**COVID-19 RESPONSE OFF-SITE FACILITY APPLICATION**

Completely fill out form.

Submit to INFOHFLC@hhsc.state.tx.us

Subject line for email is: COVID-19 Response Off-Site Facility Application Form

**1. REQUESTING FACILITY INFORMATION:**

1. Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ ZIP Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Phone No. (Direct): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No. (Mobile): \_\_\_\_\_\_\_\_\_\_\_\_
7. License Type (Circle One): Option 1: General Hospital; Option 2: Special Hospital; Option 3: End Stage Renal Disease Facility (ESRD)
8. License No.: ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicare/CMS Certification No.: \_\_\_\_\_\_\_\_\_\_\_

**2. OFF-SITE FACILITY INFORMATION:**

1. Facility Name (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Facility Status (Circle One): Option 1: Current; Option 2: Pending; Option 3: Closed)
3. Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ ZIP Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. License No. (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Off-Site Property/Facility Owner Information:
	1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. Phone No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	3. Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Description of services that will be provided at the off-site location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Off-Site Facility Type Operated by a Hospital:

[ ]  General or Special Hospital

[ ]  Exempt Hospital (State Owned)

[ ]  Freestanding Emergency Medical Care Facility (FEMC)

[ ]  Nursing Facility (NF)

[ ]  Assisted Living Facility (ALF)

[ ]  Mental Hospital

[ ]  Ambulatory Surgical Center (ASC)

[ ]  Inpatient Hospice Unit

[ ]  Outpatient Facility Operated by the Hospital

[ ]  Mobile, Transportable, or Relocatable Unit

1. Off-Site Facility Type Operated by an ESRD:

[ ]  End Stage Renal Disease Facility (ESRD)

[ ]  Physician’s Office

[ ]  Ambulatory Surgical Center (ASC)

[ ]  Freestanding Emergency Medical Care Facility (FEMC)

[ ]  Mobile, Transportable, or Relocatable Medical Unit

I attest that all information submitted in this application is true and correct. I acknowledge that I understand all the requirements associated with the approval of this request and that more information may be required. I acknowledge that authority to operate this off-site facility is temporary and subject to the discretion of HHSC.

**3. ATTESTATION**:

Requesting Facility Contact Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_­­\_\_\_\_\_\_

(Facility Administrator/CEO or Designated Facility Staff Member Signature. **Name shall match facility’s primary contact name on first page.**)

**4. FOR AGENCY USE ONLY**:

The request is granted unless otherwise noted below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved On: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE: Applicants will receive correspondence via email regarding the status of the application.**