**Nursing Home Provider**: Complete and send form tofax number: **866-880-0551** 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 HIPPS score** |
| **New HIPPS**: |  | **Effective Date of New HIPPS:**  |
| **Reason for MDS Review:** | [ ]  Change in therapies[ ]  Scheduled MDS[ ]  Change in Condition[ ]  Change in funding from Medicare to Inclusa as primary |
|  |
| **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:** |  |  |
|  |  |

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