**American Rescue Plan**

**SHIP COVID-19 Testing and Mitigation Program
FY21 Hospital Quarterly Report Form (Option B)**

***Return to [Insert SORH]* by:** **[*Insert Due Date*]**

**Reporting Period:** [Insert mm/dd/yyyy – mm/dd/yyyy]

# GENERAL INFORMATION

CMS Certification Number (CCN):

Hospital Data Universal Number System (DUNS) Number:

Hospital Name:

Address:

City:       State:       Zip:       County:

Administrator / CEO:

E-mail:       Phone:

Tribally operated hospital under Titles I and V of P.L. 93-638? Yes [ ]  No [ ]

CAH: Yes [ ]  No [ ]

**Instructions:** Please complete this form to provide details on use of COVID Testing & Mitigation funds. All activities must be appropriate given relevant clinical and public health guidance. For examples, visit the CDC the [CDC Community Mitigation Framework](https://www.cdc.gov/coronavirus/2019-ncov/community/community-mitigation.html) website. Reminder: Funding may not be used for any activity related to vaccine purchase or distribution, but could be used for community vaccine education activities. If you have questions about the appropriateness of a purchase, contact [insert SHIP Coordinator name and email].

# Total Funding:

|  |  |  |
| --- | --- | --- |
| **Total funding amount allocated/distributed to your hospital (May not exceed $258,376 per hospital)** | **Total amount spent in prior quarterly reporting periods** | **Total amount of funds spent during this quarterly reporting period** |
| $ | $ | $ |

 **Category: COVID Testing - Purchase and administer COVID-19 tests**

|  |  |
| --- | --- |
| **Total funding spent this reporting period on COVID Testing** (May not exceed $258,376) | **Percent of funding spent on COVID Testing in this reporting period.** |
| $ | % |

**Equipment Definition:**

Equipment is tangible personal property (including information technology systems), has a useful life of more than one year, has a per-unit acquisition cost of at least $5,000; is **moveable equipment** only.

Please describe **COVID** **Testing** equipment purchased during this reporting period. Brand, model, and/or serial numbers are not required.

|  |  |  |  |
| --- | --- | --- | --- |
| **Brief description of equipment including purpose:** | **Quantity purchased** | **Per-unit price including shipping and/or installation** (List in whole dollars; equipment must be at least $5,000 per unit) | **Total amount $** (Quantity \* Unit Price in whole dollars) |
|  |  | $ | $ |

# COVID Testing Activities

Please select the **testing activities** that your hospital applied funds towards this quarter from the following list:

|  |
| --- |
| Testing: Funding Categories  |
| Enter Number of test administered, if applicable: \_\_\_\_\_\_\_ (estimates acceptable) |
| [ ]  | Procure, provide, or process COVID-19 tests (including at-home tests) |
| [ ]  | Develop and implement strategies for patient testing confidence |
| [ ]  | Access for community populations to address health and social inequities |
| [ ]  | Minor alterations and renovations: installing structures, retrofitting to support COVID testing  |
| [ ]  | Leasing property |
| [ ]  | Planning for implementation of a COVID-19 program, including hiring and training staff, and reporting data. |
| [ ]  | Equipment purchased to support testing |
| [ ]  | Other activities related to COVID-19 testing. Please provide a short description: \_\_\_\_\_\_\_\_\_\_\_ |

**Category: COVID Mitigation -** Slow the spread of COVID-19 and protect all individuals, especially those at [increased risk for severe illness](https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html).

|  |  |
| --- | --- |
| **Total funding spent this reporting period on mitigation** (May not exceed $258,376 per hospital) | **Percent of funding spent on COVID response activities in this reporting period**  |
| $ | % |

**Equipment**

Please describe **COVID Mitigation** equipment purchased during this reporting period. Brand, model, and/or serial numbers are not required.

|  |  |  |  |
| --- | --- | --- | --- |
| **Brief description of equipment including purpose:** | **Quantity purchased** | **Per-unit price including shipping and/or installation** (List in whole dollars; equipment must be at least $5,000 per unit) | **Total amount $** (Quantity \* Unit Price in whole dollars) |
|  |  | $ | $ |

**COVID Mitigation Activities**

Please select the **mitigation activities** that your hospital applied funds towards this quarter from the following list:

|  |
| --- |
| Mitigation: Funding Categories |
| [ ]  | Develop and implement policies and procedures to keep staff and patients health |
| [ ]  | Maintain healthy operations for staff |
| [ ]  | Implement strategies to address employee stress and burnout |
| [ ]  | Investigate COVID-19 cases and conduct contact tracing |
| [ ]  | Minor alterations and renovations to support mitigation efforts |
| [ ]  | Equipment purchase to support mitigation  |
| [ ]  | Use digital technologies to strengthen hospital response to COVID-19 |
| [ ]  | Supporting referrals to testing, clinical services and other supports to mitigation strategies |
| [ ]  | Planning for implementation of COVID-19 mitigation |
| [ ]  | Training providers and staff on COVID-19 mitigation |
| [ ]  | Other activities related to mitigation. Please provide a short description: \_\_\_\_\_\_\_\_\_\_\_ |