Bed Availability Form Date:

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

Target Population your facility serves: (Some Examples):

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