

# Facility/MHOAC Situation Report

**DO NOT USE THIS FORM TO REQUEST RESOURCES. USE THE RESOURCE REQUEST FORM TO REQUEST RESOURCES**

A. Report Type (choose one)
Initial Final Update #:

B. Report Creation Date/Time	
1. Report Date	2. Report Time

C. Report Status (choose one)
Advisory: No Action Required ALERT: Action Required

D. Contact Information of Person Completing Report	
1. First and Last Name	2. Position / Title
3. Direct Phone Number	4. Email Address

E. Facility Name

F. Facility Type

G. Current Operational Status (choose one)	
Green: Normal Operations - No assistance from the jurisdiction is required	Orange: Modified Services - Some assistance from the jurisdiction is required
Yellow: Under Control - No assistance from the jurisdiction is required	Red: Limited Services - Significant assistance from the jurisdiction is required
Black: No Services - Unable to care for patients	

H. Facility/Organization Capacity				
1. Capacity Type (choose one →):	Bed	Chair	Patient	Other _____
2. Count of Impacted (enter below)	3. Count of Occupied (enter below)		4. Count of Open (enter below)	
N/A <input type="checkbox"/>			N/A <input type="checkbox"/>	N/A <input type="checkbox"/>

I. Prognosis		
No Change	Improving	Worsening

J. Situation Summary