Nursing Facility Change in Licensed Beds Capacity Request

APPLICATION FORM

1. Contact Information	
Name of Facility	
Medicaid Provider ID #	
National Provider Identification #	
Contact Name	
Contact Phone	
Contact Email	

If the facility is requesting a decrease in Licensed Beds, please skip section 2 and move directly to section 3.

2. Increase in Licensed Bed Request	
A. Date of Last Request for Change in # of Licensed Beds	
B. # Currently Licensed Medicaid Beds	
C. # Beds to license/bring back into service	
D. Total Licensed Beds (Add B and C)	
E. Average Medicaid Occupancy (Average Medicaid occupancy for the last 6 months, please submit supporting census information to verify)	_____ Average Medicaid Occupancy _____ Census submitted _____ Starting month _____ Ending Month
F. Other Census information to consider (Enter short description why facility should be considered if average Medicaid occupancy is below 95%)	
G. Facility Averge Occupancy (Total average occupancy for all payers for the last 6 months, please submit supporting census information to verify)	_____ Average Total Occupancy _____ Census submitted _____ Starting month _____ Ending Month
H. Other Census information to consider (Enter short description why facility should be considered if total average occupancy is below 93%)	

I. Submission of Facility Floor Plan (Facility confirms that it has submitted floor plan for placement of newly licensed beds)	☐ Floor Plan submitted
J. Description of how new beds will be utilized (Enter detailed description of how additional beds will be utilized.)	
K. Justification of new beds (Please provide any data or evidence to demonstrate a Medicaid population or service need. Please attach additional supporting information as needed.)	
L. Star Rating (from Medicare Nursing Home Compare Five-Star Rating System)	_____ Staffing _____ Health Inspection _____ Quality Measures _____ Overall Rating _____ Date of ratings shown above
M. Enter explanation for Star rating above (Enter a short description)	
N. Please list any Open Investigations being conducted by any state/federal authority (List and enter short description.)	

O. Please list any Immediate Jeopardy (IJ) findings in the last 6 months (Enter a short description of findings.)	
P. Enter explanation for open investigations (Enter reasoning for open investigation(s).)	
Q. Financial Information (all information must be submitted for application to be considered complete)	☐ Last (2) years of audited financial statements ☐ Interim financial statements for each month of facility's current fiscal year ☐ Most recent BM-64 on file with EOHHS

3. Decrease in Licensed Medicaid Bed Capacity	
A. # Currently Licensed Medicaid Beds	
B. # Beds to delicense/take out of service	
C. Total Licensensed Beds (Subtract B from A)	
D. Reason for delicensing of beds (Enter a short description for the reason facility is declicensing Medicaid beds.)	

3. Attestations

a. **Legal Entity:** This assures that Applicant is a Rhode Island corporation or other legal entity able to accept an agreement with the State.

b. **Nursing Staff Posting Requires:** Applicant attests that in accordance with 216-RICR-40-10-1.16.7(F)1 and 216_RICR-10-1.16.7(F)3 the facility has not been cited for deficiency or subjected to an immediate compliance order to increase staff in accordance with R.I Gen. Laws §23-1-21 within two years from the date of this application

c. **Comply with the Federal Minimum Data Set (MDS):** Applicant commits to completing Section Q for all residents and actively participating in nursing facility transition initiatives including the Money Follows the Person (MFP) and the Care Transitions Program. Providers will need to submit a monthly referral list to EOHHS in accordance with EOHHS specifications.

d. **Not request additional increases in licensed bed capacity:** Applicant attests they will not request additional increases in licensed Medicaid bed capacity from one year of the date of this request.

_____ _____

Signature Date (MM/DD/YY)

4. Acknowledgement

By submitting this application for a change in Licensed Medicaid Beds, I acknowledge that I am authorized to submit this request on behalf of the business and that all the information provided is accurate to the best of my knowledge and ability. I acknowledge the State of Rhode Island is relying upon the information as submitted in order to determine whether an increase or descrease in licensed beds will be approved. Therefore, if I become aware of any inaccuracies in the information provided, I will immediately notify the State of Rhode Island through email at OHHS.LTSSLicensedBeds@ohhs.ri.gov.

_____ _____

Signature Date (MM/DD/YY)

_____

Name & Title