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| **STATE HEALTH OPERATIONS CENTER STATUS REPORT QUESTIONARRE** |
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| --- | --- |
| **DATE** |  |
| **PROVIDER NAME** |  |
| **LICENSE ID** |  |
| **PROVIDER TYPE** | **(i.e. skilled nursing facility, assisted living facility, adult day care center, ambulatory surgical center, etc.)** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **ADDRESS** |  | | **COUNTY**  NEW CASTLE  KENT  SUSSEX | | |
| **CITY** |  | | **ZIP CODE** | | |
| **STATE** |  | | **TELEPHONE** | | |
| **CONTACT PERSON** | **NAME** | | **E-MAIL** | | |
| **NOVEL CORONAVIRUS (COVID-19) RELATED INFORMATION:** | | | | | |
| **INFORMATION REQUESTED** | | **ANSWER** | | **COMMENT/ADDITIONAL INFORMATION** | |
| **LICENSED BED CAPACITY** | |  | |  | |
| **CURRENT CENSUS** | |  | |  | |
| **AVAILABLE BEDS FOR SURGE** | |  | |  | |
| **AVAILABLE SPACE FOR SURGE** | |  | |  | |
| **ARE THERE ANY CONFIRMED COVID-19 POSITIVE RESIDENTS?** | | Y  N | | **IF YES, HOW MANY?** | |
| **ARE THERE ANY RESIDENTS WITH COVID-19 SYMPTOMS?** | | Y  N | | **IF YES, HOW MANY?** | |
| **HOW MANY SYMPTOMATIC PATIENTS HAVE BEEN TESTED FOR COVID-19?** | |  | |  | |
| **EMERGENCY OPERATIONS ACTIVATES** | | Y  N | |  | |
| **IMPLEMENTING VISITOR RESTRICTIONS** | | Y  N | |  | |
| **STAFFING SHORTAGES** | | Y  N | |  | |
| **MEDICAL SUPPLY SHORTAGE (i.e. PPE)** | | Y  N | |  | |
| **SUPPLY REQUEST FORM SUBMITTED TO OFFICE OF EMERGENCY MEDICAL SERVICES** | | Y  N | |  | |
| **ADDITIONAL NOTES:** | | | | |