IOWA DEPARTMENT OF PUBLIC HEALTH
CERTIFICATE OF NEED
CONVERSION OF ICF/ID BEDS
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1. Name of Facility ____

2. Address____
Street City County Zip

3. Contact Person______________________________ (_____)___________________
Name Telephone

Email ______________________________________

4. Date of conversion ___________________

5. State how many beds will be converted to a smaller facility environment. The number of beds must be consistent with bed totals reported to the Department of Inspections and Appeals for purposes of licensure and certification.

6. Explain why the beds can be converted without creating a hardship for the facility or the individuals served.

A. Describe your current bed inventory by category and provide occupancy percentages by category for the past year.

B. Project future utilization of the converted beds.

7. Explain any other advantages or disadvantages to your residents or facility which may result following the conversion of beds, e.g. more flexible scheduling of staff, different reimbursement basis, more appropriate use of space.

AUTHORIZATION: Signatures of Administrator and Chairperson of the Board of Directors.

Administrator

Board Chairperson

Date

If this form is not completed and submitted at least thirty days before the conversion, the facility is subject to review as a new or changed institutional health service under section 135.61(18)d and subject to sanctions under section 135.73.

588-1031 BEDCON (11/18)