CFS 1448-F
6/2015

State of Illinois
Department of Children and Family Services

Extended Family Support Program
Tracking Form for Request for CANTS and LEADS Information

HOUSEHOLD INFORMATION

Case ID Number: ______________________

1. Head of Household Name: ______________________ ☐ Signed CFS 600-3
2. Other Person over Age 12: ______________________ ☐ Signed CFS 600-3
3. Other Person over Age 12: ______________________ ☐ Signed CFS 600-3
4. Other Person over Age 12: ______________________ ☐ Signed CFS 600-3
5. Other Person over Age 12: ______________________ ☐ Signed CFS 600-3
6. Other Person over Age 12: ______________________ ☐ Signed CFS 600-3
7. Other Person over Age 12: ______________________ ☐ Signed CFS 600-3
8. Other Person over Age 12: ______________________ ☐ Signed CFS 600-3

Child Name: ______________________ Birth Date: ______________
Child Name: ______________________ Birth Date: ______________
Child Name: ______________________ Birth Date: ______________
Child Name: ______________________ Birth Date: ______________
Child Name: ______________________ Birth Date: ______________

CASEWORKER INFORMATION

Caseworker: ______________________ Phone: ______________
Supervisor: ______________________ Phone: ______________
Agency: ______________________ Fax: ______________

______________________ ______________
Supervisor's Signature Date

REFERRAL TRACKING INFORMATION

Date Form CANTS 48 Received: ______________
Date Form CANTS 48 Sent: ______________
Date Decision Returned: ______________

RESULTS OF CANTS AND LEADS CHECK AND SERVICE ELIGIBILITY DECISION

☐ CANTS and LEADS check were negative and services can continue.
☐ CANTS and/or LEADS check was positive but services can continue. See brief synopsis below.
☐ CANTS and/or LEADS check was positive. Conduct staffing with EFSP Coordinator.
☐ Child is a ward of IDCFS. Do not assist with guardianship. Prepare case for closure.
☐ CANTS and/or LEADS check was positive. Do not assist with guardianship. Prepare case for closure.
☐ CANTS and/or LEADS check was positive, services cannot continue and SCR should be contacted:

______________________ ______________
EFSP Coordinator Date

RESULTS OF STAFFING

☐ Staffing completed and services will continue.
☐ Staffing completed, concerns remain and case is terminated.

______________________ ______________
EFSP Coordinator Date

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Head of Household Name: ____ SCR #: ____________________

Convictions/Indications Leading to the Decision to Deny Request for Assistance with Guardianship

Person	Year	Allegation/Conviction
CANTS	______	____________________
CANTS	______	____________________
Pending Investigation	______	____________________
LEADS	______	____________________
LEADS	______	____________________
LEADS	______	____________________

Convictions/Indications Requiring Staffing before Proceeding with Assistance with Guardianship

CANTS	______	____________________
CANTS	______	____________________
LEADS	______	____________________
LEADS	______	____________________
LEADS	______	____________________

Other Convictions/Indications Obtained from the CANTS or LEADS Report

CANTS	______	____________________
CANTS	______	____________________
LEADS	______	____________________
LEADS	______	____________________
LEADS	______	____________________
LEADS	______	____________________
LEADS	______	____________________
LEADS	______	____________________
LEADS	______	____________________
LEADS	______	____________________

Warrants

______ ____________________

______ ____________________

______ ____________________

Additional Direction Provided to the EFSP Provider Pertaining to the CANTS or LEADS Report

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Information provided through LEADS report may not contain all convictions or warrants.