

Notice of Change Enriched Housing Apartment Certification for Residents Receiving Social Security Income (SSI)

Enriched Housing Sponsor Name and Address		Site Name and Address (including where change is requested)	
Operating Certificate Number: _____		County: _____	
ADDITION(S)		DELETION(S)	
APARTMENT NUMBER	DATE OF CHANGE	APARTMENT NUMBER	DATE OF CHANGE
SSI Apts. being used after change(s): 			
Mail or fax this form to the following address by the end of the month in which the change(s) occurred: <p style="text-align: center;">New York State Department of Health Adult Care Facility/Assisted Living Surveillance 875 Central Avenue Albany, NY 12206</p> <p style="text-align: center;">Fax: (518) 408-1249</p>			
Signature _____		Title: _____	
Date Signed _____		Phone Number: () _____	