New Jersey Department of Human Services
Division of Developmental Disabilities

Provider Attestation for Visitation

Date: _____

To: Division of Developmental Disabilities

From: _____

Provider Name: _____

Contact Number: _____

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 implemented all the requirements set forth in Guidance for Residential Providers on Visits with Family and Friends and Screening of Visitors and Staff in Residential Settings. I attest that no indoor visits will occur unless the setting has gone 28 days without newly COVID-19 positive residents or staff, does not have residents or staff who are currently displaying symptoms, and has a space for designated for visitation, sufficient staff, a mechanism for appointments and a plan to ensure sufficient PPE for visitation. I attest that no outdoor visits will occur unless it has been at least 14 days since a resident or staff of the home tested positive for COVID-19 and no residents or staff of the home are currently displaying symptoms.

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

July 23, 2020