



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 and mail it, in the postage paid pre-addressed envelope provided to you, with the **Residency Involuntary Termination form** to:

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

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