# SWING BED NOTICE OF TRANSFER FOR HOSPITALIZATION

**From:** (facility name and location) _____

**To:** (resident's name): _____

**Transfer Information**:

Authorization for this transfer is specified in NDAC 75-01-03-08.1(7). **CHECK ONE BOX**

- ☐ a. The resident has an urgent medical need, which cannot be met in the facility;
- ☐ b. The resident's physical condition endangers or poses a threat to the health or safety of the resident or other persons in the facility;
- ☐ c. In cases involving a mental condition or behavioral problem, the behavior of the resident creates a serious and immediate threat to the resident or other residents or persons in the facility and all reasonable alternatives to transfer or discharge consistent with the attending physician's orders, have been attempted and documented in the resident's medical record; or
- ☐ f. The resident's health or safety is at risk because the facility cannot reasonably accommodate the needs of the resident.

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

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

_____

(**Note:** For a non-emergency medical transfer, do not check a reason; only enter in writing the reason why the resident is being transferred, in the reason section, i.e., surgery.)

**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
Phone: 701-328-2311
dhslau@nd.gov

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)

_____ _____
(Family Member/Legal Representative) (date)

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