FOR OFFICE USE ONLY

CHECK AMOUNT: ______________
CHECK NUMBER: ______________
LICENSE EXPIRATION: ___________

STATE OF DELAWARE
OFFICE OF HEALTH FACILITIES LICENSING AND CERTIFICATION

APPLICATION FOR HOSPITAL LICENSE

LICENSE ID: HSPTL - _________

LEGAL NAME: ____

DBA NAME: ____

AGENCY ADDRESS: ____

____

______________________ ______ ________
CITY STATE ZIP CODE

ADMINISTRATOR/CEO/EMAIL: ____

CONTACT NAME: ____

____
POSITION/TITLE /EMAIL

DON: ______________________ ______________
NAME PHONE

DON EMAIL: ____

PHONE NUMBERS: ______________ ______________ ______________
FACILITY PHONE CONTACT PERSON CONTACT FAX

CONTACT EMAIL: ____

EMERGENCY CONTACT: ______________________ ______________
NAME PHONE

EMAIL: ____
(EMERGENCY CONTACT MUST BE AVAILABLE AT ALL TIMES IN CASE OF WEATHER EMERGENCY, NATURAL DISASTERS, ETC.)

FACILITY TYPE: **PLEASE CHECK ALL THAT APPLY**

- ☐ ACUTE CARE
- ☐ LONG TERM ACUTE CARE
- ☐ PSYCHIATRIC CARE
- ☐ CHILDREN
- ☐ REHABILITATION

TYPE OF CONTROL:

- ☐ NON-PROFIT
- ☐ FOR-PROFIT
- ☐ STATE GOVERNMENT
- ☐ OTHER: ______________

Total Number of Licensed Beds: ________ Bassinets: ____________

Total Number of Operating Beds: ________ Total Annual Patient Days: ____________

Total annual Outpatient Visits*: ________

*A visit to each organized outpatient care Program by a person who is not an inpatient (does not include the number of diagnostic &/or therapeutic treatments received).

Accredited: ☐ Yes ☐ No

If yes, print name of Accrediting Organization **AND** Accreditation Expiration Date:

______________________________ ______________

Accrediting Organization Expiration Date

Which populations are served in this hospital: (check all that apply)

☐ Pediatric (Birth – 9) ☐ Adult (19-64)

☐ Adolescent (10 – 18) ☐ Geriatric (65 and older)

Affiliated with a Medical School Identify

☐ Major ______________________________

☐ Limited ______________________________

☐ Graduate ______________________________

☐ No Affiliation ______________________________

Resident Programs Approved by: (check all that apply)

☐ AMA ☐ ADA

☐ AOA ☐ other: ______________

☐ No Program

Authorized Official

______________________________ ______________________________

Name Title

______________________________ ______________________________

Signature Date

Please attach the most current of the following:

1. Hospital directory that (at a minimum) identifies the service departments available, the department manager and phone number.
2. A list (incl. name, address, type of service) of all: Provider-based services, hospital departments located off-site; any service included under your state license, federal certification or accreditation.
3. Fire safety report.

4. Email a copy of the Accreditation Certificate, Official Accreditation Report, and Plan of Correction to: AMY-JOY.ANDREWS@DELAWARE.GOV
5. Email a copy of your Emergency Preparedness Plan to: AMY-JOY.ANDREWS@DELAWARE.GOV
6. 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 beds or less	**$250.00**	100 beds or less	**$150.00**
Over 100 beds	**$375.00**	Over 100 beds	**$250.00**

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: ________