



**APPLICATION FOR ADMINISTRATIVE ADMISSION  
TO A STATE-OPERATED CENTER**

Center: \_\_\_\_\_ Date of Application: \_\_\_\_\_

Individual's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Complete address: \_\_\_\_\_

Spouse: \_\_\_\_\_ Phone: \_\_\_\_\_

Complete address: \_\_\_\_\_

Nearest adult relative: \_\_\_\_\_ Phone: \_\_\_\_\_

Complete address: \_\_\_\_\_

Guardian: (if none, friend): \_\_\_\_\_ Phone: \_\_\_\_\_

Complete address: \_\_\_\_\_

(The applicant should check the appropriate box below:)

- I am the person seeking admission and am age 18 or older.
- I am the developmentally disabled person's court-appointed guardian.
- I am the parent, guardian, or person in loco parentis for the developmentally disabled person who is under 18 years old.

Person executing this application: \_\_\_\_\_ Relationship: \_\_\_\_\_

TO THE APPLICANT: Please write a short statement why you are applying for admission for yourself or for your child or ward.

\_\_\_\_\_  
Signed \_\_\_\_\_ Date \_\_\_\_\_

In case of emergency, or if notice of restriction of any of my rights should be sent, I designate the following person(s) to receive such notice.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

I explained the rights on the back of this form in  English  Spanish  Other (specify) \_\_\_\_\_

and I also gave a copy of this form to the individual (age 12 or older) and to the applicant. I also gave to him/her a copy of "Rights of Individuals" and explained those rights.

\_\_\_\_\_  
Employee's Name and Title: \_\_\_\_\_ Employee's Signature: \_\_\_\_\_

For center director: (name) \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ was  admitted or  was denied admission  
on (month/day/year) \_\_\_\_\_ by (Center Director) \_\_\_\_\_



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A Guardianship and Advocacy Commission has been created which consists of three divisions: Legal Advocacy Services, Human Rights Authority and the Office of the State Guardian. The Commission is located at:

**Chicago Regional Office**

160 N. La Salle Street  
Suite S500  
Chicago, IL 60601  
Phone: (312) 793-5900  
Fax: (312) 793-4311  
TTY: (866) 333-3362

**Springfield Regional Office**

830 S. Spring Street  
Springfield, IL 62704  
Phone: (217) 785-1540  
Fax: (217)524-0088  
TTY: (866) 333-3362

Equip for Equality, Inc. is an independent, not-for-profit organization that administers the federal protection and advocacy system to people with disabilities in Illinois. Equip for Equality, Inc., provides self-advocacy assistance, legal services, education, public policy advocacy, and abuse investigations. The office is located at: **Website:** [www.equipforequality.org](http://www.equipforequality.org)

**Main/Chicago Office**

20 N. Michigan, Ste 300  
Chicago, Illinois 60602  
(800) 537-2632 or  
(312) 341-0022  
TTY: (800) 610-2779  
Fax: (312) 800-0912

The information you provide on this form is protected by privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) ([PL 104-191] at 45 CFR 160 and 164). Your personally identifiable health information will only be used and/or released in accordance with HIPAA and the Illinois Mental Health and Developmental Disabilities Confidentiality Act.

I have explained these rights to the individual (or the guardian of the individual, if applicable) and have provided him or her a copy of it. A copy of this form has been filed in the individual's clinical record.

\_\_\_\_\_  
Staff signature

\_\_\_\_\_  
Signature of Individual Receiving Services

Check here if individual refuses to sign

\_\_\_\_\_  
Staff Name and Title

\_\_\_\_\_  
Witness' Name (required only if individual refuses to sign)

\_\_\_\_\_  
Date and Time

\_\_\_\_\_  
Witness' Signature (required only if individual refuses to sign)