FOR OFFICE USE ONLY

Check Amount: _____

Check Number: _____

License Expiration: _____

State of Delaware

Office of Health Facilities Licensing and Certification

Licensure Renewal Application for Personal Assistance Services Agencies (PASA)

License ID: PASA - _____

Legal Name: _____

DBA Name: _____

Agency Address: _____

City: _____ State: DE Zip Code: _____

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

Director: _____ Email: _____

Alt. 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 ☐ Non-Profit ☐ For-Profit

Office Hours: _____

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

☐ New Castle ☐ Kent ☐ Sussex

Medication administration provided? ☐ Yes ☐ No

Licensure Survey:

All PASAs providing personal assistance services exclusively are required to meet the Department of Health & Social Services Personal Assistance Services Agencies Regulations (3345).

1. List the number of consumers admitted in the previous 12 months:_____

   List your current census: _____

2. Attach the following documents regarding the organization and services of the state licensed PASA. 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 7.0)
   - Exhibit 2F - List showing the names, addresses and percent of interest of each officer, director and owner having an interest in the agency.

3. Date of your last program review and evaluation _____ (Regulation 4.3.2.5)
4. Personal assistance services are provided directly by: (Check one)
   ☐ Employee ☐ Contractor ☐ Employee and Contractor
5. Have all direct care workers passed an annual competency test? (Regulation 4.3.2.4)
   ☐ Yes ☐ No Explain a "No" response _____
6. Have all direct care workers completed an annual performance review? (Regulation 4.3.2.4 & 4.4.2.4)
   ☐ Yes ☐ No Explain a "No" response _____
7. Have all newly hired/contracted direct care workers passed a competency test prior to providing care to consumers? (Regulation 4.5.3)
   ☐ Yes ☐ No Explain a "No" response _____
8. Have all consumers received and signed the "Notice of Direct Care Worker Status" form? (Regulation 5.1.3)
   ☐ Yes ☐ No Explain a "No" response _____
9. Have all consumers received written notice of the consumer's rights? (Regulation 6.2)
   ☐ Yes ☐ No Explain a "No" response _____
10. Has there been a modification of ownership and control since the last survey?
    ☐ Yes ☐ No If yes, give date: _____
11. Is medication administration offered and in accordance with regulation section 5.4.3?
    ☐ Yes ☐ No
12. E-mail your emergency preparedness plan to: DHSS_DHCQ_OHFLCFAX@DELAWARE.GOV

Application is made to operate a personal assistance services agency in accordance with 16 Delaware Code §122(3)(x) and the Department of Health and Social Services Personal Assistance Services Agencies Regulations (3345).

I attest that all employees/contractors have had:

- 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 Agency Director: _____

Signature of Agency Director: _____

Date: _____

Checks should be made payable to: **State of Delaware**

Annual Licensure Fee: $100.00

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

For Office Use Only:

Application Reviewed & Approved By: _____ Date: _____

Director/Designee: _____ Date: _____

Type of License: ☐ Annual ☐ Provisional

Licensure Period: _____ To: _____

License Sent Date: _____ Initials: _____