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 **ResidentialReferral@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: **1st Floor** or **2nd 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, Incarcerated, 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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Email to **ResidentialReferral@dwihn.org**

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 currently residing in the home.

Member's Initials-MHWIN ID#:

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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:** _____

Discharge Type:
- ☐ Living Independently
- ☐ Living with Family
- ☐ Private Pay
- ☐ Hospital (Medical)
- ☐ Nursing Home
- ☐ Incarcerated
- ☐ Internal Transfer
- ☐ 30-Day Discharge
- ☐ Emergency Discharge
- ☐ Self-Discharge
- ☐ 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:** _____

Discharge Type:
- ☐ Living Independently
- ☐ Living with Family
- ☐ Private Pay
- ☐ Hospital (Medical)
- ☐ Nursing Home
- ☐ Incarcerated
- ☐ Internal Transfer
- ☐ 30-Day Discharge
- ☐ Emergency Discharge
- ☐ Self-Discharge
- ☐ 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:** _____

Discharge Type:
- ☐ Living Independently
- ☐ Living with Family
- ☐ Private Pay
- ☐ Hospital (Medical)
- ☐ Nursing Home
- ☐ Incarcerated
- ☐ Internal Transfer
- ☐ 30-Day Discharge
- ☐ Emergency Discharge
- ☐ Self-Discharge
- ☐ Deceased