FOR OFFICE USE ONLY
Check Amount
Check Number
License Expiration

State of Delaware

Office of Health Facilities Licensing and Certification

License Renewal Application for 3365 Free Standing Birth Center (FSBC)

(Please type) License ID: FSBC –

Provider Legal Name

Doing Business As (DBA)

Facility Address

City State DE Zip Code

Facility Phone Facility Fax

Administrator Full-time Part-time Email

Alt. Administrator Email

Clinical Director Full-time Part-time Email

Delaware Registered Nursing License Number Expiration Date

Alt. Clinical Director Email

Delaware Registered Nursing License Number Expiration Date

Emergency Contact Name

Emergency Contact Phone Email

(EMERGENCY CONTACT MUST BE AVAILABLE AT ALL TIMES IN CASE OF EMERGENCY, NATURAL DISASTER, ETC.)

Facility Type (Check all that apply)

1. Private Public
2. Non-Profit For-Profit

Office Hours

Accredited Yes No

Accrediting Organization Expiration Date

Licensure Survey

All free standing birthing centers, other than a hospital, providing delivery of new babies and immediate postpartum care exclusively are required to meet the Department of Health and Social Services 3365 Free Standing Birthing Centers Regulations (FSBC).

1. Number of birthing rooms. ________
2. Number of physicians with privileges. ________
3. Number of certified nurse mid-wives with privileges. ________
4. Do all physicians have admitting privileges to area hospitals? Yes ☐ No ☐

   Explain "No" Response ____
5. Do all Certified mid-wives have a back-up agreement with a physician? Yes ☐ No ☐

   Explain "No" Response____
6. Date of last policy and procedure manual review ________
7. Has there been a change of ownership since the last survey? Yes ☐ No ☐

   If Yes, give date ____________.
8. List the number of mothers admitted in the previous 12 months ____________
9. Date of last survey ___________. If changes have occurred in your center since your last on-site or off-site survey, briefly describe those changes (attach additional pages as needed).
10. Is a physician certified by the American Board of Obstetrics and Gynecology or who is qualified and authorized by training and experience in obstetrics and gynecology immediately available by telephone twenty-four hours a day?

    Yes ☐ No ☐

    Explain "No" Response ____
11. Has each physician providing services for the center demonstrated hospital admitting privileges for patients who develop complications?

    Yes ☐ No ☐

    Explain "No" Response ____
12. Has each certified mid-wife (nurse or professional) providing services for the center provided proof of a collaborative agreement with a physician who will accept consultation calls and referrals twenty-four (24) hours a day, seven (7) days a week?

    Yes ☐ No ☐

    Explain "No" Response ____
13. Have all new employees completed an orientation?

    Yes ☐ No ☐

    Explain "No" Response ____
14. Have all employees had an annual performance review and competency?

    Yes ☐ No ☐

    Explain "No" Response ____
15. Has an employee found to active Tuberculosis (TB) in an infectious stage provided care or service to patients?

    Yes ☐ No ☐

    Explain "Yes" Response ____
16. Have any and all employees with a positive (TB) skin test but negative chest X-Ray completed an attestation annually attesting they are asymptomatic?

    Yes ☐ No ☐

    Explain "No" Response ____

17. Does your center meet or exceed the following prenatal visit schedule?
At least every four (4) weeks until the twenty-eighth (28th) week;
At least every two (2) weeks between the twenty-eighth (28th) week and the thirty-sixth (36th) week; and
At least every week between the thirty-sixth (36th) week and delivery.

Yes ☐ No ☐

Explain "No" Response ____

18. In the past year, has labor been inhibited, stimulated or augmented with chemical agents?

Yes ☐ No ☐

Explain "Yes" Response ____

19. In the past year, has a surgical procedure, except an episiotomy, repair of episiotomy or laceration, or circumcision been performed at your center?

Yes ☐ No ☐

Explain "Yes" Response ____

20. How long does a patient remain at your center following an uncomplicated birth? Hours Days

21. Is a member of your center's professional staff accessible to patients by telephone 24 hours a day?

Yes ☐ No ☐

Explain "No" Response ____

22. Does your center provide the patient with a written notice of the patient's rights during the initial assessment visit or before admission for services?

Yes ☐ No ☐

Explain "No" Response ____

COMPLETE LICENSURE RENEWAL APPLICATION AND AFFIRMATION BELOW

Application is made to operate a free standing birthing center in accordance with Chapter 16 Delaware Code §122(3)(n) and the Department of Health and Social Services Free Standing Birthing Center Regulations (3365).

I affirm that all of the information provided herein is COMPLETE and true. Incomplete or inaccurate information IS REASON FOR NON-RENEWAL OF THE CENTER'S LICENSE. I further agree to conduct said center in accordance with the laws of the State of Delaware and with the rules and regulations of the DELAWARE DIVISION OF HEALTH CARE QUALITY.

____
Signature of Center Administrator

____
Date

Appendix A

In the past year, has a mother given birth at your center with any of the following conditions? (Attach additional pages as needed. Check all that apply) *Explain any boxes with a ✓*

a. Less than 16 years of age ☐ ______
b. Chronic hypertension ☐ ______
c. Chronic heart disease ☐ ______
d. Pulmonary embolus ☐ ______
e. Congenital heart defects ☐ ______
f. Severe renal disease ☐ ______
g. Lupus erythematosus ☐ ______
h. Drug or alcohol addiction ☐ ______
i. Required use of anticonvulsant drugs ☐ ______
j. Bleeding disorder or hemolytic disease ☐ ______
k. Paraplegia/quadriplegia ☐ ______
l. Diabetes mellitus ☐ ______
m. Cognitive impairment that would interfere with the ability to follow directions ☐ ______
n. Morbid obesity ☐ ______
o. Active genital herpes, syphilis or HIV positive ☐ ______
p. The need for general or conduction anesthesia ☐ ______
q. The need for a caesarian section ☐ ______
r. Serious congenital anomaly in a previous birth whose recurrence cannot be ruled out by antenatal evaluation ☐ ______
s. Rh sensitization ☐ ______
t. Previous uterine wall surgery including cesarean section ☐ ______
u. Five or more term pregnancies with other risk factors ☐ ______
v. Nullipara of greater than 40 years of age with other risk factors ☐ ______
w. Multipara over 45 years of age with other risk factors ☐ ______
x. Previous placenta abruption ☐ ______
y. Significant signs or symptoms of:
   aa. Hypertension ☐ ______
   bb. Toxemia ☐ ______
   cc. Polyhydramnios or oligohydramnios ☐ ______
   dd. Abruption placenta ☐ ______
   ee. Chorioamnionitis ☐ ______
   ff. Malformed fetus ☐ ______
   gg. Fetal distress ☐ ______
   hh. Multiple gestation ☐ ______
   ii. Intrauterine growth retardation or macrosomia ☐ ______
   jj. Thrombophlebitis ☐ ______
   kk. Pyelonephritis ☐ ______

Appendix B

In the past year, has your center provided care to any patients with the following conditions? (Attach additional pages as needed. Check all that apply) *Explain any boxes with a ✓*

a. Premature labor (occurring at less than 37 weeks gestation) ☐ ____________________________________

b. Development of hypertension or pre-eclampsia ☐ ____

c. Non-vertex presentation ☐ ____

d. Failure to progress in labor ☐____

e. Evidence of an infectious process ☐ ____

f. Suspected placenta previa or abruption ☐ ____

g. Hemorrhage of greater than 500 cc of blood ☐ ____

h. Premature rupture of the membranes (occurring within a timeframe agreed upon by the certified midwife and back-up physician in their collaborative agreement) ☐ ____

i. Suspected congenital anomaly ☐ ____

j. Anemia consisting of less than ten (10) grams of hemoglobin per one hundred (100) milliliters of blood or thirty (30) percent hematocrit ☐ ____

k. Persistent fetal tachycardia (heart rate greater than 160 beats per minute), repetitive fetal bradycardia (heart rate less than 120 beats per minute) or undiagnosed abnormalities of the fetal heart tones ☐

____

l. Rising antibody titre of any type that is known to affect fetal well-being ☐ ______________________________

m. Excessive need for analgesia during labor, or for anesthesia other than pudendal or local ☐;

____

n. Persistent hypothermia in the newborn ☐ ____

Appendix C

In the past year, has your center provided care to any patients with the following conditions?
(Attach additional pages as needed. Check all that apply) *Explain any boxes with a ✓*

a. Prolapsed cord ☐ ____

b. Uncontrolled hemorrhage ☐ ____

c. Need for transfusion ☐ ____

d. Placenta abruption ☐ ____

e. Retained placenta greater than sixty (60) minutes ☐ ______________________________

f. Convulsions ☐ ____

g. Thick meconium staining at the time of membrane rupture ☐ __________________________

h. Apgar score of seven (7) or less at five (5) minutes ☐ ____________________________

i. Fetal heart rate of ninety (90) or less beats per minute for three (3) minutes ☐ ________________

j. Major anomaly of the newborn ☐ ______________________________________

k. Respiratory distress in the newborn ☐ ____________________________________

l. Newborn weight less than 2500 grams ☐ ____________________________________

m. Newborn need for oxygen beyond five (5) minutes ☐ ____________________________

n. Signs of prematurity ☐ ____

Appendix D

Provide names, license numbers and expiration dates of personnel who provide services at the free standing birthing center - (Attach additional pages as needed).

Physicians:

Name	License #	Expiration Date

Certified Nurse Midwives:

Name	License #	Expiration Date

Certified Professional Midwives:

Name	License #	Expiration Date

Registered Nurses:

Name	License #	Expiration Date
Name	License #	Expiration Date
Name	License #	Expiration Date
Name	License #	Expiration Date
Name	License #	Expiration Date
Name	License #	Expiration Date
Name	License #	Expiration Date
Name	License #	Expiration Date

Attach the following documents regarding the organization and services of the State licensed Hospice Documents should be labeled with the noted Exhibit identifier. For example, the “List of Services” should be labeled “Exhibit B.”

Exhibit A – Delaware Business License (and city/town business license if applicable)

Exhibit B - List of Services

Exhibit C - Organizational Chart(s)

Exhibit D - Changes in organization (if applicable)

Exhibit E – List showing the names, addresses and percent of interest of each officer, Administrator and owners having an interest in the Facility or related business (complete “Ownership Interest” included).

Exhibit F – List of names and addresses of advisory board members if different from the preceding group.

Exhibit G - Resumes of staff mentioned above.

Exhibit H - List of Governing Body Members

Exhibit I – Proof of not-for-profit status if claiming tax exempt status

Exhibit J – List all members/employees with a criminal record

Exhibit K – List of management personnel including qualifications

Exhibit L - Outline of organization and services of the state licensed free standing birthing center program. Report any changes in your organization that may have occurred since the last report.

Exhibit M - Quality Improvement program.

Include the following:

1. An internal monitoring process that tracks performance measures;
2. A review of the program's goals and objectives at least annually;
3. A review of the grievance/complaint process;
4. A review of all major adverse incidents;
5. A review of actions taken to address identified issues; and
6. A process to monitor the satisfaction of the patients with the services of the center.

Exhibit N – A list of in-service education provided by the Birth Center for pervious license year.

Exhibit O - Any changes that have occurred in the policies for the center since your last survey (paper or on-site), please attach those policies.

Exhibit P - Transfer Agreement

Please Email the following as separate attachments to DHSS_DHCQ_OHFLCFAX@DELAWARE.GOV

Exhibit Q - Accreditation Certification, Official Accreditation report, and Plan of Correction. (If Applicable)

Exhibit R - Your Disaster Preparedness Plan (including reviewed/revised date)

Exhibit S - Evacuation Plan

Exhibit T - Written records and attendance of the quarterly simulated fire drills and emergency training Reg. 10.5.3.

Exhibit U - Delaware State Fire Marshal Inspection Letter

Ownership Interest

Name	Address	% Ownership Interest
		Total = 100%

Application is made to operate a Free Standing Birth Center in accordance with 16 Del. C. Code §122(3)(q) and the Department of Health and Social Services Free Standing Birth Center Regulations (3365).

I affirm that all the information provided herein is complete and true. I further agree to conduct said Facility in accordance with laws of the State of Delaware and with the rules and regulations of the Delaware Division of Health Care Quality.

Name of the person completing the form　　Title

Email　　Phone

Signature　　Date

Check or money order should be made payable to **State of Delaware**

Initial Licensure Fee $150　　Annual Licensure Fee $75.00
Please type and return the application with the licensure fee to
Office of Health Facilities Licensing and Certification
263 Chapman Road, Suite 200
Newark, DE 19702

For Office Use Only

Application Reviewed & Approved By　　Date

Administrator/Designee　　Date

Type of License　　Initial　　Annual　　Probationary　　Provisional

Licensure Period　　To

License Sent Date　　Initials

Rev. 10-31-2022