State y Loc. Hearing Notice for Involuntary Discharge

NOTICE OF INVOLUNTARY TRANSFER OR DISCHARGE AND OPPORTUNITY FOR A HEARING

Name, address & telephone number of facility:

_____
_____
_____
_____
_____

Name of resident & name, address & telephone number of the resident's representative:

_____
_____
_____
_____
_____

_____FEDERAL PROCEEDING. This facility admits private-pay and Medicare or Medicaid residents and is federally-certified and state-licensed or this facility admits only Medicare or Medicaid residents and is federally-certified only. This facility seeks to transfer or discharge you pursuant to the regulations of the Health Care Financing Administration for States and long-term care facilities, 42 CFR 483.12 ("federal regulations"). As recorded in your clinical record in accordance with section 483.12(a)(4) of the federal regulations, the reason for this proposed transfer or discharge is:

_____your welfare and needs cannot be met in this facility, as documented in your clinical record by your physician, 483.12(a)(2)(i);
_____your health has improved sufficiently so you no longer need the services provided by this facility, as documented in your clinical record by your physician, 483.12(a)(2)(ii);
_____the safety of individuals in this facility is endangered, 483.12(a)(2)(iii);
_____the health of individuals in the facility would otherwise be endangered, as documented in your clinical record by a physician, 483.12(a)(2)(iv);
_____you have failed, after reasonable and appropriate notice, to pay for your stay at this facility, 483.12(a)(2)(v); or
_____this facility ceases to operate, 483.12(a)(2)(vi).

On the date of transfer or discharge, you will be relocated to:

Facility/Person_____
Address:_____
Telephone:_____

Pursuant to section 483.12(a)(7) of the federal regulations, this facility will provide sufficient preparation and orientation to ensure your safe and orderly transfer or discharge from this facility.

_____STATE PROCEEDING. This facility admits only private-pay residents and is state-licensed only. This facility seeks to discharge you pursuant to the Nursing Home Care Act, 210 ILCS 45/1-101 et seq. ("state law"). You will be responsible for securing shelter and health care for yourself. You may seek relocation assistance from the Illinois Department of Public Health, including information on alternative placements. As discussed with _____on _____, 199___ and as documented in your clinical record pursuant to section 3-408 of the state law, the reason for this transfer or discharge is:

_____ medical reasons, 3-401(a);
_____ your physical safety, 3-401(b);
_____ the physical safety of other residents, the facility's staff or visitors, 3-401(c); and/or
_____ late payment or nonpayment for your stay, 3-401(d).

The responsible party, _____, has the right to pay the amount of the bill in full up to the date the transfer or discharge is to be made and then you shall have the right to remain in this facility.

To obtain the name of a local representative of the Illinois Long Term Care Ombudsman Program in your community, you may call the Department of Aging, Senior Helpline, toll-free at 1 800 252-8966 or write to The Illinois Department on Aging, 421 East Capital Avenue, Springfield, Illinois 62701

The agency responsible for the protection and advocacy of developmentally disabled or mentally ill individuals is Equip for Equality, Inc.:

-103 South Washington St., Suite 202, Carbondale, IL 62901 (618) 457-3304
-11 East Adams St., Suite 1200, Chicago, IL 60603 (312) 341-0022
-115 North Neil St., Suite 209, Champaign, IL 61820 (217) 351-1446
-427 East Monroe St., P.O. Box 276, Springfield, IL 62705 (217) 544-0720
-1612 Second Avenue, P.O. Box 3753, Rock Island, IL 61204 (309) 786-6868

The effective date of the proposed transfer or discharge is _____, 199__.
The person who will supervise your transfer or discharge is:

Name:_____
Address:_____
Telephone:_____

Regardless of whether the facility's proposed action is under federal regulations or state law, you have the right to appeal this facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may file a request for a hearing with the Department of Public Health within ten (10) days after receiving this notice. If you request a hearing, it will be held not later than ten (10) days after your request, and you generally will not be transferred or discharged during that time. If the decision following the hearing is not in your favor, you generally will not be transferred or discharged prior to the expiration of thirty (30) days following receipt of the original notice of transfer or discharge. A form to appeal the facility's decision and to request a hearing, along with a postage-paid, preaddressed envelope, is attached. If you have any questions, call the Department of Public Health at the telephone number listed below:

Regional Health Officer: Fred H. Uhlig
Address: Illinois Department of Public Health
5415 N. University
Peoria IL 61614
Telephone: (309) 693-5360

A copy of this notice was placed in your clinical record and a copy was transmitted to the Department of Public Health, to you, to your representative or a family member and, if your care is paid for, in whole or part, through Title XIX, to the Department of Public Aid on the _____day of _____, 199___.

Signature of facility's agent:_____

Title of agent:_____

Date:_____

REQUEST FOR HEARING

Name, address & telephone # of facility seeking the transfer or discharge:

_____
_____
_____
_____
_____

Name of resident & name, address, telephone # & relationship to resident of person requesting a hearing:

_____
_____
_____
_____
_____

I request a hearing, within ten days of receipt of this request by the Department of Public Health, to contest the Notice of Involuntary Transfer or Discharge received by _____ on _____,199___.

Signature of person requesting a hearing:

_____

Relationship to resident:_____

Date:_____

Instructions: If you wish to contest the proposed involuntary transfer or discharge, please complete this form and mail it, in the postage-paid, preaddressed envelope provided to you with the Notice of Involuntary Transfer or Discharge, to the regional health officer designated in the Notice of Involuntary Transfer or Discharge within TEN DAYS after receiving the Notice of Involuntary Transfer or Discharge.