



## Skilled nursing facility-initiated discharge appeal form

If the nursing facility where you live has told you they intend to transfer you or discharge you, and you would rather stay in the facility, you have the right to appeal the facility's decision. Fill out this form completely and submit it if you want to ask for a hearing to appeal your facility-initiated transfer or discharge.

\*To appeal a Medicaid denial, fill out this form:

<https://medicaid.utah.gov/Documents/pdfs/Forms/HearingRequest2023.pdf>

\*To appeal a Medicare or insurance decision, contact KEPRO at 888-317-0891 or

<https://www.keproqio.com>

Appeal requests MUST be turned in within 30 days of the discharge notice.

### 1. Who is completing this form?

- Resident  Resident representative

### 2. Who is the resident?

Full name: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Current mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Telephone number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Email: \_\_\_\_\_

The name of the person to contact if there are questions about this appeal: \_\_\_\_\_

Daytime phone number for that person: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Email: \_\_\_\_\_

### 3. Do you want another person to get notices about the hearing?

*You may represent yourself or have another person represent you. List everyone you want contacted.*

- Legal representative (*attorneys must file a Notice of Appearance*):

Name: \_\_\_\_\_ Have they been contacted by you:  Yes  No

Telephone number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Email: \_\_\_\_\_

- Local ombudsman:

Name: \_\_\_\_\_ Have they been contacted by you:  Yes  No

Telephone number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Email: \_\_\_\_\_

Family member or friend:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Other:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

#### 4. **Nursing facility information**

Name of nursing facility \_\_\_\_\_

Telephone number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

Administrator name: \_\_\_\_\_ Date of admission to the facility \_\_/\_\_\_\_/\_\_\_\_

Date of discharge notice \_\_/\_\_\_\_/\_\_\_\_ Date the facility plans to move resident \_\_\_\_/\_\_\_\_/\_\_\_\_

Discharge location \_\_\_\_\_

Resident is currently in the hospital and the facility is not allowing the resident to be readmitted

#### Reason for discharge as listed on the discharge notice:

- Transfer/discharge is necessary to meet resident's welfare and resident's needs cannot be met in the facility.
- Health has improved sufficiently so the resident no longer needs the services provided by the facility.
- The safety of individuals in the facility is endangered.
- The health of individuals in the facility is endangered.
- The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility.
- The facility is ceasing to operate.

## How to file your involuntary discharge appeal

1. **After you complete everything on this form, make a copy of this page** to keep.
2. Send this form and a copy of the discharge notice to:

<b><u>Via U.S. Post Office</u></b>	<b><u>Via UPS or FedEx</u></b>	<b><u>Email or Fax</u></b>
Office of Administrative Hearings PO Box 143105 Salt Lake City, UT 84114-3105	Office of Administrative Hearings 195 North 1950 West Salt Lake City, UT 84116	Email: <a href="mailto:utmedicaidhearings@utah.gov">utmedicaidhearings@utah.gov</a> Fax: 801-536-0143