



**Detroit Wayne  
Integrated Health Network  
Residential Services Department**

**Specialized Residential Vacancy Notification Form**  
(for LICENSED and UNLICENSED Settings)

*Please complete form to ensure content is legible.*

*Fax to (313) 989-9525; or*

*Email to ResidentialBrokering@dwihn.org*

**Contact Information**

Residential Provider completes Residential Vacancy Report form to ensure the following information is legible:

- **Provider Name**
- **Date** the form is being submitted to Residential Services
- Direct **Contact Person** (who is submitting the form)
- Provider **Fax Number**,
- Current **Email Address**, and
- Direct **Phone Number**
- **Facility Name** where vacancy is located
- **Provider ID#** (located in MWHIN)
- **Facility Address**
- Facility **Phone Number**
- **Total # of Vacant Beds** being reported as available for placement

Residential Provider completes one row for each Vacant Bed reported for availability, circling all that applies for:

- Diagnosis Designation (**AMI**, formally SMI) or **IDD**)
- Vacant beds available for **FEMALE (F)** or **MALE (M)**
- Floor Level of Vacant Bed: **1<sup>st</sup> Floor** or **2<sup>nd</sup> Floor**
- Verification of "**Barrier-Free**" vacancy (Wheelchair Accessible AND has Roll-In Shower?)
- Vacancy Type (Is Vacant Bed a **Single** or **Double** Occupancy, meaning roommate?)

**Members in the Home**

List all Members who are still residing in the home

Include for each Member still in the home:

- Initials
- MHWIN ID#

**Member Reporting**

Residential Provider completes information reporting the last Member to discharge or vacate the facility:

- **Member Name**
- **MHWIN ID#**
- **Member's Last Day at Facility**
- **Discharge Location**
- **Guardian Contact Information**
- **CRSP Contact Information**
- Was the Guardian contacted? Yes/No
- Was the CRSP contacted? Yes/No
- **Discharge Type** (Living Independently, Living with Family, Private Pay, Hospital (for medical), Nursing Home, Internal Transfer, 30-Day Discharge, Emergency Discharge, Self Discharge, Deceased)

**Submitting Report to Residential Services**

- **FAX** to 1-313-989-9525; or
- **EMAIL** to ResidentialBrokering@dwihn.org

Once report has been received, Residential Provider will be emailed receipt notification confirming their vacancy is listed for residential availability; however reports will be returned for the following reasons:

- **Missing information; incomplete vacancy reports**
- **Documentation is not legible**
- **Vacancy reporting of non-contracted facilities**



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**Contact Information**

Complete this section with the following information and indicate in the chart below all vacancies for the identified facility

Provider Name: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Provider ID#: \_\_\_\_\_

Facility Address: \_\_\_\_\_ Facility Phone#: \_\_\_\_\_

# of Total Vacant Beds: \_\_\_\_\_

Complete one row for each vacant bed reported	AMI or IDD		Female or Male		1 <sup>st</sup> Floor or 2 <sup>nd</sup> Floor?		Barrier-Free Wheelchair Accessible & Roll-In Shower?		Vacancy Type <i>(Circle One per Vacancy)</i>	
	AMI	IDD	F	M	1st	2nd	Yes	No	Single	Double
<b>Bed #1</b>	AMI	IDD	F	M	1st	2nd	Yes	No	Single	Double
<b>Bed #2</b>	AMI	IDD	F	M	1st	2nd	Yes	No	Single	Double
<b>Bed #3</b>	AMI	IDD	F	M	1st	2nd	Yes	No	Single	Double
<b>Bed #4</b>	AMI	IDD	F	M	1st	2nd	Yes	No	Single	Double

**Members in the Home**

List all Members currently residing in the home.

Member's Initials-MHWIN ID#:

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The information contained in this transmission may contain privileged and confidential information, including protected health information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If you are not the intended recipient, or you believe you have received this message by error, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender immediately at 313-989-9513 to inform them that you received this message in error, and permanently destroy all copies of the original message and any attachments



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**Member Reporting**

Complete this section for all members that have vacated/discharged from the facility:

Member Name: \_\_\_\_\_

MHWIN ID #: \_\_\_\_\_

Member's Last Day at Facility: \_\_\_\_\_

Discharge Location: \_\_\_\_\_

Guardian Contact Information: \_\_\_\_\_

CRSP Contact Information: \_\_\_\_\_

Was the Guardian contacted?  Yes  No Date: \_\_\_\_\_

Was the CRSP contacted?  Yes  No Date: \_\_\_\_\_

<b>Discharge Type:</b>	
Living Independently	Internal Transfer
Living with Family	30-Day Discharge
Private Pay	Emergency Discharge
Hospital (Medical)	Self-Discharge
Nursing Home	Deceased

Member Name: \_\_\_\_\_

MHWIN ID #: \_\_\_\_\_

Member's Last Day at Facility: \_\_\_\_\_

Discharge Location: \_\_\_\_\_

Guardian Contact Information: \_\_\_\_\_

CRSP Contact Information: \_\_\_\_\_

Was the Guardian contacted?  Yes  No Date: \_\_\_\_\_

Was the CRSP contacted?  Yes  No Date: \_\_\_\_\_

<b>Discharge Type:</b>	
Living Independently	Internal Transfer
Living with Family	30-Day Discharge
Private Pay	Emergency Discharge
Hospital (Medical)	Self-Discharge
Nursing Home	Deceased

Member Name: \_\_\_\_\_

MHWIN ID #: \_\_\_\_\_

Consumer's Last Day at Facility: \_\_\_\_\_

Discharge Location: \_\_\_\_\_

Guardian Contact Information: \_\_\_\_\_

CRSP Contact Information: \_\_\_\_\_

Was the Guardian contacted?  Yes  No Date: \_\_\_\_\_

Was the CRSP contacted?  Yes  No Date: \_\_\_\_\_

<b>Discharge Type:</b>	
Living Independently	Internal Transfer
Living with Family	30-Day Discharge
Private Pay	Emergency Discharge
Hospital (Medical)	Self-Discharge
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