State of Illinois
Department of Healthcare and Family Services

SUPPORTIVE LIVING PROGRAM
NOTICE OF INVOLUNTARY DISCHARGE

Resident Name: _____

Resident Identification Number: _____

Date of Birth: _____

Due to the following reason(s), you will be discharged from

_____ on _____
Name of Facility Date

REASON:

_____

_____

_____

_____

_____

You have a right to appeal the supportive living facility's (SLF) decision to discharge you. You may file a request for a hearing with the Department within ten days after receiving this notice. If you request a hearing, you will not be discharged during that time unless you are unsafe to yourself or others and the SLF has given you a notice for an emergency discharge. If the SLF has not given you a notice for an emergency discharge, and if the decision following the hearing is not in your favor, you will not be discharged prior to the tenth day after receipt of the Department's hearing decision unless you are unsafe to yourself or others. If the SLF provided you with a notice of emergency discharge, and the decision following the hearing is in your favor, you will be entitled to readmission to the SLF upon the first available apartment. A form to appeal the SLF's decision and to request a hearing is attached. If you have any questions, call the Department of Healthcare and Family Services at 217/782-0545.

Name, Address and Telephone Number of Person Charged With the Responsibility of Supervising the Discharge: _____

_____

_____

_____ _____
(SIGNATURE OF SLF MANAGER) (DATE)

Print Form