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| --- | --- |
| **Date request received?** |  |
| **Need originally reported to/by^:**  | *(i.e. County EMA, HCC Regional Manager, PHPC, DHS portal, legislator, Executive Staff)*  |
| **Facility or agency type:** | *(i.e. Nursing Home, home health)* |
| **Licensing agency:** | *(i.e. DOH, DHS)* |
| **County:** |  |
| **Name of facility (use licensed name):**  |  |
| **Facility address:** |  |
| **Facility Point of Contact (POC) Name:** |  |
| **Facility POC Phone #:** |  |
| **Facility POC Email:** |  |
| **Total staff:** |  |
| **Positive (+) cases in facility or unit(s) that you are required to use full PPE for?****If Home Health, are there + patients that your agency is caring for?** | Yes\* ☐ No ☐ \***IF YES, ask shaded questions below and provide Post-Acute/LTCF Toolkit, if applicable** |
| **Are there COVID tests pending for facility residents/individuals you care for or staff?** | Yes\* ☐ No ☐ \***IF YES how many tests are pending:**  |
| **Total # +cases (staff and residents):** |  |
| **Current total census (if Home Health # pts. served):** |  |
|  |  |
| **# of Ill Residents:** |  |
| **# of Ill Staff:** |  |
| **Type of unit(s) affected (i.e. ventilator, memory care, unit dedicated to COVID?)** |  |
| **Universal masking in place?**  | Yes ☐ No ☐ |
| **PPE currently in use at facility/agency and available:** | ☐ Isolation Gowns☐ Gloves☐ Eye protection:  ☐ Goggles ☐ Face shields☐ N95s☐ Other respiratory protection (PAPRs or other model masks, etc.)☐ Clinical/procedure masks |
| **Reported PPE Needs:*****Instructions: if they report need for item, check the box and list how many days are left on hand.*** | ☐ Isolation Gowns; **# days on hand:**☐ Gloves, **# days on hand:**☐ Eye protection (goggles, face shields); **# days on hand:**☐ N95s, **# days on hand:**☐ Clinical/procedure masks, **# days on hand:** |
| **Daily burn rate for items in need:**  | Isolation Gowns: Gloves: Eye protection (goggles, face shields): N95s: Clinical/procedure masks:  |
| **Was attempt made to source supplies through traditional methods?** | Yes ☐ No ☐ **\*IF YES, describe:** |
| **Conservation strategies in place?** | Yes\* ☐ No ☐ **\*IF YES, check below or describe:** **N95s/surgical masks:** ☐ Extended Use (1 clean issued each day per staff) ☐ Limited re-use (e.g. 5 issued use diff/day of wk)**Gowns:**☐ Reusable, #☐ Extended use 1gown/day/care giver; change if wet, soiled or torn☐ Hanging on room door, don prior to entry for one shift |
| **Other needs and notes:** |  |
| **For Internal Use – Facility Does Not Complete Section Below** |
| **Staff assigned:** | *(Name of person submitting the form and agency)* |
| **Known to ICOR/on Daily Outbreak Line List?** | Yes ☐ No ☐ |
| **ICOR/ECRI consultation recommended?**  | Yes ☐ No ☐ \***IF YES, consultation date:**  |
| **Received PPE through crisis fulfillment previously?** | Yes ☐ No ☐ \***IF YES, date:**  |
| **Recommend for crisis fulfillment?** | Yes ☐ No ☐ \***IF YES, date:** |