



**FAIR HEARING REQUEST FOR TRANSFER OR DISCHARGE  
FROM A NURSING HOME**  
Nursing Home Transfer and Discharge Notice Attachment

Complete this form if the resident disagrees with the discharge or transfer and wishes to request a Fair Hearing of the decision. All information must be completed. Please print.

NAME OF NURSING HOME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

AREA CODE/PHONE #: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_

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HEARING REQUESTED FOR: \_\_\_\_\_  
(Name of Resident)

RESIDENT'S REPRESENTATIVE: \_\_\_\_\_  
(If applicable)

REPRESENTATIVE'S RELATIONSHIP TO RESIDENT: \_\_\_\_\_

REPRESENTATIVE'S ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

REPRESENTATIVE'S AREA CODE/PHONE #: (\_\_\_\_) \_\_\_\_\_

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**I DISAGREE WITH THE TRANSFER OR DISCHARGE FOR THE FOLLOWING REASON(S):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Use Additional Sheet if Necessary)

\_\_\_\_\_  
Resident or Representative Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**COMPLETE THIS FORM AND EMAIL, FAX OR MAIL TO:**

**Department of Children and Families**  
**Office of Appeal Hearings**  
2415 North Monroe Street, Suite I, Room 129  
Tallahassee, FL 32303-4190  
**Telephone Number: (850) 488-1429**  
**Fax: (850) 487-0662**  
**Email: [appeal.hearings@myflfamilies.com](mailto:appeal.hearings@myflfamilies.com)**