Please return form to PHD DOC Med Ops Branch at DOCOpsCB@sbcphd.org fax to 805-681-5192/681-5142 alternate

Santa Barbara County PUBLIC Health DEPARTMENT

SNF AND LONG TERM CARE Disaster STATUS REPORT FORM

Please provide this information to the PHD Department Operation Center

SNF/LTC Name:		**Facility Contact**: Report Prepared By:
24/7 Phone Number:	**Fax:**	**Email:**
Incident Name:	**Report Date:**	**Report Time:**

Status: ☐ **Open-Full Function** ☐ **Open- Limited Function** ☐ **Evacuated to Location :**_____**(address/name where you plan to evacuated)**

☐ **Closed Reopen on**_____ ☐ **Closed Building Damaged** ☐ **Closed and Red-Tagged**

Please describe how the disaster is affecting your facility's operations and ability to serve your patients:

What is your current SNF/LTC census? **Licensed capacity**:

Can your facility take additional patients/clients within your licensed capacity? ☐**Yes** ☐**No**
(Please indicate on the next page any resources you need to continue or increase your services.)

Are you able to take additional patients during this disaster beyond your licensed capacity? ☐ **Yes** ☐ **No**

If yes, how many immediately for short-term shelter: **for long-term (1+ days):**

Are you currently providing care to disaster/event victims? ☐ **Yes** ☐ **No** **Approximate number:**

Please describe any services you are providing related to the disaster or event:

Do you have patients in your facility that need medical treatment ☐ **No** ☐ **Yes** #_____

Patients needing transfer to a hospital? ☐ **No** ☐ **Yes** #_____

Patients needing transfer to another SNF/LTC facility? ☐ **No** ☐ **Yes** #_____ **When?** _____

If you marked "Open-Limited Function" as your status, please describe your limits (e.g. staff, resources, utilities, services, hours) below:

Are you running low on any critical supply items? ☐ **YES**

☐ **No, but anticipate shortage within 24 hours** ☐ **No**

(form continues on next page)

If you have questions about this form, please contact the Public Health DOC Operations Section at **805-696-1106**

Complete a separate RESOURCE REQUEST FORM if you cannot obtain resources from vendors

In addition, list the critical supply items below, the approximate quantity remaining for each item, and about how long it will take for item to be expended:

1. Item Name/Description:	**QTY Remaining:**	**Time Until Expended:**
2. Item Name/Description:	**QTY Remaining:**	**Time Until Expended:**
3. Item Name/Description:	**QTY Remaining:**	**Time Until Expended:**

Additional Comments or Explanation:

Are you on generator power? ☐ **YES** ☐ **No** **If YES, number of days of fuel available?** _____

Are you currently short-staffed due to disaster? ☐ **YES** ☐ **No, but anticipate shortage within 24 hours** ☐ **No**

If yes or if you anticipate a shortage within 24 hours, please list the positions and the quantities you are/will be understaffed below
If you need additional staff, you may make arrangements with other facilities to share staff or complete a ResourceRequest Form to request staff via the Public Health Department Operations Center:

1. Personnel Title/Description:	**QTY Needed:**
2. Personnel Title/Description:	**QTY Needed:**
3. Personnel Title/Description:	**QTY Needed:**

Additional Comments or Explanation:

Please describe any additional concerns, critical issues, and actions suggested to be taken by county/city to help your facility function during this disaster:

Your Facility's Objectives for Next 24 hours
(example: ***obtain drinking water supplies; move patients to another facility; obtain additional food; obtain medical or other supplies to continue care; locate alternate care for our dialysis patients; obtain additional pharmaceuticals for clients; locate a building inspector to evaluate safety of building; determine amount of time for water, or other utilities to be resumed, etc)***

1.

2.

3.

Remember to complete a resource request to PHD for medical supplies, personnel, or other items.

Contact your City EOC for water or portapotty resources before you make the request to the Public Health Department.
I have contacted my city for these resources ☐ **Yes** ☐ **No**

Submit by Email **Print Form** **Clear Form**

Purpose: Report on status of PHD and all outpatient services in SB County
Origination: Clinics Branch, Ops Section **Original To**: Situation Status Unit, Plans Section
Copies To: Operations Section Chief **Replaces ICS Form:** N/A