NOTICE OF TRANSFER OR DISCHARGE REQUEST FOR HEARING

State Form 49831 (R8 / 4-23)

Indiana Department of Health-Division of Long Term Care

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| Use this form to notify the Indiana Department of Health that you wish to appeal your involuntary transfer or discharge. If you want to appeal the involuntary transfer or discharge, you must send this form (State Form 49831) along with the Notice of Transfer or Discharge (State Form 49669) to the Department of Health **within ten (10) days** of your receiving the notice of transfer or discharge from the facility to:  Indiana Department of Health Court Administrator, Office of Legal Affairs  2 North Meridian Street – Section 3-H Indianapolis, Indiana 46204  Or  CourtAdministrator@health.in.gov | | | | | | |
| I received a *Notice of Transfer or Discharge* from the health facility informing me that I am going to be transferred or discharged from the facility. I hereby request a hearing on the facility’s decision to transfer or discharge me from the health facility. | | | | | | |
| Resident Name | | | | | Date Received *(Month, Day, Year)* | |
| Resident Telephone Number | Resident Email Address | | | | Resident Preferred Method of Contact  Email  US Mail | |
| Name of Resident Representative | | | | | Representative Relation to Resident | |
| Representative Address *(Number and Street, City, State and ZIP Code)* | | | | | | |
| Representative Telephone Number | Representative Email Address | | | Representative Preferred Method of Contact  Email  US Mail | | |
| Facility Name *(Facility resident is being discharged from)* | | | | | | |
| Facility Street Address *(Number and Street)* | | Facility City | | | | Facility ZIP Code |
| Facility Telephone Number | | | Facility Email Address | | | |