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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.)** |

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| --- | --- | --- |
| **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:** |