



FOR OFFICE USE ONLY

Check Amount
Check Number
License Expiration

State of Delaware

Office of Health Facilities Licensing and Certification

License Renewal Application for 3370 Hospital (HSPTL)

License ID: HSPTL-

Provider Legal Name

Doing Business As (DBA)

Facility Address

City

State DE

Zip Code

Facility Phone

Facility Fax

Administrator/CEO

Ph.

Email

Exec. Assistant to Admin/CEO

Ph.

Email

Chief Medical Officer

Ph.

Email

Delaware Medical License Number

Expiration Date

Director of Nursing

Ph.

Email

Delaware Registered Nursing License Number

Expiration Date

Quality/Risk Manager

Ph.

Email

Patient Advocate

Ph.

Email

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
- 2. Non-Profit

- Public
- For-Profit

- State Government
- Other

Facility Type Acute Care Long Term Acute Care Psychiatric Care Children Rehabilitation

Has there been a change of ownership since the last survey? Yes No

If Yes, give date

Total Number of Licensed Beds Bassinets
 Total Number of Operating Beds Total Annual Patient Days
 Total annual Outpatient Visits*

*A visit to each organized outpatient care Program by a person who is not an inpatient (does not include the number of diagnostic &/or therapeutic treatments received).

Which populations are served in this hospital? (check all that apply)

Pediatric (Birth – 9) Adult (19-64)
 Adolescent (10 – 18) Geriatric (65 and older)

Affiliated with a Medical School Identify

Major

Limited

Graduate

No Affiliation

Resident Programs Approved by (check all that apply)

AMA ADA
 AOA Other
 No Program

Accredited Yes No Deemed Yes No

Accrediting Organization Expiration Date

Please attach the most current of the following

Exhibit A Hospital directory that (at a minimum) identifies the service departments available, the department manager and phone number.

Exhibit B list (include name, address, type of service) of all Provider-based services, hospital departments located off-site; any service included under your state license, federal certification or accreditation.

**Please Email the following as three (3) separate attachments to
 DHSS_DHCQ_OHFLCFAX@DELAWARE.GOV**

Exhibit C Accreditation Certification, Official Accreditation report, and Plan of Correction. (If Applicable)
 Exhibit D Your Emergency Preparedness Plan (including reviewed/revised date).
 Exhibit E Delaware State Fire Marshal Inspection Letter

Application is made to operate a Hospital in accordance with 16 Del. C. Code §1002(a) and the Department of Health and Social Services Hospital Regulations (3370).

I affirm that all the information provided herein is complete and true. I further agree to conduct said Facility in accordance with laws of the State of Delaware and with the rules and regulations of the Delaware Division of Health Care Quality.

Name of the person completing the form Title
 Email Phone
 Signature Date

Checks should be made payable to **STATE of DELAWARE**

Hospital Licensure Fee based on calculation below

Initial \$2 x # of beds + \$1000 + \$500 (for each ED not on the hospital main campus) = Total

Annual \$2 x # of beds + \$750 + \$500 (for each ED not on the hospital main campus) = Total

Please type and return the application with the licensure fee 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