State of Illinois
Department of Human Services
Accredition, Licensure and Certification
SURVEY REPORT FORM

SECTION I. AGENCY INFORMATION

NAME: ALC SECTION

ADDRESS: CITY/STATE/ZIP

SECTION II. PROGRAM INFORMATION

DATE(S) OF SURVEY: SURVEYOR NAME(S):

PROGRAM(S) SURVEYED (CHECK ALL APPROPRIATE)

☐ COMMUNITY INTEGRATED LIVING ARRANGEMENTS (115) - Contact Person: _____
Level Award: _____ % Compliance: _____

SITES VISITED: _____ _____

_____ _____

_____ _____

_____ _____

☐ DEVELOPMENTAL TRAINING (119) - Contact Person: _____
Level Award: _____ % Compliance: _____

SITES VISITED: _____ _____

_____ _____

☐ MEDICAID COMMUNITY MENTAL HEALTH SERVICES (132) - Contact Person: _____
Level Award: _____ % Compliance: _____
% Billing Compliance: _____

☐ PAS/BOGARD/ISSA Review Contact Person: _____
Level Award: _____ % Compliance: _____

AGENCY NAME:	DATE OF INSPECTION:

VIOLATIONS: THE FOLLOWING VIOLATIONS WERE FOUND DURING THIS INSPECTION

RULE: _____
COMMENT/EXPLANATION:

RULE: _____
COMMENT/EXPLANATION:

RULE: _____
COMMENT/EXPLANATION:

RULE: _____
COMMENT/EXPLANATION:

RULE: _____
COMMENT/EXPLANATION:

AGENCY NAME:	DATE OF INSPECTION:

RULE: _____
COMMENT/EXPLANATION:

RULE: _____
COMMENT/EXPLANATION:

RULE: _____
COMMENT/EXPLANATION:

All violations must be corrected. A written Plan of Correction must be submitted to this Department on or before:

_____

Failure to submit the required Plan of Correction by that date is grounds for revocation or non-renewal of your agency's license/certificate.

Please submit the Plan of Correction to:

_____ _____
(Authorized Organization Representative or Designee Signature) (Date)

_____ _____
(Survey Coordinator Signature) (Date)

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