Reference: 405 ILCS 5/3-910, 5/4-206 and 5/4-709

NOTICE OF TRANSFER BETWEEN STATE-OPERATED CENTERS

To: _____

You are hereby notified that: (Individual) _____ will be transferred from

_____ (Center) to _____ (Center) on _____ (month/day/year)

The reasons for this transfer are as follows:

I certify that I ☐ mailed ☐ delivered a copy of this notice in ☐ English ☐ Spanish ☐ Other: (specify) _____

to the person(s) listed above on _____ (month/day/year)

Printed Name: _____ Title: _____

Signature: _____ For Center Director: _____

PLEASE READ CAREFULLY THE INFORMATION CONTAINED BELOW. IT DESCRIBES THE RIGHTS OF BOTH THE INDIVIDUAL AND YOURSELF REGARDING THIS TRANSFER.

WHO HAS THE RIGHT TO OBJECT

MI Center:
- **Adult-** A individual may object to his or her transfer or the individual's attorney, guardian or responsible relative may object on his or her behalf.
- **Minor-** The minor (if 12 years of age or older) may object to his or her transfer or the minor's attorney or person who executed the application for admission may object to the transfer.

DD Center:
- **Adult-** An individual may object to his or her transfer or the individual's attorney or guardian, or another person whom the individual designated to receive the Notice of Admission may object to the transfer. If the individual lacks sufficient capacity to understand and consent to the designation of persons to receive notice, the nearest adult relative shall receive the Notice of Transfer and may also object.
- **Minor-** The minor (under the age of 18) may object to his or her transfer or the minor's attorney, parent, guardian, or person in loco parentis may object to the transfer.

EXPLANATION OF HOW TO OBJECT TO TRANSFER

Prior to transfer (or within 14 days after an emergency transfer), send a written and signed objection to the center director. Upon receipt, the center director will schedule a hearing to be held at the center within 7 days. The individual will remain at the center until a decision is made after the hearing.

The hearing takes place before a special committee of professional staff. The hearing is informal and you can bring in persons to make statements and present facts on your behalf.

The committee will send its recommendations to the center director, who will notify you of his or her decision within 7 days. If you do not agree with the decision, you may ask the Secretary of the Department of Human Services to review it

NOTICE OF TRANSFER BETWEEN STATE-OPERATED CENTERS

A copy of this form shall be filed in the individual's record.

RETURN TO CENTER DIRECTOR

I object to the transfer of (Individual's Name) _____

from _____ to _____
(Name of Sending Center) (Name of Receiving Center)

and request a hearing before the Utilization Review Committee.

_____ _____
(Printed Name of Objector) (Relationship to Individual)

_____ _____
(Signature of Objector) (Date)

A Guardianship and Advocacy Commission has been created which consists of three divisions: Legal Advocacy Services, Human Rights Authority and the Office of the State Guardian. The Commission is located at:

Chicago Regional Office
160 N. La Salle Street
Suite S500
Chicago, IL 60601
Phone: (312) 793-5900
Fax: (312) 793-4311
TTY: (866) 333-3362

Springfield Regional Office
830 S. Spring Street
Springfield, IL 62704
Phone: (217) 785-1540
Fax: (217)524-0088
TTY: (866) 333-3362

Equip for Equality, Inc. is an independent, not-for-profit organization that administers the federal protection and advocacy system to people with disabilities in Illinois. Equip for Equality, Inc., provides self-advocacy assistance, legal services, education, public policy advocacy, and abuse investigations. The office is located at **Website:** www.equipforequality.org

Main/Chicago Office
20 N. Michigan, Ste 300
Chicago, Illinois 60602
(800) 537-2632 or
(312) 341-0022
TTY: (800) 610-2779
Fax: (312) 800-0912

The information you provide on this form is protected by privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) ([PL 104-191] at 45 CFR 160 and 164). Your personally identifiable health Information will only be used and/or released in accordance with HIPAA and the Illinois Mental Health and Developmental Disabilities Confidentiality Act.

I have explained these rights to the individual (or the guardian of the individual, if applicable) and have provided him or her a copy of it. A copy of this form has been filed in the individual's clinical record.

_____ _____
Staff Signature Signature of Individual Receiving Services

☐ Check here if individual refuses to sign

_____
Staff Name and Title

_____ _____
Date and Time Witness' Name (required only if individual refuses to sign)

_____
Witness' Signature (required only if individual refuses to sign)