMPLETED BY SUPERVISING AGENCY

This authorization form will not be processed without completion of this section. The licensing representative must complete the following

Date Fingerprinted:______________________

Full Name of Facility______________________

Provider ID #______________________

Street Address:______________________

City______________________ IL ZIP:__________

Supervising Agency Name:______________________

Provider ID#______________________

Or

DCFS Region/Site/Field______________________

____
Name of Worker Worker ID#/Phone Number

____
Name of Supervisor Supervisor ID#/Phone Number

5

BACKGROUND RESULTS AS APPLICABLE

Sex Offender Clearance:______________________

CANTS Clearance:______________________

Illinois State Police Clearance:______________________

FBI Clearance:______________________

Transfer Clearances: SO/CANTS:______________ ISP:__________

FOR CENTRAL OFFICE OF LICENSING USE

SID#____________ Clear __________ Record ________

BC-03 Registered:______________________

FBI Sent Out:______________________

Valid Driver's License: Yes ________ No ________

WHO SHOULD USE THIS FORM: This form must be completed by every person age 13 or older as part of an application to operate or reside in a foster care home. Every person subject to a background check must complete the first three sections identifying the type of facility and what role they will have at the facility and all personal information. All identifying information must be accurate and complete. The Parent or Guardian's signature is required if background check is for a minor.

ADDITIONAL INSTRUCTIONS FOR SECTIONS 2 AND 3 OF THE FRONT PAGE

Name:	Current and all former names used by the individual must be included. If no other names, write "none."
Social Security, ITIN or Assigned #.	**THIS FORM WILL NOT BE PROCESSED WITHOUT A COMPLETE SOCIAL SECURITY, INDIVIDUAL TAXPAYER IDENTIFICATION (ITIN) NUMBER OR DEPARTMENT ASSIGNED NUMBER**
Address:	Current and all addresses, including county, where the person has lived in the past five years (Indicate if outside of Illinois)
Race:	Enter all race codes that apply. NA = Native American/Alaskan (Indian or Eskimo) AO = Asian BL = Black/African American PI = Native Hawaiian/Pacific Islander WH = White UK = Unknown DI = Declined to Identify CV = Could not be Verified
Ethnicity:	Enter the primary Ethnicity NH = Not Hispanic (NONE) HS = Hispanic South American HM = Hispanic Mexican HP = Hispanic Puerto Rican HD = Hispanic Spanish Descent HC = Hispanic Cuban HA = Hispanic Central American HN = Hispanic Dominican HO = Hispanic Other UK = Unknown DI = Declined to Indentify CV = Could not be Verified

ADDITIONAL INSTRUCTIONS FOR SECTIONS 4 OF THE FRONT PAGE

Instruction for Left Side -

Name of Facility:	The full name which appears on the license application or the license. (DO NOT USE ACRONYMS)
Provider ID #:	The Provider ID. (The number which appears on the license certificate for the facility. Initial Applications will be assigned # by Background Check Unit.)
Street/City/Zip:	The site of licensed facility where person is licensed or employed.

Instructions for Right Side –

Supervising Agency:	Print the name and Provider ID# of Agency which will supervise the facility
Provider ID #:	
DCFS Region/Site/field:	The DCFS Region/Site/Field.
Name of the Worker:	Name, ID and phone of the worker
Name of the Supervisor:	Name, ID and phone of the supervisor

The Authorization for Background Check must be submitted to the worker for completion of Section 4 and for forwarding to the DCFS pertinent Background Check Unit. The worker must check the form for completeness and accuracy, confirm that the person (if age 18 or older) has been fingerprinted, and verify the correct spelling of names alongside a form of identification, such as a driver's license or photo ID.

AUTHORIZATION/CERTIFICATION

I authorize the Illinois Department of Children and Family Services to conduct an investigation to determine whether I have ever been charged with a crime and, if so, the disposition of those charges. I authorize the Department to request information and assistance from the U.S. Justice Department and the Illinois Department of Law Enforcement in the conduct of this investigation. I authorize the Department to periodically search child abuse and neglect history reports to determine whether I have been a perpetrator of an "indicated" incident of child abuse or neglect pursuant to the Abused and Neglected Child Reporting Act. If I am applying for a foster home license, I authorize the Department of Children and Family Services to obtain information from those entities to which I had applied for license or supervision of license, regarding licensing violations or removal of children from my home. If I am or will be a member of a foster family household and will be transporting foster children, I authorize the Department to conduct periodic checks of my driver's license and driving record through the Secretary of State. The child abuse and neglect background check and the criminal history investigation may be used for considering placement of a related child or an application for licensure. Persons 13-17 years of age signing this form authorize a search of CANTS and LEADS only and are not subject to fingerprinting.

I understand that information obtained as a result of my authorizing this investigation is confidential but may be shared with the child placing worker or the licensing applicant for whom my background check is required or with authorized licensing staff in accordance with applicable state and federal law and DCFS Regulations. I further certify that the information provided on this form is true and correct. I acknowledge that falsification of any information provided above and/or the results of the background check may be full and sufficient grounds to deny the application for licensure.

Should you feel that the information on your Illinois State Police record or Federal Bureau of Investigation record is incorrect you may visit: http://www.ilga.gov/commission/jcar/admincode/020/02001210sections.html for the ISP and http://www.fbi.gov for FBI.

CFS 718-A
Rev 12/2014

Illinois Department of Children and Family Services

AUTHORIZATION FOR BACKGROUND CHECK for Foster Care & Adoption

READ INSTRUCTIONS ON REVERSE SIDE AND PRINT ALL INFORMATION

1

CHECK ONE BOX IN EACH COLUMN IN THE APPLICABLE ROW A or B:

	Category of Facility	Specific Type of Application	Person in the Home
A	Foster Care	☐ Initial ☐ Renewal ☐ Relative ☐ Traditional ☐ ICPC	☐ Applicant ☐ Member of Household (ages 13 to 17)* *Parent/Guardian signature required ☐ Member of Household (age 18 and over) ☐ Ward
B	Adoption	☐ Adopt Only Home ☐ Unlicensed Relative in Illinois ☐ Unlicensed Relative Out of State	☐ For Placement Purposes ☐ For Adoption Purposes

PERSONAL INFORMATION (Please see additions instructions on the back page)

2

Last Name/First Name/Middle Initial

_______________ _______________ ___

Social Security or ITIN Number __ __ __ - __ __ - __ __ __ __

Maiden and/or Any Names Formerly Used (Last/First/Middle Initial)

____

____

I am or will be transporting foster children ☐ Yes ☐ No
If this statement is yes, list your Drivers License number here:

__ __ __ __ - __ __ __ __ - __ __ __ __

Is this an Illinois Drivers License Number? ☐ Yes ☐ No

CURRENT ADDRESS, TELEPHONE (when applicable):

Street/Apt.#:_______________

City:_______________ State: __ __

Zip Code: __ __ __ __ __ County: _______________

Home Telephone (__ __ __) __ __ __ - __ __ __ __

Cell Phone (__ __ __) __ __ __ - __ __ __ __

List all previous addresses for the past five (5) years, including those outside of Illinois. (Street/Apt.#/City/County/State/Zip Code) — Dates From/To

_______________ _______________

_______________ _______________

_______________ _______________

_______________ _______________

_______________ _______________

Have you lived outside of Illinois in the past 3 years? ☐ Yes ☐ No

Date of Birth (Month/Date/Year)	Age	Place of Birth (City and State)	Citizenship (Country)	Gender	Height Ft. In.	Weight (lbs.)	Hair (color)	Eye (color)
____-____-____			☐ USA ☐ Other Specify	☐M ☐ F				

Race (Check all that apply)

☐ Native American/Alaskan (Indian or Eskimo) ☐ Black/African American ☐ White ☐ Declined to Identify
☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Unknown ☐ Could not be Verified

Ethnicity (see codes on Page 2)

AUTHORIZATION /CERTIFICATION

3

Have you ever been indicated as perpetrator in a child abuse/neglect investigation? ☐ Yes ☐ No
Have you ever been convicted of a criminal offense, other than a minor traffic violation? ☐ Yes ☐ No
I certify that I have read and understood the Authorization/Certification box on the back page of this form.

SIGNATURE _______________ DATE_______________

Parent/Guardian Signature (if applicable)_______________ **DATE**_______________

4

TO BE COMPLETED BY SUPERVISING AGENCY

This authorization form will not be processed without completion of this section. The licensing representative must complete the following

Date Fingerprinted:_______________

Full Name of Facility_______________

Provider ID #_______________

Street Address:_______________

City_______________ IL ZIP:_______________

Supervising Agency Name:_______________

Provider ID#_______________
Or
DCFS Region/Site/Field_______________

____
Name of Worker Worker ID#/Phone Number

____
Name of Supervisor Supervisor ID#/Phone Number

5

BACKGROUND RESULTS AS APPLICABLE

Sex Offender Clearance:_______________

CANTS Clearance:_______________

Illinois State Police Clearance:_______________

FBI Clearance:_______________

Transfer Clearances: SO/CANTS:_______________ ISP:_______________

FOR CENTRAL OFFICE OF LICENSING USE

SID#_______________ Clear _______________ Record _______________

BC-03 Registered:_______________

FBI Sent Out:_______________

Valid Driver's License: Yes _______________ No _______________

WHO SHOULD USE THIS FORM: This form must be completed by every person age 13 or older as part of an application to operate or reside in a foster care home. Every person subject to a background check must complete the first three sections identifying the type of facility and what role they will have at the facility and all personal information. All identifying information must be accurate and complete. The Parent or Guardian's signature is required if background check is for a minor.

ADDITIONAL INSTRUCTIONS FOR SECTIONS 2 AND 3 OF THE FRONT PAGE

Name:	Current and all former names used by the individual must be included. If no other names, write "none."
Social Security, ITIN or Assigned #.	**THIS FORM WILL NOT BE PROCESSED WITHOUT A COMPLETE SOCIAL SECURITY, INDIVIDUAL TAXPAYER IDENTIFICATION (ITIN) NUMBER OR DEPARTMENT ASSIGNED NUMBER**
Address:	Current and all addresses, including county, where the person has lived in the past five years (Indicate if outside of Illinois)
Race:	Enter all race codes that apply. NA = Native American/Alaskan (Indian or Eskimo) AO = Asian BL = Black/African American PI = Native Hawaiian/Pacific Islander WH = White UK = Unknown DI = Declined to Identify CV = Could not be Verified
Ethnicity:	Enter the primary Ethnicity NH = Not Hispanic (NONE) HS = Hispanic South American HM = Hispanic Mexican HP = Hispanic Puerto Rican HD = Hispanic Spanish Descent HC = Hispanic Cuban HA = Hispanic Central American HN = Hispanic Dominican HO = Hispanic Other UK = Unknown DI = Declined to Indentify CV = Could not be Verified

ADDITIONAL INSTRUCTIONS FOR SECTIONS 4 OF THE FRONT PAGE

Instruction for Left Side -

Name of Facility:	The full name which appears on the license application or the license. (DO NOT USE ACRONYMS)
Provider ID #:	The Provider ID. (The number which appears on the license certificate for the facility. Initial Applications will be assigned # by Background Check Unit.)
Street/City/Zip:	The site of licensed facility where person is licensed or employed.

Instructions for Right Side –

Supervising Agency:	Print the name and Provider ID# of Agency which will supervise the facility
Provider ID #:	
DCFS Region/Site/field:	The DCFS Region/Site/Field.
Name of the Worker:	Name, ID and phone of the worker
Name of the Supervisor:	Name, ID and phone of the supervisor

The Authorization for Background Check must be submitted to the worker for completion of Section 4 and for forwarding to the DCFS pertinent Background Check Unit. The worker must check the form for completeness and accuracy, confirm that the person (if age 18 or older) has been fingerprinted, and verify the correct spelling of names alongside a form of identification, such as a driver's license or photo ID.

AUTHORIZATION/CERTIFICATION

I authorize the Illinois Department of Children and Family Services to conduct an investigation to determine whether I have ever been charged with a crime and, if so, the disposition of those charges. I authorize the Department to request information and assistance from the U.S. Justice Department and the Illinois Department of Law Enforcement in the conduct of this investigation. I authorize the Department to periodically search child abuse and neglect history reports to determine whether I have been a perpetrator of an "indicated" incident of child abuse or neglect pursuant to the Abused and Neglected Child Reporting Act. If I am applying for a foster home license, I authorize the Department of Children and Family Services to obtain information from those entities to which I had applied for license or supervision of license, regarding licensing violations or removal of children from my home. If I am or will be a member of a foster family household and will be transporting foster children, I authorize the Department to conduct periodic checks of my driver's license and driving record through the Secretary of State. The child abuse and neglect background check and the criminal history investigation may be used for considering placement of a related child or an application for licensure. Persons 13-17 years of age signing this form authorize a search of CANTS and LEADS only and are not subject to fingerprinting.

I understand that information obtained as a result of my authorizing this investigation is confidential but may be shared with the child placing worker or the licensing applicant for whom my background check is required or with authorized licensing staff in accordance with applicable state and federal law and DCFS Regulations. I further certify that the information provided on this form is true and correct. I acknowledge that falsification of any information provided above and/or the results of the background check may be full and sufficient grounds to deny the application for licensure.

Should you feel that the information on your Illinois State Police record or Federal Bureau of Investigation record is incorrect you may visit: http://www.ilga.gov/commission/jcar/admincode/020/02001210sections.html for the ISP and http://www.fbi.gov for FBI.

CFS 718-A
Rev 12/2014

Illinois Department of Children and Family Services

AUTHORIZATION FOR BACKGROUND CHECK for Foster Care & Adoption

READ INSTRUCTIONS ON REVERSE SIDE AND PRINT ALL INFORMATION

1

CHECK ONE BOX IN EACH COLUMN IN THE APPLICABLE ROW A or B:

	Category of Facility	Specific Type of Application	Person in the Home
A	Foster Care	☐ Initial ☐ Renewal ☐ Relative ☐ Traditional ☐ ICPC	☐ Applicant ☐ Member of Household (ages 13 to 17)* *Parent/Guardian signature required ☐ Member of Household (age 18 and over) ☐ Ward
B	Adoption	☐ Adopt Only Home ☐ Unlicensed Relative in Illinois ☐ Unlicensed Relative Out of State	☐ For Placement Purposes ☐ For Adoption Purposes

PERSONAL INFORMATION (Please see additions instructions on the back page)

2

Last Name/First Name/Middle Initial

______________________ ______________ __

Social Security or ITIN Number __ __ __ - __ __ - __ __ __ __

Maiden and/or Any Names Formerly Used (Last/First/Middle Initial)

____

____

I am or will be transporting foster children ☐ Yes ☐ No
If this statement is yes, list your Drivers License number here:

__ __ __ __ - __ __ __ __ - __ __ __ __

Is this an Illinois Drivers License Number? ☐ Yes ☐ No

CURRENT ADDRESS, TELEPHONE (when applicable):

Street/Apt.#:______________________________

City:______________________ State: __ __

Zip Code: __ __ __ __ __ County: ______________

Home Telephone (__ __ __) __ __ __ - __ __ __ __

Cell Phone (__ __ __) __ __ __ - __ __ __ __

List all previous addresses for the past five (5) years, including those outside of Illinois.
(Street/Apt.#/City/County/State/Zip Code) — Dates From/To

______________________ ________

______________________ ________

______________________ ________

______________________ ________

______________________ ________

Have you lived outside of Illinois in the past 3 years? ☐ Yes ☐ No

Date of Birth (Month/Date/Year)	Age	Place of Birth (City and State)	Citizenship (Country)	Gender	Height Ft. In.	Weight (lbs.)	Hair (color)	Eye (color)
____-____-________			☐ USA ☐ Other Specify	☐M ☐ F				

Race (Check all that apply)

☐ Native American/Alaskan (Indian or Eskimo) ☐ Black/African American ☐ White ☐ Declined to Identify
☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Unknown ☐ Could not be Verified

Ethnicity (see codes on Page 2)

AUTHORIZATION /CERTIFICATION

3

Have you ever been indicated as perpetrator in a child abuse/neglect investigation? ☐ Yes ☐ No

Have you ever been convicted of a criminal offense, other than a minor traffic violation? ☐ Yes ☐ No

I certify that I have read and understood the Authorization/Certification box on the back page of this form.

SIGNATURE ______________________________ DATE______________________

Parent/Guardian Signature (if applicable)______________________________ **DATE**______________

4

TO BE COMPLETED BY SUPERVISING AGENCY

This authorization form will not be processed without completion of this section. The licensing representative must complete the following

Date Fingerprinted:______________________

Full Name of Facility______________________

Provider ID #______________________

Street Address:______________________

City______________________ IL ZIP:__________

Supervising Agency Name:______________________

Provider ID#______________________
Or
DCFS Region/Site/Field______________________

____
Name of Worker Worker ID#/Phone Number

____
Name of Supervisor Supervisor ID#/Phone Number

5

BACKGROUND RESULTS AS APPLICABLE

Sex Offender Clearance:______________________

CANTS Clearance:______________________

Illinois State Police Clearance:______________________

FBI Clearance:______________________

Transfer Clearances: SO/CANTS:______________ ISP:__________

FOR CENTRAL OFFICE OF LICENSING USE

SID#__________ Clear __________ Record __________

BC-03 Registered:______________________

FBI Sent Out:______________________

Valid Driver's License: Yes __________ No __________

WHO SHOULD USE THIS FORM: This form must be completed by every person age 13 or older as part of an application to operate or reside in a foster care home. Every person subject to a background check must complete the first three sections identifying the type of facility and what role they will have at the facility and all personal information. All identifying information must be accurate and complete. The Parent or Guardian's signature is required if background check is for a minor.

ADDITIONAL INSTRUCTIONS FOR SECTIONS 2 AND 3 OF THE FRONT PAGE

Name:	Current and all former names used by the individual must be included. If no other names, write "none."
Social Security, ITIN or Assigned #.	**THIS FORM WILL NOT BE PROCESSED WITHOUT A COMPLETE SOCIAL SECURITY, INDIVIDUAL TAXPAYER IDENTIFICATION (ITIN) NUMBER OR DEPARTMENT ASSIGNED NUMBER**
Address:	Current and all addresses, including county, where the person has lived in the past five years (Indicate if outside of Illinois)
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ADDITIONAL INSTRUCTIONS FOR SECTIONS 4 OF THE FRONT PAGE

Instruction for Left Side -

Name of Facility:	The full name which appears on the license application or the license. (DO NOT USE ACRONYMS)
Provider ID #:	The Provider ID. (The number which appears on the license certificate for the facility. Initial Applications will be assigned # by Background Check Unit.)
Street/City/Zip:	The site of licensed facility where person is licensed or employed.

Instructions for Right Side –

Supervising Agency: Provider ID #:	Print the name and Provider ID# of Agency which will supervise the facility
DCFS Region/Site/field:	The DCFS Region/Site/Field.
Name of the Worker:	Name, ID and phone of the worker
Name of the Supervisor:	Name, ID and phone of the supervisor

The Authorization for Background Check must be submitted to the worker for completion of Section 4 and for forwarding to the DCFS pertinent Background Check Unit. The worker must check the form for completeness and accuracy, confirm that the person (if age 18 or older) has been fingerprinted, and verify the correct spelling of names alongside a form of identification, such as a driver's license or photo ID.

AUTHORIZATION/CERTIFICATION

I authorize the Illinois Department of Children and Family Services to conduct an investigation to determine whether I have ever been charged with a crime and, if so, the disposition of those charges. I authorize the Department to request information and assistance from the U.S. Justice Department and the Illinois Department of Law Enforcement in the conduct of this investigation. I authorize the Department to periodically search child abuse and neglect history reports to determine whether I have been a perpetrator of an "indicated" incident of child abuse or neglect pursuant to the Abused and Neglected Child Reporting Act. If I am applying for a foster home license, I authorize the Department of Children and Family Services to obtain information from those entities to which I had applied for license or supervision of license, regarding licensing violations or removal of children from my home. If I am or will be a member of a foster family household and will be transporting foster children, I authorize the Department to conduct periodic checks of my driver's license and driving record through the Secretary of State. The child abuse and neglect background check and the criminal history investigation may be used for considering placement of a related child or an application for licensure. Persons 13-17 years of age signing this form authorize a search of CANTS and LEADS only and are not subject to fingerprinting.

I understand that information obtained as a result of my authorizing this investigation is confidential but may be shared with the child placing worker or the licensing applicant for whom my background check is required or with authorized licensing staff in accordance with applicable state and federal law and DCFS Regulations. I further certify that the information provided on this form is true and correct. I acknowledge that falsification of any information provided above and/or the results of the background check may be full and sufficient grounds to deny the application for licensure.

Should you feel that the information on your Illinois State Police record or Federal Bureau of Investigation record is incorrect you may visit: http://www.ilga.gov/commission/jcar/admincode/020/02001210sections.html for the ISP and http://www.fbi.gov for FBI.

CFS 718-A
Rev 12/2014

Illinois Department of Children and Family Services

AUTHORIZATION FOR BACKGROUND CHECK for Foster Care & Adoption

READ INSTRUCTIONS ON REVERSE SIDE AND PRINT ALL INFORMATION

1

CHECK ONE BOX IN EACH COLUMN IN THE APPLICABLE ROW A or B:

	Category of Facility	Specific Type of Application	Person in the Home
A	Foster Care	☐ Initial ☐ Renewal ☐ Relative ☐ Traditional ☐ ICPC	☐ Applicant ☐ Member of Household (ages 13 to 17)* *Parent/Guardian signature required ☐ Member of Household (age 18 and over) ☐ Ward
B	Adoption	☐ Adopt Only Home ☐ Unlicensed Relative in Illinois ☐ Unlicensed Relative Out of State	☐ For Placement Purposes ☐ For Adoption Purposes

2

PERSONAL INFORMATION (Please see additions instructions on the back page)

Last Name/First Name/Middle Initial
______________________ ______________ __

Social Security or ITIN Number __ __ __ - __ __ - __ __ __ __

Maiden and/or Any Names Formerly Used (Last/First/Middle Initial)
____
____

I am or will be transporting foster children ☐ Yes ☐ No
If this statement is yes, list your Drivers License number here:
__ __ __ __ - __ __ __ __ - __ __ __ __

Is this an Illinois Drivers License Number? ☐ Yes ☐ No

CURRENT ADDRESS, TELEPHONE (when applicable):

Street/Apt.#:______________________________________

City:______________________________ State: __ __

Zip Code: __ __ __ __ __ County: ____________________

Home Telephone (__ __ __) __ __ __ - __ __ __ __

Cell Phone (__ __ __) __ __ __ - __ __ __ __

List all previous addresses for the past five (5) years, including those outside of Illinois. (Street/Apt.#/City/County/State/Zip Code) — Dates From/To

______________________________ __________
______________________________ __________
______________________________ __________
______________________________ __________
______________________________ __________

Have you lived outside of Illinois in the past 3 years? ☐ Yes ☐ No

Date of Birth (Month/Date/Year)	Age	Place of Birth (City and State)	Citizenship (Country)	Gender	Height Ft. In.	Weight (lbs.)	Hair (color)	Eye (color)
_____-_____-_________			☐ USA ☐ Other Specify	☐M ☐ F				

Race (Check all that apply)

☐ Native American/Alaskan (Indian or Eskimo) ☐ Black/African American ☐ White ☐ Declined to Identify
☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Unknown ☐ Could not be Verified

Ethnicity (see codes on Page 2)

3

AUTHORIZATION /CERTIFICATION

Have you ever been indicated as perpetrator in a child abuse/neglect investigation? ☐ Yes ☐ No
Have you ever been convicted of a criminal offense, other than a minor traffic violation? ☐ Yes ☐ No
I certify that I have read and understood the Authorization/Certification box on the back page of this form.

SIGNATURE ______________________________ DATE______________________

Parent/Guardian Signature (if applicable)______________________________ **DATE**______________

4

TO BE COMPLETED BY SUPERVISING AGENCY

This authorization form will not be processed without completion of this section. The licensing representative must complete the following

Date Fingerprinted:______________________________

Full Name of Facility______________________________

Provider ID #______________________________

Street Address:______________________________

City______________________ IL ZIP:__________

Supervising Agency Name:______________________________

Provider ID#______________________________
Or
DCFS Region/Site/Field______________________________

____
Name of Worker Worker ID#/Phone Number

____
Name of Supervisor Supervisor ID#/Phone Number

5

BACKGROUND RESULTS AS APPLICABLE

Sex Offender Clearance:______________________________
CANTS Clearance:______________________________
Illinois State Police Clearance:______________________________
FBI Clearance:______________________________
Transfer Clearances: SO/CANTS:______________ ISP:__________

FOR CENTRAL OFFICE OF LICENSING USE

SID#____________ Clear __________ Record _________
BC-03 Registered:______________________________
FBI Sent Out:______________________________
Valid Driver's License: Yes __________ No __________

WHO SHOULD USE THIS FORM: This form must be completed by every person age 13 or older as part of an application to operate or reside in a foster care home. Every person subject to a background check must complete the first three sections identifying the type of facility and what role they will have at the facility and all personal information. All identifying information must be accurate and complete. The Parent or Guardian's signature is required if background check is for a minor.

ADDITIONAL INSTRUCTIONS FOR SECTIONS 2 AND 3 OF THE FRONT PAGE

Name:	Current and all former names used by the individual must be included. If no other names, write "none."
Social Security, ITIN or Assigned #.	**THIS FORM WILL NOT BE PROCESSED WITHOUT A COMPLETE SOCIAL SECURITY, INDIVIDUAL TAXPAYER IDENTIFICATION (ITIN) NUMBER OR DEPARTMENT ASSIGNED NUMBER**
Address:	Current and all addresses, including county, where the person has lived in the past five years (Indicate if outside of Illinois)
Race:	Enter all race codes that apply. NA = Native American/Alaskan (Indian or Eskimo) AO = Asian BL = Black/African American PI = Native Hawaiian/Pacific Islander WH = White UK = Unknown DI = Declined to Identify CV = Could not be Verified
Ethnicity:	Enter the primary Ethnicity NH = Not Hispanic (NONE) HS = Hispanic South American HM = Hispanic Mexican HP = Hispanic Puerto Rican HD = Hispanic Spanish Descent HC = Hispanic Cuban HA = Hispanic Central American HN = Hispanic Dominican HO = Hispanic Other UK = Unknown DI = Declined to Indentify CV = Could not be Verified

ADDITIONAL INSTRUCTIONS FOR SECTIONS 4 OF THE FRONT PAGE

Instruction for Left Side -

Name of Facility:	The full name which appears on the license application or the license. (DO NOT USE ACRONYMS)
Provider ID #:	The Provider ID. (The number which appears on the license certificate for the facility. Initial Applications will be assigned # by Background Check Unit.)
Street/City/Zip:	The site of licensed facility where person is licensed or employed.

Instructions for Right Side –

Supervising Agency:	Print the name and Provider ID# of Agency which will supervise the facility
Provider ID #:	
DCFS Region/Site/field:	The DCFS Region/Site/Field.
Name of the Worker:	Name, ID and phone of the worker
Name of the Supervisor:	Name, ID and phone of the supervisor

The Authorization for Background Check must be submitted to the worker for completion of Section 4 and for forwarding to the DCFS pertinent Background Check Unit. The worker must check the form for completeness and accuracy, confirm that the person (if age 18 or older) has been fingerprinted, and verify the correct spelling of names alongside a form of identification, such as a driver's license or photo ID.

AUTHORIZATION/CERTIFICATION

I authorize the Illinois Department of Children and Family Services to conduct an investigation to determine whether I have ever been charged with a crime and, if so, the disposition of those charges. I authorize the Department to request information and assistance from the U.S. Justice Department and the Illinois Department of Law Enforcement in the conduct of this investigation. I authorize the Department to periodically search child abuse and neglect history reports to determine whether I have been a perpetrator of an "indicated" incident of child abuse or neglect pursuant to the Abused and Neglected Child Reporting Act. If I am applying for a foster home license, I authorize the Department of Children and Family Services to obtain information from those entities to which I had applied for license or supervision of license, regarding licensing violations or removal of children from my home. If I am or will be a member of a foster family household and will be transporting foster children, I authorize the Department to conduct periodic checks of my driver's license and driving record through the Secretary of State. The child abuse and neglect background check and the criminal history investigation may be used for considering placement of a related child or an application for licensure. Persons 13-17 years of age signing this form authorize a search of CANTS and LEADS only and are not subject to fingerprinting.

I understand that information obtained as a result of my authorizing this investigation is confidential but may be shared with the child placing worker or the licensing applicant for whom my background check is required or with authorized licensing staff in accordance with applicable state and federal law and DCFS Regulations. I further certify that the information provided on this form is true and correct. I acknowledge that falsification of any information provided above and/or the results of the background check may be full and sufficient grounds to deny the application for licensure.

Should you feel that the information on your Illinois State Police record or Federal Bureau of Investigation record is incorrect you may visit: http://www.ilga.gov/commission/jcar/admincode/020/02001210sections.html for the ISP and http://www.fbi.gov for FBI.