

Attachment 3
Change in Service



Massachusetts Department of Public Health Determination of Need Change in Service

Application Number:

Original Application Date:

Applicant Information

Applicant Name:

Contact Person: Title:

Phone: Ext: E-mail:

Facility: Complete the tables below for each facility listed in the Application Form

1 Facility Name: CMS Number: Facility type:

Change in Service

2.2 Complete the chart below with existing and planned service changes. Add additional services with in each grouping if applicable.

Add/Del Rows		Licensed Beds		Change in Number of Beds (+/-)		Number of Beds After Project Completion (calculated)		Patient Days	Patient Days	Occupancy rate for Operating Beds		Average Length of Stay (Days)	Number of Discharges	Number of Discharges
		Existing	Existing	Licensed	Operating	Licensed	Operating	(Current/Actual)	Projected	Current Beds	Projected	(Days)	Actual	Projected
	Acute													
	Medical/Surgical									0%	0%			
	Obstetrics (Maternity)									0%	0%			
	Pediatrics									0%	0%			
	Neonatal Intensive Care									0%	0%			
	ICU/CCU/SICU									0%	0%			
<input type="button" value="+"/> <input type="button" value="-"/>										0%	0%			
	Total Acute									0%	0%			
	Acute Rehabilitation									0%	0%			
<input type="button" value="+"/> <input type="button" value="-"/>										0%	0%			
	Total Rehabilitation									0%	0%			
	Acute Psychiatric													

Add/Del Rows		Licensed Beds		Change in Number of Beds (+/-)		Number of Beds After Project Completion (calculated)		Patient Days	Patient Days	Occupancy rate for Operating Beds		Average Length of Stay (Days)	Number of Discharges	Number of Discharges
		Existing	Existing	Licensed	Operating	Licensed	Operating	(Current/ Actual)	Projected	Current Beds	Projected		Actual	Projected
	Adult	20	20	28	28	48	48	6,464	16,043	89%	92%	9.88	531	1,763
	Adolescent									0%	0%			
	Pediatric									0%	0%			
	Geriatric			36	36	36	36		12,048	0%	92%			1,004
<input type="checkbox"/> + <input type="checkbox"/> -										0%	0%			
	Total Acute Psychiatric	20	20	64	64	84	84	6,464	28,091	89%	92%	9.88	531	2,767
	Chronic Disease									0%	0%			
<input type="checkbox"/> + <input type="checkbox"/> -										0%	0%			
	Total Chronic Disease									0%	0%			
	Substance Abuse													
	detoxification									0%	0%			
	short-term intensive									0%	0%			
<input type="checkbox"/> + <input type="checkbox"/> -										0%	0%			
	Total Substance Abuse									0%	0%			
	Skilled Nursing Facility													
	Level II									0%	0%			
	Level III									0%	0%			
	Level IV									0%	0%			
<input type="checkbox"/> + <input type="checkbox"/> -										0%	0%			
	Total Skilled Nursing									0%	0%			

2.3 Complete the chart below if there are changes other than those listed in table above.

Add/Del Rows	List other services if Changing e.g. OR, MRI, etc	Existing Number of Units	Change in Number +/-	Proposed Number of Units	Existing Volume	Proposed Volume
<input type="checkbox"/> + <input type="checkbox"/> -						

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To submit the application electronically, click on the "E-mail submission to Determination of Need" button.

This document is ready to file:

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E-mail submission to
Determination of Need