CFS 151- E
Rev. 11/2011

State of Illinois
Department of Children and Family Services

Final Clinical Decision on Change of Placement or Removal
With Appeal Rights

Date of Notice: ____/____/_____

Name **Address:**

Dear _____:

A Clinical Placement Review was convened on ____/____/____ regarding the children listed below: (date)

Child (ren)'s name: _____ _____
_____ _____
_____ _____

The **final** Clinical Placement Review Decision was made on ____/____/____

It was determined that it was in the best interests of the child (ren) to:

If you disagree with the final Clinical Placement Review Decision, you may request a Fair Hearing **within 10 days** of the decision date. This request must be **in writing** and should **include a copy of the CFS 151-C, Placement Review Summary** as verification that the Clinical Review Process has been completed.

Send your request for a Fair Hearing to

DCFS Administrative Hearings Unit
Department of Children and Family Services
406 East Monroe, Station # 15
Springfield, Illinois 62701

During the appeal, the child (ren) shall be placed in accordance with the decision of the Clinical Placement Review.