CFS 119-W
10/2001

STATE OF ILLINOIS
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

UIR WAIVER REQUEST

Sections I, II, and III of this form must be completed. Attach Mental Health Assessment reports, medical reports, Individual Treatment Plans, ITP Reviews, progress reports, psychological reports, and other reports to be considered.

I. CHILD INFORMATION

Name _____ **ID** _____ **DOB**____/____/____ **Region**_____

Worker _____

Phone _____ **FAX number** _____

Supervisor _____

Phone _____ **FAX number** _____

II. PROVIDER INFORMATION

Name of POS Provider requesting the waiver: _____

Address _____

City, State, Zip _____

Phone _____ **FAX number** _____

Name of staff member requesting this waiver _____

Title _____

Signature _____ **Date**____/____/_____

III. CLINICAL REVIEW INFORMATION

Diagnosis (Axis I – V, if available):

I. _____ III. _____

_____ _____

_____ IV. _____

II. _____ _____

_____ V. _____

_____

UIR WAIVER REQUEST

List the code(s) and type of UIR(s) for which a waiver is requested (e.g. (J01) Ward on runaway/Missing). A single UIR Waiver Requests may be submitted for more than one type of incident.

_____ _____ _____

Is this an extension request? _____

Describe the behavior*(s)* exhibited by this child or the events for which a waiver is requested.

_____

_____

_____

_____

Attach the following documents and reports that are applicable to the UIR Waiver Request:

- Medical Evaluation(s) and Reports
- Psychological Evaluation and Reports
- Mental Health Assessment
- Most recent treatment / progress reports
- PRT / LOC Reports
- Individual Treatment Plan
- ITP reviews summaries for the most recent two reviews, when available

UIR WAIVER REQUEST

To be completed by the DCFS Division of Clinical Services

Division of Clinical Services
UIR Waiver Request Determination

Child's name _____ ***ID*** _____

POS Provider requesting UIR waiver _____

Date received _____ ***Date of review*** _____

DCFS staff member completing review _____

Determination:

I. Additional information requested on (date): _____

II. Determination deferred because _____

_____

III. Approved until (review or expiration date): _____

IV. Not Approved: _____

Reason(s) waiver request could not be approved: _____

_____

V. Date POS Provider notified of Determination: _____

Signature _____ ***Date:*** _____