



## 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
	<b>Acute</b>													
	Medical/Surgical									0%	0%			
	Obstetrics (Maternity)									0%	0%			
	Pediatrics									0%	0%			
	Neonatal Intensive Care									0%	0%			
	ICU/CCU/SICU									0%	0%			
+	-									0%	0%			
	<b>Total Acute</b>									0%	0%			
	<b>Acute Rehabilitation</b>									0%	0%			
+	-									0%	0%			
	<b>Total Rehabilitation</b>									0%	0%			
	<b>Acute Psychiatric</b>									0%	0%			

Add/Del Rows		Licensed Beds	Operating 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									0%	0%			
	Adolescent									0%	0%			
	Pediatric									0%	0%			
	Geriatric									0%	0%			
+ -										0%	0%			
	<b>Total Acute Psychiatric</b>									0%	0%			
	<b>Chronic Disease</b>									0%	0%			
+ -										0%	0%			
	<b>Total Chronic Disease</b>									0%	0%			
	<b>Substance Abuse</b>													
	detoxification									0%	0%			
	short-term intensive									0%	0%			
+ -										0%	0%			
	<b>Total Substance Abuse</b>									0%	0%			
	<b>Skilled Nursing Facility</b>													
	Level II									0%	0%			
	Level III									0%	0%			
	Level IV									0%	0%			
+ -										0%	0%			
	<b>Total Skilled Nursing</b>									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
+ -	Changing from 1 OR and 1 procedure room to 2 OR's and 1 procedure room	1	1	2	1,400	1,600
+ -						

### Document Ready for Filing

When document is complete click on "document is ready to file". This will lock in the responses and date and time stamp the form. To make changes to the document un-check the "document is ready to file" box. Edit document then lock file and submit. Keep a copy for your records. Click on the "Save" button at the bottom of the page.

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

This document is ready to file:



Date/time Stamp: 08/14/2020 12:25 pm

E-mail submission to  
Determination of Need