Involuntary Discharge Packet

This packet contains vital information pertaining to the Involuntary Discharge Process as outlined in the Centers for Medicare & Medicaid Services ESRD Facilities Conditions for Coverage. Please read carefully.

- The Network must be notified by phone or in writing **30 days prior** to the discharge.
- This entire packet must be completed on all involuntary discharges and sent to the Network office **prior to** the discharge.
- Completed packets for documented cases of immediate and severe threat must be sent **within 24 hours** of the discharge.
- Retain a copy of this completed packet in the patient’s medical record.


All information must be completed in full and faxed to:
Network 8, Inc.
Attention: NaTasha Avery
Fax: (601)932-4446

Do not send this information by email due to HIPAA requirements.
§ 494.180 Condition: Governance

(f) Standard: Involuntary Discharge and Transfer Policies and Procedures

The governing body must ensure that all staff follow the facility’s patient discharge and transfer policies and procedures. The medical director ensures that no patient is discharged or transferred from the facility unless:

(1) The patient or payer no longer reimburses the facility for the ordered services;

(2) The facility ceases to operate;

(3) The transfer is necessary for the patient’s welfare because the facility can no longer meet the patient’s documented medical needs; or

(4) The facility has reassessed the patient and determined that the patient’s behavior is disruptive and abusive to the extent that the delivery of care to the patient or the ability of the facility to operate effectively is seriously impaired, in which case the medical director ensures that the patient’s interdisciplinary team:

   (i) Documents the reassessments, ongoing problem(s), and efforts to resolve the problem(s), and enters this documentation into the patient’s medical record;

   (ii) Provides the patient and the local ESRD Network with a 30-day notice of the planned discharge;

   (iii) Obtains a written physician’s order that must be signed by both the medical director and the patient’s attending physician concurring with the patient’s discharge or transfer from the facility;

   (iv) Contacts another facility, attempts to place the patient there, and documents that effort; and

   (v) Notifies the State survey agency of the involuntary transfer or discharge

(5) In the case of immediate severe threats to the health and safety of others, the facility may utilize an abbreviated involuntary discharge procedure.
Involuntary Discharge Checklist for Dialysis Facilities

If you have made the decision to involuntarily discharge a patient, complete the attached information to ensure compliance with the Conditions for Coverage. **Remember:** The Network requires this documentation for all involuntary discharges. Be aware that your submitted documentation is the only paper evidence of the situation for the Network review. **This information is to be completed and faxed to the Network PRIOR to discharge or within 24 hours of an immediate discharge.**

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**Demographic Information**

Patient Name: ___________________________ Date of Birth: _______ / _____ / _____

Facility Provider Number: ___________________________ (Tip: this is the facility’s six-digit Medicare provider number. If you are an AL facility, your provider number will begin with 01; if you are a MS facility, your provider number will begin with 25; if you are a TN facility, your provider number will begin with 44).

Name and title of person completing this form (please print): ___________________________

Facility telephone number: ________________ Facility Fax Number: ________________

Name of Facility Medical Director: ___________________________

Name of Patient’s Attending Physician: ___________________________

Name of Facility Administrator: ___________________________

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**Involuntary Discharge Information**

Date of Last Treatment: _____ / _____ / _____ Date Facility Notified Network: _____ / _____ / _____

Date Facility Notified the State Survey Agency: _____ / _____ / _______

Date patient was notified of Discharge: _____ / _____ / _______

Date of Anticipated Discharge: _____ / _____ / _______
Part I: Reason for Discharge

- Non-Payment for services ordered
- Facility ceases to operate
- Cannot meet documented medical needs
- Ongoing disruptive and abusive behavior
- Immediate severe threat to health and safety of others

*For facility closures, complete only one packet and attach a list of patients who are being discharged and their disposition. Skip Parts II and IV.

Please provide a brief description of the incident(s) leading to the involuntary discharge (Please attach all pertinent documentation):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Part II: Mental Health Assessment

*Not required for facility closure

Mental Health Problem/Diagnosis Reported:  Yes  No
If yes, provide explanation and/or diagnosis (attach physician documentation)
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Chemical Dependency/Abuse Reported:  Yes  No
If yes, provide explanation and/or diagnosis (attach documentation)
______________________________________________________________________________
______________________________________________________________________________
Cognitive Deficit Reported:  □ Yes  □ No  
If yes, provide explanation and/or diagnosis (attach physician documentation)  
______________________________________________________________________________  
______________________________________________________________________________  

Part III: Patient’s Disposition  
(Where will the patient dialyze immediately after discharge):  
*For facility closure attach a copy of your census with the disposition of each patient.  

 □ Unknown  
 □ Admitted to another Outpatient Facility  
 □ Patient in Correctional Facility  
 □ Patient Died  
 □ Patient Transplanted  
 □ Not Admitted to another Outpatient Facility – Other – Comment _____________________________  
 □ No Outpatient Facility Accepts – Hospital Acute  
 □ No Outpatient Facility Accepts – Other – Comment _____________________________  

Part IV: Required Documentation*  
*Not required for facility closure  

<table>
<thead>
<tr>
<th>Date Sent to Network office:</th>
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| Patient discharge letter or transfer notice | / /  
| Police Report *(if applicable)* | / /  
| Facility’s discharge and transfer policy/procedure | / /  
| Facility’s patient rights and responsibilities document | / /  
| Documentation of Medical Director approval | / /  
| Documentation of facility’s inability to meet patient’s medical need *(if applicable)* | / /  
| Copies of patient’s interdisciplinary reassessments *(if applicable)* | / /  
| Documentation of ongoing problem and efforts to resolve | / /  
| Medical Director and attending Physician’s signed order | / /  
| Documentation of efforts to relocate patient | / /  
| Documentation of facility notifying State Survey Agency of discharge | / /  
| Other: ________________________________ | / /  

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Part V: State Survey Agency Contact Information

<table>
<thead>
<tr>
<th>State</th>
<th>Division of Health Care Facilities</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Alabama</td>
<td>Al. Dept. of Public Health 201 Monroe St., Ste. 600</td>
<td>1-800-356-9596</td>
</tr>
<tr>
<td></td>
<td>Montgomery, AL 36104</td>
<td></td>
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<tr>
<td>Mississippi</td>
<td>MS State Dept. of Health P.O. Box 1700</td>
<td>1-800-227-7308</td>
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<tr>
<td></td>
<td>Jackson, MS 39215</td>
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<tr>
<td>Tennessee</td>
<td>Division of Health Care Facilities</td>
<td>1-877-287-0010</td>
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<tr>
<td></td>
<td>TN Dept. of Health Cordell Hull Building, 1st Floor</td>
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<tr>
<td></td>
<td>425 5th Avenue North Nashville, TN 37247</td>
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