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

Completely fill out form.

Submit to [INFOHFLC@hhsc.state.tx.us](mailto: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.**