FOR OFFICE USE ONLY

CHECK AMOUNT: _____
CHECK NUMBER: _____
LICENSE EXPIRATION: _____

STATE OF DELAWARE
OFFICE OF HEALTH FACILITIES LICENSING AND CERTIFICATION

APPLICATION FOR HOSPITAL LICENSE

LICENSE ID: HSPTL - _____

LEGAL NAME: _____

DBA NAME: _____

AGENCY ADDRESS: _____

_____

_____ _____ _____
CITY STATE ZIP CODE

ADMINISTRATOR/CEO/EMAIL: _____

CONTACT NAME: _____

_____
POSITION/TITLE/EMAIL

DON: _____ _____
NAME PHONE

DON EMAIL: _____

PHONE NUMBERS: _____ _____ _____
FACILITY PHONE CONTACT PERSON CONTACT FAX

CONTACT EMAIL: _____

EMERGENCY CONTACT: _____ _____
NAME PHONE

EMAIL: _____
(EMERGENCY CONTACT MUST BE AVAILABLE AT ALL TIMES IN CASE OF WEATHER EMERGENCY, NATURAL DISASTERS, ETC.)

FACILITY TYPE:

☐ General - providing diverse patient services, diagnostic and therapeutic, for a variety of medical conditions. A general hospital must provide onsite:

- Diagnostic x-ray services with facilities and staff for a variety of procedures;
- Clinical laboratory services with facilities and with anatomical pathology services regularly and conveniently available;
- Operating room service with facilities and staff; and
- Emergency Department with facilities and staff.

☐ Long Term Care - providing inpatient services for patients whose medically complex conditions require a long hospital stay with an average length of stay of greater than 25 days.

☐ Psychiatric - providing services for the diagnosis and treatment of patients with psychiatric-related illness.

☐ Rehabilitation - providing intensive inpatient rehabilitative services for one or more conditions requiring rehabilitation

TYPE OF CONTROL:

☐ NON-PROFIT ☐ FOR-PROFIT

☐ STATE GOVERNMENT ☐ OTHER: _____

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).

ACCREDITED: ☐ YES ☐ NO

IF YES, PRINT NAME OF ACCREDITING ORGANIZATION **AND** ACCREDITATION EXPIRATION DATE:

_____ _____

ACCREDITING ORGANIZATION EXPIRATION DATE

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

AUTHORIZED OFFICIAL

_____ _____

NAME TITLE

_____ _____

SIGNATURE DATE

Please attach the most current of the following:

1. Hospital directory that (at a minimum) identifies the service departments available, the department manager and phone number.
2. A list (incl. 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.
3. Fire safety report.
4. Email a copy of the Accreditation Certificate, Official Accreditation Report, and Plan of Correction to: AMY-JOY.ANDREWS@DELAWARE.GOV
5. Email a copy of your Emergency Preparedness Plan to: AMY-JOY.ANDREWS@DELAWARE.GOV
6. Other: _____

Name of Person Completing this Form: _____

Signature: _____

Title: _____

Date: _____

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

Initial Application Fee	Annual Licensure Fee
$1000 plus $2 per licensed inpatient bed and $500 for each emergency department not located on the hospital's main campus	$750 plus $2 per licensed inpatient bed and $500 for each emergency department not located on the hospital's main Campus

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

Office of Health Facilities Licensing and 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: _____