Member Notification Form
Nursing Home

Nursing Home Provider: Complete and send form to fax 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	

Date enrolled in Hospice:
Date disenrolled From Hospice:
Date Medicare started Coverage:

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 ACS. *Hospitalizations greater than 10 days require a Family Care Change Form submitted to the Change Routing Form mailbox.*