New Jersey Department of Health
Office of Certificate of Need and Healthcare Facility Licensure
P.O. Box 358
Trenton, NJ 08625-0358

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR THE ADDITION OF LONG-TERM CARE BEDS (PURSUANT TO N.J.S.A. 26:2H-7.2)

- Please submit a cover letter, including a detailed project narrative, as well as scaled plans of the entire facility. Indicate where the new beds will be located. Plans should be submitted with ALL applications, regardless of whether renovations will be required. Label all rooms according to use (i.e., dining room, resident room, activity room, etc.) and indicate room numbers of resident rooms.

- Checks should be made payable to *"Treasurer, State of New Jersey."*

- Forward completed applications to:

  Mailing Address:
  New Jersey Department of Health
  Office of Certificate of Need and Healthcare Facility Licensure
  P. O. Box 358
  Trenton, NJ 08625-0358

  Overnight Services (DHL, FedEx, UPS):
  New Jersey Department of Health
  Office of Certificate of Need and Healthcare Facility Licensure
  120 South Stockton Street, 3rd Floor
  Trenton, NJ 08608-1832

- To obtain additional information regarding the application process, please call:

  609-292-6552 Team A: for facilities located in Bergen, Hudson, Mercer, Morris, Passaic, Somerset, Sussex and Warren Counties

  609-633-9042 Team B: for facilities located in Burlington, Gloucester, Hunterdon, Middlesex, Monmouth and Ocean Counties

  609-292-7228 Team C: for facilities located in Atlantic, Camden, Cape May, Cumberland, Essex, Salem and Union Counties

New Jersey Department of Health
Office of Certificate of Need and Healthcare Facility Licensure
P. O. Box 358
Trenton, NJ 08625-0358

APPLICATION FOR THE ADDITION OF LONG-TERM CARE BEDS (PURSUANT TO N.J.S.A. 26:2H-7.2)

1. Name of Facility

2. Name of Licensed Operator/Owner

3. Facility Street Address

4. City

5. State

6. Zip Code

7. County

8. Application Fee Amount ($1500 plus $15 per additional bed):

Check Number

Check Date

9. Name of Facility Representative

10. Telephone Number

11. Current Number of Licensed Long-Term Care Beds

12. Were any of the above referenced long-term care beds approved through a previous Add-a-Bed Application, pursuant to N.J.S.A. 26:2H-7.2? ☐ No ☐ Yes

If Yes, Number of Beds

Date Approved

13. Does the facility currently have any waivers of building requirements? ☐ No ☐ Yes

If Yes, please cite specific waivers:

APPLICATION FOR THE ADDITION OF LONG-TERM CARE BEDS
(Continued)

14 Number of Additional Long-Term Care Beds Requested

15. Identify the proposed location of the additional beds, including the floor, wing, and room numbers:

6. Does the facility have any three or four-bedded rooms? ☐ No ☐ Yes

If Yes, please describe the facility's plan to reduce the capacity of all rooms to a maximum of two beds:

17. Will this project require renovation and/or construction? ☐ No ☐ Yes

18. Does the facility have adequate dining and recreation space for the additional beds, in accordance with Section 8.3.A of the AIA Guidelines? ☐ No ☐ Yes

19. Does the facility maintain a minimum of one bathtub or shower for every 20 residents, not otherwise served by bathing facilities in resident rooms? ☐ No ☐ Yes

Name of Individual Completing Form

Title

Signature

Date