Healthcare Facility/Agency PPE Critical Needs Assessment

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:

^NOTE: if elevated by ICOR/ECRI refer to their notes. Do not contact facility.

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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:**

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