



SETON HALL | LAW

# Medical Repatriation Advocacy Packet

**OCTOBER 2015**

*A guide for attorneys and other advocates working with patients at risk of forced deportation by hospitals.*

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The information in this guide is provided for informational and educational purposes only, and nothing in this guide is to be considered legal advice for specific cases. This guide was developed for use by lawyers who represent, or seek to assist, patients who risk being repatriated for medical reasons, as well as advocates, friends, and family members of the patient. You should consult an immigration lawyer for legal advice based on your individual situation.

## Contents

Introduction _____	1
Why You Need This Packet _____	3
How to Use this Packet _____	5
Writing a Carefully Worded Letter to the Hospital _____	6
Filing for Guardianship to Secure the Patient’s Rights _____	7
Using Tort Law to Discourage Repatriation of the Patient _____	14
Using Criminal Law to Protect the Patient from Repatriation _____	14
Employing Licensing Regulations to Monitor Medical Misconduct _____	16
Applying JOINT COMMISSION Accreditation Standards to Hospital Discharge/Transfer Policies _____	18
Operating within Medicare’s Conditions of Participation to Deter Repatriation _____	21
Monitoring Discrimination under the Office for Civil Rights to Prevent Repatriation _____	28
Guiding Compliance under New York’s Public Health Law and Applying For Medical Assistance Programs (Charity Care; PRUCOL) to Avoid Repatriation _____	30
Ensuring Hospitals Obtain Informed Consent Prior to Proceeding with Healthcare Decisions _____	34
Conclusion _____	35
Appendix 1: Checklist of Action Items _____	36
Appendix 2: Model Letter 1 _____	37
Appendix 3: Model Letter 2 _____	38
Appendix 4: Model Letter 3 (for Non-Lawyers) _____	39
Appendix 5: Short Guide (for Non-Lawyers) _____	40
Appendix 6: Flyer (front) _____	41
Appendix 7: Flyer (back) _____	42
Appendix 8: Palm Card _____	43
Appendix 9: Patients’ Bill of Rights, As Compiled by the NY State Department of Health _____	44

# Introduction

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*Medical repatriation is the practice by which hospitals in the United States transport ill or injured non-citizens to medical facilities abroad.*

*“Hospitals engage in de facto deportations of immigrant patients without any governmental oversight or accountability, and this situation is ripe for abuse.” – Professor Lori Nessel, Seton Hall University School of Law*

*This packet summarizes federal and state guidelines relevant to involuntary medical repatriation, and strategies to delay or prevent the practice.*

This packet was prepared by the Seton Hall Law Center for Social Justice (“CSJ”), and the accompanying website<sup>1</sup> is a joint project with New York Lawyers for the Public Interest (NYLPI). Involuntary medical repatriation, also known as medical deportation, occurs when hospitals in the United States, through force or coercion, transport unwilling ill or injured non-citizens, or those perceived to be non-citizens, to medical facilities abroad. Such nonconsensual repatriations completely circumvent the federal immigration process. According to Lori A. Nessel, Director of the CSJ and Professor at Seton Hall University School of Law, “When hospitals repatriate vulnerable patients without consent, or when consent is obtained through coercion, they are engaging in *de facto* deportation without any governmental oversight or accountability, and this situation is ripe for abuse.” The consequences of involuntary medical repatriation can be dire. When hospitals send seriously ill or injured immigrant patients directly from their hospital beds to their native countries, patients’ lives are jeopardized because they are sent to facilities that do not have the resources to provide needed care. Often, this results in significant deterioration of a patient’s health, or even death.

The purpose and objective of this packet is primarily to assist lawyers who represent, or seek to assist, patients who risk being repatriated for medical reasons against their will, as well as advocates, friends, and family members of the patient.<sup>2</sup> Two Seton Hall Law students with the CSJ interviewed five lawyers who have represented patients facing involuntary medical repatriation, and discussed best strategies and practices when representing a client in this situation. The information contained herein provides a summary of relevant federal laws on medical services and discharge plans, model letters to send to a hospital trying to engage in involuntary medical repatriation, and possible strategies that a lawyer or advocate could consider to delay or prevent the practice. This packet was prepared by Seton Hall Law students Yasmine Fulena, Agnes Isabel Heine, Phillip DeFedele and Sabrina Mirza, under the supervision of Professor Lori A. Nessel.

Lastly, the CSJ would like to acknowledge the following attorneys for their time and invaluable insight into this endeavor: Lisa Palumbo at the Legal Assistance Foundation, Thomas Duff at the Duff Law Firm, John Redmann at Redmann Law, Fernando Gaxiola at QuikHelp Tucson, and John de Leon at The Law Offices of Chavez and de Leon.

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<sup>1</sup> <http://medicalrepatriation.wordpress.com/>

<sup>2</sup> The strategies included in this packet are intended solely as suggestions, not legal advice.

Additionally, we would like to thank New York Lawyers for the Public Interest for their help in initiating this project and for providing guidance along the way.

## Why You Need This Packet

Repatriations can occur in a number of contexts. The most common scenarios are:

1. Hospitals seeking state court orders to repatriate patients
2. Hospitals repatriating patients on their own
3. Hospitals hiring private companies to repatriate their patients

*Highlighting that a hospital will violate federal laws grabs the hospital's attention.*

➤ **Hospitals cannot use state court orders to forcibly repatriate patients because:**

**ONLY** the federal government has the power to regulate immigration and naturalization, including deportation.

- Nation-states have the inherent authority to admit and exclude foreigners, and set forth regulations upon which to determine admissibility and excludability (*See Ekiu v. United States*, 142 U.S. 651, 659 (1892)).
- The authority to admit and exclude foreigners is “an incident of sovereignty belonging to the government of the United States.” (*The Chinese Exclusion Case*, 130 U.S. 581, 609 (1889)).
- The power to regulate admission, exclusion, and deportation lies exclusively with the federal government (*See DeCanas v. Bica*), not hospitals.
- Only Congress is vested with regulating immigration (*Plyler v. Doe*, 457 U.S. 202, 237 (1992); *Graham v. Richardson*, 403 U.S. 365, 377 (1972)). This power is plenary (*Sale v. Haitian Centers Council, Inc.*, 509 U.S. 155, 201 (1993); *Kleindienst v. Mandel*, 408 U.S. 753, 765-766 (1972); *Oceanic Navigation Co. v. Stranaham*).
- Congress has delegated to the Secretary of Homeland Security and the United States Attorney General the authority to deport persons. (8 U.S.C. § 1103 (2006)).
- An immigration judge conducts the proceeding, which unless otherwise specified by chapter 8 of the United States Code, shall be the sole and exclusive procedure that decides the deportability of an alien (8 U.S.C. § 1129a(a) (2006)).
- “Federal immigration law preempts deportation” by state courts. State courts do not have the authority to engage in what are essentially hospital deportations due to lacking subject-matter jurisdiction. (*Montejo v. Martin Mem’l Med. Ctr., Inc.*, 874 So.2d 654 (Fla. Dist. Ct. App. 2004)).

➤ **Hospitals do not have the authority to forcibly repatriate patients on their own because:**

Forcibly repatriating an immigrant is tantamount to a deportation order.

- Although medical repatriation may appear to only involve guardianship or health law, courts have recognized that when questions of subject matter jurisdiction arise, it is sometimes necessary to take a “broader inquiry into the nature of the claim rather than resolution of the issue by technical application,” and since this action involves an involuntary transfer to a foreign country, it is an immigration action. (*Jagiella v. Jagiella*, 647 F.2d 561, 565 (5th Cir. 1981)).



*Montejo v. Martin Mem’l Med. Ctr. is one of the seminal cases in the medical deportation area, and highlights that deportation is reserved to the federal government, not the states.*

- **Even with the use of private repatriation companies, these involuntary deportations are unlawful because:**
  - The hospitals are functioning as unauthorized immigration officers and are deporting seriously ill or injured immigrant patients directly from their hospital beds to their native countries, often without the consent of the immigrant patient or by exercising coercion to obtain consent.
  - Federal requirements for informed consent can be found in the **Centers for Medicare and Medicaid Services (CMS) Conditions of Participation** and hospitals must abide by these guidelines to continue to receive reimbursement from Medicare.
    - The **Patient Rights Condition of Participation** states that the patient has the right to make informed decisions about his/her care. The patient must remain informed of his/her health status, be involved in care planning and treatment, and be able to request or refuse treatment. Repatriation often breaches each of these requirements by removing any control of healthcare outcomes by pressuring the patient into repatriation or simply carrying out the repatriation without consulting the patient. It removes the “informed” from the informed consent process by not fully disclosing the hospital’s intent to deport.
    - The **Medical Records Condition of Participation** provides that the patient’s medical record must contain copies of any informed consent use to proceed with procedures and treatments requiring informed consent.

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## How to Use this Packet

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**Part 1** illustrates strategies that have been successful in the past to delay or prevent involuntary medical repatriation. As attorneys who have worked with these types of cases have explained, an advocate's most powerful tool, and the first action one could take, is to send a letter to the hospital and additional staff highlighting the laws violated if involuntary medical repatriation occurs (see Appendices 2, 3, and 4 for model letters).

**Part 2** includes strategies that have been used by attorneys, both with and without success. These strategies include:

- Filing for guardianship of the patient being threatened with involuntary repatriation (see section on guardianship) to ensure that any medical decisions that should be made by the patient (who may be unable to make them on his or her own) are made by a competent individual.
- Filing a tort action after or at the same time that the repatriation occurs. False imprisonment is the tort action which has been used in these types of cases. This tort may be called something different in your state.
- Alerting a hospital that their actions may constitute a criminal act (depending upon your state's laws). However, this should be a last resort as it may antagonize the hospital.

**Part 3** focuses on health law and techniques that have not yet been tried.

If the letter does not generate a response by the hospital, consider filing complaints with both state and federal organizations that regulate hospital conduct. You may consider:

- Submitting an internal hospital grievance. Speaking with a hospital social worker may assist in this process.
- Filing a misconduct complaint against the physician in charge (see section on licensing).
- Submitting a JOINT COMMISSION complaint (see section on JOINT COMMISSION Accreditation Standards).
- Submitting a complaint with the Centers for Medicare and Medicaid Services (see the section on CMS).
- Submitting a discrimination claim to the Office for Civil Rights.

You may also consider researching financial sources, such as charity care and other state medical assistance programs. See the section on charity care within Article 28 of New York's Public Health Law and the section on PRUCOL Status.

**The Appendix** includes other useful documents. If involuntary repatriations are common in your area or you want to help in getting the word out, the flyer and palm card can be distributed to various organizations or community centers so that individuals threatened with involuntary medical deportation know who to contact. Lastly, there is a Patient's Bill of Rights, which the state has generated. Every patient should know what their rights are when they are at the hospital.



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## Writing a Carefully Worded Letter to the Hospital

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- Sending a letter to hospital administration alerts the hospital to a possible involuntary medical repatriation. Not all parties may be aware that this is happening.
- The letter could be mailed, faxed, and emailed to the hospital's general counsel and ethics committee, the case manager of the trauma center, the nurses' station, the floor of the patient, the case worker assigned to the case, and the president of the hospital. Sending it to the nurses' station and the floor ensures that the letter ends up in the patient's medical record, which is critical.
- It is crucial to state in the letter that the patient, or the patient's guardian, does not consent to repatriation. By stating that the patient does not consent to leaving the hospital, the letter reminds the hospital that removing the patient is equivalent to a deportation, which is reserved to the U.S. Citizenship and Immigration Services.
- Two lawyers have been successful in delaying or preventing involuntary medical deportation by using a well-crafted letter. Appendix 3 is a letter that was provided by John Redmann, Esq., in New Orleans, LA. By sending a letter to the hospital and informing a hospital representative, in a face-to-face meeting, that the hospital risked violating federal and state laws if it removed his client, Mr. Redmann was able to halt his client's imminent removal.
- It is important to include both state and federal laws that are being violated. Appendix 2 includes federal laws that may be implicated. Make sure to research relevant state laws so that you can include them.
- Appendix 4 includes a letter intended for use by non-lawyers that may be sent to the relevant hospital representatives.

## Filing for Guardianship to Secure the Patient's Rights

*Two-day old U.S. citizen Elliot, born with Down syndrome and a heart problem, was being treated in a hospital neonatal intensive care unit in Arizona when it became clear that he would be needing continuing care. The hospital's policy was to transfer patients to their "community of residence" when such needs arose. Elliot's mother contacted Fernando Gaxiola, a local lawyer, while Elliot was en route to the airport. Mr. Gaxiola had Elliot's parents agree to transfer custody of their son to him, at which point Mr. Gaxiola called 9-1-1 to report a kidnapping. He also called the hospital and informed them that his consent was required before moving Elliot, who was eventually approved for Medicaid coverage.*

*In the Montejo v. Martin Mem'l Med. Ctr. case, the patient's relative was appointed as the legal guardian. A year after an accident which resulted in traumatic brain injury, the hospital intervened in the guardianship proceedings to seek court approval to discharge the patient and transport him back to his native country, Guatemala. The court authorized this transfer, and although the guardian appealed, the hospital flew the patient back before the court ruled on the appeal. This demonstrates that filing for guardianship is not a guarantee against repatriation because the court has discretion to consider a hospital's petition contesting the guardian's decision.*

*The process varies by state, so be sure to check your state's requirements if you are not filing for guardianship in New York State.*

One strategy to consider is encouraging a patient's family member or other involved party to file for guardianship. This is advantageous because the hospital should not be able to discharge the patient during the guardianship proceedings and once the guardian is appointed without obtaining the guardian's permission. Having a guardian appointed also ensures that decisions concerning a patient's medical future are made by a competent individual who is less likely to be influenced by the hospital and its staff. The disadvantage is that there is no guarantee that the judge will find a need for a guardian. Additionally, if a guardian is appointed, the hospital can petition the court to contest the guardian's directions, leaving the guardian essentially at the mercy of the court's discretion.

Below is an outline of the procedure for filing for guardianship as per [Article 81 of New York's Mental Hygiene Law](#).

## WHERE TO FILE THE PETITION

### § 81.04 Jurisdiction

- The Supreme Court in New York City and the County Courts outside the city have the power to provide the relief requested; therefore the petition should be filed with these courts. The petition may also be filed in Surrogate's Court when the alleged incapacitated person has an interest in an estate proceeding.

### § 81.05 Venue

- The proceeding may be brought:
  - (a) in the county where the person resides, or in the county where the person is physically present, or in the Surrogates Court where an estate proceeding, in which the person is interested has been brought.Residents in a facility will be considered residents of the county where the facility is located and the proceeding will be brought in that county.

## WHO MAY BRING A GUARDIANSHIP PROCEEDING?

### § 81.06 Who may commence a proceeding

- A proceeding for a guardian may be commenced by the filing of the petition with the court by:
  1. the alleged incapacitated person;
  2. a presumptive distributee (person entitled to take or share in the estate of the alleged incapacitated person) of the alleged incapacitated person;
  3. an executor or administrator of an estate when the alleged incapacitated person is or may be a beneficiary;
  4. a trustee of a trust when the alleged incapacitated person is or may be the grantor or beneficiary;
  5. the person with whom the alleged incapacitated person resides;
  6. a person otherwise concerned with the welfare of the alleged incapacitated person (which may include a corporation or public agency, including the department of social services in the county where the alleged incapacitated person resides);
  7. the chief executive officer, or the designee of the chief executive officer of a facility, in which the alleged incapacitated person is a patient or resident.

*Almost anyone can file for guardianship.*

## SERVICE AND NOTICE

### § 81.07 Notice

- An Article 81 proceeding shall be commenced upon the filing of the petition. The court shall set the date on which the order to show cause is heard no more than 28 days from the date of the signing of the order to show cause. The notice shall be written in large type, in plain language and in a language other than English if necessary to inform the person alleged to be incapacitated of his/her rights.

There is no specific requirement that medical information be contained in the petition, which is likely due to concerns for confidentiality of the patient.

- **What information is to be served?**

The following documents are to be served:

1. the order to show cause;
2. the notice; and
3. the petition and any supporting papers such as a medical affirmation and financial statements

- **Who is to be served?**

The following parties shall be served:

1. the alleged incapacitated person;
2. his/her attorney; and
3. the court evaluator

- **How are the Parties to be served?**

The manner and time frames for service are as follows:

1. the order to show cause and a copy of the petition shall be personally delivered to the alleged incapacitated person not less than 14 days prior to the hearing date of the order to show cause. However, the court may direct that the order to show cause and a copy of the petition be served on the alleged incapacitated person in a manner other than personal delivery when the petitioner demonstrates to the court's satisfaction that the person alleged to be incapacitated has refused to accept service.
2. the order to show cause and a copy of the petition shall be served upon the court evaluator and the attorney for the alleged incapacitated person, if there is one, by fax, provided that the fax telephone number is designated by the attorney for that purpose, or by delivering the papers personally or by overnight delivery service to the office of the court evaluator and the attorney for the alleged incapacitated person, if there is one, within three business days following the appointment of the court evaluator and the attorney or the appearance of an attorney retained by the alleged incapacitated person.

- **What Must the Notice Contain?**

Other interested parties are entitled only to Notice of the proceeding.

The notice of the proceeding shall contain:

1. The name and address of the alleged incapacitated person to whom the guardianship proceeding relates;
2. The name and address of the petitioner;
3. The names of all persons to be given Notice of the proceeding;
4. The time and place where the order to show cause shall be heard;
5. The object of the proceeding and the relief sought;
6. The name, address, and telephone number of the petitioner's attorney.

- **Who Must Be Given Notice of the Guardianship Proceeding?**



*Ensure that all parties who must be served receive a copy of the guardianship petition.*



*You may want to alert the hospital that guardianship proceedings have commenced.*

Notice of the proceeding together with a copy of the order to show cause shall be mailed, not less than fourteen days prior to the hearing date on the order to show cause, to the following persons:

1. the spouse, parents, siblings and children of the alleged incapacitated person;
  2. persons with whom the AIP resides;
  3. agents under a power of attorney or health care proxy;
  4. any person or organization who has demonstrated a genuine interest in the wellbeing of the alleged incapacitated person;
  5. the local department of social services if appropriate;
  6. if the AIP resides in a facility, the chief executive officer of that facility;
  7. the mental hygiene legal service if the AIP resides in a mental hygiene facility; and
  8. other persons as directed by the court.
- **How Long Will It Take to Get a Guardian Appointed**
    1. A proceeding under this Article is entitled to a preference over all other cases in the court, unless the court for good cause orders otherwise. § 81.13.
    2. The hearing must be held no more than 28 days from the signing of the Order to Show Cause. § 81.07(b).
      - a. **Note:** The court may for good cause set a hearing date earlier than the 28-day time frame. For example, a hearing on a petition for a temporary guardian could be held as early as the court directs for good cause shown. § 81.13.
    3. The decision shall be rendered within 7 days after the hearing, unless the court extends the time for good cause to be shown. § 81.13.
    4. The commission is to be issued to the Guardian within 15 days of the decision. § 81.13.

#### **§ 81.08: Petition**

- The petition shall include the following information:
  1. the name, age, address and telephone number of the alleged incapacitated person;
  2. the name, address and telephone number of any persons with whom the alleged incapacitated person resides, if any, and the name, address and telephone number of any persons that the petitioner intends to serve with the order to show cause and the nature of their relationship to the alleged incapacitated person;
  3. a description of the alleged incapacitated person's functional level including that person's ability to manage the activities of daily living, behavior, and understanding and appreciation of the nature and consequences of any inability to manage the activities of daily living;
  4. if powers are being sought with respect to personal needs of the alleged incapacitated person, specific facts must be alleged as to the personal actions, or other actual occurrences involving the alleged incapacitated person which are

claimed to demonstrate that the person is likely to suffer harm because he/she cannot adequately understand and appreciate the nature and consequences of his/her inability to provide for personal needs;

5. if powers are being sought with respect to property management for the alleged incapacitated person, specific facts must be alleged as to the financial transactions or other actual occurrences involving the alleged incapacitated person which are claimed to demonstrate that the person is likely to suffer harm because he/she cannot adequately understand and appreciate the nature and consequences of his/her inability to provide for property management; if powers are sought to transfer a part of the alleged incapacitated person's property or assets to or for the benefit of another person, including the petitioner or guardian, the petition shall include the information required by section 81.21;
6. the particular powers being sought and their relationship to the functional level and needs of the alleged incapacitated person;
7. the duration of the powers being sought;
8. approximate value and description of the financial resources of the alleged incapacitated person, and whether the alleged incapacitated person is a recipient of public assistance;
9. the nature and amount of any claim, debt, or obligation of the alleged incapacitated person;
10. the name, address and telephone number of the person proposed as guardian and standby guardian, their relationship to the alleged incapacitated person and reasons why they would be suitable to exercise the powers necessary to assist the alleged incapacitated person;
11. any provisional remedies being sought (temporary guardian or injunction);
12. the "available resources", if any, that have been considered by the petitioner and the petitioner's opinion as to their sufficiency and reliability;
13. any other information that will assist the court evaluator in completing his/her investigation and report (such as any conflicts of interest between the petitioner and the alleged incapacitated person or the alleged incapacitated person and the proposed guardian).

## WHO CAN SERVE AS GUARDIAN?

### § 81.17 Nomination of Guardian

- The alleged incapacitated person may nominate a guardian in the petition or other written document.

### § 81.19 Eligibility as Guardian

- Any individual over eighteen years of age, or any parent under eighteen years of age, who is found by the court to be suitable to exercise the powers necessary to assist the

*A guardian does not have to be a family member.*

incapacitated person may be appointed as guardian, including but not limited to a spouse, adult child, parent, or sibling.

- A not-for-profit corporation organized to act in such capacity, a social services official, or public agency authorized to act in such capacity which has a concern for the incapacitated person, a corporation authorized to act with respect to financial affairs, and any community guardian program operating pursuant to the provisions of title three of article nine-B of the social services law that is found by the court to be suitable to exercise the powers necessary to assist the incapacitated person may be appointed as guardian. The community guardian program can be appointed only if the proceeding was commenced by a social services agency, such as Adult Protective Services (APS).
- The following specific persons are not eligible unless the court finds that no other person or corporation is available or willing to act as guardian, or to provide needed services for the incapacitated person:
  1. One whose only interest in the person alleged to be incapacitated is that of a creditor;
  2. One, other than a relative, who is a provider, or the employee of a provider of health care, day care, educational, or residential services to the incapacitated person, whether direct or indirect.

This section also provides that in determining who should be appointed guardian, priority should be given 1) to a person who is nominated by the allegedly incapacitated person in the petition or in a writing filed in the proceeding and 2) in the absence of such a nomination, to a person nominated orally or by conduct by the person alleged to be incapacitated during the hearing or trial.

## **PERSONAL NEEDS POWERS**

### **§ 81.22 Powers of guardian; personal needs**

- With respect to personal care, the guardian may be granted the power to:
  1. Determine who shall provide personal care or assistance;
  2. Make decisions regarding social environment and other social aspects of the life of the incapacitated person;
  3. Determine whether the incapacitated person should travel;
  4. Determine whether the incapacitated person should possess a license to drive;
  5. Authorize access to or release of confidential records;
  6. Make decisions regarding education;
  7. Apply for government and private benefits;
  8. Consent to or refuse generally accepted routine or major medical or dental treatment
  9. Choose the place of abode.
- Note: this is **not** an exhaustive list.

## MEDICAL DECISIONS

- **What Must The Guardian Consider When Making Medical Decisions?**

If the guardian is authorized to make medical decisions, the guardian shall make treatment decisions in accordance with the patient's wishes, including the patient's religious and moral beliefs, or if the patient's wishes are not known and cannot be ascertained with reasonable diligence, in accordance with the person's best interests, including a consideration of the dignity and uniqueness of every person, the possibility and extent of preserving the person's life, the preservation, improvement or restoration of the person's health or functioning, the relief of the person's suffering, the adverse side effects associated with the treatment, any less intrusive alternative treatments, and such other concerns and values as a reasonable person in the incapacitated person's circumstances would wish to consider. § 81.22.

- **Life Sustaining Treatment**

- "Life Sustaining Treatment" means medical treatment which is sustaining life functions and without which, according to reasonable medical judgment, that patient will die within a relatively short time period. § 81.03.
- Article 81 neither authorizes nor prohibits the court from allowing a guardian to make these types of decisions, including those related to artificial nutrition and hydration. § 81.29. However, New York is one of two states in the country that conditions the withdrawal or withholding of life sustaining treatment on a showing by clear and convincing evidence that it is consistent with the patient's wishes.



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## Using Tort Law to Discourage Repatriation of the Patient

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### FALSE IMPRISONMENT

False imprisonment has been the vehicle to challenge medical repatriation in the two reported cases. In Florida this claim failed because state law required a showing that the hospital's actions were unreasonable at the time and the hospital had received a court order allowing the transfer (and that was later held to have been unlawfully granted). *Montejo v. Martin Memorial Medical Center, Inc.*, 935 So.2d 1266 (Fla. Dist. Ct. App. 2006). False imprisonment was also brought in a case in Iowa, but failed because the comatose men were unconscious and therefore not aware of their imprisonment. *Cruz v. Central Iowa Hosp. Corp.*, 826 N.W.2d 516 (Iowa Ct. App. 2012). However, depending on the facts of the case and state law, false imprisonment may be successful.

### WHAT ARE THE ELEMENTS FOR FALSE IMPRISONMENT IN NEW YORK?

The plaintiff must show that:

- The defendant intended to confine the plaintiff,
- The plaintiff was conscious of the confinement,
- The plaintiff did not consent to the confinement and
- The confinement was not otherwise privileged (Broughton v. State, 37 N.Y.2d 451, 456-457 (1975)).

*Fernando Gaxiola, a lawyer practicing in Arizona, argued in two cases that his clients had been kidnapped while they were transported to the airport and border in hospital vehicles. In the first case, two-week old Elliott was en route to the airport, and in the second, the patient was en route to the Mexican border in a hospital ambulance, when Mr. Gaxiola called the authorities and alerted them to an international kidnapping. These repatriations were stopped by using this argument and by contacting the authorities, and his clients were returned to the hospital.*



*These crimes may be known by other names in your jurisdiction, such as kidnapping.*

## Using Criminal Law to Protect the Patient from Repatriation

Borrowing legal arguments from areas of law outside the health law context may also prove useful. One lawyer reported the crimes of kidnapping and assault to the police when a medical deportation was taking place as a way to delay or prevent it from happening. The elements for crimes such as kidnapping, assault, and false imprisonment, however, may vary by jurisdiction, and therefore their success may ultimately depend on the jurisdiction in which they are brought.

### UNLAWFUL IMPRISONMENT & CUSTODIAL INTERFERENCE:

#### Unlawful Imprisonment

- A person is guilty of unlawful imprisonment in the second degree when he restrains another person. N.Y. Penal Law § 135.05 (McKinney).
- A person is guilty of unlawful imprisonment in the first degree when he restrains another person under circumstances which expose the latter to a risk of serious physical injury. § 135.10.

#### Custodial Interference

- A person is guilty of custodial interference in the second degree when ... knowing that he has no legal right to do so, he takes or entices from lawful custody any incompetent person or other person entrusted by authority of law to the custody of another person or institution. § 135.45.
- A person is guilty of custodial interference in the first degree when he commits the crime of custodial interference in the second degree:
  1. With the intent to permanently remove the victim from this state, he removes such person from the state; or
  2. Under circumstances which expose the victim to a risk that his safety will be endangered or his health materially impaired. § 135.50.

#### Relevant Definition: Restrain

- “Restrain” means to restrict a person's movements intentionally and unlawfully in such manner as to interfere substantially with his liberty by moving him from one place to another, or by confining him either in the place where the restriction commences or in a place to which he has been moved, without consent and with knowledge that the restriction is unlawful. A person is so moved or confined “without consent” when such is accomplished by
  - (a) physical force, intimidation or deception, or
  - (b) any means whatever, including acquiescence of the victim, if he is a child less than sixteen years old or an incompetent person and the parent, guardian or other person or institution having lawful control or custody of him has not acquiesced in the movement or confinement.

*Sending a letter to the hospital's general counsel and other parties is an effective way of informing the hospital that it risks losing its license by engaging in forced or coerced medical deportation.*

## Employing Licensing Regulations to Monitor Medical Misconduct

*The following case demonstrates actions that may be considered medical misconduct. One New Jersey hospital did not arrange for its patient to receive any medical services once he reached Guatemala. The hospital simply sent him home with prescriptions for medication, and provided his sister – who had no medical training – with instructions on his dietary needs and restrictions, as well as for exercises to aid his recovery.*

### WHY IS LICENSING IMPORTANT?

Every doctor practicing in New York State will be licensed to practice in the state. The Office of Professional Medical Conduct was established to protect the public by investigating professional discipline issues involving physicians, physician assistants, and specialist assistants. They investigate all complaints of misconduct. Depending on the facts of the case at hand, forced or coerced medical repatriation may involve improper practices by physicians, physician assistants, or specialist assistants, some of which may rise to the level of medical misconduct. Because complaints trigger an investigation, a physician attempting a forced or coerced repatriation of a patient may be deterred from completing the act.

Sending a letter to the hospital's general counsel and other parties is an effective way of informing the hospital that it risks losing its license by engaging in medical deportation.

### RELEVANT MEDICAL MISCONDUCT PROVISIONS

#### Article 131-A, §6530:

- Each of the following is professional misconduct, and any licensee found guilty of such misconduct under the procedures prescribed in section 230 of the public health law shall be subject to penalties as prescribed in section 230-a of the public health law except that the charges may be dismissed in the interest of justice:
  4. Practicing the profession with gross negligence on a particular occasion;
  10. Refusing to provide professional service to a person because of such person's race, creed, color or national origin;
  16. A willful or grossly negligent failure to comply with substantial provisions of federal, state, or local laws, rules, or regulations governing the practice of medicine;
  26. Performing professional services which have not been duly authorized by the patient or his or her legal representative;



*Notes 16 and 30, which refer to state and federal laws, are clear that arrangements must be made by the hospital for the continuation of care if the client is discharged.*

30. Abandoning or neglecting a patient under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care, or abandoning a professional employment by a group practice, hospital, clinic or other health care facility, without reasonable notice and under circumstances which seriously impair the delivery of professional care to patients or clients;

31. Willfully harassing, abusing, or intimidating a patient either physically or verbally;

*Filing a misconduct complaint is straightforward.*

*This is another tool in the lawyer's toolkit to prevent or delay a medical deportation. It alerts the relevant state organization that one of its hospitals is violating state and federal laws.*

### FILING A MISCONDUCT COMPLAINT

- Consider Contacting the Office of Professional Medical Conduct:

NYS Department of Health  
Riverview Center  
150 Broadway, Suite 355  
Albany, NY 12204-2719

Phone: 518-402-0836 or 1-800-663-6114

- All complaints are kept confidential.
- Complaints against other licensed professionals that are not physicians can be directed to the Office of Professional Discipline:

NYS Education Department  
475 Park Ave. South  
New York, NY 10016-6901

*Hospitals will be deterred from engaging in any practices that potentially endanger JOINT COMMISSION accreditation.*

## Applying JOINT COMMISSION Accreditation Standards to Hospital Discharge/Transfer Policies

### WHY IS JOINT COMMISSION IMPORTANT?

- The Joint Commission, (formerly the Joint Commission on Accreditation of Healthcare Organizations) is a private, nonprofit entity that acts as a national accrediting organization for more than 20,000 health care organizations and programs in the United States. This accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.
- Filing a complaint with JOINT COMMISSION may delay the forced or coerced medical repatriation procedure by bringing the hospital's actions to the attention of a third party who is involved with the hospital's accreditation.
- JOINT COMMISSION is an important accreditation for hospitals. Therefore, actions that may lead to losing this accreditation may cause the hospital to ensure they are following proper, and legal, patient discharge programs.

### ACCREDITATION STANDARDS RELATED TO DISCHARGE OR TRANSFER

- Excerpt from the JOINT COMMISSION 2008 Hospital Accreditation Standards on Provision of Care, Treatment and Services:
 

Patients may be discharged from the hospital entirely or discharged or transferred to another level of care, treatment, and services, to different health professionals, or to settings for continued services. The hospital's processes for transfer or discharge are based on the patients' assessed needs. To facilitate discharge or transfer, the hospital assesses the patient's needs, plans for discharge or transfer, facilitates the discharge or transfer process and helps to ensure that continuity of care, treatment, and services is maintained.
- STANDARD PC.15.10
 

A process addresses the needs for continuing care, treatment, and services after discharge or transfer.
- STANDARD PC.15.20
 

The transfer or discharge of a patient to another level of care, treatment, and services, different professionals, or different settings is based on the patient's assessed needs and the hospital's capabilities.
- STANDARD PC.15.30
 

When patients are transferred or discharged, appropriate information related to the care, treatment, and services provided is exchanged with other service providers.

## FILING A COMPLAINT WITH JOINT COMMISSION

Excerpt from the JOINT COMMISSION 2008 Hospital Accreditation Standards on Provision of Care, Treatment and Services:

*Filing a JOINT COMMISSION complaint is easy, and can be completed online.*

*Lawyers with whom the CSJ spoke noted that this is another important tool in the lawyer's toolkit, and could be used to assist the patient.*

- Online: Submit a new complaint: the following page shows the information you'll need. <http://jcwebnoc.Joint Commission.org/QMSInternet/IncidentEntry.aspx>
- Submit an update to a complaint (You must have your complaint reference number): <http://jcwebnoc.Joint Commission.org/QMSInternet/IncidentUpdate.aspx>
- Other forms of contact:
  - E-mail: [complaint@jointcommission.org](mailto:complaint@jointcommission.org)
  - Complaint hotline: (800) 994-6610
  - Fax: 630-792-5636
  - Mail: Office of Quality Monitoring  
The Joint Commission  
One Renaissance Boulevard  
Oakbrook Terrace, Illinois 60181  
Or  
The Joint Commission  
601 13th Street NW  
Suite 1150N  
Washington, DC 20005
- What information do you need to include in the complaint?
  - The name and address of the organization
  - Tell us about your concern in one or two pages
  - Give your name, address or e-mail address if you would like follow-up information sent to you

*This is a screenshot from the JOINT COMMISSION website that a patient's family, or the lawyer, could complete in order to file a JOINT COMMISSION complaint.*

**Health Care Organization Information**

Complete the three steps below. In step 3, only health care organizations accredited/certified by The Joint Commission are included in the list.

1. Select the state/country where the incident occurred:	2. Select the city where the incident occurred:	3. Select the health care organization where the incident occurred:
Select... <input type="text"/>	<input type="text"/>	<input type="text"/>

If you DID NOT find the name of the health care organization from the list in step 3 above or the address below is incorrect, Press  and please complete the information below.

Organization Name: \*Required

Country:

Organization Street Address:

City:

State:

Zip Code:

**Personal Information**

Complete the information below if you would like The Joint Commission to notify you about any action taken on your complaint. Your name will be kept confidential.

I am: \*Required

Do you wish to remain anonymous? \*Required  Yes  No

May we contact you if we need more information related to the incident? \*Required  Yes  No

Salutation:

First Name:

Middle Initial:

Last Name:

Suffix:

Professional Credentials:

Street Address:

City:

State:

Zip:

Email:

Your Company Name:

**Incident Information**

Incident Date:  \*Required

Incident Narrative (Provide a brief overview of your complaint. Please limit your narrative to 3 pages (15,000 characters)) \*Required

**Disclaimer (Please read the disclaimer before submitting your complaint)**

When submitting a complaint to The Joint Commission about an accredited organization, you may either provide your name and contact information or submit your complaint anonymously. Providing your name and contact information enables The Joint Commission to inform you about the actions taken in response to your complaint, and also to contact you should additional information be needed.

It is our policy to treat your name as confidential information and not to disclose it to any other party. However, it may be necessary to share the complaint with the subject organization in the course of a complaint evaluation. Joint Commission policy forbids accredited organizations from taking retaliatory actions against employees for having reported quality of care concerns to The Joint Commission.

## Challenging Hospital's Failure to Operate within Medicare's Conditions of Participation to Deter Repatriation

*Eduardo suffered from severe head injuries and was admitted to a hospital in Charlotte, N.C. He was placed on a ventilator, and the hospital then transferred him to Guatemala. The hospital did not arrange for Eduardo to receive continued care at a Guatemalan hospital upon his arrival. Subsequently, Eduardo suffered an aneurism, causing further brain injury and requiring continued use of the ventilator. He spent one night in the hospital, and then was taken to his family's home, where he died 15 days later.*

*CMS is the agency charged with monitoring EMTALA compliance.*

*As a condition of participation in Medicare, hospitals must provide discharge planning services to all patients, regardless of their insurance or immigration status, to ensure that all hospitals receive appropriate post-hospital care.*

*Federal discharge planning regulations require that patients, or their representatives, should consent to their discharge plans.*

### WHY IS Centers for Medicare and Medicaid Services (CMS) IMPORTANT?

- CMS is housed under the Department of Health and Human Services and regulates Medicare and Medicaid. Filing a grievance with CMS may assist in delaying medical deportation. A grievance procedure is a complaint expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare participant or its providers, regardless of whether remedial action is requested. Because exclusion from Medicare is extremely disadvantageous to a hospital, the hospital has a strong incentive to avoid breaking any of the Conditions of Participation required under Medicare.
- CMS is also responsible for investigating possible Emergency Medical Treatment & Labor Act (EMTALA) violations. The investigation of a hospital's policies/procedures and processes and any subsequent sanctions are initiated by a complaint. If the results of a complaint investigation indicate that a hospital violated one or more of the anti-dumping provisions (prohibiting a hospital from transferring patients, solely for financial reasons, without consideration of their medical condition or stability for the transfer), a hospital may be subject to terminations of its provider agreement and/or impositions of civil monetary penalties (CMPs). CMPs may be imposed against hospital or individual physicians for EMTALA violations.

### RELEVANT STATUTORY PROVISIONS: TITLE XVIII OF THE SOCIAL SECURITY ACT, ALSO KNOWN AS MEDICARE

#### Sec. 1861 [42 U.S.C 1395x]: Discharge Planning Process:

- (ee)(1) A discharge planning process of a hospital shall be considered sufficient if it is applicable to services furnished by the hospital to individuals entitled to benefits under this title and if it meets the guidelines and standards established by the Secretary under paragraph (2).
- (2) The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate



type of and setting for post-hospital or rehabilitative care. The guidelines and standards shall include the following:

- (A) The hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.
- (B) Hospitals must provide a discharge planning evaluation for patients identified under subparagraph (A) and for other patients upon the request of the patient, patient's representative, or patient's physician.
- (C) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.
- (D) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services, including hospice care and post-hospital extended care services and the availability of those services, including the availability of home health services through individuals and entities that participate in the program under this title and that serve the area in which the patient resides and that request to be listed by the hospital as available and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides.
- (E) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).
- (F) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.
- (G) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel.
- (H) Consistent with section 1802, the discharge plan shall—
  - (i) not specify or otherwise limit the qualified provider which may provide post-hospital home health services, and
  - (ii) identify (in a form and manner specified by the Secretary) any entity to whom the individual is referred in which the hospital has a disclosable financial interest (as specified by the Secretary consistent with section 1866(a)(1)(S)) or which has such an interest in the hospital.
- (3) With respect to a discharge plan for an individual who is enrolled with a Medicare+Choice organization under a Medicare+Choice plan and is furnished inpatient hospital services by a hospital under a contract with the organization—
  - (A) the discharge planning evaluation under paragraph (2)(D) is not required to include information on the availability of home health services through individuals and entities which do not have a contract with the organization; and
  - (B) notwithstanding subparagraph (H)(i), the plan may specify or limit the provider (or providers) of post-hospital home health services or other post-hospital services under the plan.

## CMS CONDITIONS OF PARTICIPATION

### Conditions of Participation Related to Discharge Planning: §482.43:

- The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.
- (a) Standard: Identification of Patients in Need of Discharge Planning  
The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.
- (b)(1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.
- (b)(3) - The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.
- (b)(4) - The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.
- (b)(5) - The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.
- (b)(6) - The hospital ... must discuss the results of the evaluation with the patient or individual acting on his or her behalf.
- (c)(4) - The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.
- (c)(7) The hospital, as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post-hospital care services and must, when possible, respect patient and family preferences when they are expressed. The hospital must not specify or otherwise limit the qualified providers that are available to the patient.
- (d) Standard: Transfer or Referral: 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.

### CMS Authority to Terminate Medicare and Medicaid Participation State Operations Manual: Chapter 3, Sec. 3000C

- The Regional Office (RO) is delegated authority to terminate Medicare participation of all providers and suppliers because of noncompliance with the applicable regulatory requirements, or Conditions of Participation (CoPs).
- New York/New Jersey Regional Office: <http://www.cms.gov/About-CMS/Agency-Information/RegionalOffices/Downloads/NewYorkRegionalOffice.pdf>

*One lawyer noted that it may be helpful to have another individual, preferably a lawyer, in the room with the patient when any decisions are made, or information conveyed by the hospital. If this person is a lawyer, then he or she can ensure that the patient or the family has freely consented, and not consented because of the hospital's pressure to repatriate. Additionally, a lawyer can verify whether the discharge procedure offered by the hospital was followed.*

*Under EMTALA, if a patient appears at a facility with “an emergency medical condition that has not been stabilized,” the hospital must provide emergency treatment for the condition in order to stabilize the patient or transfer the patient to an “appropriate” medical facility.*

*The statute defines “stabilized” at 45 U.S.C. 1395dd(e)(3)(A).*



*A facility’s obligations under EMTALA end when the patient has been “stabilized.”*

- The specific contact for concerns regarding noncompliance is Victoria Vachon, the Survey Branch Manager: Centers for Medicare & Medicaid Services  
Division of Survey and Certification  
26 Federal Plaza Room 37-130  
New York, NY 10278  
Phone: 212-616-2442  
Fax: 443-380-6359

## RELEVANT EMTALA PROVISIONS

### Examination and treatment for emergency medical conditions and women in labor: 42 U.S.C. 1395dd

- **(a) Medical screening requirement:** In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual’s behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.
- **(b) Necessary stabilizing treatment for emergency medical conditions and labor**
  - (1) **In general:** If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—
    - (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
    - (B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section. [...]
- **(c) Restricting transfers until individual stabilized**
  - (1) **Rule:** If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless—
    - (A)(i) the individual (or a legally responsible person acting on the individual’s behalf) after being informed of the hospital’s obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,
    - (ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the

*Whether a patient is stabilized is largely factual, requiring an inquiry into the reasonableness of the transfer under the circumstances. Cherukuri v. Shalala, 175 F.3d 446, 454 (6th Cir. 1999).*

*I'm worried about the above comment and the one on p. 26. Many courts (and apparently CMS) think of EMTALA obligations as ending (whether or not a patient is clinically stable) if the patient is admitted as an inpatient. See 77 FR 5213, but see Moses, 561 F.3d 573 (6th Cir. 2009)*

*Under EMTALA, the federal government may impose a penalty of \$50,000 per violation on non-compliant hospitals, or terminate their participation in Medicare.*

increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility. A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

**(2) Appropriate transfer**

An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

• **(d) Enforcement**

**(1) Civil money penalties**

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than \$50,000 (or not

more than \$25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a-7a (a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—

(i) signs a certification under subsection (c)(1)(A) of this section that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section, is subject to a civil money penalty of not more than \$50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a-7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a-7a (a) of this title.

## (2) Civil enforcement

(A) **Personal harm:** Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

- (e) **Definitions**

(3)(A): The term “to stabilize” means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(3)(B): The term “stabilized” means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the



*Definition of  
“to stabilize” and  
“stabilized”  
according to the  
statute.*

*There is a circuit split on what constitutes “stability” within the meaning of the EMTALA. Lawyers should verify the requirements for assessing “stability” in their jurisdiction when bringing an EMTALA violation.*

*Note that succeeding on this complaint can be difficult because its requirements are quite narrow, and may require a particular set of facts. If the patient is stable when transferred, this can decrease the chances of succeeding on an EMTALA claim.*

condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

- (g) **Nondiscrimination:** A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or, with respect to rural areas, regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.
- (h) **No delay in examination or treatment:** A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual’s method of payment or insurance status.

#### **FILING A COMPLAINT WITH CMS REGARDING AN EMTALA VIOLATION**

- An individual may file a complaint about a possible EMTALA violation with the Centers for Medicare and Medicaid Services (CMS) at HHS. Complaints should contain the following information: the patient’s name, address and phone number of the complainant and a description of the alleged violation, including the date and time of the incident. Telephone calls are preferred; however, complaints can also be sent to:  
HHS HCFA DMSO MSOB  
Federal Building  
Attn: Nurse Consultant  
26 Federal Plaza, Room 3800  
New York, NY 10278

## Monitoring Discrimination under the Office for Civil Rights to Prevent Repatriation

### WHY IS THE CIVIL RIGHTS DIVISION IN THE OFFICE FOR CIVIL RIGHTS (OCR) IMPORTANT?

*CMS regulates Medicare and Medicaid. Filing a grievance procedure with CMS means the hospital risks exclusion from Medicare funding.*

- The Civil Rights Division enforces Federal laws and regulations to prohibit discrimination, including healthcare provider conscience rights, on the basis of race, color, national origin, disability, age and, in certain circumstances, sex and religion, in programs and activities that receive financial assistance from the Department of Health & Human Services.
- OCR helps to protect patients from discrimination in certain healthcare settings, including hospitals, health clinics, nursing homes, Medicaid and Medicare agencies, and doctors' offices.
- CMS will investigate complaints filed by individuals alleging that they or someone else has been discriminated against on a prohibited basis.
- CMS conducts compliance reviews of covered entities that OCR believes may not be in compliance with the law.

### HOW DO I FILE A COMPLAINT WITH THE OFFICE FOR CIVIL RIGHTS?

- If you feel a health care provider, or state or local government agency, has discriminated against you (or someone else) based on race, national origin, disability, or age, you may file a civil rights complaint. OCR can also investigate disability-based discrimination complaints against programs operated by HHS. Under certain statutes and regulations, OCR also has limited authority to investigate complaints of discrimination based on sex and religion. If you believe your health care provider conscience protection rights have been violated, you may file a complaint with OCR.
- For more information about the Civil Rights Laws and Regulations we enforce, please review our [Understanding Civil Rights](#) section or look at our [Frequently Asked Questions \(FAQs\)](#).
- The [Case Resolution Manual for Civil Rights Investigations \(CRM\)](#) provides OCR staff and managers with the procedures and strategies designed to promptly and effectively evaluate, investigate, and resolve complaints and compliance reviews, and to enforce violation findings where warranted.
- **COMPLAINT REQUIREMENTS - Your complaint must:**
  - Be filed in writing, either on paper or electronically via the [OCR Complaint Portal](#), by mail, fax, or e-mail;
  - Name the health care or social service provider involved, and describe the acts or omissions you believe violated the civil rights laws or regulations; and



*More information can be found using the hyperlinks on this page and the next page.*

- File within 180 days of when you knew that the act or omission complained of occurred. OCR may extend the 180-day period if you can show "good cause."
- **ANYONE CAN FILE!**

Anyone can file electronically via the [OCR Complaint Portal](#) or **through** written complaints with OCR. We recommend that you use the [Civil Rights Discrimination Complaint Form Package](#) to submit a written complaint. You can also request a copy of this form from an [OCR regional office](#). If you need help filing a complaint or have a question about the complaint or consent forms, please email OCR at [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov).
- **THE CIVIL RIGHTS NONDISCRIMINATION LAWS AND REGULATIONS PROHIBIT RETALIATION**

Under Civil Rights Laws an entity cannot retaliate against you for filing a complaint. You should notify OCR immediately in the event of any retaliatory action.
- **HOW TO SUBMIT YOUR COMPLAINT TO OCR**

To submit a complaint to OCR, you could use one of the following methods.

  - [File A Complaint Electronically Using OCR Complaint Portal](#)
  - [File A Complaint Using Our Civil Rights Discrimination Complaint Form Package](#)
  - [File A Complaint Without Using Our Civil Rights Discrimination Complaint Form Package](#)

If you mail or fax the complaint, be sure to send it to the appropriate [OCR regional office](#) based on where the alleged violation took place. OCR has ten regional offices, and each regional office covers specific states. Send your complaint to the attention of the OCR Regional Manager. *You do not need to sign the complaint and consent forms when you submit them by email because submission by email represents your signature.*



## Guiding Compliance under New York's Public Health Law to Avoid Repatriation

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### WHY IS ARTICLE 28 OF THE PUBLIC HEALTH LAW IMPORTANT?

- Article 28 pertains to all hospitals in New York State and sets forth standards related to transfer, discharge, emergency treatment, and treatment specifically to indigent populations. There are both civil and criminal penalties for noncompliance with the law. The New York State Department of Health is responsible for the ongoing monitoring of these facilities to assure compliance with Article 28.

### RELEVANT PORTIONS OF ARTICLE 28

#### § 2805-b. Admission of patients and emergency treatment of non-admitted patients:

- After examination, diagnosis and treatment by an attending physician and where, in the opinion of such physician, the patient has been stabilized sufficiently to permit it, subsequent medical care may be provided or procured by the general hospital at a location other than the general hospital if, in the opinion of the attending physician, it is in the **best interest of the patient** because the general hospital does not have the proper equipment or personnel on hand to deal with the particular medical emergency or because all appropriate beds are filled and none are likely to become available within a reasonable time after the patient has been stabilized.
- Whenever a previously stabilized emergency room patient is thereafter transferred for medical care to another location by means of an ambulance, the attending physician authorizing the transfer in the general hospital from which the patient is transferred shall determine that a receiving hospital is available and willing to receive such patient and that an attending physician there is available and willing to admit such patient.

#### § 2807-k. General hospital indigent care pool ("Charity Care"):

- 9-a. (a) As a condition for participation in pool distributions ... general hospitals shall ... establish financial aid policies and procedures, in accordance with the provisions of this subdivision, for reducing charges otherwise applicable to low-income individuals without health insurance, or who have exhausted their health insurance benefits, and who can demonstrate an inability to pay full charges, and also, at the hospital's discretion, for reducing or discounting the collection of co-pays and deductible payments from those individuals who can demonstrate an inability to pay such amounts.
- (b) Such reductions from charges for uninsured patients with **incomes below at least 300 percent of the federal poverty level** shall result in a charge to such individuals that does not exceed the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (Medicare) or for services provided pursuant to title XIX of the federal social security act (Medicaid) and provided further that such amounts shall be adjusted according to income level as follows:

*Additionally, New York City Health and Hospitals Corporation (HHC) may be of interest to lawyers and patients. Its mission is to provide care to all New Yorkers, including undocumented immigrants, regardless of their ability to pay.*

*Rather than medically deport these patients, HHC either provides such patients with post-acute care at its hospitals or transfers them to its specialty hospital and nursing facility, if there is available space.*

- (i) For patients with incomes at or below **at least 100 percent of the federal poverty level, the hospital shall collect no more than a nominal payment amount**, consistent with guidelines established by the commissioner;
- (ii) For patients with **incomes between at least 101 percent and 150 percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding fee schedule under which patients with lower incomes shall pay the lowest amount**. Such schedule shall provide that the amount the hospital may collect for such patients increases from the nominal amount described in subparagraph (i) of this paragraph in equal increments as the income of the patient increases, up to a maximum of twenty percent of the greater of the amount that would have been paid for the same services by the “highest volume payor” for such general hospital, as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (Medicare) or for services provided pursuant to title XIX of the federal social security act (Medicaid);
- (iii) For patients **with incomes between at least 151 percent and 250 percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding fee schedule under which patients with lower income shall pay the lowest amounts**. Such schedule shall provide that the amount the hospital may collect for such patients increases from the twenty percent figure described in subparagraph (ii) of this paragraph in equal increments as the income of the patient increases, up to a maximum of the greater of the amount that would have been paid for the same services by the “highest volume payor” for such general hospital, as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (Medicare) or for services provided pursuant to title XIX of the federal social security act (Medicaid); and
- (iv) For patients **with incomes between at least 251 percent and 300 percent of the federal poverty level, the hospital shall collect no more than the greater of the amount that would have been paid for the same services by the “highest volume payor”** for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (Medicare), or for services provided pursuant to title XIX of the federal social security act (Medicaid).
- (v) For the purposes of this paragraph, “highest volume payor” shall mean the insurer, corporation or organization licensed,

organized or certified pursuant to article 32, 42 or 43 of the insurance law or article 44 of this chapter, or other third-party payor, which has a contract or agreement to pay claims for services provided by the general hospital and incurred the highest volume of claims in the previous calendar year.

### HOW DO I FILE AN ARTICLE 28 COMPLAINT?

- To initiate a complaint about a hospital or a diagnostic and treatment center, you may call the toll-free number at 1-800-804-5447, or you may print and complete the [Health Facility Complaint Form](#),
- [Health Facility Complaint Form \(DOH-4299\) with Instructions](#) (PDF, 38KB, 4pg.) and send it to:  
New York State Department of Health  
Centralized Hospital Intake Program  
Mailstop: CA/DCS  
Empire State Plaza  
Albany, NY 12237



*Click on these links to access the Health Facility Complaint Form.*

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## PERMANENTLY RESIDING UNDER COLOR OF LAW (PRUCOL) STATUS

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### WHAT IS PRUCOL?

- PRUCOL is a classification given to certain immigrants who, although not lawful permanent residents (i.e., those possessing a green card), provide evidence to the appropriate social services district that United States Citizenship and Immigration Services (USCIS) or United States Immigrations and Customs Enforcement (ICE) is aware that such immigrants are in the United States and has either given them permission to be in the country or, through inaction, has acquiesced in their presence in the country.
- Classifying an immigrant as PRUCOL is a determination made by the State and functions independently of the federal immigration laws.

### WHAT ARE IMMIGRANTS CONSIDERED PRUCOL ENTITLED TO?

- Immigrants who are considered PRUCOL are eligible for all of the medical assistance programs in the State, including Medicaid.

### WHO CAN BE CONSIDERED PRUCOL?<sup>3</sup>

- Immigrants who are considered PRUCOL include those who have been granted the following statuses by USCIS or ICE:
  - Deferred action;
  - Order of Supervision;
  - Parole of less than 1 year;
  - K3 or K4 Visa;
  - V Visa;
  - U Visa; or
  - Temporary Protected Status.
- Immigrants who have applied for any of the above or any other immigration benefit and have pending applications before USCIS are considered PRUCOL. This also applies to an immigrant on whose behalf an immediate relative petition has been approved.
- Immigrants that prove they have continuously resided in the United States since January 1, 1972 are considered PRUCOL regardless of whether they filed an application under the Immigration and Nationality Act for permanent residence.

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<sup>3</sup> See DOH guidance: [http://www.health.ny.gov/health\\_care/medicaid/publications/docs/inf/08inf-4.pdf](http://www.health.ny.gov/health_care/medicaid/publications/docs/inf/08inf-4.pdf).

**HOW TO PROVE PRUCOL STATUS?**

- An immigrant may prove that he or she should be considered PRUCOL by providing to the appropriate social services district either:
  - Express permission by USCIS or ICE to remain in the United States (see above); or
  - I-797 receipt notice demonstrating pending action by USCIS or ICE on:
    - an application or request for deferred action, provided that such application is pending and has not been denied; or
    - a request by letter for relief from deportation, provided that six months have passed since the mailing of the letter and that proof is offered to support that both the letter and a follow up letter have been sent to the agency.
- The most common proof of PRUCOL status for individuals with pending immigration applications or petitions is I-797 receipt notice.

**IMMIGRATION REPRESENTATION FOR OBTAINING PRUCOL**

- NYLPI provides immigration representation for the purposes of getting undocumented immigrants with serious healthcare issues PRUCOL status so that they can apply for Medicaid. For assistance, please contact NYLPI at: (212) 244-4664.

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## Ensuring Hospitals Obtain Informed Consent Prior to Proceeding with Healthcare Decisions

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Repatriations are all too often carried out without the true informed consent of the patient involved or his/her family. Patients or their family members often feel coerced into consenting because hospitals tell them that they have no choice and no rights.

The first case in New York to consider the idea of consent in the healthcare context was *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125 (1914). In its opinion, the court eloquently noted that:

“Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent, commits an assault, for which he is liable in damages.”

Although this opinion pertained specifically to the act of conducting a surgery without consent, a faulty discharge and repatriation to a country that lacks appropriate resources to ensure care is no less serious.

### INFORMED CONSENT IN NEW YORK STATE:

A lack of informed consent means the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical, dental, or podiatric practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation. N.Y. Pub. Health Law § 2805-d.

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## Conclusion

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The purpose of this packet is to provide lawyers and advocates of patients facing involuntary medical repatriation with tools that can assist in either delaying or preventing the patient's deportation. The legal strategies provided herein, although focused on New York law and although not intended as legal advice, may still be helpful to lawyers and advocates throughout the United States.

Obtaining consent, either by the patient, the patient's guardian, or the patient's family, is a crucial piece in medical repatriation cases. In our conversations with lawyers who have represented clients in these situations, the fact most frequently mentioned was the pressure and coercion placed on the patient and their families by hospital staff to obtain their consent to transfer and discharge the patient. The patients and their families often feel forced into consenting to the transfer, unaware of the fact that hospitals cannot engage in any type of deportation and that hospitals are required to stabilize and provide proper discharge plans for patients. For these reasons, it is important that lawyers and advocates be available and able to assist the client and their families when making these decisions, and that these lawyers and advocates have strategies to stop an involuntary medical repatriation in the event that the patient is in the process of being transferred to another facility outside of the United States.

Please visit <http://medicalrepatriation.wordpress.com/> for additional information and do not hesitate to contact the Seton Hall Law Center for Social Justice or New York Lawyers for the Public Interest if you have any further questions.

*These action items provide a guideline for approaching medical repatriation matters.*



*If the letter does not generate a response, you can follow these steps.*

## Appendix 1: Checklist of Action Items

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- \_\_\_\_\_ Visit website for a collection of resources:  
medicalrepatriation.wordpress.com.
- \_\_\_\_\_ Prepare and send letter to hospital concerning medical repatriation and patient consent. See examples in this packet.
  
- \_\_\_\_\_ Consider submitting an internal hospital grievance. This procedure varies by hospital.
- \_\_\_\_\_ Consider petitioning for guardianship. See section on guardianship.
- \_\_\_\_\_ Consider filing a misconduct complaint against the physician in charge with the Office of Professional Medical Conduct. See section on Licensing.
- \_\_\_\_\_ Consider submitting a complaint with the Joint Commission on Accreditation of Healthcare Organizations (JOINT COMMISSION). See section on JOINT COMMISSION.
- \_\_\_\_\_ Consider submitting a complaint with the Centers for Medicare and Medicaid Services (CMS). See section on CMS.
- \_\_\_\_\_ Contact an immigration lawyer, New York Lawyers for Public Interest, or Seton Hall Law Center for Social Justice for legal assistance.
- \_\_\_\_\_ Consider filing additional civil claims or pursuing criminal actions



## Appendix 2: Model Letter 1

*Sending a letter to the hospital alerts the hospital to a possible medical repatriation.*

*The letter could be mailed and faxed to the hospital's general counsel and ethics committee, the case manager of the trauma center, the nurses' station, the floor of the patient, the case worker assigned to the case, and the president of the hospital.*

*It is crucial to state in the letter that the patient, or the patient's guardian, does not consent to repatriation.*

*According to two lawyers, sending a letter of this nature has been successful in delaying or preventing medical deportation.*

Date: [Insert Date]

[Recipient]

[Title]

[Company]

[Address 1]

Re:

DOB:

To Whom It May Concern/General Counsel/Ethics Committee:

I represent [insert name of client], a patient in your hospital. Mr./Mrs. \_\_\_\_\_ has informed me that you intend to repatriate him/her. I write to make you aware that my client does not consent to repatriation. I also write at this time to remind you that the hospital does not possess the authority to repatriate anyone against his or her will. Repatriating my client would violate many federal and state statutes, regulations, and policies.<sup>1</sup> Forcibly returning my client to his/her home country without his/her consent would amount to a deportation, which is beyond your authority. Furthermore, as a hospital that receives Medicare, you are bound by the discharge standards set by the Centers for Medicaid and Medicare Services.<sup>2</sup>

Please also be aware that a grievance procedure has been filed with your hospital, and as per your own regulations, must be addressed within \_\_\_\_\_.

Sincerely,

[Your Name]

[Your Title]

<sup>1</sup> EMTALA demands that the hospital "stabilize the medical condition" prior to transferring or discharging the patient to an appropriate medical facility. 42 U.S.C. Sec. 1395dd(b)(1)(a). The physician responsible for the deportation risks losing his/her license due to practicing gross negligence or a willful or grossly negligent failure to comply with federal and state laws or regulations governing the practice of medicine. The hospital risks losing its accreditation with the Joint Commission on Accreditation of Healthcare Organizations due to violating discharge and transfer standards (Standard PC.15.10). Additionally, only the federal government has the power to regulate immigration, naturalization, and deportation. 8 U.S.C. 1103 (2006).

<sup>2</sup> The Duty to Discharge as per Medicare and Medicaid requires appropriate discharge planning. Discharge planning must include an evaluation of a patient's likely need for appropriate post-hospital services, including hospice care and post-hospital extended care services and the availability of home health services through individuals and entities that participate in the program under this title and that serve the area in which the patient resides and that request to be listed by the hospital as available and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides. 42 U.S.C.A 1395x(ee)(1)(D).

Appendix 3: Model Letter 2

This model letter was provided by John Redmann, Esq., in New Orleans, LA. By sending a letter to the hospital and informing a hospital representative, in a face-to-face meeting, that the hospital risked violating federal and state laws if it removed his client, Mr. Redmann was able to halt his client's imminent removal.



Note that the letter states that the patient does not consent to leaving the hospital. Consequently, by engaging in this process, the letter reminds the hospital that removing the patient is equivalent to a deportation, which is reserved to the U.S. Citizenship and Immigration Services.

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www.redmannlaw.com

OF COUNSEL
Eugene P. Redmann
Richard L. Root

June 8, 2010
Via Fax & Certified Mail #

Dr. Roxane Townsend
Hospital Administrator
University Hospital
2021 Perdido Street
New Orleans, Louisiana 70112

Re: DOB:
Letter of Legal representation and demand for All Appropriate Medical Care Owed
REQUEST THAT YOU DO NOT DISCHARGE PATIENT.

Dear Sir/Madam:

I represent the next of kin, including mother, Note
Mr. is unmarried and has no children of the age of majority. The Family of
expressly does not authorize Mr. for any discharge from your facility. The Family
opposes any steps by anyone in your facility that will in any way endanger Mr. health
and safety.

We will hold you and anyone else responsible for any Failure to abide by all medical,
State and Federal obligations owed to this critically injured patient.

You may reach me at my office or cellular phone (504)905-4995 if you wish to discuss
any of this. Thank you for your attention to this serious matter.

Best regards,

Handwritten signature of John W. Redmann

JWR/csm
Case Manager
Trauma ICU
University Hospital
2021 Perdido Street
New Orleans, Louisiana 70112

Via Fax & Certified Mail #

## Appendix 4: Model Letter 3 (For Non-Lawyers)

*This model letter is intended for use by non-lawyers.*

*The letter could be mailed and faxed to the hospital's general counsel and ethics committee, the case manager of the trauma center, the nurses' station, the floor of the patient, the case worker assigned to the case, and the president of the hospital.*

Date: [Insert Date]

[Recipient]  
[Title]  
[Company]  
[Address 1]

Re: [Patient's Name]      DOB: [Patient's DOB]  
PATIENT'S LACK OF CONSENT TO REPATRIATION

Dear Sir/Madam:

I am a (friend/family member/guardian) of (Patient's Name), a patient in your hospital. (Patient's Name) has informed me that you intend to repatriate (him/her). I write to make you aware that (Patient's Name) does not consent to the repatriation. As (Patient's Name)'s (friend/family member/guardian), I expressly do not authorize you to discharge (him/her) from your facility. I also write at this time to remind you that the hospital does not possess the authority to repatriate anyone against their will. Repatriating (Patient's Name) would violate many federal and state statutes, regulations, and policies.<sup>1</sup> Furthermore, as a hospital that receives Medicare, you are bound by the discharge standards set by the Centers for Medicaid and Medicare Services<sup>2</sup> and further delineated in the Emergency Medical Treatment and Labor Act and Title XVIII of the Social Security Act.

You can reach me at (your phone number) if you wish to discuss any of this. Thank you for your attention to this serious matter.



Sincerely,


[Your Name]  
[Your Title]

<sup>1</sup> EMTALA demands that the hospital "stabilize the medical condition" prior to transferring or discharging the patient to an appropriate medical facility. 42 U.S.C. Sec. 1395dd(b)(1)(a). The physician responsible for the deportation risks losing his/her license due to practicing gross negligence or a willful or grossly negligent failure to comply with federal and state laws or regulations governing the practice of medicine. The hospital risks losing its accreditation with the Joint Commission on Accreditation of Healthcare Organizations due to violating discharge and transfer standards (Standard PC.15.10). Additionally, only the federal government has the power to regulate immigration, naturalization, and deportation. 8 U.S.C. 1103 (2006).


<sup>2</sup> The Duty to Discharge as per Medicare and Medicaid requires appropriate discharge planning. Discharge planning must include an evaluation of a patient's likely need for appropriate post-hospital services, including hospice care and post-hospital extended care services and the availability of home health services through individuals and entities that participate in the program under this title and that serve the area in which the patient resides and that request to be listed by the hospital as available and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides. 42 U.S.C.A 1395x(ee)(1)(D).










## Appendix 5: Short Guide for Non-Lawyers







**IF YOU OR A LOVED ONE MIGHT BE SUBJECT TO INVOLUNTARY  
MEDICAL REPATRIATION, TAKE THESE STEPS TO TRY TO STOP IT:**



-  Visit the website for a collection of resources: [medicalrepatriation.wordpress.com](http://medicalrepatriation.wordpress.com).
-  Read the full Medical Repatriation Advocacy Packet for how to file complaints and other strategies.
-  Send a written letter to hospital administration. (See Appendix 4 of the Packet for a sample letter).
  - What should go in it:**
    - State in the letter that the patient, or the patient's guardian, does not consent to repatriation.
    - Include both state and federal laws that are being violated. Federal laws include:
      - 42 U.S.C. Sect. 1395dd(b)(1)(a): EMTALA requires the hospital to "stabilize the medical condition" prior to transferring or discharging the patient to an appropriate medical facility.
      - 8 U.S.C. 1103 (2006): only the federal government has the power to regulate immigration, naturalization, and deportation.
      - 42 U.S.C.A 1395x(ee)(1)(D): Duty to Discharge as per Medicare and Medicaid
  - Who you should send it to:**
    - The hospital's general counsel and ethics committee;
    - The case manager of the trauma center;
    - The nurses' station;
    - The floor of the patient;
    - The case worker assigned to the case; and
    - The president of the hospital.
-  **Have a presence.** Do not leave the patient alone. Have family and friends display cameras.
-  **Get the media involved.** Media outlets that have expressed interest in this issue include: The New York Times; The Star Ledger; ABC News; Univision Online; Latin Times; Medical News Today; Tucson Weekly; Boulder Weekly.
-  **Contact the consulate.** Let them know that the patient, or the patient's guardian, does not consent to medical repatriation.
-  **Ask the hospital about financial resources** (ie. Charity Care; PRUCOL; See pp. 29-33 of the Packet). Talk to a hospital social worker.
-  **Consider having a loved one file for guardianship.** Almost anyone can file. (See pp. 6-12 of the Packet).
-  **For a referral to a legal services office, call:**
  - Seton Hall Law Center for Social Justice (Newark, NJ): 973-642-8700
  - New York Lawyers for Public Interest (NY): 212-244-4664



Hospitals Deporting Patients = Injustice

Appendix 6: Flyer (front)

**NYLPI**

**Immigrants  
and  
Medical  
Deportation**



Hospitals Deporting Patients = Injustice

**SETON HALL | LAW** 

**Appendix 7: Flyer (back)**

**Do I have any rights as an immigrant when I am in the hospital?**

**Yes. All patients at the hospital have certain rights, regardless of his/her immigration status.**

**What are those rights?**

**You have the right to emergency care under a law called EMTALA. The hospital cannot discharge you without giving you information on how to get follow-up care.**

**Can the hospital deport me?**

**The hospital does not have the authority to deport you.**

**Who can I call for information?**

**Seton Hall School of Law  
Center for Social Justice  
One Newark Center  
Newark, NJ 07102  
Email: [lori.nessel@shu.edu](mailto:lori.nessel@shu.edu)  
Phone: 973.642.8700**

**New York Lawyers for  
the Public Interest  
151 W. 30<sup>th</sup> St., 11<sup>th</sup> Flr.  
New York, NY 10001  
Email: [healthjustice@nylpi.org](mailto:healthjustice@nylpi.org)  
Phone: 212.244.4664**

## Appendix 8: Palm Card

- Todos los pacientes en el hospital tienen ciertos derechos, sin importar su status migratorio.
- Usted tiene el derecho a la atención de emergencia bajo una ley llamada EMTALA.
- El hospital no le puede descargar sin darle la información sobre cómo conseguir la atención de seguimiento.
- El hospital no tiene la autoridad para deportarlo.
- Para más información, póngase en contacto con
  - Seton Hall Law Center for Social Justice  
One Newark Center, Newark, NJ 07102  
lori.nessel@shu.edu | 973.642.8700
  - New York Lawyers for the Public Interest  
151 West 30th St., 11th Flr., New York, NY 10001  
healthjustice@nylpi.org | 212.244.4664

- All patients at the hospital have certain rights, regardless of his/her immigration status.
- You have the right to emergency care under a law called EMTALA.
- The hospital cannot discharge you without giving you information on how to get follow-up care.
- The hospital does not have the authority to deport you.
- For more information contact
  - Seton Hall Law Center for Social Justice  
One Newark Center, Newark, NJ 07102  
lori.nessel@shu.edu | 973.642.8700
  - New York Lawyers for the Public Interest  
151 West 30th St., 11th Flr., New York, NY 10001  
healthjustice@nylpi.org | 212.244.4664

## Appendix 9: Patients' Bill of Rights, As Compiled by the NY State Department of Health

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**As a patient in a hospital in New York State, you have the right, consistent with law, to:**

- (1) Understand and use these rights. If for any reason you do not understand or you need help, the hospital MUST provide assistance, including an interpreter.
  - (2) Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, source of payment, or age.
  - (3) Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
  - (4) Receive emergency care if you need it.
  - (5) Be informed of the name and position of the doctor who will be in charge of your care in the hospital.
  - (6) Know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination or observation.
  - (7) Be placed in a non-smoker room.
  - (8) Receive complete information about your diagnosis, treatment and prognosis.
  - (9) Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
  - (10) Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Deciding About Health Care — A Guide for Patients and Families."
  - (11) Refuse treatment and be told what effect this may have on your health.
  - (12) Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
  - (13) Privacy while in the hospital and confidentiality of all information and records regarding your care.
  - (14) Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.
  - (15) Review your medical record without charge. Obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
  - (16) Receive an itemized bill and explanation of all charges.
  - (17) Complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you and if you request it, a written response. If you are not satisfied with the hospital's response, you can complain to the New York State Health Department. The hospital must provide you with the State Health Department telephone number.
  - (18) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.
  - (19) Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the hospital.
- (Public Health Law 2803, 10NYCRR, 405.7)