CFS 1425
Rev. 12/2006

IILINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES

CHANGE OF STATUS FORM

FAMILY NAME _____ ID _____

TRANSFER

CASE ID	CASE NAME	CASE ID	CASE NAME	CASE ID	CASE NAME

SENDING: REGION _____ SITE _____

FIELD _____

DATE SENT: _____

Types of Transfer – check **all** that apply:

☐ Region ☐ Site ☐ Field
☐ Case Worker

_____ / _____
Caseworker Signature ID

_____ / _____
Supervisory Approval Date

RECIEVING: REGION _____ SITE _____

FIELD _____

DATE ACCEPTED: _____

Check **One**: ☐ Acceptance of Fiscal/Planning Responsibility
☐ Agreement to Provide Services Only

_____ / _____
Caseworker Signature ID

The assigned caseworker acknowledges that there is no pre-existing non-professional relationship which would indicate a conflict of interest with the above assigned case.

_____ / _____
Supervisory Approval Date

Dates covered in summary:_____ **Frequency and types of contacts:** _____

Reason for involvement: _____

Significant Developments or Events in the Case: _____

Progress in accomplishing Service Plan: _____

Clinical Reason for Closing/Reassignment/Transfer: _____

Suggestions for Future Services: _____

After Care Plan *(Case closing only)***:** _____

CLOSE

Case ID	Case Name	Close Reason	Close Date	Rls To	Lgl Sta	Lgl Sta Date	Docket Number	Grd	Eval	Eval Date

_____ _____
Worker's Signature/Date **Authorizing Signature/Date**