OMB No.: 0915-0285. Expiration Date: XX/XX/20XX

| **DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration Form 10:** **EMERGENCY PREPAREDNESS REPORT** | **FOR HRSA USE ONLY** |
| --- | --- |
| **Grant Number** | **Application Tracking Number** |
|  |  |
| **SECTION I - EMERGENCY PREPAREDNESS AND MANAGEMENT (EPM) PLAN** |
| 1. Has your organization conducted a thorough Hazards Vulnerability Assessment?

If Yes, date completed:\_\_\_\_\_\_\_ | [\_] Yes [\_] No |
| 1. Does your organization have an approved EPM plan?

If Yes, date that the most recent EPM plan was approved by your Board:\_\_\_\_\_\_  If No, skip to the Readiness section below. | [\_] Yes [\_] No |
| 1. Does the EPM plan specifically address the four disaster phases?

(This question is mandatory if you answered Yes to Question 2.) |  |
| 3a. Mitigation | [\_] Yes [\_] No |
| 3b. Preparedness | [\_] Yes [\_] No |
| 3c. Response | [\_] Yes [\_] No |
| 3d. Recovery | [\_] Yes [\_] No |
| 1. Is your EPM plan integrated into your local/regional emergency plan?

(This question is mandatory if you answered Yes to Question 2.) | [\_] Yes [\_] No |
| 1. 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.) | [\_] Yes [\_] No |
| 1. Does the EPM plan address your capacity to render mass immunization/prophylaxis?

(This question is mandatory if you answered Yes to Question 2.) | [\_] Yes [\_] No |
| **SECTION II - READINESS** |
| 1. Does your organization include alternatives for providing primary care to the current patient population if you are unable to do so during emergency?
 | [\_] Yes [\_] No |
| 1. Does your organization conduct annual planned drills?
 | [\_] Yes [\_] No |
| 1. Does your organization's staff receive periodic training on disaster preparedness?
 | [\_] Yes [\_] No |
| 1. Will your organization be required to deploy staff to Non-Health Center sites/locations according to the emergency preparedness plan for the local community?
 | [\_] Yes [\_] No |
| 1. Does your organization have arrangements with Federal, State, and/or local agencies for the reporting of data?
 | [\_] Yes [\_] No |
| 1. Does your organization have a back-up communication system?
 | [\_] Yes [\_] No |
| 6a. Internal | [\_] Yes [\_] No |
| 6b. External | [\_] Yes [\_] No |
| 1. Does your organization coordinate with other systems of care to provide an integrated emergency response?
 | [\_] Yes [\_] No |
| 1. Has your organization been designated to serve as a point of distribution for providing antibiotics, vaccines, and medical supplies?
 | [\_] Yes [\_] No |
| 1. Has your organization implemented measures to prevent financial/revenue and facilities loss due to an emergency? (e.g., insurance coverage for short-term closure)
 | [\_] Yes [\_] No |
| 1. Does your organization have an off-site back up of your information technology system?
 | [\_] Yes [\_] No |
| 1. Does your organization have a designated EPM coordinator?
 | [\_] Yes [\_] 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 14N-39, Rockville, Maryland, 20857