

Department of Children and Family Services
Differential Response Final Cash Assistance Reconciliation

1. Provider No.	<input type="text"/>	2. Contract No.	<input type="text"/>	-	<input type="text"/>
Provider Name	_____	3. FEIN No.	_____		
Program Name	_____	4. Reporting Period	FROM: _____		
Address	_____		TO: _____		
	_____ Zip Code _____	5. Date Submitted	_____		
Phone	_____	6. D.R. Project Director	_____		

Appropriation No.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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line 7	Amount of funds advanced to the agency for the program		
line 8	Amount of cash assistance provided to clients		
line 9	Amount of cash assistance that was not used by the client		
line 10	Amount of assistance provided that was not authorized by DCFS		
line 11	Amount of authorized assistance provided to the client (subtract line 9 and 10 from line 8)		-
line 12	Administration fee (multiply line 11 by administration fee allowed by contract)		400.00
line 13	Amount authorized to bill, unless amount exceeds contract (add line 11 and 12)		400.00
line 14	Maximum amount contract allows agency to bill		
line 15	Amount agency is authorized to bill (enter the smaller amount of line 13 or 14)		
line 16	Amount agency already returned to the Department		
line 17	Amount agency should return to DCFS (subtract line 15 and 16 from line 7)		\$ -

18. SELLER'S CERTIFICATION
For Agency Provider Use

I hereby certify that the amounts listed above are an accurate summary for payments received and services provided for the fiscal year.

Provider's Signature _____
Position _____

CONTRACT LIAISON DATE

CERTIFICATION OF RECEIVING AGENCY
It is hereby certified that the information provided on this form has been reviewed for mathematical accuracy.

HEAD OF UNIT OR AUTHORIZED AGENCY DATE

INSTRUCTIONS FOR COMPLETING CASH ASSISTANCE RECONCILIATION AND ADVANCE REQUEST

This Reconciliation form is authorized for use with providers for Cash Assistance services to Department when a cash advance was provided by the Department to serve the clients. This Reconciliation is not authorized for any other Cash Assistance or other services.

1. PROVIDER NO.
Insert your 6-digit DCFS I.D. number, and your name and address as it appears in your contract. Telephone number of person preparing reconciliation may be inserted.
2. CONTRACT NO.
For contracted service, insert contract number stated in contract. For non-contracted services, type "non-contracted" above the contract number.
3. FEIN NO.
Use the number as it appears in your contract.
4. SERVICE REPORTING PERIOD
The term of the contract (i.e. From 7/1/07 To: 6/30/07).
5. DATE SUBMITTED
Self-explanatory.
6. DCFS DIFFERENTIAL RESPONSE (DR) PROJECT DIRECTOR
Insert the name of Differential Response (DR) Project Director who authorized this service.
7. AMOUNT OF FUNDS ADVANCED TO THE AGENCY FOR THE PROGRAM
Enter the total amount of cash advances, including both funds provided to the agency for cash assistance checks and for administrative fees for the year.
8. AMOUNT OF CASH ASSISTANCE PROVIDED TO CLIENTS
Enter the total amount of cash assistance checks provided to the client for the entire fiscal year.
9. AMOUNT OF CASH ASSISTANCE THAT WAS NOT USED BY THE CLIENT
Enter the amount of any cash assistance checks that were not used and voided and any funds that were returned from the provider.
10. AMOUNT OF CASH ASSISTANCE THAT WAS NOT AUTHORIZED BY DCFS
Enter the amount of assistance that DCFS has determined was not authorized by DCFS and therefore should not have been provided.
11. AMOUNT OF AUTHORIZED ASSISTANCE PROVIDED TO THE CLIENT
Subtract the amount of assistance that was not used (line 9) and the amount of assistance that was not authorized (line 10) from the amount of assistance provided to the client (line 8).
12. ADMINISTRATION FEE
Multiply the amount of authorized assistance provided to the client by the amount the agency is allowed to bill for their administrative fee.
13. AMOUNT AUTHORIZED TO BILL, UNLESS AMOUNT EXCEEDS CONTRACT ALLOCATION
Add the amount of authorized assistance provided to the client (line 11) with the administrative fee (line 12).
14. MAXIMUM AMOUNT CONTRACT ALLOWS AGENCY TO BILL
Enter the maximum amount that the contract allows the agency to bill. This may be the contract allocation but could be an amount defined by the contract (for example, a maximum amount the agency can bill for each client served).
15. AMOUNT THE AGENCY IS AUTHORIZED TO BILL
Enter the smaller amount of the amount the the agency is authorized to bill (line 13) and the maximum amount the contract allows the agency to bill (line 14).
16. AMOUNT AGENCY ALREADY RETURNED TO THE DEPARTMENT
Enter the total amount of funds the agency has already returned to the Department for the fiscal year being reconciled.
17. AMOUNT AGENCY SHOULD RETURN TO DCFS

Subtract the amount that the agency already returned to the Department (line 16) from the amount of funds advanced to the agency for the program. If the amount is a negative balance, meaning the Department owes the agency money for providing the service the agency should submit a bill for the amount. If the amount is a positive number, the agency should write a check for the amount owed. The check should be made out to "DCFS" and include the agency's contract number on the check. The check should be sent to the contract liaison who should report that the cash advances have been reconciled with the

Treasurer, State of Illinois
c/o Illinois Department of Children and Family Services
406 E. Monoe, Station 412
Springfield IL 62701
18. SELLER'S CERTIFICATION
An authorized official of the Provider must sign this Reconciliation and include her or his position.