

| DEPARTMENT OF HEALTH AND HUMAN SERVICES<br>Health Resources and Services Administration<br><br>FORM 10: ANNUAL EMERGENCY PREPAREDNESS<br>REPORT  | FOR HRSA USE ONLY              |  |
|--|--------------------------------|--|
|  | Application Tracking<br>Number | Grant<br>Number  |
|  |                                |  |
| <b>SECTION I - EMERGENCY PREPAREDNESS AND MANAGEMENT PLAN</b>  |                                |  |
| 1. Has your organization conducted a thorough Hazards Vulnerability Assessment?<br><br><i>If Yes, date completed:</i>  |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Does your organization have an EPM plan?<br><br><i>If Yes, date most recent EPM plan was approved by your Board:</i> <input type="text"/><br><i>If No, skip to Readiness section below.</i> |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Does the EPM plan specifically address the four disaster phases? (This question is mandatory if you answered Yes to Question 2.)  |                                |  |
| 3a. Mitigation   |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3b. Preparedness   |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3c. Response   |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3d. Recovery   |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Is your EPM plan integrated into your local/regional emergency plan? (This question is mandatory if you answered Yes to Question 2.)  |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. If No, has your organization attempted to participate with local/regional emergency planners? (This question is mandatory if you answered Yes to Question 2 and No to Question 4.)          |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Does the EPM plan address your capacity to render mass immunization/prophylaxis? (This question is mandatory if you answered Yes to Question 2.)  |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>SECTION II - READINESS</b>  |                                |  |
| 1. Does your organization include alternatives for providing primary care to your current patient population if you are unable to do so during emergency?                                      |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Does your organization conduct annual planned drills?   |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Does your organization's staff receive periodic training on disaster preparedness?  |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Will your organization be required to deploy staff to Non-Health Center sites/locations according to the emergency preparedness plan for the local community?                               |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Does your organization have arrangements with Federal, State, and/or local agencies for the reporting of data?  |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Does your organization have a back up communication system?   |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6a. Internal   |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6b. External   |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Does your organization coordinate with other systems of care to provide an integrated emergency response?   |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Has your organization been designated to serve as a point of distribution (POD) for providing antibiotics, vaccines, and medical supplies?  |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Has your organization implemented measures to prevent financial/revenue and facilities loss due to an emergency? (e.g., insurance coverage for short-term closure)                          |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Does your organization have an off-site back up of your information technology system?   |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Does your organization have a designated EPM coordinator?  |                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0285. Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-33, Rockville, Maryland, 20857