NOTICE OF TRANSFER OR DISCHARGE FOR NONPAYMENT

From: (facility name and location) _____

To: (resident's name): _____

Transfer or Discharge Information:

NDAC 75-01-03-08.1(7)(j) authorized a transfer or discharge due to lack of payment for nursing facility covered services.

j. The resident fails to pay, or to arrange for payment of, any part of charges based on the daily rate established under chapter 75-02-06, provided that no involuntary transfer or discharge may be based on a failure to pay charges for private rooms, bed-holds in excess of fifteen consecutive hospital days or twenty-four therapeutic leave days per calendar year, special services not included in the daily rate, or Medicare Part B coinsurance and deductible.

You are being transferred or discharged to (specific location) _____

on (date) _____ because (specific reason(s) _____

_____

Right to Appeal:

If you do not agree with this transfer or discharge, you have the right to appeal within 30 days after the date of this notice. Your written request for a hearing must be made by 5:00 p.m. (CT) on _____ (date) to the Appeals Supervisor listed below. Either a written request or the generic **Request for Hearing form (SFN 162)** at https://www.nd.gov/eforms/Doc/sfn00162.pdf can be used. If needed, the Appeals Supervisor will assist you in completing and submitting the appeal hearing request.

Appeals Supervisor
Department of Human Services
600 East Boulevard Avenue, Dept. 325
Bismarck, ND 58505
dhslau@nd.gov
Phone: 701-328-2311

If your appeal request is filed before the transfer or discharge is to occur, the transfer or discharge will be delayed until the hearing decision is made, unless the failure to discharge or transfer would endanger the health or safety of yourself or other individuals in the facility.

If the Medicaid program is paying for any of the cost of your services in the facility, Medicaid will continue to pay for these services until the hearing decision is made unless you are notified in writing that:

1. There is a change in your eligibility for the Medicaid program and benefits; or
2. That the Medicaid payments for services will stop because of a specific state or federal law or policy which prohibits such payments.

Right of Representation:

You have the right to represent yourself at the hearing or may use legal counsel, a relative, a friend, or another spokesperson.

If you would like assistance with your appeal, you may also contact:

State Long-Term Care Ombudsman
Aging Services Division
1237 W Divide Ave Ste 6
Bismarck, ND 58501-1208
dhsagingombud@nd.gov
701-328-4617 or 1-855-462-5465

If you are a resident with intellectual and developmental disabilities or related disabilities, or a mental disorder or related disabilities, assistance may be obtained from:

Office of Protection and Advocacy
400 E Broadway Ste 409
Bismarck, ND 58501-4071
panda_intake@nd.gov (underscore between panda and intake)
701-328-2950 or 1-800-472-2670

Persons Notified In Writing:

_____ _____
(Resident) (date)

_____ _____
(Resident Representative) (date)

_____ _____
(Facility Representative Who Completed Form) (date)

In accordance with 42 CFR §483.15 (c)(3)(i), a copy of this notice has been sent to a representative of the Office of the State Long-Term Care Ombudsman on _____ (date).