

Residential Care and Assisted Living Facilities
LESS THAN 30 DAY MOVE-OUT NOTICE

Notice issued to: Last name: _____ First name: _____
 Date issued: ____ / ____ / ____ Date of proposed move-out: ____ / ____ / ____
 Name of facility: _____ RCF ALF MCC
 Address: _____
 City/state/ZIP: _____
 Telephone: _____ Fax: _____

This move-out notice is being issued for:

- A. Medical/psychiatric care:** You have left the facility to receive urgent medical or psychiatric care. You have been evaluated by an appropriate staff person from the facility. The facility has determined your current health or service needs cannot be met by the facility (*see description below*). You have the right to an administrative hearing. If you request an administrative hearing, the facility must hold your room and may charge room and board pending resolution of the hearing.

The specific needs that cannot be met are:

- B. Health and safety reasons:** The facility has determined that your health and safety, or the health and safety of other residents, is in jeopardy and undue delay in moving would increase the risk of harm to yourself and others, as indicated in the description below. You have the right to an administrative hearing. If you request an administrative hearing, the facility must hold your room without charging for room and board or services pending resolution of the hearing.

(Facility note: Your Salem central office policy analyst must be contacted prior to giving this notice to a resident that is still in the facility.)

The specific health and safety concerns are:

If you object to this move based on the reasons stated in this notice:

You have **five (5)** working days to request an administrative hearing after receipt of this notice by completing the attached Hearing Request form (DHS 0443).

- APD may hold an informal meeting to resolve this matter. If you are satisfied with the outcome of this meeting then no administrative hearing will be held.
- Hearings are held before an administrative law judge who works for the Office of Administrative Hearings.
- You can have a lawyer or someone else help you if a hearing is held. You may obtain free legal services through the local legal aid office or the bar association.
- **Note to military personnel:** Active duty service members have a right to stay these proceedings under the federal service members Civil Relief Act. For more information, you may contact the Oregon state bar (800-452-8260), the Oregon military department (503-584-3980), or the nearest legal assistance office, <https://legalassistance.law.af.mil>.

If you are having difficulty understanding this notice, your rights or if you need an advocate, the Long-Term Care Ombudsman Office can help you.

you can contact them at:

Office of the Long-Term Care Ombudsman
3855 Wolverine NE, Suite 6
Salem, OR 97305-1251
Telephone: 1-800-522-2602 or TTY: 1-503-378-5834

Copies of this notice have also been issued to the following people and agencies:

Name and relationship

Address and phone number

Name and relationship	Address and phone number

Signature and title of facility representative

Date

This notice is being issued pursuant to Oregon Administrative Rule 411-054-0080(6)(a-c)

A copy of this notice must be faxed to the Community Based Care Licensing Unit at 503-378-8966, or emailed to: CBC.Team@dhs.oha.state.or.us and to the Long-Term Care Ombudsman Office at 503-373-0852 on the same day it is delivered to the resident.



Administrative Hearing Request (Short Form)



If you want a hearing for cash, child care or medical services (*specific medical procedure or medicine*), you or your representative must fill out this form. You can also use this form to ask for a medical program or food benefit hearing, or you can make an oral request. **A DHS or OHA employee can help you complete this form.**

Claimant or claimant's representative completes this part

Is claimant English speaking? Yes No
If "no," claimant's preferred language:

Do you want your hearing documents in an alternate format? Yes No
If "yes," please specify type of alternate format:

The administrative law judge may conduct the hearing by phone. You may be at the branch or another place. Do you need a reasonable accommodation to participate?

Yes No If "yes," please specify:

Claimant's name:	Telephone number: - -	Message number: - -	Email address (optional):
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Address:	City:	State:	ZIP code:
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Name of lawyer or representative:	Email address (optional):	Telephone number: - -
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Address:	City:	State:	ZIP code:
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I am asking for a hearing because I do not agree with the decision to Close Reduce my benefits
 Deny Charge me with an overpayment Other: _____

I did I did not (*choose one*) receive a written notice to deny my application or to reduce or close my benefits.

Date of the notice: / /

Hearing requested for: Medical service (*procedure or medicine*) TANF (*Cash benefits*)
 Domestic violence Medical program SNAP (*Food benefits*)
 Long-term care Child care Other:

Briefly explain why you disagree.

Check this box if you meet the requirements for an expedited hearing.

Do you want your benefits to stay the same (*not be reduced or stopped*) while you wait for the hearing?

Yes No (**Note:** *Your benefits may change if something else happens that affects benefit.*)

I understand I will be asked to have an informal conference with an agency representative.

Claimant's signature (*or claimant's representative*): Claimant's Social Security or case number*: Date:

x _____ - - / /

*The Department of Human Services (DHS) and the Oregon Health Authority (OHA) are authorized to request your Social Security Number (SSN) under 42 USC 1320b-7(a) and (b), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 435.920, 42 CFR 457.340(b), and OAR 461-120-0210. Your SSN will be used to locate your file and records. Providing an SSN is voluntary.

DHS|OHA completes this part

Date of notice: / /	Date received by DHS or OHA (<i>can be oral for SNAP and medical programs</i>): / /	Program:	Cost center/branch number:
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Case number:	Worker I.D. number:
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