ESRD INVOLUNTARY DISCHARGE REPORT

Facility Information

CCN #:	Facility Name:
Date Reported [Date]	Address:
	City, ST ZIP:

Discharged Patient Information

Name:	Date of Birth:

Per regulations, a patient may be discharged only for the following reasons. Please select the reason that applies:

- ☐ **Failure to pay for services**
- ☐ **Facility ceases to operate**
- ☐ **Facility can no longer meet the patient's documented medical needs**
- ☐ **Patient's behavior is disruptive and abusive to the extent that delivery of care to the patient or the ability of the facility to operate effectively is seriously impaired**

Please provide detailed information:

Required Discharge Notifications Made by Facility

Step Taken	Date	Step Taken	Date
Medical Director Notified	[Date]	Contacted another facility to attempt to place the patient Facility:	[Date]
Documentation of reassessments, ongoing problems and efforts to resolve problem entered in patient record	[Date]	Provided Patient 30-day notice* of discharge. ***Please attach a copy of written notice.***	[Date]
Written physician's order obtained signed by both the medical director and the patients attending physician concurring with the discharge or transfer	[Date]	Provided ESRD Network 11 30-day notice of discharge	[Date]

Facility Administrator Information

Name:	Title:
Phone | Fax:	Email:
Signature	Date:

Please scan as PDF and email this notification to: BCHS-CMSCertification@Michigan.gov