Ref. 405 ILCS 5/3-903(a), 5/4-206 and 5/4-709(a)

NOTICE OF DISCHARGE FROM A STATE-OPERATED CENTER

To:

You are hereby notified: _____ (Individual) will be given a _____ (Specify type)

discharge from _____ (Center) on _____ (Date)

The reason* for this discharge 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: _____

* For notification to school districts enter "not applicable" here.

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

WHO HAS THE RIGHT TO OBJECT

MI Center: **Adult -** An individual may object to his or her discharge or the individual's attorney or guardian may object on his or her behalf.

Minor - The minor (if 12 years of age or older) may object to his or her discharge or the minor recipient's attorney or person who executed the application for admission may object to the discharge.

DD Center: An individual (if 12 years of age or older) may object to his or her discharge or the individual's attorney or guardian, or the person who executed the application for admission may object on the individual's behalf.

School districts do not have the right to object to discharge.

EXPLANATION OF HOW TO OBJECT TO DISCHARGE

Prior to discharge, send a signed objection to the center director. On 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 fact 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.

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

IMPORTANT INFORMATION IS ON THE BACK OF THIS FORM

I object to the discharge of _____ (individual's name) from _____ (name of facility)

and request a hearing before the Utilization Review Committee.

Name of objector: _____ Relationship to individual: _____

Signature of objector: _____ Date: _____

A Guardianship and Advocacy Commission is a state agency with three divisions: Legal Advocacy Services, Human Rights Authority and the Office of the State Guardian. The Commission can be reached at: Phone: 1-866-274-8023, TTY:(866) 333-3362, or in writing.

Chicago Regional Office
160 N. La Salle Street
Suite S500
Chicago, IL 60601

Springfield Regional Office
830 S. Spring Street
Springfield, IL 62704

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
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.

ILLINOIS DEPARTMENT OF HUMAN SERVICES
MENTAL HEALTH CENTER

WAIVER OF RIGHT TO A HEARING ON DISCHARGE

I, _____ have been given a Notice of Discharge from

_____ Mental Health Center. I understand I have seven (7) days from this

I understand I have seven (7) days from this date to decide to object. I understand that I may object to this discharge and that if I do object, I have a right to a utilization review hearing to contest the discharge. With a full understanding of my rights, I waive my right to object to my discharge and a utilization review hearing. I further waive the right to stay at the facility for the entire period of time, and that I request to be discharged as soon as possible. I am waiving these rights knowingly and voluntarily.

_____ _____
Patient's Signature Date

_____ _____
Guardian's Signature (if applicable) Date

_____ _____
Staff's Signature Date

Patient Name: _____

Unit: _____

Admission Date: _____