State of Illinois
Illinois Department of Public Health

ASSISTED LIVING AND SHARED HOUSING
APPEAL HEARING REQUEST FORM

Name of Resident Requesting Appeal Hearing_____

_____
Address City/ZIP Code Telephone Number

Name of Establishment _____

_____
Address City/ZIP Code Telephone Number

I request a hearing to be conducted by the Illinois Department of Public Health, to contest the notice of residency termination or discharge received by

_____ on _____ 20 _____.

Signature of Person Requesting a Hearing _____

Relationship to Resident (if applicable)_____ Date_____

INSTRUCTIONS: If you wish to contest the proposed residency termination or discharge, please complete this form. Use the postage-paid, pre-addressed envelope provided to you to mail this form and the **Residency Involuntary Termination form** to:

Illinois Department of Public Health
Division of Assisted Living,
525 West Jefferson Street, Fifth Floor
Springfield, Illinois 62761

or fax: 217-557-2432

These forms must be mailed to us within 10 DAYS after receiving the Residency Involuntary Termination form from the establishment.