NURSING HOME
NOTICE OF TRANSFER/DISCHARGE

1) DATE OF NOTICE: ______________________

2) RESIDENT: ____
FACILITY: ____
ADDRESS: ____
ADMINISTRATOR: _________________________________ PHONE: ___________________________

3) **DATE OF TRANSFER/DISCHARGE:** ____

Under federal law (42 U.S.C 1396r(c)(2)(A); 42 CFR 483.12), you may only be transferred or discharged from this nursing facility for one of the following reasons:

- It is necessary for your welfare and 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 safety of individuals in this facility is endangered;
- The health of individuals in this facility would otherwise be endangered;
- You have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at this facility; or
- The facility ceases to operate.

4) **THE REASON FOR THIS NOTICE OF YOUR TRANSFER/DISCHARGE IS**: ___________________
____

5) In addition to notifying you (i.e. the resident) of this transfer/discharge, ______________________________ has also been notified.
(family member/legal representative)

6) Check **ONE** and **INDICATE LOCATION** below:

{ } THIS FACILITY PLANS TO **TRANSFER** YOU TO:
{ } THIS FACILITY PLANS TO **DISCHARGE** YOU TO:

NAME OF FACILITY/LOCATION: ____
ADDRESS: ____ PHONE: _________________________

You have the **RIGHT TO APPEAL** this transfer/discharge to the DHHS Hearing Office **WITHIN 11 DAYS** of the date of this notice if you want to continue to stay at this facility. The appeal will be at no cost to you or your representative. The request for an appeal (see attached form) must be received by the hearing officer no later than the 11th day or your right to appeal is waived. If you wish to review your medical record, we must allow you to see it no later than five working days prior to the hearing.

You may wish to contact your regional **LONG TERM CARE OMBUDSMAN** for help in mediation with the facility or for assistance in obtaining free legal services, if qualified. The ombudsman's name, address and phone number is:

7) NAME:____

ADDRESS: ____ PHONE: _________________________

If mentally ill or developmentally disabled, you or your family member or legal representative may wish to contact:
DISABILITY RIGHTS NORTH CAROLINA, 2626 Glenwood Avenue, Suite 550, Raleigh, NC 27608.
Telephone number: (919) 856-2195 or 1-800-821-6922 or TTY 1-877-235-4210

8) ____ ___________________________________
Signature of Administrator Date

DMA-9050 (11/07)