NURSING HOME TRANSFER AND DISCHARGE NOTICE

Refer to section 400.0255, Florida Statutes. This form is required for those transfers or discharges initiated by the nursing home facility, and not by the resident or by the resident's physician or legal guardian or representative.

Resident Information

Name: _____

Medicaid ID # (if applicable): _____

Resident Representative (if applicable)

Name: _____

Address: _____

Phone: _____

Nursing Home Information

Name: _____

Address: _____

_____

Phone: _____

Facility contact person: _____

Contact phone: _____

Date Notice is given: _____

Effective Date: _____

The effective date must be at least 30 days from date notice is given unless an exception applies. The resident may choose to move earlier than effective date.

Location to which resident is transferred or discharged (required):

Name: _____

Address: _____

_____

Phone: _____

Reason for Discharge or Transfer:

☐ Your bill for services at this facility has not been paid after reasonable and appropriate notice to pay.

☐ This facility is closing.

The following reasons require either this form be signed by a physician or a physician's written order for discharge or transfer be attached. The signing physician may be the resident's attending or treating physician, the facility medical director, or a nurse practitioner or physician's assistant as a physician designee:

☐ 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 health of other individuals in this facility is endangered.

☐ The safety of other individuals in this facility is endangered.

Brief explanation to support this action, (attach additional documentation if necessary):

_____

_____

REQUESTING ASSISTANCE
If requested, facility staff must provide assistance necessary to contact the organizations below or request an appeal of this decision if you disagree with the discharge or transfer. Please see nursing home contact person's name and phone number on the front of this form.

LOCAL LONG-TERM CARE OMBUDSMAN
You have the right to request review of this notice by the Local Long-Term Care Ombudsman Program. They are available to assist you with any questions about this notice or the appeal process (see below). If you wish to request a review of this notice or request assistance from the Local Long-Term Care Ombudsman, call the Ombudsman Office toll-free at **(888) 831-0404**. You may also make your request in writing by completing the attached form and sending it to the local Ombudsman address, also attached.

REQUESTING AN APPEAL OF THIS DECISION
You have the right to appeal if you disagree with this decision. You have up to 90 days upon receipt of this notice to request a fair hearing. If you request a fair hearing within 10 days after receiving this notice, you will not be transferred or discharged until the hearing decision has been made, unless your circumstances requires an emergency transfer or discharge. If you do not request a fair hearing within 10 days after receiving this notice, you will be transferred or discharged at the end of the 30-day notice period.

If you wish to appeal this notice and request a hearing, you may call the appeals office or complete the attached form and mail to:

Department of Children and Families
Office of Appeal Hearings
2415 North Monroe Street, Suite I, Room 129
Tallahassee, FL 32303-4190
Telephone Number: (850) 488-1429 Fax: (850) 487-0662
Email:appeal.hearings@myflfamilies.com

Notice presented by:

_____	_____	_____
Nursing Home Administrator/Designee Name	Signature	Date
_____	_____	_____
Physician/Designee Name (when required)	Signature	Date

Notice received by:

_____	_____	_____
Resident or Representative Name	Signature	Date

Notice given to: Resident, Legal Guardian or Representative _____ (date)
Local Long Term Care Ombudsman Council _____ (date)
Resident Clinical Record _____ (date)

Attachments: Request for Ombudsman Review
Request for Fair Hearing