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: ____________________________________

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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):

____

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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 Council. 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.

ADVOCACY CENTER FOR PERSONS WITH DISABILITIES

If you have a diagnosis of mental illness or mental retardation, you may contact the Advocacy Center for Persons with Disabilities for assistance with an appeal of this decision.

The Advocacy Center's toll free telephone number is (800) 342-0823. Written correspondence may be sent to:
Advocacy Center for Persons with Disabilities, Inc.
2671 Executive Center Circle West
Webster Building, Suite 100
Tallahassee, Florida 32301-5024
(850) 488-9071 Fax: (850) 488-8640

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
1317 Winewood Boulevard, Building 5, Room 203
Tallahassee, FL 32399-0700
(850) 488-1429 Fax: (850) 487-0662

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