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

STATE OF DELAWARE

OFFICE OF HEALTH FACILITIES LICENSING AND CERTIFICATION

(302) 292-3930

APPLICATION FOR FREE STANDING BIRTHING CENTER LICENSE

License ID: FSBC - _____

CENTER NAME: _____

CENTER ADDRESS: _____

_____

_____ DE _____
City State Zip Code

ADMINISTRATOR/CEO: _____ EMAIL: _____

ALTERNATE CONTACT:_____ EMAIL: _____

PHONE NUMBERS: _____ _____ _____
Center Phone Contact Phone Center Fax

EMERGENCY CONTACT: _____ _____
Name Phone

EMAIL: _____

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

NUMBER OF BIRTHING ROOMS: _____

NUMBER OF PHYSICIANS WITH PRIVILEGES: _____

NUMBER OF CERTIFIED NURSE MID-WIVES WITH PRIVILEGES: _____

ALL PHYSICIANS HAVE ADMITTING PRIVILEGES TO AREA HOSPITALS: ☐ YES ☐ NO

ALL CERTIFIED NURSE MID-WIVES HAVE A BACK-UP AGREEMENT WITH A PHYSICIAN: ☐ YES ☐ NO

ACCREDITED: ☐ YES ☐ NO

IF YES, NAME OF ACCREDITING ORGANIZATION

_____

ACCEDITATION EXPIRATION 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 INTERESST IN THE CENTER.
2. A LIST SHOWING THE NAMES AND ADDRESSES OF THE GOVERNING BODY, IF DIFFERENT FROM THE PRECEDING GROUP.
3. FIRE SAFETY REPORT
4. OTHER _____

PLEASE EMAIL THE FOLLOWING TO: DHSS_DHCQ_OHFLCFAX@DELAWARE.GOV

5. COPY OF THE ACCREDITATION CERTIFICATE, OFFICIAL ACCREDITATION REPORT, AND PLAN OF CORRECTION
6. COPY OF YOUR EMERGENCY PREPAREDNESS PLAN

NAME OF PERSON COMPLETING THIS FORM: _____

SIGNATURE: _____ TITLE: _____

DATE: _____

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

INITIAL APPLICATION FEE:	ANNUAL LICENSURE FEE:
$150	$75.00

PLEASE COMPLETE AND RETURN APPLICATION WITH LICENSURE FEE TO:
OFFICE OF HEALTH FACILITIES LICENSING & 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: _____

Tracking Update – Date: _____ Initials: _____

STATE OF DELAWARE
OFFICE OF HEALTH FACILITIES LICENSING AND CERTIFICATION
LICENSURE SURVEY FOR
FREE STANDING BIRTHING CENTER

License #_____

(Please print or type all information)

Name of Center:_____

DBA:_____

Address:_____

_____

☐ Please ✓ if this is a new address Center Hours:_____

Status: ☐ Profit ☐ Non-Profit

Center Administrator:_____

Is the Center Administrator a full-time employee? ☐ YES ☐ NO

Clinical Director/Title:_____

Is the Clinical Director available at all times during the operating hours? ☐ YES ☐ NO

Attach job descriptions, resumes/qualifications and proof of licensure for Center Administrator and Clinical Director.

Has there been a change of ownership since the last survey? ☐ YES ☐ NO

If yes, give date:_____

Name of Contact Person if any questions:_____

Title:_____

Phone Number:_____

E-mail: _____

LICENSURE SURVEY QUESTIONS

All free standing birthing centers, other than a hospital, providing delivery of new babies and immediate postpartum care exclusively are required to meet the Department of Health and Social Services Free Standing Birthing Centers Regulations (4403).

1. List the number of mothers admitted in the previous 12 months:_____

   Fill out and attach Appendix A

2. Outline the organization and services of the state licensed free standing birthing center program. Respond by attaching organizational chart(s), and report any changes in your organization that may have occurred since the last report.

   Exhibit 2A – Organizational Chart(s)
   2B – Changes in Organization (if applicable)
   2C – List of Governing Body Members
   2D – Proof of not-for-profit status if claiming tax exempt status
   2E – List all members who have a financial interest in the operation or related business
   2F – List all members/employees with a criminal record
   2G – List of management personnel including qualifications

3. Date of last survey: On-site _____ Paper _____. If changes have occurred in your center since your last on-site or off-site survey, briefly describe those changes (attach additional pages as needed).

4. Submit a copy of the most recent documented quality improvement program. Include the following:

   a. An internal monitoring process that tracks performance measures;

   b. A review of the program's goals and objectives at least annually;

   c. A review of the grievance/complaint process;

   d. A review of all major adverse incidents;

   e. A review of actions taken to address identified issues; and

   f. A process to monitor the satisfaction of the patients with the services of the center.

5. If changes have occurred in the policies for the center since your last survey (paper or on-site), please attach those policies.

FREE STANDING BIRTHING CENTER

1. Is a physician certified by the American Board of Obstetrics and Gynecology or who is qualified and authorized by training and experience in obstetrics and gynecology immediately available by telephone twenty-four hours a day?

YES ☐ NO ☐ Explain a "no" answer

2. Has each physician providing services for the center demonstrated hospital admitting privileges for patients who develop complications?

YES ☐ NO ☐ Explain a "no" answer

3. Has each certified mid-wife (nurse or professional) providing services for the center provided proof of a collaborative agreement with a physician who will accept consultation calls and referrals twenty-four (24) hours a day, seven (7) days a week?

YES ☐ NO ☐ Explain a "no" answer

4. Have all new employees completed an orientation?

YES ☐ NO ☐ Explain a "no" answer

5. Have all employees had an annual performance review and competency?

YES ☐ NO ☐ Explain a "no" answer

6. Attach a copy of all the following personnel policies
   a. Pre-employment requirements
   b. Position descriptions
   c. Orientation of all new employees
   d. In-service education
   e. Annual performance review and competency

7. Has an employee found to active Tuberculosis (TB) in an infectious stage provided care or service to patients?

YES ☐ NO ☐ Explain a "yes" answer

8. Have any and all employees with a positive (TB) skin test but negative chest X-Ray completed an attestation annually attesting they are asymptomatic?

YES ☐ NO ☐ Explain a "no" answer

9. Does your center meet or exceed the following prenatal visit schedule.

At least every four (4) weeks until the twenty-eighth (28th) week;

At least every two (2) weeks between the twenty-eighth (28th) week and the thirty-sixth (36th) week; and

At least every week between the thirty-sixth (36th) week and delivery.

YES☐ NO☐ Explain a "no" answer

10. In the past year, has labor been inhibited, stimulated or augmented with chemical agents?

YES☐ NO☐ Explain a "yes" answer

11. In the past year, has a surgical procedure, except an episiotomy, repair of episiotomy or laceration, or circumcision been performed at your center?

YES☐ NO☐ Explain a "yes" answer

12. How long does a patient remain at your center following an uncomplicated birth? _____ days

13. Is a member of your center's professional staff accessible to patients by telephone 24 hours a day?

YES☐ NO☐ Explain a "no" answer

14. Complete and attach Appendix A, B, C and D

15. Does your center provide the patient with a written notice of the patient's rights during the initial assessment visit or before admission for services?

YES☐ NO☐ Explain a "no" answer

16. Attach a copy of the disaster preparedness plan and staff attendance for disaster preparedness plan orientation.

17. Attach a copy of the following:

a. Transfer Agreement

b. Evacuation Plan

c. Written records and attendance of the quarterly simulated fire drills

NOTE: COMPLETE LICENSURE RENEWAL APPLICATION AND AFFIRMATION BELOW

Application is made to operate a free standing birthing center in accordance with Chapter

16 Delaware Code §122(3) (n) and the Department of Health and Social Services Free Standing Birthing Center Regulations (4403).

I affirm that all of the information provided herein is COMPLETE and true. Incomplete or inaccurate information IS REASON FOR NON-RENEWAL OF THE CENTER'S LICENSE. I further agree to conduct said center 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 Center Administrator

_____

Date

Appendix A

In the past year, has a mother given birth at your center with any of the following conditions? (Check all that apply)

a. Less than 16 years of age ☐
b. Chronic hypertension ☐
c. Chronic heart disease ☐
d. Pulmonary embolus ☐
e. Congenital heart defects ☐
f. Severe renal disease ☐
g. Lupus erythematosus ☐
h. Drug or alcohol addiction ☐
i. Required use of anticonvulsant drugs ☐
j. Bleeding disorder or hemolytic disease ☐
k. Paraplegia/quadriplegia ☐
l. Diabetes mellitus ☐
m. Cognitive impairment that would interfere with the ability to follow directions ☐
n. Morbid obesity ☐
o. Active genital herpes, syphilis or HIV positive ☐
p. The need for general or conduction anesthesia ☐
q. The need for a caesarian section ☐
r. Serious congenital anomaly in a previous birth whose recurrence cannot be ruled out by antenatal evaluation ☐
s. Rh sensitization ☐
t. Previous uterine wall surgery including cesarean section ☐
u. Five or more term pregnancies with other risk factors ☐
v. Nullipara of greater than 40 years of age with other risk factors ☐
w. Multipara over 45 years of age with other risk factors ☐
x. Previous placenta abruption ☐
y. Significant signs or symptoms of:
   aa. Hypertension ☐
   bb. Toxemia ☐
   cc. Polyhydramnios or oligohydramnios ☐
   dd. Abruption placenta ☐
   ee. Chorioamnionitis ☐
   ff. Malformed fetus ☐
   gg. Fetal distress ☐
   hh. Multiple gestation ☐
   ii. Intrauterine growth retardation or macrosomia ☐
   jj. Thrombophlebitis ☐
   kk. Pyelonephritis ☐

Explain any boxes with a ✓

Appendix B

In the past year, has your center provided care to any patients with the following conditions? (Check all that apply)

a. Premature labor (occurring at less than 37 weeks gestation) ☐

b. Development of hypertension or pre-eclampsia ☐

c. Non-vertex presentation ☐

d. Failure to progress in labor ☐

e. Evidence of an infectious process ☐

f. Suspected placenta previa or abruption ☐

g. Hemorrhage of greater than 500 cc of blood ☐

h. Premature rupture of the membranes (occurring within a timeframe agreed upon by the certified midwife and back-up physician in their collaborative agreement) ☐

i. Suspected congenital anomaly ☐

j. Anemia consisting of less than ten (10) grams of hemoglobin per one hundred (100) milliliters of blood or thirty (30) percent hematocrit ☐

k. Persistent fetal tachycardia (heart rate greater than 160 beats per minute), repetitive fetal bradycardia (heart rate less than 120 beats per minute) or undiagnosed abnormalities of the fetal heart tones ☐

l. Rising antibody titre of any type that is known to affect fetal well-being ☐

m. Excessive need for analgesia during labor, or for anesthesia other than pudendal or local ; ☐

n. Persistent hypothermia in the newborn ☐

Explain any boxes with a ✓

Appendix C

In the past year, has your center provided care to any patients with the following conditions? (Check all that apply)

a. Prolapsed cord ☐

b. Uncontrolled hemorrhage ☐

c. Need for transfusion ☐

d. Placenta abruption ☐

e. Retained placenta greater than sixty (60) minutes ☐

f. Convulsions ☐

g. Thick meconium staining at the time of membrane rupture ☐

h. Apgar score of seven (7) or less at five (5) minutes ☐

i. Fetal heart rate of ninety (90) or less beats per minute for three (3) minutes ☐

j. Major anomaly of the newborn ☐

k. Respiratory distress in the newborn ☐

l. Newborn weight less than 2500 grams ☐

m. Newborn need for oxygen beyond five (5) minutes ☐

n. Signs of prematurity ☐

Explain any boxes with a ✓

Appendix D

Provide names, license numbers and expiration dates of personnel who provide services at the free standing birthing center.

Physicians:

Name	License #	Expiration Date

Certified Nurse Midwives:

Name	License #	Expiration Date

Certified Professional Midwives:

Name	License #	Expiration Date

Registered Nurses:

Name	License #	Expiration Date