Illinois Department of
Healthcare and Family Services

Long Term Care

Bed Reserve/Temporary Absence Form

Document Control Number

Facility Name

Facility Number

Facility Address

Facility City

State

Zip

Facility Reference Number

Recipient Name

First

Last

Recipient Number

Bed Reserve Information

Type	Begin Date	End Date	Type	Begin Date	End Date

I certify that all entries on this form are true, accurate, complete and meet all the rquirements of the Illinois Department of Healthcare and Family Services.

Signature of Certifying or Operating Officer of Authorized Agent

Date