

# 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)/Adresse(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	_____





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Cover Sheet (*cont.*)

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

## Services to Be Provided:

- |                                                                                                     |                                                                                                                               |
|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Diagnosis and treatment of acute medical conditions                        | <input type="checkbox"/> Minor laboratory tests                                                                               |
| <input type="checkbox"/> Identification and referral of chronic conditions                          | <input type="checkbox"/> Diagnosis and treatment of STDs<br><i>(subject to school board or governing entity approval)</i>     |
| <input type="checkbox"/> Mental health counseling and referral                                      | <input type="checkbox"/> HIV testing and counseling services<br><i>(subject to school board or governing entity approval)</i> |
| <input type="checkbox"/> Prescribing and/or dispensing of non-prescription/prescription medications | <input type="checkbox"/> Reproductive health services<br><i>(subject to school board or governing entity approval)</i>        |
| <input type="checkbox"/> Health education                                                           | <input type="checkbox"/> Other                                                                                                |
| <input type="checkbox"/> Immunizations                                                              |                                                                                                                               |
| <input type="checkbox"/> Nutrition counseling, consultation, and/or education                       |                                                                                                                               |



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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

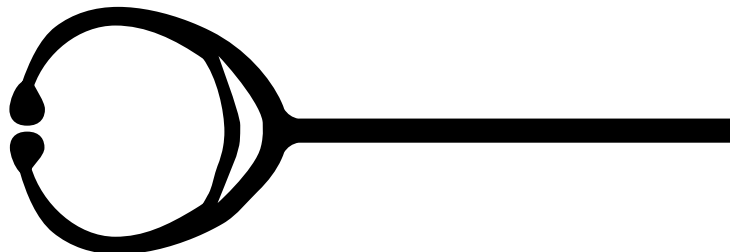
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Please complete Attachments A and B.

The completed package may be emailed to [DHSS\\_DPH\\_SBHC@Delaware.gov](mailto: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.**