Date:

1. **Name of Facility:**
2. **Contact person (name and title):**
3. **Contact information:**
4. **Type of Facility (SNF, LTAC, Assisted Living, Rehab, Hospice, mixed, etc:**
5. **Total bed capacity:**   Current Occupancy:
6. **If facility is mixed, bed capacity of each unit:**
    - SNF: Current Occupancy:
    - LTAC: Current Occupancy:
    - Assisted Living: Current Occupancy:
    - Rehab Center: Current Occupancy:
    - Hospice: Current Occupancy:
    - Other(specify):   Current Occupancy:
7. **Is this facility part of a large chain (Y/N?):**
    - If yes, please specify (include name and contact info of local locations):
8. **Affiliated with local health system (Y/N?):**
9. **Able to create isolation units (Y/N?):**
    - Bed capacity of isolation unit:
10. **Total number of staff members:**
    - Admin:
    - Healthcare workers (includes all staff members who have any contact with patients):
11. **Last date of updated hygiene training for staff:**
12. **Personal protective equipment status currently (how long will current supply last?):**
13. **Occupational Health Unit (Y/N?):**
14. **Infection Control Practitioner (Y/N?):**
15. **Name of Director of Nursing:**

- o Cell phone number:
16. **Name of ICP if applicable:**
    - o Cell phone number:
17. **Name of Medical Director:**
    - o Cell phone number:
18. **Mechanism for admitting patients to hospital if needed (direct admit/ ER):**
19. **Hospitals where patients are usually transported to:**
20. **Transportation mode of EMS (Public vs Private):**
    - If private specify company:
21. **Name of laboratory for COVID testing (patients):**
22. **Turnaround time for COVID testing:**
23. **Name of laboratory for COVID testing (staff):**
24. **Number of current positive cases include date:**
    - o **Patients:**
        - I. **Disposition:**
          No. Admitted:
          No In-house:
    - o **Staff:**
        - I. **No Home:**
          Admitted: