

State of Illinois  
Department of Children and Family Services

**SUBSIDIZED GUARDIANSHIP  
AGREEMENT**

The following agreement has been entered into by and between the Department of Children and Family Services, hereinafter called "the Department," and \_\_\_\_\_

\_\_\_\_\_  
Name of Guardian(s)

\_\_\_\_\_  
Home Address

\_\_\_\_\_  
Mailing Address (if different than above)

hereinafter called the "guardian(s)" for the purpose of facilitating the transfer of guardianship of

\_\_\_\_\_  
Child's Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth

Child is IV-E Eligible  Yes  No

If yes, write eligibility number: \_\_\_\_\_

**I. LEGAL BASE**

Public Law 110-351 provides the authority for subsidized guardianship. Department Rules and Procedures 302.410, Subsidized Guardianship, govern the provision of subsidized guardianship by the Department.

**II. GENERAL PROVISIONS**

Following the transfer of guardianship:

1. This agreement may not be amended, suspended, or terminated except by mutual agreement in writing.
2. While payment may be increased based on changes in the needs of the child, payments will not be decreased based on changes in the needs of the child. All modifications/amendments to this agreement require documentation that the mental, emotional and/or physical condition or risk factors existed prior to the finalization of adoption.
3. This agreement shall remain in place regardless of the place of residence of the guardian(s) and the child. However, if the guardian(s), who now reside in Illinois, move to another state in the future, the child may not receive a Medicaid card in that state. Illinois will reimburse the guardian(s) at Illinois Medicaid reimbursement rates for eligible services. If the out-of-state medical provider participates in the Illinois Medicaid program, the provider will bill the Illinois Medicaid program for medical expenses.

Child's Name: \_\_\_\_\_

Guardian(s) Name: \_\_\_\_\_

Date: \_\_\_\_\_

4. This agreement cannot be transferred by the guardian(s) to any other party.
5. An ongoing monthly payment can be issued to only one custodial caretaker identified as payee in Section V b) of this agreement, and this person will be the designated authority for the purpose of service provision. In the event that there is a change in the custodial status of the child, the Department must be notified. If a change in payee is necessary, notification must be sent to the Department in writing with the supporting legal documentation attached.

### III. OBLIGATIONS OF THE GUARDIAN(S)

The following are obligations of the guardian(s). Failure to comply with these obligations may result in suspension or termination of the Medicaid Card and the subsidy.

1. The Department is required to conduct reviews to confirm that the guardian(s) remains legally and financially responsible for the child, in part, to re-certify the child's eligibility for Medicaid benefits. Written notice will be sent annually to the guardian(s) along with a form that must be completed and returned to the Department.
2. The guardian(s) agrees to notify their DCFS Post Adoption Subsidy worker no later than 30 days after the following occurrences:
  - a) When the child is no longer the legal responsibility of the guardian(s);
  - b) When the guardian(s) no longer financially supports the child;
  - c) When the child graduates from high school or equivalent;
  - d) When there is a change of residential address or mailing address of the guardian(s) or the child;
  - e) When the guardianship is vacated;
  - f) When the child becomes an emancipated minor;
  - g) When the child marries;
  - h) When the child enlists in the military;
  - i) When the mental or physical incapacity of the guardian(s) prevents the guardian(s) from discharging the responsibilities necessary to protect and care for the child;
  - j) When the custodial status of the child changes;
  - k) When the child dies.

### IV. OBLIGATIONS OF THE DEPARTMENT

The Department agrees to pay for services resulting from any pre-existing psychological, medical, emotional or physically handicapping condition at the rate that is customary and usual in the guardians' community, if not covered by the Medicaid card or other public resources.

This child may require services not currently being provided for pre-existing physical, emotional or mental health needs or risk factors. Such pre-existing conditions must be described in the CFS 1800-C-G to be eligible for assistance through the Adoption Assistance or Subsidized Guardianship Program at a future date. Assistance cannot be granted for services for pre-existing conditions if the condition(s) is not listed on the CFS 1800-C-G.







**Child's Name:** \_\_\_\_\_

**Guardian(s) Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

12) Physical abuse experiences of which the child was the victim, if known;

13) Sexual abuse incident(s) in which the child was the victim or the perpetrator, if known;

14) Neglect experiences in which the child was the victim, if known;

15) Educational issues: names of schools attended, dates of Individual Education Plans (IEP) and/or Individual Family Service Plans (IFSP) or 504 Educational Special Needs Plan (attach IEPs or IFSPs or 504 Educational Special Needs Plan if applicable);

**Child's Name:** \_\_\_\_\_

**Guardian(s) Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

16) Assessments and/or diagnoses of any learning disorders;

17) Special services provided in the school, now or in the past;

18) Separation and loss issues;

19) Other pre-existing health issues including mental health conditions of immediate family, including parents, siblings and grandparents. Do not include identifying information;

**Child's Name:** \_\_\_\_\_

**Guardian(s) Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

20) Additional non-identifying information regarding the child or immediate family. Do not include identifying information;

21) List all of the therapy, counseling or other services that the child is currently receiving including the name of the provider, service type and frequency of treatment.

22) List all of the documents that have been attached to this agreement including the name of the treatment or service provider, date of report or service, and the type of service.

Child's Name: \_\_\_\_\_

Guardian(s) Name: \_\_\_\_\_

Date: \_\_\_\_\_

**V. SERVICES PROVIDED UNDER THE AGREEMENT FOR ASSISTANCE**

The Department shall provide assistance for the approved services as listed below upon the transfer of guardianship. Services being provided to the child at the time of the agreement will continue with the same provider and are allowable when the services are described in section d) Needs Not Payable Through Other Sources (below).

**a) 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.

Specify expenses other than legal fees.

\$ \_\_\_\_\_  
\$ \_\_\_\_\_  
\$ \_\_\_\_\_  
\$ \_\_\_\_\_

*Nonrecurring Expenses are approved for payment through this agreement:*

Yes                       No

**b) Monthly Cash Payment**

The monthly cash payment shall not exceed the amount the child receives in the current licensed foster family home.

Direct monthly payments to \_\_\_\_\_ at the rate of  
Name of Payee

\$ \_\_\_\_\_ per month.

*The Department has approved monthly cash payments as a part of this agreement:*

Yes                       No

**c) Medicaid Card**

In no event can the Department make supplemental payments, pay for deductibles or make co-payments for medical services.

- 1) When the child and family live in Illinois, medical benefits are provided under Title XIX of the Social Security Act (Medicaid). Medicaid pays for eligible services not covered by medical insurance (if the child has been added to a medical insurance policy). If there is not a service provider who participates in the Illinois Medicaid program within 25 miles of the child's home, a non-participating provider may be used. Guardian(s) will be reimbursed for eligible services.
- 2) When a family moves out of state and the new state will not provide Medicaid coverage, Illinois will reimburse the family at Illinois Medicaid reimbursement rates for eligible services.
- 3) In the event the family lives in another state and a medical provider participates in the Illinois Medicaid program, the provider will bill the Illinois Medicaid program for medical expenses.

*A Medicaid Card is a part of this agreement:*

Yes                       No

Child's Name: \_\_\_\_\_

Guardian(s) Name: \_\_\_\_\_

Date: \_\_\_\_\_

**d) Needs Not Payable Through Other Sources**

- 1) Payment for physical, emotional and mental health services cannot be made until the Department has been notified that such services will begin, the Department has approved the requested services, and a contract (when applicable) with the identified vendor is in place.
- 2) The Department will pay the service provider directly or reimburse the family for Medicaid ineligible services relating to a pre-existing condition, which must be approved by the Department prior to providing services and at a rate negotiated regardless of the state in which the child lives.
- 3) The Department will make direct payments to providers not enrolled in Medicaid. Prior approval from the Department is required.
- 4) The Department will also make direct payments to the provider or reimburse the family when services from a Medicaid enrolled provider are not available within a twenty-five mile radius of the family's home.
- 5) Current Services:  
The child is currently receiving the following services that will be continued following the finalization of the transfer of guardianship: (Add additional pages if necessary)

*The Department has approved payment or reimbursement for the above services that are not payable through other sources for physical, mental or emotional problems or disorders as a part of this agreement:*

Yes                       No

- 6) Future Services:  
Specify each medical and/or clinical service that the child may need in the future and that is being requested as part of this agreement. List all reports, records and correspondence that are attached to the subsidy agreement including documentation from a licensed medical professional or qualified mental health practitioner of the child's diagnosis and related future service needs.

*The Department has approved payment or reimbursement for the above services which may be needed in the future if found at the time of need to not be payable through other sources:*

Yes                       No\*

**\*Checking the "No" box at the time of completion of this form does not preclude the guardians from requesting services following the finalization of the transfer of guardianship through the amendment process as described in Procedures 302.410.**

Child's Name: \_\_\_\_\_

Guardian(s) Name: \_\_\_\_\_

Date: \_\_\_\_\_

**e) Therapeutic Day Care**

Therapeutic day care provides services to children who cannot be served in traditional childcare settings or other childhood programs because of their inability to participate in such programs and because of the intensity of 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 that 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. Local school districts are responsible for developing the Individual Education Plan or Individual Family Services Plan for students requiring special education services.

- 1) Payment may be made for specialized 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).
- 2) Approval of payment for therapeutic day care requires documentation of the child's specific physical, mental or emotional disability and the special training, licensing or credentialing of the individual providing the therapeutic day care.
- 3) Payment for therapeutic day care cannot be made until the Department has been notified that such services will begin, has approved the requested service, and a contract with the identified vendor is in place (when applicable).
- 4) The Department's reimbursement will be limited to what is usual, customary, and reasonable in the community as determined by the Department.

***The Department has approved payment or reimbursement for therapeutic day care as a part of this agreement:***

Yes

No

**f) Employment Related Day Care**

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).

- The guardian(s) is employed or participating in a training program that will lead to employment.
- A single guardian is employed or in a training program that will lead to employment or both guardians in a guardianship home are working or in a training program that will lead to employment.
- One guardian works and the other guardian is unable to care for the child due to a disability.

***The Department has approved payment or reimbursement for employment-related day care as a part of this agreement:***

Yes

No

Child's Name: \_\_\_\_\_

Guardian(s) Name: \_\_\_\_\_

Date: \_\_\_\_\_

## VI. SOCIAL SERVICES

Social services, as provided under Title XX of the Social Security Act shall be available in accordance with the procedures of the state of residence. Illinois residents may apply at the local Department of Human Services office.

## VII. REVIEW / RECERTIFICATION

1. The Department will conduct reviews to determine whether the guardian(s) remains legally and financially responsible for the child. This review is a necessary step in re-certifying the child's eligibility for Medicaid benefits.
2. Written notice will be sent annually to the guardian(s) along with a form that must be completed and returned to the Department. Failure of the guardian(s) to participate in the review process may result in payment termination of the Medicaid Card and the subsidy.

## VIII. TERMINATION

The Subsidized Guardianship Agreement shall terminate when the Department has determined that one of the following has occurred:

1. When the terms of the subsidized guardianship agreement are fulfilled.
2. The guardian(s) has requested that the payment permanently stop.
3. The guardian(s) is no longer legally or financially responsible for the child.
4. The child becomes an emancipated minor.
5. The child marries.
6. The child enlists in the military.
7. A) The child reaches age 18 and is not in high school or equivalent; or  
B) The child 18 years of age graduates from high school or equivalent or reaches age 19, whichever occurs first; or  
C) The child with a physical, mental or emotional disability which affects his/her major life activities, which existed prior to the guardianship transfer and which was documented in the assistance agreement, reaches age 21; or  
D) The child reaches age 21 who prior to the guardianship transfer, was determined to be at risk of developing a physical, mental or emotional disability due to environmental, genetic or hereditary factors, which subsequently manifested itself. The disability affects his/her major life activities, and it is documented that it was developed prior to age 18.
8. The guardian(s) die.
9. The guardian(s) rights are terminated.
10. The child dies.

Child's Name: \_\_\_\_\_

Guardian(s) Name: \_\_\_\_\_

Date: \_\_\_\_\_

## IX. APPEAL

Guardian(s) may appeal the Department's decision to change or terminate assistance in accordance with 89 Ill. Adm. Code, Part 337, Service Appeal Process. Decisions that may be appealed include payments for services for the child for whom you are guardian or denial of a request for increased assistance to provide the child with additional services.

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, a written request for a service appeal is submitted to:

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

## X. AMENDMENTS

Upon notification by the guardian(s) of a change in the guardian(s) circumstances or the child's needs as set forth in Section IV, Obligations of the Department, amendments to the Agreement may be made at times other than at the review.

Following the guardianship transfer, the agreement may be amended, suspended or terminated with the mutual agreement of the guardian(s). Amendments to the agreement must be completed on a CFS 1800-F, Amendment to Agreement for Assistance, and can only be completed by Subsidy Unit staff. An amendment to increase the ongoing monthly payment may be made only when authorized by the Post Adoption/Guardianship Services Review Committee (PAGSRC).

If it becomes necessary to change a subsidy that has been signed by all parties prior to finalization, a new agreement must be completed, approved and signed.

Child's Name: \_\_\_\_\_

Guardian(s) Name: \_\_\_\_\_

Date: \_\_\_\_\_

**XI. EFFECTIVE DATE**

This agreement is effective as of the date the transfer of guardianship of this child.

The guardian(s) acknowledges receipt of a copy of this agreement at the time of signing this agreement.

**SIGNATURES:**

\_\_\_\_\_

Guardian

\_\_\_\_\_

Date

\_\_\_\_\_

Guardian

\_\_\_\_\_

Date

**The information contained in this application is complete to the best of my knowledge.**

\_\_\_\_\_

Signature of DCFS Adoption Supervisor/Coordinator

\_\_\_\_\_

Date

\_\_\_\_\_

Print Name of DCFS Adoption Supervisor/Coordinator

**The information contained in this application is complete to the best of my knowledge.**

\_\_\_\_\_

Signature of DCFS or POS Supervisor

\_\_\_\_\_

Name of DCFS or POS Supervisor

**DCFS Office:**

\_\_\_\_\_

Name

\_\_\_\_\_

Street Address

\_\_\_\_\_

City

State

ZIP Code

**Worker Preparing the Form:**

\_\_\_\_\_

Name

Date

\_\_\_\_\_

Agency

\_\_\_\_\_

Worker's Supervisor