LTC 2PREPARE

Email completed form to:
nhsafety@louisville.edu

LONG TERM CARE FACILITY DISASTER ASSESSMENT FORM

REPORT STATUS (check one) ☐ Initial Report ☐ Update

Date: _____/_____/_____ Time: _____ AM/PM

NATURE OF THE EVENT: _____

_____

FACILITY NAME: _____

ADDRESS: _____

CITY: _____ COUNTY: _____

24 HOUR TELEPHONE NUMBER: (____) _____ – _____

HPC REGION: _____ KYEM REGION: _____

GPS LATITUDE: _____ GPS LONGITUDE: _____

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:	☐	☐	

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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: _____ ☐ Windows: _____ ☐ Roof: _____ ☐ Doors: _____ ☐ Floor: _____ ☐ 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?	☐	☐	

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?	☐	☐	

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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: Current Bed Census/Available Beds			
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: Are there adequate medications, clinical supplies, i.e., O2, sharps containers, biohazard bags, etc?	☐	☐	
H-5: Are there adequate facility supplies, i.e, cleaning supplies, trash bags, etc	☐	☐	

PERSON REPORTING (Please Print Legibly)

Name: _____

Job Title: _____

Phone: (____) _____ – _____ Mobile: (____) _____ – _____

Alt Phone: (____) _____ – _____ Fax: (____) _____ – _____

Email: _____

This form was created as a result of a grant from the KY Department of Public Health.
Project partners:

UNIVERSITY OF LOUISVILLE KENT SCHOOL OF SOCIAL WORK
Kentucky Public Health
University of Kentucky College of Public Health