DRAFT
(Facility letterhead)

(Date)

(Name and address of resident)

Re: Transfer Notice and Bed-hold Notice

Dear _________________

TRANSFER NOTICE

As you are aware, you (are being/were) transferred to (name of hospital) on (insert date) for treatment of a medical condition.

It is the expectation of (name of facility) ("Facility") that you will return to our Facility following your hospital treatment. If the Facility believes that you cannot return to the Facility following your hospitalization, you will receive a separate written involuntary discharge notice providing information regarding your involuntary discharge.

Even though our Facility expects that you will return to our Facility following your hospitalization, federal regulations under 42 C.F.R. §§483.15(c)(3), (4), (5) and (6) require that we provide you with a written notice regarding your transfer to the hospital and your appeal rights.

[NOTE TO FACILITY: Select the appropriate language below-Non-Emergency or Emergency—depending on the situation. Delete this note and the non-applicable option below.]

IF THIS IS A **NON-EMERGENCY** TRANSFER OR DISCHARGE:
[You have a right to appeal the Facility's decision to transfer or discharge you. If you think you should not have to leave this Facility, you may request a hearing, in writing or verbally, with the Iowa Department of Inspections, Appeals, and Licensing (hereinafter referred to as "department") within 7 days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after the department's receipt of your request and you will not be transferred before a final decision is rendered. Extension of the 14-day requirement may be permitted in emergency circumstances upon request to the department's designee. If you lose the hearing, you will not be transferred before the expiration of either (1) 30 days following your receipt of the original notice of the discharge or transfer, or (2) 5 days following final decision of such hearing, including the exhaustion of all appeals, whichever occurs later. To request a hearing or receive further information, call the department at (515) 281-4115, or write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections, Appeals, and Licensing, 6200 Park Avenue, Suite 100, Des Moines, IA 50319, or contact the department via email: ______@dia.iowa.gov. (Insert email address of program coordinator.)]

IF THIS IS AN **EMERGENCY** TRANSFER OR DISCHARGE:
[You have a right to appeal the facility's decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing, in writing or verbally, with the Iowa Department of Inspections, Appeals, and Licensing (hereinafter referred to as "department") within 7 days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after the department's receipt of your request. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, call the department at (515) 281-4115, or write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections, Appeals, and Licensing, 6200 Park Avenue, Suite 100, Des Moines, IA 50319, or contact the department via email: ______@dia.iowa.gov. (Insert email address of program coordinator.)]

LONG TERM CARE OMBUDSMAN
321 E 12th St.
4th Floor
Des Moines, IA 50319
SLTCO@hhs.iowa.gov
866-236-1430 (toll free)

DISABILITY RIGHTS IOWA
Provides protection and advocacy for persons with mental illness or disabilities
606 Walnut St.,
Suite 2220
Des Moines, IA 50309
info@DRIowa.org
515-278-2502

BED-HOLD NOTICE

You are receiving this notice because you recently were admitted to the hospital.
Residents whose stay is paid by Medicaid will be offered a bed-hold benefit at no cost to you, which will reserve your room upon hospitalization for a maximum of ten (10) days in a calendar month. Should these days expire, and hospitalization is still required, you or your Representative may choose to request that our Facility extend the bed-hold beyond ten days to reserve your bed. However, to hold your bed after the ten (10) day period, you must use your own income to pay for the bed-hold.

If your stay is paid by Medicaid, and you do not hold a bed following the bed-hold benefit for hospitalization, and you wish to return to the Facility, you will be allowed to return to the Facility to your previous room, if available, or immediately upon the first availability of a bed in a semi-private room if you:

(A) Require the services provided by the Facility; and

(B) Are eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.

Medicare does not offer bed-hold coverage. Therefore, Medicare and private pay residents may choose to hold the room at the current room and board rates until the resident's return to the Facility.

According to the Facility's bed-hold policy, verification of room reservation must be made within a 24-hour period from the time the resident is admitted to the hospital, or the bed will be relinquished. Extensions shall be granted for good cause shown. Bed-hold fees are due prior to return to the Facility.

I wish to reserve the room.___________

I do not wish to reserve the room.____________

______________________________ ____________________________

Signature Date

____

(Title if not the Resident)

Private Pay Rates as of **[insert date]:** Semi-Private $_______, Private Room $______ daily

If you have any questions relating to the transfer or bed-hold notice, do not hesitate to contact me at (insert phone number).

Sincerely,

Administrator

cc: (name and address of legal representative/family member of resident - mailed certified, return receipt)

Long-Term Care Ombudsman's Office
321 E 12th St., 4th Floor
Des Moines, IA 50319

[Note: This notice can be sent on a monthly basis to the Ombudsman's Office]