CFS 152
3/2004

State of Illinois
Illinois Department of Children and Family Services

DISABILITY RELATED SERVICES REPORT

Child's Name: _____

Child's ID: _____ Age: _____ DOB: _____

Worker's Name: _____

Agency/Office Name & Address: _____

_____

Worker's Telephone Number & Extension: _____

☐ This child is no longer with our agency/office.

Reason: _____ Date: _____

☐ This child has been professionally assessed and does not have a disability (attach assessment).

Child Assessed By: _____

Date of Assessment: _____

☐ This child is being underserved and we feel a staffing might be helpful.

☐ This child is inaccessible due to hospitalization, run-away, detention etc.

☐ The caregiver is not supporting service delivery to this child.

ASSESSMENT

☐ Child receives medication monitoring or follow-up for a physical disability.

Physician/Psychiatrist-Frequency seen: _____

Date of last follow-up: _____

Medications: _____

☐ Child has been hospitalized within last 6 months.

Reason: _____

Length of stay: _____ Discharge date: _____

☐ The child is age 5 or younger. Date of the 0-3 assessment: _____
0-3 recommendations, (or attach copy):

_____

_____

_____

☐ The child receives special education early childhood, special education or appears to need special education.

Date of the most recent IEP/IFSP: _____

If not done or current, date that a MDC/IEP was requested in writing _____.

Type of academic placement and services (***do not copy if on the CFS 407, Evaluation Report Form***):

_____

_____

☐ Child 14 and older (regardless of his/her goal) has been assessed for independent living skills and/or there are areas of need that are documented in the service plan.

Date of Daniel Memorial: _____

☐ Daniel Memorial not required due to developmental delays.

☐ **What report service or support recommendations** did physicians, educators, other professionals and/or foster parents who work with the child make?

_____

_____

_____

CURRENT SERVICES

☐ The child receives the following **services to address his or her disability**. Documentation available for review identifies the service provider; the frequency the child receives the services and the child's progress.

_____

_____

_____

_____

PLANNING

Child's current placement type: _____ Current payment amount: _____

☐ The account is in excess of $1,000. **Attach copies the child's assessment and disbursement forms that have been sent to Springfield or create a spend down plan**.

☐ There are unmet needs; recommended services that are not in place; missing documents, or other recommendations related to disability and/or income. List the issues and plans to address them.

Service or Support Need	Who Will Address the Need	Timeframe

SIGNATURES

_____ _____

Worker Date

_____ _____

Supervisor Date

Please TAKE this form with supporting documentation to the Administrative Case Review.