

STATE OF ILLINOIS
ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES

INTER-ETHNIC PLACEMENT ACT ASSESSMENT FORM

I. Purpose

In order to comply with the Federal Multiethnic Placement Act, the Department or purchase of service agency may not:

- o deny to any person the opportunity to become an adoptive or foster parent on the basis of race, culture, or national origin of the adoptive or foster parent or the race, culture, or national origin of the child involved in the foster or adoptive placement; and
- o delay or deny the placement of a child for adoption or into foster care on the basis of race, culture, or national origin of the adoptive or foster parent or the race, culture, or national origin of the child involved in the foster or adoptive placement.

Placement decisions require a case by case approach. While race, culture or national origin are not to be routinely considered when placing a child, an individual case may present facts that require the Department or purchase of service agency to consider the racial, cultural, national origin of the child. However, the Department or placing agency must ensure that their decisions rest on a child's particular and documented needs and not on a set of assumptions that individuals may hold as to what a child of a particular race, culture, or national origin may need. Therefore, if race, culture, or national origin are raised as factors in a particular child's initial placement or change in placement, the consideration of race, culture, or national origin by the placing worker must be narrowly tailored to advance the child's best interests. An individualized determination must be made and must be based on concerns arising out of the circumstances of the individual case.

The purpose of this form is to document the individualized assessment of a child for whom race, culture, or national origin, has been raised as a consideration in the child's placement, including the initial placement and all changes in placement.

II. Identifying Information

Child's Name: _____

I.D. Number: _

Child's Race: _____

Placement Type (Foster Care, Adoption): _

III. State below who raised race, culture, or national origin as a factor to be considered in the child's placement:

Person's name: _____

Person's relationship to the child: _____

IV. List the reasons why the person who raised the issue of race, culture, or national origin believes that the child should be placed with a caregiver of a particular race, culture, or national origin:

Attach documentation that supports any of the factors listed above, including any relevant school reports, medical, and psychological evaluations, etc.

V. Worker's Assessment

The placing worker:

- _____ Agrees with the contention that race, culture, or national origin should be considered in the placement of this child. If the DCFS or private agency worker agrees or is the person who is raising the issue, an individualized staffing must be conducted. See Section VI.
- _____ Disagrees with the contention that race, culture, or national origin should be considered in the placement of this child. If the DCFS or private agency worker disagrees, go to Section VII. If the party who raised the issue of race, culture, or national origin challenges the worker's decision, an individualized staffing must be conducted. See Section VI.

VI. Individualized Staffing

A staffing was conducted to determine whether placement of this child with a caregiver of a particular race, culture, or national origin is in the best interests of the child.

Date of staffing: _

The following persons participated in the staffing:

Placing worker: _____

Supervisor: _

Clinical Manager: _

Others: _

VII. Decision

The decision made as a result of the staffing and in consideration of Procedures Section 301.60(b) is that a placement of this child with a caregiver of a particular race, culture, or national origin is:

_____ essential to the best interests of the child

_____ not essential to the best interest of the child

The following reasons were given for the decision:

Attach any documentation supporting the decision.

This decision is valid for no more than one year from completion. A signed written update may be prepared anytime within two years following completion of the assessment.

VIII. Signature and Approval

Caseworker's Name: _

Office: _

Caseworker's Signature: _ Date: _____

Supervisor's Name: _____

Supervisor's Signature: _ Date: _____

Clinical Manager/Coordinator's Name: _____

Purchase of Service Counterpart: _

Clinical Manager/Coordinator's Signature: __

Date: _____

Purchase of Service Counterpart's Signature: _

Date: _____

Name and Position of Others Who Provided Consultation for the Final Decision:

Name: _

Position: _____

Name: _

Position: _____

Name: _

Position: _____

Copies: Case File
Clinical Manager
Office of Quality Assurance
IEPA Monitor
Regional Counsel (If participating)