NATIONAL IMMIGRATION LAW CENTER

Advocating On Behalf of Patients in Immigration Custody:

A Resource for Health Care Providers and Medical Staff

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Contents

The information provided here is intended for general education purposes and is not legal advice for individual situations. When interacting with immigration officers, we recommend that a medical professional with questions about their own liability or rights be in contact with an attorney with experience in immigration, civil rights, and/or employment law.

I. The Growing Trend of Patients in ICE Custody is a Public Health Crisis

The Trump administration's militarized approach to immigration enforcement has resulted in new challenges for hospitals across the country. Increasingly, patients are showing up at emergency departments and other health care facilities accompanied by and in the custody of U.S. Immigration and Customs Enforcement (ICE) or U.S. Customs and Border Protection (CBP) officers.[1] Medical providers and patients are experiencing this shift alongside other frightening changes in immigration policy, especially now that the government has rescinded the long-standing restrictions on enforcement at or near hospital grounds.[2]

For clinicians and hospital leaders seeking to fulfill their duty of care to detained immigrant patients, this new reality has given rise to urgent, practical questions, such as:

- Can a nurse call the family of a patient in ICE or CBP custody?
- Can a doctor ask an immigration officer to leave the room during a physical examination?
- Can ICE or CBP force a hospital to discharge a patient who is not medically stable?
- Will ICE continue medical treatment for a patient who has left the hospital and will relocate to a detention center?

This resource aims to provide guidance for medical staff grappling with these and other questions. It provides some legal context on the workings of the immigration system as it relates to patients, explains the laws and policies related to patients under immigration supervision, and grounds the information in the day-to-day realities of patient care.

It's important to note that immigration enforcement is not a single issue. **It spans civil rights, public health, and workers' rights issues as well.** Without clear guidance on how to respond to immigration officers' demands involving patients, hospitals face the following challenges:

- Doctors and nurses' ability to provide standard-of-care medicine may be compromised.[3]
- As the inability to fulfill their moral and ethical duties deepens, health care providers may experience trauma, contributing to burnout and workforce attrition.[4]
- Institutions are more likely to be exposed to liability or litigation from patients, personnel, or civil rights organizations.
- The privacy rights of all patients will be threatened if facilities and providers do not invoke privacy rights for their immigrant or non-citizen patients.
- Patients may experience preventable harm, leading to worse and potentially deadly clinical outcomes.
- People may die preventable deaths when returned to immigration detention where medical care is routinely unavailable or inadequate.[5]

Our goal with this resource is to ensure that providers have the information they need to keep hospitals safe and maintain high standards for patient welfare, and that health care workers can fulfill their ethical and professional obligations without fear of reprisal.

II. How the Immigration Enforcement System Affects People in Need of Medical Care

During a workplace raid in early 2026, immigration officers arrested Mr. R-M, and he sustained serious injuries. The officers took Mr. R-M to a local hospital.[6] For more than a month, immigration officers or contract guards stayed in his hospital room day and night. They controlled when he could talk to his lawyer, his family, and even his doctors. They also listened to his private conversations with doctors and attorneys. Additionally, although Mr. R-M had a broken leg, officers still insisted on shackling him to his bed.

Mr. R-M's attorneys filed a federal lawsuit on his behalf to end this 24-hour surveillance. As a result, a judge ordered officers to release Mr. R-M from his bed shackles and stop interfering with his ability to speak privately with attorneys and medical personnel.

Elements of Mr. R-M's story are widespread across the nation. Congress has given immigration officers expansive authority to arrest and detain people.[7] Under the Trump administration, officers are also stretching these authorities to extreme and, at times, unlawful limits.

Understanding how the Department of Homeland Security (DHS) works can be difficult enough for most people, and with ICE's expanded enforcement, medical providers are struggling with how to prevent Mr. R-M's situation from happening to other patients. Further, immigration officers have also arrested U.S. citizens and other people with lawful immigration status. Medical providers and hospitals cannot assume that every person an immigration officer brings in for medical care is undocumented or lacks lawful immigration status.

The following section summarizes what medical providers and hospitals need to know about parts of the immigration system, so they can provide appropriate care for their patients. Bear in mind that immigration officers often rely on acronyms and professional shorthand; refer to **Appendix A: Acronyms and Terminology** in the Addendum to learn more.

Immigration Officers

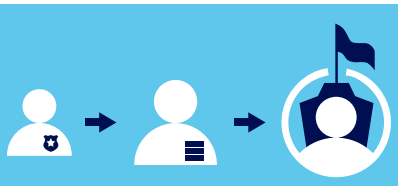
U.S. immigration law lists who is authorized to arrest people for immigration violations and under what circumstances.[8] In nearly all cases, it will be an ICE or CBP officer who will bring in a detained person for medical care. ICE is the agency tasked with interior enforcement of U.S. immigration laws. Although CBP's name may imply they only work at the border, its officers can operate across the country and have been involved in many militarized immigration operations in U.S. cities.[9]

ICE is one agency, but it has multiple components, including Enforcement and Removal Operations (ERO), the Office of the Principal Legal Advisor (OPLA), and Homeland Security Investigations (HSI). These components all work together to enforce U.S. immigration laws and carry out deportations. ERO and HSI officers handle investigations, and arrest and detain people, while OPLA attorneys represent the government in deportation cases. CBP also has multiple components, including Border Patrol (BP) and the Office of Field Operations (OFO).[10] BP officers monitor the border and intercept people attempting to enter the United States outside of official entry points. OFO officers work at the official entry points (known as "ports of entry") and do visa and passport control, among other duties.

While CBP officers do have uniforms, ICE officers do not and will often be in plain clothes.[11] However, ICE officers may carry a badge or wear ICE-branded gear like vests, jackets, or hats. Immigration officers are authorized to carry firearms and are supposed to adhere to standards governing the use of force.[12] At the time of an arrest, immigration officers are also supposed to identify themselves as immigration officers, if it is practical and safe to do so.[13] ICE has also given its officers permission to wear masks as a safety precaution, and they may continue to wear one inside the hospital. This is why it's important to ask for identifying information, as the officer's face may otherwise be concealed, and they may be in plain clothes.

Other federal and local law enforcement officers are increasingly participating in immigration enforcement operations as well, which was previously less common. For example, DHS has diverted thousands of federal law enforcement officers from the Drug Enforcement Administration and the Bureau of Alcohol, Tobacco, Firearms and Explosives (both under the Department of Justice) to do immigration enforcement.[14] Additionally, DHS has agreements with local law enforcement agencies, allowing police to assist in immigration enforcement. Some of these agreements are known as "287(g)" agreements per its section reference in immigration law.[15] As such, it is possible that some other federal or local law enforcement officer that is not an ICE or CBP officer may accompany a patient to a hospital.

For example, if a patient has been detained at a Federal Bureau of Prisons facility for a criminal charge or criminal conviction of an immigration-related violation, the officer accompanying them could be a U.S. Marshal.[16] (See below for more information on civil versus criminal custody.)



The Chain of Command

Like many other law enforcement agencies, ICE and CBP follow a "chain of command." Knowing this structure may help a medical provider, administrator, or legal counsel know who to speak to if they need to reach a certain level of approval or obtain information involving a patient, especially if the officer accompanying the patient is unable or unwilling to work with the provider's requests.

ICE is divided into field offices across the country that each have areas of responsibility (AOR). Field offices refer to a level of organizational structure, not necessarily a single physical location. Depending on the city and state, ICE may work out of multiple buildings spread across an AOR that are all part of the same field office. At the time of this publication, ICE has 25 field offices.[17] Typically, a patient will be brought in by an ICE ERO officer, sometimes called a detention and deportation officer (DDO) or deportation officer (DO). That officer will report up to a supervising detention and deportation officer (SDDO). The SDDO reports to the Field Office Director (FOD), who then reports to ERO Headquarters (ERO HQ), who ultimately reports to DHS Headquarters (HQ).[18]

CBP officers typically report to an Agent in Charge, up to a Section Chief, who in turn reports up to Senior Executive Service level staff at HQ.[19] Unfortunately, while the names and titles of ICE and CBP leadership are publicly available, both agencies have long resisted providing contact information for personnel. We discuss strategies for obtaining contact information for people at these agencies in **Section IV**.

If a patient is brought into the hospital directly from an immigration detention site, the facility's medical staff has likely given ICE or CBP officers instructions regarding the patient's medical care.

Facility medical staff report to ICE Health Service Corps (IHSC), which is a component of ERO. IHSC employees may be officers from the Commissioned Corps of the U.S. Public Health Service (USPHS Commissioned Corps), or they may be federal employees, or contract medical professionals.[20] IHSC is the entity responsible for assessing a detained patient's fitness for travel and providing medical care in compliance with ICE and CBP facilities' detention standards.[21] It would be highly unusual to have a member of IHSC accompany a patient. This is because IHSC medical personnel work in only a small number of ICE's detention facilities. IHSC's bigger footprint in the detention system is as an overseer of medical care and detention standards at IHSC and non-IHSC facilities. We discuss those standards and how IHSC functions in further detail in **Section III**.

Confusion over Criminal vs. Civil Custody

Understanding the officers and ICE and CBP's organizational structure is just one part of attending to a detained patient. Another important point is recognizing there is a difference between criminal and civil custody.

A patient in immigration detention is considered a "civil" detainee, even if they have a criminal record.[22] This has implications to how they can be treated while in government custody. A Supreme Court case looked at the treatment of civil detainee in a similar context and held that they should be given "more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish."[23] The Court based its decision by finding that civil detainees had a constitutionally protected liberty interest under the Due Process Clause of the Fourteenth Amendment.[24] It is also worth noting that the government cannot subject someone in civil detention, like immigration detention, to conditions that would constitute "punishment" since they have not been found guilty of any criminal offense.[25] After all, a patient is not meant to be held in immigration detention as a punishment, but to ensure they show up for immigration court hearings or follow through on deportation orders.

Because local law enforcement is increasingly working with ICE, many immigrants are taken into immigration custody following a criminal arrest or criminal court proceeding. This can be after a judge or magistrate grants bail to a defendant, releases them pending resolution of the cases, and even before any criminal charges have been decided. ICE also routinely takes people into custody directly from prison after they have completed a criminal sentence. The interaction between the criminal and immigration systems can make it unclear to medical staff and hospital administrators whether a patient is in criminal or civil detention. It is therefore critical for hospitals to probe officers about the type of custody that applies to a patient.

What To Know About Civilian Detainees

- Because patients in immigration custody are in civil detention, hospitals may need to revise policies that were designed for addressing law enforcement in a criminal context.
- Regardless of a patient's past interactions with the criminal legal system, a patient brought in by an immigration officer is in civil, *not* criminal, custody.
- ICE officers typically impose restrictions on a detained patient, such as prohibiting them from calling their family or having visitors because they are in immigration custody. A hospital should not proactively restrict visits or phone calls for a patient who is held for civil immigration violations. We discuss strategies for responding to these demands in **Section IV**.

24-Hour Monitoring of a Patient and Use of Restraints

Over time, Congress and the courts have permitted some restrictions on people detained for immigration purposes. For example, immigration officers are allowed to maintain custody of any person they've arrested and are required to stay with that person during transport, unless they have to perform a "law enforcement function."[26] Practically, this means officers may insist on always staying with a patient, even after transport has ended, such as after a patient has arrived at and been admitted to a hospital.

ICE internal policies, while not federal law, also allow for the use of shackles or zip-ties to restrain a detained person. Additionally, because that person is in restraints, officers will likely insist on staying in the room, ostensibly to ensure the safety of a patient in restraints.

Judicial Warrants, Administrative Warrants and Deportation Orders

Medical providers treating a detained patient should know the difference between judicial and administrative warrants. Immigration officers do not need or use judicial warrants to arrest someone suspected of violating immigration laws. [27] A judicial warrant is only necessary if an immigration officer is attempting to enter a private space.

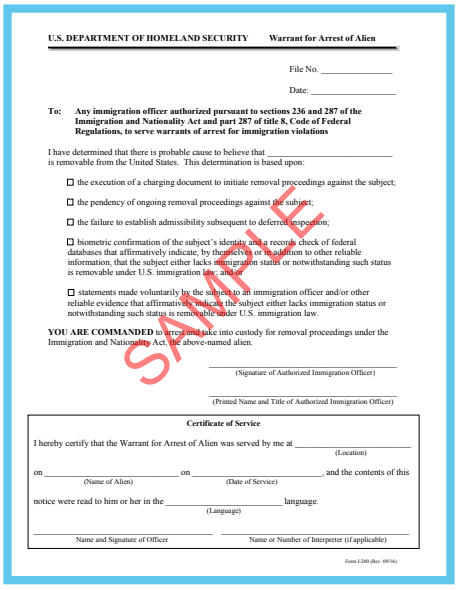
In some cases, immigration officers will have an administrative warrant to arrest a person suspected of violating U.S. immigration law, meaning they've received explicit permission to arrest and detain the named person from their office based on that person's immigration details.[28] This is more likely the case when an officer brings in a patient for medical care who is being held at a detention center.

In cases where the patient is brought in for medical treatment immediately following a street-level arrest, officers may not have an administrative warrant. This is because they are allowed to make warrantless arrests if they believe the individual will flee before the officer can write up an administrative warrant. The Trump administration has tried to dramatically expand officers' warrantless arrest authority, raising significant civil rights concerns.[29]

Officers may also bring in a patient for medical care who has a deportation or removal order. [30] While it may seem odd that someone ordered to leave the country is stuck in detention, delays in deporting someone (even if they have a deportation order) are not uncommon.

What to Know About Administrative Warrants

- In the case of an arrest made without an administrative warrant, federal regulations require immigration officers to decide within 48 hours if they will keep someone in custody (absent extraordinary circumstances or emergencies).[31]
- An administrative warrant is not a *judicial* warrant. A judicial warrant must be issued by a court and signed by a judge.[32]
- An administrative warrant does not charge anyone with a criminal offense (though they may reference past criminal encounters).[33]



U.S. DEPARTMENT OF HOMELAND SECURITY **Warrant for Arrest of Alien**

File No. _____

Date: _____

To: **Any immigration officer authorized pursuant to sections 236 and 287 of the Immigration and Nationality Act and part 287 of title 8, Code of Federal Regulations, to serve warrants of arrest for immigration violations**

I have determined that there is probable cause to believe that _____ is removable from the United States. This determination is based upon:

☐ the execution of a charging document to initiate removal proceedings against the subject;

☐ the pendency of ongoing removal proceedings against the subject;

☐ the failure to establish admissibility subsequent to deferred inspection;

☐ biometric confirmation of the subject's identity and a records check of federal databases that affirmatively indicate, by themselves or in addition to other reliable information, that the subject either lacks immigration status or notwithstanding such status is removable under U.S. immigration law; and/or

☐ statements made voluntarily by the subject to an immigration officer and/or other reliable evidence that affirmatively indicate the subject either lacks immigration status or notwithstanding such status is removable under U.S. immigration law.

YOU ARE COMMANDED to arrest and take into custody for removal proceedings under the Immigration and Nationality Act, the above-named alien.

SAMPLE

_____
(Signature of Authorized Immigration Officer)

_____
(Printed Name and Title of Authorized Immigration Officer)

Certificate of Service

I hereby certify that the Warrant for Arrest of Alien was served by me at _____ (Location)

on _____ (Name of Alien) on _____ (Date of Service), and the contents of this notice were read to him or her in the _____ (Language) language.

_____ Name and Signature of Officer

_____ Name or Number of Interpreter (if applicable)

Form I-200 (Rev. 09/16)

- An administrative warrant does not require action by anyone other than immigration officers. Its scope is limited to allowing the officer to arrest an individual for civil detention and does not itself grant any additional authority to advise medical personnel.
- An administrative warrant does not authorize officers to enter a private space within a hospital, unless permission is given. Only a judicial warrant does so. As we discuss below in **Section III**, asserting privacy protections for patients and personnel is critical.

III. Understanding Federal Laws and Policies that Address Detained Immigrants' Medical Care

Understanding how a hospital's legal obligations apply to patients in immigration detention, and what an immigration officer's legal obligations and required conduct are, allows medical staff to better provide quality care under difficult circumstances.

Guaranteed Treatment in Emergencies

Federal law under the Emergency Medical Treatment and Labor Act (EMTALA) guarantees that no patient can be denied treatment for emergency services because of their inability to pay.[34] Immigration status is irrelevant to a hospital's obligation. Even if a patient is ineligible for Medicaid due to their immigration status, hospitals can receive reimbursement under a program known as Emergency or Limited-Scope Medicaid.[35]

As with any patient, emergency departments have a duty to evaluate the patient's needs, provide care necessary to "stabilize the medical condition," and discharge or transfer the patient safely.[36] A hospital's obligations under EMTALA end in the case of a good-faith admission for inpatient care, although some courts have extended this beyond admission.[37] Hospitals generally establish policies and procedures for EMTALA patients because they hold legal and financial responsibility.

Regardless of the presence of an immigration officer, it is the role of the doctor in charge of a patient's care to determine whether a patient is stabilized, and the validity of those decisions are judged by the doctor's actual knowledge at the time.[38] The Centers for Medicare & Medicaid Services has noted that emergency situations are complex and must be evaluated on a case-by-case basis using specific medical facts, not blanket rules.[39] For detained immigrants in a hospital emergency room, like any other patient, this means the hospital cannot release a patient until the patient's doctor determines, based on a patient's specific circumstances, that they can safely leave the hospital.

Involving Patients and Their Care Partners in Medical Decisions

Under federal law, hospitals must ensure that when possible, a patient is involved in and able to make decisions regarding their own care.[40] Providers also have an ethical obligation to respect patient decision-making at all times.[41] Medical consent laws and constitutional protections for bodily integrity restrain the government, and anyone acting on the government's behalf, from making decisions about a detained person's care, including respecting their right to refuse treatment.[42]

Medical providers must also respect a patient's right to inform and involve family or trusted individuals in their care.[43] If a patient wants someone to be notified that they have been admitted, federal regulations require the hospital to make that notification promptly upon the patient's admission.[44] Additionally, nearly all states have laws that dictate how

family or other representatives must be involved in making decisions on behalf of a patient who is incapacitated or otherwise not competent to make their own health care decisions.[45]

Under federal law and regulations, immigration officers are authorized to exert custody over immigrants who have been detained. ICE detention standards discussed below provide that officers may, for example, limit visitation or communication, such as phone access while in a hospital.[46] However, unless they have some other court order, ICE officers do not have authority to give orders to anyone who is not in their custody, such as medical staff. As discussed in **Section IV**, a hospital should generally set its own policies and procedures for all patients. Not only is it best practice for meeting legal obligations, but it provides an alternative authority for staff to rely on when responding to immigration officers' demands.

Constitutional Limits on Access to Information and Spaces

The Fourth Amendment of the U.S. Constitution protects against unreasonable search and seizures, which is based on a reasonable expectation of privacy.[47] This means that a hospital or other health care facility can limit access to spaces and records that are not accessible to the general public, unless presented with a valid warrant signed by a judge or magistrate. Some state laws require hospitals to deny access without a judicial warrant.[48]

If a facility allows an immigration officer to enter the hospital because they are accompanying a patient, the facility may still restrict the officer from entering other areas if they are established as private spaces. This may include other patients' rooms, secure wards, and internal waiting areas. Otherwise, allowing an officer to roam the halls of a hospital while guarding a patient could lead to invasive questioning and even the arrest of others in the hospital. This is because officers have the power to interrogate and detain anyone they believe does not have permission to be in the United States or who may have committed certain migration-related crimes.[49] An officer may also observe any patient records that are in plain view, even if they don't have a warrant.

If a facility allows an immigration officer to enter the hospital because they are accompanying a patient, the facility may still restrict the officer from entering other areas if they are established as private spaces.

Fourth Amendment guidelines can be helpful in clarifying and maintaining boundaries for ICE and CBP presence in the hospital. **Section IV** includes general recommendations for how to prepare hospital staff (including those providing functions beyond medical care, like receptionists, social services, and security guards), but there are nuances that are be crucial to discuss with legal counsel.

HIPAA Protections for Private Health Information

Hospitals and medical staff are required to protect personally identifying health information under the Health Insurance Portability and Accountability Act (HIPAA).[50] Because the law is based on respecting a patient's privacy rights, in this context it governs how *medical staff* should interact with immigration officers as it relates to the delivery of medical care. There are two key relevant issues involving HIPAA: patient records and direct communication between medical staff and their patients.

No medical records can be shared with a third party without the consent of the patient or in accordance with a specific exception outlined in HIPAA. A hospital should establish if an exception applies before releasing information.[51] For example, upon discharge a hospital may release records to health care providers at a detention center without violating HIPAA.[52] Another exception allows medical providers to disclose private medical

There is no HIPAA exception that would authorize an ICE officer's presence while a medical staff member discusses treatment.

information for "law enforcement" purposes without violating HIPAA, but the exception is limited to specific circumstances, such as complying with a court order.[53] No medical staff member should override a person's HIPAA rights due to this exception without consulting legal counsel.

Regardless of the different possible circumstances, the exceptions make disclosure permissible, not mandatory.[54] The hospital's own privacy rights under the Fourth Amendment are separate and hospital administrators may still decline to provide records to law enforcement without a valid judicial warrant, even if that disclosure would not violate HIPAA due to an exception.

There is no HIPAA exception that would authorize, without a patient's consent, an ICE officer's presence while a medical staff member discusses treatment with that patient. There may be some situations where additional conditions could allow a medical provider to override a patient's HIPAA rights due to a "threat to the health or safety of a person or the public," but the medical provider should justify the decision based on existing professional standards for public safety disclosure, not just a civil immigration arrest.[55] Although the ICE officer is not a "covered entity" with responsibilities under HIPAA, a medical staff member should make it clear that hospital staff cannot carry out their medical duties under federal law while the officer is present. ICE's own detention standards as described below require deference to a hospital in the provision of care.

Detention Standards for ICE and CBP Officers

Unlike the laws previously mentioned, ICE and CBP have adopted various detention standards to govern the medical care of people in their custody and in their detention facilities.[56] These standards are agency policy and not federal legislation. In fact, ICE and CBP have been sued for violating their own agency standards under various legal theories, and advocates have criticized their shortcomings.[57]

ICE's detention standards describe a detained patient's right to many critical activities like making phone calls, meeting with their family and attorneys, and accessing legal information while in ICE custody, to name a few.[58] There are two main sets of detention standards that cover most ICE detention facilities. One is the National Detention Standards (NDS).[59] The Trump administration updated these standards on June 18, 2025, although only to remove references to transgender people.[60] Other detention facilities are governed by the Performance Based National Detention Standards (PBNDS), which were last updated in 2016.[61] There are two detention standards because they apply to different types of facilities. The PBNDS is applied to facilities that only detain immigrants, whereas the NDS apply to jails that may have a mixed population of criminal and civil detention. The PBNDS is considered generally more protective because it provides more details about what the facility must do to keep people safe.[62]

For providers, it may be useful to review the National Detainee Handbook, a document that ICE is supposed to provide to every person in detention because it informs them of their rights under ICE's detention standards. The handbook may offer a useful summary of the standards for a medical provider or caregiver team. It is available for download on ICE's website in multiple languages.[63]

CBP facilities and officers should adhere to the CBP National Standards on Transport, Escort, Detention, and Search (TEDS).[64] Unfortunately, there is very little in the TEDS as to how officers should conduct themselves in hospital settings.[65]

Reasonable Accommodations for Disabilities

Both health care providers and DHS are bound to comply with Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination against people with disabilities.[66] The Rehabilitation Act requires ICE and CBP to provide accommodations that meet the specific needs of a person in their custody who has temporary or permanent disabilities.[67]

This law can prove particularly helpful when it comes to the use of restraints. In 2023, a complaint was filed on behalf of a detained immigrant who was forced to endure ankle restraints during a deportation flight while suffering from a grade 3 ankle sprain. In response, the DHS Office for Civil Rights and Civil Liberties (CRCL) relied on the Rehabilitation Act to order ICE to change their policy on using restraints for people with permanent or temporary disabilities, requiring officers to complete an individualized assessment of whether restraints are necessary or appropriate for a person with disabilities prior to placing them on that person.[68]

Rights for Receiving Care in a Preferred Language

Federal civil rights laws require health care providers that receive federal funding, such as Medicare and Medicaid reimbursement, to ensure that their patients can communicate and receive information in their preferred language at no cost to themselves.[69] This must be provided by a qualified medical interpreter or translator. Qualified interpreters and translators must have demonstrated proficiency in understanding the patient's language and must be able to, using the necessary specialized vocabulary, interpret or translate into English and back into the patient's language.[70] They must adhere to ethics and impartiality.

ICE's detention standards also state that professional in-person or telephonic interpretation should be provided through translation services or bilingual personnel.[71] Except in emergencies, their standards state that other detained people should not be used as interpreters or translators.

In a hospital setting, ICE officers should never be used as interpreters because the specialized medical material is not part of their training and they are not impartial parties. Machine translation, such as Google Translate, is also not an allowed alternative without review by a human translator.[72] Several states have additional requirements to ensure language access rights are respected.[73]

Providers are required to have written policies and procedures for how they fulfill these legal obligations. There is no exception to these obligations for patients in immigration custody that would allow a health care provider to forgo interpretation services or bar a third-party interpreter from being present.[74] Providers that do not adhere to these requirements could be subject to a civil rights investigation or sued for intentional discrimination on the basis of national origin.

Laws Regarding Safe Discharge

Even outside of an emergency department, federal regulations require hospitals that accept Medicare to follow a discharge plan process made in collaboration with the patient and/or their designated family or representative. The plan must "ensure an effective transition," and account for post-hospital service and support needs.[75] State licensing laws may place further obligations on providers: for example, a hospital may not remove or transfer a patient if, based on the judgement of a licensed clinician, the move could endanger the patient's health.[76] A third party, such as an immigration officer, does not have the authority to determine when a patient can be safely discharged.

Brief Synopsis of Medical Care in ICE and CBP Detention

As noted above in **Section II**, IHSC is responsible for medical care in immigration detention facilities. It is widely reported that the delivery of medical services to people in detention routinely falls short of acceptable standards of care. [77] Medical neglect and dangerous factors such as facility overcrowding and malnutrition are common in immigration detention. Detained individuals typically are not provided their home medications and acute conditions may go unaddressed. Thirty-two people died in U.S. immigration custody in 2025, the highest record in more than two decades, and 2026 is outpacing that alarming number.[78]

For a more complete understanding of inadequate medical care within ICE detention facilities, medical staff are encouraged to consult "Deadly Failures: Preventable Deaths in U.S. Immigrant Detention," a 2024 report by the American Civil Liberties Union, Physicians for Human Rights, and American Oversight.[79] It provides a comprehensive review of the failures of medical care in ICE custody. Critically, the authors found that 95 percent of the ICE detention deaths they reviewed were preventable.[80] For a review of medical care in CBP custody, a January 2025 Senate Judiciary Committee minority report provides a thoughtful review of issues with inadequate medical care.[81]

Below is a brief overview of how medical care functions in ICE and CBP detention to help medical staff better understand what health conditions their patient may present and how to make informed decisions about plans for discharge.

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ICE Health Service Corps (IHSC)

Within ICE, ERO Headquarters Custody Management (ERO HQ) and IHSC oversee the provision of medical care to people in detention.[82] They manage medical staff and their adherence to ICE's detention standards. Within CBP, medical care in their facilities is provided through contracted medical providers.[83] CBP detention is meant to be short-term (defined as 72 hours or less).[84]

IHSC also includes a Clinical Services Division that provides medical oversight, guidance, and instructions to medical staff tasked with delivering medical care.[85] Each facility has a designated clinical medical authority (CMA) who is a doctor (MD or DO) responsible for medical clinical care.[86] Each ICE Field Office also has an assigned Field Medical Coordinator (FMC). The FMC is responsible for addressing continuity of care issues when a patient returns to a facility or is deported. Some detention facilities will have IHSC staff present to directly manage care and continuation of any services post-hospitalization. However, there are fewer than 20 IHSC facilities.[87] Patients held at non-IHSC facilities receive medical care from contract staff and IHSC monitors compliance with ICE detention standards through the FMC program.[88]

The IHSC Special Operations Unit is responsible for providing medical care for detained individuals outside of detention facilities, usually during air travel or to support the United States Coast Guard during encounters at sea.[89]

Key Takeaways About ICE Medical Detention

- Every person booked into an ICE detention facility is supposed to receive a health screening within 12 hours of arrival and a complete health assessment within 14 days of admission.[90]
- CBP standards require officers to assess someone for any observed or reported serious physical or mental injury or illness. When someone enters a CBP holding room, officers are supposed to ask them about any injuries, illnesses, or physical concerns.[91]
- The exact number of detention facilities and places where the government holds people for immigration violations is constantly in flux. At the end of fiscal year 2025, ICE reported having over 180 detention sites across the country. [92]
- Over time, IHSC has issued directives on a variety of subjects ranging from guidance on management of hepatitis to providing care to a pregnant person.[93] Unfortunately, these directives are not easily accessible. They are usually posted on ICE's Freedom of Information Act website or found by searching archived webpage sites.[94] While difficult to find, they may help medical personnel to understand IHSC's guidelines on care.

IV. Strategies for Navigating ICE Encounters and Providing Care

In a real-world situation, interactions between medical staff and immigration officers can be difficult, because their interests and priorities are often at odds. Additionally, a health care institution and its leaders may be hesitant to push back on officers' requests for fear of retribution, creating additional challenges for the institution's doctors, nurses, and other staff. This section discusses strategies for continuing to provide quality care for patients in immigration custody in these difficult situations, using the relevant law as it might apply in a real situation.

Create an Action Plan Before It's Needed

It's important to prepare a facility so that it complies with HIPAA and can effectively invoke its Fourth Amendment protections when necessary. Policies and procedures should relate not only to the patient who is in immigration custody, but to all patients whose care could be disrupted. The presence of immigration officers could also affect the families of other patients, and could open staff to invasive questioning, generating fear even for people who are lawfully present and authorized to work.[95]

Establish Private Spaces

The hospital itself is the entity that invokes the Fourth Amendment rights described in **Section III**, but it must first establish private spaces where there is a reasonable expectation of privacy. Note:

- Just saying a space is private is not sufficient. A reasonable person must be able to perceive a space as private.
- Hospitals can take steps toward clarifying the private nature of a space. For example, it can restrict non-staff and patient access by having an obvious process for admitting guests, using clear signage, and having physical barriers like locked doors that require badge access from hospital staff.[96]
- If spaces are established as private, staff can then prevent access to those spaces unless presented with a signed judicial warrant.

Create and Practice Procedures for When Immigration Officers are Present

Every hospital should have policies that outline how to proceed if an immigration officer arrives with a patient or seeks entry.[97] Hospitals should also train both medical and non-medical hospital staff on how to interact with immigration officers. The following procedures can be particularly helpful in creating boundaries for where the officer can be once they have entered the hospital:

- Along with training, all hospital staff should have access to written procedures they can continually refer to. It's recommended to include directions and scripts for hospital staff, including security guards or receptionists.
- An authorized person or team (often the hospital's attorney, administrator, or other supervisor) should be designated as the point of contact to interact with officers upon their arrival, and all staff should be trained to direct any officers to that point of contact. This is also good practice for other situations where officers may arrive seeking to enter and make an arrest.
- The presence of immigration officers underscores the need to prepare a HIPAA compliance plan to keep health records and other information private, which also supports Fourth Amendment protections. In a busy hospital ward, there may be monitors, records and charts — including on mobile stations — in plain view of people walking through hallways. Staff should lock all unused workstations, limit visible information about patients, and secure doors to private patient care areas.

Include Immigrant Staff in Your Action Plan

Many people who have federal permission to work in the U.S. could be part of hospital staff; this includes, for example, people with a visa, green card, or Deferred Action for Childhood Arrivals (known as DACA). People may assume that immigration officers are only interested in undocumented immigrants, but agency practice suggests otherwise. There are detailed guides on immigration issues in the workplace.[98] However, a few tips are below:

- Hospital staff should be aware of general constitutional rights for immigrants as well as what to do if a staff member is arrested or detained.[99]
- Non-citizen staff should have a family preparedness plan, even if it seems unlikely that they would be a target of immigration enforcement.[100]

Gather Information and Set Boundaries as Soon as a Patient Arrives

When immigration officers arrive at a hospital or health care facility, the point of contact established above should immediately ask for the purpose of the visit. If the officers are there to find and arrest an individual, please refer to the resources found in the **Addendum: Legal Resources and Emotional Support for Providers**. When the officer is accompanying a detained patient, the point of contact should continue to support the medical staff providing care. This first interaction between the patient and their medical team can be crucial to establishing a successful care plan.

Gathering Information from Officers

- Hospital staff should not make any assumptions about whether a patient has a lawful immigration status. As a reminder, not all people arrested by immigration officers are undocumented, and just because someone is arrested does not mean they will ultimately be deported.
- The medical staff member conducting the intake should also ask to see and make a note or copy of the immigration enforcement officer's credentials, including name and badge number.
- Ask for and note the telephone number of the immigration enforcement officer's supervisor. At minimum, ask the officer to confirm what field office they are from and if there is a detention center or holding location they intend to use.
- Ask for the contact information of the Field Medical Coordinator (FMC) for the area, although the officer may not have this information. If the patient is coming in from a detention facility, medical staff can ask for the Clinical Medical Authority (CMA).
- Ask accompanying officers for the patient's In-Processing Health Screening Form (I-794), a standardized form that IHSC provides at the detention facility and uses for initial medical screening.[101] Immigration officers will not bring a patient's full medical file when they arrive with the patient from immigration detention.

Set Expectations

- The medical staff and the point of contact for immigration issues should use this moment to acknowledge to the officer that they are aware that ICE facilities and officers must follow certain standards and procedures. They should emphasize that those same detention standards clearly state that the hospital has the final call on all medical decisions. [102]
- It may also be appropriate for a medical staff to state that, for a seriously ill, injured, or dying patient, the staff will follow the hospital's standard rules and procedures (as permitted by ICE's own standards). This can lay the groundwork for communicating with the patient's family. Arguably, if someone is needing hospital attention, they likely fall into the category of "seriously ill or injured."[103]
- For patients who are incapacitated, medical staff should ask for contact information for next of kin or another patient-identified representative authorized as a surrogate health decision-maker in accordance with federal and state law, although an officer may not have that information.
- This is a good time for medical staff to ask about any other instructions from the officer and identify any future sources of conflict. Once this information is received, direct officers to a pre-designated location that does not interfere with patient privacy.

Gather Information from Patients

- A medical staff member should use a private triage space or take the patient to a private room as soon as practically possible. This is also good practice to reduce opportunities for immigration officers to interact with other patients, staff, and visitors. Because taking a patient's history and providing a physical exam both require patients to share extensive and highly sensitive information, staff should inform the officer that the hospital cannot conduct an evaluation or treatment in the presence of the officer due to medical privacy laws, as described in **Section III**.

- If officers resist allowing a medical staff member who is attending to the patient to gather information in private, the staff member can lower their voice and use portable screens to create some auditory and visual privacy. If an officer demands to see the patient at all times, the staff member can agree to leave curtains open in a private room or otherwise ask the officer to step away while keeping the patient within view.
- Once in a private setting, the medical staff member can continue taking the patient's medical history. Do not rely on names and birth dates written in immigration paperwork; rather, confirm directly with the patient. If possible, include the patient's "alien registration" or "A" number (a nine-digit number assigned to persons involved in the U.S. immigration system) in the chart and ask where the patient has received previous medical care.
- Be sure to also ask the patient for the contact information of any surrogate decision-makers. Often, a detained person is transferred to a detention facility in a different state from their home, so a preferred surrogate may not be available in person.

Protect a Patient's Legal Right to Privacy

Immigration officers may state that they must maintain custody over a detained person by remaining by their side. During an examination or discussion between patient and provider, this is not only in conflict with the patient's HIPAA rights as described in **Section III** but also interferes with a medical provider's ethical obligation to provide quality care. To protect a patient's privacy rights, medical staff should consider the following procedures:

- Even after the initial intake process, set a boundary and state that officers need to leave the room during examinations and care discussions for HIPAA compliance. An example would be to have the officer step outside and close the door or step away to be out of earshot. Medical staff should not only stress HIPAA regulations but also assert that an honest conversation with the patient is necessary to ensure they receive the correct treatment. This is also consistent with detention center standards, which state that medical visits should be "private confidential sessions." [104]
- Staff should avoid writing patient information on walls in a patient's room or placing medical records in public view if an immigration officer will be in the room. They should also ensure that workstations are always locked, and mobile units removed when not in use.
- No medical provider should answer immigration officers' questions about the patient's medical situation during treatment. The only possible exception is to provide information about how long a treatment will take in response to a directly related question. This typically does not have anything to do with patient confidentiality and is often asked so the officers can make administrative decisions, such as planning shift changes.
- If immigration enforcement officials refuse to comply with requests for privacy, medical staff should document the details of the interaction, along with the name and badge number of the officers. They should then report up and escalate the issue to hospital administrators and legal staff, who can seek other authorities to prevail upon the officer. Ultimately, it is the role of the medical staff member to protect the patient's privacy.

Suggested Script:

"I provide all my patients with the same degree of respect and privacy under federal law. This is also in accordance with the National Commission on Correctional Health Care's standards, which require medical visits to be private confidential sessions. Could you please step out of the room while I conduct this private examination?"

Prioritize Emergency Care

Providers working in the acute care setting (e.g., emergency department or trauma bay) may encounter critically ill patients who have been newly detained. Immigration officers or other law enforcement officers may seek to accompany the patient to the resuscitation room and immediately start interrogating or taking photos for evidence, impeding a provider's ability to evaluate and stabilize the patient. In addition to the provider's HIPAA obligations, patient stabilization and care should take precedence.

Suggested Script:

"This patient has not been evaluated and is at risk of grave injury or death. Please step out of the room while we work to stabilize these severe injuries. We will let you know as soon as this patient is medically stabilized."

Ensure That Patients Can Communicate Regarding Their Care

Language justice is not only a legal obligation, but a keystone of patient care, especially for vulnerable patients. ICE's own detention standards also require facilities to provide in-person interpreters or a virtual "language line" service to people in detention to access mental health and medical care, among other needs.[105] To ensure patients have equitable language access, medical providers shoulder consider the following recommendation:

- Identify the patient's preferred language upon intake or any other initial interactions, without implying that the provision of language services would be a burden or come with financial costs. Providers should also assess if, aside from limited English proficiency, a patient may also have disabilities that impair their ability to communicate.
- If a patient requests language services, inform the immigration enforcement officer that an additional person or service will be involved as part of that patient's care team during every communication, oral or written. Medical staff members can assure the officer that there are legal and professional limits on the interpreter's involvement, and that they have a duty of confidentiality.
- Immigration enforcement officers should never act as interpreters or translators. Although ICE's standards state that appropriate staff may interpret, it is a direct conflict of interest in health care setting outside of detention and they cannot be verified as qualified interpreters who will use properly translated medical terminology and adhere to ethics requirements. [106]

Suggested Script:

"This patient's preferred language is [language other than English]. I'm required by federal law and our facility's language access policies to ensure any communications with her are in [preferred language]. To do so, I will be bringing in [an in-person or virtual] interpreter. This person will only interpret our conversation and they are bound by privacy laws and their contract from discussing the contents of this conversation with anyone else."

Limit Use of Restraints When Medically Necessary

Medical staff are trained to determine the use and medical necessity of restraints consistent with clinical safety standards (e.g. the risk of harm to self or others). However, immigration officers regularly insist on keeping patients in restraints. To provide the best care for patients in immigration custody, medical staff are advised as follows:

- Assess the necessity of restraints with the officer and request removal or limitations if those restraints are in any way interfering with medical care. Medical staff can remind the immigration officer of ICE's obligations under the Rehabilitation Act as discussed in **Section III**.

- For a pregnant patient, medical staff can share their understanding that restraints are generally prohibited during transport or at a medical facility.[107] Historically, ICE generally prohibited the use of restraints on pregnant people or those in post-delivery recovery. Under ICE's own policy, restraints are never permitted on individuals who are in active labor or delivery.[108] Some states have laws limiting restraints that may be helpful to reference.[109]

- If an officer declines to adjust restraints and it interferes with care, medical staff should document the situation, including the officer's name and badge number, and escalate either through the officer's chain of command or through internal hospital protocols, to ensure standards of care.

Suggested Script:

"As health care providers, we need access to the patient's [right/left] arm(s) for IVs and blood draws. I'm hoping we can work together to ensure that we are meeting both of our obligations to make reasonable accommodations for this patient's particular needs. Could you please remove the handcuffs or at least transfer the cuffs to the leg so that it is not impeding medical care?"

Ensure Patient and Care Partners Participate in Medical Decisions

Even when patients are in immigration custody, as discussed in **Section III**, they must have autonomy in making health decisions or have trusted individuals involved if incapacitated, and they have the right to have family informed of admittance.

- As described above, medical staff should ask (if possible) during intake if a patient wants anyone contacted on their behalf and if anyone is authorized as a surrogate decision-maker.

- If the patient is incapacitated at arrival, the hospital should follow state law regarding surrogate decision-makers as applied to all patients.

- Under no circumstances should an officer make medical decisions on behalf of a patient.

- Conflicts may arise with immigration officers who seek to control information and access regarding the patient. As discussed in **Section I**, understanding who has legal custody, and why, can help guide hospital decisions. Under ICE's detention standards, officers have the power to make "administrative decisions" about patients in their custody, such as rules around visitors, movement, and authorizing or limiting services. However, these rules do not apply to third parties, so they do not restrict medical staff from following their hospital's own rules. And in the case of seriously ill, injured, and dying patients, ICE detention standards direct their officers to follow hospital procedures on reaching out to family.

Suggested Script:

"This patient is no longer conscious, and there are significant emergency medical decisions that need to be made regarding her course of treatment. For all my patients, I am required by federal and state law to reach out to the person she identified [or without this, the person established by law] to make medical decisions on her behalf. I am going to call that person myself, discussing only the patient's medical condition and what decisions need to be made."

- Medical staff should limit any outside communication to their duty as health care providers and avoid discussing immigration or detention issues. If officers attempt to restrict staff from following procedures, staff should document and escalate to hospital administrators and legal counsel for support in ensuring the hospital meets its legal obligations.

Prepare Patient Safety After Leaving

Due to the issues with medical care in immigration detention, a patient in ICE custody is unlikely to have regular access to medical staff or receive high-quality health care when returned to immigration detention. The patient may also be facing deportation to a country where access to medication and/or treatment may be limited.

- While in the hospital, ICE's detention standards state plainly that the hospital assumes medical decision-making authority for a detained patient.[110] This includes drug regimen, lab tests, x-rays, and treatments. The physician considering discharge should therefore consider the limits of detention and deportation in developing a plan, which might differ from plans for patients not in immigration custody.
- Outpatient follow-up may not be possible because the length and location of detention is unpredictable, the patient is unable to obtain prescriptions or follow up with medical staff at detention centers, and/or the patient is being deported. Health care providers should therefore assume that detained patients will not be able to attend future follow-up outpatient appointments.
- Patients may not know the name of the detention center where they are detained. Medical staff will need to ask the immigration officer about plans for the person's detention. They should also ask the accompanying officer whether the detention facility has medical providers on site, what their contact information is, and if they have the capacity to fill prescriptions or dispense medications.
- For discharge planning, providers should contact the FMC or IHSC liaison at the patient's detention center. If the officer is unable or unwilling to provide this information, medical providers can try contacting the field office. Sometimes field office phones numbers do not work, so physicians may need to use an ICE field office general outreach email address or ask peers for advice.[111]
- Hospitals should transfer medical records in a method that maintains confidentiality requirements under HIPAA.
- If the patient in immigration custody has needs that cannot be met by their detention facility that could result in a significant rate of treatment failure or relapse, a physician may need to admit or retain patients within the hospital. A hospital's duty to safely transfer or discharge a patient, as described in **Section III**, relies on the decision of a physician, not an immigration officer.
- Medical care providers may wish to consider printing out a copy or relevant sections of the National Detainee Handbook (mentioned above in **Section III**) in a language of the patient's choice and giving them a copy to review before discharge.

Suggested Script:

"Who should I speak with about this patient's medical needs upon discharge? What are the medical capacities of the facility that the patient will go to upon discharge? Are there doctors or advanced care providers and how will necessary medications be dispensed to the patient? Is the patient scheduled for imminent deportation and if so, do they need a longer supply of medications?"

Document to Help, Not Harm

Accurate medical records are an important tool for providing care both in a hospital and beyond. However, medical staff should be careful to ensure a patient's records do not become evidence for immigration enforcement. To protect patient privacy, medical staff should consider the following:

- Include notes that a patient is in active immigration custody. To get a full account of the patient's health and to address any conflicts over discharge, medical staff should also clearly document any harms or injuries reportedly experienced during an immigration arrest or while detained. Also document how a patient's chronic medical conditions have worsened or gone untreated in detention, as this could be relevant to decisions regarding the patient's future care. A clear and accurate physical exam is critical, and providers should take and upload photos of injuries, wounds, rashes, etc., to the patient's chart. If there are any documents provided by the immigration officer, medical staff should scan and upload these documents to the patient's chart.
- Even if immigration officers are not present in the room, a patient in custody may avoid answering questions that could implicate their immigration status. To ensure trust and accurate communication, physicians should be careful when asking about a detained patient's background or personal history. When documenting, limit to what is clinically relevant and necessary for diagnosis and treatment. Avoid asking or documenting where a patient was born and if or how they crossed the border.
- To maintain HIPAA compliance, medical staff should not review specific discharge instructions with law enforcement officials at the patient's bedside. If practical, a doctor can place discharge instructions in sealed envelopes for officers or contracted guards at the patient's bedside to give to IHSC. However, providers should ask these officials for an IHSC or FMC contact to discuss any discharge instructions that the patient may have. Providers should document this discussion with immigration officials as well as any communication with the IHSC contact at that patient's detention center, even if it is in email form.

Suggested Documentation:

- 35-year-old M who presents with left leg pain after a fall from 20 feet in height.
- 35-year-old M who presents with left leg pain after falling from US-Mexico Border wall, ~20ft.

Conclusion

Regardless of the changing tides of immigration enforcement, the provision of medical attention and care must remain the priority in a hospital. Anything less risks undermining the public's trust in health care institutions. Hospitals can retain this trust by applying policies that prioritize patient health and support medical staff's decision-making in a consistent and equal manner to all patients, but especially those in immigration custody.

Addendum

A | Acronyms and Terminology

B | Quick Reference: Legal Resources for Patients

C | Legal Resources and Emotional Support for Providers

Acronyms and Terminology

A–C

A-Number — Alien Registration Number
AOR — Area of Responsibility (in ICE facilities)
ATF — the Bureau of Alcohol, Tobacco, Firearms and Explosives
BP — U.S. Border Patrol (a component of U.S. Customs and Border Protection)
BOP — the Federal Bureau of Prisons
CBP — U.S. Customs and Border Protection
CFR / C.F.R. — the Code of Federal Regulations
CMA — Clinical Medical Authority (in ICE facilities)
CMS — Centers for Medicare & Medicaid Services
CRCL — Office for Civil Rights and Civil Liberties (DHS)

D–F

DEA — the Drug Enforcement Administration (DOJ)
DHS — U.S. Department of Homeland Security
DO — Doctor of Osteopathic Medicine
DRIL — ICE Detention Reporting and Information Line
EMTALA — Emergency Medical Treatment and Labor Act
ERO — Enforcement and Removal Operations (ICE)
ERO HQ — Enforcement and Removal Operations Headquarters
FMC — Field Medical Coordinator (in ICE facilities)
FOIA — Freedom of Information Act
FOD — Field Office Director (part of ICE)

G–I

GAO — U.S. Government Accountability Office, the congressional watchdog
HIPAA — Health Insurance Portability and Accountability Act
HQ — Headquarters (referring to DHS Headquarters)
HSI — Homeland Security Investigations (ICE)
ICE — U.S. Immigration and Customs Enforcement
IHSC — ICE Health Service Corps
ISOU — IHSC Special Operations Unit

J–N

MD — Medical Doctor
NCCHC — the National Commission on Correctional Health Care
NDS — National Detention Standards

O–P

OFO — Office of Field Operations (CBP)
OPLA — Office of the Principal Legal Advisor (ICE)
PHR — Physicians for Human Rights
PBNDS — Performance-Based National Detention Standards

R–Z

SDDO — Supervisory Detention & Deportation Officer (ICE)
TEDS — CBP National Standards on Transport, Escort, Detention, and Search (U.S. CBP)
USPHS Commissioned Corps — the Commissioned Corps of the U.S. Public Health Service

Quick Reference: Legal Resources for Patients

American Bar Association (ABA) Guide for Family and Friends of Individuals in Detention (2023) (https://www.americanbar.org/content/dam/aba/administrative/immigration/guide-for-family-and-friends-of-individuals-in-detention-3-2023.pdf)

Finding a Lawyer:

- Immigration Advocates Network National Immigration Legal Services Directory (https://www.immigrationadvocates.org/legaldirectory/)
- American Immigration Lawyers Association Find a Lawyer (www.ailalawyer.com)

Treating Fear: Sanctuary Doctoring (offering resources for physicians to share with patients) (https://www.luc.edu/sanctuarydoctor)

Patients: Know your immigration rights | National Nurses United (https://www.nationalnursesunited.org/patients-know-your-immigration-rights)

ICE Detainee Information

- The ICE Detention Reporting and Information Line (DRIL) receives calls about complaints/abuse in custody. It should be available to detained people using the pro-bono network number at 9116#. These calls are free and facility staff cannot record or monitor them. Outside of detention, people can call DRIL to report abuse in detention: 1-888-351-4024
- The Detainee Information site through the ICE Portal is publicly posted information that ICE claims is available to detained individuals through a detention facility's law library (https://portal.ice.gov/detainee)

Legal Resources and Emotional Support for Providers

- The Workplace Change Collaborative (WCC) Resources: The WCC works to improve mental health, reduce burnout, and address moral injury among health and public safety workers and learners. (https://www.wpchange.org/)
- NILC's Know Your Rights: Health Care Providers & Immigration Enforcement This report offers guidance for hospitals and health care workers on patient privacy and facility access. Published January 24, 2025. (https://www.nilc.org/resources/healthcare-provider-and-patients-rights-imm-enf/)
- The Office of Minnesota Attorney General's Guidance on ICE Enforcement in Sensitive Locations: This offers detailed guidance for schools, hospitals, churches, and other organizations on facility access, warrant requirements, and staff rights. Published May 2025. (https://www.ag.state.mn.us/Office/Communications/2025/docs/PublicGuidance_ICE_SensitiveLocations.pdf)
- NILC and Physicians for Human Rights' Health Care and U.S. Immigration Enforcement: What Providers Need to Know Guide: This guide informs health care advocates on how to prepare for enforcement actions in medical spaces. Published March 2025. (https://phr.org/wp-content/uploads/2025/03/Health-Care-and-U.S.-Immigration-Enforcement_What-Providers-Need-to-Know_Guide_PHR-and-NILC-2025.pdf)
- The Journalist's Resource ICE and Hospitals: What does the removal of the protected areas policy mean for hospitals?: This article offers an analysis of how the January 2025 rescission of protected areas policy affects healthcare facilities. (https://journalistsresource.org/home/what-does-the-removal-of-the-protected-areas-policy-mean-for-hospitals/)

Endnotes

1 See, e.g., Katrina Pross, *Hennepin County health care workers say ICE presence at hospital is 'disruptive'*, Sahan Journal (Jan. 13, 2026), **https://sahanjournal.com/health/ice-agents-hospitals-hennepin-county-medical-center/**; Eli Newman, *ICE presence rising at Michigan health facilities, rights group say*, Bridge Michigan (Mar. 24, 2026), **https://bridgemi.com/michigan-health-watch/ice-presence-rising-at-michigan-health-care-facilities-rights-groups-say**.

2 *Factsheet: Trump's Rescission of Protected Areas Policies Undermines Safety for All*, National Immigration Law Center (NILC) (Feb. 25, 2025), **nilc.org/wp-content/uploads/2025/01/2025-02.25-Protected-Areas-Fact-Sheet-English_.pdf**.

3 Andrew Schwartz, *Union Says Portland Hospital Fails to Address Inappropriate Behavior by ICE Agents*, Willamette Week (Dec. 12, 2025), **https://www.wweek.com/news/health/2025/12/12/union-says-portland-hospital-fails-to-address-inappropriate-behavior-by-ice-agents/**.

4 Karen Landman, *Some Public Health Service Officers Deployed in Detention Centers Suffer 'Moral Distress'*, NPR (Feb. 5, 2026), **https://www.npr.org/2026/02/05/nx-s1-5698538/public-health-service-ice-detention-centers**.

5 Eunice Hyunhye Cho and Tessa Wilson, *Deadly Failures: Preventable Deaths in U.S. Immigrant Detention*, American Civil Liberties Union (ACLU) (June 21, 2024), **https://www.aclu.org/publications/deadly-failures-preventable-deaths-in-us-immigrant-detention**.

6 *MALDEF Files Claim on Behalf of Immigrant for Discriminatory Treatment and Privacy Violations by Harbor-UCLA Medical Center*, Mexican American Legal Defense and Education Fund (Mar. 5, 2026), **https://www.maldef.org/2026/03/maldef-files-claim-on-behalf-of-immigrant-for-discriminatory-treatment-and-privacy-violations-by-harbor-ucla-medical-center**.

7 See Hillel R. Smith, Congressional Research Service, LB10362, *Immigration Arrests in the Interior of the United States: A Primer* (June 13, 2025), **https://www.congress.gov/crs-product/LSB10362**.

8 8 U.S.C. § 1357; 8 C.F.R. § 287.5(c).

9 See, e.g., Christopher Can, et al, *What Trump's federal crackdown looks like in 5 US cities*, USA Today (Oct. 25, 2025), **https://www.usatoday.com/story/news/nation/2025/10/25/trump-crime-immigration-crackdown-cities-troops/86815712007/**.

10 *Leadership & Organization*, U.S. Customs and Border Protection (CBP), (Updated Mar. 24, 2026), **https://www.cbp.gov/about/leadership-organization**.

11 CBP, Policy No. IOP-MSDRES-2025-0002-01, *USBP Uniform and Grooming Standards 2025* (July 2, 2025), **https://www.cbp.gov/sites/default/files/2025-11/usbp_uniform_and_grooming_standards_2025.pdf**.

12 8 C.F.R. § 287.5(f) (concerning power and Authority to carry firearms).

13 8 C.F.R. § 287.8.

14 David J. Bier, *ICE Has Diverted Over 25,000 Officers from Their Jobs*, Cato Institute (Sept. 3, 2025), **https://www.cato.org/blog/ice-has-diverted-over-25000-officers-their-jobs**.

15 *What to Understand About the 287(g) Program*, Immigrant Legal Resource Center (Mar. 28, 2025), **https://www.ilrc.org/community-resources/what-understand-about-287g-program**.

16 *Fact Sheet: Prisoner Transportation* (2026), U.S. Marshals Service (Oct. 1, 2025), **https://www.usmarshals.gov/sites/default/files/media/document/2026-Prisoner-Transportation.pdf**; *see also Prosecuting People for Coming to the United States*, American Immigration Council (August 23, 2021), **https://www.americanimmigrationcouncil.org/fact-sheet/immigration-prosecutions/** (summarizing laws passed to criminalize migration).

17 *ICE Field Offices*, U.S. Immigrations & Customs Enforcement (ICE) (Feb. 2, 2026), **https://www.ice.gov/contact/field-offices**.

18 *ICE Organizational Structure*, ICE (May 8, 2026), **https://www.ice.gov/leadership/organizational-structure**.

19 *CBP Organization Chart*, CBP (May 6, 2026), **https://www.cbp.gov/document/publications/cbp-organization-chart**; *see also Sectors and Stations*, CBP (Apr. 22, 2025), **https://www.cbp.gov/border-security/along-us-borders/border-patrol-sectors** (listing the different CBP sectors).

20 *ICE Health Service Corps*, ICE (Apr. 14, 2026), **https://www.ice.gov/detain/ice-health-service-corps**.

21 *Id*. Their authority comes from Section 232 of the Immigration and Naturalization Act, Immigration Act of 1891, the Public Health Service Act, and Title 42 of the U.S. Code of Federal Regulations. Immigration and Nationality Act of 1952, Pub. L. No. 82-414, § 232 (codified as amended at 8 U.S.C. § 1222); Immigration Act of 1891, ch. 551, 26 Stat. 1084; Public Health Services Act of 1944, Pub. L. 780410; 42 C.F.R. ch. I. See *Health Service Corps Fiscal Year 2020*, ICE (2021), **https://www.ice.gov/doclib/ihsc/IHSCFY20AnnualReport.pdf**.

22 *Zadvydas v. Davis*, 533 U.S. 678, 690 (2001)(this case involved an immigrant challenging his prolonged detention and whose proceedings were noted as being civil, not criminal, and as such "nonpunitive in purpose and effect."); *Wong Wing v. United States*, 163 U.S. 228, 235 (1896).

23 *Youngberg v. Romeo*, 457 U.S. 307, 321-22 (1982) (discussing standards for civil detention broadly in a case involving a young man in conditions similar to civil immigration detention).

24 *Id*.

25 *Bell v. Wolfish*, 441 U.S. 520, 535 (1979) (noting that "under the Due Process Clause, a detainee may not be punished *prior to an adjudication of guilt* in accordance with due process of law." (emphasis added)); *see also Kingsley v. Hendrickson*, 576 U.S. 389 (2015) (finding that pre-trial detainees may enjoy greater protection against mistreatment in custody than do convicted prisoners).

26 8 C.F.R. §§ 287.5(c)(6), 287.8(d).

27 8 U.S.C. § 1357(a)(2), (4)–(5).

28 See 8 U.S.C. § 1226(a) (establishing the underlying immigration authority to issue a warrant); *see also Warrants & Subpoenas: What to Look Out for and How to Respond*, NILC (Jan. 28, 2025), **https://www.nilc.org/resources/warrants-and-subpoenas-facts/**.

29 *Frequently Asked Questions: Leaked ICE Memos About Arrests and Warrants*, NILC (Feb. 17, 2026), **https://www.nilc.org/resources/frequently-asked-questions-on-leaked-ice-memos-about-arrests-and-warrants/**; *see also, How ICE Went Rogue*, American Immigration Council (Feb. 11, 2026), **https://www.americanimmigrationcouncil.org/fact-sheet/ice-cbp-legal-analysis/**.

30 There is no set form for an immigration judge's deportation or removal order. Instead, it is usually a document that has the title of "Order of the Immigration Judge" and a judges' signature. However, ICE may have Form I-205 Warrant of Removal/Deportation which is an ICE form that confirms the existence of a removal/deportation order.

31 8 C.F.R. § 287.3(d) (describing custody procedures).

32 *Know Your Rights: Warrants*, NILC (Dec. 22, 2025), **https://www.nilc.org/resources/know-your-rights-warrants/**.

33 *Id*.

34 42 U.S.C. § 1395dd; 42 C.F.R. § 489.24.

35 42 U.S.C. §1396b(v); 42 C.F.R. § 440.255.

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