



<b>FOR OFFICE USE ONLY</b>	
Check Amount:	_____
Check Number:	_____
License Expiration:	_____

**STATE OF DELAWARE**  
**OFFICE OF HEALTH FACILITIES LICENSING AND**  
**CERTIFICATION**  
**(302) 292-3930**  
**APPLICATION FOR ADULT DAY CARE LICENSE**

ADC - \_\_\_\_\_

LEGAL NAME \_\_\_\_\_

DBA NAME \_\_\_\_\_

FACILITY ADDRESS \_\_\_\_\_

Address 1

Address 2

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code

ADMINISTRATOR \_\_\_\_\_

Print

E-MAIL \_\_\_\_\_

Print

PHONE NUMBERS \_\_\_\_\_

Facility Phone Number

Facility Fax Number

EMERGENCY CONTACT: \_\_\_\_\_

Name

Phone

E-MAIL \_\_\_\_\_

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

FACILITY TYPE

Please Check All That Apply

PRIVATE

NOT FOR PROFIT

PUBLIC

PROPRIETARY

OTHER: \_\_\_\_\_

Print

HOURS OF OPERATION \_\_\_\_\_

CAPACITY \_\_\_\_\_

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 FACILITY.
2. FIRE SAFETY REPORT
3. OTHER: \_\_\_\_\_

DOES YOUR FACILITY PROVIDE NURSING SERVICES AS DEFINED IN SECTION 2.0 OF THE DELAWARE REGULATIONS FOR ADULT DAY CARE FACILITIES?

YES

NO

IF YES, NAME AND LICENSE NUMBER OF SUPERVISING NURSE:

\_\_\_\_\_

Print

NAME & TITLE OF PERSON DESIGNATED TO ACT IN ABSENCE OF DIRECTOR:

\_\_\_\_\_

Print

NAME OF PERSON COMPLETING THIS FORM: \_\_\_\_\_

Print

SIGNATURE: \_\_\_\_\_

TITLE: \_\_\_\_\_

DATE: \_\_\_\_\_

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

INITIAL APPLICATION FEE:

**\$100.00**

ANNUAL LICENSURE FEE:

**\$50.00**

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PLEASE COMPLETE AND RETURN APPLICATION WITH LICENSURE FEE AND ATTACHMENTS 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: \_\_\_\_\_