Long Term Care Facility Disaster Assessment Form

REPORT STATUS (check one) ☐ Initial Report ☐ Update **Date:** _____/_____/_____ **Time:**

NATURE OF THE EVENT:

FACILITY IDENTIFICATION

Facility Name: _____ **Address:** _____

City: _____ **County:** _____ **24 Hour Telephone Number:** (_____) _____-_____

SECTION A	IMMEDIATE NEEDS	Y	N	COMMENTS
A-1: Does your facility have any immediate needs, i.e., staffing?		○	○	
A-2: Are there any immediate health and medical needs?		○	○	
☐ Minor Injuries ☐ Serious Injuries ☐ Life Threatening Injuries	☐ Fatalities ☐ Behavioral Health ☐ Crisis Standards of Care			
A-3: Is your facility accessible by normal routes?		○	○	

SECTION B	COMMUNICATIONS	Y	N	LIST CONTACT INFORMATION
B-1: Are landline telephones available?		○	○	
B-2: Are cell phones available? – Is Texting Available?		○	○	
B-3: Can you access the internet?		○	○	
B-4: Are email services available?		○	○	
B-5: Is there a Satellite Radio located near your facility?		○	○	
B-6: Does your facility have access to a Ham Radio?		○	○	
B-7: Other:_____		○	○	

SECTION C	SECURITY	Y	N	COMMENTS
C-1: Do you have security in place?		○	○	
C-2: Is your facility currently on lockdown?		○	○	
C-3: Is there a security risk from outside people or patients/clients?		○	○	
C-4: Can all outside access sites (doors/windows) be locked?		○	○	
C-5: Does your facility need security assistance?		○	○	

SECTION D	STRUCTURAL ASSESSMENT/HVAC	Y	N	COMMENTS
D-1: Does your facility have more than one floor?		○	○	
D-2: Does your facility have more than one building?		○	○	
D-3: Is there structural damage to your facility? If yes, what % of building is damaged?		○	○	
☐ Walls: _____ ☐ Roof:_____ ☐ Floor:_____	☐ Windows: _____ ☐ Doors:_____ ☐ Other:_____			
D-4: Can your facility maintain normal operations? If no, do you need to evacuate?		○	○	
D-5: Is the heating and air (HVAC) system operational? If no, is there adequate ventilation?		○	○	

V6 Nov 2015 Completed forms should be faxed, e-mailed or verbally transmitted to: (check all that apply) County EOC_____, State EOC _____, State Public Health SHOC _____, and/or Parent Organization_____.

SECTION E	ELECTRICAL POWER	Y	N	COMMENTS
E-1: Is your facility currently using commercial electrical power?		○	○	
E-2: Does your facility have a generator?		○	○	
E-3: Is the generator currently being used?		○	○	
E-4: Can the generator run 100% of the facility? If no, what does the generator supply power to?		○	○	
E-5: How many days can your generator currently run based upon current fuel supply?		○	○	
E-6: What type of fuel does the generator use? Diesel ☐ Gasoline ☐ Natural Gas ☐ Propane ☐		○	○	

SECTION F	WATER AND SEWER	Y	N	COMMENTS
F-1: Are hot and cold running water available?		⊙	○	
F-2: If yes, is this water safe to drink? If no, is there an adequate water supply onsite of at least 1 to 2 gal/day/person for 3-5 days?		○	○	
F-3: Are ice supplies available from an approved source?		○	○	
F-4: Are there an adequate # of hand washing stations?		○	○	
F-5: Is the sewage system operational? If no, does your facility require assistance with sewage disposal?		○	○	

SECTION G	FOOD SERVICE	Y	N	COMMENTS
G-1: Is there a safe food source for staff /residents/visitors?		○	○	
G-2: Can foods be held at proper temperatures (<41°F - >145°F)		○	○	
G-3: Is there an adequate supply of food (3-5 days)?		○	○	

SECTION H	BED CENSUS/HEALTH CARE	Y	N	COMMENTS
H-1: Bed Census/Availability				
SNF: ____ _____ NF: _____ _____ NH: _____ _____ ICF:_____ _____	ALZ: ____ _____ PC: _____ _____ ICF/MR: _____ _____	○	○	
H-2: Does your facility require transportation assistance for movement/evacuation of patients? (check all that apply)		○	○	
☐ Ambulatory: #_____ ☐ Non-ambulatory: #_____ ☐ Bedfast: #_____	☐ Bariatric: #_____ ☐ Memory Disorders: #_____ ☐ Other: #_____			
H-3: Does your facility have refrigeration for medications?		○	○	
H-4: Is there adequate number medications, clinical supplies, i.e., O2, sharps containers, biohazard bags, etc?		○	○	
H-5: Is there adequate number of facility supplies, i.e, cleaning supplies, trash bags, etc		○	○	

PERSON REPORTING (Please Print Legible)

Name: _____ **Job Title**: _____

Phone: (_____) _____-_____ **Mobile Phone**: (_____) _____-_____ **Alt Phone**: (_____) _____-_____

Fax: (_____) _____-_____ **Email**:_____

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