

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.