Illinois Department of Human Services - Division of Developmental Disabilities
Application for Waiver of CANTS Indication to Allow Employment in a Community Development Disabilities Services Agency

Directions: This form is for use only by persons desiring a waiver of findings from a DCFS investigation that would otherwise prohibit employment in a Division of Developmental Disabilities funded setting or program. Completion of this form is a shared responsibility of the person for whom a CANTS background check indicates active finding(s) and the employer who is seeking to employ that individual. Submit this completed form along with supporting documentation to:

Illinois Department of Human Services Division of Developmental Disabilities
Quality Review Section
CANTS Waiver Request
600 East Ash, Building 400, Mail Stop 2 North
Springfield, IL 62703
email: DHS.CANTSDDWaiver@illinois.gov
Fax: (217) 782-9444

Part 1 – To Be Completed by Employee Seeking a Waiver

_____ _____
Printed Full Name of Applicant Date of Birth

_____ _____
Other names used in the past by this person, including alias and maiden names Last Four Digits of Social Security Number

_____
Current Address including City/State/Zip

_____
For home-based services only, what is your relationship (if any) to the person receiving services?

In the space below, please describe the events that led to this investigation and finding by DCFS. If you have been subject of multiple investigations by DCFS, include information about each. If more room is needed, attach additional pages.

In the space below, please describe actions taken by you following the investigation to address concerns noted by DCFS and help to prevent similar issues in the furture. If more room is needed, attach additional pages.

I confirm that the information provided above is accurate _____ _____
Signature of applicant Date

Part 2 – To be Completed by the Employer

_____ _____
Name of Person Completing Form Job Title

_____ _____
Business Name FEIN

_____
Mailing address including city/state/zip

_____ _____ _____
Phone Number Fax Number Email Address

_____ _____
Targeted Job Title for Applicant Program(s) in which applicant will work if a waiver is granted (ICF/DD, Home-based, CILA, DT, SEP, etc)

Has this applicant been employed by you in the past? ____ No ____ Yes (_____)
If yes, dates of employment

Use the space below for comments about the employee's work history with your organization and/or rationale for seeking a waiver of CANTS findings. If more room is needed, attach additional pages.

Following completion of any requested training period, what portion of the employee's work time will be under direct supervision?

_____%

Do you anticipate an increased need for training and/or supervision for this employee given the information you have regarding the events that led to an investigative finding? ____No ____Yes (If yes, describe how you intend to provide that increased training/supervision:_____

_____

_____

Attach copies of each of the following documents:
___ Results of CANTS Background Check
___ Copy of Health Care Worker Registry Clearance showing no administrative or criminal findings that would exclude the applicant from employment (Print out must have SSN verification. For purposes of confidentiality, redact all but the last 4 digits.)

I have reviewed the information on this form and in the attached documentation and request a waiver of the CANTS findings to allow employment of this applicant. I understand that a waiver, if granted, is valid only for the job title and program(s) listed on Section 2 of this application.

Signature of Executive Director_____ Date _____