



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	Home Health Agency – Aide Service Only
Dialysis Center	Hospice
Free Standing Birthing Center	Hospital
Free Standing Emergency Center	Personal Assistance Services Agency
Free Standing Surgical Center	Prescribed Pediatric Extended Care Center
Skilled Home Health Agency	

3. **This agency/facility will seek Federal Centers for Medicare and Medicaid Services (CMS) certification as a:** *(Not applicable to HHAO & PASA)*

Ambulatory Surgical Center	Hospital
Comprehensive Outpatient Rehab Facility	Outpatient Physical Therapy
End Stage Renal Dialysis Facility	Portable X-Ray Supplier
Skilled Home Health Agency	None – Not Applicable
Hospice	

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: _____
