NURSING HOME
NOTICE OF TRANSFER/DISCHARGE

1) DATE OF NOTICE: _____

2) RESIDENT: _____
FACILITY: _____
ADDRESS: _____
ADMINISTRATOR: _____ PHONE: _____

3) **DATE OF TRANSFER/DISCHARGE:** _____

4) **REASON(S) FOR TRANSFER/DISCHARGE:**
Under federal law 42 CFR §483.15, you may only be transferred or discharged from this nursing facility for one of the following reasons:

☐ It is necessary for your welfare and your needs cannot be met in this facility;
☐ Your health has improved sufficiently so that you no longer need the services provided by this facility;
☐ The safety of individuals in this facility is endangered due to the clinical or behavioral status of the resident;
☐ The health of individuals in this facility would otherwise be endangered;
☐ You have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at this facility; or
☐ The facility ceases to operate.

5) In addition to notifying you (i.e. the resident) of this transfer/discharge, _____ has also been notified. [Resident's representative(s)]

6) **THIS FACILITY PLANS TO TRANSFER OR DISCHARGE YOU TO:**

NAME OF FACILITY/LOCATION: _____
ADDRESS: _____ PHONE: _____

APPEAL RIGHTS

You have the right to appeal this transfer/discharge to the DHHS Hearing Office **WITHIN 11 CALENDAR DAYS** of the date of this notice if you 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 hearing officer no later than the 11th calendar day or your right to appeal is waived. If you wish to review your medical record, the facility must allow you to see it no later than five working days prior to the hearing.

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 contact information is below:

NAME: _____ EMAIL: _____

ADDRESS: _____ PHONE: _____

Facility sent Ombudsman a copy of the Notice: ☐ Yes ☐ No

If 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 1-877-235-4210 or TTY 1-888-268-5535

_____ _____
Signature of Administrator Date