PUBLIC HEALTH DIVISION
Health Care Regulation and Quality Improvement Section
Health Facility Licensing and Certification Program
healthoregon.org/hflc

Oregon Health Authority

Hospital License – Temporary Space for COVID-19 Application

Hospital Information		
Existing Hospital License #		
Hospital Legal Name:		
Hospital DBA Name (if applicable):		
Hospital Physical Address, City, State & ZIP:		
Administrator Name:	Administrator Phone:	Administrator Email:
Emergency Contact Name:	Emergency Contact Phone:	Emergency Contact Email:

Hospital Classification (choose one)	
◯ General Hospital	◯ Mental or Psychiatric Hospital
◯ Low Occupancy Acute Care Hospital (25 beds or fewer)	

Current Licensed Bed Capacity
Total on-campus inpatient beds:
Total psychiatric satellite beds:

Type of Action	
☐ Increase on-campus inpatient bed count to beds. Please briefly describe where these beds will be located, e.g., doubling up patient rooms, converting conference rooms, converting exam rooms, etc.	Effective Date of Change:
☐ Request to move a service within existing licensed space. Please briefly describe the move requested.	Effective Date of Change:
☐ Add Temporary Licensed Location(s). *Complete Temporary Licensed Location form for each location*	

New space will be used:			
◯ As soon as it is approved	◯ In days	◯ In weeks	◯ If/when our patient census reaches

I declare, under penalty of perjury, that I have examined this application and any attached temporary satellite information forms, and to the best of my knowledge and belief, this information is true, correct and complete. These changes are temporary, in order to respond to COVID-19. Services will be provided in a manner which ensures compliance with all applicable hospital Oregon Administrative Rules and Medicare Conditions of Participation that have not been waived. Temporary and/or mobile spaces are not subject to Facilities Planning and Safety review.

Administrator's Signature _____ *Print Name* _____

Print Title _____ *Date (mm/dd/year)* _____

Person who filled out this license application	
Name:	Email:
Title:	Phone:

Revised 11/09/2022

Temporary Licensed Location		
◯ On-campus		◯ Off-campus
Name (if different from hospital name):		
Street Address:		
Phone:		Hours of Operation:
Type:	☐ Outpatient Services	
	☐ Inpatient Services beds	
	☐ Off-campus Emergency Department	
	☐ COVID-19 screening location (non-ED)	

For Inpatient Locations Complete the Following:			
☐ Request waiver of OAR 333-500-0025(7) and OAR 333-500-0010(46) to allow off-campus, inpatient beds			
☐ Adding COVID-19 General (non-acute) Care	General, low-level care for mildly to moderately symptomatic COVID-19 patients. This includes patients that may need oxygen (less than or equal to 2L/min), who do not require extensive nursing care, and who can generally move about on their own. This type of ACS might care for nursing home residents who have COVID-19 and need to be moved out of their facility or patients with COVID-19 who are currently hospitalized but can be discharged to a lower level of care.		
☐ Adding non-COVID-19 General (non-acute) Care	General, low-level care. This includes patients that may need oxygen (less than or equal to 2L/min), who do not require extensive nursing care, and who can generally move about on their own. This type of ACS might care for patients who are currently hospitalized but can be discharged to a lower level of care.		
☐ Adding COVID-19 Acute Care	Higher acuity care for COVID-19 patients. This level includes critical care, emergency care, and advanced cardiovascular life support (ACLS).		
☐ Adding non-COVID-19 Acute Care	Higher acuity care. This level includes critical care, emergency care, and advanced cardiovascular life support (ACLS).		
☐ Temporary Licensed Location with Individual Patient Rooms		☐ Temporary Licensed Location with Open Floor Plan	
Space previously licensed as a Skilled Nursing Facility?		◯ Yes	◯ No

Describe type and scope of services provided. If multiple suites at this location that are not separately licensed, list suite #s and services provided in each suite.

HCRQI Office Use Only

Approved/Denied by: Entered by:

☐ Change ☐ Approved ☐ Denied Initials: _____ Date:_____ Initials: _____ Date:_____

Questions? Contact us by email at: mailbox.hclc@odhsoha.state.or.us, or by phone at: 971-673-0540