State of Illinois
Department of Children and Family Services

INTERIM SUBSIDIZED GUARDIANSHIP AGREEMENT

The following Interim Guardianship Assistance Agreement has been entered into by and between the Department of Children and Family Services, hereinafter called "the Department," and _____

_____
Name of Prospective Guardian(s)

_____
Home Address

_____
Mailing Address (if different than above)

hereinafter called the "guardian(s)" for the purpose of facilitating the transfer of guardianship of

_____ _____ / _____ / _____
Child's Name Date of Birth

Child is IV-E Eligible ☐ **Yes** ☐ **No**

If yes, write eligibility number: _____

I. LEGAL BASE

A Title IV-E waiver provides the authority for subsidized guardianship. Department Rules and Procedures 302.405, Subsidized Guardianship, govern the provision of subsidized guardianship by the Department.

II. PROVISIONS OF THE INTERIM SUBSIDIZED GUARDIANSHIP AGREEMENT

The prior subsidized guardianship agreement concerning _____, children for whom guardianship was previously transferred to:

Name: _____

is incorporated by reference into this Interim Agreement. We agree to accept all provisions of that agreement until a new agreement is drafted and signed by us and the appropriate DCFS representatives.

III. OBLIGATIONS OF THE GUARDIAN(S)

The following are obligations of the guardian(s). Failure to comply with these obligations may result in suspension or termination of the Medicaid Card and the subsidy.

1. The Department is required to conduct reviews to confirm that the guardian(s) remains legally and financially responsible for the child, in part, to re-certify the child's eligibility for Medicaid benefits. Written notice will be sent annually to the guardian(s) along with a form that must be completed and returned to the Department.

Child's Name: _____

Guardian(s) Name: _____

Date: _____

2. The guardian(s) agrees to notify their DCFS Post Adoption Subsidy worker no later than 30 days after the following occurrences:

   a) When the child is no longer the legal responsibility of the guardian(s);
   b) When the guardian(s) no longer financially supports the child;
   c) When the child graduates from high school or equivalent;
   d) When there is a change of residential address or mailing address of the guardian(s) or the child;
   e) When the guardianship is vacated;
   f) When the child becomes an emancipated minor;
   g) When the child marries;
   h) When the child enlists in the military;
   i) When the mental or physical incapacity of the guardian(s) prevents the guardian(s) from discharging the responsibilities necessary to protect and care for the child;
   j) When the custodial status of the child changes;
   k) When the child dies.

IV. OBLIGATIONS OF THE DEPARTMENT

The Department agrees to pay for services resulting from any pre-existing psychological, medical, emotional or physically handicapping condition at the rate that is customary and usual in the guardians' community, if not covered by the Medicaid card or other public resources.

This child may require services not currently being provided for pre-existing physical, emotional or mental health needs or risk factors. Such pre-existing conditions must be described in the CFS 1800–C–G to be eligible for assistance through the Adoption Assistance or Subsidized Guardianship Program at a future date. Assistance cannot be granted for services for pre-existing conditions if the condition(s) is not listed on the CFS 1800–C–G.

In this section documentation must be provided regarding why the child and all other siblings, if known, came into care, as well as all known mental health, medical, and substance abuse histories of the biological parents (include additional pages as necessary).

Documentation of the child's unique physical, mental, or emotional conditions must be provided. Attached records relating to the history, medical, physical or mental condition of the child are considered part of this agreement. All of the child's pre-existing conditions must be identified, including what physical, emotional and mental health services the child is receiving and will continue to receive and specify frequency and duration, the start date and anticipated end date. If there is no information to provide, state the reason.

Specifically, complete the following:

1) Why the child's case came into the system;

_____

_____

_____

_____

Child's Name: _____

Guardian(s) Name: _____

Date: _____

2) Why the child's siblings came into the system, if known;

3) Information as to the existence of any other children born to the birth parent(s), including birth dates and genders:

4) The reason(s) the child was unable to return to his/her birth family;

5) The child's current relationship with his/her birth family:

6) Dates of all placements, whether the caregiver was a relative or non-relative, residential placements, and reasons for moves;

7) Mental health treatment history of the child, if known. Attach copy of diagnoses, including assessment reports.

Child's Name: _____

Guardian(s) Name: _____

Date: _____

8) Substance abuse history of the immediate family, including birth parents, siblings and grandparents. Do not include identifying information.

9) Physical disabilities, prior injuries, diagnosed medical conditions, including dates of diagnoses and hospitalizations, medication history, genetic history. Attach supporting documentation of diagnoses.

10) Names of all service/health-care providers, past and present, specifying what services were provided and dates of services;

11) Behavioral problems - both past and present;

12) Physical abuse experiences of which the child was the victim, if known;

13) Sexual abuse incident(s) in which the child was the victim or the perpetrator, if known;

Child's Name: _____

Guardian(s) Name: _____

Date: _____

14) Neglect experiences in which the child was the victim, if known;

15) Educational issues: names of schools attended, dates of Individual Education Plans (IEP) and/or Individual Family Service Plans (IFSP) or 504 Educational Special Needs Plan (attach IEPs or IFSPs or 504 Educational Special Needs Plan if applicable);

16) Assessments and/or diagnoses of any learning disorders;

17) Special services provided in the school, now or in the past;

18) Separation and loss issues;

19) Other pre-existing health including mental health conditions of immediate family, including parents, siblings and grandparents. Do not include identifying information;

Child's Name: _____

Guardian(s) Name: _____

Date: _____

20) Additional non-identifying information regarding the child or immediate family. Do not include identifying information;

_____

_____

_____

_____

21) List all of the therapy, counseling or other services that the child is currently receiving including the name of the provider, service type and frequency of treatment.

_____

_____

_____

_____

22) List all of the documents that have been attached to this agreement including the name of the treatment or service provider, date of report or service, and the type of service.

_____

_____

_____

_____

V. SERVICES PROVIDED UNDER THE AGREEMENT FOR ASSISTANCE

The Department shall provide assistance for the approved services as listed below upon the transfer of guardianship. Services being provided to the child at the time of the agreement will continue with the same provider and are allowable when the services are described in section d) Needs Not Payable Through Other Sources (below).

a) Nonrecurring Expenses for Subsidized Guardianship

This is a one-time only payment for reasonable and necessary miscellaneous costs and legal fess related to subsidy review, that are directly related to the transfer of guardianship of a child, subject to the maximum set by the Department of $500 per child.

Specify expenses other than legal fees.

_____ $ _____

_____ $ _____

_____ $ _____

_____ $ _____

Nonrecurring Expenses are approved for payment through this agreement:

☐ **Yes** ☐ **No**

Child's Name: _____

Guardian(s) Name: _____

Date: _____

b) Monthly Cash Payment

The monthly cash payment shall not exceed the amount the child receives in the current foster family home unless the child is in an unlicensed relative placement. In such a case, upon the transfer of guardianship, the guardian(s) may receive up to the applicable DCFS rate for licensed foster family homes.

Direct monthly payments to _____ at the rate of
Name of Payee

$_____ per month.

The Department has approved monthly cash payments as a part of this agreement:

☐ **Yes** ☐ **No**

c) Medicaid Card

In no event can the Department make supplemental payments, pay for deductibles or make co-payments for medical services.

1) When the child and family live in Illinois, medical benefits are provided under Title XIX of the Social Security Act (Medicaid). Medicaid pays for eligible services not covered by medical insurance (if the child has been added to a medical insurance policy). If there is not a service provider who participates in the Illinois Medicaid program within 25 miles of the child's home, a non-participating provider may be used. Guardian(s) will be reimbursed for eligible services.

2) When a family moves out of state and the new state will not provide Medicaid coverage, Illinois will reimburse the family at Illinois Medicaid reimbursement rates for eligible services.

3) In the event the family lives in another state and a medical provider participates in the Illinois Medicaid program, the provider will bill the Illinois Medicaid program for medical expenses.

A Medicaid Card is a part of this agreement:

☐ **Yes** ☐ **No**

d) Needs Not Payable Through Other Sources

1) Payment for physical, emotional and mental health services cannot be made until the Department has been notified that such services will begin, the Department has approved the requested services, and a contract (when applicable) with the identified vendor is in place.

2) The Department will pay the service provider directly or reimburse the family for Medicaid ineligible services relating to a pre-existing condition, which must be approved by the Department prior to providing services and at a rate negotiated regardless of the state in which the child lives.

3) The Department will make direct payments to providers not enrolled in Medicaid. Prior approval from the Department is required.

4) The Department will also make direct payments to the provider or reimburse the family when services from a Medicaid enrolled provider are not available within a twenty-five mile radius of the family's home.

Child's Name: _____

Guardian(s) Name: _____

Date: _____

5) Current Services:
The child is currently receiving the following services that will be continued following the finalization of the transfer of guardianship: (Add additional pages if necessary)

_____

_____

_____

_____

The Department has approved payment or reimbursement for the above services that are not payable through other sources for physical, mental or emotional problems or disorders as a part of this agreement:

☐ **Yes** ☐ **No**

6) Future Services:
Specify each medical and/or clinical service that the child may need in the future and that is being requested as part of this agreement. List all reports, records and correspondence that are attached to the subsidy agreement including documentation from a licensed medical professional or qualified mental health practitioner of the child's diagnosis and related future service needs.

_____

_____

_____

_____

The Department has approved payment or reimbursement for the above services which may be needed in the future if found at the time of need to not be payable through other sources:

☐ **Yes** ☐ **No***

***Checking the "No" box at the time of completion of this form does not preclude the guardians from requesting services following the finalization of the transfer of guardianship through the amendment process as described in Procedures 302.405.**

e) Therapeutic Day Care

Therapeutic day care provides services to children who cannot be served in traditional childcare settings or other childhood programs because of their inability to participate in such programs and because of the intensity of services they require as a result of their physical, mental or emotional disabilities.

Payment will be made for therapeutic day care only for those children who are determined to have a disability that requires special educational services through a current, Individual Education Plan (IEP), an Individual Family Services Plan (IFSP), or a 504 Educational Special Needs Plan, updated on at least an annual basis, when such day care is not payable through another source. Local school districts are responsible for developing the Individual Education Plan or Individual Family Services Plan for students requiring special education services.

1) Payment may be made for specialized care that provides therapeutic intervention rather than only regular childcare services. The day care must include treatment of a disability or a disease as an integral part of the programming (i.e., speech, physical or occupational therapy; behavior modification; psychological or psychiatric services).

Child's Name: _____

Guardian(s) Name: _____

Date: _____

2) Approval of payment for therapeutic day care requires documentation of the child's specific physical, mental or emotional disability and the special training, licensing or credentialing of the individual providing the therapeutic day care.

3) Payment for therapeutic day care cannot be made until the Department has been notified that such services will begin, has approved the requested service, and a contract with the identified vendor is in place (when applicable).

4) The Department's reimbursement will be limited to what is usual, customary, and reasonable in the community as determined by the Department.

The Department has approved payment or reimbursement for therapeutic day care as a part of this agreement:

☐ **Yes** ☐ **No**

f) Employment Related Day Care

Guardian(s) receiving assistance for a child under three years of age are eligible for payment of day care services for that child, if day care is required due to one of the following. (Check the appropriate box below).

☐ The guardian(s) is employed or participating in a training program that will lead to employment.

☐ A single guardian is employed or in a training program that will lead to employment or both guardians in a guardianship home are working or in a training program that will lead to employment.

☐ One guardian works and the other guardian is unable to care for the child due to a disability.

The Department has approved payment or reimbursement for employment-related day care as a part of this agreement:

☐ **Yes** ☐ **No**

VI. SOCIAL SERVICES

Social services, as provided under Title XX of the Social Security Act shall be available in accordance with the procedures of the state of residence. Illinois residents may apply at the local Department of Human Services office.

VII. REVIEW / RECERTIFICATION

1. The Department will conduct reviews to determine whether the guardian(s) remains legally and financially responsible for the child. This review is a necessary step in re-certifying the child's eligibility for Medicaid benefits.

2. Written notice will be sent annually to the guardian(s) along with a form that must be completed and returned to the Department. Failure of the guardian(s) to participate in the review process may result in termination of the Medicaid Card.

Child's Name: _____

Guardian(s) Name: _____

Date: _____

IX. TERMINATION

The Subsidized Guardianship Agreement shall terminate when the Department has determined that one of the following has occurred:

1. When the terms of the subsidized guardianship agreement are fulfilled.

2. The guardian(s) has requested that the payment permanently stop.

3. The guardian(s) is no longer legally or financially responsible for the child.

4. The child becomes an emancipated minor.

5. The child marries.

6. The child enlists in the military.

7. A) The child reaches age 18 and is not in high school or equivalent; or

   B) The child 18 years of age graduates from high school or equivalent or reaches age 19, whichever occurs first; or

   C) The child with a physical, mental or emotional disability which affects his/her major life activities, which existed prior to the guardianship transfer and which was documented in the assistance agreement, reaches age 21; or

   D) The child reaches age 21 who prior to the guardianship transfer, was determined to be at risk of developing a physical, mental or emotional disability due to environmental, genetic or hereditary factors, which subsequently manifested itself. The disability affects his/her major life activities, and it is documented that it was developed prior to age 18.

8. The guardian(s) die.

9. The guardian(s) rights are terminated.

10. The child dies.

X. APPEAL

Guardian(s) may appeal the Department's decision to change or terminate assistance in accordance with 89 Ill. Adm. Code, Part 337, Service Appeal Process. Decisions that may be appealed include payments for services for the child for whom you are guardian or denial of a request for increased assistance to provide the child with additional services.

Decisions or actions made by the Department are appealed after the guardian(s) has received notice of the decision or action. Any written notices from the Department will provide specific information about the appeal rights of adoptive parents, guardians and foster parents.

To appeal a decision or action made by the Department, a written request for a service appeal is submitted to:

Administrative Hearings Unit
Department of Children and Family Services
406 E. Monroe, Station 15
Springfield, IL 62701
217.782-6655

Child's Name: _____

Guardian(s) Name: _____

Date: _____

XI. AMENDMENTS

Upon notification by the guardian(s) of a change in the guardian(s) circumstances or the child's needs as set forth in Section IV Obligations of the Department, amendments to the Agreement may be made at times other than at the review.

Following the guardianship transfer, the agreement may be amended or terminated with the mutual agreement of the guardian(s). Amendments to the agreement must be completed on a CFS 1800–F, Amendment to Agreement for Assistance, and can only be completed by Subsidy Unit staff. An amendment to increase the ongoing monthly payment may be made only when authorized by the Post Adoption/Guardianship Services Review Committee (PAGSRC).

If it becomes necessary to change a subsidy that has been signed by all parties prior to finalization, a new agreement must be completed, approved and signed.

XII. EFFECTIVE DATE

The guardian(s) acknowledges receipt of a copy of this agreement at the time of signing this agreement.

SIGNATURES:

_____ _____
Guardian Date

_____ _____
Guardian Date

The information contained in this application is complete to the best of my knowledge.

_____ _____
Signature of DCFS Adoption Supervisor/Coordinator Date

_____
Print Name of DCFS Adoption Supervisor/Coordinator

The information contained in this application is complete to the best of my knowledge.

_____
Signature of DCFS or POS Supervisor

_____
Name of DCFS or POS Supervisor

DCFS Office:

_____
Name

_____
Street Address

_____
City State ZIP Code

Worker Preparing the Form:

_____
Name Date

_____
Agency

_____
Worker's Supervisor