

Michigan Department of Licensing and Regulatory Affairs

BUREAU OF HEALTH SYSTEMS

Division of Operations, Complaint Investigation Unit
 P.O. Box 30664, Lansing, Michigan 48909
 (517) 241-4712 (Telephone); (517) 241-0093 (Fax)

FACILITY INVOLUNTARY TRANSFER/DISCHARGE PLAN CHECKLIST

Name of resident:		Name of Present Facility:	
Resident's guardian/designated representative:		Telephone Number:	
Street Address:	City:	Zip Code:	
Date counseling provided to resident prior to transfer/discharge:			
Person providing counseling prior to transfer/discharge:		Title:	Telephone Number:
Name of receiving facility:			
<input type="checkbox"/> Statement (attached) by physician indicating how resident's condition and needs will be accommodated during Transfer/Discharge and in the new placement.			
Date resident or guardian/designated representative visited receiving facility:			
OR			
<input type="checkbox"/> Waiver (attached) of site visit in writing, by physician, resident, or guardian/designated representative			
AND			
<input type="checkbox"/> Statement (attached) from resident or guardian/designated representative acknowledging resident received appropriate information about receiving facility such as brochure, floor plan, and pictures to familiarize the resident with the new facility.			
Date resident will move to new facility:			
Family member <input type="checkbox"/> WILL <input type="checkbox"/> WILL NOT accompany resident during move.			
Person providing counseling within 72 hours of transfer/discharge:		Title:	Telephone Number:
Signature of Facility Representative:		Title:	Date:
Name of Resident/Family Representative:		Relationship to Resident:	
Signature of Resident/Family Representative:			Date: