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):
120 South Stockton Street, 3rd 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."***

$10 (per slot) X _____ (number of slots) = $ _____ + $1,500 = $ _____

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

GENERAL INFORMATION		
1. Name of Facility		
2. Street Address of Facility		3. Official Facility Email
4. City, State, Zip		5. County
6. Name of Contact Person for Project Application	7. Email Address	8. Telephone Number

PROGRAM INFORMATION	
9. Number of licensed adult day health services slots requested: _____	
10. Current Days and Hours of Operation:	11. Number of Current Sessions:
12. Proposed Days and Hours of Operation:	13. Number of Proposed Sessions:

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

Name of Facility

PROGRAM INFORMATION, Continued

14. 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).

15. 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****.*

16. Submitted By (Print)	17. Title
18. Signature	19. Date

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Approved ☐ Yes ☐ No	ID Number	Signature	Date