MOVE-OUT AGREEMENT

_____ is committed to providing its residents high
(Residence Name)
quality service for as long as it is possible and appropriate. However, there are needs that cannot be met

at _____ and are better served in a different setting.
(Residence Name)

Our move-out decisions are made in consultation with the resident and/or designated family members and are based on whether the community can continue to appropriately meet the residents' needs as their care needs change with the progression of disease.

- The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the residence.
- The safety of individuals in the residence is endangered by the resident's being here.
- The health of individuals in the residence would be endangered by the resident's being here.
- The resident has failed, after reasonable and appropriate notice, to pay for (or has failed to have Medicare or Medicaid pay for) this stay at the residence.
- _____
- _____

This move-out is ❑ Voluntary ❑ Involuntary

Planning for move-out will involve a cooperative effort between our staff, the resident and designated responsible family members. Once a decision has been made, a _____ day written notice will be sent, unless a shorter time is necessary to protect the safety or health of the resident, our other residents or staff. As much prior notice as possible will be given in these situations.

Upon move-in to _____ I was informed orally and received
(Residence Name)
a written copy of the community's move-out criteria listed above. I read or had the criteria explained to me and I understand the circumstances under which a move-out of the community will be initiated.

_____	_____
Administrator Signature	Resident or Responsible Party, Signature
_____	_____
Administrator Print Name	Resident or Responsible Party, Print Name
_____	_____
Date	Date

PART 1 – Residence			PART 2 – Resident or Family		
NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed