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

PROJECT APPLICATION FOR AN 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):
171 Jersey Street, Building 5, 1st Floor
Trenton, NJ 08611-2425

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 = $ _____

In accordance with N.J.A.C. 8:43F-2.1(a)9., the owner(s) and administrator must obtain prior clearance from the Criminal Background Investigation Unit (CBIU), of the Department of Health (DOH), prior to approval of the owner(s) application for licensure and prior to the operation of the facility by the administrator.

Please be advised that incomplete applications will delay the review and approval process. A minimum of 60 days to review your project application is required. **You are not authorized to implement any portion of your proposal until you receive written approval from the Certificate of Need and Health Care Facility Licensure Program.**

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. City, State, Zip		4. County
5. Name of Contact Person for Project Application	6. Email Address	7. Telephone Number
8. Number of licensed adult day health services slots requested: _____		

OWNERSHIP AND DISCLOSURE
9. Identify 100% of the ownership, including the names and home addresses of all principals, (individuals or corporations owning 10% or more), and the percent owned by each. (For nonprofit facilities, provide the names and home addresses of the members of the Board.) An attestation, signed by each individual listed below, that they have read the regulations at N.J.A.C. 8:43F and will comply with them must be included in the application package. List any ownership interest(s) held by each person in any licensed health care facility in New Jersey or any other state. If out-of-state facilities are owned, it is necessary to submit copies of letters from the respective state regulatory agencies regarding the track records of those facilities with this application.

PROJECT APPLICATION FOR AN ADULT DAY HEALTH SERVICES FACILITY (CONTINUED)

Name of Facility

OWNERSHIP AND DISCLOSURE, Continued

9. (Continued)

PROGRAM INFORMATION

10. How will the following services be provided? (Check all items that apply)

Occupational Therapy as per N.J.A.C. 8:43F-14.12	☐ On site	☐ Off site
Physical Therapy as per N.J.A.C. 8:43F-14.13	☐ On site	☐ Off site
Speech Therapy as per N.J.A.C. 8:43F-14.14	☐ On site	☐ Off site
Laundry as per N.J.A.C. 8:43F-14.16	☐ On site	☐ Off site
Meal Preparation as per N.J.A.C. 8:43F-14.11	☐ On site	☐ Off site

11. Days and Hours of Operation:	12. Number of Sessions:

13. Scaled architectural floor plans must be submitted, regardless of whether renovation/construction is required, with all rooms in areas clearly labeled with dimensions and their proposed use.

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****.*

14. Submitted By (Print)	15. Title

16. Signature	17. Date

FOR STATE USE ONLY

Approved ☐ Yes ☐ No	ID Number	Signature	Date