



Massachusetts Department of Public Health
Determination of Need
Change in Service

Version: DRAFT
6-14-17

DRAFT

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	Operating Beds	Change in Number of Beds (+/-)		Number of Beds After Project Completion (calculated)		Patient Days (Current/ Actual)	Patient Days Projected	Occupancy rate for Operating Beds		Average Length of Stay (Days)	Number of Discharges	Number of Discharges
		Existing	Existing	Licensed	Operating	Licensed	Operating			Current Beds	Projected		Actual	Projected
	Acute													
	Medical/Surgical	83	83	0	0	83	83	13,148	12,605	43%	42%	2.8	4,664	4,066
	Obstetrics (Maternity)	0	0	0	0	0	0			0%	0%			
	Pediatrics	0	0	0	0	0	0			0%	0%			
	Neonatal Intensive Care	0	0	0	0	0	0			0%	0%			
	ICU/CCU/SICU	6	6	0	0	6	6	1,496	1,483	68%	68%	5.8	257	396
+	-									0%	0%			
	Total Acute	89	89	0	0	89	89	14,644	14,088	45%	43%	8.6	4,921	4,462
	Acute Rehabilitation									0%	0%			
+	-									0%	0%			
	Total Rehabilitation									0%	0%			
	Acute Psychiatric													

Add/Del Rows		Licensed Beds	Operating Beds	Change in Number of Beds (+/-)		Number of Beds After Project Completion (calculated)		Patient Days (Current/ Actual)	Patient Days Projected	Occupancy rate for Operating Beds		Average Length of Stay (Days)	Number of Discharges	Number of Discharges
		Existing	Existing	Licensed	Operating	Licensed	Operating			Current Beds	Projected		Actual	Projected
	Adult	30	30	0	0	30	30	8,806	8,412	80%	77%	8.1	1,088	1,062
	Adolescent	0	0	0	0	0	0			0%	0%			
	Pediatric	0	0	0	0	0	0			0%	0%			
	Geriatric	0	0	0	0	0	0			0%	0%			
<input type="checkbox"/> + <input type="checkbox"/> -										0%	0%			
	Total Acute Psychiatric	30	30	0	0	30	30	8,806	8,412	80%	77%	8.1	1,088	1,062
	Chronic Disease	0	0	0	0	0	0			0%	0%			
<input type="checkbox"/> + <input type="checkbox"/> -										0%	0%			
	Total Chronic Disease	0	0	0	0	0	0			0%	0%			
	Substance Abuse													
	detoxification	0	0	0	0	0	0			0%	0%			
	short-term intensive	0	0	0	0	0	0			0%	0%			
<input type="checkbox"/> + <input type="checkbox"/> -		0	0			0	0			0%	0%			
	Total Substance Abuse	0	0	0	0	0	0			0%	0%			
	Skilled Nursing Facility													
	Level II	0	0	0	0	0	0			0%	0%			
	Level III	0	0	0	0	0	0			0%	0%			
	Level IV	0	0	0	0	0	0			0%	0%			
<input type="checkbox"/> + <input type="checkbox"/> -										0%	0%			
	Total Skilled Nursing	0	0	0	0	0	0			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"/> -	Cat Scan							2	1	3	15,912	15,912		

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

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