SKILLED NURSING FACILITY/SURGERY CENTER

ASSISTANCE CAPACITY REPORT

**FACILITY NAME:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **TYPE (SNF ONLY):**  SKILLED | ASSISTED

**CONTACT PERSON:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PHONE:** (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_ **FAX:** (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_

**FACILITY STREET ADDRESS:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FACILITY CITY:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FACILITY ZIP CODE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **BEDS** | **# TOTAL** | **# OCCUPIED** | **# AVAILBLE** |
|  |  |  |

(SIT-STAT AS OF) DATE: \_\_\_\_\_\_\_\_\_\_\_ TIME: \_\_\_\_\_\_\_\_\_\_\_\_

FIRST REPORT or CHANGE IN STATUS

***Santa Cruz County is experiencing an emergency event. If needed, is your facility:***

Willing and able to receive patients from the hospital? YES | NO

How many patients can your facility receive at this time? \_\_\_\_\_\_

What level of care can you provide?

Are you willing and able to discharge patients (on a short term basis) to make room to receive patients? YES | NO

Do you need assistance with transporting discharged patients? YES | NO

***IN ORDER TO PROVIDE ASSISTANCE FOR THIS EVENT, does your facility need assistance from the Santa Cruz County (e.g., supplies)?*** *If yes, please complete and submit a Resource Request Form—Supplies and Equipment (PH DOC 02), which can be found on the* *Hospital Preparedness Program Partnership (HPP) webpage****.***

***If your status changes, please send an updated version of this report to the Santa Cruz County DOC right away.***

Instructions: During a DOC Activation, e-mail this form to hsadoc@santacruzcounty.us or

FAX to 831.454.4488. If you would like to contact someone by phone, dial: 831.454.444