Utah Department of
Health & Human
Services

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:

Via U.S. Post Office	**Via UPS or FedEx**	**Email or Fax**
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: utmedicaidhearings@utah.gov Fax: 801-536-0143