

**SUBMIT THIS FORM AND ALL SUPPORTING DOCUMENTS TO:**

**Department of Human Services  
Office of Long-Term Living  
Bureau of Finance  
Participation Review Unit  
Forum Place, 6<sup>th</sup> Floor  
P.O. Box 8025  
Harrisburg, Pennsylvania 17105-8025**

**REPLACEMENT BED REQUEST**

*This form is to be completed by all Medical Assistance (MA) certified Nursing Facility providers who intend to seek capital component payments under the November 29, 1997 Nursing facility replacement beds - statement of policy. (See 55 Pa. Code §1187.113a at <http://www.pacode.com/secure/data/055/chapter1187/s1187.113a.html>). Please complete in full and provide documentation as appropriate to substantiate the information provided. Shaded areas will be completed by Department of Human Services (DHS) once verification is received.  
Any questions, please contact our email account at: [RA-PartReview@pa.gov](mailto:RA-PartReview@pa.gov).*

**NURSING FACILITY INFORMATION**

Facility Name MA ID#  
Address  
City State Zip Code  
County Telephone #  
Date Facility was Built Owner  
Request Submitted by: Title

**Contact Person Information:**

Name  
Affiliation to Nursing Facility  
Address  
City State Zip Code  
Telephone # Fax #  
Email Address

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

<b>DHS Use Only</b>		
Occ Report _____	Total: _____	MA: _____

## PROJECT SUMMARY DATA

- |     |  | FOR DHS USE ONLY         |
|-----|--|--------------------------|
| 1.  | # of Certified Beds in the Facility  | <input type="checkbox"/> |
| 2.  | # of Pre-moratorium Beds<br>(currently receiving capital component payments)   | <input type="checkbox"/> |
| 3.  | # of Replacement Beds requested  |                          |
| 4.  | Are the beds to be replaced currently certified?   | <input type="checkbox"/> |
| 5.  | Are the beds to be replaced pre-moratorium beds?   | <input type="checkbox"/> |
| 6.  | Have any Corporate Integrity Agreements been negotiated with<br>OLTL? If yes, please explain   | <input type="checkbox"/> |
| 7.  | Are there any DOH licensure violations? If yes, please explain   | <input type="checkbox"/> |
| 8.  | If the project involves replacement of only some of the facility's beds, are the replacement beds attached or immediately adjacent to the existing facility?   |                          |
| 9.  | Will MA residents have access to private rooms created as a result of this project?  |                          |
| 10. | Does the facility understand and provide assurance that the beds will be decertified and closed permanently effective the same date the replacement beds are certified?  |                          |
| 11. | What is the projected completion date for this project?  |                          |
| 12. | Do licensure violations exist that will not be corrected by this project?<br>please identify the violations that won't be corrected and explain why.   | If yes,                  |
| 13. | If the project involves total replacement of all beds, are the replacement beds being constructed within a one-mile radius of the existing structure in which the beds that are being replaced are situated? If not, please explain any exceptional circumstances. |                          |

## PROJECT SUMMARY NARRATIVE

I Summary of the Replacement Bed project:

## II Guidelines for Replacement Bed projects:

A. Describe why the construction of replacement beds is necessary to ensure the health, safety and welfare of the facility's residents.

B. (1) Address whether, and to what extent, building code violations or other regulatory conditions, including Americans with Disabilities Act (ADA) compliance, exist at the facility requiring the construction of all of the replacement beds.

(2) Will the replacement project remove the need for any existing waivers and building code exceptions? If yes, please provide a copy of the code violation waiver/exceptions.

C. (1) What consideration has been given to the development of Home and Community Based Services (HCBS) in lieu of replacing some or all of the NF beds?

(2) Is the nursing facility an Aging Waiver provider?

If not, is the facility willing to become an Aging Waiver provider?

If so, what Aging services is the facility willing to provide?

(3) What other type of services are part of the facility's continuum of care?

D. Will the project be completed in phases?

If yes, please provide a detailed timeline and the number of beds involved in each phase.

E. How much will it cost to complete this project?

If new construction is being proposed, provide information along with documentation on the cost to construct a new facility or wing vs. cost to renovate the existing facility. Clearly identify if demolition costs are included in the cost estimate for new construction and provide documentation to verify all cost estimates.

F. Describe how the area to be replaced will be utilized.