**New Jersey Department of Human Services**

**Division of Developmental Disabilities**

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### **Congregate Day Program Re-Opening Attestation**

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| --- | --- | --- |
| Date: | Enter Date | |
| To: | Division of Developmental Disabilities | |
| From: | Enter Name of Agency CEO or Designee | |
| Provider Name: | Enter Name of Provider | |
| Contact Number: | Enter Contact Number for CEO or Designee | |
| Facility Address: | Enter Address of Facility | |
| Facility County: | Enter County of Facility | |
| Facility Maximum Occupancy, per Certificate of Occupancy (CO): | | Enter Maximum Occupancy of Facility, per CO |

I, of full age, hereby certify that I represent the aforementioned provider in the capacity listed and that I am duly authorized to the make the representations contained within this attestation on behalf of the provider and to bind the provider thereto. I attest that the provider has reviewed and implemented all the requirements set forth in [Congregate Day Program Re-Opening Requirements](https://nj.gov/humanservices/ddd/documents/covid19-congregate-day-program-reopening-requirements.pdf) and [Facility Readiness Tool](https://nj.gov/humanservices/ddd/documents/covid19-facility-readiness-tool.docx). Daily screening protocols are in place for staff and individuals attending day program as well as other safety protocols, all staff trainings have been completed, individual cohorts will be maintained at all times and action will be immediately taken to isolate anyone who shows symptoms of COVID-19.

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| CEO or Designee Name | Signature | Date |
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| Witness Printed Name | Signature | Date |

**This form shall be completed, signed and returned to the Division by the Day Program Provider at least 48 hours before in-person congregate day services begin. This form indicates that all requirements for the location have been met.**