FOR OFFICE USE ONLY

Check Amount

Check Number

License Expiration

State of Delaware

Office of Health Facilities Licensing and Certification

Licensure Renewal Application for 3345 Personal Assistance Services Agencies (PASA)

(Please type)

						License ID PASA -	
Provider Legal Name							
Doing Business As (DBA)							
Agency Address							
City				State	DE	Zip Code	
Agency Phone				Agenc	y Fax		
Director				Email			
Alt. Director				Email			
Emergency Contact Name							
Emergency Contact Phone				Email			
(EMERGENCY CONTACT MUS	T BE /	AVAILABLE AT A	LL TIMES I	IN CASE O	F EMERGENCY, NA	ATURAL DISASTER, ETC.)	
Agency Type (Check all that apply)							
	1.	Private			Public		
	2.	Non-Profit			For-Profit		
Office Hours							
Check the county(ies) in which your agency will provide services							
New Castle	Ke	nt	Susse	x			

Licensure Survey

All PASAs providing personal assistance services exclusively are required to meet the Department of Health & Social Services Personal Assistance Services Agencies Regulations (3345).

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

List your current census

- 2. Date of your last program review and evaluation (Reg. 4.3.3) (not by OHFLC)
- 3. Personal assistance services are provided directly by (Check one) Employee Contractor Employee and Contractor
- 4. Have all direct care workers completed an annual competency test? (Reg. 4.3.2.4) Yes No Explain a "No" response
- 5. Have all direct care workers passed an annual performance review? (Reg. 4.3.2.4 & 4.4.2.4)

Yes No Explain a "No" response

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

Yes No Explain a "No" response

- Have all consumers received and signed the "Notice of Direct Care Worker Status" form? (Reg. 5.1.3)
 Yes No Explain a "No" response
- 8. Have all consumers received written notice of the consumer's rights? (Reg. 6.2)
 Yes No Explain a "No" response
- 9. Has there been a modification of ownership and control since the last survey?

Yes No If yes, give date

10. Is medication administration offered and in accordance with Reg. 5.4.3?

Yes No

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

- Exhibit A 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 Proof of insurance (Reg. 9.0)

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

Exhibit H - Name, address and types of agencies owned or managed by the applicant.

Exhibit I - Resumes of Director and Alternate Director.

Please <u>Email the following to DHSS_DHCQ_OHFLCFAX@DELAWARE.GOV</u>

Exhibit J - Your Disaster Preparedness Plan (including reviewed/revised date).

Ownership Interest

Name	Address	% Ownership Interest		
		Total = 100%		

Application is made to operate a personal assistance services agency in accordance with 16 Del. C. Code \$122(3)(x) and the Department of Health and Social Services Personal Assistance Services Agencies Regulations (3345).

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 agency in accordance with laws of the State of Delaware and with the rules and regulations of the Delaware Division of Health Care Quality.

Print Name of Director

Email

Signature of Director

Phone Date

Annual Licensure Fee \$100.00 Checks should be made payable to **State of Delaware**

Please type and return the application with the licensure fee and attachments to Office of Health Facilities Licensing and Certification 263 Chapman Road, Suite 200 Newark, DE 19702

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Application Reviewed & Approved By							
Director/Designee				Date			
Type of License	Annual	Probationary	Provisional				
Licensure Period		То					
License Sent Date		Initials					
Rev. 10-31-2022							