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 Hospice License

License ID: HSPC - _____

Legal Name: _____

DBA Name: _____

Agency Address: _____

_____

_____ _____ _____
City State Zip Code

Please Check Which County Your Office is Located In: ☐ New Castle ☐ Kent ☐ Sussex

Administrator/email: _____

Director of Nursing/email: _____

Date of Hire: _____ _____
DE Registered Nurse License # & Expiration Date

Phone Numbers: _____ _____
Agency Phone Agency Fax

Contact Email: _____

Emergency Contact: _____ _____
Name Phone

Email: _____

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

Agency Type: ☐ Private ☐ Not for Profit

Please check all that apply ☐ proprietary ☐ Other: _____

Geographic Area;

Please check the county(ies) your Agency Serves: ☐ New Castle ☐ Kent ☐ Sussex

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Services Provided: ☐ Home Care ☐ Inpatient Beds

Of Beds: _____

☐ Free Standing

☐ Leased Beds

ACCREDITED: ☐ YES ☐ NO

IF YES, PRINT NAME OF ACCREDITING ORGANIZATION **AND** ACCREDITATION EXPIRATION DATE:

_____ _____

ACCREDITING ORGANIZATION EXPIRATION DATE

PLEASE INCLUDE THE FOLLOWING WITH THE LICENSURE APPLICATION SUBMISSION:

1. THE COMPLETED "OWNERSHIP INTEREST" FORM (ATTACHED)
2. A LIST SHOWING THE NAMES AND ADDRESSES OF THE GOVERNING BODY, IF DIFFERENT FROM THE PRECEDING GROUP. EX. PRESIDENT, V.P., TREASURER, SECRETARY, ETC.
3. THE COMPLETED "HOSPICE AGENCY SERVICES AND EMPLOYMENT INFORMATION" FORM (ATTACHED)
4. E-MAIL A COPY OF THE ACCREDITATION CERTIFICATE, OFFICIAL ACCREDITATION REPORT, AND PLAN OF CORRECTION TO: AMY-JOY.ANDREWS@DELAWARE.GOV
5. FIRE SAFETY REPORT FOR INPATIENT FACILITY
6. E-MAIL A COPY OF YOUR EMERGENCY PREPAREDNESS PLAN TO: AMY-JOY.ANDREWS@DELAWARE.GOV
7. 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
$ 100.00	$ 50.00

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

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: _____

Hospice Agency Services and Employee Information

Services Provided	Does your company provide these services?		Are the services provided by employees of the agency?		Number of persons employed in each service	Are the services provided by contractors?		Number of contractors providing each service	Are services provided by both employees and contractors?		Total number of caregivers in each service
	Yes	No	Yes	No		Yes	No		Yes	No	
Registered Nurse *											
Licensed Practical Nurse											
Physical Therapy											
Nutritional Services											
Social Services (LCSW) *											
Aide											
Homemaker											
Companion Services											
Durable Medical Equipment											
Physician Services *											
Ordained Clergy											
Pastoral Counseling *											
Trained Volunteer Services *											
Other (please list):											
* Required											

Ownership Interest

Name	Address	% Ownership Interest