**Nursing Home Provider** complete and send form tofax number: **608-785-6315** or email to: absenceandchangereporting@inclusa.org Please use one form per member.

|  |
| --- |
| This section *must be* completed and submitted to Inclusa within 24 hours of absence, or by Monday morning if absence occurs during weekend/holiday hours, if the member does not return within 24 hours. |
| **Date Completed**:  |       | **Member Name**:  |       |
| **Provider Name**:  |       |
| **Community Resource Coordinator**:  |       | **Health & Wellness Coordinator**:  |       |
| **Submitted By**:  |       | **Submitter Phone Number**:  |       |
| **Date/Time Care Conference Scheduled:** |  |
|  |
| **Change in Inclusa Member RUGS** |
| **New RUGS**: |  | **Effective Date of New RUGS:**  |
| **Reason for MDS Review:** | [ ]  Change in therapies[ ]  Scheduled MDS[ ]  Change in Condition |
|  |
| **Member Enrolled in Hospice Care:** | **Date:**  |
|  |
| **Member Absence from Nursing Home** |
| **Date Member Left:**  |       |
| **Reason for Absence:** |       |
| **Expected Length of Absence:**  |       |
| **Date of Return, if Known:**  |       | [ ]  Unknown |
| ***Bed Hold Request (provider must certify required occupancy below)***  |
| **Nursing Home provider hereby certifies that the provider’s facility meets the Medical Assistance occupancy requirements qualifying for bed hold reimbursement.** |
| **Printed Name and Title:** *(If completing this form electronically, printed name and title will suffice as Authorized Signature).* |
| **Authorized Signature:**  |

***Internal Directions:*** *Receptionist send to AES. \*Hospitalizations greater than 10 days require a Family Care Change Form submitted to the Change Routing Form mailbox.*