ADULT CARE HOME NOTICE
OF TRANSFER/DISCHARGE

1) DATE OF NOTICE: _____

Resident Name: _____

Facility: _____ Address: _____

Administrator: _____ Phone: _____

2) DATE OF TRANSFER/DISCHARGE: _____

3) REASON FOR THIS NOTICE:

Under North Carolina rules and regulations, you may only be transferred or discharged from this facility for one of the following reasons:

- It is necessary for your welfare and your needs cannot be met in this facility as documented by the resident's physician, physician assistant, or nurse practitioner;
- Your health has improved sufficiently so that you no longer need the services provided by this facility as documented by the resident's physician, physician assistant, or nurse practitioner;
- The safety of the resident or other individuals in this facility is endangered;
- The health of the resident or other individuals in this facility is endangered as documented by a physician, physician assistant, or nurse practitioner;
- You have failed to pay the cost of services and accommodations by the payment due date specified in the resident's contract, after receiving written warning of discharge for failure to pay; or
- The discharge is mandated under Article 1 or Article 3 of N.C.G.S. Chapter 131D or rules adopted by the Medical Care Commission.

The reason for this notice of your transfer/discharge is: _____

_____

4) NOTIFICATION: In addition to notifying you (i.e. the resident) of this transfer/discharge, _____ has also been notified.
(Responsible person or contact person)

5) PLANNED DISCHARGE LOCATION: This facility plans to transfer/discharge you to:

Name of facility/location: _____

Address: _____ Phone: _____

The facility has convened the adult care home resident discharge team: ☐ YES ☐ NO

6) APPEAL RIGHTS: You have the right to appeal this transfer/discharge to the DHHS Hearing Office if you disagree with the reason given and want to continue to stay at this facility. The appeal will be at no cost to you or your representative. The request for an appeal (see attached form) must be received by the DHHS Hearing Office **within 11 calendar days** of the date of this notice or your right to appeal is waived. [**Note**: if a discharge is initiated due to "it is necessary for your welfare and your needs cannot be met" on the basis that a resident's physician requires a different level of care for the resident, the discharge is **not** subject to appeal unless there is a documented conflict between two or more of the resident's physicians regarding the resident's appropriate level of care.

7) LONG TERM CARE OMBUDSMAN: You may wish to contact your regional long-term care ombudsman for help in mediation with the facility or for assistance in obtaining free legal services, if qualified. The ombudsman's name, address and phone number is:

Name: _____

Address: _____ Phone: _____

If you are mentally ill or developmentally disabled, you or your family member or legal representative may wish to contact: DISABILITY RIGHTS NORTH CAROLINA, 3724 National Drive, Suite 100, Raleigh, NC 27612. Telephone number: (919) 856-2195 or toll-free 1-877-235-4210 or TTY 1-888-268-5535

8) _____ _____
Signature of Administrator Date