State of Illinois
Department of Healthcare and Family Services

SUPPORTIVE LIVING PROGRAM
NOTICE OF APPEAL

Use this form to file an appeal ONLY if you think someone has made an incorrect decision about your case or has failed to process your case correctly for Supportive Living Services. If you decide to appeal, you must file the appeal in writing.

1. Appellant Name (Resident): _____

Telephone Number with Area Code: _____

Address: _____

City: _____

Date of Birth: _____

2. Appellant's Representative: _____

Telephone Number with Area Code: _____

Address: _____

City: _____

Relationship: _____

3. I am appealing a decision or action regarding my case. The reason for this appeal is:

_____

_____

4. The date of the NOTICE regarding the action or decision being appealed:

_____ _____ _____
Month Day Year

NOTE: Department staff will help you fill out this form, please contact the Bureau of Long Term Care at 217/782-0545 for assistance. Upon completion, file this notice with the Illinois Department of Healthcare and Family Services, Bureau of Long Term Care 201 South Grand Avenue East, Springfield, Illinois 62763. You are entitled by law to a final decision on your appeal within 90 days from the time you requested the appeal, unless you have requested a delay.

FOR AGENCY OFFICE USE:TO BE COMPLETED BY THE BUREAU OF LONG TERM CARE

Date this Notice of Appeal was received _____

Date of postmark, if mailed _____ **(attach envelope)**

Date of Decision being appealed _____

Case Name _____

Case Identification Number _____

Recipient Identification Number _____

Print Form