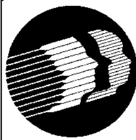

STATE OF DELAWARE
OFFICE OF HEALTH FACILITIES
LICENSING AND CERTIFICATION
(302) 292-3930

APPLICATION FOR DIALYSIS CENTER LICENSURE

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

Reason for Application		
Initial	Renewal	
	License Number:	Expiration Date:

Facility Information		
Legal Name:		
Doing Business As:		
Facility Address:		
City:	State:	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 qualifications)	
Name:	
Address:	
Telephone Number:	Fax:
Email Address:	

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

Nurse Manager: (MUST provide a copy of qualifications)	
Name:	
Address:	
Telephone Number:	Fax:
Email Address:	
Infection Prevention and Control Program Leader: (MUST provide a copy of qualifications)	
Name:	
Address:	
Telephone Number:	Fax:
Email Address:	
Dietitian: (MUST provide a copy of qualifications)	
Name:	
Address:	
Telephone Number:	Fax:
Email Address:	
Social Worker: (MUST provide a copy of 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)

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, number of kilowatts

Attach evidence of monthly testing of emergency power source

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

Services Provided: (Check all that apply)

In-Center Hemodialysis
In-Center Nocturnal Hemodialysis

In-Center Peritoneal Dialysis

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

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. IF APPLICABLE, EMAIL A COPY OF THE DEEMING CERTIFICATE, OFFICIAL DEEMING REPORT, AND PLAN OF CORRECTION TO: AMY-JOY.ANDREWS@DELAWARE.GOV
4. FIRE SAFETY REPORT
5. EMAIL A COPY OF YOUR EMERGENCY PREPAREDNESS PLAN TO: AMY-JOY.ANDREWS@DELAWARE.GOV

Name of person completing the form:

Signature:	Title:

Date:

FEE CALCULATION FOR INITIAL APPLICATION:

Check which services are provided:

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

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

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

The Department of Health and Human 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: Annual Provisional

Licensure Period: _______________ to ________________

License Sent – Date: _______________ Initials: _______________

Tracking Update – Date: _____________ Initials: ________________