State of Illinois Department of Children and Family Services

Children's Account Unit Assessment Form

Ward's Name:	Name: DCFS ID Number: Name: Address: City, State, and Zip:				
Current Placement					
Permanency goal :	SGH	☐ Adoption	Return	Home	☐ Independence
Is DCFS guardianshi	p expected to	end within 30 days?	☐ Yes	☐ No	
Does the child have be met with allowable					that you believe could No
IF YES, please provi these funds (attach a			hild's disabili	ty and caus	se for requesting use of
Do you recommend items to meet these s				nt to provid	e services or purchase
IF YES, please comp Report.	lete and attac	h Disbursement Ro	equest Form	n and Disak	oility Related Services
Case worker			ate	() lephone
Supervisor			ate		

RETURN ALL FORMS TO:

Illinois Department of Children and Family Services 406 East Monroe Street, Mail Station 410 Springfield, IL 62701

FAX: 217-782-3882