Reset Form

NOTICE OF TRANSFER OR DISCHARGE REQUEST FOR HEARING

State Form 49831 (R8 / 4-23)
Indiana Department of Health-Division of Long Term Care

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	