CFS 151
Rev. 3/00

State of Illinois
Department of Children and Family Services

NOTICE OF DECISION

Date of Notice ____________________

Client Name and Address

Dear ____________________________ :

This is to advise you that the following decision(s) has/have been made in regard to your involvement with the Department of Children and Family Services:

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(Attach additional sheets, if necessary)

This/these decision(s) will become effective ___________________________ .

This/these decision(s) were made for the following reason(s): ______________________________

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(Attach additional sheets, if necessary)

Department policy in support of this/these decision(s) is found in ____________________________________.
(Rule/Procedure Citation)

You have the right to appeal this/these decision(s). The appeal process consists of 1) an optional mediation where both you and Department staff discuss your differences with a neutral third party, and 2) a fair hearing. If you choose not to mediate, or if you choose mediation and it is not successful, you may request to have a fair hearing scheduled.

Should you choose to appeal, your request must be in writing and must be mailed within 45 days of the date you receive this notice to:

Administrative Hearings Unit,
Department of Children and Family Services
406 E. Monroe Street
Springfield, IL 62701

You may wish to submit a brief, written summary of your position. This summary may include additional information for consideration as to why the Department or its provider agency should change its decision.

If this/these decision(s) affect services you are currently receiving and you appeal within 10 days of the date you receive this notice, the Department will not take action while your appeal is pending, unless the Department determines that your child/foster child is in serious risk of harm, if services remain unchanged.*

You have the right to bring an attorney or other representative at your own expense and to request that witnesses or other individuals having knowledge of the issues in dispute be present to testify.

If you do not understand this notice, talk to your DCFS or provider agency worker.

Your worker's telephone number is ______________________________________ .

If you are hearing impaired and have a TDD, call __________________________ . If you need help in putting your appeal in writing, the Department will assist you. Call your worker at the above regular or TDD number.

* You may request an emergency review within ten days of the date you appeal, if the Department has taken action without timely notice because a child was determined to be at serious risk of harm. An emergency review may also be requested, if allowing visitation or placement to remain un-changed during the appeal process would be harmful to a child. Requests for an emergency review shall be directed in writing to the same office and address that you sent your request for an appeal

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Worker's Signature