STATE OF DELAWARE
OFFICE OF HEALTH FACILITIES
LICENSING AND CERTIFICATION
(302) 292-3930

APPLICATION FOR DIALYSIS CENTER LICENSURE

FOR OFFICE USE ONLY
Check Amount: _____
Check Number: _____
License Expiration: _____

Reason for Application		
☐ Initial	☐ Renewal	
	License ID:DC-	Expiration Date:

Facility Information		
Legal Name:		
Doing Business As:		
Facility Address:		
City:	State: DE	Zip:

Ownership: ☐ For Profit ☐ Not-For Profit ☐ Public

Is this Unit/Facility Hospital-Based? ☐ Yes ☐ No

SNF-Based ☐ Yes ☐ No

Name of Hospital/SNF _____

Days and Hours of Operation:	**Specify AM or PM**
Monday	to
Tuesday	to
Wednesday	to
Thursday	to
Friday	to
Saturday	to
Sunday	to

Administrator: (MUST provide a copy of resume/qualifications)	
Name:	
Address:	
Telephone Number:	Fax:
Email Address:	

Medical Director: (MUST provide a copy of resume/qualifications)	
Name:	
Address:	
Telephone Number:	Fax:
Email Address:	

Nurse Manager: (MUST provide a copy of resume/qualifications)	
Name:	
Address:	
Telephone Number:	Fax:
Email Address:	
Infection Prevention and Control Program Leader: (MUST provide a copy of resume/qualifications)	
Name:	
Address:	
Telephone Number:	Fax:
Email Address:	
Dietitian: (MUST provide a copy of resume/qualifications)	
Name:	
Address:	
Telephone Number:	Fax:
Email Address:	
Social Worker: (MUST provide a copy of resume/qualifications)	
Name:	
Address:	
Telephone Number:	Fax:
Email Address:	
Emergency Contact: (Must be available at all times in case of weather emergency, natural disaster, etc.)	
Name:	
Address:	
Telephone Number:	Fax:
Email Address:	

Staffing: (List Full-Time Equivalents in numbers)

- ☐ Registered Nurse
- ☐ Licensed Practical Nurse
- ☐ Masters Social Worker
- ☐ Registered Dietitian
- ☐ Technical staff (Water,Machine)
- ☐ Certified Patient Care Technician
- ☐ Others _____

Emergency Power Source: Does this facility have an emergency power source? ☐ Yes ☐ No

If Yes, can the emergency power source operate all dialysis machines for at least four (4) hours following a power shutdown or outage? ☐ Yes ☐ No

Attach evidence of monthly testing of emergency power source for the past three (3) months.

If no, provide update on status of obtaining emergency power source.

Services Provided: (Check all that apply)

☐ In-Center Hemodialysis
☐ In-Center Nocturnal Hemodialysis

☐ Home Hemodialysis Training & Support
Provided in Long Term Care Facility ☐ Yes ☐ No

☐ In-Center Peritoneal Dialysis

☐ Home Peritoneal Dialysis Training & Support
Provided in Long Term Care Facility ☐ Yes ☐ No

Number of Stations:

☐ Number of In-Center Hemodialysis Stations approved
Does this include an isolation room? ☐ Yes ☐ No
If yes, number _____

☐ Number of Home Therapy Treatment Rooms approved
Does this include an isolation room? ☐ Yes ☐ No
If yes, number _____

Please attach the most current copy of the following:

1. A list showing the names, addresses and percent of interest of each officer, director, and owner having an interest in the facility.
2. A list showing the names and addresses of the governing body, if different from the preceding group.
3. Fire inspection report.

Please email the following to: DHSS_DHCQ_OHFLCFAX@DELAWARE.GOV

4. Copy of your emergency preparedness plan.
5. If applicable, email a copy of the deeming certificate, official deeming report, and plan of correction.

Name of person completing the form:

Signature:	Title:

Date:

FEE CALCULATION FOR APPLICATION:

Check which services are provided:

☐ In-Center Hemodialysis
☐ In-Center Peritoneal Dialysis
☐ Home Hemodialysis Training & Support
☐ Home Peritoneal Dialysis Training & Support

Initial Application: Total Initial Licensure Fee = $1000 for 1 service + $500 for each additional service

Renewal Application: Total Renewal Licensure Fee = $600 for 1 service + $300 for each additional service

CHECKS SHOULD BE MADE PAYABLE TO: **STATE OF DELAWARE**

The Department of Health and Social Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for licensure.

I, _____, being duly authorized to assume responsibility for the conduct of the Dialysis Center herein described, do hereby apply for a license to operate the Dialysis Center and do agree to assume responsibility that the Dialysis Center will comply with all current State of Delaware regulations governing Dialysis Centers.

Title: **Signature of Administrator:** **Date:**

PLEASE COMPLETE AND RETURN APPLICATION WITH LICENSURE FEE TO:
OFFICE OF HEALTH FACILITIES LICENSING AND CERTIFICATION
261 CHAPMAN ROAD
SUITE 200
NEWARK, DE 19702

FOR OFFICE USE ONLY

Application Reviewed & Approved by: _____
Director/Designee: _____
Type of License: ☐ Initial ☐ Annual ☐ Provisional
Licensure Period: _____ to _____
License Sent – Date: _____ Initials: _____
Tracking Update – Date: _____ Initials: _____