New Jersey Department of Health  
Division of Certificate of Need and Licensing  
Office of Certificate of Need and Healthcare Facility Licensure

PROJECT APPLICATION FOR EXPANSION SLOTS AT A LICENSED ADULT DAY HEALTH SERVICES FACILITY

**INSTRUCTIONS:** Complete all questions directly on this form. Completed application packages, which includes a cover letter and two (2) copies of the project narrative, the fee, and architectural plans are to be sent to:

Assistant Director  
Certificate of Need and Healthcare Facility Licensure  
New Jersey Department of Health

Mailing Address:
PO Box 358  
Trenton, NJ 08625-0358

Overnight Services (DHL, FedEx, UPS):
25 South Stockton Street, 2nd Floor  
Trenton, NJ 08608-1832

A non-refundable application fee (Government agencies are exempt) MUST accompany each application. Please make check payable to “Treasurer, State of New Jersey.”

\[
\text{\$10 (per slot) } \times \text{ (number of slots)} = \text{ \$} \quad + \text{ \$1,500} = \text{ \$} \\
\]

If you have any questions, you may contact the program at (609) 633-9042.

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<tr>
<th>GENERAL INFORMATION</th>
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<tbody>
<tr>
<td>1. Name of Facility</td>
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<tr>
<td>2. Street Address of Facility</td>
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<td>3. City, State, Zip</td>
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<td>5. Name of Contact Person for Project Application</td>
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<tr>
<th>PROGRAM INFORMATION</th>
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<tr>
<td>8. Number of licensed adult day health services slots requested:</td>
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<tr>
<td>9. Current Days and Hours of Operation:</td>
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<td>11. Proposed Days and Hours of Operation:</td>
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13. Provide scaled architectural floor plans with dimensions. Plans shall delineate the existing and proposed conditions, and label spaces with their intended use.
Will renovations and/or new construction be required to accommodate the additional slots? □ No □ Yes
If yes, describe to what extent (constructing a new building, adding an addition to an existing structure, alteration or renovation of an existing facility, and what other structures are on the property and the surrounding properties).

14. Additional Information/Remarks

CERTIFICATION: I certify that the information provided in this application is true and correct to the best of my knowledge and belief. I understand and agree not to implement any portion of this proposal prior to receiving written approval from the Certificate of Need and Healthcare Facility Licensure Program.

15. Submitted By (Print) 16. Title

17. Signature 18. Date

FOR STATE USE ONLY
Approved □ Yes □ No ID Number Signature Date