CFS 1800–B–G
Rev 8/2012

State of Illinois
Department of Children and Family Services

SUBSIDIZED GUARDIANSHIP APPLICATION

(SECTION I TO BE COMPLETED BY THE WORKER)

If you do not wish to apply for subsidized guardianship, complete Sections I, II and III.

If you wish to apply for subsidized guardianship, complete Sections I, II and IV.

I. GUARDIAN AND CHILD INFORMATION

_____ _____
Guardian Home Telephone Number

_____
Guardian

_____ _____ _____ _____
Address City State Zip Code

_____ _____/_____/_____
Child's Name Date of Birth

II. INFORMATION REGARDING SUBSIDIZED GUARDIANSHIP

Following is information regarding the availability of subsidized guardianship for the child for whom you are planning to assume guardianship. Please indicate the types of subsidized guardianship for which you wish to apply.

1. Nonrecurring Expenses for Subsidized Guardianship

   This is a one-time only payment for reasonable and necessary miscellaneous costs and legal fees related to subsidy review, that are directly related to the transfer of guardianship of a child, subject to the maximum set by the Department of $2000 per child. The non-recurring cost limit is $500 for cases of a subsequent guardianship after the death/incapacitation of a guardian in which the initial guardianship was established under the IDCFS Subsidized Guardianship Waiver.

   ☐ I request this assistance. ☐ I **do not** request this assistance.

2. Monthly Cash Payment

   The amount of the monthly cash payment is determined in accordance with DCFS Rules and Procedures 302.410 and shall not exceed the amount the child receives in the current licensed foster family home.

   ☐ I request this assistance. ☐ I **do not** request this assistance.

Child's Name: _____

Guardian(s) Name: _____

Date: _____

3. A Medicaid Card

A Medicaid card will be issued for the child upon the transfer of guardianship. This card shall be used for all Medicaid-eligible services obtained through Medicaid-enrolled provider(s) that are not payable through your health insurance or through other public resources. If there is not a Medicaid enrolled provider within 25 miles of a child's home, services may be obtained from a provider who does not participate in the Illinois Medicaid program. If the guardian(s), who now reside in Illinois, move to another state in the future, the child may not be eligible for a Medicaid card in that state. When a family moves out of state or currently resides out of state and that state will not provide Medicaid coverage, Illinois will reimburse the guardian(s) at the Illinois Medicaid reimbursement rates for eligible services. In the event that the out-of-state medical provider participates in the Illinois Medicaid program, the provider will bill the Illinois Medicaid program for medical expenses.

☐ I request this assistance. ☐ I **do not** request this assistance.

4. Payment for Other Approved Services

a) Needs Not Payable Through Other Sources

This is payment for allowable medical, emotional and mental health needs not payable through insurance or public resources that are associated with a pre-existing condition documented on the CFS 1800–C–G, Guardianship Assistance Agreement, prior to the transfer of guardianship. Payment cannot be made until the Department has been notified in writing that such services will begin, has approved the requested services and a contract (when applicable) with the identified vendor is in place. The Department's reimbursement will be limited to what is usual, customary, and reasonable in the community as determined by the Department.

Current Services Not Payable through other sources:

The child is currently receiving the following services that will be continued upon the transfer of guardianship. Include only those services which are not paid for through other sources and that are allowable per Rule 302.410, Subsidized Guardianship Program (KinGap) (Add additional pages if necessary);

Service	Current Provider

☐ I request this assistance. ☐ I **do not** request this assistance.

Child's Name: _____

Guardian(s) Name: _____

Date: _____

b) Therapeutic Day Care

Therapeutic day care provides services to children who cannot be served in traditional childcare services or other childhood programs because of their inability to participate in such programs and because of the intensity of the services they require as a result of their physical, mental or emotional disabilities.

Payment will be made for therapeutic day care only for those children who are determined to have a disability, which requires special educational services through a current, Individual Education Plan (IEP), an Individual Family Services Plan (IFSP) or a 504 Educational Special Needs Plan, updated on at least an annual basis, when such day care is not payable through another source. In order for payment to be made, the worker must obtain a copy of the current IEP, IFSP, or 504 Educational Special Needs Plan.

i. Payment may be made for therapeutic day care that provides therapeutic intervention rather than only regular childcare services. The day care must include treatment of a disability or a disease as an integral part of the programming (i.e., speech, physical or occupational therapy, behavior modification, psychological or psychiatric services).

ii. Approval of payment for therapeutic day care requires documentation of the child's specific medical, mental or emotional disability as stated in the IEP, IFSP, or 504 plan and the special training, licensing or credentialing of the individual providing the therapeutic day care.

iii. Payment for therapeutic day care cannot be made until the Department has been notified that such services will begin, has approved the requested services, and a contract with the identified vendor is in place (when applicable).

iv. The Department's reimbursement will be limited to what is usual, customary, and reasonable in the community as determined by the Department.

☐ I request this assistance. ☐ I **do not** request this assistance.

c) Employment Related Day Care for Children Under Age 3

Guardian(s) receiving assistance for a child under three years of age are eligible for payment of day care services for that child, if day care is required due to one of the following. (Check the appropriate box below).

i. ☐ The guardian(s) employment or participation in a training program will lead to employment.

ii. ☐ A single guardian is employed or both guardians in a guardianship home are either working or in a training program.

iii. ☐ One guardian works and the other guardian is unable to care for the child due to a disability.

☐ I request this assistance. ☐ I **do not** request this assistance.

Child's Name: _____

Guardian(s) Name: _____

Date: _____

III. REFUSAL OF ASSISTANCE

The subsidized guardianship program has been explained to me/us, and I/we understand that benefits are available to the eligible child. However, I/we do not want to apply for any component of subsidized guardianship benefits or services as detailed in Section II of this document.

I/We understand that as a result of this refusal we will not be able to apply for or receive any of the benefits or services available under the Subsidized Guardianship program after the transfer of guardianship.

_____ _____
Guardian Date

_____ _____
Guardian Date

IV. ACKNOWLEDGEMENT

I/We, the undersigned, hereby apply for subsidized guardianship from the Illinois Department of Children and Family Services (DCFS).

1. I/We understand that health-related subsidized guardianship payments cannot be made if my/our health insurance coverage or community resources, including DPA Medicaid, can appropriately meet the child's health-related needs

2. I/We understand that the Department cannot pay for health insurance deductibles or make co-payments for medical services, nor supplement health related payments made by health insurance or DPA Medicaid.

   Information to be provided by guardian(s):

   ☐ Check box if child will be insured by the family's health insurance provider.

   Name of Company _____ Policy number _____

3. I/We understand that after the child's transfer of guardianship, I/we must apply for such financial benefits to which the child may be entitled (such as Supplementary Security Income or Veterans benefits).

   The child is presently eligible for:

Benefit	Amount	Verified by:	Date
☒ Social Security Benefits			
☐ Veterans Benefits			
☐ Other (specify): _____			
☐ MANG (Not IV-E eligible)			
☐ AFDC-FC (IV-E eligible) (98-211)			

   Any benefits the child currently receives may be affected through the Subsidized Guardianship program.

Child's Name: _____

Guardian(s) Name: _____

Date: _____

4. I/we are unable to assume guardianship for the child without assistance.

5. I/We understand that the following information is necessary for the Department to meet the reporting requirements of the Adoption and Foster Care Analysis and Reporting System (AFCARS) mandated by Section 479 and 1123A of the Social Security Act.

Guardian #1 Information

_____

Date of Birth _____/_____/_____

Check all that apply.

RACE:
- ☐ Black or African American
- ☐ White
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Undetermined

Hispanic Origin (Y/N): _____

MARITAL STATUS:
- ☐ Married
- ☐ Civil Union
- ☐ Single Mother
- ☐ Single Father

Guardian #2 Information

_____

Date of Birth _____/_____/_____

Check all that apply.

RACE:
- ☐ Black or African American
- ☐ White
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Undetermined

Hispanic Origin (Y/N): _____

6. I/We understand that I/We may appeal the determination of DCFS regarding this application in accordance with 89 Ill. Adm. Code Part 337, Service Appeal Process.

Guardian(s) may appeal the Department's decisions regarding payment for guardianship in accordance with 89 Ill. Adm. Code, Part 337, Service Appeal Process.

Decisions or actions made by the Department are appealed after the guardian(s) has received notice of the decision or action. Any written notices from the Department will provide specific information about the appeal rights of adoptive parents, guardians and foster parents.

To appeal a decision or action made by the Department, the guardian submits a written request for a service appeal to:

Administrative Hearings Unit
Department of Children and Family Services
406 E. Monroe, Station 15
Springfield, IL 62701
217-782-6655

Child's Name: _____

Guardian(s) Name: _____

Date: _____

7. I/We have read and understand the application.

_____ _____-_____-_____
Guardian SS#

_____ _____-_____-_____
Guardian SS#

_____
Date