IOWA DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF NEED
CLOSURE OF AN INSTITUTIONAL
HEALTH FACILITY
==========

1. Name of Facility _____

2. Address_____
Street City County Zip

3. Contact Person_____ (____)_____
Name Telephone

Email _____

4. Date of closure _____

5. Current number of beds _____

6. State the reasons for the closure, include the number of beds and the services to be eliminated in the county as a result.

7. Explain why services offered by the facility can be eliminated without creating a hardship for the community or the individuals served.

8. Explain any other advantages or disadvantages to your residents or community which may result from the closure of the facility.

9. **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 closure the facility is subject to review as a new or changed institutional health service under section 135.61(18)f and subject to sanctions under section 135.73.