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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:** |