Long-Term Care Ombudsman Program
Facility Closure CHECKLIST[1]

Facility Name Closing:			Type of Facility: ☐ NH ☐ ALF ☐ AFCH ☐ SNU (Hospital)		
Ombudsman Assigned:			Date of Visit:		
Resident Name:			Room #:		
Address:			City:		County:
Date Facility Closing:					
Resident's Legal Representative or Family Member Name:			Relationship to Resident:		
Legal Authority: ☐ POA ☐ Healthcare Surrogate ☐ Guardian ☐ Other: _____			Address of Legal Representative:		
Phone Number of Representative:			Additional Information regarding Representative:		
Yes	No	N/A	**ATTACH CONSENT FORM**		
			• Is there an open case? If yes, what is the case #_____ Comment:		
			• Did you inform the resident of their rights? Comment:		
			• Was a brochure and Resident Rights Information provided to the resident? Comment:		
			• Was the resident given a choice of facilities to choose from? Comment:		
			• Did you provide a list of facilities to the resident? Comment:		
			• Was the Agency for Health Care Administration called? Comment:		
			• Was Adult Protective Services called? If yes, who is the Investigator?_____ Comment:		
			• Is there a Case Manager to assist the resident? If yes, who is the Case Manager? _____ Case Manager's Organization? _____ Comment:		
			• Are all personal belongings with the resident? Comment:		
			• Are all the medications with the resident? Comment:		
			• Is the resident due a refund of any kind from the facility? Comment:		
			• Is the resident and resident's representative satisfied with the current placement? Comment:		
			• Was the resident given a change of address from to inform the post office? If no, please provide a change of address form to resident. Comment:		

[1] Developed by the Florida State LTC Program in 2008. You can download the original form here: http://ltcombudsman.org/uploads/files/issues/Facility-Closure-Checklist-2008.doc.

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			• Does resident have a personal phone line service (land line)? If yes, please remind resident to make appropriate changes for phone service. • Comment:	
Other Issues:				
Facility Transferred To:				Date of Transfer:
Address of New Facility:				Type of Facility: ☐ NH ☐ ALF ☐ AFCH ☐ SNU (Hospital) ☐ Other _____
Ombudsman Assigned to Visit with Resident at New Facility:				Date of Visit:
Yes	No	N/A		**ATTACH Resident Visitation Form**
			• Is the resident and resident's representative satisfied with the current placement? Comment:	
			• Is there a need to open a case? If so, please contact the District Ombudsman Manager to file a complaint. Comment:	
Other Concerns:				
Ombudsman Signature:				**Date:**