

State of Illinois
Department of Children and Family Services

AFFIDAVIT OF INFORMATION DISCLOSURE FOR ADOPTION/GUARDIANSHIP

Caseworker's Name _____

Child's Name _____ Birth date ____/____/____

Termination Date _____ Termination Type Voluntary Court Ordered
 Combination N/A

Placement Date _____

Foster Home Conversion Yes No

Adoptive Parent/Guardian(s) _____

The following reflects all known non-identifying information available to the Department as of this date:

	YES	NO	N/A	INFO UNKNOWN
1. I have provided the family with all available non-identifying information on the child's birth parents as required by law and AP-5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I have informed the family of the child's relationship with his/her birth family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I have informed the family of any known alcohol/drug addiction the child's birth parents may have had (if the Department has that information).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I have provided the reasons and the date the child came into foster care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I have provided information as to the reason the child was unable to return to his/her family of origin.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I have provided the number of placements the child has experienced since he/she has been in the care of the Department.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I have provided information (as reflected in the Department's case record) regarding the child's:				
Health History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Placements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I have given information as to the existence of any other children born to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Birthdates of the children

Sex of the children

- | | YES | NO | N/A | INFO UNKNOWN |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 9. I have provided information pertaining to any: | | | | |
| (a) physical abuse experiences of which the child was the victim (if the Department has that information) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) sexual abuse experiences of which the child was the victim (if the Department has that information) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) neglect experiences of which the child was the victim (if the Department has that information) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. I have given information of any known incident(s) of physical or sexual abuse perpetrated by the child. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. I have informed the family of any known incident(s) or trauma(s) suffered by the child while in the care of the Department. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. I have explained that the child being placed may have undiagnosed mental, physical, or emotional problems. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. I have provided available pictures of the child from his/her case record. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. In addition to the above, the following non-identifying information has been disclosed to the family regarding the child: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. I have informed the family of available services for which the child may be eligible following the adoption/guardianship finalization: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

I understand that this Affidavit of Disclosure will be placed in the child's case record and will be accessible to the Department or family (upon request) at any time after the child's adoption/guardianship is finalized.

Name of Caseworker Completing Form: _____
 DCFS Private Agency

 Department Caseworker Date

 Private Agency Caseworker Date

 Department Supervisor Date

 Private Agency Supervisor Date

 Adoptive Parent/Guardian Date

 Adoptive Parent/Guardian Date

Copy of Affidavit was sent to parent on _____
 Date