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| **DEPARTMENT OF PUBLIC HEALTH**  SEAL**DIVISION OF HEALTH CARE FACILITY**  **LICENSURE & CERTIFICATION**  **67 Forest Street**  **Marlborough, MA 01752** | **Nursing Home Resident Bedroom**  **2-Bed Maximum**  **Good Faith Efforts Attestation Form** |

**INSTRUCTIONS:** Submit this form to attest to good faith efforts to comply with the requirement that by April 30, 2022, no nursing home resident bedroom contain more than two beds (the “2-bed maximum requirement”), pursuant to 105 CMR 150.017(B)(3)(b)(1) and 105 CMR 150.320(B)(1). Submit the completed attestation form to [stephanie.carlson@mass.gov](mailto:stephanie.carlson@mass.gov).

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| **CONTACT INFORMATION** |

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| **Nursing Home Name:** | |  | | | | | | | | | |
| **Nursing Home Address:** | |  | | | | | | | **Telephone #:** |  | |
|  | |  | | | | | | | **Fax #:** |  | |
|  | |  | | | | | | |  | |  |
| **Nursing Home Contact Person:** | | |  | | | **Title:** | |  | | | |
|  | **Telephone #:** | | |  | **Email:** | |  | | | | |
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| **ATTESTATION of COMPLIANCE** |

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| **Based upon full review of the requirements at 105 CMR 150.017(B)(3)(b)(1) and 105 CMR 150.320(B)(1), I attest that the above-named Nursing Home (check all that apply):** | | |
| ☐  ☐ | Has submitted an application with the Determination of Need program by March 31, 2022 that is deemed complete by the Determination of Need program and assigned a filing date by April 30, 2022;  Has been issued a Determination of Need; | |
| ☐ | Completed applicable Plan Review application(s), submitted all related forms and documentation by January 17, 2022, including architectural plans that meet the Plan Review requirements, and have a written agreement with contractors who will oversee the construction project and implementation of the building plans; | |
| ☐  ☐ | \  Has applications submitted and all required permits related to the construction plans (including building, electrical, plumbing, mechanical, and use permits) issued by the applicable permitting authorities; or  Other (must specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **and that all of the information provided in this document is accurate and complete; that the Nursing Home is aware that the Department must be notified of any change in information, and that all interested parties, if any, have received copies of the attestation form. The Nursing Home must keep documentation of the attested to good faith efforts towards compliance with the 2-Bed Maximum requirement and must make available to the Department upon request.** | | |
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| Signature of Nursing Home or Nursing Home’s authorized representative | | Date |
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| Typed/printed name of Nursing Home or Nursing Home’s authorized representative | |  |