[FACILITY NAME/LOGO]

 **Notification of Emergency Relocation**

Resident name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of emergency relocation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above-named resident was relocated/transferred to:

* Acute hospital
* Emergency department
* Inpatient psychiatric stay
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and contact information for the location to which the resident has been relocated:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Reason for the relocation/transfer of the resident:

* Altered mental status  Fall, fracture, or injury
* Infection  Fever of unknown source
* Difficulty breathing  Cardiac concerns (chest pain, CHF)
* Suspected Stroke  Gastrointestinal complaints
* Abnormal labs  Pain

  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Estimated length of stay:

* Expected return date is currently unknown
* Estimated length of stay 1-3 days
* Estimated length of stay 4-7 day

Notice: If the assisted living facility refuses to provide housing or services immediately after this relocation/transfer, the resident has the right to appeal that decision. A resident, or another individual acting on the resident’s behalf, wishing to appeal an assisted living contract termination must submit an appeal request to the Minnesota Department of Health’s Health Regulation’s Reconsideration Unit:

Reconsideration Unit Health Regulation Division

PO Box 64970

St. Paul, MN 55164-0970

Fax: 651-215-5963

Email: Health.HRD.Appeals@state.mn.us

For additional information and directions on submitting an appeal, go to this website location:
<https://www.health.state.mn.us/facilities/regulation/assistedliving/docs/allcontractappeal.pdf>

Notifications provided to:

* Resident Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Resident legal representative (if there is a legal representative)
Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Resident designated representative (if there is a designated representative)

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Case Manager for residents who receive home and community-based waiver services
* Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Ombudsman for LTC (required if the resident has not returned to the assisted living facility ***within 4 days***). Use Ombudsman cover template with the notice.

Contact information for the Ombudsman for Long-Term Care and the Ombudsman for Mental Health and Developmental Disabilities:

Office of Ombudsman for Long-Term Care

P.O. Box 64971

St. Paul, MN 55164-097

Telephone: 651-431-2555

Office of the Ombudsman for Mental Health and Developmental Disabilities

121 7th Place East

Suite 420 Metro Square Building

St. Paul, Minnesota 55101-2117

Please contact this facility’s Licensed Assisted Living Director or Clinical Nurse Supervisor if you have any questions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Job title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Contact Information