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

# 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 |
| | | | |
| | | | |
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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:

**New York State Department of Health**
**Adult Care Facility/Assisted Living Surveillance**
**875 Central Avenue**
**Albany, NY 12206**

**Fax: (518) 408-1249**

Signature _____ Title: _____

Date Signed _____ Phone Number: (  ) _____