|  |
| --- |
| **STATE HEALTH OPERATIONS CENTER STATUS REPORT QUESTIONARRE** |
|  |

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