Delaware Health and Social Services
Division of Public Health
Attachment A

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

Application for Becoming a State-Recognized School Health Services Provider

Cover Sheet

Name of Applicant Organization and Tax ID#: _____

_____

Applicant Organization Contact: _____

Contracted Entity: ☐ **Noncontracted Entity:** ☐

Name: _____

Phone: _____

Email: _____

School Name(s) and Location(s)/Addresse(s) of the Center(s):

Source of Health Services Program Funding: (Check all that apply.)

	Source	Amount, if known
_____	None	_____
_____	Local/county funds	_____
_____	Other health providers	_____
_____	Other state funds	_____
_____	Private donors/organizations	_____
_____	Federal funds	_____
_____	Other	_____
_____	In-kind	_____

Application for Becoming a State-Recognized School Health Services Provider

Cover Sheet (*cont.*)

Program Description: (Please provide a description of the program and services to be provided.)

Services to Be Provided:

_____ Diagnosis and treatment of acute medical conditions

_____ Identification and referral of chronic conditions

_____ Mental health counseling and referral

_____ Prescribing and/or dispensing of non-prescription/prescription medications

_____ Health education

_____ Immunizations

_____ Nutrition counseling, consultation, and/or education

_____ Minor laboratory tests

_____ Diagnosis and treatment of STDs *(subject to school board or governing entity approval)*

_____ HIV testing and counseling services *(subject to school board or governing entity approval)*

_____ Reproductive health services *(subject to school board or governing entity approval)*

_____ Other

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Cover Sheet (*cont.*)

Compliance with DE SBHC Regulations:

I have read and agree to comply with the State of Delaware Regulation(s), 18 Del.C. §§3365 & 3571G.

_____ _____

Signature Date

_____

Title

Updating of Contact Information:

I agree to notify DPH if any of the information provided in this application to become a State-Recognized School Health Services Provider changes.

_____ _____

Signature Date

Date of Provider Application:

Application for becoming a State-Recognized School Health Services Provider is submitted on

_____ .

Date

_____ _____

Signature Date

Please complete Attachments A and B.

The completed package may be emailed to DHSS_DPH_SBHC@Delaware.gov or mailed to:

Division of Public Health
School-Based Health Centers
1351 W. North St., Suite 103
Dover, DE 19904

For questions, call 302-608-5741.