FOR OFFICE USE ONLY

Check Amount

Check Number

License Expiration

State of Delaware
Office of Health Facilities Licensing and Certification
Licensure Renewal Application for 3351 Home Health Agency – Aide Only (HHAAO)

(Please type)

License ID HHAAO -

Provider Legal Name

Doing Business As (DBA)

Agency Address

City | State DE | Zip Code

Agency Phone | Agency Fax

Director | Email

Alt. Director | Email

Clinical Director | Email

Delaware Registered Nursing License Number | Expiration Date

Alt. Clinical Director | 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.)

Facility Type (Check all that apply)

1. Private   Public
2. 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

Licensure Survey

All home health agencies providing services are required to meet the Delaware Department of Health and Social Services Home Health Agencies -Aide Only Regulations (3351).

1. List the number of unduplicated intermittent patients admitted in the previous 12 months.
   a. 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. 4.2.11)
   - 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. Home health aide services are provided Directly By Contract Both N/A
5. Do all individuals who furnish home health services on behalf of the agency meet competency evaluation and skill assessment requirements? Yes No
   - 5a. Attach a list of home health aide in-service conducted in the previous year that reflects Reg. 5.7.6.
   - 5b. All home health aides have received in-service training as required 12 hours per year
     Yes No
     Explain "No" Response

Attach the following documents regarding the organization and services of the state licensed HHAAO. 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 body minutes that show Budget approval, approval of annual programs evaluation, and appointment of any new director since last survey (Reg 4.1 and 4.2).
Exhibit H - List showing the names, addresses and percent of interest of each officer, director and owners having an interest in the agency (complete "Ownership Interest" included).
Exhibit I - Resumes of Director, Clinical Director and Alternates for each.

Please Email the following to DHSS_DHCQ_OHFLCFAX@DELAWARE.GOV

Exhibit J - Your Disaster Preparedness Plan (including reviewed/revised date).

Home Health 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?
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)							

Ownership Interest

Name	Address	% Ownership Interest
		Total = 100%

Application is made to operate a Home Health Agency Aide Only with 16 Del. C. Code §122(3)(o) and the Department of Health and Social Services Home Health Agency Aide Only Regulations (3351).

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 Director

Email Phone

Signature of Director Date

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

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 Date

Director/Designee Date

Type of License Annual Probationary Provisional

Licensure Period To

License Sent Date Initials

Rev. 01-30-2023