CFS 151- B
Rev. 10/2006

State of Illinois
Department of Children and Family Services

Notice of Change of Placement

Date of Notice: ____/____/_____

Name

Address:

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)**

Copies to: Guardian ad litem
Parent (unless parental rights have been terminated)