NEW YORK STATE DEPARTMENT OF HEALTH
CERTIFIED MEDICAL RESPITE PROGRAM

Discharge Notice

Medical Respite Program Legal Name:
Contact Person:
Phone Number:
Email Address:

Medical Respite Recipient Full Name:
Authorized Representative *(if applicable)*:
Social Care Network:
Managed Care Organization:
Other Payor(s):

Date:

Dear :

The medical respite program will discharge you on:

You will be discharged to:

The address of the discharge location is:

You should receive this discharge notice at least 14 days before your discharge date, *unless* your length of stay is expected to last less than 14 days; or you meet criteria for involuntary discharge; or you decide to move out of the medical respite program with less than 14 days' notice.

IF YOU BELIEVE YOU DID NOT RECEIVE PROPER NOTIFICATION OF DISCHARGE, YOU HAVE THE RIGHT TO SUBMIT A COMPLAINT. You must submit the complaint within 30 days of your discharge date. Please see page 2 of this notice for information about how to submit a complaint.

In accordance with 10 NYCRR §1007.8, you are being discharged because:

- ☐ Your health improved and you are no longer at high risk for in-patient hospitalization or emergency room usage.
- ☐ You now have safe and stable housing.
- ☐ You were admitted for pre-procedure care only, and you are now ready to have the scheduled procedure.

- ☐ You were admitted for pre-procedure care only, and the scheduled procedure was canceled.
- ☐ You have been in medical respite for the maximum time allowed by the payor.
- ☐ Your needs cannot be fully met at the medical respite program, even with reasonable accommodation.
- ☐ You informed the medical respite program that you want to move out.
- ☐ You were away from the medical respite program for more than 3 days (*72 hours)*.
- ☐ You were away from the medical respite program for more than 2 days (*48 hours*) and did not tell staff where you were going or respond to attempts to contact you.
- ☐ Your actions put your safety or the safety of others at risk.
- ☐ You have a contagious illness, and state or local laws require you to be quarantined.
- ☐ The medical respite program plans to close permanently and has received permission to do so from New York State Department of Health.
- ☐ Other:

Is supporting documentation attached? ☐ Yes ☐ No ☐ N/A

IF YOU BELIEVE THE DISCHARGE REASON IS WRONG, YOU HAVE THE RIGHT TO SUBMIT A COMPLAINT. You must submit the complaint within 30 days of your discharge date.

You have the right to submit a complaint to the medical respite program and/or the payor(s) for your medical respite services. The payor(s) for your medical respite services may include a Social Care Network, a Managed Care Organization, or another entity, such as a hospital system or local department of social services. The payor(s) for your medical respite services are listed at the top of page 1 of this notice.

You have the right to ask medical respite program staff for help submitting your complaint. Medical respite program staff must help you with your complaint if you ask.

You have the right to designate another person to submit your complaint for you.

You have the right to contact a lawyer or advocacy group for more help.

CONTACT INFORMATION FOR SUBMITTING A COMPLAINT

Medical Respite Program: Each medical respite program has its own complaint process. Ask medical respite program staff for instructions.

Social Care Network (SCN): Each Social Care Network has its own complaint process. Call or email your Social Care Network to ask for instructions. If you are not sure whether you belong to a Social Care Network, you can find that information on page 1 of this notice.

Social Care Network	Call:	Email:
Care Compass	(607) 352-5264	SCNhelpdesk@carecompassnetwork.org
Forward Leading IPA (FLIPA)	(888) 808-1845	concern@forwardleadingipa.org
Health Equity Alliance of Long Island (HEALI)	(516) 505-4434	heali@hwcli.com
Healthy Alliance Foundation, Inc.	(518) 379-0233	communitymember@healthyalliance.org
Hudson Valley Care Coalition (HVCC)	(800) 768-5080	info@hvcare.net
Public Health Solutions (PHS)	(888) 755-5045	GetInfoWholeYouNYCSCN@healthsolutions.org
Staten Island Performing Provider System (SIPPS)	(917) 830-1140	SCN-navigation@northwell.edu
SOMOS Healthcare Providers, Inc.	1-833-SOMOSNY	memberservice@somosscn.org
Western New York Integrated Care Collaborative (WNYICC)	(716) 431-5100	Support@wnyicc.org

Managed Care Organization (MCO): Refer to your member handbook to learn how to use the plan's complaint/grievance process or call the plan's member services or complaint/ grievance phone line listed on your health plan identification card. If you are not sure whether you belong to a Managed Care Organization, you can find that information on page 1 of this notice.

Other payor(s): Ask medical respite program staff for help finding contact information for any other payor(s) listed on page 1 of this notice.

Please sign below to acknowledge that all parties received this discharge notice and information about submitting complaints.

Recipient

Name:_____

Signature: _____ Date: _____

Recipient's Authorized Representative *(if applicable)*

Name:_____

Signature: _____ Date: _____

Medical Respite Program Representative

Name and Title: _____

Signature: _____ Date: _____

Authorized representative verbally informed on: _____

Notice mailed to authorized representative on: _____

Notice provided to Social Care Network on: _____