



# ECCF

## Application for Emergency Child Care Facility

Instructions: Please print clearly using only blue or black ink, no pencil. Send with applicable documentation to the address on the back of the form.

### Section 1: Emergency Child Care Facility Information

Facility Name:

Site Address	City	Zip Code	County
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Site Mailing Address	City	State	Zip Code
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Site Phone Number	Fax	Email
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### Owner

Owner Name

Mailing Address	City	State	Zip Code
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Phone Number	Fax	Email
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### Primary Contact

Contact Person's Name (First, Last)	Contact Person's Phone Number
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### Section 2: Program Operation

Facility Type:

- Hospital, as defined in ORS 442.015(15).
- Health care facility providing inpatient treatment for COVID-19
- Child Care Facility serving employees of a hospital or of a health care facility providing inpatient treatment for COVID-19

Per ORS 442.015(15) "Hospital" means:

- (a) A facility with an organized medical staff and a permanent building that is capable of providing 24-hour inpatient care to two or more individuals who have an illness or injury and that provides at least the following health services:
  - (A) Medical;
  - (B) Nursing;
  - (C) Laboratory;
  - (D) Pharmacy;
  - (E) Dietary; or
- (b) A special inpatient care facility as that term is defined by the authority by rule

**Age Range of Children Served and Capacity:** Please check all that apply and include capacity number.

- 0 to 2 years olds \_\_\_\_\_ Capacity
- 3 to 5 years olds \_\_\_\_\_ Capacity
- School-aged (6 to 12) \_\_\_\_\_ Capacity

\* Please see "Emergency Child Care Health and Safety Checklist" for maximum group size and ratio requirements.

Hour of Operation	Days of the Week in Operation <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday
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**Continued on back (signature and date required)**

**Section 3: Preferred Language: NOTE: Not all Office of Child Care materials are available in other languages**

English  Spanish  Vietnamese  Russian  Chinese  Other: specify \_\_\_\_\_

**Application Submission**

All staff and volunteers 18 years of age and older must pass the Office of Child Care's Emergency Background Check or be enrolled in the Office of Child Care's Central Background Registry

**Application Process:**

**Submitting an incomplete application will delay processing**

- Complete the application
- There is no fee for this application.
- Complete Facility Staff List (EBC-612)
- Email completed application and facility staff list to: [OCC.CustomerService@state.or.us](mailto:OCC.CustomerService@state.or.us)

**By submitting this application, you agree to do the following:**

1. Abide by the requirements included in Executive Orders issued by the Governor applicable to Emergency Child Care Facilities and in the "Temporary Changes to Child Care Rules in Response to COVID-19 State of Emergency" issued by the Early Learning System Director
2. Serve only children of employees of a hospital as defined in ORS 442.015(15) or of a health care facility providing inpatient treatment for COVID-19.
3. Maintain awareness and follow "Child Care Provider COVID-19 Requirements and Recommendations" established by the [Oregon Health Authority](#) and the [Early Learning Division](#).

**Applicants Signature**

The information I have provided on this application is true and complete to the best of my knowledge.

An approved Emergency Child Care Facility is only valid for the duration of the emergency. The Office of Child Care may suspend or revoke your approval prior to the end of the emergency.

\_\_\_\_\_  
Applicant's Signature  
(Person must be authorized by the owner to complete the application)

\_\_\_\_\_  
Date

**Email signed, completed application, and documentation: [OCC.CustomerService@state.or.us](mailto:OCC.CustomerService@state.or.us)  
Fax: 503-947-1428**

Department of Education is an equal opportunity program/employer.

**FOR OFFICE OF CHILD CARE REPRESENTATIVE TO COMPLETE**

Emergency Child Care Facility Start Date:	RA
Close Date:	Closure Reason: <input type="checkbox"/> Voluntary <input type="checkbox"/> Agency <input type="checkbox"/> Denied
Reinstate Date	C&C <input type="checkbox"/> Y <input type="checkbox"/> N Intake Initials: <input type="checkbox"/> Continue Process <input type="checkbox"/> Other (see CCRIS) CS Initials: