State of Illinois
Department of Children and Family Services

TRANSITION FUNDING APPLICATION AND DISBURSEMENT PLAN

DCFS Case ID: _____

Name:_____

Birth Date: _____/_____/_____ SSN: _____

Date of Expected Exit from Care: _____/_____/_____

Address (Needs to be a current address for the next 60 days for payment to be received):

Street: _____

_____

City: _____ State: _____ Zip: _____

In order to be eligible to apply/receive Transition Funding, all of the following criteria must be met. For payment to be processed, all check boxes must be marked "completed", and full signatures below.

- ☐ Youth is in a Department approved substitute care placement.
- ☐ In-Person participation in the 90-Day C21 held. Date of Meeting: _____
- ☐ CFS 2032-1 Youth Driven Transition Plan or CFS 375-2 Quarterly Discharge Launch Plan completed.
- ☐ Youth has identified a supportive resource person.
- ☐ Department approved financial literacy course completed. Date of Completion: _____
- ☐ Disbursement Plan Amount of $_____ from page 2, verified and approved.

The signatures below indicate agreement and verification that all criteria checked above have been met.

Caseworker: Signature:_____ Date: _____/_____/_____

Supervisor: Signature:_____ Date: _____/_____/_____

D-CIPP Facilitator: Signature:_____ Date: _____/_____/_____

Send signed and completed application and disbursement plans to Central Payment Unit for payment processing via email to DCFS.CPUDCFSMailbox@illinois.gov or via fax to 217-557-0639.

Plan for Intended Use of Transition Funds

The purpose of Transition Funding is to provide financial support to youth as they leave the child welfare system and become self-sufficient. The Department will authorize payment only if the youth is in compliance with the checked criteria on Page 1. Please provide amounts planned for the categories below, which will equal the total Transition Fund amount to be paid for the youth.

Budget Category	Amount to be Disbursed
Housing (e.g. rent, security deposit)	
Education Related Expenses	
Transportation	
Medical/Health	
Daycare/Childcare	
Furniture (electronics not included)	
Debt Reduction	
Savings Account Deposit	

Total of category amounts must equal approved disbursement total entered on Page 1.

Youth's signature below reflects they intend to utilize the Transition Funds according to the budgeted amounts listed above.

Youth Signature:_____ Date: _____/_____/_____