

## Nursing Home Transfer or Discharge Notice

This form may be used to meet the requirements for notice of transfer or discharge initiated by the nursing home facility, and not by the resident, resident's physician, legal guardian for representative. Specific requirements may be found in 42 CFR §483.15(c), RCW 74.42.450, WAC 388-97-0120, and WAC 388-97-0140. **Per 42 CFR §483.15(c)(3) a copy of a facility initiated transfer or discharge notice MUST be sent to the Office of the State Long Term Care Ombuds.**

<b>Resident Information</b>	
RESIDENT NAME	PHONE NUMBER (INCLUDE AREA CODE)
ADDRESS	
<b>Nursing Home Information</b>	
NURSING HOME'S NAME	PHONE NUMBER (INCLUDE AREA CODE)
ADDRESS	
CONTACT PERSON'S NAME	CONTACT PHONE NUMBER (INCLUDE AREA CODE)
<b>Date Notice Given / Effective Date</b>	
NOTE: The effective date must be at least 30 days from the date notice is given unless an exception applies according to WAC 388-97-0120. The resident may choose to move earlier than the effective date.	
DATE NOTICE GIVEN	EFFECTIVE DATE (DATE OF DISCHARGE)
<b>Location to which Resident is Transferred or Discharged (required)</b>	
NAME	PHONE NUMBER (INCLUDE AREA CODE)
ADDRESS	
REASON FOR DISCHARGE OR TRANSFER	
<input type="checkbox"/> Transfer or discharge is necessary for your welfare and your needs cannot be met in this facility. <input type="checkbox"/> Your health has improved sufficiently so that you no longer need the services provided by this facility. <input type="checkbox"/> The safety of other individuals in this facility is endangered due to the status of the resident. <input type="checkbox"/> The health of other individuals in this facility would otherwise be endangered. <input type="checkbox"/> You have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at this facility. <input type="checkbox"/> This facility is closing.	
Please provide a brief explanation to support this action. Attach additional documentation if necessary.	

**Requesting assistance:** If requested, facility must provide 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.

**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: If 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](mailto: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](mailto:info@dr-wa.org) or mail at Disability Rights Washington, 315 5<sup>th</sup> Avenue S, Suite 850, Seattle, WA, 98104.

**Notice presented by:**

\_\_\_\_\_  
 NURSING HOME ADMINISTRATOR / DESIGNEE SIGNATURE

\_\_\_\_\_  
 DATE

\_\_\_\_\_  
 PRINTED NAME

**Notice provided to:**

\_\_\_\_\_  
 RESIDENT OR RESIDENT REPRESENTATIVE PRINTED NAME

\_\_\_\_\_  
 DATE