Illinois Department of Human Services

NOTICE OF DHS COMMUNITY - BASED SERVICES

TO: **FROM:** _____

RE: NAME _____

ADDRESS _____

_____

☐ **"INITIAL NOTICE"** ☐ **CHANGE OF INFORMATION (CHECK ONLY ONE BOX)**

EFFECTIVE DATE/ANTICIPATED EFFECTIVE DATE OF SERVICE: _____

TERMINATION DATE OF SERVICE: _____

SERVICE (CHECK ONLY ONE BOX) ESTIMATED MONTHLY COST

PROVIDED THROUGH THE DHS - OFFICE OF DEVELOPMENT DISABILITIES

☐ **COMMUNITY -INTEGRATED LIVING ARRANGEMENT (CILA) SERVICES** $ _____

☐ **COMMUNITY HABILITATION SERVICES (NON-RESIDENTIAL)** $ _____

☐ **IN-HOME/REMEDIAL CARE SERVICES (RESIDENTIAL)**

_REMEDIAL CARE SERVICES (NON-WAIVER) $ _____

_IN-HOME CARE SERVICES (WAIVER) $ _____

PROVIDED THROUGH THE DHS - OFFICE OF MENTAL HEALTH

☐ **COMMUNITY MENTAL HEALTH SERVICES**

_ASSERTIVE COMMUNITY TREATMENT $ _____

_COMMUNITY RESIDENTIAL SERVICES $ _____

_CASE MANAGEMENT $ _____

_CILA SERVICES $ _____

COSTS FOR ROOM AND BOARD ARE NOT INCLUDED IN THE "ESTIMATED MONTHLY COST"

REMARKS:

THE PROVIDER WILL NOTIFY THE DHS LOCAL OFFICE OF ANY CHANGES IN SERVICES AND/OR MONTHLY COSTS.

SIGNATURE _____ TITLE _____ TELEPHONE NUMBER _____ DATE _____

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