Bed Availability Form

Facility Name:

Facility Address:

Contact Person to call regarding openings:

Contact Person Phone Number/email address:

Facility Type: ____AFH  ____CBRF(Class A)  ____CBRF(Class C)  ____RCAC  Facility Size:_____

Groups Supported (Please mark all that are noted on your license):

___AODA  ___Alzheimer/Dementia
___Advanced Age  ___Physically Disabled
___Developmentally Disabled  ___Mental Illness
___Traumatic Brain Injury  ___Corrections
___Terminal Illness

Target Population your facility serves: (Some Examples):

___Young individuals with Developmental Disability  ___Sex offenders
___Advanced Age with severe Mental Illness  ___All male/all female populations
___Individuals with Developmental Disabilities  ___Respite services
___Primarily 18-45/ primarily 45-60 / primarily over 60  ___AODA services

Current Staffing Levels

M-F 1st Shift ___________  M-F 2nd Shift___________  M-F 3rd Shift___________
Saturday__________  Sunday__________

Facility Accessibility:  ___Ambulatory  ___Semi-Ambulatory  ___Non-Ambulatory

Does your facility accommodate Hoyer lift transfers?  ___Yes  ___No

Does your facility accommodate 2-person assist transfers?  ___Yes  ___No

Does your facility have RN oversight?  ___Yes  ___No
If Yes,  ___Diabetic Management  ___Sliding Scale Diabetic Management  ___Wound Care
___B12 injections  ___Tube Feeding  ___Hoyer Lift
___Other(describe)_______________________

The placement available is:  ___Private  ___Shared  ___Male  ___Female
___ADA Accessible  ___Non-Accessible

*Please send the completed form via email: placementteam@milwaukeeecounty.com