

*New Jersey Department of Health*  
*Division of Certificate of Need & Licensing*

**LICENSE**  
**PLANNED PARENTHOOD OF NCSNJ**

*Pursuant to N.J.S.A. 26:2H-1 et seq.,  
which is hereby licensed to operate*

**PLANNED PARENTHOOD OF NORTHERN, CENTRAL AND SOUTHERN**

8 MORAN STREET - NEWTON, NJ 07860

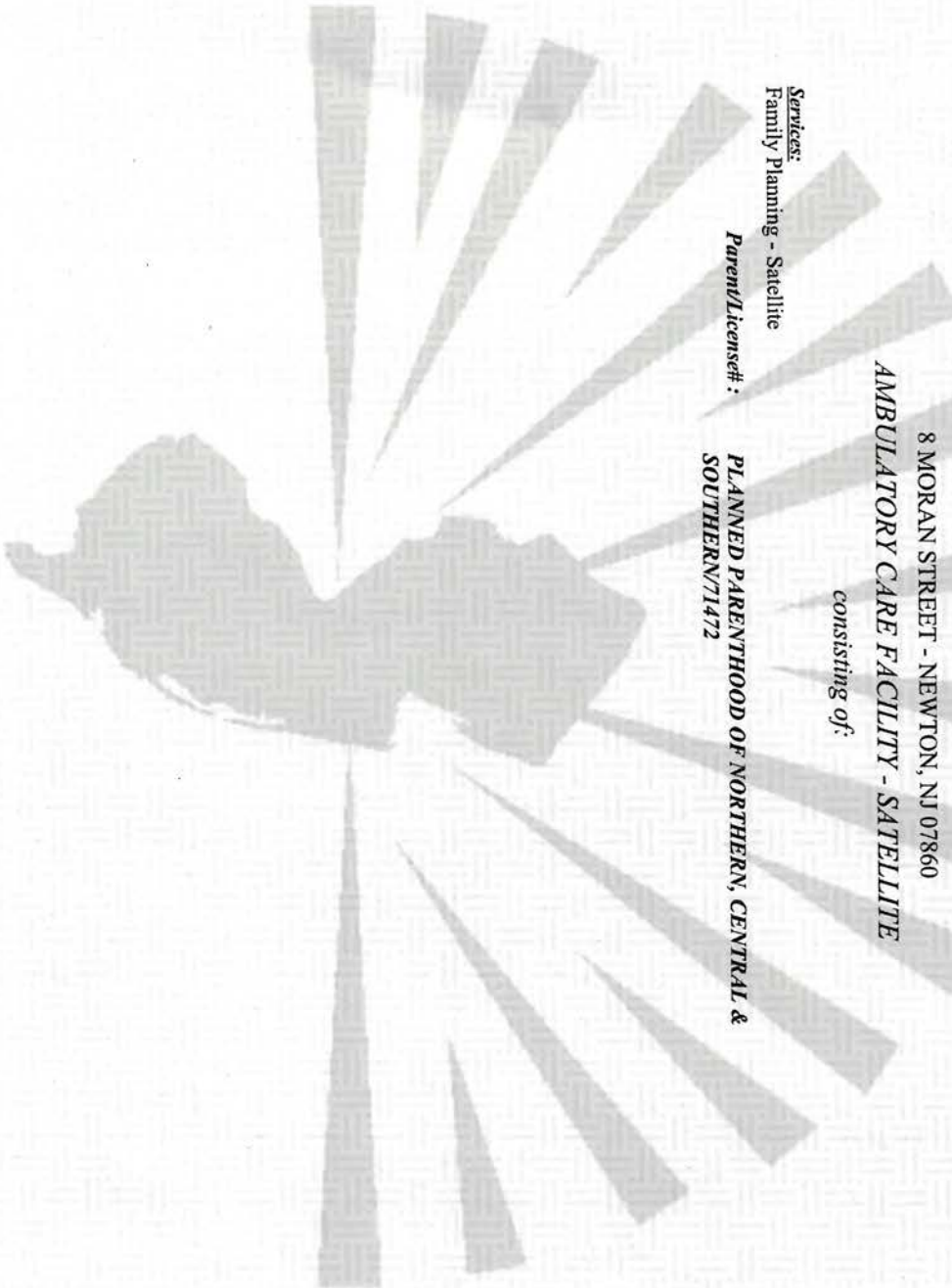
**AMBULATORY CARE FACILITY - SATELLITE**

*consisting of:*

*Services:*  
Family Planning - Satellite

*Parent/License#:*  
**PLANNED PARENTHOOD OF NORTHERN, CENTRAL &  
SOUTHERN/71472**

License #: **22470**  
Effective: **May 1, 2022**  
Expires: **April 30, 2023**  
Issued: **April 18, 2022**



*Judith M. Persichilli*  
**Judith M. Persichilli**  
Commissioner

MUST BE POSTED IN A CONSPICUOUS PLACE IN THE FACILITY  
THIS LICENSE IS NOT TRANSFERABLE. APPLIES ONLY TO THE ABOVE LOCATION, AND TERMINATES ON NOTICE BY THE DEPARTMENT



State of New Jersey  
**DEPARTMENT OF HEALTH**

PO BOX 358  
TRENTON, N.J. 08625-0358  
[www.nj.gov/health](http://www.nj.gov/health)

PHILIP D. MURPHY  
*Governor*

SHEILA Y. OLIVER  
*Lt. Governor*

JUDITH M. PERSICHILLI, RN, BSN, MA  
*Commissioner*

April 18, 2022

Ms. TRISTE BROOKS

PLANNED PARENTHOOD OF NORTHERN, CENTRAL AND  
SOUTHE  
8 MORAN STREET  
NEWTON, NJ 07860

RE: Facility#: NJ22470/ License#: 22470  
License Renewal

Dear Ms. TRISTE BROOKS:

Enclosed please find the official license for your health care facility, authorizing continued operation for the next twelve month period. The license must be posted in a conspicuous place in the facility. The license may not be transferred or assigned without the prior approval of the Department.

We appreciate your ongoing efforts to participate as a long term health care provider in NJ. In accordance with N.J.S.A. 26:2H-5, the Department may conduct surveys of the facility to ascertain compliance with all regulatory requirements. The renewal is valid for a one year period, unless revoked or suspended for failure to meet licensure requirements.

Please include the official name of the facility, the license number and contact email(s) on all correspondence if available.

If you have any questions about the license or licensure process, please call this office at (609)292-6552.

Sincerely,

Michael J. Kennedy, J.D.  
Executive Director  
Certificate of Need and Licensing  
New Jersey Department of Health

**Your creditCard transaction has been successfully processed. The transaction confirmation number is 163676312 . Please print this page for your record.**

**Credit Card Payment**

**Payer Information**

Last Name:

BROOKS

First Name:

TRISTE

**Contact Information**

\* Telephone Phone: 9733494803

\* Email Address: jarret.allende@ppgennj.org

**Payment Information**

\* Application Payment Amount: \$875.00

\* Payment Including Service Fee: \$893.00

Please PRINT this confirmation for your records.

If your registration requires completion of an application please use RETURN button to open the application and follow the instruction. Otherwise use RETURN button to go back.

Note: Do not click on the back button.

PRINT

RETURN

## Facility Data Sheet

### Facility Detail

Facility: Planned Parenthood of Northern, Central and Southern New Jersey, Inc.	Facility ID: NJ22470	
Type: AMBULATORY CARE FACILITY - SATELLITE	Tracking: LR-22470-21195	
License#: 22470	License Expires: 4/30/2022 12:00:00 AM	

RECEIVED

APR 06 2022

BY: .....

### Payment Information

Renewal Fees: \$475.00	Inspection Fees: \$400.00	Other Fees: \$0.00	Total Due: \$875.00
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### Facility Information

Address: 8 MORAN STREET, NEWTON, NJ, 07860	Medicare#: _____
County: SUSSEX	Medicaid#: _____
Telephone: (973) 383-5214	New Telephone: _____
Fax: (973) 862-6670	New Fax: _____
Email: amy.raspatello@ppggnj.org	New Email: _____

### Mailing Address

Address: 8 MORAN STREET	New Address: _____
City: NEWTON	New City: _____
State: _____	New State: _____
Zip: 07860	New Zip: _____

### Emergency Contact

Name: Amy Raspatello	New Name: _____
Phone: (973) 879-1306	New Phone: _____
Fax: _____	New Fax: _____
Email: amy.raspatello@ppggnj.org	New Email: _____

### Administrator

Salutation: Ms	New Salutation: _____
First Name: TRISTE	New First Name: _____
Middle Name: A	New Middle Name: _____
Last Name: BROOKS	New Last Name: _____
Title: _____	New Title: _____
Phone Number: _____	New Phone Number: _____
Email: _____	New Email: _____
Current Primary: Yes	New Current Primary: _____
Start Date: 11/02/2009	New Start Date: _____
End Date: _____	New End Date: _____

### Owner Detail

Company Name: PLANNED PARENTHOOD OF NCSNJ	
Type: AMBULATORY CARE FACILITY - SATELLITE	Business Type: _____
Company Tax ID: _____	Company Tax ID: _____
Address: 196 SPEEDWELL AVENUE	New Address: _____
City: MORRISTOWN	New City: _____

Phone Number: (973) 539-9580

New Phone Number: \_\_\_\_\_

Fax Number:

New Fax Number: \_\_\_\_\_

Email:

New Email: \_\_\_\_\_

**Facility Officers/Principals Name and Ownership Detail**

VINITA JETHWANI		0.00%
RALPH PADILLA		0.00%
JOSHUA S SAKS	BRD MEMBER	0.00%
PATRICK STOVER	CHAIR	0.00%
PATRICIA COOK		0.00%
KATHERINE E KLEEMAN	CHAIR	0.00%
BENN MEISTRICH	1ST VP	0.00%
STEPHANIE A FISHER	VICE CHAIR	0.00%
CONNIE NEWMAN	SECRETARY	0.00%
MICHAEL ROEMER	TREASURER	0.00%
JOAN GOTTI	GOV CHAIR	0.00%
SHELDEN PISANI	BRD MEMBER	0.00%
MARC BRAHANEY	2ND VP	0.00%
KEVIN LAU	ESQ	0.00%

**Bed / Services / Slots**

*Facility ID: NJ22470*

*Tracking: LR-22470-21195*

Services & Designations:

Family Planning - Satellite

**Related Facilities**

Name	License#
<b>Current Accreditation</b>	<b>New Accreditation</b>
Accrediting Body:	Accrediting Body: _____
Effective Date:	Effective Date: _____
Expiration Date:	Expiration Date: _____
Hospital Attestation :	Hospital Attestation (Yes/No): _____
Hospital Attestation Letter Date:	Hospital Attestation Letter Date: _____
Deem :	Deem (Yes/No): _____

**Note:** Please include the accreditation certificate(s) and hospital attestation letter, if applicable.

LICENSE RENEWAL QUESTIONNAIRE

AMBULATORY CARE FACILITY - SATELLITE

License#: 22470

Expires: NJ22470

Ref#: LR-22470-21195

Please answer the following questions (attach additional sheets if necessary)

1. Have any of the principals of the operating entity ever applied, directly or indirectly, for health care facility approval in New Jersey or any other state, which was denied or revoked? NO (Yes/No) If Yes, indicate whom and give details:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Do any of the principals of the operating entity have an ownership, operational or management interest in any other licensed health care facility in New Jersey, or any other state? NO (Yes/No) If Yes, explain the nature of the interest and give name and address of each facility:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Have any principals of the operating entity ever been found guilty of a criminal or administrative charge of resident/patient fraud, abuse and/or neglect? have any of these ever been indicted for the same charge? NO (Yes/No) If Yes, explain in detail:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Have any principals of the operating entity ever been indicted for or convicted of a felony crime? NO (Yes/No) If Yes, indicate whom and give details

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CERTIFICATION

The applicant certifies:

- 1) that all information contained in this application and attachments is true and correct, to the best of his/her knowledge and belief, and that willful misrepresentation of these facts may make the applicant subject to civil penalties;
- 2) that the application has been duly authorized by the governing body of the applicant;
- 3) that the facility has been and will be operated in accordance with applicable licensing requirements;
- 4) that the facility is not suspended, debarred, or otherwise excluded for any reason from entering into the covered transaction; and
- 5) that the facility is in compliance with the requirements of Section 6032 of The Federal Deficit Reduction Act.

Name of authorized individual completing form (print or type):	
Print Name: <u>Jarret Allende</u>	Title: <u>VP Medical Services</u>
Signature: <u>[Signature]</u>	Date: <u>3/22/22</u>