**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.**