NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH, LICENSURE UNIT
NEBRASKA HEALTH CARE CERTIFICATE OF NEED
APPLICATION FOR ADDITIONAL LONG-TERM CARE BEDS

Applicant Facility Name to be Licensed by DHHS: _____

Applicant Facility Address: _____

Applicant Facility City, State, Zip: _____

Applicant Corporate/Entity Name: _____

Applicant Contact Person: _____

Contact Email Address: _____

Contact Phone #: _____

Applicable CON Section:

_____ Medical and Nursing Needs Exception - Neb. Rev. Stat. § 71-5829.04 (1)(a)
Please attach documentation which shows: 1) the unmet need for complex or intensive medical/nursing services; 2) proposed care and treatment; 3) population demographics; 4) staffing; and 5) environment.

_____ Occupancy Over 90% Exception - Neb. Rev. Stat. § 71-5829.04 (1)(b)
Please attach documentation which shows: 1) the estimated occupancy rates for facilities within a 25-mile radius for the previous three reporting quarters; and 2) population demographics.

_____ Sale or Transfer Exception - Neb. Rev. Stat. § 71-5829.04 (1)(b)
Please attach documentation which shows: 1) the number of long-term care beds sold or transferred more than 25 miles away from the facility (summary of situation is sufficient); 2) that the facility's location is in a second-class city or a village (population according to Census); 3) that there are no more long-term care beds within the corporate limits of the city/village (signed statement from applicant contact person is sufficient); 4) that the applicant entity is a political subdivision or nonprofit organization (include copies of approved incorporation or similar documents); and 5) that the applicant entity will not sell or increase the number of long-term care beds for five years from the occupancy date (signed statement from applicant contact person is sufficient).

Number of New Beds Requested: _____ Anticipated Licensure Date: _____

Project Summary:

I certify that I am authorized to represent the applicant entity. To the best of my knowledge, all information on the application and attached documentation is true and correct.

_____ _____ _____
Signature of CON Applicant Contact Person Title Date

Please submit this form to the address shown below, with the CON application fee of $1,000 and any relevant supporting documentation. The CON application fee is nonrefundable, and must be a check or money order.

Heidi Burklund, CON Program Manager
Licensure Unit, Division of Public Health
NE Dept of Health and Human Services
301 Centennial Mall South, 1st Floor
P.O. Box 94986
Lincoln, NE 68509-4986

Questions? Please call 402-471-4963 or send an email to Heidi.Burklund@nebraska.gov.