State of Illinois
Illinois Department of Public Health

ASSISTED LIVING AND SHARED HOUSING
INVOLUNTARY TERMINATION of RESIDENCY FORM

Name of Resident _____ Date of Notice _____

Name of Establishment _____

_____
Address City/ZIP Code

_____
Contact Name Telephone Email

Reason for Residency Termination _____

_____

_____

Proposed Date of Termination _____

The above resident has the right to appeal residency termination. 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 establishment must notify the Illinois Department of Public Health when it initiates the termination process. All forms given to the resident can be faxed to the Illinois Department of Public Health (IDPH) at 217-557-2432.

THE RESIDENT MAY INITIATE AN APPEAL BY:

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

OR

b) sending the signed Appeal Hearing Request form to IDPH ***(see Appeal Hearing Request form)***

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

State of Illinois
Illinois Department of Public Health

ASSISTED LIVING AND SHARED HOUSING
FACILITY REPRESENTATIVE DISCLOSURE

Pursuant to Section 100.4 (a) of the Department of Public Health's Rules of Practice and Procedure in Administrative Hearings:

> "A corporation, a limited liability company, partnership, association or certified local health department shall appear and be represented only by an attorney authorized to practice law in the State of Illinois. A shareholder, corporate officer, employee, or member of the board of directors may not appear or represent a corporation or association unless that individual is authorized to practice law in the State of Illinois."

The facility is required to be represented by counsel. Please identify the attorney who will represent the facility at all hearings:

Name of Facility to be represented: _____

Representative name: _____

Firm name: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Fax: _____

Email: _____
(used for hearings with Administrative Law Judges)

Please forward the completed forms to IDPH by one of the following methods.

US mail:
Illinois Department of Public Health
Division of Assisted Living
525 West Jefferson Street, 5th Floor
Springfield, IL 62761

Fax:
217-557-2432

Email:

DPH.LTCQA.POCHearing@illinois.gov

State of Illinois
Illinois Department of Public Health

ASSISTED LIVING AND SHARED HOUSING HEARING REQUEST FORM

Name of Resident Requesting Appeal Hearing_____

_____
Address City/ZIP Code

_____
Telephone Number

Name of Facility _____

_____
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 _____
(Resident or Resident's Representative)

Relationship to Resident (if applicable)_____Date_____

Resident or Resident's Representative Printed Name _____

_____
Address City/ZIP Code

_____
Telephone Number Email

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 **Involuntary Termination of Residency form** to:

Illinois Department of Public Health
Division of Assisted Living,
525 West Jefferson Street, 5th Floor
Springfield, Illinois 62761

or fax: 217-557-2432

Please submit completed forms within 10 DAYS after receiving the Involuntary Termination of Residency form from the facility.