Request For Bed Changes And Bed Relocations

Revised October 23, 2001

The facility must adhere to the procedures and timeframes outlined in Provider Letter 01-39. Failure to follow the outlined procedures and timeframes could jeopardize the request and effective date. For any request to be considered complete, all accompanying information must be received with the request. Incomplete requests will not be processed. All requests must be signed and dated.

Facility Name:____ Facility ID #__________________

Street Address:____ Provider #____________________

City:______________________________ Zip Code:____________ Tentative Effective Date:__________

Fiscal Intermediary:____ Fiscal Year End Date:___________
(Indicate NA if not applicable) (Also known as cost-reporting year)

Name of Contact Person:_______________________________________ Telephone # (____)____________

ATTACH CURRENT AND PROPOSED FLOOR PLANS

Section 1. CURRENT BED CONFIGURATION

List room numbers and include the number of beds in each room. Example: **Rooms 1-10:** 2 beds each; **Room 11:** 4-bed ward; **Rooms 12 & 13:** 2 beds each; **Room 14:** 1 bed; **Rooms 15-25:** 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 __________	

Request for Bed Changes and Bed Relocations

Facility Name:____**Facility ID #:**______________

ATTACH CURRENT AND PROPOSED FLOOR PLANS

Section 2. PROPOSED BED CONFIGURATION

List room numbers and include the number of beds in each room. Example: **Rooms 1-10:** 2 beds each; **Room 11:** 4-bed ward; **Rooms 12 & 13:** 2 beds each; **Room 14:** 1 bed; **Rooms 15-25:** 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:

Texas Department of Human Services
Facility Enrollment
Long Term Care Regulatory (E-342)
P.O. Box 149030
Austin, Texas 78714-9030

or, overnight to:

Texas Department of Human Services
Facility Enrollment
Long Term Care-Regulatory (E-342)
701 West 51st Street
Austin, Texas 78751

For related questions, please contact Facility Enrollment at (512) 438-2630.
Requests may be submitted by FAX to (512) 438-2728.