**Facility Request for Home Health and/or Home Care Staffing**

Name of Facility:

Facility Address:

Facility Type:

Owner Name, Phone, Email:

Scheduling Contact Name, Phone, Email (if different):

Current Staffing requests:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **# Staff needed Per Shift** | **Discipline**  **(LPN, RN, HHA, Housekeeping, Other)** | **Hours** | **Days** | **Care Ratio** | **Dependent on Hospital Discharge (DC) (Y or N)** | **Comments** |
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**If individual patient care requested above, provide the following patient information:**

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| --- | --- | --- | --- | --- | --- |
| Name | Age | Diagnosis | Care Needs | COVID Status | Notes/Comments (if hospital DC, include name, phone, email of individual who will coordinate discharge) |
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**Facility Questions**

Facility Capacity:

Current Occupied Beds:

How many COVID-19 positive patients are currently in facility?

How many COVID-19 suspected are in facility?

Facility Regular FT and PT Staffing (include all nursing, therapy and personal care aides):

Facility Current FT and PT Staffing:

Please provide copies of facility-specific policies on infection control and COVID-19.

**Personal Protective Equipment**

Is PPE available for home health/homecare staff providing care?

Please specify number available of:

N95:

KN95:

Surgical Masks:

Aprons:

Gowns:

Gloves:

Other:

Will the facility arrange fit-testing for N95s?

If yes, please provide contact information for fit-tester:

Name:

Address:

Phone:

Email:

Describe any limitations or facility policies that would impact providers’ ability to provide staffing or care. Please note that requirements of “exclusivity,” such as those limiting a nurse or home health aide’s ability to provide care to others while providing care in the facility, or similar restrictions, will make it more difficult to provide staff