State of Illinois
Healthcare and Family Services

Long Term Care Bed Reserve / Temporary Absence Form

Document Control Number

Facility Name	Facility Number

Facility Address	Facility City	State	Zip Code

Facility Reference Number

Recipient Name - Last	Recipient Name - First	Recipient ID Number

Bed Reserve Information

Type	Begin Date	End Date

Type	Begin Date	End Date

Type	Begin Date	End Date

Type	Begin Date	End Date

Type	Begin Date	End Date

Type	Begin Date	End Date

Type	Begin Date	End Date

Type	Begin Date	End Date

I certify that all entries on this form are true, accurate, complete and meet all the requirements of the Illinois Department of Healthcare and Family Services.

Signature of Certifying or Operating Officer or Authorized Agent

Date

Upon completion of this form, please print, sign and fax it to the Illinois Department of Healthcare and Family Services, Bureau of Long Term Care 1-217-524-7114.

Reset Form | Print Form