

FOR OFFICE USE ONLY

Check Amount

Check Number

License Expiration

State of Delaware Office of Health Facilities Licensing and Certification

License Renewal Application for 3380 Hospice License (HSPC)

(Please type)

License ID HSPC -

Provider Legal Name

Doing Business As (DBA)

Agency Address

City State DE Zip Code

Agency Phone Agency Fax

Administrator Email

Alt. Administrator Email

Director of Nursing Email

Delaware Registered Nursing License Number Expiration Date

Alt. Director of Nursing 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.)

Agency Type (Check all that apply)

1. Private Public

Non-Profit For-Profit

Hours of Operation

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

Check the county(ies) in which your agency will provide services

New Castle

Kent

Sussex

Services Provided Free Standing Home Care

Number of Beds Inpatient Beds Licensed Beds

Accredited: Yes No (If Yes, print name of Accrediting Organization and Accreditation expiration date)

Accrediting Organization: Expiration Date:

Licensure Survey

All hospice agencies providing services are required to meet the Delaware Department of Health and Social Services Hospice Regulations (3380).

List the number of unduplicated intermittent patients admitted in the previous 12 months.
 Census

2. Date of your agency last program evaluation (not by OHFLC)

Please attach a summary of your last annual program evaluation, along with your policies and procedures review. Identify what steps you took to resolve any problems. (Reg. 4.7.2 - 4.7.3)

- 2a. Attach a list of members involved in the evaluation
- 2b. Attach a list of findings and recommendations
- 2c. What follow-up is being done or planned to be done?
- 3. Has there been a change of ownership since the last survey? Yes No If Yes, give date
- 4. Do all individuals who furnish hospice services on behalf of the agency meet in-service and skill assessment requirements? Yes No
 - 4a. Attach a list of continuing education conducted in the previous year that reflects (Reg. 6.7).

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 Div. of Revenue 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 of governing body members

Exhibit F - Proof of insurance (Reg. 9.0)

Exhibit G - Evidence such as governing authority minutes that show evaluation of the appropriateness of the scope of services offered, approval of annual programs evaluation, and appointment of any new director since last survey (Reg. 4.6 - 4.7).

Exhibit H - Resumes of Administrator, Director of Nursing and Alternates for each.

Please <u>Email</u> the following as two (2) separate attachments to DHSS_DHCQ_OHFLCFAX@DELAWARE.GOV

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

Exhibit J – Your Emergency Preparedness Plan (including reviewed/revised date).

Exhibit K – Delaware State Fire Marshal Inspection Letter (inpatient facilities).

Hospice Agency Services and Employee Information

Hospice Agency Services and Employee Information								
Services Provided	Does your company provide these services? Yes or No	Are the services provide by employees of the agency? Yes or No	Number of persons employed in each service	Are the services provided by contractors? Yes or No	Number of contractors providing each service?	Are services provided by both employees and contractors?	Total number of caregivers in each service?	
Registered Nurse *								
Licensed Practical Nurse								
Physical Therapy								
Nutritional Services								
Social Services (LCSW) *								
Aide								
Homemaker								
Companion Services								
Durable Medical Equipment								
Physician Services *								
Ordained Clergy								
Pastoral Counseling *								
Trained Volunteer Services *								
Other (please list):								
*Required								

Ownership Interest

Name	Address	% Ownership Interest
		Total = 100%

Application is made to operate a hospice agency in accordance with 16 Del. C. Code §122(3)(m) and the Department of Health and Social Services Delivery of Hospice Services (3380).

I attest that all employees/contractors have had the following:

- A criminal background check and drug testing (16 Del.C. §1145 and §1146)
- Child and adult abuse check (11 Del.C. §8563 and §8564)
- Services letter(s) (19 Del.C. §708)

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.

Print Name of Administrator

Email Phone
Signature of Administrator Date

Checks should be made payable to: **State of Delaware**Annual Licensure Fee: \$50.00

Please type and return the application with the licensure fee and attachments to

Office of Health Facilities Licensing and Certification 263 Chapman Road, Suite 200 Newark, DE 19702

For Office Use Only

Application Reviewed & Approved By

Director/Designee

Date

Type of License Annual Probationary Provisional

Licensure Period To

License Sent Date Initials

Rev. 01-30-2023