MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF HEALTH CARE SERVICES
LONG TERM CARE DIVISION
P.O. BOX 30664, LANSING, MI 48909
PHONE NUMBER: (517) 241-4712 FAX NUMBER: (517) 241-0093

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:
Please attach a list of special medical needs of resident (i.e., oxygen, tube feedings, catheters, medications, etc.:		
Please attach a list of the medical conditions of resident (i.e., wheelchair bound, para/quadriplegic, etc.:		
Date(s) counseling provided to resident prior to transfer/discharge:		
Person providing counseling prior to transfer/discharge:	Title:	Telephone Number:
Name of receiving facility:		
☐ Statement (**attached)** by physician indicating how resident's condition and needs will be accommodated during the Transfer/Discharge and in the new placement.		
Date resident or guardian/designated representative visited receiving facility:		
OR		
☐ Waived (**attached)** of site visit in writing, by physician, resident, or guardian/designated representative **AND** ☐ 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 ☐ WILL ☐ 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: