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50 STATE DISCHARGE LAW CHART[1]

For many hospitalized patients, particularly those with chronic conditions and long-term care needs, discharge planning is critical. Discharge planning refers to the process by which hospital staff, including social workers, nurses, and physicians, help prepare patients to leave the hospital. The following chart provides a summary of state discharge laws, outlining healthcare facilities' obligations to patients prior to, during, and after discharge. In many cases, state discharge laws provide additional requirements hospitals must fulfill beyond those set forth under federal law. Pursuant to federal law, all hospitals that participate in the Medicare, a government insurance program, must implement a written discharge planning process that applies to *all* patients – regardless of immigration or insurance status. [2] Any patient (or patient's representative) can request a discharge evaluation or plan even if hospital staff does not feel that one is necessary. In addition, under federal law, hospitals must:

1. Direct social workers, nurses or other qualified individuals to develop an evaluation process to identify patients, "at an early stage of hospitalization", who are likely to suffer "adverse health consequences" if they are discharged without sufficient discharge planning. The evaluation must weigh:

    a. the patient's need for post-hospital services and the availability of those services; and
    b. the patient's ability to care for himself post-discharge or be cared for in the environment from which he entered the hospital.

2. Complete the evaluation in a timely manner to avoid delays in discharge and ensure that proper post-discharge arrangements may be made

3. Discuss the results of the evaluation with the patient or the patient's representative

4. Include a copy of the evaluation in the patient's medical records

5. Direct social workers, nurses or other qualified individuals to develop and arrange for the initial implementation of a discharge plan, upon the request of the patient's physician, the patient or patient's representative

6. Reassess the appropriateness of the patient's discharge plan if the patient has changing medical conditions that affect his continuing care needs

7. As needed, counsel the patient and patient's family in preparation for the patient's post-hospital care

8. Include in the patient's discharge plan a list of home health aides or skilled nursing facilities that serve the area the patient lives in and are available to the patient, if such services are listed as necessary in the patient's discharge plan

[1] All laws and regulations are current through the 2011 legislative session.
[2] 42 U.S.C.A. § 1395x(ee); 42 C.F.R. § 482.43.

9. Transfer the patient with necessary medical information for follow-up care to "appropriate facilities, agencies, or outpatient services" that can meet the patient's needs and comply with federal and state health and safety standards.[3]

The following chart provides a summary of additional state discharge requirements, which may help advocates determine whether a hospital has violated its obligations to a patient. For some states, discharge planning requirements apply to long-term care facilities, such as nursing homes, rather than to hospitals. Unless otherwise noted in the chart, the discharge laws cited apply to hospitals.

State	State Discharge Laws	Summary of Hospital Requirements and Obligations
Alabama	Existing discharge laws do not apply to hospitals generally	
Alaska	ALASKA ADMIN. CODE tit. 7, § 12.870; ALASKA STAT. ANN. §§ 18.05.040, 32.32.010, 47.32.030; ALASKA ADMIN. CODE tit. 7, § 12.880; ALASKA STAT. ANN. §§ 18.05.040, 18.20.010, 18.20.060; ALASKA ADMIN. CODE tit. 7, § 12.890; ALASKA STAT. ANN. §§ 18.05.040, 47.32.010, 47.32.030	_A patient's medical records must contain the patient's condition upon discharge or transfer. _A patient has the right to participate in the development of a discharge plan and receive instructions for self-care and treatment, including an explanation of adverse symptoms and necessary precautions.
Arizona	ARIZ. ADMIN. CODE § R9-10-211, pursuant to 8 Ariz. Admin. Reg. 2785	_For an inpatient, discharge planning must: 1) identify the specific needs of the patient after discharge; 2) include the participation of the patient or the patient's representative; 3)be completed before discharge occurs; 4) provide the patient or the patient's representative with written information identifying classes or subclasses of health care institutions and the level of care that the health care institutions provide that may meet the patient's assessed and anticipated needs after discharge, if applicable; and 5) must be documented in the patient's medical record. _At discharge, the hospital must complete a discharge summary that includes: 1) a description of the patient's medical condition and the medical services provided to the patient; and 2) the signature of the patient's attending physician or the attending physician's designee; _ The attending physician (or his designee) must authorize a discharge order, prior to the patient's discharge, unless the patient leaves the hospital against medical advice.

[3] 42 C.F.R. § 482.43(d); Ctr. For Medicare & Medicaid Serv., State Operations Manual: Appendix A- Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, § 482.43(d), *available at* https://www.cms.gov/manuals/downloads/som107ap_a_hospitals.pdf. (stating that " '[a]ppropriate facilities' refers to facilities that can meet the patient's assessed needs on a post-discharge basis and that comply with Federal and State health and safety standards."). This requirement is particularly important in the medical deportation context where hospitals send patients to receive care at facilities in their home countries that are ill-suited to provide the services that these patients actually require. Hospitals that transfer patients to these facilities, to family members unable to provide appropriate care, or that simply dump these patients on the street, are likely in violation of this requirement.

		_If a patient is discharged to any location other than a health care institution, the patient or his family must receive a copy of discharge instructions _For a discharge of an outpatient receiving emergency services, the patient must receive a discharge order and discharge instruction unless the patient leaves against a medical staff member's advice
Arkansas	ARK. ADMIN. CODE §§ 007.05.10-6(E), 007.05.17-6(E)	_There must be an ongoing plan, consistent with available community and hospital resources to provide social work, psychological and educational services to meet the medical needs and follow up care of the patients. _Discharge planning starts at the time of the patient's admission. _Patients, along with necessary medical information, shall be transferred or referred to appropriate facilities, agencies, or outpatient services, as needed for follow-up or ancillary care
California	CA. HEALTH & SAFETY CODE § 1262.5, 2001 Cal. Legis. Serv. c. 691, § 2, *amended by* 2007 Cal. Legis. Serv. c. 472, § 3	_Each hospital must implement a discharge policy that requires the hospital to make post-hospital care arrangements prior to discharge for patients who are likely to suffer adverse health consequences in the absence of such a plan. The hospital must inform the patient of his discharge needs orally and in writing. _If necessary, the hospital must provide post-hospital care counseling to the patient. _The patient must be informed of the continuing health care requirements, orally or in writing. _If a patient is transferred to a nursing or intermediate care facility, the patient must be transferred with a transfer summary signed by the patient's physician, which includes information about the patient diagnosis, hospital course, pain treatment and management, medications, treatments, dietary requirement, rehabilitation potential, known allergies, and treatment plan. The hospital must give a copy of the transfer summary to the patient. _Upon discharge, the hospital must provide patients in need of long term care with information about at least one public, nonprofit agency, or organization that can give the patient information about the long-term care options in the patient's county of residence.
Colorado	6 COLO. CODE REGS. § 1011-1; COLO. REV. STAT. §§ 25-1.5-103, 25-3-101 *et seq.*	_Each hospital must have a discharge plan policy for inpatients that begins early on in the treatment and includes: an overview of the discharge planning process; a description of the qualifications of the staff responsible for implementing discharge planning; initiation of discharge planning in a timely manner to allow for the arrangement of post-hospital care as needed; and evaluation of the discharge planning process periodically for effectiveness. _The discharge plan must include: an evaluation of the post-hospital care needs of the patient and the availability of corresponding services; identification of the role of the hospital staff, patient, patient's family or designated representative in implementing the planning process; _The hospital must discuss the discharge plan with the patient prior to discharge. _For patients who need post-hospital health care services, the hospital must: inform the patient of her freedom to choose among providers of post-hospital care and choices available under applicable health insurance coverage; provide a comprehensive list of relevant, licensed post-hospital care providers in the geographic area requested; ensure that the receiving health care provider receive written documentation of the patient's discharge diagnosis, continuing care orders, current medications prior to discharge and the patient's discharge or transfer instructions.

		_For patients who *do not* need post-hospital health care services, the hospital must provide the patient with: a contact to call in case the patient has questions; written instructions about self-care, follow-up care, modified diet, and medications. _The hospital must prepare a discharge summary to facilitate continuity of care that is signed by the attending physician, which includes: reason for admission; significant findings; procedures and treatments provided; patient's discharge condition; patient and family instructions; a medication list; and a list of outstanding medical issues and pending tests at the time of discharge that require follow-up.
Connecticut	CONN. GEN. STAT. ANN. § 19a-504c; CONN. AGENCIES REGS. § 19a-504c-1	_Every hospitalized patient must receive a written discharge plan prior to discharge. _The discharge plan must include, but not necessarily be limited, to identification of the patient's needs for continued skill care or support services, and the specific resources to needed to meet those needs. _The discharge plan must be completed on a timely basis so that appropriate arrangements for post hospital care management can be made before discharge. _The discharge plan must be developed in collaboration with the patient. _The discharge plan must be approved by the physician of record. _The written discharge plan must be signed by the patient and/or family member or representative indicating their understanding of the discharge plan of care. _The documentation of the written discharge plan must be retained as a permanent part of the patient's medical record. _Information necessary to ensure the continuity of care will be sent to participating providers, as appropriate.
Delaware	Existing discharge laws do not apply to hospitals generally	
District of Columbia	Existing discharge laws do not apply to hospitals generally	
Florida	Existing discharge laws do not apply to hospitals generally	
Georgia	GA. COMP. R. & REGS. 290-9-7-.20; GA. CODE ANN. § 31-7-2.1	For Inpatients: _The hospital must use an effective and on-going discharge planning process that identifies post-hospital needs and arranges for appropriate resource referral and follow-up care. _Upon admission, the hospital must identify patients who are likely to suffer adverse consequences upon discharge in the absence of adequate discharge planning. _For patients identified as needing a discharge plan, designated qualified staff must complete an evaluation of post-hospital needs and develop a plan for meeting those needs. The discharge plan must be revised as needed with changes in the patient's condition. _The hospital must educate patients and their family members to prepare them for the patient's post-hospital care. _The hospital must arrange for the initial implementation of any discharge plan, including any transfer or referral to appropriate facilities, agencies, or outpatient services for follow-up or ancillary care. The hospital is responsible for transferring any necessary medical information to other facilities

		for the purpose of post-hospital care. _The hospital must regularly reassess the discharge planning process to ensure that it is responsive to patients' discharge needs.
Hawaii	HAW. CODE R. § 11-93-26; HAW. REV. STAT. §§ 321-9, 321-11	_A hospital must have policies and procedures for transferring or discharging a patient only for the patient's welfare or other patients' welfare, or other causes as determined by the hospital's director. The patient must be given reasonable advance notice to ensure orderly transfer or discharge. A patient has the right to receive discharge planning by qualified hospital staff to ensure appropriate post-hospital placement
Idaho	IDAHO ADMIN. CODE R. 16.03.14.200, pursuant to IDAHO CODE ANN. § 39-1307	A hospital must screen each patient for discharge planning needs. If discharge planning is necessary, a qualified person must be designated responsible for such planning. The hospital must have a transfer agreement with a Medicare and/or Medicaid skilled nursing home. If there is a common governing board for a hospital and a skilled nursing home, a policy statement concerning transfers will be sufficient.
Illinois	ILL. ADMIN. CODE tit. 77, § 250.240, 35 Ill. Reg. 13875	_The hospital must develop a discharge plan of care for all patients who present themselves to the hospital for care. The discharge plan must be based on an assessment of the patient's needs. _When a patient is discharged to another level of care, the hospital must ensure that the patient is being transferred to a hospital that is capable of meeting the patient's assessed needs. _At least 24 hours prior to discharge from the hospital, each patient who qualifies for the federal Medicare program must be notified of the discharge. The notification must be provided by a member of the hospital's medical staff. The notification must include: (1) the anticipated date and time of discharge; (2) written information concerning the patient's right to appeal the discharge pursuant to the federal Medicare program, including the steps to follow to appeal the discharge and the appropriate telephone number to call if the patient intends to appeal the discharge. This written information does not need to be included in the notification, if it has already been provided to the patient. _The hospital must develop and implement policies and procedures to provide discharge notification. The policies and procedures may provide for waiver of the notification requirement in either or both of the following cases: (1) when a discharge notice is not feasible due to a short length of stay in the hospital by the patient. The hospital policy must specify the length of stay when discharge notification will not be considered feasible; and (2) when the patient voluntarily desires to leave the hospital before the expiration of the 24 hour period.
Indiana	410 IND. ADMIN. CODE 2-3.1-5, IND. CODE ANN. §§ 16-28-1-7, 16-28-1-12; 410 IND. ADMIN. CODE 2-3.1-12, IND. CODE ANN. §§ 16-28-1-7, 16-28-1-12; 410 IND. ADMIN. CODE 2-3.1-36, IND. CODE ANN. §§ 16-28-1-7, 16-28-1-12	_A hospital must immediately inform the patient, consult with the patient's physician, and notify the patient's legal representative when there is a decision to transfer or discharge the patient from the hospital. _For Medicare and Medicaid certified facilities, an interfacility transfer and discharge means the movement of a patient to a bed outside of the certified hospital whether that bed is in the same physical plant or not."Intrafacility transfer" means the movement of a patient to a bed within the same hospital. For Medicare and Medicaid certified facilities, an intrafacility transfer means the movement of a patient to a bed within the same hospital. _When a transfer or discharge of a patient is proposed, whether intrafacility or interfacility, provision for continuity of care must be provided by the hospital.

		_Hospitals must permit each patient to remain and not transfer or discharge the patient from unless: (1) the transfer or discharge is necessary for the patient's welfare and the patient's needs cannot be met in the hospital; (2) the transfer or discharge is appropriate because the patient's health has improved sufficiently so that the patient no longer needs services; (3) the safety of individuals in the hospital is endangered; (4) the health of individuals in the hospital would otherwise be endangered; (5) the patient has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital; or (6) the hospital ceases to operate. _When the hospital proposes to transfer or discharge a patient, the patient's clinical records must be documented and the documentation must be made by: (1) the patient's physician when transfer or discharge is necessary; (2) any physician when transfer or discharge is necessary. _Before an interfacility transfer or discharge occurs, the hospital must: (1) notify the patient of the transfer or discharge and the reasons for the move in writing and in a language and manner that the patient understands, place a copy of the notice in the patient's clinical record, and transmit a copy to the patient, the person responsible for the patient's placement, maintenance, and care, and the patient's physician when the transfer or discharge is necessary; (2) record the reasons in the patient's clinical record; (3) include in the notice the reason for transfer or discharge, the effective date of transfer or discharge, the location to which the patient is transferred or discharged, a statement in not smaller than 12-point bold type that reads, "You have the right to appeal the health hospital's decision to transfer you. If you think you should not have to leave this hospital, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the hospital earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the hospital is authorized to transfer you. _The notice of transfer or discharge must be made at least 30 days before the patient is transferred or discharged, unless the notice may be made sooner as practicable before transfer or discharge. _If the patient appeals the transfer or discharge, the hospital may not transfer or discharge the patient within 34 days after the patient receives the initial transfer or discharge notice, unless an emergency exists. _If nonpayment is the basis of a transfer or discharge, the patient has the right to pay the balance owed to the hospital up to the date of the transfer or discharge and then is entitled to remain in the hospital. _The department must provide a patient who wishes to appeal the transfer or discharge from a hospital the opportunity to file a request for a hearing postmarked within ten (10) days following the patient's receipt of the written notice of the transfer or discharge from the hospital. _If a patient requests a hearing, the department must hold an informal hearing at the hospital within twenty-three (23) days from the date the patient receives the notice of transfer or discharge. The department must attempt to give at least five (5) days written notice to all parties prior to the informal hearing. The department must issue a decision within thirty (30) days from the date the patient receives the notice. The hospital must convince the department by a preponderance of the evidence that the transfer or discharge is authorized. If the department determines that the transfer is

		appropriate, the patient must not be required to leave within the thirty-four (34) days after the must patient's receipt of the initial transfer or discharge notice unless an emergency exists. Both the patient and the hospital have the right to administrative or judicial review of any decision or action by the department. If a hearing is to be held de novo, that hearing must be held in the hospital where the patient resides. _Prior to any interfacility or involuntary intrafacility relocation, the hospital must prepare a relocation plan to prepare the patient for relocation and to provide continuity of care. In nonemergency relocations, the planning process must include a relocation planning conference to which the patient must be invited. Patients may waive the planning conference. _At the planning conference, the patient's medical, psychosocial, and social needs with respect to the relocation must be considered. The plan devised must meet these needs. _The hospital must provide reasonable assistance to you to carry out the relocation plan. _The hospital must provide sufficient preparation and orientation to the patient to ensure safe and orderly transfer or discharge from the hospital. _If the relocation plan is disputed, a meeting must be held prior to the relocation with the administrator or his or her designee and the patient. An interested family member, if known, must be invited. _A written report of the content of the discussion at the meeting and the results of the meeting must be reviewed by the administrator or his or her designee, you, and an interested family member, if known, and each may make written comments on the report. _The written report of the meeting must be included in the patient's permanent record. _Before a hospital transfers the patient to a hospital or allows the patient to go on therapeutic leave of twenty-four (24) hours duration or longer, the hospital must provide written information to the patient and a family member or legal representative that specifies the duration of the bed-hold policy under the Medicaid state plan during which the patient is permitted to return and resume residence in the hospital and the hospital's policies regarding bed-hold periods. _Except in an emergency, at the time of the patient's transfer for hospitalization or therapeutic leave, a hospital must provide the patient and a family member or legal representative written notice which specifies the duration of the bed-hold policy. _When the hospital anticipates discharge, the patient must receive a discharge summary that includes: (1) a recapitulation of the patient's stay; (2) a final summary of the patient's status; (3) a post discharge care plan presented both orally and in writing in a language that the patient understands that was developed with the participation of the patient and his or her family.
Iowa	IOWA ADMIN. CODE R. 441-81.5(249A)	_Applies to hospital-based nursing facilities _When a public assistance recipient requests transfer or discharge, or another person requests this for the recipient, the administrator must promptly notify the local office of the department. This must be done in sufficient time to permit a social service worker to assist in the planning for the transfer or discharge. _A Case Activity Report, Form 470-0042, must be submitted to the department whenever a Medicaid applicant or recipient enters the hospital, changes level of care, or is discharged from the hospital. _ The administrator and staff must assist the patient in planning for transfer or discharge through

		development of a discharge plan. _ When a patient is transferred to another hospital, transfer information must be summarized from the hospital's records in a copy to accompany the patient. This information must includes: (1) a transfer form of diagnosis; (2) transfer orders; (3) nursing care plan; (4) physician's orders for care and the patient's personal records; (5) when applicable, the personal needs fund record; and (6) patient care review team assessment.
Kansas	Existing discharge laws do not apply to hospitals generally	
Kentucky	Existing discharge laws do not apply to hospitals generally	
Louisiana	Existing discharge laws do not apply to hospitals generally	
Maine	10-144-112 ME. CODE R. §§ XXII.A, .B, .C pursuant to ME. REV. STAT. tit. 22, §§ 3, 5, 6, 42, 1711, 1813, 1815, 1816, 1817 as amended, 1820	The hospital must have written policies and procedures for a coordinated discharge planning program that includes: _identifying patients through pre-admission screening or upon admission _continual screening for needs not identified at admission _written criteria for automatic referrals of high risk patients to hospital discharge planning staff. identifying needs of the patient for continuing health care services _assessing patient's and family's coping ability and attitude toward the illness or the health condition, and the adequacy of the home environment _assessing patient's financial resources for post hospital care _preliminary determination as to what community resources will be needed _intervention to arrange post-hospital care, including, assistance with application(s) when post-hospital care requires enrollment in a financial assistance program(s) _ providing a written list (documented in the medical record) of licensed providers to all patients requiring nursing home services or home health services prior to discharge. _Information provided to the patient, prior to discharge, must include: a list of nursing facilities and home health care agencies in the area the patient wishes to reside or currently resides; written disclosure of any financial interest the hospital has in a nursing home or home health care agency. If the patient is going to be referred to an affiliated provider or hospital with any financial interest, the patient and/or patient's family must sign or initial the referral form to acknowledge that they have been informed of the referring hospital's financial or other interest in the hospital accepting the patient; after the patient and/or patient's family has had an opportunity to review the list of licensed home care providers and nursing facilities, the discharging hospital must request that the patient and/or patient's family indicate a preference for any provider, either listed or unlisted. The list of licensed home care providers or nursing facility must be maintained in the patient's medical record, and the selection of a provider by the patient and/or patient's family must be noted on that list _The hospital must clearly define the lines of authority for discharge planning functions and appoint an individual to direct discharge planning, assign responsibility for discharge planning functions to sufficient personnel and provide them with appropriate training and supervision.

		_Discharge planning activity must be documented in the clinical records of patients identified in the process and must reflect intervention related to discharge needs and patient and/or family involvement in the discharge planning process, including decision making _Discharge planning provisions apply to critical access hospitals
Maryland	MD. CODE REGS. 10.07.09.11, MD. CODE ANN., HEALTH-GEN. §§ 19-345, -345.1, -345.2; *see generally* MD. CODE REGS. 10.07.01.27, MD. CODE ANN., HEALTH-GEN. § 19-308.8	_A patient of a hospital may not be transferred or discharged from the hospital involuntarily except if: (1) the transfer or discharge is necessary for the patient's welfare and the patient's needs cannot be met in the hospital; (2) the transfer or discharge is appropriate because the patient's health has improved sufficiently so that the patient no longer needs the services provided by the hospital; (3) the health or safety of an individual in a hospital is endangered; (4) the patient has failed, after reasonable and appropriate notice, to pay for, or under Medicare or Medicaid or otherwise, to have paid for a stay at the hospital; or (5) the hospital ceases to operate. _A Medicaid certified hospital may not: include in the admission contract of a patient any requirement that, to stay at the hospital, the patient will be required to pay for any period of time or amount of money as a private pay patient for any period when the patient is eligible for Medicaid benefits; or transfer or discharge a patient involuntarily because the patient is a Medicaid benefits recipient. This applies if a patient is or becomes eligible for Medicaid _A hospital must provide the patient with written notice of: (1) any proposed discharge or transfer; and (2) the opportunity for a hearing in accordance with the provisions of this section before the discharge or transfer. _The Department must prepare and provide each hospital with a standardized form that provides, in clear and simple language, at least the following information: (1) notice of the intended discharge or transfer of the patient; (2) each reason for the discharge or transfer; (3) the right of the patient to request a hearing; (4) the right of the patient to consult with any lawyer the patient chooses; (5) the availability of the services of the Legal Aid Bureau, the Older American Act Senior Legal Assistance Programs, and other agencies that may provide assistance to individuals who need legal counsel; (6) the availability of the Department of Aging and local Office on Aging Long-Term Care Ombudsman to assist the patient; and (7) the provisions of this law. _At least 30 days before the hospital involuntarily transfers or discharges a patient, the hospital must provide to the patient the written notice and provide the written notice to the next of kin, guardian, or any other individual known to have acted as the individual's representative, the Long-Term Care Ombudsman; and the Department. _The hospital must provide the patient with an opportunity for a hearing on the proposed transfer or discharge. _The regulations adopted by the Secretary may provide for the establishment of an escrow account when: (1) The basis for the discharge is nonpayment; and (2) the patient continues to reside in the hospital while the appeal is pending. _Any hearing on a proposed discharge or transfer of a patient is not a contested case and may not include the Secretary as a party. _A decision by an administrative law judge on a proposed discharge or transfer of a patient: is not a decision of the Secretary; unless appealed, is final and binding on the parties; is not reviewable by the Board of Review of the Department; and may be appealed as if it were a contested case but the

		appeal does not automatically stay the decision of the administrative law judge. _The provisions of this section requiring 30 days' notice and an opportunity for a hearing before discharge or transfer of a patient do not apply if an emergency exists and health or safety of the patient or other patients would be placed in imminent and serious jeopardy if the patient were not transferred or discharged from the hospital as soon as possible or the patient has not resided in the hospital for 30 days. _If a hospital discharges or transfers a patient under the provisions of this subsection, the hospital must provide reasonable notice of the proposed discharge or transfer. _A hospital may not involuntarily discharge or transfer a patient unless, within 48 hours before the discharge or transfer, the hospital has: _(1) provided or obtained: (i) a comprehensive medical assessment and evaluation of the patient, including a physical examination, that is documented in the patient's medical record; (ii) a post discharge plan of care for the patient that is developed, if possible, with the participation of the patient's next of kin, guardian, or legal representative; and (iii) written documentation from the patient's attending physician indicating that the transfer or discharge is in accordance with the post discharge plan of care and is not contraindicated by the patient's medical condition; and _(2) provided information to the patient concerning the patient's rights to make decisions concerning health care, including: (i) the right to accept or refuse medical treatment; (ii) the right to make an advance directive, including the right to make a living will and the right to appoint an agent to make health care decisions; and (iii) the right to revoke an advance directive. _The hospital must provide the patient or the patient's next of kin, guardian, or legal representative with: (1) a written statement of the medical assessment and evaluation and post discharge plan of care required under subsection (a) of this section; (2) a written statement itemizing the medications currently being taken by the patient; (3) to the extent permitted under State and federal law, at least a 3-day supply of the medications currently being taken by the patient; (4) the information necessary to assist the patient, the patient's next of kin, or legal representative in obtaining additional prescriptions for necessary medication through consultation with the patient's treating physician; and (5) a written statement containing the date, time, method, mode, and destination of discharge. _A hospital may not discharge or transfer a patient unless the patient is capable of and has consented in writing to the discharge or transfer. _A hospital may discharge or transfer a patient without obtaining the written consent of the patient if the discharge or transfer is in accordance with a post discharge plan of care developed and is to a safe and secure environment where the patient will be under the care of another licensed, certified, or registered care provider or another person who has agreed in writing to provide a safe and secure environment. _A hospital that is certified as a continuing care provider is not subject to these provisions if the hospital transfers a patient to a lesser level of care within the same hospital in accordance with a contractual agreement between the hospital and the patient and the transfer is approved by the attending physician.
Massachusetts	105 MASS. CODE REGS. §§ 130.340, -130.342, -130.343, MASS. GEN. LAWS ANN. ch. 111, §§ 3,	_Each hospital must organize a multi-disciplinary discharge planning service to help the attending physician and patient plan for continued care upon discharge

	51–56, 70	_Each hospital must designate either a discharge planning coordinator or unit for patients' discharge planning _Each patient must receive an oral and written, comprehensive and individualized discharge plan that is developed with the participation of health care professionals and the patient _The discharge plan must be communicated in a language understandable to the patient and the patient's family _Non-English speakers must be provided translation services _Any disagreement with a discharge plan may be discussed at a meeting between the patient and the patient's family and the discharge planning coordinator and the attending doctor
Michigan	MICH. COMP. LAWS ANN. § 333.20201	_Each hospital must adopt a policy describing the rights and responsibilities of patients or patients admitted to the health hospital or agency. _The policy must be posted at a public place in the hospital and must be provided to each member of the health hospital or agency staff. _The policy must include, at minimum that a patient is: entitled to know who is responsible for and who is providing his or her direct care; entitled to receive information concerning his or her continuing health needs and alternatives for meeting those needs; and entitled to be involved in his or her discharge planning, if appropriate.
Minnesota	MINN. STAT. ANN. § 158.10	For University of Minnesota Hospitals: _ When, in the opinion of the superintendent of the University of Minnesota Hospitals, any patient should be discharged as cured, or as no longer needing treatment, or for the reason that treatment cannot benefit the case, the superintendent must discharge the patient. If the patient is a county patient and is unable to return home alone, the superintendent must appoint some suitable person to accompany the patient home from the hospital. Such person must receive actual and necessary expenses; and, if not a salaried officer of the state, or any political subdivision thereof, must receive in addition $3 per day for the actual time necessarily consumed. _Patients must be encouraged and assisted, throughout their stay in a hospital or their course of treatment, to understand and exercise their rights as patients, patients, and citizens. Patients may voice grievances and recommend changes in policies and services to hospital staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the hospital or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman must be posted in a conspicuous place.
Mississippi	Existing discharge laws do not apply to hospitals generally	
Missouri	Existing discharge laws do not apply to hospitals generally	
Montana	Existing discharge laws do not apply to hospitals generally	

Nebraska	175 NEB. ADMIN. CODE § 9-006, pursuant to NEB. REV. STAT. ANN. §§ 71-401–71-459	_Each hospital must provide discharge planning to patients who request information or who are identified as likely to suffer adverse health consequences upon discharge if there is not adequate discharge planning. _The discharge planning program must include: a system for timely evaluation of any discharge planning needs of patients; identification of staff responsible for the program; development of a discharge plan with the patient or representative when need is identified; maintenance of a complete and accurate list of community-based services, resources and facilities to which patients can be referred; and arrangement for the initial implementation of a discharge plan including transfer of necessary medical information. _Each hospital must establish and implement a written process that promptly addresses grievances filed by patients or their representatives.
Nevada	NEV. REV. STAT. ANN. §§ 449.700, .705	_A patient may be transferred to another facility or home only if the patient has received an explanation of the need to transfer him and the alternatives available, unless his condition necessitates an immediate transfer to a facility for a higher level of care and he is unable to understand the explanation. _If a patient in a medical facility or facility for the dependent is transferred to another facility, the facility must forward a copy of the medical records of the patient, on or before the date the patient is transferred, to the other facility. The facility is not required to obtain the oral or written consent of the patient to forward a copy of the medical records.
New Hampshire	N.H. CODE ADMIN. R. ANN. He-P 802.18, -802.19	_The hospital must complete discharge planning on all patients admitted to the hospital and provide written instructions to the patient, agent or guardian. _Discharge planning must include, as applicable: (1) the patient's medication needs upon discharge; (2) the need for medical equipment and special diets; (3) the need for further placement in another health care hospital; (4) the need for home health services upon discharge; and (5) written discharge instructions _Discharge documentation must include: (1) the date and time of discharge; (2) the status of the patient at the time of discharge; and (3) any discharge planning or referrals that have been conducted for the patient.
New Jersey	N.J. ADMIN. CODE 8:43G-4.1, -5.2, -11.5; -11.6, pursuant to N.J. STAT. ANN. § 26:2H-5(b)	_A patient has the right to be informed by her treating physician of any continuing health care requirements which may follow discharge and to receive assistance from the physician and appropriate hospital staff in arranging for required follow-up care after discharge; a patient has a right to receive sufficient time before discharge to have arrangements made for healthcare needs after hospitalization; be informed by hospital of any discharge appeal process to which the patient is entitled by law _Hospitals must have written policies on discharge of patients; patients must be discharged only on doctor's orders or after signing a waiver that exempts the hospital and the doctor from liability as a result of the patient's decision to leave the hospital against medical advice _Patients who require post-discharge continuity of care must be linked to needed resources. _The hospital must make a diligent effort to find and effect an appropriate placement for any patient

		ready for discharge but requiring further care. _Documentation must be included in the patient's medical record. _Patient care conferences or discharge planning rounds must be held to discuss planning for patients needing continuity of care. _The patient must participate in the development of the discharge plan, where possible. The family or significant other must participate in the development of the plan, where possible, and when the patient is able to agree, and does agree, to their involvement. _Discharge planning must be initiated within 24 hours of admission. If a patient's needs for post-discharge care change after a discharge plan is developed, the plan must be modified to meet the patient's needs. _The hospital must have a mechanism to ensure that each patient receives, upon discharge, written instructions about follow-up care and medications, if relevant, and the telephone number of a contact person to call in case he or she has questions after discharge. _For all patients who receive discharge planning, the patient's medical record must include on-going documentation and a summary or summaries of the patient's discharge plan prepared by a member of the discharge planning team at the time of discharge, or within 30 days of discharge. _There must be a mechanism in place for monitoring the effectiveness of the discharge planning process on a periodic basis. _Appeal procedures vary from hospital to hospital
New Mexico	N.M. CODE R. § 7.7.2.18.K	Hospitals must have an effective, ongoing program to facilitate the provision of appropriate follow-up care to patients who are discharged. The discharge planning program must: have a mechanism to identify patients who require discharge planning to provide continuity of medical care to meet their identified needs; initiate discharge planning in a timely manner; identify the role of the patient's provider, nursing staff, social work staff, other appropriate staff, the patient, and the patient's family or representative in the initiation and implementation of the discharge planning process; assure documentation in the medical record of the discharge plan; allow for the timely and effective transmittal of all medical, social, economic information concerning the patient to persons responsible for subsequent care of the patient; provide that every patient, or their legal representatives, receive relevant information concerning their health needs and is involved in his or her own discharge planning; and be reviewed at least once a year to evaluate effectiveness.
New York	N.Y. PUB. HEALTH L. § 2803-i, N.Y. COMP. CODES R. & REGS. tit. 10, §§ 405.9(b), (f)-(g)	_Patients must be given written notice of their discharge rights upon admission to hospital _Patients must receive a comprehensive discharge plan that meets their specific health care needs _Patients and their families can participate in decisions about post-discharge care _Patients must receive written and verbal information about range of services in their communities available to meet their post-hospital needs _To be discharged, patients must receive a written, discharge notice stating that they are ready to be discharged and receive a copy of a discharge plan before leaving the hospital, with the opportunity for to sign both documents _Patients cannot be removed, transferred, or discharged because of the type of insurance they have or method of payment. Patients may be discharged based on a doctor's orders that doing so will not create a medical hazard or is in the patients' best interest

		_Patients cannot be discharged until the services needed, as outlined in the discharge plan, are secured or reasonably available _Patients may appeal their discharge
North Carolina	Existing discharge laws do not apply to hospitals generally	
North Dakota	N.D. ADMIN. CODE 33-07-01.1-09, -17, -30	_Every patient must receive effective discharge planning consistent with identified patient and family needs from the hospital. Discharge planning must be initiated in a timely manner. Patients must be transferred or referred to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care along with any necessary medical information. _ Discharge planning must be initiated upon admission and kept current. _Appropriate discharge instructions must be provided to patients
Ohio	Existing discharge laws do not apply to hospitals generally	
Oklahoma	Existing discharge laws do not apply to hospitals generally	
Oregon	OR. ADMIN. R. 333-505-0030, OR. REV. STAT. ANN. § 441.025	_A hospital must adopt, maintain transfer and discharge policies that address: (A) types of clinical conditions not acceptable for admission; (B) constraints imposed by limitations of services, physical facilities or staff coverage; (C) emergency admissions; and (D) requirements for informed consent signed by the patient or legal representative of the patient for diagnostic and treatment procedures; (E) requirements for identifying persons responsible for obtaining informed consent and other appropriate disclosures; (F) a process for the internal transfer of patients from one level or type of care to another; (G) discharge and termination of services; and (H) planning for continuity of patient care following discharge.
Pennsylvania	28 PA. CODE §§ 105.22, 105.24, 105.25	_Discharge planning must commence as soon as possible after admission. _If the hospital determines no discharge planning is necessary in a particular case, that conclusion must be noted on the medical record of the patient. _The hospital must have written policies governing discharge planning. These must include but need not be limited to the following: (1) appropriate referral and transfer plans; (2) methods to facilitate the provision of follow-up care; (3) information for the patient or his family concerning the patient's condition from the attending physician, including information about the patient's health care needs; the amount of activity he should engage in; any necessary medical regimens including drugs, diet, or other forms of therapy; sources of additional help from other agencies; and procedures to follow in case of complications; (4) procedures for assisting the patient and his family in gaining information regarding financial assistance in paying hospital bills. _A patient must not be transferred to another medical care facility unless prior arrangements for admission have been made. Clinical records of sufficient content to insure continuity of care must accompany the patient. _Any individual who cannot legally consent to his own care must be discharged only to the custody of parents, legal guardian, person standing *in loco parentis,* or another responsible party unless

		otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, the decision must be in writing and the statement must become a part of the permanent medical record of the patient.
Rhode Island	R.I. GEN. LAWS ANN. § 23-17.26-3, 31 4 R.I. CODE R. § 18.0	On or before July 1, 2015, each hospital operating in the State of Rhode Island must submit to the director: (1) Evidence of participation in a high-quality comprehensive discharge planning and transitions improvement project operated by a nonprofit organization in this state; or (2) A plan for the provision of comprehensive discharge planning and information to be shared with patients transitioning from the hospitals' care. Such plan must contain the adoption of evidence-based practices including, but not limited to: (i) providing in-hospital education prior to discharge; (ii) ensuring patient involvement such that, at discharge, patients, and caregivers understand the patient's conditions and medications and have a point of contact for follow-up questions; (iii) attempting to identify patients' primary care providers and assisting with scheduling post-hospital follow-up appointments prior to patient discharge; (iv) expanding the transmission of the Department of Health's continuity of care form, or successor program, to include primary care providers' receipt of information at patient discharge when the primary care provider is identified by the patient; and (v) coordinating and improving communication with outpatient providers. _ Each hospital must have written discharge policies and procedures pertaining to requirements for informed consent signed by the patient or legal representatives for diagnostic and treatment procedures, internal transfer of patients from one level or type of care to another, discharge and termination of services; and provisions for a mechanism for recording, transmitting patient-specific information to other health care providers and receiving information essential to the continuity of patient care. _Each hospital must not discourage persons who cannot afford to pay from seeking essential medical services _ The hospital must have a discharge planning process for all inpatients. Discharge planning policies and procedures must be in writing and must include a mechanism for discharge planners to receive regular updates regarding new offerings of community programs and the complete range of current options available at discharge. _The hospital must identify, at an early stage in hospitalization, all inpatients who are likely to suffer adverse health consequences on discharge if there is no adequate discharge planning. _A discharge planning evaluation must be provided to all inpatients, to other patients on patient request, the request of the person acting on the patient's behalf, or upon the request of the physician. _The evaluation must be timely to avoid unnecessary delays in discharge and must be part of the patient's medical record. _The evaluation must include a needs assessment, the patient's capacity for self-care, and the availability of post-hospital services to meet the needs of the patient. _A registered nurse or social worker must develop or supervise the development of the evaluation. _The results of the evaluation must be discussed with the patient or the individual acting on the patient's behalf. _The evaluation must be used to establish an appropriate discharge plan.

		_A registered nurse or social worker must develop or supervise the development of a discharge plan if the discharge planning evaluation indicates the need for a discharge plan. _The hospital must arrange for implementation of the discharge plan. _The hospital must transfer or refer inpatients and outpatients to appropriate facilities, agencies, or outpatient services, as needed, for follow-up care.
South Carolina	Existing discharge laws apply do not apply to hospitals generally	
South Dakota	S.D. ADMIN. R. 44:04:04:17, S.D. CODIFIED LAWS § 34-12-13	_A facility must have policies and procedures for discharge planning that identifies members of the discharge planning team, provides a list of all area agencies and resources that can provide post-discharge care, and describes the discharge planning process. _Outside caregivers may be included in discharge planning conferences. _Within 24 hours after admission, a hospital must determine each patient's potential need for continuing care following discharge. The facility must initiate planning with applicable agencies to meet the patient's identified needs and offer assistance to patients to obtain needed services upon discharge. The hospital must provide information necessary for care coordination and continuity of care to the patient and relevant referral agencies.
Tennessee	TENN. COMP. R. & REGS. 1200-08-01-.05, TENN. CODE ANN. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-255	_The hospital must ensure continuity of care and provide an effective discharge planning process that applies to all patients. The hospital's discharge planning process, including discharge policies and procedures, must be specified in writing and must: (a) be developed and/or supervised by a registered nurse, social worker or other appropriately qualified personnel; (b) begin upon admission of any patient who is likely to suffer adverse health consequences; (c) be provided when identified as a need by the patient, a person acting on the patient's behalf, or by the physician; (d) include the likelihood of a patient's capacity for self-care or the possibility of the patient returning to his or her pre-hospitalization environment; (e) identify the patient's continuing physical, emotional, housekeeping, transportation, social and other needs and must make arrangements to meet those needs; (f) be completed on a timely basis to allow for arrangement of post-hospital care and to avoid unnecessary delays in discharge; (g) involve the patient, the patient's family or individual acting on the patient's behalf, the attending physician, nursing and social work professionals and other appropriate staff, and must be documented in the patient's medical record; and (h) be conducted on an ongoing basis throughout the continuum of hospital care. _Coordination of services may involve promoting communication to facilitate family support, social work, nursing care, consultation, referral or other follow-up. _A discharge plan is required for every patient, even if the patient will be discharged to his or her home _The hospital must arrange for the initial implementation of the patient's discharge plan and must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan. _As needed, the patient and family members or interested persons must be taught and/or counseled to prepare them for post-hospital care. _The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.

		_When a hospital proceeding in compliance with these rules seeks to appropriately transfer a patient to another hospital, the proposed receiving hospital may not decline the transfer for reasons related to the patient's ability to pay or source of payment, rather than the patient's need for medical services. The determination of the availability of space at the receiving hospital may not be based on the patient's ability to pay or source of payment.
Texas	Existing discharge laws do not apply to hospitals generally	
Utah	Existing discharge laws do not apply to hospitals generally	
Vermont	Existing discharge laws do not apply to hospitals generally	
Virgin Islands	Existing discharge laws do not apply to hospitals generally	
Virginia	12 VA. ADMIN. CODE § 5-410-1170	_Each outpatient surgical hospital must develop a policy manual that includes provisions covering admission and discharge procedures, including the hospital's criteria for evaluating the patient before admission and before discharge
Washington	WASH. REV. CODE ANN. § 70.41.320	_Hospitals and acute care facilities must: establish and maintain a system for discharge planning and designate a person responsible for system management and implementation; establish written policies and procedures to identify patients needing further nursing, therapy, or supportive care following discharge from the hospital, develop a documented discharge plan for each identified patient and date such follow-up care is to be initiated, coordinate with patient, family, caregiver, and appropriate members of the health care team, provide any patient, regardless of income status, written information and verbal consultation regarding the array of long-term care options available in the community, including the relative cost, eligibility criteria, location, and contact persons, promote an informed choice of long-term care services on the part of patients, family members, and legal representatives, and coordinate with the department and specialized case management agencies to ensure timely transition to appropriate home, community residential, or nursing facility care; and work in cooperation with the department which is responsible for ensuring that patients eligible for Medicaid long-term care receive prompt assessment and appropriate service authorization. _The role of the department is to assist the hospital and to assist patients and their families in making informed choices by providing information regarding home and community options.
West Virginia	W. VA. CODE ANN. § 64-12-14, W. VA. CODE R. § 64-12-14	_The hospital must have a discharge planning process for patients in need of post-hospital services, including hospice care, which includes early assessment of the needs of each patient, particularly those with potential risk for adverse consequences upon discharge. The assessment must be based on the patient's functional abilities and the environment to which the patient will likely return following discharge. The hospital's policies and procedures must be specified in writing. _A discharge needs assessment, evaluating the factors that affect the patient's need for post-hospital care, must be performed or supervised by a registered nurse, social worker or other appropriately qualified person, as identified by hospital policy, and be completed in enough time for appropriate

		arrangements to be made prior to discharge. The assessment must address the biopsychosocial needs of the patient, the level of understanding of those needs and an identification of post hospital care resources. _The hospital must provide counseling as needed to the patient and family members or interested persons, to prepare them for post-hospital care. _The hospital must arrange for the initial implementation of the patient's discharge plan, including obtaining post-hospital services as necessary. _The hospital must ensure that the discharge plan be reassessed and entered into the patient's record. _The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies or outpatient services, as needed, for follow-up or ancillary care.
Wisconsin	WIS. ADMIN. CODE DHS § 94.23	_When a voluntary inpatient requests a discharge, the hospital director must either release the patient or file a statement of emergency detention with the court. _If a voluntary inpatient requests a discharge and he or she has no other living quarters or is in need of other services to make the transition to the community, the following actions must be taken by the hospital director prior to discharge: (1) counsel the patient and, assist the patient in locating living quarters when possible; (2) inform the applicable program director of the patient's need for residential and other necessary transitional services; and (3) if no living arrangements have been made by the time of discharge, refer the patient to an appropriate service agency for emergency living arrangements.
Wyoming	Existing discharge laws do not apply to hospitals generally	

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KNOW YOUR RIGHTS:

MEDICAL DEPORTATION & YOUR DISCHARGE RIGHTS IN NEW YORK

What is Medical Deportation?

Medical deportation refers to the practice in which hospitals send uninsured undocumented immigrants in need of long-term care back to their home countries outside of the federal immigration process, placing the health and safety of these immigrants in jeopardy.

Hospitals engaging in this practice may be violating patients' discharge rights. This fact sheet provides a general overview of these rights under New York state law.

What is Discharge Planning?

Discharge planning refers to the process by which hospital staff, including social workers, nurses, and physicians, help prepare patients to leave the hospital. Discharge planning services may include helping patients understand their diagnoses and medication needs or facilitating their transfer from the hospital to nursing homes or rehabilitative centers. In the medical deportation context, hospital staff may discharge undocumented patients, many of whom have serious continuing health care needs, without adequate planning and preparation. These patients may find themselves transported back to their home countries unable to access the medical services they need to survive.

What are Your Rights?

All patients – regardless of their insurance or immigration status – have certain discharge rights, including the right to appeal a discharge. Here are your rights:

- Upon admission to the hospital, you must be given written notice of your discharge rights.
- You have the right to a comprehensive discharge plan that meets your specific health care needs.

- You and your family have the right to participate in decisions about the care you will receive after leaving the hospital. For instance, if you need rehabilitative care, you and your family can help decide where you will receive that care.
- You must receive written and verbal information about the range of services available in your community that can help you meet your post-hospital needs.
- You must receive a written notice stating that you are ready to be discharged (called a discharge notice) and a copy of a discharge plan before leaving the hospital, and you should have the opportunity to sign both.
- You cannot be removed, transferred or discharged because of the type of insurance you have or your method of payment. You can only be discharged based on doctor's orders that doing so will not create a medical hazard or is in your best interest.
- You cannot be discharged until the services you need in your discharge plan are secured or reasonably available.
- You have the right to appeal your discharge.

How Can You Appeal Your Discharge?

If you question the appropriateness of your discharge plan or the availability of the health care services in your discharge plan, you can appeal your discharge by calling the number listed on the discharge notice you receive. If you are still an in-patient, you must call no later than **noon of the next working day** after you receive the discharge notice. If you are no longer an in-patient at the time you wish you dispute the discharge, you must call no later than 30 days after receiving the discharge notice or 7 days after receiving your complete hospital bill, whichever is later.

If you feel like you are being discharged too soon or improperly, please contact the **Health Justice Program** at **New York Lawyers for the Public Interest** (NYLPI) at **212-244-4664** and we may be able to connect you to someone who can help.

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What are Your Rights?

All patients – regardless of their insurance or immigration status – have certain discharge rights, including the right to appeal a discharge. Here are your rights:

- The hospital must begin planning for your discharge within 24 hours of your admission, modifying your plan as necessary to meet your health needs.
- You can only be discharged upon a doctor's order.

- If you require post-discharge care, the hospital must help arrange that care for you.
- You and your family have the right to participate in your discharge planning.
- Upon discharge, you must receive written instructions about follow-up care and medications, if necessary. In addition, you must receive the telephone number of a contact person at the hospital to call in case you have any questions related to your discharge.
- You have the right to appeal your discharge and must be informed of the appeal process.

How Can You Appeal Your Discharge?

If you question the appropriateness of your discharge plan or the availability of the health care services in your discharge plan, you can appeal your discharge by contacting a social worker or patient advocate at the hospital where you received health care services.

If you feel like you are being discharged too soon or improperly, please contact the **Health Justice Program** at **New York Lawyers for the Public Interest** (NYLPI) at **212-244-4664** and we may be able to connect you to someone who can help.