CFS 402-1 Rev 2/2023

## State of Illinois Department of Children and Family Services

# WAIVER OF LICENSING STANDARDS FOR FOSTER FAMILY HOMES PART 402

# SECTION BELOW TO BE COMPLETED BY LICENSING STAFF

Day Care Provider ID # (If applicable.):
Region foster home is located in:
-
Phone #:
in 14 days.)
(*Please attach licensing home visit record.)
f so, why?:
ld release, if applicable.)
most recent CFS 602 Medical Examination Form.):
s per week and name of child(ren)'s caregiver during work hours:
If so, please give a brief explanation:
is exceptional enough to manage this situation:
1

# SECTION BELOW TO BE COMPLETED BY CASE MANAGEMENT STAFF

**LIST ALL <u>CHILDREN</u> 0-18 YEARS OLD WHO LIVE IN THIS FOSTER HOME:** (Include biological, foster and adoptive; note the child's relationship to foster parent below.)

Name	Sex	Date of Birth	Age	DCFS ID#	Relationship	Specialized	Placement Date

Are any children specialized receiving (diagnosis, counsel					s/behavior(s) and what se	ervices is the c	hild(ren) are
LEADS/SACWIS:							
Please attach the current (wit	hin 14	days) LEADS	S/SACWI	S for all adults and	teenagers 13 and older re	siding in the fo	ster home.
Are there any positive hits?		Provide a	written e	xplanation for any	positive hits:		
SLEEPING ARRANGEMI	ENTS:						
List number of bedrooms for	the ch	ildren in the h	ome:				
List number of beds in each of	of the b	pedrooms:					
List names of children match	ed wit	h his or her be	droom:				

#### SECTION BELOW TO BE COMPLETED BY CASE MANAGEMENT STAFF

**FOSTER CHILD THIS REQUEST PERTAINS TO:** (Attach One Copy for Each Child Seeking a Waiver.) DOB: Name: DCFS ID#: Traditional or Specialized: Current Goal: Potential placement date: Father's parental rights terminated? ☐ Yes ☐ No Case Manager: Phone #: Agency: Mailing Address: If specialized, what is the child's diagnosis/behavior(s), and what services is the child receiving (diagnosis, counseling, medication, therapies, and so forth): With whom is the child currently placed? Specific reason for the child's removal: Explain why the waiver is in the best interest of the foster child: Explain the specific services your agency plans to provide to this foster home and child(ren) that will preserve this placement:

#### PLEASE PROVIDE THE FOLLOWING NAMES, COMPLETE MAILING ADDRESSES, and FAX NUMBERS:

Biological Parents (Mark N/A if all parental rights have been terminated.):

State's Attorney:

Guardian ad Litem:

## SECTION BELOW TO BE COMPLETED BY STAFF WHO RECOMMENDED THE WAIVER

Case Management signatures must be secured for ALL children placed in the home, not just the waived child(ren).

		Provider ID#:	Date:
Case Management:			
Typed Name	Signature	Agency's Name	Child's Name
Case Management Super	visor:		
Typed Name	Signature	Agency's Name	Child's Name
Case Management:			
Typed Name	Signature	Agency's Name	Child's Name
Case Management Super	visor:		
Typed Name	Signature	Agency's Name	Child's Name
Licensing worker:	Typed Name	Signature	Date
Licensing supervisor:	Typed Name	Signature	Date
Program director:	Typed Name	Signature	Date
	OF CLINICAL SERVIC		
JEPUTY DIRECTOR (			
Expanded capacity reques	st is for one or more child	ren receiving specialized services in t	the home, or there are more than
Expanded capacity requeshildren under 6 years, or		ren receiving specialized services in t	the home, or there are more than
Expanded capacity request hildren under 6 years, or	st is for one or more childs r more than 2 children und	ren receiving specialized services in the ler 2 years in the home.  Deny	he home, or there are more than Date
Expanded capacity requestibilitien under 6 years, or App  Signature of I	st is for one or more childs r more than 2 children und prove Deputy Director of Clinical S	ren receiving specialized services in the ler 2 years in the home.  Deny	
Expanded capacity requestibilities under 6 years, or	st is for one or more childs r more than 2 children und prove  Deputy Director of Clinical S  NEE:	ren receiving specialized services in the ler 2 years in the home.  Deny	
Expanded capacity requestions believed to the control of the contr	st is for one or more childs r more than 2 children und prove  Deputy Director of Clinical S  NEE:	ren receiving specialized services in the ler 2 years in the home.  Deny ervices or Designee	
Expanded capacity requestions of the control of the	st is for one or more children und remove  Deputy Director of Clinical S  NEE:  st for:	ren receiving specialized services in the ler 2 years in the home.  Deny ervices or Designee	
Expanded capacity requestions of the control of the	st is for one or more children und remove  Deputy Director of Clinical S  NEE:  st for:  censed relative or fictive k	ren receiving specialized services in the ler 2 years in the home.  Deny ervices or Designee	
Expanded capacity requestions of the control of the	st is for one or more children und remore than 2 children und prove  Deputy Director of Clinical S  NEE: st for: censed relative or fictive kerove  Director or Designee	ren receiving specialized services in the ler 2 years in the home.  Deny ervices or Designee	Date
Expanded capacity request thildren under 6 years, or   App  Signature of E  DIRECTOR or DESIGN  Expanded capacity request   unline   App  Signature of E  DIRECTOR or Designe  Request for a waiver of L	st is for one or more children und remore than 2 children und prove  Deputy Director of Clinical S  NEE: st for: censed relative or fictive kerove  Director or Designee	ren receiving specialized services in the ler 2 years in the home.  Deny ervices or Designee	Date