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| <b>FOR OFFICE USE ONLY</b> |       |
| Check Amount:              | _____ |
| Check Number:              | _____ |
| License Expiration:        | _____ |

State of Delaware  
Office of Health Facilities Licensing and Certification  
Licensure Renewal Application for Skilled Home Health Agency (HHA)

License ID: HHAS - \_\_\_\_\_

Legal Name: \_\_\_\_\_

DBA Name: \_\_\_\_\_

Agency Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Which county is your office located in (Check only one):    New Castle                  Kent                  Sussex

Director: \_\_\_\_\_ Email: \_\_\_\_\_

Alternate Director: \_\_\_\_\_ Email: \_\_\_\_\_

Clinical Director: \_\_\_\_\_ Email: \_\_\_\_\_

Alt. Clinical Director: \_\_\_\_\_ Email: \_\_\_\_\_

Agency Phone: \_\_\_\_\_ Agency Fax: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_ Email: \_\_\_\_\_

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

Agency Type: (Check all that apply)

Private

Public

Not-For-Profit

Proprietary

Office Hours: \_\_\_\_\_

Check the county(ies) in which your agency provides services:

New Castle

Kent

Sussex

|             |     |    |         |     |    |
|-------------|-----|----|---------|-----|----|
| Accredited? | Yes | No | Deemed? | Yes | No |
|-------------|-----|----|---------|-----|----|

If yes, print name of the Accrediting Organization and Accreditation Expiration date?

Accreditation Organization:

Expiration Date:

**Licensure Survey:**

All home health agencies providing skilled services are required to meet the Delaware Department of Health and Social Services Skilled Home Health Agencies regulations (4410).

1. List the number of unduplicated intermittent patients admitted in the previous 12 months.
  - a. Census:
  - b. Skilled:
  - c. Unskilled:
  
2. Has there been a change of ownership since the last survey? Yes      No  
 If Yes, give date: \_\_\_\_\_
  
3. Home health aide services are provided directly by contract Both N/A
  
4. Do all individuals who furnish home health services on behalf of the agency meet competency evaluation and skill assessment requirements? Yes No
  - a. Attach a list of home health aide in-service conducted in the previous year that reflects regulation 5.8.6.
  - b. All home health aides have received in-service training as required:
    - i. 12 hours per year (Ref 5.8.6 for required topics) Yes      No

Explain "No" Response: \_\_\_\_\_

5. Attach the following documents regarding the organization and services of the state licensed HHA. Documents should be labeled with the noted Exhibit identifier. For example, the "List of Services" should be labeled "Exhibit 2A".

- Exhibit 2A - List of Services
- Exhibit 2B - Organizational Chart(s)
- Exhibit 2C - Changes in organization (if applicable)
- Exhibit 2D - List of governing body members
- Exhibit 2E - Proof of insurance (Regulation 9.0)

Exhibit 2F - Evidence such as governing body minutes that show: Budget approval, approval of annual programs evaluation, and appointment of any new director since last survey. (4.1 – 4.2)

Exhibit 2G - Name, addresses & types if agencies owned or managed by the applicant

Exhibit 2H - Resumes of Director, Clinical Director, and Alternates

**Please Email the following to:** [dhss\\_dhcq\\_ohflcfax@delaware.gov](mailto:dhss_dhcq_ohflcfax@delaware.gov)

Exhibit 2I - Accreditation Certification, Official Accreditation report, and Plan of Correction(if applicable)

Exhibit 2J - Your Emergency Preparedness Plan

### Home Health Agency Services and Employee Information

| <b>Services Provided</b>       | <b>Does your company provide these services? Yes or No</b> | <b>Are the services provide by employees of the agency? Yes or No</b> | <b>Number of persons employed in each service</b> | <b>Are the services provided by contractors? Yes or No</b> | <b>Number of contractors providing each service?</b> | <b>Are services provided by both employees and contractors?</b> | <b>Total number of caregivers in each service?</b> |
|--------------------------------|--|---|---|--|--|---|--|
| Licensed Nursing               |  |   |   |  |  |   |  |
| Physical Therapy               |  |   |   |  |  |   |  |
| Speech Therapy                 |  |   |   |  |  |   |  |
| Audiology Services             |  |   |   |  |  |   |  |
| Occupational Therapy           |  |   |   |  |  |   |  |
| Nutritional Services           |  |   |   |  |  |   |  |
| Social Services                |  |   |   |  |  |   |  |
| Home health aide               |  |   |   |  |  |   |  |
| Homemaker                      |  |   |   |  |  |   |  |
| Companion Services             |  |   |   |  |  |   |  |
| Durable Medical Equipment      |  |   |   |  |  |   |  |
| Intravenous Therapy            |  |   |   |  |  |   |  |
| Respiratory/Inhalation Therapy |  |   |   |  |  |   |  |
| Pharmaceutical Services        |  |   |   |  |  |   |  |
| Other (please list):           |  |   |   |  |  |   |  |
|                                |  |   |   |  |  |   |  |
|                                |  |   |   |  |  |   |  |
|                                |  |   |   |  |  |   |  |
|                                |  |   |   |  |  |   |  |



Application is made to operate a skilled home health agency in accordance with Title 16 Health and Safety, Delaware Administrative Code and the Department of Health and Social Services Skilled Home Health Agencies regulations (4410).

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

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Print Name of Agency Director: \_\_\_\_\_

Signature of Agency Director: \_\_\_\_\_

Date: \_\_\_\_\_

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Checks should be made payable to: **State of Delaware**  
Renewal Licensure Fee: \$300.00

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Please complete and return the application with the licensure fee and attachments to:

**Office of Health Facilities Licensing and Certification**  
**261 Chapman Road, Suite 200**  
**Newark, DE 19702**

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**For Office Use Only:**

Application Reviewed & Approved By: \_\_\_\_\_ Date: \_\_\_\_\_

Director/Designee: \_\_\_\_\_ Date: \_\_\_\_\_

Type of License:                      Annual                                      Provisional

Licensure Period: \_\_\_\_\_ To: \_\_\_\_\_

License Sent Date: \_\_\_\_\_ Initials: \_\_\_\_\_