

**NOTICE OF CHANGE
ENRICHED HOUSING APARTMENT CERTIFICATION**

NEW YORK STATE

DEPARTMENT OF SOCIAL SERVICES

Enriched Housing Sponsor Name and Address		Site Name and Address Where Change is Requested	
SPONSOR TYPE		County Name:	Code:
<input type="checkbox"/> Non-Profit <input type="checkbox"/> Public Agency		Operating Certificate No.	
ADDITION(S)		DELETION(S)	
APT. NO.	DATE OF CHANGE	APT. NO.	DATE OF CHANGE
Apts. being used after change(s):			
_____ Capacity On Operating Certificate _____ Number of Residents Being Served After Change			
This form should be mailed to the following address at least two weeks before the effective date of change: <div style="text-align: center;"> New York State Department of Health Bureau of Licensure and Certification 161 Delaware Avenue Albany, NY 12054 </div>			
Signature _____ Title: _____ Date Signed _____ Phone Number: () _____			