Request for Licensed & Medicare/Medicaid Bed Changes and Bed Relocations

Facility Name:	Facility License #
Street Address:	Provider #
City, State, Zip	Effective Date:
Fiscal Intermediary:	End of Cost Reporting Year:
Contact Person:	Telephone # ( )

Attach Current & Proposed Floor Plans (Include room numbers and number of beds in each).

Section 1. <u>Current</u> Bed Configuration

*Example: Rooms 1-10, 12, 14-16 and 19 (1 bed each); Rooms 11, 15 and 20-30 (2 beds each).

Title 18 only Medicare (SNF) only Beds _____	_____ _____ _____
Title 18/19 Medicare/Medicaid (SNF/NF) Beds_____	_____ _____ _____ _____
Title 19 only Medicaid (NF) only Beds_____	_____ _____ _____
Licensed-only Beds_____	_____ _____ _____
Total Licensed Beds_____	

Facility Name_____ **Facility License #**_____

Section 2. <u>Proposed</u> Bed Configuration
*****Example: Rooms 1-10, 12, 14-16 and 19 (1 bed each); Rooms 11, 15 and 20-30 (2 beds each).

Title 18 only Medicare (SNF) only Beds _____	_____ _____ _____
Title 18/19 Medicare/Medicaid (SNF/NF) Beds_____	_____ _____ _____ _____
Title 19 only Medicaid (NF) only Beds_____	_____ _____ _____
Licensed-only Beds_____	_____ _____ _____
Total Licensed Beds_____	

Signature:_____ **Date**_____

Submit your request to:

Nebraska Department of Health & Human Services
Licensure Unit
Office of Long Term Care Facilities
PO Box 94986, 301 Centennial Mall South
Lincoln NE 68509-4986

Requests may be submitted by FAX to (402) 471-0555.
For Related questions, please contact (402) 471-0309.