Long-Term Care Ombudsman Program
Facility Closure CHECKLIST

Facility Name Closing:	Type of Facility: ☐ RCFE ☐ ARF ☐ SNF ☐ ICF	
Ombudsman Assigned:	Date of Visit:	
Resident Name:	Room #:	
Address:	City:	County:
Date Facility Closing:		
Resident's Legal Representative or Family Member Name:	Relationship to Resident:	
Legal Authority: ☐ POA ☐ Healthcare Surrogate ☐ Guardian ☐ Other: _____	Address of Legal Representative:	
Telephone Number of Representative:	Additional Information regarding Representative:	

***** ATTACH RESIDENT CONSENT FORM *****

Actions the **Ombudsman** is Responsible for Confirming	Yes	No	N/A
• Is there an open case? If yes, what is the case #_____ Comment:			
• Did you inform the resident of their rights? Comment:			
• Was an Ombudsman Program brochure and Resident Rights Information provided to the resident? Comment:			
• Is there a Case Manager to assist the resident? If yes, who is the Case Manager? _____ Comment:			
• Was the resident given a choice of facilities to choose from? Comment:			
• Was a discharge plan developed in consultation with the resident? Comment:			
• Is the resident and resident's representative satisfied with the proposed new placement? Comment:			
Actions the **Facility Administration** is Responsible for Confirming (Ombudsman may also consider verifying)	**Yes**	**No**	**N/A**
• Has the resident received a recent medical/clinical assessment? Comment:			
• Has an inventory been prepared of the resident's personal belongings? Comment:			
• Are all the resident's medications with the resident? Comment:			
• Is the resident due a refund of any kind from the facility? Comment:			
• Was the resident given a change of address form to inform the post office? Comment:			
• Does the resident have a personal phone line? If yes, please remind resident to make appropriate changes for phone service. Comment:			

Other Issues:

Facility Resident Has Been Transferred To:	Date of Transfer:
Address and Telephone Number of New Facility:	Type of Facility: ☐ RCFE ☐ ARF ☐ SNF ☐ ICF ☐ Other _____
Name and Contact information of Ombudsman Assigned to Visit with Resident at New Facility:	Date of Visit:

***** ATTACH RESIDENT VISITATION FORM *****

Actions the **Ombudsman** is Responsible for Confirming	Yes	No	N/A
• Is the resident and resident's representative satisfied with the current placement? Comment:			
• Is there a need to open a case? If so, please contact the Ombudsman Coordinator to file a complaint. Comment:			
Actions the Facility Administration is Responsible for Confirming (Ombudsman may also consider verifying)	Yes	No	N/A
• Is the new facility in another county?			
• If yes, is the resident on Medi-Cal?			
• If yes, have they re-enrolled in the Medi-Cal program in the new county? Comment:			

Other Concerns:

Ombudsman Signature: **Date:**