State of Illinois
Department of Human Services - Division of Rehabilitation Services

REQUEST FOR HEARING

This information **must** be completed. (Please Print)

Customer Name: _____

Customer Date of Birth (Required): _____ / _____ / _____
month day year

I am appealing a decision made by:

- ☐ Vocational Rehabilitation (VR)
- ☐ Home Services Program (HSP)
- ☐ Bureau of Blind Services (BBS)

Address: _____

City/State: _____ Zip: _____ Telephone with area code: _____

My DRS counselor's name is: _____

If you need help in completing this form, please ask your Rehabilitation Counselor, HSP Representative, Rehabilitation Instructor, or Case Manager.

If you need help requesting your appeal, or you would like to ask about possible representation, please contact the appropriate program below:

Home Services Program (HSP) Customers
Home Care Ombudsman Program (HCOP)
One Natural Resources Way, Suite 100
Springfield, IL 62702-1271
1-800-252-8966 (Voice)
1-888-206-1327 (TTY)

Vocational Rehabilitation (VR) Customers
Bureau of Blind Services (BBS) Customers
Client Assistance Program (CAP)
100 South Grand Ave E, PO Box 19429
Springfield, IL 62794-9429
1-800-642-3929 (Voice/TTY)

- ☐ I want to appeal a decision made by DRS on the following date: _____ .
- ☐ I want to appeal DRS' failure to respond to a request I made on the following date: _____ .
- ☐ I also want to request an informal resolution before the hearing, and understand it is my responsibility to contact my DRS representative or the office supervisor for scheduling.
- ☐ I am a VR or BBS customer and would like to request mediation before the hearing.

Briefly describe the decision(s) or lack of action you would like to appeal:

State of Illinois
Department of Human Services - Division of Rehabilitation Services

REQUEST FOR HEARING

Check Only Those That Apply

☐ My disability is deafness or hard of hearing and I will need: **(Check One)**

- ☐ Sign language interpreter
- ☐ Tactile interpreter
- ☐ Video - phone conference
- ☐ CART services

☐ My disability is blindness or visual impairment and I will need: **(Check One)**

- ☐ audiotape or disc
- ☐ all materials provided in large print
- ☐ all materials provided in Braille
- ☐ a reader to assist in my preparation for the hearing

☐ My language preference is _____ rather than English. I will need an interpreter to participate in the hearing. **(Please fill in your normally spoken language.)**

☐ I am unable to attend the hearing in the local DHS-DRS office due to my disability. I am requesting to participate in the hearing by telephone.

☐ I have chosen to be represented by the following person or organization in this appeal: (PLEASE PRINT)

Name/Organization: _____

Address: _____

City/State/Zip Code: _____

Telephone with area code: _____ Alternate Telephone with area code: _____

NOTE: If this form is not signed by the customer or by the designated representative, the request for hearing will be denied. If signed by the designated representative, attach the written authorization signed by the customer to request a hearing on behalf of the customer.

▪ **Sign your name or Make your mark** Customer: _____ Date: _____

▪ **If you have made your mark (x) instead of signing your name, two witnesses must sign here**

Signature of Witness _____ Date _____

Signature of Witness _____ Date _____

▪ _____ _____
Representative or legal guardian of adult 18 years of age or older — Relationship to customer

▪ **Parent or guardian signature is required if customer is 17 years of age or younger.**

_____ _____ I am the parent or guardian of: _____
Signature of Parent or Guardian — Date

Please mail this form to the Bureau of Administrative Hearings, **with the notice you received**, if any, informing you of the decision you are appealing. You may send a copy of your appeal to the local field office listed below.

Illinois Department of Human Services
Bureau of Administrative Hearings
69 W. Washington, 4th Floor
Chicago, IL 60602

cc: Local Field Office