

### Notice of Change of Placement

Date of Notice: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

<b>Name</b>  <b>Address:</b>
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Dear \_\_\_\_\_:

This is to advise you that a notice has been issued to change the placement of the child(ren) listed below on the following date:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(date)

Child (ren)'s name: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This decision was made for the following reason(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you disagree with the decision, you may request a Clinical Placement Review. At the review you may express your opinions regarding the decision.

You may request a Clinical Placement Review by calling the Clinical Review Team immediately at 866-225-1431.

If you are hearing impaired and have a TDD, call 312-814-4117.

You may also fax your request for a review to the DCFS Clinical Placement Review Team within 3 days of this notice by checking the box below and signing your name and faxing this form to 800-733-3308.

\_\_\_\_\_  
(Worker's Signature) (Date)

\_\_\_\_\_  
(Supervisor's Signature) (Date)

I wish to request a Clinical Placement Review of the above decision to change the placement of

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Signature) (Date)