Nursing Home Transfer or Discharge Notice

Written notice of transfer or discharge, and the reasons for the move, must be provided to the resident and the resident's representative(s), in a language and manner they understand, a minimum of 30 days prior to transition or discharge, or as soon as practicable when one of the exceptions at 42 CFR 483.15(c)(4)(ii) or (8) applies. Regulatory requirements are found at 42 CFR 483.15(c), RCW 74.42.450, WAC 388-97-0120, and WAC 388-97-0140.

☐ **Transfer** ☐ **Discharge**

Resident Information	
RESIDENT NAME	PHONE NUMBER (INCLUDE AREA CODE)
ADDRESS	
Resident Representative Information	
RESIDENT REPRESENTATIVE NAME	PHONE NUMBER (INCLUDE AREA CODE)
ADDRESS	RELATIONSHIP TO RESIDENT
Nursing Home Information	
NURSING HOME'S NAME	PHONE NUMBER (INCLUDE AREA CODE)
ADDRESS	
CONTACT PERSON'S NAME	CONTACT PHONE NUMBER (INCLUDE AREA CODE)

Date Notice Given / Effective Date

Note: The effective date must be at least 30 days from the date notice is given unless one of the exceptions at 42 CFR 483.15(c)(4)(ii) or (8) applies. The resident may choose to move earlier than the effective date.

DATE NOTICE GIVEN	EFFECTIVE DATE (DATE OF DISCHARGE)

Location to which Resident is Transferring or Discharging (required)	
NAME	PHONE NUMBER (INCLUDE AREA CODE)
ADDRESS	

REASON FOR DISCHARGE OR TRANSFER

Note: The facility must permit each resident to remain in the facility, and not transfer or discharge the resident, unless one of the following is true.

- ☐ Transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility.
- ☐ The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.
- ☐ The safety of other individuals in this facility is endangered due to the clinical or behavioral status of the resident.
- ☐ The health of other individuals in the facility would otherwise be endangered.
- ☐ The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at this facility.
- ☐ This facility is closing.

Please provide a brief explanation to support this action. Attach additional documentation if necessary.

Requesting assistance: If requested, the facility must provide the assistance necessary to contact the organizations on the next page and/or request an appeal of this decision if you disagree with the transfer or discharge. Please see the nursing home contact person's name and phone number above.

Appeal Rights:

- You have the right to appeal this discharge or transfer by making a request for a hearing to the Washington State Office of Administrative Hearings. Your request for a hearing may be made any time up to 90 days from the date you receive this notice.
- If you decide to appeal, you may request a hearing in person, by telephone / voice mail or in writing. You may use the attached form (DSHS 10-238, Request for an Administrative Hearing) to request an appeal but are not required to.
- **You have the right to remain in the facility until the appeal is decided, if the hearing request is received on or before the proposed date of transfer / discharge, or the day you are actually transferred / discharged**. Exception f not discharging or transferring you from the facility would endanger your health or safety, or the health or safety of other individuals in the facility, you may be discharged or transferred. The proposed discharge / transfer date is on the front page of this notice.
- If you do not appeal, the nursing facility may proceed with your transfer or discharge.
- If the decision at the hearing supports the nursing facility's decision (you lose the appeal), the nursing facility may proceed with your transfer or discharge 30 days after a final order is entered that upholds the decision.
- If the discharge / transfer is not upheld (you win the appeal), and you are no longer in the facility, you have the right to readmission to the facility immediately upon the first available bed in a semi-private room, provided you require and are eligible for the services provided by the facility.

Send hearing requests to: OFFICE OF ADMINISTRATIVE HEARINGS
PO BOX 42489
OLYMPIA WA 98504-2489
Telephone number: 1-800-583-8271 FAX: (360) 586-6563

Washington State Ombuds:

The Washington State Long-Term Care Ombudsman Program is available to answer questions and provide assistance regarding this notice and other issues. Through the work of individual "LTC Ombuds," the Ombudsman Program protects and promotes the legal rights of residents who live in LTC facilities. The Ombudsman Program is not part of state government and not affiliated with any long-term care facilities. If you wish to request assistance from the LTC Ombuds, call toll-free at 1-800-562-6028. You may also make your request in writing by fax at (253) 815-8173, email at ltcop@mschelps.org or mail at PO Box 23699, Federal Way, WA 98093-0699.

Disability Rights Washington:

If you have a diagnosis of a mental illness or an Intellectual disability, you may contact Disability Rights Washington for assistance with appeal of this decision, toll-free at 1-800-562-2702, or (206) 324-1521. You may also make your request in writing by fax at (206) 957-0729, email at info@dr-wa.org or mail at Disability Rights Washington, 315 5th Avenue S, Suite 850, Seattle, WA, 98104.

Facility Administrator / Designee

Please check all that apply:

☐ Prior to transfer of the resident to a hospital, written notice of the facility's bed-hold policy was provided to the resident and resident's representative(s) in compliance with requirements at 42 CFR 483.15(d) and WAC 388-97-0120(4).

☐ On _____, in compliance with federal and state rule, copies of this document, mandatory attachment DSHS 10-238, and all optional attachments were provided to the resident, resident's representative(s), the Office of State LTC Ombudsman, and DSHS.

Notice provided by:	
NURSING HOME ADMINISTRATOR / DESIGNEE SIGNATURE DATE	PRINTED NAME

Notice provided to:	
RESIDENT PRINTED NAME DATE	RESIDENT REPRESENTATIVE PRINTED NAME DATE