State of Illinois
Department of Human Services

CHILD CARE CENTER - APPEAL REQUEST FORM

Use this form only if you are a child care center wanting to file an appeal about a child care payment. Your Child Care Resource and Referral Center (CCR&R) may help you fill out this form. Child care centers wishing to appeal a decision about a child care payment must start by filing a first-level appeal with the IDHS Office of Early Childhood, Bureau of Subsidy Management. If you disagree with the Bureau of Subsidy Management's decision following your first-level appeal hearing, you may file a second-level appeal with the IDHS Bureau of Hearings. **First-level appeals must be filed within 60 calendar days of the payment or overpayment you are disputing. Second-level appeals must be filed within 60 calendar days of the Bureau of Subsidy's Management decision following the first-level appeal hearing.** This form may be submitted to IDHS by email, fax, mail, or in person as follows:

First-Level Appeals
IDHS Bureau of Subsidy Management
Attn: CCAP Appeals Coordinator
100 South Grand Ave. East, 2nd Floor
Springfield, IL 62762-0002
Fax: (217) 785-2559
Email: DHS.CCAP.Policy@illinois.gov

Second-Level Appeals
IDHS Bureau of Hearings
69 W. Washington, 4th Floor
Chicago, IL 60602
Fax: (312) 793-3387
Email: DHS.BAH@illinois.gov

PROVIDER INFORMATION

Provider Name:	Provider FEIN:	Provider ID Number:	
Service Street Address:	City:	State:	Zip Code:
Payment Address:	City:	State:	Zip Code:
Contact First Name:	Contact Last Name:	Phone Number:	
Email Address:			

APPEAL INFORMATION

Please provide as much information on the payment you are appealing below. If you don't know the information, just leave the box blank. If there are multiple cases or service months associated with the payment(s)/overpayment(s) you are appealing, please attach the necessary information.

Case Number:	Case Name:	Child(ren) Name(s):	
Service Month:	Dollar Amount:	Warrant/EFT Number:	Payment/Overpayment Date:

Will you need an interpreter for the hearing? Yes ☐ No ☐ If Yes, what language? _____

I AM APPEALING BECAUSE:

☐ I am disputing the number of days paid by the Child Care Assistance Program (CCAP)
☐ I am disputing the rate I was paid at.
☐ A penalty period was imposed, and I disagree with this.
☐ A sanction was imposed, and I disagree with this.
☐ My payments were stopped or reduced, and I disagree with this.
☐ I was charged with an overpayment, and I disagree with this.
☐ IDHS has not acted on my request for appeal.
☐ Other Reason: _____

Please include any documents in support of your appeal request (e.g., attendance records, child care certificate, payment detail from the Office of the Comptroller, overpayment letter) when you submit this form.

Documents Attached (list): _____

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Do you want someone else to represent you at the hearing? Yes ☐ No ☐

If yes, provide their information in the space below.

Approved Representative Name:	Phone Number:	Email Address:
Address (No. & Street, Apt. No.)	City, State, Zip Code	Representative's Firm (if applicable)

If signed by a person other than the appellant, you must attach written authorization to file an appeal on behalf of appellant. Please note: You may submit your own written authorization or use Form IL444-0960 - Authorized Representative Form for Appeals. Form IL444-2998 - Approved Representative Consent Form, will not be accepted for appeal representation.

Your Printed Name (or Printed Name of Approved Representative)

Your Signature (or Signature of Approved Representative)

Date

For IDHS Office Use Only

Date Notice of Appeal Received:	Date of Postmark, if mailed (attach envelope):	Date of written request for hearing, if preceding this form:
Date of Payment Being Appealed:	Provider Name:	Provider ID Number: