

  
 Signature of person requesting program flexibility

*Administration*  
 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

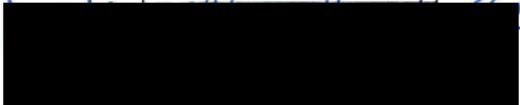
Permission Denied: Briefly describe why request was denied in comments / conditions below:

Comments / Conditions: This is approved with the condition that the facility must implement the Mitigation Plan and utilize staffing agencies (registry) prior to flexing staffing regulations. The facility must keep the 3.2 NHPP requirement.

CHCQ Printed Name:

CHCQ Staff Signature: \_\_\_\_\_

Date:



Program Manager

07/17/20

L&C District Office Staff Signature

Title

Date

If you are seeking a staffing waiver, has your facility laid off any clinical staff within the previous 60 days?  
If so, please explain (Note: Attach supporting documentation if necessary)

NONE

**Justification for the Request**

Other:

COVID-19.

**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 alternative 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.

COVID-19- (employees)  
Monthly TESTING is ongoing  
Some employees are being affected  
as well families of the employees

### Temporary Permission for Program Flexibility and for Emergencies

When the Medical Health Coordination Center (MHCC) is activated, Providers and District Offices (DOs) will submit requests to [CHCQDutyOfficer@cdph.ca.gov](mailto: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 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

Astoria Nueſing Rehab. C

License Number

920000004

Facility Address

14040 Astoria st.

City

Sylmar

State

CA

Zip Code

91342

#### 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

#### Program Flex Request

What regulation are you requesting program flexibility for? TITLE 22- Section 72329.2/72329.1

#### 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).

Date of Request

July 10-2020

Facility Phone

818-367-5881

Facility Fax Number

818-362-1350

E-Mail Address

[Redacted]

Contact Person's Name

[Redacted]

#### Duration of Request

Start Date July 10-20

End Date 9-10-20