BREAKDOWN OF ROOM NUMBERS AND BEDS WITHIN THOSE ROOMS

NAME OF FACILITY: _____ TOWN: _____ PROVIDER NUMBER: NH0_____

If there is a change in beds or room numbers, what is the effective date of the change:_____

Room Number	# of Beds within Room	Medicare Medicaid	Medicaid Only	Medicare Only	*Licensed Only		Room Number	# of Beds within Room	Medicare Medicaid	Medicaid Only	Medicare Only	*Licensed Only

INSTRUCTIONS: Complete and email to your licensure contact for bed changes, initial application, or Change of Ownership (CHOW)
Total the beds for the different classifications (Medicare, Medicaid, etc.) at the bottom of the continuation page. The administrator ***must sign and date*** the form on page 2
***** Identify type of beds Nursing Home (NH) or Adult Care Home (ACH)

BREAKDOWN OF ROOM NUMBERS AND BEDS WITHIN THOSE ROOMS

NAME OF FACILITY: _____ TOWN: _____ PROVIDER NUMBER: NH0_____

If there is a change in beds or room numbers, what is the effective date of the change: _____

Room Number	# of Beds within Room	Medicare Medicaid	Medicaid Only	Medicare Only	*Licensed Only		Room Number	# of Beds within Room	Medicare Medicaid	Medicaid Only	Medicare Only	*Licensed Only

TOTAL

Medicare/Medicaid = _____(Beds) Medicaid Only = _____(Beds)

Medicare Only =_____(Beds) Licensed Only = _____(Beds)

FOR YOUR INFORMATION: Adult Care Home beds cannot be certified in Medicare nor Medicaid

***Identify type of beds Nursing (NH) or Adult Care Home (ACH)**

Administrator's Signature _____ Date _____