**NOTICE OF TRANSFER OR DISCHARGE**

State Form 49669 (R8 / 1-19)

Indiana State Department of Health - Division of Long Term Care

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Resident Information** | | | | | | | |
| Resident Name | | | Date Notice Issued *(month, day, year)* | | | | |
| Facility Name*(Facility resident is being discharged from)* | | | | | | | |
| Facility Street Address *(number and street)* | | | | Facility City | | | Facility ZIP Code |
| **Transfer / Discharge Notice** | | | | | | | |
| Transfer or Discharge Effective Date*(month, day, year)* | | | | | | | |
| Resident Is Being Transferred To:  Another Nursing *Facility (Specify facility name below.)*  Another Health Facility *(Specify facility name below.)*  A private residence *(including home)*  Other *(Please specify)*: | | | | | | | |
| Name of Facility Being Transferred To | | | | | | | |
| Address of Facility Being Transferred To *(number and street)* | | | | | | | |
| City | State | | | | ZIP Code | | |
| **Reason for Transfer or Discharge *(Must select one of the reasons below.)*** | | | | | | | |
| The transfer or discharge is necessary to meet the resident’s welfare and the resident’s needs  cannot be met in the facility.  The transfer or discharge is appropriate because the resident’s health has improved  sufficiently so the resident no longer needs the services provided by the nursing facility.  The safety of the individuals in the facility is endangered.  The health of the individuals in the facility would otherwise be endangered.  The resident has failed, after reasonable and appropriate notice, to pay or payment has not  been made under Medicare/Medicaid for a stay in a nursing facility.  The facility ceases to operate. | | | | | | | |
| **Bed Hold Policy** | | | | | | | |
| The facility must attach a copy of the facility’s bed hold policy to this *Notice of Transfer or Discharge* and provide contact information for a facility employee to contact about the bed hold policy. | | | | | | | |
| Facility Contact Name | | Facility Contact Title | | | | Facility Contact Telephone Number | |

|  |  |  |
| --- | --- | --- |
| **Appeal Rights** | | |
| **You have the right to appeal the health facility’s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana State Department of Health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge, unless the facility is authorized to transfer you as an emergency transfer under 410 IAC 16.2-3.1-12(a)8. If you wish to appeal this transfer or discharge, please fill out the attached State Form 49831 and return to the address below. If you have any questions, call the Indiana State Department of Health at 317-233-7540 between the hours of 8:15 am and 4:45 pm.**  To appeal this transfer or discharge, use the attached State Form 49831 and mail it to:  Indiana State Department of Health  Court Administrator, Office of Legal Affairs  2 North Meridian St. Section 3-H  Indianapolis, IN 46204 | | |
| **Attachments** | | |
| The facility must attach the following documents to this *Notice of Transfer or Discharge:*  Attach facility bed hold policy  Attach State Form 49831 *Notice of Transfer or Discharge Request for Hearing* | | |
| **State Long Term Care (LTC) Ombudsman** | | |
| The State LTC Ombudsman is a State Office that serves as an advocate for nursing home residents.  The State long term care Ombudsman’s address and telephone number is:  State LTC Ombudsman  Family and Social Services Administration  P.O. Box 7083, 402 W. Washington St.  IGC South, Room W451 – MS 27  Indianapolis, IN 46207-7083  (317) 232-7134 or Toll free 1-800-622-4484  Fax: (317) 972-3285  [***http://www.in.gov/ombudsman/2348.htm***](http://www.in.gov/ombudsman/2348.htm) | | |
| **Your Local Ombudsman** | | |
| The following is contact information for your local Ombudsman: | | |
| Name of Local Ombudsman | | Telephone of Local Ombudsman |
| Address of Local Ombudsman *(number and street)* | | |
| City | State | ZIP Code |
| **Indiana Disability Rights** | | |
| The Indiana Disability Rights organization provides assistance, if needed, for residents who are mentally ill or developmentally disabled. Their address and telephone number is:  Indiana Disability Rights  4701 North Keystone Avenue, Suite 222  Indianapolis, IN 46205  Voice 1-800/622-4845 or 317/722-5555  TTY 1-800/838-1131; Fax 317/722-5564  [***http://www.IndianaDisabilityRights.org***](http://www.IndianaDisabilityRights.org) | | |