Schedule 7E
Decertification of Bed Capacity

Instructions: Use this application to request the decertification of any Adult Care Facility, Assisted Living Residence, Enhanced Assisted Living Residence, Special Needs Assisted Living Residence and Assisted Living Program beds. If the decertification project requires construction, additional submissions may be requested.

Facility Information

FACILITY NAME | TYPE OF FACILITY

STREET AND NUMBER

CITY | COUNTY | ZIP

Operator Information

OPERATING CERTIFICATE NUMBER | OPERATOR

STREET AND NUMBER

CITY | COUNTY | ZIP

Contact Information

NAME AND TITLE

STREET AND NUMBER

CITY | STATE | ZIP

E-MAIL ADDRESS | TELEPHONE | FAX

Program Configuration:

Type	☐ AH	☐ EHP	☐ ALP	☐ ALR	☐ EALR	☐ SNALR
Current Number of Beds						
Proposed Number of Beds						

Schedule 7E - Decertification of Bed Capacity

1. Explain the reason for decertification of the beds. Indicate whether the beds being decertified are currently occupied. If the beds are occupied, describe the plan and timetable for transferring residents to an appropriate setting.

2. Will this change result in a change to your staffing schedule? ☐ Yes ☐ No

   If yes, attach a copy of the new staffing schedule.

   ☐ Attachment #_____.

3. Does your project involve renovations? ☐ Yes ☐ No

   If yes, attach a resident safety plan that describes the work to be completed, the duration of the project and the measures taken to protect residents during that time. (Additional submission may be required).

   ☐ Attachment #_____.

Certification of Applicant

I declare that to the best of my knowledge all information provided herein is true, correct and complete. Further, if this application is approved, I agree to operate the facility in accordance with all Department regulations and the proposal contained herein.

SIGNATURE DATE

PRINT OR TYPE NAME

TITLE