

# Notice of Exit or Transfer ODDS Residential Settings



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

Address: \_\_\_\_\_

You are being provided with a notice from \_\_\_\_\_ to move from your home:  
*(residential service provider)*  
\_\_\_\_\_ at \_\_\_\_\_. The home you are being asked to move from is a(n): *(check one)*  
*(name of home site)* *(address of home)*

- Adult Foster Home (OAR 411-360-0190)    
  Child Foster Home (OAR 411-346-0240)    
  24-Hour residential setting (OAR 411-325-0390)    
  Host home (OAR 411-348-0390)

This notice to move is a:

30-day notice requiring you to move out on or before \_\_\_\_\_ due to the following reason(s):  
*(date of move)*

*(check all that apply)*

- Behavior posing an imminent risk of danger to you or others in the home
- Significantly increased ongoing support needs due to a medical emergency that your provider is unable to meet
- Care needs exceed your provider's ability to safely meet your needs
- Provider has not received payment for room and board or services provided to you
- Home is relocating to another place or you are being asked to move to another home operated by your provider
- Provider intends to rent, sell, or lease the home
- Provider's license, certification, or endorsement has been revoked, surrendered, suspended, or not renewed
- Provider's Medicaid contract is terminated

Less than 30-day notice requiring you move out on or before \_\_\_\_\_ due to the following reason(s):  
*(date of move)*

*(check all that apply)*

- Medical emergency that poses an imminent danger to you or others and any delay in moving out makes the situation more dangerous
- Behavior that poses an imminent risk of danger to you and others and any delay in moving out make the situation more dangerous

Provider's explanation for the reason for the notice of exit or transfer:

Copies of this notice have also been given to:

Name	Relationship	Address (may be used for hearing correspondence)
	Services coordinator	
	Legal guardian	
	Provider issuing notice	

Signature of provider issuing notice \_\_\_\_\_ Date \_\_\_\_\_ Provider's email address \_\_\_\_\_

# Your rights when you are given a notice of involuntary exit or transfer

You have the right to:

- A notice from your provider at least 30 days before the date you are being asked to move, unless there is an emergency with a risk of imminent danger to you or others.
- A notice as soon as possible if your provider is asking you to move in less than 30 days.
- An explanation why you are being asked to move.
- Only be asked to move from your home when there is an unsafe situation, your needs cannot be met, the home is closing, or your provider is no longer a Medicaid service provider. Your provider must follow Oregon Administrative Rules (411-325-0390; 411-348-0390; 411-346-0240; 411-360-0190).
- Ask for a hearing if you do not agree with the notice to move out unless the notice to move is because the provider is not renewing their license, has their license revoked or suspended, or has their Medicaid provider number terminated.
- Have services from your provider until your move date on the notice or a Final Order if you ask for a hearing (*within 15 days of the date of notice and request for service to continue*).
- Have your room kept for you until your move date on the notice or a Final Order (*if you ask for a hearing*).

## How to ask for a hearing

Ways to request a hearing:

1. Fill out the attached part of this form, “Request for Hearing” and send it with the “Notice of Exit” part of the form to:  
Complaint Coordinator, ODDS  
500 Summer St NE, E-09  
Salem, OR 97301
2. Fax the filled out “Request for Hearing” and “Notice of Exit” to: 503-373-7274
3. Email the filled out “Request for Hearing” and “Notice of Exit” to: [ODDS.Complaints@dhsosha.state.or.us](mailto:ODDS.Complaints@dhsosha.state.or.us)
4. Ask for a hearing by speaking directly with your Services Coordinator, or a DHS or ODDS employee.

You may have help from your Services Coordinator or other personal representative to request a hearing and fill out the “Request for Hearing” form. Both parts of the form (*“Notice of Exit or Transfer” and “Request for Hearing”*) are needed for your request for a hearing to be processed by the Office of Administrative Hearings.

You will receive a written Notice of Hearing from the Office of Administrative Hearings which will tell you the date, time, and place of your hearing.

If you need to delay your hearing, you must contact the hearing coordinator listed on your Notice of Hearing immediately. Only the Office of Administrative Hearings can postpone a hearing.

At the hearing, you can explain why you disagree with the notice of exit or transfer, including why the situation does not meet or match the reason your provider gave for issuing the notice. You can have people testify and you can submit materials and case file information related to this matter. You may have a legal representative or a friend help you. DHS does not pay for the cost of witnesses or an attorney. You may be able to get assistance or legal services from Disability Rights Oregon or your local Legal Aid Services.

## Important timelines:

- If you want your services to continue until there is a Final Order, you must request a hearing within **15 calendar days after the date of the notice** and request services to continue. Your provider is required to maintain your room and make services available to you if you request services to continue.
- You may request an expedited hearing if you have been given less than 30 days’ notice due to a medical emergency or behavior that poses a risk of imminent danger to you or others, or if it is more than 15 days from the date of the notice and you want services to continue until the Final Order.
- Even after you move from your home, you may still request a hearing. A hearing can be requested up to 90 days from the date of the Notice of Exit. If you do not ask for a hearing within the 90 days, you may lose your right to have a hearing.

# Request for Hearing for Notice of Exit or Transfer- ODDS Residential Service Settings



If you want a hearing to challenge the Notice of Exit or Transfer you received from your residential services provider, you (or your legal representative) may request a hearing by filling out this form.

## I want to request a hearing

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Prime number: \_\_\_\_\_  
*(individual receiving notice)* *(if known)*

Address: \_\_\_\_\_ Phone number: \_\_\_\_\_

Name of provider issuing notice: \_\_\_\_\_

Did you receive a written notice?  Yes, date of notice: \_\_\_\_\_  No

You are asking for a hearing because you do not agree with the notice of exit asking you to:

- Exit (*move out*)    Move to another home your provider operates    Move to a new home with your provider

Please check the box if you want your residential provider to continue to provide service to you until a Final Order following the hearing or default.

- Yes, I want to stay in my home until the final order after the hearing  
*(only applies if you ask for a hearing within 15 days of the Notice of Exit)*

You may be entitled to an expedited hearing if:

- You received less than 30 days' notice to move; or
- You would like to stay in your home and this request for a hearing is more than 15 days from the date of the notice of exit.

Please check the box indicating if you want an expedited hearing:  I would like to request an expedited hearing

If your request for an expedited hearing is granted, a hearing will be held within seven days from the date the Office of Administrative Hearings receives this request for an administrative hearing.

## If someone other than the individual claimant completed this form, please provide the following information:

Name of person completing the form: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to individual (*guardian, legal counsel, advocate*): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of individual: \_\_\_\_\_ Date: \_\_\_\_\_

## Department of Human Services (DHS) completes this part

DHS contact for this matter:			Phone:
Issue code:			Date:
Date of notice:	Cost center:	Date of initial hearing request:	Date request rec'd by DHS:
Case number, prime number or DD followed by last 4 digits of SSN:			
Claimant speaks English? <input type="checkbox"/> Yes <input type="checkbox"/> No		Claimant primary language:	
Alternate format? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, specify below:	
<input type="checkbox"/> Braille		<input type="checkbox"/> Audio tape	<input type="checkbox"/> Large print
		<input type="checkbox"/> Diskette	<input type="checkbox"/> Oral presentation