Detroit Wayne
Integrated Health Network
Residential Services

Specialized Residential Vacancy Notification Form

Please complete form to ensure content is legible.
Fax to: **DWIHN Residential Services, 313-989-9525**

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: **1st Floor** or **2nd Floor**
- Verification of "**Barrier-Free**" vacancy (Wheelchair Accessible, have a Roll-In Shower?)
- Vacancy Type (Is Vacant Bed a **Single** or **Double** Occupancy?)

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#

Consumer Reporting

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

- **Consumer Name**
- **MHWIN ID#**
- **Consumer'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** (Transferred Facilities, Nursing Home, Private Insurance/Medicare, 30-Day Discharge, Emergency Discharge, Deceased)

Submitting Report to Residential Services

- **FAX** to **1-313-989-9525**; or
- **EMAIL** to **residentialreferral@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	1st Floor or 2nd Floor?	♿ Barrier-Free Wheelchair Accessible & Roll-In Shower?	Vacancy Type *(Circle One per Vacancy)*
Bed #1	AMI IDD	F M	1st 2nd	Yes No	Single Double
Bed #2	AMI IDD	F M	1st 2nd	Yes No	Single Double
Bed #3	AMI IDD	F M	1st 2nd	Yes No	Single Double
Bed #4	AMI IDD	F M	1st 2nd	Yes No	Single Double

Members in the Home

List all Members who are still residing in the home.

Initials/MHWIN ID#:

____

____

____

____

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 313-833-2500 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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Consumer Reporting

Complete this section for all consumers that have vacated/discharged from the facility within the last **30 days**

Consumer 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:** __________

Discharge Type:
- ☐ Transferred Facilities
- ☐ Nursing Home
- ☐ Private Insurance/ Medicare
- ☐ 30-Day Discharge
- ☐ Emergency Discharge
- ☐ Deceased

Consumer 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:** __________

Discharge Type:
- ☐ Transferred Facilities
- ☐ Nursing Home
- ☐ Private Insurance/ Medicare
- ☐ 30-Day Discharge
- ☐ Emergency Discharge
- ☐ Deceased

Consumer 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:** __________

Discharge Type:
- ☐ Transferred Facilities
- ☐ Nursing Home
- ☐ Private Insurance/ Medicare
- ☐ 30-Day Discharge
- ☐ Emergency Discharge
- ☐ Deceased