Geisinger

Shift care notification form

Form must be sent within five (5) days of any changes in the status of a Geisinger Health Plan member receiving shift care services. Fax the completed form to 570-271-5507 upon any change in status.

Provider name:	Phone #:	Contact name at provider:	Date:

Member information

Member name:	DOB:	MAID:
GHP ID #:	Authorization #:	
Date of change in member's status:	Shift care services placed ON HOLD: Yes ☐ No ☐	
Member discharged from shift care services: Yes ☐ No ☐ (If yes, copy of discharge order **must** be faxed to GHP at 570-271-5507)	If Yes, member discharged, why: (choose one) Unable to cover service (staffing) ☐ Patient no longer in need of services ☐	
Hospital admission: Facility name: Date of admission: Facility phone #:	**Admission to a pediatric care facility:** **Name of facility:** **Date of admission:** **Facility phone #:**	
Member discharged back to home: Yes ☐ No ☐ Discharge date:	Admission to a group home: Date of admission: Phone #:	
Resumption of shift care services: Yes ☐ No ☐ Date of resumption: _____	Co-vending of shift care services: Yes ☐ No ☐ Name of agency/agencies: _____ Phone #: _____ Hours covered (ex. M – F, 8 a.m. – 5 p.m.):	
Member has expired: Yes ☐ No ☐ Date of expiration: _____ Name of facility: _____ If member has expired, notification of a member's death **must** be made verbally to a member of the Shift Care team at 800-544-3907 **AND** via fax to 570-271-5507.	If Yes, provide details: GHP Medical Director requests that upon the death of any GHP member receiving shift care services the provider is to fax the last two weeks of records to 570-271-5507.	

Is OCYF/APS involved with the child's care? Yes ☐ No ☐	If Yes, provide agency name, phone #, caseworker name and contact information:

If member is discharged from services due to lack of staffing

What had been done to re-staff the case?

Community Resource Referrals

Were any community resource referrals made? Yes ☐ No ☐
List all community resource referrals *(referral type/referral date/date of resource utilization)*:

Shift Care/Waiver Services (fields in this section are optional)

Has member been referred for TSS services? Yes ☐ No ☐	Provide details/dates of authorization:
Is member enrolled in a waiver? Yes ☐ No ☐	Waiver Name/Enrollment Date:
Does member require waiver services? Yes ☐ No ☐	Will member age out within 180 days? Yes ☐ No ☐
If Yes, has the waiver/age out process been initiated? Yes ☐ No ☐	If Yes, attach all age out/waiver documents