

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

SECTION I. AGENCY INFORMATION

NAME	STREATOR Unlimited		ALC SECTION
ADDRESS	305 North Sterling St.		Springfield
	CITY/STATE/ZIP		

SECTION II. PROGRAM INFORMATION

DATE(S) OF SURVEY	SUEVEYOR NAME(S)
5-8-2014	E. Mitchell

PROGRAM(S) SURVEYED (CHECK ALL APPROPRIATE) SURVEY REVIEW _____ COMPLAINT REVIEW _____

COMMUNITY INTEGRATED LIVING ARRANGEMENTS (115) – CONTACT PERSON _____

Site(s) Visited	Level Award _____	% Compliance _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DEVELOPMENTAL TRAINING (119) – CONTACT PERSON LYNN FUKAR

Site(s) Visited	Level Award <u>I</u>	% Compliance <u>100</u>
<u>305. N. Sterling St.</u>	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAID COMMUNITY MENTAL HEALTH SERVICES (132) – CONTACT PERSON _____

Site(s) Visited	Level Award _____	% Compliance _____
_____	_____	_____
_____	_____	_____
_____	_____	_____

AGENCY NAME:

DATE OF INSPECTION

PAGE ___ OF ___

STREATOR Unlimited 5-8-14

RULE: _____
COMMENT/EXPLANATION:

RULE: _____
COMMENT/EXPLANATION:

RULE: _____
COMMENT/EXPLANATION:

All violations must be corrected. A written Plan of Correction compliant with the Criteria for Submission of a Plan of Correction must be submitted to this Department on or before:

N/A

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:

Tracy Adden
Department of Human Services
Bureau of Accreditation, Licensure and Certification
401 North 4th Street, 2nd Floor
Springfield, Illinois 62702

All citations in the above report have been presented during the Exit Conference on 5-8-14 at which I was present.

Lynn Fula
(Authorized Organization Representative or Designee Signature)

5-8-2014
(Date)

Eric Mitchell
(Lead Surveyor Signature)

5-8-2014
(Date)