

NOTICE OF TRANSFER OR DISCHARGE

RESIDENT NAME	NURSING FACILITY NAME
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This notice contains important information about your legal rights. If you do not understand it, ask a relative or friend for help or see the back of this form for assistance information.

This is notice that _____ intends to transfer or discharge you to
FACILITY

_____ on _____. The reason for this action is:
LOCATION DATE

1. Transfer or discharge is necessary for your welfare and your needs cannot be met in this facility because (give reason):

2. Your health has improved sufficiently so that you no longer need the services this facility provides.

3. The safety or health of persons in this facility is endangered as a result of (give reason):

4. You have failed, after reasonable and appropriate notice, to pay the charges for which you are responsible for your stay at this facility.

Your outstanding balance is \$ _____ .
AMOUNT

You have the right to appeal this decision as explained on the back of this form.

The person at the nursing facility who can help you with relocation or with sending in your request for hearing as described on the back of this form is:

_____, _____
NURSING FACILITY REPRESENTATIVE NAME TITLE

NURSING FACILITY STAFF SIGNATURE	TITLE	DATE
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Read the back of this form for important information regarding your legal rights.

Copies to: Resident Representative (if appropriate) _____ (name)

Field Manager (Reasons 1, 3, and 4 above) _____ (name)

HCS Case Manager (Reason 2 above) _____ (name)

APPEAL RIGHTS

You have the right to appeal this decision 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 of transfer or discharge.

However, in order for you to remain in the nursing facility until the matter is decided at the hearing, your hearing request must be received by the Office of Administrative Hearings on or before the proposed date of transfer/discharge listed on the front page of this form.

If you do not appeal, or if the judge's decision at the hearing supports the nursing facility's decision, the nursing facility may proceed with your transfer or discharge.

If you decide to request a hearing, you have a right to appear in person at the hearing and to have someone (relative, ombudsman, lawyer, or other person) represent you. A form for requesting a hearing is attached for you to use, if you wish.

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

The Nursing Facility Representative listed on the front page of this form can help you with your request for a hearing.

SOURCES OF HELP FROM OUTSIDE THE NURSING FACILITY

Advocate for residents: STATE LONG TERM CARE OMBUDSMAN
1200 S 336TH STREET
FEDERAL WAY WA 98003

Toll-free telephone number: 1-800-562-6028

Legal services: The State Long Term Care Ombudsman can help you locate legal services, if needed.

For persons with a developmental disability or mental illness:

DISABILITY RIGHTS WA
315 5TH AVENUE SOUTH, SUITE 850
SEATTLE WA 98104

Toll-free telephone number: 1-800-562-2702