**Department of Health Services State of Wisconsin**

Division of Quality Assurance Wis. Stat. § Ch. 150

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# Application for Redistribution of Closed Nursing Home Beds

Instructions: Completion of this form is required by Chapter 150, Wis. Stat. Only existing nursing homes licensed under DHS 132, Wis. Admin. Code are eligible to apply. All documentation must be submitted at the time of application along with the required fee. Approvals are not transferrable and do not change the nursing home’s Medicaid daily payment rates.

Submit the application form, two recommendations from affected parties (F-03405), and supplemental documentation to [dhsdqabnhrclicensing@dhs.wisconsin.gov](mailto:dhsdqabnhrclicensing@dhs.wisconsin.gov). The recommendations from affected parties (F-03405) must be submitted by the affected party to [dhsdqabnhrclicensing@dhs.wisconsin.gov](mailto:dhsdqabnhrclicensing@dhs.wisconsin.gov). The appropriate fee must be paid to Division of Quality Assurance Box 93679 Milwaukee, WI 53293-0679.

### Contact person

Provide the name and contact information of the person DHS can contact regarding questions about this application.

Name:       Title:

Address – Street (physical):

City:       State:       ZIP code:

Mailing address (if different from physical address):

City:       State:       ZIP code:

Phone number:       Email:

### General information

Provide general information on the facility that is applying for nursing home beds.

Facility name:       License number:

Address – Street (physical):

City:       County:       State:    ZIP code:

Mailing address (if different from physical address):

City:       State:       ZIP code:

### Bed capacity and request

Provide information about the request for closed nursing home beds.

Current licensed bed capacity:

Number of closed nursing home beds requested:

Total bed capacity request:

### Project description

Provide information about how the facility plans to incorporate the new beds.

Describe how the facility plans to add the redistributed beds. For example, will the facility add the beds to an existing space in the building, construct a new wing, etc.

Estimated project cost to add requested beds. Wis. Stat. 150.39(2):

Cost per bed requested. Wis. Stat. 150.39(2):

### Justification

Justify the need for additional beds and demonstrate the applicant meets the criteria outlined in Wis. Stat. 150.39.

Justify the need for this request. Include the following information in your justification:

* The need for additional beds in the health planning area. Wis. Stat. 150.39(4)
* How the project is consistent with local plans for developing community-based services to provide long-term care. Wis. Stat. 150.39(5)
* The availability of appropriate methods alternative to providing nursing home care in the health planning area. Wis. Stat. 150.39(8)

**Optional:** include supplemental documentation to justify the need.

Describe the availability of health care personnel, capital and operating funds and other resources that are needed to increase the nursing home’s licensed bed capacity. In your response, demonstrate that the proposed staffing and funding of this facility is sufficient to sustain this change. Wis. Stat. 150.39(6)

**Optional:** include supplemental documentation to justify the need.

**Optional:** Provide response and/or supplemental documentation that demonstrate the quality of care to be provided is satisfactory. This may include independent evaluations of performance in nursing homes owned or operated by the applicant and patient satisfaction surveys. Wis. Stat. 150.39(10)

### Recommendations

Provide at least two recommendations from affected parties concerning the quality of care provided in nursing homes owned or operated by the applicant. The affected party must submit the recommendation using F-03405 to [dhsdqabnhrclicensing@dhs.wisconsin.gov](mailto:dhsdqabnhrclicensing@dhs.wisconsin.gov). Wis. Stat. 150.39(10)(c)

“Affected party” means the applicant, local planning agencies, governmental agencies, other persons providing similar services in the applicant’s service area, the public to be served by the proposed project, 3rd-party payers and any other person who the department determines to be affected by an application for approval of a project. Wis. Stat. 150.01(2)

**Affected party 1**

Name of party:       Affiliation:

Phone number:       Email:

**Affected party 2**

Name of party:       Affiliation:

Phone number:       Email:

### Attestation

I attest that I have included all information required and attest that the information provided is truthful and accurate to the best of my knowledge.

**Signature (Full)** — Applicant:

Name — Applicant (print or type):

Title — Applicant:       Date signed: