Attachment 5 – Certification

New York State Department of Health
Center for Health Care Provider Services and Oversight
Division of Adult Care Facilities/Assisted Living Surveillance

Opportunity for Development

Assisted Living Program 3400 Initiative

Sponsorship: All applicants please check one ___ Proprietary ___ Non - Profit ___ Public

Certification

I/We certify that the information submitted on this form and on any attachment to this schedule is true, accurate and complete in all material respects. (Attach additional sheets if necessary.)

APPLICANT SIGNATURE(S):

By: _____ Date: _____
(Signature)

Printed Name: _____

Title: _____

By: _____ Date: _____
(Signature)

Printed Name: _____

Title: _____

STATE OF NEW YORK

County of _____

On the __ day of _____ in the year _____, before me personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____
(Signature and office of the individual taking acknowledgement)