COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL
DIVISION OF CERTIFICATE OF NEED

NOTICE OF TERMINATION OR REDUCTION OF A HEALTH SERVICE OR REDUCTION OF BED CAPACITY

Pursuant to 900 KAR 6:110, Section 3, a health facility shall notify this office within thirty (30) days prior to termination or reduction of a health service, or reduction of bed capacity.

1. Name of Health Facility _____

   License Number _____

   Address of Facility _____

   _____
   (City) (State) (Zip) (County)

2. Health service that will be terminated or reduced: _____

   _____

3. Date that health service will be terminated or reduced: _____

4. Type and number of beds that will be reduced, and bed capacity after reduction:

   _____

5. Date that bed capacity will be reduced: _____

_____
(PRINTED NAME) (TITLE)

_____
(EMAIL ADDRESS) (AREA CODE-TELEPHONE NO-EXT)

_____
(Signature of Authorized Representative) (Date)

COMPLETE AND RETURN TO:

OFFICE OF INSPECTOR GENERAL
DIVISION OF CERTIFICATE OF NEED
275 EAST MAIN STREET 5EA
FRANKFORT, KY 40621
Phone: (502) 564-9592
Email: CON@ky.gov
Fax: (502) 564-6546