DEPARTMENT OF HEALTH

Nursing Home (NH) Bed Changes – Notice Form

Complete all the following information.

Health Facility Identification Number (HFID): _____

CMS Certification Number (CCN): _____

Nursing Home Doing Business As (DBA) name: _____

Current number of active nursing home beds: _____

Current number of nursing home beds on layaway status: _____

Bed Layaway

Number of beds to place on layaway status: _____

- Effective date: _____
- This request requires a 60-day notice prior to the effective date.

Bed Delicensure

Total number of beds to delicense: _____

- Number of these beds currently on active status: _____
- Number of these beds currently on layaway status: _____
- Effective date: _____
- Note: Beds will be permanently delicensed.

Bed Relicensure

Number of beds to relicense: _____

- Effective date: _____
- This request requires a 60-day notice prior to the effective date.

Instructions for bed relicensure from layaway status.

1. Submit Payment for Bed Relicensure

   A fee of $142.00 per bed is required for each bed being relicensed from layaway status.

   Make check payable to "**Minnesota Department of Health**" (MDH) and include the request form.

2. Mail payment to:

   Minnesota Department of Health
   Health Regulation Division
   P.O. Box 64900
   St. Paul, MN 55164-0900

3. Engineering Department Approval

   Begin the relicensure process with the MDH Engineering Services Section. Detailed instructions including the applicable fee, are available on the MDH Layaway/Active Status Bed Plan Submitted Process (https://www.health.state.mn.us/facilities/regulation/engineering/layaway.html).

   Important: Submit a separate check for the engineering fee, along with the required engineering paperwork. Do not combine it with the bed relicensure payment.

Next Steps for NH

- Email form to health.hrd-fedlcr@state.mn.us.
- Once the above request is processed, MDH will issue an approval letter to the facility.

Affirmation

☐ I certify that the information provided on this form is accurate and complete.

Signature of Administrator/Authorized Agent: _____

Name (print or type): _____

Title: _____

Date: _____

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Health.HRD-FedLCR@state.mn.us

07/21/2025

If you have questions, please email Health.HRD-FedLCR@state.mn.us or call 651-201-4200.