Michigan Department of Community Health
Bureau of Health Systems
LONG TERM CARE FACILITY INNOVATIVE DESIGN SUPPLEMENTAL (FIDS)
P.O. Box 30664
Lansing, MI 48909

LONG TERM CARE FACILITY INNOVATIVE DESIGN (FIDS) SUPPLEMENTAL APPLICATION
08/01/2006

Instructions:

- Application should be completed in black ink or typed.
- If attaching additional information, please specify which questions are being addressed.

All applications must be submitted by **MAIL** and **POSTMARKED** no later than **November 1, 2006**.

Michigan Department of Community Health
Bureau of Health Systems
FIDS APPLICATION
1808 W. Saginaw St.
Lansing, MI 48915

Questions:

Questions regarding the application form can be addressed to Wendy Ehnis at (517) 241-4115 e-mail waehnis@michigan.gov , Deborah Ayers at (517) 241-2656, e-mail at dayers@michigan.gov or Louise Jones at (313) 456-0199, e-mail jonesl@michigan.gov .

Applicant Information:	
Facility Name and Address:	
Facility License Number:	
Application Contact Person (Name and Title):	
Contact Telephone #: ( ) Contact Fax #: ( ) Contact Email Address:	Total Number of Licensed Beds: _____ (as of November 1, 2006) Total Number of Medicaid or Medicaid/Medicare Beds: _____

Select type and scope of the construction project (check more than one if applicable):

☐ Renovation of Existing Facility

☐ Complete or partial replacement

☐ New LTC inpatient facility

☐ Number of beds involved: _____

CERTIFICATION BY APPLICANT:

1. As a condition of applying for this supplemental, the undersigned applicant hereby agrees to: 1) Provide additional information upon request. 2) Accept all decisions of the Michigan Department of Community Health or Office of Services to the Aging as final, and hereby waives any right to administrative, judicial or other appeal of those decisions.

2. The applicant certifies that the information provided on this application is true, complete and accurate to the best of his/her knowledge, and that any false or misleading information is cause for denial or revocation of a Facility Innovation Grant.

Facility Administrator Signature: _____

Date: _____

To proceed with your Facility Innovative Design Supplemental Application please prepare the following. (Attach additional sheets if necessary, however, be sure to clearly identify which questions are being addressed.)

Criterion: To be eligible for this supplemental, the facility cannot have been cited by the Department for one or more Substandard Quality of Care (SQOC) citations, as defined in federal regulations, in the past 12 months.

Criterion: To be eligible for this supplemental, the facility's parent or any subsidiary must have taken actions acceptable to the Department to correct, improve or remedy any condition or concern that resulted in an SQOC citation issued over the past 12-month period in any facility under it's parent or any subsidiary.

1. Has your facility been cited by the Department for one or more Substandard Quality of Care (SQOC) citations, as defined in federal regulations, in the past 12 months?

Yes_____ No_____

2. If another facility owned by your facility's parent or any subsidiary has been cited by the Department for one or more Substandard Quality of Care (SQOC) citations, as defined in federal regulations, in the past 12 months, has your parent taken actions acceptable to the Department to correct, improve or remedy any condition or concern that resulted in the citation(s)? (Please attach a copy of a letter from the Bureau of Health Systems, Division of Operations confirming the acceptability of the actions.)

   Yes_____ No_____

3. If the issue has not yet been resolved, have you requested a meeting to discuss the issue with the Bureau of Health Systems? (Please attach copies of any correspondence regarding the request.)

   Yes_____ No_____

Criterion: This supplemental is intended to support projects that will result in innovative, resident friendly and home-like facility designs.

4. Describe your proposed project. *(*Submit only one project per application.)

   _____

   _____

   _____

   _____

   _____

   _____

   _____

5. Provide a detailed estimate of the cost of this project including total capital expenditure and other costs.

   _____

   _____

   _____

   _____

   _____

   Estimated Capital Expenditure: _____

   Other Estimated Costs: _____

   Total Project Estimate: _____

Criterion: Construction must begin on or before April 1, 2008. Construction start dates after April 1, 2008 may be accepted by MDCH if the delay is for good cause and approval of a later construction date is deemed by MDCH to be consistent with the purposes of this program.

Criterion: If construction on your project has already started, the project is only eligible if construction has not been completed before July 31, 2006. (See Appendix B of the General Information Sheet for the Facility Innovative Design Supplemental dated July 1, 2006 for definitions of "started" and "completed" as used in this application.)

6. If started, what was the construction start date? _____

7. If started, was the construction completed before July 31, 2006? Yes_____ No_____

8. If not started, what is the projected start date of construction? _____

Criterion: Priority will be given to proposals replacing older facilities in higher need of physical repair.

9. Does your project involve replacing all or part of an existing facility?

   Yes____ No_____

10. If the answer to 11 is yes, what year was the physical plant to be replaced built? _____

Criterion: All beds involved in the project must be dually certified for Medicare and Medicaid. Priority will be given to facilities that serve higher numbers of Medicaid eligible patients.

11. What was your facility's average Medicaid census in calendar 2005? _____

12. Will all beds in the project be dually certified for Medicare and Medicaid?

    Yes____ No_____

Criterion: Projects must comply with Certificate of Need (CON) requirements as evidenced by a submitted Letter of Intent for the proposed FIDS project or a CON Program Review Section determination that the project is not subject to CON requirements.

Criterion: The proposed project must comply with all requirements of the CON Addendum for New Design Model Pilot Programs, whether or not a CON is required. The CON requirements are found at:: http://www.michigan.gov/con (See links to Review Standards for Nursing Home Beds and Online Letter of Intent).

13. Has a Certificate of Need Letter of Intent been filed for the proposed FIDS project?

    Yes_____ No_____

    A. If no, please note that a Letter of Intent must be filed by November 1, 2006 in order for the Department to determine need for CON review/approval.

B. If yes, please identify the CON No. assigned to the submitted Letter of Intent: CON No._____

14. Has a Certificate of Need application been filed for the proposed FIDS project?

Yes_____ No_____

A. If no, please note that a CON application must be filed by September 1, 2007.

B. If yes, please indicate if the proposed project has already received a FINAL CON decision for approval? Yes_____ No_____

C. If approved, do you plan to file an amendment to modify the proposed project to meet the FIDS requirements? Yes_____ No_____

15. Will all new or renovated areas include at least 80% single occupancy resident rooms in the new or renovated areas with an adjoining bathroom serving no more than 2 residents in both the central support inpatient facility and any supported small resident housing units?

Yes_____ No_____

16. If the project is for replacement/renovation of an existing facility and utilizes only a portion of its currently licensed beds, will the remaining beds at the existing facility exceed double occupancy?

Yes_____ No_____

17. Will the new or renovated areas exceed 100 beds? Yes_____ No_____

18. If it is <u>not</u> limited to group resident housing of 10 beds or less, will be project comply with the construction standards for nursing homes in the document entitled “Minimum Design Standards For Health Care Facilities in Michigan” dated March 1998 and incorporated by reference in section 20145(6) of the Public Health Code, being section 333.20145(6) of the Michigan Compiled Laws? Yes____ No_____

19. If it <u>is</u> limited to small resident housing units of 10 beds or less that are supported by a central support inpatient facility, will the project comply with construction standards applicable to hospice residences providing an inpatient level of care, except that:

a. At least 100% of all resident sleeping rooms shall meet barrier free requirements;
b. Electronic nurse call systems shall be required in all facilities, which shall meet the requirements of Section 8.32G of the “Minimum Design Standards for Health Care;
c. Handrails shall be required on both sides of patient corridors;
d. Ceiling heights shall be a minimum of 7 feet 10 inches; and
e. There shall be an emergency generator for all critical or life-support equipment, including fire alarm systems, night lights, corridor and exit lights, heating and ventilation.

Yes_____ No_____

20. Will the project comply with applicable life safety code requirements and will be fully sprinkled and air conditioned?

Yes_____ No_____

21. If the answer to question 20 is no with respect to air conditioning, will you be requesting BHS to approve an alternative to air conditioning as appropriate to the climate of the location of the facility?

Yes_____ No _____

Criterion: The project includes demonstration of current or future commitment to an approved culture change process by meeting the requirements of Appendix A of the General Information Sheet for the Facility Innovative Design Supplemental dated July 1, 2006, found at:

http://www.michigan.gov/documents/BHS-NHM-GenInfoSheet-Inno_rev_7-20-06_166476_7.pdf

22. Which culture change process is involved in the project?

☐ a. Eden Alternative
Contact: Carol Ende
512-847-6061
wwweEdenalt.com

☐ b. Live Oak Regeneration Model
Contact: Barry Barkin
(510) 749-8815
E-mail: Info@LiveOakInstitute.Org

☐ c. CMS Person-Centered Planning Model
Contact: Barry Barkin
(510) 749-8815
E-mail: Info@LiveOakInstitute.Org

☐ d. LEAP (Learning, Empowerment, Action and Performance)
Mather Lifeways
847-492-6817
leap@matherlifeways.com

☐ e. Green House
Contact: Marilyn Ellis
202-336-7761
mellis@ncbdc.org
www.ncbdc.org/ta_hs_GreenHouse.aspx

☐ f. Core Expressions
Contact: Henry Boutros
248-496-6619
hbconnects@yahoo.com

☐ g. Other culture change processes approved by MSA and OSA

23. Describe the approach to culture change to be adopted by the project.

_____

_____

_____

_____

24. Have you entered into an agreement with My InnerView to evaluate your project? (Please attach copy of contract.)

Yes_____ No_____

A. If no, note that data collection with My Innerview must begin by October 1, 2007 for an existing facility.

25. Will the project conform to the requirements of Appendix A of the General Information Sheet for the Facility Innovative Design Supplemental dated July 1, 2006?

Yes_____ No_____

26. Have plans been submitted to the Health Facilities Engineering Section (HFES)

Yes_____ No_____

A. Schematic plans must be submitted to HFES by October 1, 2007.

B. Final construction documents must be submitted to HFES by February 15, 2008.

27. Supply any information you think is relevant as attachments to this application.

Subsequent verification of information supplied in this application may be required.