

State of Illinois  
Department of Children and Family Services

**GRANDPARENT VISITATION WITH YOUTH IN CARE**

Date of Notice: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Dear \_\_\_\_\_:

The Illinois Department of Children and Family Services is required by the Department of Children and Family Services Act [20 ILCS 505/35] to make reasonable efforts and accommodations to provide for visitation privileges to non-custodial grandparents or great-grandparents of a child who is in the care and custody of the Department.

The Department is required to provide visitation only if it is in the best interest of the child to do so. The criteria or factors taken into consideration for the granting of visitation are outlined in **Rule and Procedure 301.240 Grandparent and Great-Grandparent Visitation**. Interested parties may reference **Rule and Procedure 301.240** on the DCFS website.

**The Department's Response to Your Request**

The Department has made a determination that it is **not** in the youth's best interest to provide you with visitation privileges. Please contact the child's caseworker if you have questions regarding this decision.

**Reason(s) visitation is not recommended:**

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If you do not agree with the Department's decision, you have the right to request a Clinical review of the decision. Upon request, a clinical review will be scheduled to discuss the issues. You may be present at the review and will be afforded an opportunity to provide a rebuttal regarding the Department's decision.

You may request a Clinical review by calling the Clinical Division at 866-225-1431 and leaving your call back information so that staff can return your call. You may also fax your request for a review to the Clinical Division by signing your name and faxing this form to 800-733-3308. If you are deaf or hearing impaired, please call the relay service to make your request.

**Note:** In order to set up the review in a timely manner, please call or fax with your request as soon as possible.

\_\_\_\_\_  
(Worker's Signature) (Date)

\_\_\_\_\_  
(Supervisor's Signature) (Date)

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**I wish to request a Clinical staffing to discuss the above decision regarding visitation with: \_\_\_\_\_.**  
(Name of child)

\_\_\_\_\_  
(Signature) (Date)

\_\_\_\_\_  
(Telephone number)