State of Illinois
Illinois Department of Public Health

Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents (for Assisted Living forms, visit www.dph.illinois.gov)

FACILITY INFORMATION

Facility Name _____ Address _____

County _____ Telephone Number _____ Fax Number _____ Date of Notice to Resident _____

RESIDENT INFORMATION

Resident's Name _____ Resident's Date of Birth _____ Representative's Name _____

Representative's Address _____ Representative's Telephone Number _____

☐ **FEDERAL PROCEEDING** ☐ **STATE PROCEEDING** **EMERGENCY TRANSFER OR DISCHARGE** ☐ Yes ☐ No

☐ **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 483.15 ("federal regulations"). As recorded in your clinical record in accordance with Section 483.15 (c)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, 483.15 (c)(1)(i)(A);

☐ 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, 483.15 (c)(1)(i)(B);

☐ the safety of individuals in this facility is endangered, 483.15 (c)(1)(i)(C);

☐ the health of individuals in the facility would otherwise be endangered, as documented by a physician in your clinical record, 483.15 (c)(1)(i)(D);

☐ you have failed, after reasonable and appropriate notice, to pay for your stay at this facility, 483.15 (c)(1)(i)(E); or

☐ this facility ceases to operate, 483.15 (c)(1)(i)(F).

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

Facility/Person _____

Address _____

Telephone _____

Pursuant to Section 483.15(c)(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.

☐ A copy of the Facility's bed hold policy has been given to the nursing home resident or their responsible party, along with a copy of this notice.

Please submit all forms to: Illinois Department of Public Health, Division of Administrative Hearing Review, 535 W. Jefferson St., 5th Floor, Springfield, IL, Email DPH.AdminHearings@illinois.gov; or fax: 217-557-3497

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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, One Natural Resources Way, Suite 100, Springfield, IL 62702-1271.

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 _____

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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.

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_____.

If you are a Williams/Colbert Class Member, you may be entitled to certain benefits under the Consent Decrees, which give you the right to receive information about housing and service options prior to being discharged from the facility. You may have already been engaged with a Williams/Colbert provider, called a “Prime Agency”, who is required to support you in the discharge process. You may contact them, through your facility or on your own if you already have their contact information, for linkage to housing and services if you have been assessed and recommended for a community-based setting. You may also request that the Prime Agency provide an assessment and related services after your discharge. Prime Agency contact information and facility assignment information can be found on the IDHS Olmstead webpage at https://www.dhs.state.il.us/page.aspx?item=125944. If you are a Class Member, a List of Community Services that may be available to you as a Class Member will be provided to you before, or at the point of your discharge from the facility. If you are a Williams/Colbert Class Member, answers to questions about your rights can be found by calling the IDHS Williams/Colbert hotline (312) 793-7205 prior to your discharge from the facility.

Signature of facility's agent _____ **Date** _____

Title of agent _____

Name of facility’s attorney _____

Attorney’s address _____

Attorney's telephone number _____

Please submit all forms to: Illinois Department of Public Health, Division of Administrative Hearing Review, 535 W. Jefferson St., 5th Floor, Springfield, IL, Email DPH.AdminHearings@illinois.gov; or fax: 217-557-3497

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Involuntary Transfer or Discharge Request for Hearing

INSTRUCTIONS

If you wish to contest the proposed involuntary transfer or discharge, please complete this form **submit it to: Illinois Department of Public Health, Division of Administrative Hearing Review, 535 W. Jefferson St., 5th Floor, Springfield, IL, Email DPH.AdminHearings@illinois.gov; Fax: 217-557-3497** within 10 days after receiving the Notice of Involuntary Transfer or Discharge.

FACILITY INFORMATION

Facility Name _____ Address _____

County _____ Telephone Number _____ Fax Number _____ Date of Notice to Resident _____

RESIDENT INFORMATION

Resident's Name _____ Resident's Date of Birth _____ Representative's Name _____

Representative's Address _____ Representative's Telephone Number _____

I request a hearing, within 10 days of receipt of this request by the Illinois Department of Public Health, to contest the Notice of Involuntary Transfer or Discharge received by

_____ on _____, 20____.

Signature of person requesting a hearing _____

Relationship to the resident _____

Date _____

Name of resident's attorney _____

Attorney's address _____

Attorney's telephone number _____