Washington State Department of Health

| FOR DEPARTMENT USE ONLY |
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| *Date Stamp Here*<br><br>Fee Received:_____<br>Check #: _____<br><br>Initials_____ |

# NURSING HOME ALTERNATIVE USE BED BANKING EXTENSION NOTICE

The following information will be used to evaluate the conformance of the project with all applicable review criteria contained in Revised Code of Washington (RCW), 70.38.111 Washington Administrative Code (WAC) 246-310-395 and WAC 246-310-580.

**Alternate Use Bed Banking Extension notices must be submitted with a fee in accordance with WAC 246-310-990 and the completed invoice on page 2 of this form.**

This notice is made for Nursing Home Bed Banking for Alternative Use-Extension in accordance with provisions in RCW 70.38, WAC 246-310-395 and WAC 246-310-580, rules and regulations adopted by the Washington State Department of Health. I hereby certify that the statements made in this notice are correct to the best of my knowledge and belief.

_____

Name of the Nursing Home (facility)

_____

Name of the facility's Licensee

_____ _____

**Print** Name of person making the request Telephone Number

_____ _____

Title of person making the request Relationship to licensee

**I understand that any evasion or suppression of material facts, misrepresentation, false statements or misleading statements regarding any of the information contained in this notice shall be grounds for actions under the provisions of WAC 246-310-500 and forfeiture of the beds.**

_____ _____

Signature of Licensee Date

Address:

_____

_____

_____

_____

**Invoice for Submission of Alternate Use Bed Banking Extension Request**

1. This form must be accompanied by a check payable to: ***The Department of Health*** for the review fee as identified below.

2. Complete the following prior to submission for review:

REVIEW FEE: _____ (Refer to fee schedule)

APPLICANT NAME:_____

DATE OF SUBMISSION:_____CHECK NUMBER:_____

3. Mail **Original**, signed notice and payment to:

**Department of Health**
**Certificate of Need Program**
**310 Israel Road SE**
**Tumwater, Washington 98501**
**or**
**Department of Health**
**Certificate of Need Program**
**P O Box 47852**
**Olympia, Washington 98504-7852**

# WASHINGTON STATE CERTIFICATE OF NEED PROGRAM
# RCW 70.38 AND WAC 246-310

## ALTERNATE USE BED BANKING EXTENSION NOTICE REQUIREMENTS

The following information will be used to evaluate the conformance of the project with all applicable review criteria contained in Revised Code of Washington (RCW) 70.38.111 and Washington Administrative Code (WAC) 246-310-580.

**Bed Banking Extension notices must be submitted a minimum of 90 days prior to the end of the bed banking period with the fee in accordance with WAC 246-310-990**

Information Requirements

1. For the entire facility, please provide a **current** facility room listing showing each room, its room number, its use, the number of beds in each room, and whether the room is Medicare certified.

2. For the entire facility, please provide a floor diagram of the **current** facility room listing showing each room, its room number, its use, the number of beds in each room and whether the room is Medicare certified. **PLEASE NOTE**: The diagrams provided must be clearly readable.

3. Please complete the table below for the banked beds proposed to be extended. (Attached Additional Pages if necessary).

| Room Number | Current # of Beds in Room (Before Bed Banking) | # of Beds to Bank | Purpose of Proposed Bed Banking | # of Beds Remaining in Room (if any) |
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| Total | | | | |

4. Is the existing licensee the building owner? _____Yes _____No. **(If yes, go to question 6)**

5. Does the building have a secured interest in the nursing home bed rights? _____Yes _____No. In the event the existing nursing home licensee is not the building owner, the licensee shall provide:

a) If the building owner has a secured interest in the bed rights, an **original** written statement signed by the building owner indicating the building owner's approval of the bed reduction extension,

**OR**

b) If the building owner does not have a secured interest in the bed rights, a copy of the notice sent to the building owner by the licensee informing the building owner of the planned bed reduction extension.

6. If the purpose of banking the beds was to provide an alternate service(s), please identify the date the alternate service was implemented.

7. If the alternate service has not been implemented, please explain in detail what steps have been taken toward implementing the alternate service(s).

8. If the answer to question 7 is nothing or nothing currently, please explain why.

9. If the answer to question 7 is nothing or nothing currently, please explain why the department should grant the extension request when the alternate service has not been implemented.

**By submitting this extension request, I understand that the Certificate of Need statute permits only one extension. At the end of any approved extension timeline, I must either re-license the beds for patient care within the same nursing facility or relinquish the beds.**