DELAWARE HEALTH AND SOCIAL SERVICES
Division of Developmental Disabilities Services

REQUEST TO DEVELOP A PROVIDER MANAGED RESIDENTIAL SITE

General Information:

Residential Contracted Provider:	Type of Request:	Region:
	Check all that apply:	Check one:
Contact Name:	☐ Expansion	☐ New Castle East
(*Please include all necessary contacts*) Contact Email(s):	☐ Residence Relocation *(complete the previous site section on this application)*	☐ New Castle West ☐ Kent ☐ Sussex
Phone number(s):	☐ Individual Relocation ☐ Transfer ☐ Other:	
Date of the Request:		
Proposed Move-in Date:		

New Site Information:

Property Address: _____

City: _____ Zip Code: _____

Number of bedrooms at this site: _____

Number of bedrooms that will be utilized as sleeping quarters: _____

Number of beds intended to be used for sleeping: _____

**Written approval must be given by the Regional Program Director if number of bedrooms at the site differs from the number of bedrooms intended to be utilized as sleeping quarters. Otherwise, unoccupied bedrooms will count as vacancies.
NGH: Maximum number of residents allowed is four. CLA: Maximum number of residents allowed is three.

Site Type:

☐ Single Family Home ☐ Duplex ☐ Townhome ☐ Condominium ☐ Apartment ☐ Mobile Home

Rent/Mortgage Amount:

$ _____

Proposed Residents and Staffing Plans:

Proposed Residents Names:

Required number of staff to support the proposed residents: _____

Trainings needed to support the proposed residents:

Did the proposed resident(s) assist with location selection: ☐ Yes ☐ No
If no, why not:

Is this site ADA compliant? ☐ Yes ☐ No
Are all areas of this site accessible to all proposed residents? ☐ Yes ☐ No
If no, why not:

Signature: Date:

Complete and save this form as a PDF. Send to the following resource mailbox:
DHSS_DDDS_NewSite@delaware.gov (click for a direct link)
DHSS_DDDS_NewSite@delaware.gov

The subject line must read:
Provider Name_QAFRM200A_Name of the region being requested
Example: ABC Provider_QAFRM200A_Kent County

Previous Site:
Complete if Residence Relocation is checked

Will Previous site be closing after the move? ☐ Yes ☐ No

Property Address:

City: State: Delaware

Provider Transfer:
Complete if Provider Transfer is checked

Name of previous provider:

Completed by DDDS Community Services Only

Regional Approval: ☐ Yes ☐ No
Approved Expedited site: ☐ Yes ☐ No
Maximum # of residents approved:

Additional Comments:

Community Services Representative Signature: Date:

Residential Contracted Provider: Complete this section if you would like to appeal the decision:

Reason for the appeal (please attach any additional information):

Signature: Date: