CLEAR

State of California-Health and Human Services Agency | California Department of Public Health

BED OR SERVICE REQUEST

Date

This form is intended to identify the types of beds or services requested for adult day health center, acute psychiatric hospitals, general acute care hospitals, special hospitals and skilled nursing facilities. For new facilities, complete the column marked "Requested Beds." For existing facilities, complete both columns. The form is to accompany the application form (HS 200) for any new facility, change in capacity, service, or bed classification.

Name of facility	Type		
Address (number, street)	City	State	ZIP code

Please enter the number of beds requested for each category:

EXISTING BEDS

_____ Acute Respiratory Care Services
_____ Burn Center
_____ Cardiovascular Surgery Service
_____ Coronary Care Unit
_____ General Acute Care (Unspecified)
_____ General Nursing (Long-Term)
_____ Intensive Care (Newborn)
_____ Intensive Care Unit
_____ Pediatric Service
_____ Perinatal Unit
_____ Psychiatric Unit
_____ Rehabilitation Center
_____ Renal Transplant Center
_____ Respiratory Care Service
_____ Skilled Nursing Service (DP)
_____ Other (specify) _____
_____ Other (specify) _____

_____ **APPROVED CAPACITY**

REQUESTED BEDS

_____ Acute Respiratory Care Services
_____ Burn Center
_____ Cardiovascular Surgery Service
_____ Coronary Care Unit
_____ General Acute Care (Unspecified)
_____ General Nursing (Long-Term)
_____ Intensive Care (Newborn)
_____ Intensive Care Unit
_____ Pediatric Service
_____ Perinatal Unit
_____ Psychiatric Unit
_____ Rehabilitation Center
_____ Renal Transplant Center
_____ Respiratory Care Service
_____ Skilled Nursing Service (DP)
_____ Other (specify) _____
_____ Other (specify) _____

_____ **APPROVED CAPACITY** (For Departmental use only)

Please check services which the facility currently provides or is requesting:

EXISTING SERVICES

_____ Adult Day Program (only applies to an ADHC)
_____ Basic Emergency Physician on Duty
_____ Cardiovascular Surgery
_____ Chronic Dialysis Service
_____ Comprehensive Emergency
_____ Dental Service
_____ Nuclear Medicine Service
_____ Occupational Therapy Service
_____ Outpatient Service (i.e. Family Practice, Pediatrics, Primary Care, Rural Health Clinic, etc.)
Specify: _____
Specify: _____
_____ Physical Therapy
_____ Podiatric Service
_____ Radiation Therapy
_____ Social Service
_____ Speech Pathology and/or Audiology Service
_____ Other (specify): _____
_____ Other (specify): _____

REQUESTED SERVICES

_____ Adult Day Program (only applies to an ADHC)
_____ Basic Emergency Physician on Duty
_____ Cardiovascular Surgery
_____ Chronic Dialysis Service
_____ Comprehensive Emergency
_____ Dental Service
_____ Nuclear Medicine Service
_____ Occupational Therapy Service
_____ Outpatient Service (i.e. Family Practice, Pediatrics, Primary Care, Rural Health Clinic, etc.)
Specify: _____
Specify: _____
_____ Physical Therapy
_____ Podiatric Service
_____ Radiation Therapy
_____ Social Service
_____ Speech Pathology and/or Audiology Service
_____ Other (specify): _____
✔ Other (specify): _____