



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 | | 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 | | | | | | | | | | | | | | |
| <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 (Current/Actual) | Patient Days Projected | Occupancy rate for Operating Beds | | Average Length of Stay (Days) | Number of Discharges Actual | Number of Discharges Projected |
|---|---------------------------------|---------------|--------------------|--------------------------------|-----------|--|-----------|-------------------------------|------------------------|-----------------------------------|-----------|-------------------------------|-----------------------------|--------------------------------|
| | | Existing | Operating Existing | Licensed | Operating | Licensed | Operating | | | Current Beds | Projected | | | |
| | Adult | | | | | | | | | 0% | 0% | | | |
| | Adolescent | | | | | | | | | 0% | 0% | | | |
| | Pediatric | | | | | | | | | 0% | 0% | | | |
| | Geriatric | | | | | | | | | 0% | 0% | | | |
| <input type="checkbox"/> + <input type="checkbox"/> - | | | | | | | | | | 0% | 0% | | | |
| | Total Acute Psychiatric | | | | | | | | | 0% | 0% | | | |
| | 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"/> - | Addition of 3 operating rooms and 3 procedure rooms | 0 | 6 | 6 | 0 | 4,180 |

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

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Date/time Stamp: 06/11/2018 9:35 am

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Determination of Need