FOR OFFICE USE ONLY

Check Amount: _____

Check Number: _____

License Expiration: _____

State of Delaware

Office of Health Facilities Licensing and Certification

Licensure Renewal Application for Skilled Home Health Agency (HHA)

License ID: HHAS - _____

Legal Name: _____

DBA Name: _____

Agency Address: _____

City: _____ State: DE Zip Code: _____

Which county is your office located in (Check only one): ☐ New Castle ☐ Kent ☐ Sussex

Director: _____ Email: _____

Alternate Director: _____ Email: _____

Clinical Director: _____ Email: _____

Alt. Clinical Director: _____ Email: _____

Agency Phone: _____ Agency Fax: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Email: _____

(EMERGENCY CONTACT MUST BE AVAILABLE AT ALL TIMES IN CASE OF EMERGENCY, NATURAL DISASTER, ETC.)

Agency Type: (Check all that apply)

☐ Private ☐ Public ☐ Not-For-Profit ☐ Proprietary

Office Hours: _____

Check the county(ies) in which your agency provides services:

☐ New Castle ☐ Kent ☐ Sussex

Accredited? ☐ Yes ☐ No Deemed? ☐ Yes ☐ No

If yes, print name of the Accrediting Organization and Accreditation Expiration date?

Accreditation Organization: Expiration Date:

Licensure Survey:

All home health agencies providing skilled services are required to meet the Delaware Department of Health and Social Services Skilled Home Health Agencies regulations (4410).

1. List the number of unduplicated intermittent patients admitted in the previous 12 months.
    a. Census:
    b. Skilled:
    c. Unskilled:
2. Has there been a change of ownership since the last survey? ☐ Yes ☐ No

    If Yes, give date: _____
3. Home health aide services are provided ☐ Directly ☐ By Contract ☐ Both ☐ N/A
4. Do all individuals who furnish home health services on behalf of the agency meet competency evaluation and skill assessment requirements? ☐ Yes ☐ No
    a. Attach a list of home health aide in-service conducted in the previous year that reflects regulation 5.8.6.
    b. All home health aides have received in-service training as required:
        i. 12 hours per year (Ref 5.8.6 for required topics) ☐ Yes ☐ No

        Explain "No" Response: _____
5. Attach the following documents regarding the organization and services of the state licensed HHA. Documents should be labeled with the noted Exhibit identifier. For example, the "List of Services" should be labeled "Exhibit 2A".

    Exhibit 2A - List of Services
    Exhibit 2B - Organizational Chart(s)
    Exhibit 2C - Changes in organization (if applicable)
    Exhibit 2D - List of governing body members
    Exhibit 2E - Proof of insurance (Regulation 9.0)

Exhibit 2F - Evidence such as governing body minutes that show: Budget approval, approval of annual programs evaluation, and appointment of any new director since last survey. (4.1 – 4.2)

Exhibit 2G - Name, addresses & types if agencies owned or managed by the applicant

Exhibit 2H - Resumes of Director, Clinical Director, and Alternates

Please Email the following to: dhss_dhcq_ohflcfax@delaware.gov

Exhibit 2I - Accreditation Certification, Official Accreditation report, and Plan of Correction(if applicable)

Exhibit 2J - Your Emergency Preparedness Plan

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%

Revised: 10-09-2020

Application is made to operate a skilled home health agency in accordance with Title 16 Health and Safety, Delaware Administrative Code and the Department of Health and Social Services Skilled Home Health Agencies regulations (4410).

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 Agency Director: _____

Signature of Agency Director: _____

Date: _____

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

Please complete and return the application with the licensure fee and attachments to:

Office of Health Facilities Licensing and Certification
261 Chapman Road, Suite 200
Newark, DE 19702

For Office Use Only:

Application Reviewed & Approved By: _____ Date: _____

Director/Designee: _____ Date: _____

Type of License: ☐ Annual ☐ Provisional

Licensure Period: _____ To: _____

License Sent Date: _____ Initials: _____