Maryland Alternate Care Site
Location Assessment Tool

Organization Name: ____________________ Date: ____________

Location of Proposed ACS: ____________________

Site Address: ____________________ Site evaluated by DHMH (y/n): ____________

Max. Occupancy #: ________ Evaluated for patient care (y/n): ________ If yes, patient care occupancy #: ________Level of Care:____________

Site Primary POC: ____________________ Site Secondary POC: ____________________

POC Title: ____________________ POC Title: ____________________

Best Email/Phone: ____________________ Best Email/Phone: ____________________

Please anwser ***"Yes" or "No"*** *AND provide total numbers as appropriate to the following* *for the proposed patient care area :*

Patient Care Area Infrastructure/Capabilities

Doorways ≥ 36": ________#:________ Nonporous Floor: ________Material: ____________ Floor Sq. Footage: ________

Air Conditioning: ________ Heating: ________ Lighting: ________ Walls: ________#:________ Emergency Power: ________

If yes, list any limitations to emergency power: ____________________

Exterior Exits: ________#:________ Toilets: ________#:________ Showers: ________#:________ Utility Sink: ________ #:________

ADA Toilets: ________#:________ ADA Showers: ________#:________ Access to Water: ________Location:____________

Access to Oxygen: ________Location:____________ Power Outlets: ________#:________ Phone Jacks: ________#:________

TV/Cable Access: ________#:________ Internet Access: ________Type (ex. T1):____________Wireless: ________If no, #:________

Independent Air Handling System: ________ If no, list areas included in air handling system: ____________________

____________________ Medical Capabilities: ________ List:____________ Ability to lock down area: ____________

List security capabilities: ____________________

Access to nearby parking: ________Location: ____________# spaces: ________ Site accessible by Ambulance: ____________

List any accessibility or other site ***limitations*** not mentioned above: ____________________

____

List any additional site ***capabilities*** not mentioned above: ____________________

____

Please anwser ***"Yes" or "No"*** *AND provide total numbers as appropriate to the following* *for the building/total area :*

Building Infrastructure

Accessible loading dock: ____________ Generator Back-up:________ # hrs:________ If no, Generator Hookup: ________

Staff/Visitor Parking: ________# Spaces:________Location: ____________________ Locker Room/Showers: ________ #:________

Staff Bathrooms: ________ Refridgeration: ________ Kitchen/Food Prep: ________ Medical Capabilities: ________ List:____________

List all accessible internal/external communication capabilities: ____________________

____

List all physical/staffing security capabilities: ____________________

____________________ Will external security assistance be needed: ________

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*Please anwser **"Yes" or "No"** AND provide location as appropriate to the following for accomodating ancillary services :*

Entity/Building Ancillary Capabilities/Areas

On-site waste removal: _______ Hazardous waste removal: _______ Catering services: _______ Onsite security: _______

Equipment/supply storage: ______Location: ___________________________ Call Center: ______ Location: ____________________________

Mortuary holding area: _______Location: _________________________________ Pharmacy area: ______Location:_____________________________

Lab speciman handling area: _______Location: ____________________________ Staff sleep/rest area(s): ______Location: ______________________

Discharge/Family area: ______Location: __________________________________ Staff check-in/out area:______Location: ______________________

List all additional staffing/property/supply support that may be available (non-binding): ____

____

Please provide any additional important comments/information related to the proposed ACS or its use.

Additional Comments Information

____

____

____

____

Acknowldgements

Survey prepared by (printed name/title): ____

Signature: ____