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 _____ Email Address _____ Date of Notice to Resident _____

RESIDENT INFORMATION

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

Resident's Representative Address _____ Resident's Representative Telephone No. _____

☐ **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 in your clinical record by your physician, 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 this facility would otherwise be endangered, as documented in your clinical record by your physician, 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 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., Springfield, IL 62761; Email DPH.AdminHearings@illinois.gov; or fax: 630-954-3502.

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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, as documented in your clinical record by your physician, 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 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.

300 East Main St., Suite 18, Carbondale, IL 62901, 618-457-7930, (Voice) 800-758-6869, (TTY) 800-610-2779, (Fax) 618-457-7985.

1 West Old State Capitol Plaza, Suite 500, Springfield, IL 62701, 217-544-0464, (Voice) 800-758-0464, (TTY) 800-610-2779, (Fax) 312-800-0912.

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

Name:_____

Address: _____

Telephone: _____

Email: _____

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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 Hearing with the Illinois Department of Public Health within 10 days after receiving the 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, Administrative Hearing Review, at 217-557-9592 or 217-557-5688.

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 before 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 discharge. Prime Agency contact information and facility assignment information are on the Illinois Department of Human Services (DHS) 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 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 or emailing ILOA@maximus.com prior to your discharge from the facility.

Printed name of facility's agent: _____ **Agent's Title:** _____

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

Facility agent's email: _____

Printed name of facility's attorney: _____

Attorney's email: _____ **Telephone:**_____

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Involuntary Transfer or Discharge Request for Hearing

INSTRUCTIONS

If you wish to contest the proposed involuntary transfer or discharge, complete this form and submit to: Illinois Department of Public Health, Division of Administrative Hearing Review, 535 W. Jefferson St., Springfield, IL 62761, Email: DPH.AdminHearings@illinois.gov; Fax: 630-954-3502 within 10 days after receiving the Notice of Involuntary Transfer or Discharge.

FACILITY INFORMATION:

Facility Name	Address	County

Telephone Number	Fax Number	Email Address	Date of Notice to Resident

RESIDENT INFORMATION:

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

Resident's Representative Address	Resident's Representative Telephone No.

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 the _____ day, of _____, 20_____.

Printed name of person requesting a hearing: _____

Signature of person requesting a hearing: _____ Date: _____

Relationship to the resident: _____

Email address: _____

Printed name of resident's attorney (if applicable): _____

Resident's attorney's address: _____

_____

Resident's attorney's email: _____

Resident's attorney's telephone number: _____

Please submit all forms to: Illinois Department of Public Health, Division of Administrative Hearing Review, 535 W. Jefferson St., Springfield, IL 62761; Email DPH.AdminHearings@illinois.gov; or fax: 630-954-3502.

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Availability of Translation and Interpretation Services

English

"You have the right to an interpreter. You also have the right to have this notice translated into another language. You must make your request to the Administrative Law Judge identified below within seven (7) days of receiving this notice. All of these services will be provided to you by the Illinois Department of Public Health at no cost to you."

Arabic

"لديك الحق في الحصول على مترجم فوري. ولديك أيضًا الحق في ترجمة هذا الإشعار إلى لغة أخرى. يجب عليك تقديم طلبك إلى القاضي الإداري (Administrative Law Judge) الوارد اسمه أدناه في غضون سبعة (7) أيام من استلام هذا الإشعار. سيتم تقديم جميع هذه الخدمات من قبل إدارة الصحة العامة في إلينوي إليك مجانًا."

Simplified Chinese

"您有权获得口译服务。您也有权要求将此通知翻译成其他语言。您必须在收到此通知后的七（7）天内向下方所列的行政法法官提出请求。伊利诺伊州公共卫生部将免费为您提供所有这些服务。"

Gujarati

"તમને દુભાષિયા મેળવવાનો અધિકાર છે. તમને આ સૂચનાનો અન્ય ભાષામાં અનુવાદ મેળવવાનો અધિકાર પણ છે. તમારે આ નોટિસ મળ્યાના સાત (7) દિવસની અંદર નીચે આપેલા વહીવટી કાયદાના ન્યાયાધીશને તમારી વિનંતી સબમિટ કરવી પડશે. ઇલિનોઇસ ડિપાર્ટમેન્ટ ઓફ પબ્લિક હેલ્થ (Illinois Department of Public Health) દ્વારા તમને આ બધી સેવાઓ કોઈપણ ખર્ચ વિના પૂરી પાડવામાં આવશે.

Korean

"당신은 통역사를 가질 권리가 있습니다. 또한 귀하는 이 통지문을 다른 언어로 번역할 권리가 있습니다. 귀하는 이 통지를 받은 날로부터 칠(7) 일 이내에 아래에 명시된 행정 법원 판사에게 요청해야 합니다. 이러한 모든 서비스는 일리노이 공중보건부에서 무료로 제공합니다."

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Traditional Chinese

“您有權獲得口譯服務。您也有權要求將此通知翻譯成其他語言。您必須在收到此通知後的七（7）天內向下方所列的行政法法官提出請求。伊利諾州公共衛生部將免費為您提供所有這些服務。”

Polish

„Masz prawo do tłumacza. Masz również prawo zażądać przetłumaczenia niniejszego powiadomienia na inny język. Wniosek należy złożyć do sędziego sądu administracyjnego wskazanego poniżej w ciągu siedmiu (7) dni od otrzymania niniejszego powiadomienia. Wszystkie te usługi zostaną Państwu zapewnione bezpłatnie przez Departament Zdrowia Publicznego stanu Illinois.
Russian

«Вы имеете право на переводчика. Вы также имеете право на перевод настоящего уведомления на другой язык. Вы должны подать ходатайство указанному ниже судье по административным делам в течение семи (7) дней с даты получения настоящего уведомления. Все эти услуги будут предоставлены вам Департаментом здравоохранения штата Иллинойс совершенно бесплатно».

Spanish

“Usted tiene derecho a un intérprete. También tiene derecho a que este aviso se traduzca a otro idioma. Debe presentar su solicitud al Juez de Derecho Administrativo identificado a continuación dentro de los siete (7) días posteriores a la recepción de este aviso. El Departamento de Salud Pública de Illinois le brindará todos estos servicios sin costo alguno”.

Tagalog

“May karapatan kang magkaroon ng interpreter. May karapatan ka ring ipasalin ang pabatid na ito sa ibang wika. Dapat mong gawin ang iyong kahilingan sa Administrative Law Judge na tinukoy sa ibaba sa loob ng pitong (7) araw pagkatapos matanggap ang pabatid na ito. Ibibigay sa iyo ng Illinois Department of Public Health ang lahat ng serbisyong ito nang libre.”

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Urdu

آپ کو ترجمان رکھنے کا حق حاصل ہے۔ *آپ کو اس نوٹس کا دوسری زبان میں ترجمہ کروانے کا بھی حق حاصل ہے۔* آپ کو یہ نوٹس موصول ہونے کے سات (7) دنوں کے اندر ذیل میں شناخت کردہ ایڈمنسٹریٹو لاء جج کو اپنی درخواست کرنی چاہیے۔ یہ تمام خدمات آپ کو الینوائے ڈپارٹمنٹ آف پبلک ہیلتھ کی طرف سے آپ کو مفت فراہم کی جائیں گی۔

Ukranian

«Ви маєте право на перекладача. Ви також маєте право на переклад цього повідомлення іншою мовою. Ви маєте подати своє клопотання зазначеному нижче судді з адміністративних справ протягом семи (7) днів із дати отримання цього повідомлення. Усі ці послуги буде надано вам Департаментом охорони здоров'я штату Іллінойс цілком безкоштовно».

Vietnamese

"Quý vị có quyền được có thông dịch viên. Quý vị cũng có quyền yêu cầu dịch thông báo này sang một ngôn ngữ khác. Quý vị phải gửi yêu cầu của mình tới Thẩm Phán Luật Hành Chính được nêu dưới đây trong vòng bảy (7) ngày kể từ khi nhận được thông báo này. Tất cả các dịch vụ này sẽ được Sở Y tế Công Cộng Illinois cung cấp cho quý vị mà không mất phí."