



ASSISTED LIVING AND SHARED HOUSING RESIDENCY INVOLUNTARY TERMINATION FORM

Name of Resident _____ Date of Notice _____

Name of Establishment _____

Address _____ City/ZIP Code _____ Telephone Number _____

Reason for Residency Termination _____

Proposed Date of Termination _____

The above resident has the right to appeal residency termination and a 30-day prior written notice must be provided to the resident, resident’s representative, or both, and to the long-term care ombudsman.

THE RESIDENT MAY INITIATE AN APPEAL BY:

- a) calling the Division of Assisted Living at 217-782-2448

OR

- b) requesting an Appeal Hearing Request form from the establishment

The resident has the right to continue to reside in the establishment until a decision is rendered. The person at the establishment who will assist with relocation is:

Name of Person _____

Address _____ City/ZIP Code _____ Telephone Number _____