



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 <input type="checkbox"/> NEW CASTLE <input type="checkbox"/> KENT <input type="checkbox"/> 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 | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| IMPLEMENTING VISITOR RESTRICTIONS | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| STAFFING SHORTAGES | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| MEDICAL SUPPLY SHORTAGE (i.e. PPE) | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| SUPPLY REQUEST FORM SUBMITTED TO OFFICE OF EMERGENCY MEDICAL SERVICES | <input type="checkbox"/> Y <input type="checkbox"/> N | |

ADDITIONAL NOTES:

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