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. Assist. 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)

Private ☐ Public ☐ State Government ☐

Non-Profit ☐ For-Profit ☐ Other ☐ _____

Office Hours

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 _____

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. 10-31-2022