State of Illinois
Department of Public Health

Notice of Involuntary Transfer or Discharge and Opportunity for Hearing

FACILITY INFORMATION

Name _____ Address _____

County _____ Telephone Number _____ Date of Notice to Resident _____

RESIDENT INFORMATION

Name _____ Representative _____

Representative's Address _____ Representative's Telephone Number _____

☐ **FEDERAL PROCEEDING** ☐ **STATE PROCEEDING**

☐ **FEDERAL PROCEEDING.** This facility admits private-pay and Medicare or Medicaid residents and is federally-certified and state licensed, or this facility admits only Medicare or Medicaid residents and is federally funded. **This facility seeks to transfer or discharge you** pursuant to the regulations of the Health Care Financing Administration for states and long-term care facilities, 42 CFR 483.12 ("federal regulations"). As recorded in your clinical record in accordance with Section 483.12 (a)(4) of the federal regulations, the reason for this proposed transfer or discharge is:

☐ your welfare and needs cannot be met in this facility, as documented in your clinical record by your physician, 483.12 (a)(2)(i);

☐ your health has improved sufficiently so you no longer need the services provided by this facility, as documented by your physician in your clinical record, 483.12(a)(2)(ii);

☐ the safety of individuals in this facility is endangered, 483.12(a)(2)(iii);

☐ the health of individuals in the facility would otherwise be endangered, as documented by a physician in your clinical record, 483.12(a)(2)(iv);

☐ you have failed, after reasonable and appropriate notice, to pay for your stay at this facility, 483.12(a)(2)(v); or

☐ this facility ceases to operate, 483.12(a)(2)(vi).

On the date of transfer or discharge, you will be relocated to:

Facility/Person _____

Address _____

Telephone _____

Pursuant to Section 483.12(a)(7) of the federal regulations, this facility will provide sufficient preparation and orientation to ensure your safe and orderly transfer or discharge from this facility.

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☐ **STATE PROCEEDING.** This facility admits only private-pay residents and is state-licensed. **This facility seeks to transfer or discharge you** pursuant to the Nursing Home Care Act, 210 ILCS 45/1-101, *et seq*., ("state law"). You will be responsible for securing shelter and health care for yourself. You may seek relocation assistance from the Illinois Department of Public Health, including information on alternative placements.

As discussed with _____ on _____ , 20____ , and as documented in your clinical record pursuant to Section 3-408 of the state law, the reason for this proposed transfer or discharge is:

☐ medical reasons, 210 ILCS 45/3-401(a);

☐ your physical safety, 210 ILCS 45/3-401(b);

☐ the physical safety of other residents, the facility's staff or visitors, 210 ILCS 45/3-401(c); or

☐ late payment or nonpayment for your stay, 210 ILCS 45/3-401(d).

The responsible party, _____ , has the right to pay the amount of the bill in full up to the the date the transfer or discharge is to be made and then you shall have the right to remain in this facility.

To obtain the name of a local representative of the Illinois Long-term Care Ombudsman Program in your community, you may call the Illinois Department on Aging, Senior Helpline, toll-free at **800-252-8966** or write to the Illinois Department on Aging, 421 E. Capital Ave., Springfield, IL 62701.

The agency responsible for the protection and advocacy of the developmentally disabled or mentally ill individuals is Equip for Equality, Inc.:

20 N. Michigan Ave., Suite 300, Chicago, IL 60602, 312-341-0022, (Voice) 800-537-2632, (TTY) 800-610-2779, (Fax) 312-341-0295

1617 Second Ave., Suite 210, P.O. Box 3753, Rock Island, IL 61204, 309-786-6868, (Voice) 800-758-6869, (TTY) 800-610-2779, (Fax) 309-786-2393

235 S. Fifth St., P.O. Box 276, Springfield, IL 62705, 217-544-0464, (Voice) 800-758-0464, (TTY) 800-610-2779, (Fax) 217-523-0720

The effective date of the proposed transfer or discharge is _____ , 20____ . The person who will supervise your transfer or discharge is:

Name _____

Address _____

Telephone _____

APPEAL RIGHTS

Regardless of whether the facility's proposed action is under federal regulations or state law, **you have the right to appeal the decision to transfer or discharge you.**

If you think you should not have to leave this facility, you may file a Request for a Hearing with the Illinois Department of Public Health within 10 days after receiving this notice.

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If you request a hearing, it will be held not later than 10 days after your request, and you generally will not be transferred or discharged during that time. If the decision following the hearing is not in your favor, you generally will not be transferred or discharged prior to the expiration of 30 days following receipt of the original Notice of Transfer or Discharge.

A form to appeal the facility's decision is attached. If you have questions, call the Illinois Department of Public Health at 217-782-4977. Your call will be directed to the appropriate individual.

A copy of this notice was placed in your clinical record and a copy was transmitted to the Illinois Department of Public Health, to you, to the long-term care ombudsman, to your representative or a family member, and, if your care is paid for, in whole or in part, through Title XIX, to the Illinois Department of Healthcare and Family Services on the ___ day of _____ , 20 ___ .

Signature of facility's agent _____

Title of agent _____

Date _____

Name of facility attorney _____

Attorney address _____

Attorney phone number _____