Notification to Operate a Temporary Residential Services/Respite Program

| FACILITY | |
|--|---|
| Name: | |
| Operating Certificate Number: | |
| Address: | |
| Street | |
| City Sta | |
| Current Certified Capacity of the Facility: | Beds |
| Current Census of the Facility: | |
| Proposed Temporary Residential Services/Respite Program: | |
| If requesting more than 5 beds, please explain need: | |
| | |
| | |
| | |
| | |
| PROGRAM DIRECTOR FOR TEMPORARY RESIDENTIAL SERVICES PROGRAM: | |
| | |
| NamePlease Print | |
| Phone: () Fax: () | |
| ACKNOWLEDGEMENT AND SIGNATURES | |
| We, the undersigned, acknowledge that this notification has been accurately com | npleted and to the best of our knowledge is in compliance with al |
| applicable codes, rules and regulations, including 18 NYCRR Part 485. | species and to the best of our knowledge is in complainte min as |
| We acknowledge that the facility will not exceed its approved certified capacity are be given the "Model Temporary Residential Care Addendum to the Admission/Residential Care Admission | |
| 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

DOH-5241 (3/17)