MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

NURSING FACILITY TRANSFER OR DISCHARGE HEARING REQUEST

RESIDENT'S NAME	RESIDENT'S TELEPHONE	DATE
EMAIL ADDRESS		
LEGAL GUARDIAN OR POA NAME AND RELATION. IF PUBLIC ADMINISTRATOR, PLEASE PROVIDE THE COUNTY.		
LEGAL GUARDIAN OR POA ADDRESS, PHONE NUMBER AND EMAIL ADDRESS		
NURSING FACILITY NAME	NURSING FACILITY TELEPHONE	NURSING FACILITY FAX
ADDRESS		
EMAIL ADDRESS		

ON ________________________________ (DATE OF DISCHARGE LETTER) THE ABOVE NAMED RESIDENT RECEIVED A NOTICE OF THE ABOVE NAMED NURSING FACILITY'S INTENT TO TRANSFER OR DISCHARGE THE RESIDENT.

THE RESIDENT IS REQUESTING A HEARING TO APPEAL THE NURSING FACILITY'S DECISION AS PROVIDED FOR UNDER 19 CSR 30-82.050.

(RESIDENT'S SIGNATURE, WHEN POSSIBLE)

INDIVIDUAL MAKING REQUEST ON RESIDENT'S BEHALF:

NAME	FACILITY NAME, if applicable	
ADDRESS		
TELEPHONE	FAX NUMBER	EMAIL ADDRESS
SIGNATURE	RELATIONSHIP TO RESIDENT	

ADDITIONAL INFORMATION OR COMMENTS: Please provide the name and contact information for any family members (if no POA or Guardian) involved in the care of the resident.

FAX, EMAIL OR MAIL TO:

DEPARTMENT OF HEALTH AND SENIOR SERVICES
APPEALS UNIT
P.O. BOX 570, 912 WILDWOOD DRIVE 3RD FLOOR
JEFFERSON CITY, MO 65109-0570
FAX: (573) 751-0247 EMAIL: DHSS.APPEALS@health.mo.gov
TELEPHONE: (573) 522-1699