Your address
Date

Bureau of Administrative Hearings
Illinois Department of Human Services
401 S. Clinton 6th floor
Chicago, IL 60007

Re: (name) DOB _____ RIN: _____ (Medicaid Recipient ID Number)

Dear Sir/Madam:

On ____ (date) _____, I received the attached letter from (name of provider agency) stating that on ___ (date) _____, they will seek authorization to discontinue their _____program.
Their decision creates an immediate and acute crisis for my child/ward, ____ (name) ____, and me.

My (age) year old child, __ (name) ___, has _ (state diagnosis here) _____.
Include more information about your child here

Under _(name)_'s_____ 1915(c) Home and Community Based Services Medicaid waiver, ___ is entitled to ____hours per week of individualized services .
The services which s/he receives from __ (provider agency name) _____allow __ (name) ___ to live at home with me, where s/he has some good friends and is actively involved in religious, educational and community activities.

As a single parent who must work full-time, these services and supports for (name) enable me to maintain my employment and provide a stable home for my child (example of impact- customize to fit your situation).

This letter is my appeal of (provider agency's name) decision to close their _____ program and terminate services to my child/ward...

Please contact me at (phone number) if you have any questions or require any additional information.

Sincerely,

Parent/
Court-appointed guardian for __ (name) _____

Cc: Director, Service Provider Agency
Case Manager, Independent Service Coordination Agency
Lilia Teninty, DHS, Division of Developmental Disabilities
State Senator: _____
State Representative: _____
Tony Paulauski, The Arc of Illinois