State of Illinois
Department of Children and Family Services

60+ SUBSIDY CHECKLIST

Instructions: This checklist, to be completed by the caseworker, is REQUIRED for each child when the pre-guardianship or pre-adoptive caregiver(s) is (are) age 60 and older. The completed checklist will be reviewed in detail at the Child and Family Team Meeting in conjunction with the assigned Adoption Liaison/Coordinator (this may be done in conference or by phone) along with the back-up caregiver (in person or by phone) and a determination made as to whether additional permanency planning is necessary. If additional permanency planning is required, the family will be referred to the Child Protection Mediation Program (in Cook County), Metropolitan Family Services Older Caregiver Program (in Cook County), or to additional planning or services. If no additional permanency planning is required, the assigned DCFS Adoption Liaison/Coordinator signs the completed checklist reflecting agreement with the planning, and the original checklist will be maintained in EACH individual child's file.

Child Information:

1. **Child name**:_____ Male ☐ Female ☐ D.O.B. _____
2. **Child I.D.**:_____
3. **Child's special needs**: (specify all)

   _____

   _____
4. **Child's contact with biological family**: (specify who, frequency)

   _____

   _____
5. **Services currently in place for the child**:_____

   Counseling:_____
   Occupational Therapy:_____
   Physical Therapy:_____
   Respite:_____
   Other:_____
6. **Names/ages of others in home and their relationship to the child**:

   _____

   _____

   _____
7. **Child centered collaterals**: e.g. who does the child identify as important to him/her (for children age 4 and older)._____

   _____

   _____
8. **Hotline contacted in past 6 months**: No ☐ If Yes, ☐ Unfounded ☐ Indicated ☐
   Outcome:_____
9. **Name of current GAL**:_____

10. **Concerns the GAL has about caregiver or placement**:

_____

_____

_____

11. **Date of last conversation with GAL**:_____
(Must be within 6 months of date checklist is submitted for review.)

Placement Information:

12. **Current placement**:

Caregiver's Name:_____ D.O.B.:_____

Caregiver's Name:_____ D.O.B.:_____

Address:_____

Phone:_____

Licensed ____ Unlicensed ____ If unlicensed, ***Home Safety Checklist*** **(CFS 2025)** completed in accordance with Administrative Procedure #25: ____

Date completed:_____

Relative ____ Non-relative ____

Date of placement _____

CANTS/LEADS: Date:_____ Results:_____

13. **Currently rent or own home**:_____ How long:_____

Caregiver Information:

14. **Informal Supports**: Who comes into home to assist/support caregiver/s:_____

_____

Reason for assistance:_____

Frequency of Assistance:_____

N/A:_____

15. **Formal Supports**: Other agency/ies involved in home or with caregiver/s

Agency name:_____

How involved:_____

N/A: _____

16. **Department of Aging** services in place:_____ or needed:_____ (1-800-252-8966)

For Caregiver/s:_____ Other Family Member:_____

Homemaker services:_____

Meals on Wheels:_____

Transportation Assistance:_____

Respite:_____

Other:_____

17. **Caregiver health status:**

Caregiver #1:_____

Caregiver #2:_____

18. **Received & reviewed the caregiver(s) medical evaluation form**: (Attach CFS 604)

Caregiver #1

Dated_____ from (Dr./Clinic)_____

Caregiver #2

Dated_____ from (Dr./Clinic)_____

19. **Household income**: **(not including child's stipend)**

Annual or monthly (Amount):_____

How verified:_____

Back-Up Caregiver Information:

20. **Back-up caregiver participated in conference**: Yes____ No____

In person _____

By telephone _____

21. **Back-up caregiver**:

Name(s):_____

D.O.B.(s):_____

Address:_____

Phone:_____

Relationship to child:_____

Does child agree (children 4 and older):_____

22. **Date back-up caregiver identified**:_____

23. **Back-up caregiver currently involved with child**: Yes____ No____

How:_____

Frequency:_____

24. **Caseworker reviewed back-up caregiver's future role/responsibilities for child**:

Date:_____

Others present:_____

Back-up caregiver is prepared to assume future role. Yes____ No____

25. **Caseworker reviewed circumstances that may require back-up caregiver to assume future care of the child**:_____

Date:_____

Others present:_____

Back-up prepared to assume future role:_____

Signatures:

26 _____ _____

Placement/Permanency Caseworker (Print Name) Phone Number

Signature:_____ Date:_____

27 _____ _____

Placement/Permanency Supervisor (Print Name) Phone Number

Signature:_____ Date:_____

28. **Agency/DCFS Region, Site and Field**:_____

I have reviewed answers to each of the above questions.

( ) I have concerns regarding

( ) the living arrangement (e.g. housing, finances, health, safety, etc.)

( ) the back-up plan

AND I will ask the caseworker to

- ***(in Cook County)* refer the family to the Child Protection Mediation Program or to Metropolitan Family Services - Older Caregiver Program;**
- ***(in all other counties)* confer with the supervisor for additional planning and/or services**

OR

I have reviewed answers to each of the above questions.

( ) I am satisfied that appropriate plans have been made for this child, including a back-up plan.

29 _____ _____

Adoption Liaison /Coordinator (Print Name) Phone Number

Signature:_____ Date:_____

30. **Adoption/Liaison Coordinator participated:** by phone ____ in person ____