CFS 152A
3/2004

State of Illinois
Department of Children and Family Services

Children's Account Unit Assessment Form

Ward's Name: Case Note Entry Date: February 14, 2026. A DCFS ID Number: _____

Current Placement Name: Sunshine Group Home

Address: 442 Maplewood Drive

City, State, and Zip: Springfield, IL 62704

Permanency goal : ☐ SGH ☑ Adoption ☐ Return Home ☐ Independence

Is DCFS guardianship expected to end within 30 days? ☐ Yes ☑ No

Does the child have any special needs, currently or in the foreseeable future, that you believe could be met with allowable expenditures from the child's account? ☑ Yes ☐ No

IF YES, please provide a detailed explanation of the child's disability and cause for requesting use of these funds (attach additional pages if necessary).

Marcus has severe sensory processing sensitivities which impede his ability to focus in traditional classroom settings. Funds are requested to purchase a specialized high-fidelity noise-canceling auditory stimulation kit and a weighted sensory lap pad to aid in his emotional regulation.

Do you recommend allocation of the funds from the child's account to provide services or purchase items to meet these special needs? ☑ Yes ☐ No

IF YES, please complete and attach **Disbursement Request Form** and **Disability Related Services Report**.

_____	_____	(217) 555-0198
Case worker	Date	Telephone
_____	_____	
Supervisor	Date	

RETURN ALL FORMS TO:

Illinois Department of Children and Family Services
406 East Monroe Street, Mail Station 410
Springfield, IL 62701
or
FAX : 217-782-3882