

DISCHARGE NOTICE

RESIDENT/DECISION-MAKER'S NAMES
ADDRESSES
CITY, STATE, ZIP

Date: _____

Dear M _____;

This letter serves as a **notice of discharge** from _____ (FACILITY NAME) _____.

The **reason** for your being discharged is that: (CHECK ONE)

- Your needs can't be met by this facility or you require care other than that which this facility is licensed and required to provide, or for medical reasons as ordered by your physician
- Your health has improved and you no longer need the services of this facility or the short-term care period for which you were admitted has expired
- Your health and/or safety and/or the safety of others is endangered by your remaining at this facility
- Your health and/or safety is endangered by a medical emergency or disaster
- You've failed to pay, after having been given a reasonable notice and opportunity to pay, for your care at this facility
- This facility is ceasing to operate.

The **anticipated date** of your discharge is _____ (DATE) _____.

The **location** to which you'll be moving is _____ (LOCATION) _____.

You have a right to **relocation assistance** and to be **prepared for and oriented to being discharged**. A separate notice will be provided inviting you and others to a **discharge planning conference**.

You have a right to **contact an advocate** to discuss this notice, and to seek assistance. You may call or write an Ombudsman (for persons over age 60) or a representative from Disability Rights Wisconsin (for persons under age 60.)

Board on Aging and Long Term Care
OMBUDSMAN'S NAME
ADDRESS
CITY, STATE, ZIP
PHONE
(800) 815-0015

Disability Rights Wisconsin
ADVOCATE'S NAME
ADDRESS
CITY, STATE, ZIP
PHONE

You may **appeal this discharge decision** by

- 1.) Writing a letter, within **seven (7) days** of having received this notice, to the regional office of the Wisconsin Department of Health Services - Division of Quality Assurance (DQA) asking for a review of this discharge decision and stating why this discharge should not take place.
- 2.) Sending a copy of the appeal letter to the administrator of this facility.
- 3.) Within five (5) days of having received your written appeal, the facility must provide written justification for the discharge to the Wisconsin Department of Health Services - Division of Quality Assurance (DQA.)
- 4.) You may not be discharged, if you've filed a written appeal within **seven (7) days** of receiving this notice, until the Wisconsin Department of Health Services -Division of Quality Assurance (DQA) has completed its review and notified both you and the facility of its decision, within **fourteen (14) days** of having received written justification from the facility.
- 5.) You may appeal the decision of the Wisconsin Department of Health Services - Division of Quality Assurance (DQA) in writing, to the Wisconsin Department of Administration - Division of Hearing and Appeals, General Government Unit within **five (5) days** after having received the decision by the Wisconsin Department of Health Services -Division of Quality Assurance (DQA.)

The name/address/phone number for the regional office of **the Wisconsin Department of Health Services - Division of Quality Assurance (DQA)** is:

DQA REGIONAL OFFICE
RFOD'S NAME
ADDRESS
CITY, STATE, ZIP
PHONE

The name/address/phone number of **this facility's administrator** is:

FACILITY NAME
ADMINISTRATOR'S NAME
ADDRESS
CITY, STATE, ZIP
PHONE

The name/address/phone number of **Wisconsin Department of Administration - Division of Hearing and Appeals, General Government Unit** is:

Division of Hearings and Appeals-General Government Unit
ADDRESS
CITY, STATE, ZIP
PHONE

Please feel free to contact me to answer any questions about this notice or your impending discharge from this facility. Thank you.

SIGNATURE/ADDRESS/CITY, STATE, ZIP/PHONE

cc: DECISION-MAKER, FAMILY MEMBER, PHYSICIAN