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 & SOUTHERN

349 COUNTRYSIDE PLAZA - RT 31 - FLEMINGTON, NJ 08822

AMBULATORY CARE FACILITY - SATELLITE

consisting of:

Services:
Family Planning - Satellite

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

License #: 22542
Effective: May 1, 2022
Expires: April 30, 2023
Issued: April 13, 2022

THE GREAT SEAL OF THE STATE OF NEW JERSEY

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

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

JUDITH M. PERSICHILLI, RN, BSN, MA
Commissioner

April 13, 2022

Ms. TRISTE BROOKS

PLANNED PARENTHOOD OF NORTHERN, CENTRAL & SOUTHERN
349 COUNTRYSIDE PLAZA - RT 31

FLEMINGTON,NJ 08822

RE: Facility#: NJ22542/ License#: 22542

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 163678572 . 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@ppgnnj.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:	NJ22542
Type:	AMBULATORY CARE FACILITY - SATELLITE	Tracking:	LR-22542-21190
License#:	22542	License Expires:	4/30/2022 12:00:00 AM

Payment Information

Renewal Fees:	$475.00	Inspection Fees:	$400.00	Other Fees:	$0.00	Total Due:	$875.00

Facility Information

Address:	349 COUNTRYSIDE PLAZA - RT 31, FLEMINGTON, NJ, 08822	Medicare#:	
County:	HUNTERDON	Medicaid#:	
Telephone:	(908) 782-7727	New Telephone:	
Fax:	(908) 806-8729	New Fax:	
Email:	amy.raspatello@ppgnnj.org	New Email:	

Mailing Address

Address:	349 COUNTRYSIDE PLAZA - RT 31	New Address:	
City:	FLEMINGTON	New City:	
State:		New State:	
Zip:	08822	New Zip:	

Emergency Contact

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

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: NJ22542* *Tracking: LR-22542-21190*

Services & Designations:

Family Planning - Satellite

Related Facilities

Name	License#

Current Accreditation	New Accreditation	
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#: 22542 Expires: NJ22542 Ref#: LR-22542-21190

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: Janet Allendo Title: VP Medical Services

Signature: Date: 3/22/22