|  | 1 |
|--|---|
|  |   |

Check Amount

Check Number

License Expiration

# State of Delaware

Office of Health Facilities Licensing and Certification

License Renewal Application for 3360 Adult Day Care (ADC)

|  | (Please type)                                |                       | <u>)</u> լ  | License ID ADC –              |  |
|--|--|-----------------------|-------------|-------------------------------|--|
| Provider Legal Name                        |  |                       |             |                               |  |
| Doing Business As (DBA)                    |  |                       |             |                               |  |
| Facility Address                           |  |                       |             |                               |  |
| City                                       |  | State                 | DE          | Zip Code                      |  |
| Facility Phone                             |  | Facilit               | y Fax       |                               |  |
| Director                                   |  | Email                 |             |                               |  |
| Nurse                                      |  | Email                 |             |                               |  |
| Delaware Registered Nursing License Number |  |                       | E           | Expiration Date               |  |
| Activities Director                        |  | Email                 |             |                               |  |
| Emergency Contact Name                     |  |                       |             |                               |  |
| Emergency Contact Phone                    |  | Email                 |             |                               |  |
| (EMERGENCY CONTACT M                       | UST BE AVAILABI                              | LE AT ALL TIMES IN CA | SE OF EMERG | ENCY, NATURAL DISASTER, ETC.) |  |
| Facility Type (Check all that apply)       | <ol> <li>Private</li> <li>Non-Pro</li> </ol> | Public<br>fit For-P   |             |                               |  |
| Hours of Operation                         |  |                       |             |                               |  |
| Monday                                     |  |                       |             |                               |  |
| Tuesday                                    |  |                       |             |                               |  |
| Wednesday                                  |  |                       |             |                               |  |
| Thursday                                   |  |                       |             |                               |  |
| Friday                                     |  |                       |             |                               |  |

Saturday

Sunday

### Licensure Survey

All Adult Day Cares providing skilled services are required to meet the Delaware Department of Health and Social Services Adult Day Care Regulations (3360).

1. List the number of unduplicated intermittent patients admitted in the previous 12 months.

| Census           | Capacity |    |    |       |
|------------------|----------|----|----|-------|
| Support Services | Speech   | PT | OT | Other |

- 2. Has there been a change of ownership since the last survey? Yes No If Yes, give date
- Do all the aides/assistants/technicians meet the minimum criteria that reflects Reg. 13.13.
   Yes No

Explain "No" Response

Attach a list of ongoing staff development conducted in the previous year that reflects Reg. 13.14.

4. All individuals who are responsible for direct care of participants have received at least twelve (12) hours annually of staff development that reflects Reg. 13.14.

Yes No Explain No

Attach the following documents regarding the organization and services of the State licensed ADC Documents should be labeled with the noted Exhibit identifier. For example, the "List of Services" should be labeled "Exhibit B."

Exhibit A – Delaware Div. of Revenue Business License (and city/town business license if applicable)

- Exhibit B List of Services
- Exhibit C Organizational Chart(s)

Exhibit D - Changes in organization (if applicable)

Exhibit E - List of governing body members

Exhibit F - Evidence such as Quality Assurance/Improvement minutes that shows

F.1) An internal monitoring process that tracks performance measures Reg. 14.1.1.

F.2) review of programs, goals and objectives annually Reg. 14.1.2.

Exhibit G - List showing the names, addresses and percent of interest of each officer, director and owners having an interest in the Facility (complete "Ownership Interest" included).

Exhibit H - Resumes of staff mentioned above.

# Please Email the following as two (2) separate attachments to DHSS\_DHCQ\_OHFLCFAX@DELAWARE.GOV

Exhibit I – Your Emergency Preparedness Plan (including reviewed/revised date).

Exhibit J – Delaware State Fire Marshal Inspection Letter

### **Ownership Interest**

| Name | Address | % Ownership Interest |
|------|---------|----------------------|
|      |         |                      |
|      |         |                      |
|      |         |                      |
|      |         |                      |
|      |         |                      |
|      |         |                      |
|      |         |                      |
|      |         |                      |
|      |         | Total = 100%         |

Application is made to operate an Adult Day Care in accordance with 16 Del. C. Code §122(3)(s) and the Department of Health and Social Services Adult Day Care Regulations (3360).

I attest that all employees/contractors have had

- A criminal background check and drug testing (16 Del.C. §1145 and §1146)
- Child and adult abuse check (11 Del.C. §8563 and §8564)
- Services letter(s) (19 Del.C. §708)

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 formTitleEmailPhoneSignatureDate

Check or money order should be made payable to State of Delaware

#### Annual Licensure Fee \$50.00 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                   |        | То           |             |      |
| License Sent Date                  |        | Initials     |             |      |
| Rev. 02-10-2023                    |        |              |             |      |