

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS**  
**BUREAU OF COMMUNITY AND HEALTH SYSTEMS**  
P.O. BOX 30664, LANSING, MI 48909  
Phone: (517) 241-1970 FAX: (517) 763-0213  
Email: LARA-BCHS-InvoluntaryTransfer@michigan.gov

**FACILITY INVOLUNTARY TRANSFER/DISCHARGE PLAN**

Resident Name		Nursing Home Facility Name	
Resident's Guardian/Designated Representative			Telephone Number
Street Address		City	Zip Code
Date(s) counseling provided to resident prior to transfer/discharge:			
Person that Provided Counseling		Title	Telephone Number
Receiving Facility Name			
Date Resident/Guardian Visited Receiving Facility:			
<input type="checkbox"/>	Alternative: Resident/guardian received appropriate information about the receiving facility such as brochure, floor plan, and pictures to familiarize the resident with the new facility.		
<input type="checkbox"/>	Alternative: Site visit was waived in writing by physician, resident, or guardian.		
Date Resident Will Move to New Facility:			
Guardian/family member will accompany resident during move: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Person providing counseling within 72 hours of transfer/discharge:		Title:	Telephone Number:
Signature of Facility Representative		Title	Date
Name of Resident/Guardian/Family Representative		Relationship to Resident	
Signature of Resident/Family Representative			Date
Attach a list of medical needs of resident (i.e., oxygen, tube feedings, catheters, medications, etc.).			
Attach a list of the medical conditions of resident (i.e., wheelchair bound, para/quadruplegic, etc.).			
Attach physician statement indicating how resident's condition and needs will be accommodated during the transfer/discharge and in the new placement.			

Send Involuntary Transfer/Discharge Plan to address above for department review prior to move.