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

State of Delaware
Office of Health Facilities Licensing and Certification
Application for Personal Assistance Services Agency

License ID: PASA - _____

Legal Name: _____

DBA Name: _____

Agency Address: _____

_____

_____ _____ _____
City State Zip Code

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

Director/Email: _____

Designated alternate

To Director/Email: _____

Phone Numbers: _____ _____
Agency Phone Agency Fax

Additional Emails : _____

Emergency Contact: _____ _____
Name Phone

Email: _____
(Emergency contact must be available at all times in case of weather emergency, natural disasters, etc.)

Agency type: (check all that apply)

☐ Private ☐ Public

☐ Non-Profit ☐ For-Profit

☐ Employees Only ☐ Contractors Only

☐ Employees and Contractors

Office Hours: _____

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

Services Provided: ☐ ADLs ☐ Live-In

☐ Companionship ☐ Homemaker

☐ Transportation ☐ Licensed Home Health

☐ Other: _____

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, addresses of the governing body, if different from the preceding group.
3. Other: _____
   _____

Name of person completing this form: _____

Signature: _____

Title/Email: _____

Date: _____

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

Initial Application Fee	Annual Licensure Fee
$250.00	$100.00

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: _____

STATE OF DELAWARE
OFFICE OF HEALTH FACILITIES LICENSING AND CERTIFICATION
LICENSURE SURVEY FOR AGENCIES
PROVIDING PERSONAL ASSISTANCE SERVICES ONLY

License ID: PASA-_____

(Please print or type all information)

Name of Agency:_____

DBA:_____

Address:_____

_____

☐ please ✓ if this is a new address Agency hours:_____

Agency Director:_____

Date of Hire:_____

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

If yes, give date:_____

Does this agency have other offices? Yes ☐ No ☐

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

Name of Contact Person if any questions:_____

Title:_____

Phone Number:_____

E-mail: _____

LICENSURE SURVEY QUESTIONS

All personal assistance service agencies (PASAs) providing personal assistance services exclusively are required to meet the Department of Health & Social Services Personal Assistance Services Agencies Regulations (4469).

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

   List your current census:_____

2. (a) Outline the organization and services of the state licensed PASA program (Ref. 3.10). 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)
   2C – Changes in Organization (if applicable)
   2D – List of Governing Body Members

   (b) Please include proof of continued insurance and bonding. (Ref. 7.0)

   Exhibit 2E – Proof of insurance

3. Date of your last program review and evaluation _____. (Ref. 4.3.2.5)

4. If changes have occurred in the policies for the establishment of the Service Plan since your last survey (paper or on-site), please attach those policies. (Ref. 5.3)

PERSONAL ASSISTANCE SERVICE AGENCY

1. Personal assistance services are provided directly ☐, by contract ☐, or both ☐ ?

2. (a) Have all direct care workers passed an annual competency test? (Ref. 4.3.2.4)

   YES ☐ NO ☐ Explain a "no" response.

   (b) Have all direct care workers received an annual performance review? (Ref. 4.3.2.4 & 4.4.2.4)

   YES ☐ NO ☐ Explain a "no" response.

(c) Have all newly hired/contracted direct care workers passed a competency test prior to providing care to consumers? (Ref. 4.5.3)

YES ☐ NO ☐ Explain a "no" response.

(d) Have all consumers received and signed the "Notice of Direct Care Worker Status" Form?

YES ☐ NO ☐ Explain a "no" response.

(e) Have all consumers received written notice of the consumer's rights?

YES ☐ NO ☐ Explain a "no" response.

NOTE: PLEASE COMPLETE LICENSURE RENEWAL APPLICATION AND AFFIRMATION BELOW

Application is made to operate a personal assistance services agency in accordance with Chapter 16 Delaware Code §122(3) (n) and the Department of Health & Social Services Personal Assistance Services Agencies Regulations (4469).

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