

REQUEST FOR INVESTIGATION OF STATE COMPLAINT

Send copy of completed form to both addresses shown below:

1) Chief
Bureau of Early Intervention
Illinois Dept. of Human Services
222 South College, 2nd Floor
Springfield, IL 62704

2) Enter name and address of child's CFC:
Child and Family Connections # _____

I am hereby filing a complaint because I believe that the provider(s) below violated provisions of the Early Intervention Program. I would like for the Department of Human Services to investigate this situation and impose corrective action.

Section 1: Information about the Child and Family

Child's Last Name, First Name & Middle Initial _____
Child's Birthdate (Month/Day/Year) _____ Phone Number _____
Parent/Guardian/Surrogate's Name(s) _____
Address _____
City, State & Zip _____ Primary Language _____

Section 2: Information about the Person Filing a State Complaint

Name _____
Address _____
City, State & Zip _____ Phone Number _____

Section 3: Service Delivery Agency(ies) and/or Provider(s) who violated provisions of the Early Intervention Program

Name 1 _____
Address _____
City, State & Zip _____ Phone Number _____
Name 2 _____
Address _____
City, State & Zip _____ Phone Number _____

Attach Section 3 additional pages, if needed.

Section 4: The nature of the violation, including specific facts (Section 4 - continued on next page):

**Section 4: CONTINUED - The nature of the violation, including specific facts
(Attach additional Section 4 pages if needed):**

Section 5: Remedy being sought or proposed resolution (attach additional pages if needed):

Attach material supporting the request and proposed remedy.

I understand that by requesting complaint investigation I am hereby authorizing the release of information as necessary to investigate the issue(s). I also understand that Department of Human Services Bureau of Early Intervention staff will investigate my complaint and make a determination as to corrective action which may be necessary, and will let me know the outcome.

Signature _____ Date _____
Name (Printed) _____
Address _____
City, State & Zip _____ Phone Number _____

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Family Educational Rights and Privacy Act, 20 USC 1232g, and the Health Insurance Portability and Accountability Act of 1996, information collected hereunder may not be redisclosed unless the person who consented to this disclosure specifically consents to such redisclosure or the redisclosure is allowed by law.