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

STATE OF DELAWARE
OFFICE OF HEALTH FACILITIES LICENSING AND CERTIFICATION
APPLICATION FOR HOME HEALTH AGENCY AIDE ONLY LICENSE

License ID: HHAAO - _____

Legal Name: _____

DBA Name: _____

Agency Address: _____
Address 1

_____
Address 2

_____ _____ _____
City State Zip Code

Please check which county your agency is located in: ☐ New Castle ☐ Kent ☐ Sussex

Director: _____ _____
Name Director Email

Clinical Director: _____ _____
Name Clinical Director Email

Phone Numbers: _____ _____
Office Fax

DE RN License #: _____

EMERGENCY CONTACT: _____
Name Phone

E-Mail: _____
(Emergency contact must be available at all times in case of weather emergency, natural disaster, etc.)

Agency Type	☐ Private	☐ Not for Profit
	☐ Public	☐ Proprietary
	☐ Skilled	☐ Aide Only

Other: _____

Office Hours: _____

Geographic Area: Please check the county(ies) your Agency serves: ☐ New Castle ☐ Kent ☐ Sussex

ACCREDITED? ☐ YES ☐ NO

If yes, provide name of Accrediting Organization and Accreditation Expiration Date:

_____ _____
Accrediting Organization Exp. Date

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 agency.
2. A list showing the names and addresses of the governing body, if different from the preceding group.
3. Names, addresses & types of agencies owned or managed by the applicant and located in Delaware.
4. Email a copy of the Accreditation Certificate, Official Accreditation Report, and Plan of Correction to: AMY-JOY.ANDREWS@DELAWARE.GOV
5. Résumés, of the Director and Clinical Director
6. Email a copy of your Emergency Preparedness Plan to: AMY-JOY.ANDREWS@DELAWARE.GOV
7. Other: _____

NAME OF PERSON COMPLETING THIS FORM: _____

SIGNATURE: _____

EMAIL: _____

TITLE/DATE: _____

Checks should be made payable to: **State of Delaware**

Initial Application Fee:	Annual Licensure Fee:
$500.00	$300.00

PLEASE COMPLETE AND RETURN APPLICATION WITH LICENSURE FEE TO:

Office of Health Facilities Licensing & Certification
261 Chapman Road, Suite 200
Newark, DE 19702
(302) 292-3930

FOR OFFICE USE ONLY

Application Reviewed & Approved by:_____ Date:_____

Director/Designee:_____ Date:_____ Type of License: ☐Annual ☐Provisional

Licensure Period:_____ to _____

License Sent: Date: _____ Initials:_____

Tracking Update: Date: _____ Initials: _____

Home Health Agency Services and Employee Information

Services Provided	Does your company provide these services?		Are the services provided by employees of the agency?		Number of persons employed in each service	Are the services provided by contractors?		Number of contractors providing each service	Are services provided by both employees and contractors?		Total number of caregivers in each service
	Yes	No	Yes	No		Yes	No		Yes	No	
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%

STATE OF DELAWARE
OFFICE OF HEALTH FACILITIES LICENSING AND CERTIFICATION
LICENSURE SURVEY FOR AGENCIES
PROVIDING **HOME HEALTH AIDE SERVICES ONLY**

License ID: HHAAO-_____

Name of Agency: _____

DBA: _____

Address: _____

_____

☐ please ✓ if this is a new address

Name of Director: _____

Enclose a copy of Director's resume. Date of Hire: _____

Clinical Director: _____

Enclose a copy of Clinical Director's resume. Date of Hire: _____

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

If yes, give date: _____

Does this agency have branches? Yes ☐ No ☐

If yes, attach a separate sheet of paper with date opened and address for each branch.

Name of Contact Person if any Questions _____

Title: _____

Phone Number: _____

LICENSURE SURVEY QUESTIONS

All home health agencies providing home health aide services exclusively are required to meet the Delaware Department of Health & Social Services Home Health Agencies – Aide Only Regulations (4400).

1. List the number of unduplicated intermittent unskilled patients admitted in the previous 12 months.

Census: _____

2. (a) Outline the organization and services of the state licensed home health agency (HHA) program (Ref. 4.0). Respond by listing services you provide, attaching organizational chart(s) and report any changes in your organization that may have occurred since the last report.

Exhibit 2A – Listing of Services
2B – Organizational Chart(s) including branches
2C – Changes in Organization (if applicable)

(b) Please include copies of portions of agency documents such as governing body minutes that show: budget approval, approval of annual program evaluation and appointment of any new administrator since last state agency survey. (Ref. 4.0)

Exhibit 2D – Portions of agency documents

3. Date of your last program evaluation _____. Please attach a summary of your last annual program evaluation. Identify what steps you took to resolve any problems. What were the results of your efforts? (Ref. 4.2.11)

Exhibit 3A – Attach a list of members involved in the evaluation
3B – Attach a list of findings and recommendations
3C – What follow-up is being done or planned to be done?

4. If changes have occurred in the policies for the establishment of the Plan of Care since your last survey (paper or on-site), please attach those policies. (Ref.6.3)

HOME HEALTH AIDE SERVICES

1. Home health aide services are provided directly ☐, by contract ☐, or both ☐?

2. Provide evidence that the home health agency ensures that individuals who furnish home health aide services on behalf of the agency meet competency evaluation and skills assessment requirements. If changes have occurred since your last paper or on-site survey, please include sample copies of competency test and skills assessment.

    (a) Attach a listing of all home health aide inservices conducted in the previous year with attendance sheets. (Ref. 5.7.6 for required topics)

    (b) Have all home health aides received 12 hours of in-service training in the previous 12 months? YES ☐ NO ☐ Explain a "no" response.

NOTE: PLEASE COMPLETE LICENSURE RENEWAL APPLICATION AND AFFIRMATION BELOW

Application is made to operate a home health agency in accordance with Chapter 16 Delaware Code §122(3)(n) and the Department of Health & Social Services Home Health Agencies – Aide Only Regulations.

I attest that all employees/contractors have had a criminal background check, drug testing, child and adult abuse checks as required in Chapter 11 Delaware Code §8563 and §8564; Chapter 16 Delaware Code §1141 and §1142; and Chapter 19 Delaware Code §708.

I affirm that all of the information provided herein is COMPLETE and true. Incomplete or inaccurate information IS REASON FOR NON-RENEWAL OF THE AGENCY'S LICENSE. I further agree to conduct said agency in accordance with the laws of the State of Delaware and with the rules and regulations of the DELAWARE DIVISION OF HEALTH CARE QUALITY..

Signature of Agency Administrator

_____

Date