State of Illinois
Illinois Department of Public Health

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. 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 at 217-557-2432.

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