State of Illinois
Department of Human Services - Division of Developmental Disabilities

COMMUNITY INTEGRATED LIVING ARRANGEMENT (CILA) CLOSURE CHOICE FORM

1. Individual Name:	
2. Current Address:	
3. Current CILA Provider:	

4. The individual is eligible for the following service options:

☐	**24-hour CILA**	☐	**Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD)**	☐	**Family CILA**
☐	**Host-Family CILA**	☐	**Intermittent CILA**	☐	**Homed Based Services**
☐	**Community Living Facility (CLF)**				

5. On _____ (date), all eligible service options were presented to the individual and/or legal guardian regardless of availability and in sufficient detail in order to ensure an informed choice could be made. It was also explained that it is not the responsibility of the Independent Service Coordination (ISC) agency (Individual Support and Service Agency (ISSA) agent), Department of Human Services/Division of Developmental Disabilities (DHS/DDD), or a provider agency to make the selection of service options for the individual and/or legal guardian.

6. The individual and/or legal guardian has chosen the following service option(s):

_____

7. Potential Service Provider	**Date Referral Packet Sent/Given**	**Provider's Response**

(Attach additional referrals, if needed)

8. Individual and/or legal guardian's choice of service provider	
9. If the Individual is temporarily in an alternate setting (e.g., family home, hospital, etc) before transitioning, please indicate setting:	

10. Date verbal approval given by individual and/or legal guardian prior to an individual's transition to alternate services:	

11. Signature of ISC Agency Staff:		**Date:**	

A copy of this completed form will be sent to the individual an/or legal guardian, receiving provider, sending ISC agency, and receiving ISC agency (if applicable).

Process and Procedures

1. **Name:** Type the individual's full name.
2. **Current Address:** Address of CILA site that is closing.
3. **Current CILA Provider:** Name of provider agency that the individual is receiving services from at the time of closure.
4. **Service Options:** Check all service options that the individual is eligible for regardless of availability.
5. **Date Service Operations Reviewed:** List date that the service options were presented to the individual and/or legal guardian.
6. **Service Options Chosen:** Write the service option chosen by the individual and/or legal guardian. If the individual and/or legal guardian does not want any services, indicate "None" on the form. If the individual chooses to terminate from all DDD Waiver services they were receiving, the ISC will:
   - Discuss the individual/legal guardian's concerns that resulted in this decision.
   - Explain to the individual/legal guardian that they are waiving their current right to DDD Waiver services.
   - Explain that any future request for services will require the individual to be selected from the PUNS or meet the DDD's Crisis Criteria.
7. **Potential Service Providers:** List Service Providers that were discussed with the individual and/or legal guardian. Note the date the provider received the modified referral packet (i.e., any information available) about the individual's service and supports needs and the provider's response. Attach additional pages as needed.
8. **Service Provider Choice:** List name of service provider chosen by the individual and/or legal guardian.
9. **Alternative Setting:** Indicate type (e.g., family home, hospital, hotel, etc.) chosen by the individual or legal guardian and the address of this setting. If the individual does not transition to alternative setting, type "NA" on the line.
10. **Verbal Approval:** List date that verbal approval was received from the individual and/or legal guardian for alternative services to begin with a new provider.
11. **Signature and Date:** Date and written signature of the ISC agent involved in the CILA closure.