Temporary Permission for Program Flexibility and for Emergencies

When the MHCC is activated, Providers and DO's will submit requests to CHCQDutyOfficer@cdph.ca.gov.

This form is to be used **ONLY** for program flexibility requests when providers temporarily need to comply with licensing requirements by using alternative concepts, methods, procedures, techniques, equipment, or personnel.

Providers are required to submit a program flexibility request to the California Department of Public Health (CDPH), Center for Health Care Quality (CHCQ) for approval. This form is a mechanism to expedite the request directly to the Medical Health Coordination Center (MHCC) for approval in emergency situations.

https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/DistrictOffices.aspx

Facility Name	Date of Request
License Number	Facility Phone / Facility Fax Number
Facility Address	E-mail Address
City / State / Zip Code	Contact Person Name

Approval Request

Complete one form total per facility

- ☐ Staffing
- ☐ Tent use (High patient volume)
- ☐ Space conversion (other than tent use)
- ☐ Other
- ☐ Bed use
- ☐ Over bedding

Duration of Request

Start Date:

End Date:

Program Flex Request

What regulation are you requesting program flexibility for?

Justification for the Request

☐ A disease outbreak (verifiable through sources such as the local emergency medical service agency (LEMSA), local Public Health Officer, CDPH Division of Communicable Disease Control, the Centers for Disease Control and Prevention) is present in the community where the hospital is located or in a contiguous area(s) causing a rapid influx (surge) of patients to the hospital. Examples of this type of surge include: Increased cases of seasonal influenza, onset of a severe acute respiratory syndrome-type or other highly contagious virus requiring acute care, an epidemic/pandemic, a bioterrorism agent, or a declared public health emergency.

☐ An emergency resulting in the need for increased patient accommodations has occurred in the community where the hospital is located or in a contiguous area(s) causing a rapid influx (surge) of patients to the hospital. Examples of this type of surge include: A natural or human-caused disaster, a crime incident or transportation accident resulting in numerous mass casualties, an emergency causing the evacuation of patients or diversions from another hospital (LEMSA diversion has been implemented).

Facility Name	License Number	Request Date

Justification for the Request

☐ Other:

Exhausting Available Alternatives

The provider must exhaust available alternatives before requesting increased patient accommodations. Check all that apply:

- ☐ Rescheduling non-emergent surgeries and diagnostic procedures.
- ☐ Transferring patients to other beds or discharge as appropriate.
- ☐ Setting clinics for non-emergency cases (if possible).
- ☐ Requesting ambulance diversion from LEMSA, if appropriate.
- ☐ Other:

Adequate Staff, Equipment and Space

The provider must make arrangements for adequate staffing, equipment and space for increased patient accommodations. Check all that apply:

- ☐ A plan is in place for staff if the request is for use of alternate space.
- ☐ A plan is in place for equipment if the request is for use of alternate space.
- ☐ The proposed space for care of patients provides sufficient square footage to ensure access for safe care.
- ☐ Other:

Additional Information

Provide a brief description of your conditions and explain the need for program flexibility. Provide a brief description of the alternative concepts, methods, procedures, techniques, equipment or personnel to be used, and the conditions under which this program flexibility will be used. Attach additional supporting documentation as needed.

Signature of person requesting program flexibility _____ Title _____

Printed name _____

Note: Approval for tent use, space conversion, bed use and over-bedding will be time limited and dependent on the facts presented that substantiate the emergency. Initial approval may be given verbally by the local DO; however, a signed written approval must be distributed (faxed) to the facility and filed in the facility's folder.

For CDPH Use Only:

Center for Health Care Quality Approval:

☐ Permission Granted from:_____to_____

☐ Permission Denied: Briefly describe why request was denied in comments / conditions below:

Comments / conditions:

_____

_____

_____

CHCQ Printed Name:

CHCQ Staff Signature: _____

Date: _____

L&C District Office Staff Signature _____ Title _____ Date _____