

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: _____
