Reset Form

NOTICE OF TRANSFER OR DISCHARGE REQUEST FOR HEARING

State Form 49831 (R7 / 2-13)
Indiana State Department of Health-Division of Long Term Care

Use this form to notify the Indiana State Department of Health that you wish to appeal your transfer/discharge. If you want to appeal the transfer or discharge, you must send it to the Department of Health **within ten (10) days** of your receiving the notice of transfer or discharge from the facility to:

Indiana State Department of Health
Court Administrator, Office of Legal Affairs
2 North Meridian Street – Section 3-H
Indianapolis, Indiana 46204

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)*
Name of Resident's Representative	Representative's Telephone Number ( )
Representative's Address *(Number and Street, City, State and ZIP Code)*	
Facility Name *(Facility resident is being discharged from)*	

Facility Street Address *(Number and Street)*	Facility City	Facility ZIP Code
Facility Telephone Number ( )		