

**Montana Mental Health Nursing Care Center**

***Information for Business Office  
on Resident Transfers***

**Resident Name:** \_\_\_\_\_

**Date and Time of Transfer:** \_\_\_\_\_

**Amount of Cash Needed for Travel:** \_\_\_\_\_  
***(Check or Cash)*** \_\_\_\_\_

**Permanent Placement or 30 Day Trial:** \_\_\_\_\_  
\_\_\_\_\_

**Burial Arrangements:**  
***(If with specific mortuary and resident has purple cross)***  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**New Residence:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Contact Person at New Residence:** \_\_\_\_\_  
\_\_\_\_\_