

**WAIVER OF LICENSING STANDARDS FOR FOSTER FAMILY HOMES
PART 402**

SECTION BELOW TO BE COMPLETED BY LICENSING STAFF

Standard to be waived [# and letter(s)]:

Reason that the standard cannot be met:

Does the waiver require a clinical review? (Please see **Appendices B & C of Rule 402.**):

Name(s) of foster parent(s):

Mailing Address:

Foster Home Provider ID #:

Day Care Provider ID # (If applicable.):

License Capacity (Verify on LC-02.):

Region foster home is located in:

Licensing Agency:

Mailing Address:

Licensing Representative:

Phone #:

Date of last licensing monitoring visit: (Must be within 14 days.)

Visit completed by:

(*Please attach licensing home visit record.)

Has the foster parent(s) ever been placed on hold? If so, why?:

(Please attach previous hold request and the subsequent hold release, if applicable.)

What is the age and health of the foster parent(s)? (Attach the most recent **CFS 602 Medical Examination Form.**):

Does the foster parent work?

If so, number of hours per week and name of child(ren)'s caregiver during work hours:

Has the foster parent ever cared for this number of children?

If so, please give a brief explanation:

Give a detailed explanation as to why you feel the foster parent is exceptional enough to manage this situation:

SECTION BELOW TO BE COMPLETED BY CASE MANAGEMENT STAFF

LIST ALL CHILDREN 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? If so, list the child(ren)'s diagnosis/behavior(s) and what services is the child(ren) are receiving (diagnosis, counseling, medication, therapies, and so forth):

LEADS/SACWIS:

Please attach the current (within 14 days) LEADS/SACWIS for all adults and teenagers 13 and older residing in the foster home.

Are there any positive hits? Provide a written explanation for any positive hits:

SLEEPING ARRANGEMENTS:

List number of bedrooms for the children in the home:

List number of beds in each of the bedrooms:

List names of children matched with his or her bedroom:

SECTION BELOW TO BE COMPLETED BY CASE MANAGEMENT STAFF

FOSTER CHILD THIS REQUEST PERTAINS TO: (Attach One Copy for Each Child Seeking a Waiver.)

Name:

DOB:

DCFS ID#:

Traditional or Specialized:

Current Goal:

Potential placement date:

Mother's parental rights terminated? Yes No

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:

When completed, please Fax this form to the Director's Office at 312-814-9408

