THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health and Social Services

DIVISION HEALTH CARE SERVICES
Health Facilities Licensing & Certification

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Hospital / Long Term Care (LTC) COVID-19 Alternate Care Site & Bed Increase Emergency License Application and Instructions

This process applies to both tribal and non-tribal health care facilities.

These instructions are for the temporary license of additional hospital/LTC space in order to respond to the COVID-19 pandemic. Hospitals & LTCs must complete and submit this application to add or change patient care locations or bed counts.

Temporary Bed Increases

Hospitals & LTCs can increase currently licensed bed capacity, add an on-campus location to their current license, or move an existing service to another location. Hospitals & LTCs must specify the type of space being added. Facilities are expected to follow the Center for Disease Control and Prevention (CDC's) Alternate Care Sites Guidance.

Temporary Satellite Requests

Facilities can add inpatient beds and/or outpatient services at an off-campus location. Facilities are expected to follow the CDC's Alternate Care Sites Guidance and in conjunction with Center for Medicare & Medicaid Services (CMS) provider specific regulations that are not waived.

Duration

Temporary licenses are granted for six months or as otherwise noted in the final decision made by the Department of Health & Social Service (DHSS). If the COVID-19 pandemic is still impacting healthcare services in the month prior to the license expiration, the facility may request an extension of the temporary license. Health Facilities Licensing and Certification (HFL&C) will not issue a paper license to reflect these temporary license changes or additional off-campus locations. Facilities are expected to maintain a copy of the approved application for their record.

Processing

License applications must be submitted to Matthew Thomas, Health Care Facilities Licensing & Certification at matthew.thomas2@alaska.gov. Please allow 1-3 business days for processing and review. Health Facilities Licensing and Certification will evaluate applications in the order received and will notify the facility of the application decision by email. If you need this material in an alternate format, please call 907.334.2664.

Alaska Department of Health & Social Services
Hospital / Long Term Care (LTC) Emergency Licensure Application

Facility Information
Existing State License # (if applicable):
Facility Legal Name:
Facility Physical Address, City, State & ZIP:

Administration Information:	
Administrator Name:	Emergency Contact Name:
Phone:	Phone:
Email:	Email:

Facility Type	**Current Licensed Bed Capacity (as applicable)**
Choose Facility Type	Number of LTC Beds:
	Number of Inpatient Beds:

Type of Action

☐ Add temporary beds and/or service at satellite location. *Complete Satellite Information Form on Page 2*

☐ Increase on-campus inpatient bed count Number of requested beds:

Please briefly describe where the beds will be located, e.g., doubling up patient rooms, converting conference rooms, converting exam rooms, etc. (*additional space provided on last page*)

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 & long-term care state statues/regulations and Medicare Conditions of Participation that have not been waived. Assurance of safety and comfortability for patients/resident & staff will be maintained and sufficiently addressed.

_____ _____

Administrator's Signature *Print Name*

_____ _____

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

Temporary Licensed Location		
☐ On-campus ☐ Off-campus	Number of beds at this location:	
Name (if different from hospital name):		
Street Address:		
Phone:	Hours of Operation:	
What is original purpose of the building/area you are requesting as an alternate site?		Choose One
Has a safe & comfortable environment for patients/residents/staff been evaluated?		Choose One
Do you anticipate caring for COVID-19 positive patients at this location?		Choose One
Do you anticipate caring for Non-COVID-19 patients at this location?		Choose One
Has the space previously been licensed as a Skilled Nursing Facility?		Choose One

Type of Space per CDC Alternate Care Sites Guidance	
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 General Care
Acute Care: Higher acuity care for COVID‐19 patients. This level includes critical care, emergency care, and advanced cardiovascular life support (ACLS).	☐ Adding Acute Care
If adding space regularly licensed as an Ambulatory Surgical Center (ASC); this space will be operated by the hospital and used exclusively for hospital patients for the duration of this temporary license. **By checking this box, I confirm that ASC has agreed to allow their space to be used as described above. Please include ASC's Administrator contact information:** Name: Phone: Email:	☐ Adding ASC Space

Types of Service to be Provided
☐ Outpatient ☐ Inpatient ☐ COVID Testing Site (Non-ED) ☐ Other:
Describe type and scope of services provided. (*additional space provided on last page*)

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

You may provide any additional details in the space provided below:

Questions? Contact HFL&C Manager, Matthew Thomas at 907.334.2664 or matthew.thomas2@alaska.gov.

DHSS Office Use Only	
Completed by:	Facility Name:
Date Received:	Date Reviewed:
Decision Date:	Date Facility Notified:

Increase Bed Request Decision	**Alternate Care Site Request Decision**
◯ Approved ◯ Denied ◉ N/A	◯ Approved ◯ Denied ◉ N/A

Comments (if applicable):