State of Delaware
Office of Health Facilities Licensing and Certification
Statement of Intent

Note that each question must have a response. Failure to complete this form in its entirety and submit all required information will result in your statement being rejected.

1. **Intended name of agency/facility: Please note that this will be how your agency/facility will be referenced until you provide notice of change in writing. Please check the OHFLC website for names already in use.**

   Intended Legal Name: *(Name on Business License)* ______________________

   DBA: (Doing Business As- *leave blank if N/A)* ______________________

2. **This agency/facility will seek licensure as:** *(Choose only one)*
   - Adult Day Care Facility
   - Dialysis Center
   - Free Standing Birthing Center
   - Free Standing Emergency Center
   - Free Standing Surgical Center
   - Skilled Home Health Agency
   - Home Health Agency – Aide Service Only
   - Hospice
   - Hospital
   - Personal Assistance Services Agency
   - Prescribed Pediatric Extended Care Center

3. **This agency/facility will seek Federal Centers for Medicare and Medicaid Services (CMS) certification as a:** *(Not applicable to HHAAO & PASA)*
   - Ambulatory Surgical Center
   - Comprehensive Outpatient Rehab Facility
   - End Stage Renal Dialysis Facility
   - Skilled Home Health Agency
   - Hospice
   - Hospital
   - Outpatient Physical Therapy
   - Portable X-Ray Supplier
   - None – Not Applicable

4. **For those agencies/facilities seeking CMS certification, will the agency/facility seek accreditation from an approved accreditation organization (i.e., The Joint Commission, etc.)** - *This would be applicable only for agencies/facilities that are certified and seeking licensure or a licensed agency seeking certification. This should not be the selection for any NEW agency/facility. HHAO & PASA are not eligible for CMS certification. Please check None & leave accreditation organization blank.*

   Yes No If yes, list the name of the accreditation organization: ______________________

5. **Geographic location or area to be served** *(home care agencies may only provide services in the county in which the office is located and the adjacent county/counties):*

   New Castle County Kent County Sussex County

6. **The facility will be located in:** *(this does not apply to home care agencies-leave blank)*
   - An existing healthcare structure with renovation. Indicate type of healthcare structure: ______________________
   - An existing commercial structure with renovation
   - An existing healthcare structure without renovation.
   - Business or administrative offices; services are provided off-site
   - Current place of business – no changes renovation
   - New construction

7. **Primary contact. There should be one person coordinating activities with OHFLC. Changes must be provided in writing.**

   Name: ______________________ Job Title: ______________________

   Agency Address: ____

   City: ______________________ State: __________ Zip Code: __________

   Phone: __________ Fax: __________ Email: ______________________

8. **Intended location of agency/facility (this must be a Delaware address). Changes must be provided in writing.** *(Agencies applying for a new license do not need to submit agency address until after their document compliance review)*

   Name: ______________________ Job Title: ______________________

   Agency Address: ____

   City: ______________________ State: ___DE___ Zip Code: __________

   Phone: __________ Fax: __________ Email: ______________________

9. **Capacity:** *(this does not apply to home care agencies-leave blank)*

   Check the agency/facility type and provide requested information. Changes must be submitted in writing.

   Adult Day Care: Number of adults that can be served ______

   Ambulatory Surgical Center or Free-Standing Surgical Center:

   Number of Operating Rooms ______ Number of Procedure Rooms ______

   Comprehensive Outpatient Rehabilitation Facility (in full time equivalents):

   Number of Physicians ______ Number of Physical Therapists ______ Number of Physical Therapy Assistants ______

   Number of Social Workers/Psychologist/Vocational Rehab Counselor ______ Number of Occupational Therapists ______

   Number of Occupational Therapy Assistants ______ Number of Speech Therapists ______

   Dialysis Center: Number of stations ______ Number of isolation stations ______ Total number of stations ______

   Free Standing Birthing Center: Number of birthing rooms ______

   Free Standing Emergency Center: Number of treatment bays ______

   Hospice: Number of inpatient beds ______

   Hospital: General Medical Long Term Acute Care Pediatric Rehabilitation Psychiatric

   Other: ______________________ Number of inpatient beds ______

   Outpatient Physical Therapy: *(numbers below should be in full-time equivalents)*

   Number of Physical Therapists ______ Number of Physical Therapy Assistants ______ Number of Speech Therapists ______

   Number of Occupational Therapists ______ Number of Occupational Therapy Assistants ______

Prescribed Pediatric Extended Care Facility:

Number of children that can be served in "well" area ______ Number of children that can be served in "sick" area ______

10. **Does the owner or contracted management group have other agencies/facilities of this type located in Delaware?**

    Yes No If Yes, how many? ____________________

11. **Attach a list of services and/or procedures that will be offered by this agency/facility.** *(Print on separate piece of paper)*

OHFLC Notes:

- **3.13- The personal assistance services agency must not use the word "healthcare", or any other language which implies or indicates the provision of healthcare services, in its title or in its advertising.**
- **Please submit the updated attached Statement of Intent fillable form which should be typed After you have typed the form, print, sign, and return the Statement of Intent along with your list of services and/or procedures as an Adobe PDF (JPG, RTF, Share Point, Google Docs etc. is not acceptable) document via email to: mailto: DHSS_DHCQ_OHFLCFAX@DELAWARE.GOV**
- **Regulations: Please print and review the regulations in detail for your type of agency/facility on our website, below:** http://www.dhss.delaware.gov/dhss/dltcrp/ohflcmain.html
- **Please do not submit payment until your agency/facility drops off your Document Compliance Submission packet. At that time, you are required to bring a "Certified Check" for the appropriate amount made payable to: "State of Delaware."**
- **Please note that further information may be required and must be made available upon request.**

Print name of person completing form: ______________________________ Date: ______________

Signature: ____