NEW YORK STATE DEPARTMENT OF HEALTH
Adult Care Facility/Assisted Living

Notification to Operate a Temporary Residential Services/Respite Program

FACILITY

Name: _____

Operating Certificate Number: _____

Address: _____
Street

_____
City State ZIP County

Current Certified Capacity of the Facility: _____ Beds

Current Census of the Facility: _____ Beds

Proposed Temporary Residential Services/Respite Program: _____ Beds

If requesting more than 5 beds, please explain need: _____

PROGRAM DIRECTOR FOR TEMPORARY RESIDENTIAL SERVICES PROGRAM:

Name _____
Please Print

Phone: (_____) _____ Fax: (_____) _____

ACKNOWLEDGEMENT AND SIGNATURES

We, the undersigned, acknowledge that this notification has been accurately completed and to the best of our knowledge is in compliance with all applicable codes, rules and regulations, including 18 NYCRR Part 485.

We acknowledge that the facility will not exceed its approved certified capacity and that any residents wishing to participate in this program shall be given the "Model Temporary Residential Care Addendum to the Admission/Residency Agreement".

Person Completing the Application

Name _____ _____
Please Print Title

_____ _____
Signature Date

Administrator/Program Coordinator

Name _____ _____
Please Print Title

_____ _____
Signature Date

Administrator e-mail address: _____

Please submit this completed form to:

New York State Department of Health
Division of Adult Care Facility/Assisted Living Surveillance
Bureau of Licensure and Certification
Respite Notification
875 Central Avenue
Albany, New York 12206