New York State Department of Health

Division of Home and Community Based Services

Abbreviated Emergency Response Provider Survey

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Please enter the requested data in the fields below. When you have finished entering your data, click 'Save All' and then 'Review and Submit' to finalize the form.

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Combined Data

Certified Home Health Agencies (CHHAs) that also operate a Long Term Home Health Care Program (LTHHCP) may combine the data for both agencies and report on one form.

Does this form contain the combined information for the CHHA and the LTHHCP? [Yes][No]

 If yes, please identify the names of the CHHA and LTHHCP that are represented on this form.

Emergency Information

1. Has your agency initiated its emergency response plan? [Yes][No]

 If no, please explain:

 2. Current patient census in impacted area(s):

      3. Current number of Level 1, Level 2, and Level 3 patients in impacted area(s):

 Level 1:

 Level 2:

 Level 3:

 4. Have you contacted all patients and/or responsible parties in impacted area(s)? [Yes][No]

 If no, when do you expect to have all patients and/or responsible parties contacted?

 If no, how many patients and/or responsible parties have you been unable to contact?

 Who have you reported this issue to?

 5. Are there travel restrictions or access issues into or out of area(s) where you need to provide services to Level 1 patients? [Yes][No]

 If yes, please provide details of the travel or access issues:

6. How many patients are you aware of that need to evacuate but are unable to due to road/travel problems, lack of transportation, or other barriers?

 7. Have any patients been re-located? [Yes][No]

 If yes, please provide information regarding the number of patients and the relocation site(s):

**Required Fields. ** Repeatable Sections.*

Form Rules: