30 DAY NOTICE OF TRANSFER OR DISCHARGE of NURSING HOME RESIDENT

*____ (Resident's Name)

*____ (Date

____ (Nursing facility name)

____ (Family member/legal representative name)

____ (Nursing facility address)

____ (Family member/legal representative address

__________________________ __________________ (Nursing facility address phone #)

__________________________ __________________ (Family member/legal representative address & phone#)

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This notice is to inform you that, for the reason(s) explained below, you will be transferred or discharged from this facility.

YOU WILL BE TRANSFERRED/DISCHARGED FOR THE FOLLOWING REASON(S):

*____

____

____

A listing of the only legally allowable reasons for transfer and discharge is found at federal regulation 42 CFR 483.12 (a)(2). Specific documentation is required in the resident's clinical record as indicated by federal regulation 42 CFR 483.12 (a)(3).

TRANSFER/DISCHARGE LOCATION:

You will be *_______________________ to the following location *____
(transferred or discharged) (placement location/address)

____
(additional room for placement location / address)

DATE: *_____________________________
(Effective date of transfer / discharge)

This nursing facility will take the following steps to ensure a safe and orderly transfer or discharge from the facility.

____

____

____

____

_____ **Bed hold information has been provided to the resident regarding transfer/discharge**

All stared (*****) fields must be completed in order for this notice to be legally complete. **In addition, a statement informing the resident of the right to appeal the action to the State of Montana Fair Hearings Officer and contact information for the State Long Term Care Ombudsman's Office are mandatory.** Contact information for Disability Rights Montana must be included if the relevant resident has a mental illness or developmental disability. An Advocates/Assistance form may be attached that contains this required information.

BY: ____ **TITLE:** ____
(Facility Representative Signature)

This form and the Advocates/Assistance form provided to Montana Nursing Facilities as optional discharge notice assistance devices by The Montana Long Term Ombudsman Program –revised 01/2015

IMMEDIATE OR LESS THAN 30 DAY NOTICE OF TRANSFER OR DISCHARGE of NURSING HOME RESIDENT

*____ (Resident's Name)

*____ (Date)

____ (Nursing facility name)

____ (Family member/legal representative name)

____ (Nursing facility address)

____ (Family member/legal representative address)

____________________________ ________________ (Nursing facility address phone #)

____________________________ ________________ (Family member/legal representative address & phone#)

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This notice is to inform you that, for the reason(s) explained below, you will be transferred or discharged from this facility.

YOU WILL BE TRANSFERRED/DISCHARGED FOR THE FOLLOWING REASON(S):

*____

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A listing of the only legally allowable reasons for transfer and discharge in less than 30 days is found at federal regulation 42 CFR 483.12 (a)(2). Specific documentation is required in the resident's clinical record as indicated by federal regulation 42 CFR 483.12 (a)(3).

TRANSFER/DISCHARGE LOCATION:

You will be *____________________ to the following location *____
(transferred or discharged) (placement location/address)

____
(additional room for placement location / address)

DATE: *______________________________
(Effective date of transfer / discharge)

This nursing facility will take the following steps to ensure a safe and orderly transfer or discharge from the facility.

____

____

____

____

_____ **Bed hold information has been provided to the resident regarding transfer/discharge**

All stared (*) fields must be completed in order for this notice to be legally complete. **In addition, a statement informing the resident of the right to appeal the action to the State of Montana Fair Hearings Officer and contact information for the State Long Term Care Ombudsman's Office are mandatory.** Contact information for Disability Rights Montana must be included if the relevant resident has a mental illness or developmental disability. An Advocates/Assistance form may be attached that contains this required information.

BY: ____ **TITLE:** ____
(Facility Representative Signature)

ADVOCATES / ASSISTANCE:

For assistance in understanding your rights or filing an appeal, you may contact the State Long Term Care Ombudsman. The ombudsman's name and address is: **Jerry Sorensen, Montana State Long Term Care Ombudsman, 2030 11th Avenue, PO Box 4210, Helena, Montana 59604-4210.** The Ombudsman's Telephone number is **1-800-332-2272 or 406-444-7785**.

For assistance in understanding and asserting your rights, if you are developmentally disabled or mentally ill you may contact the **Disability Rights Montana** (formerly the Montana Advocacy Program). The address is **PO Box 1680, Helena, Montana 59624-1680.** Their phone number is: **1-800-245-4743.**

FAIR HEARING RIGHTS:

If you disagree with the facility's decision to transfer or discharge you, **you may request a hearing WITHIN 30 DAYS** of the date of this letter. A hearing may be requested for you by a family member, a friend, legal counsel, an advocate or other representative of your choice. Your request must be mailed or delivered to:

Office of Fair Hearings
Department of Public Health and Human Services
PO Box 202953
2401 Colonial Drive Third Floor
Helena, Montana 59620-2653 (FAX 406-444-3980)

Upon receipt of your timely request, a hearings officer will be appointed by the Department of Public Health and Human Services to hear your case and issue a decision. You will be contacted by the hearing officer regarding scheduling of a hearing. You have the right to represent yourself at the hearing or to use legal counsel, an advocate, a relative, a friend or another person to represent you.

The facility's decision to transfer or discharge you does not affect your Medicaid eligibility. If you have any questions regarding Medicaid coverage of services in the setting to which the facility proposes to transfer or discharge you, please contact your local county office of human services or the Department's Senior and Long Term Care Division at (406) 444-4077 or 1-800-332-2272.

REQUEST FOR A FAIR HEARING:

If you would like to request a fair hearing you may fill out the information below and mail it to the above address.

TO: Fair Hearings Officer: I would like to request a Fair Hearing to appeal the decision to transfer/discharge me from a nursing facility.

_______________________________ _______________________________
(Facility Name) (Residents Name – please print)

____
(Requestor's Name, if different than resident ------ please print)

_______________________________ _______________________________
(Resident or Requestor's Signature) (Date of Request)

_______________________________ _______________________________
(Resident or Requestor's Address) (Telephone Number)