**ISNP Change Form**

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| **ISNP Contracted Partner** | Click or tap here to enter text. |
| **Facility Name** *(include dba when applicable)* | Click or tap here to enter text. |
| **Facility Owner** | Click or tap here to enter text. |
| **Address** | Click or tap here to enter text. |
| **City** | Click or tap here to enter text. |
| **State** | Click or tap here to enter text. |
| **Zip** | Click or tap here to enter text. |
| **County** | Click or tap here to enter text. |
| **Sales/Marketing Contact****Name / Phone / Email** | Click or tap here to enter text. |
| **Type of Change** | Add *(60-day notice required)* [ ] Remove *(90-day notice required)* [ ]  |
| **Requested Effective Date**  | Click or tap to enter a date. |
| **Model of Care Training** **Date Completed** |  Y [ ]  N [ ] Click or tap to enter a date. |
| **Assisted Living****Number of Beds** |  Y [ ]  N [ ] Click or tap here to enter text. |
| **Memory Care****Number of Beds** |  Y [ ]  N [ ] Click or tap here to enter text. |
| **Skilled Nursing Facility****Number of Beds** |  Y [ ]  N [ ] Click or tap here to enter text. |
| **Designated Primary Care Provider Group/Care Coordinator** *(if not partner contracted with UCare)* | Click or tap here to enter text. |
| **List the ownership group of the added facility on the UCare.org  - ISNP participating facility list** |  Y [ ]  N [ ]  |
| **Notes:** | Click or tap here to enter text. |

**Please email the completed form to: prcdemographic@ucare.org.**