

**MONTANA MENTAL HEALTH NURSING CARE CENTER
800 CASINO CREEK DRIVE
LEWISTOWN, MONTANA 59457
(406-538-7451)**

NOTICE OF TRANSFER OR DISCHARGE

| | |
|----------------------------|--------------------------------|
| _____ | _____ |
| (Resident's Name) | (Date) |
| _____ | _____ |
| (Nursing Facility Name) | (Family Member/Legal Guardian) |
| _____ | _____ |
| _____ | _____ |
| (Nursing Facility Address) | (Address) |

You are being provided this notice to inform you that, for the reasons explained below, you will be Transferred or discharged from this facility.

YOU WILL BE TRANSFERRED/DISCHARGED FOR THE FOLLOWING REASONS:

Listing of the permitted reasons for transfer and discharge is found at federal regulation 42 CFR 483.12(a)(2)

TRANSFER/DISCHARGE LOCATION; (Mark and complete one of the following)

_____ You will be _____ to the following location _____
(transfer/discharge)

_____ (Placement/location facility)

on _____ (Effective date of transfer/discharge)

OR,
_____ The location to which you will be transferred or discharged is unknown at the time of this notice. This nursing facility will take the following steps to ensure a safe and orderly transfer or discharge from the facility.

_____ Bed hold information has been provided to the resident regarding transfer/discharge.

BY: _____ **TITLE:** _____
(Facility Representative Signature)

ADVOCATES/ASSISTANCE:

For assistance in understanding your rights or filing an appeal, you may contact the state long term care ombudsman. The ombudsman address and telephone number are listed below.
MONTANA LONG TERM CARE OMBUDSMAN

PO BOX 4210
HELENA MONTANA 59604
TELEPHONE: 1-800-332-2272

For assistance in understanding and asserting your rights, if you are developmentally disabled or mentally ill you may contact the Montana Advocacy Program. The address and telephone number are listed below.

DISABILITY RIGHTS OF MONTANA
1022 CHESTNUT STREET
HELENA MT 59601
TELEPHONE: 1-800-245-4743

FAIR HEARING RIGHTS:

If you disagree with the facility's decision to transfer or discharge you, YOU MAY REQUEST A HEARING WITHIN 30 DAYS of the date of this letter. A hearing may be requested for you, by a family member, a friend, legal counsel, an advocate, or other representative of your choice. Your request must be mailed or delivered to:

OFFICE OF FAIR HEARING
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
2401 COLONIAL DRIVE
PO BOX 202953
HELENA MONTANA 59620

Upon receipt, of your timely request, a hearing officer will be appointed by the department of public health and human services to hear your case and issue a decision. You will be contacted by the hearing officer regarding scheduling of a hearing. You have the right to represent yourself at the hearing or to use legal counsel, an advocate, a relative, a friend or another person to represent you.

The facility's decision to transfer or discharge you does not affect your Medicaid eligibility. If you have any questions regarding Medicaid coverage of services in the setting to which the facility proposes to transfer or discharge you, please contact your local county office of human services or the department's Medicaid Services Division at (406) 444-4540.

REQUEST FOR A FAIR HEARING:

If you would like to request a fair hearing you may fill out the information below and mail it to the above address.

TO: Fair Hearing Officer: I would like to request a Fair Hearing to appeal the decision to transfer/discharge me from a nursing facility.

(Nursing Facility Name)

(Resident Name)

(Requestor's Name (if different from residents) please print)

(Requestor's Signature)

(Date of Request)

(Requestor's Address)

(Telephone Number)