REQUEST FOR INVESTIGATION OF STATE COMPLAINT

Send copy of completed form to both addresses shown below:	
1) Chief Illinois Dept. of Human Services Bureau of Early Intervention 823 East Monroe Springfield, IL 62701	2) Enter the Child & Family Connections (CFC) Information for the child below: CFC #: ________ CFC Name ________ CFC Address ________ CFC City, State, Zip Code ________

I am hereby filing a complaint because I believe that the provider(s) below violated provisions of the Part C of the Individuals with Disabilities Act (IDEA). I would like for the Illinois Department of Human Services to investigate this situation and impose corrective action. **A copy has been submitted to the agency or provider listed in Section 3**.

Section 1: Information about the Child and Family

Child's Last Name, First Name & Middle Initial ________

Child's Date of Birth (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, (Attach additional pages as needed)

Name 1 ________

Address ________

City, State & Zip ________ Phone Number ________

Name 2 ________

Address ________

City, State & Zip ________ Phone Number ________

Section 4: The nature of the violation, including specific facts (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 supporting materials, 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. **I verify I have sent a copy of this complaint to the agency or provider listed in Section 3.**

Signature ______________________________ Date ______________

Printed Name ______________________________

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.