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|  | AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  RESIDENTIAL CARE SERVICES  **Rapid Response Team 2 Request** | | | | | |  | |
| REQUEST DATE | |
| Submit your completed form to [rapidresponse@dshs.wa.gov](mailto:rapidresponse@dshs.wa.gov). Include all required information to complete the request. “Rapid Response Team 2 Management will review and screen your staffing request using the priority criteria in the following order:  Priority 1 for patient admissions from hospital. Priority 2 for COVID outbreaks at a certain staff percentage. Priority 3 for other urgent staffing. | | | | | | | | |
| FACILITY/ HOME/PROVIDER NAME | | | | | | | LICENSE/ CERTIFICATION NUMBER | |
| PHYSICAL ADDRESS: STREET CITY STATE ZIP CODE  **WA** | | | | | | | | |
| FACILITY/HOME/PROVIDER TYPE  AFH  ALF  CCRSS  ICF/IID  ESF  NH  SL | | | | | | | | |
| REQUESTOR’S NAME | | | | POSITION | | | | |
| EMAIL ADDRESS | | | | CELL/OFFICE NUMBER (INCLUDE AREA CODE) | | | | |
| FACILITY/HOME BED CAPACITY (NH, ALF, AFH, ESF, ICF/IID) | | | | SL CLIENTS ASSIGNED TO PROVIDER (SL ONLY) | | | | |
| **Facility/Home/Provider Information (completed by requestor)** | | | | | | | | |
| PRIORITY 1  Are you participating in the DSHS Incentive for Acute Care Hospital Discharges?.............................  Yes  No  Is this request necessary to admit patients from acute care hospitals to expedite a  necessary hospital discharge?.............................................................................................................  Yes  No  **If yes**, how many residents admitted a) in the past 72 hours?       b) this week?  Is this request necessary to readmit residents and clients from acute care hospitals  (not related to the incentive program)? ……………………………………………………………………  Yes  No  **If yes**, how many residents admitted a) in the past 72 hours?       b) this week?. | | | | | | | | |
| PRIORITY 2  Is this request related to staffing needs for high COVID-19 + cases?..................................................  Yes  No | | | | | | | | |
| PRIORITY 3  Is this request related to staffing needs other than to support patient admissions from  from hospitals and COVID-19 + cases? ………………………………………………………………..… . Yes  No | | | | | | | | |
| **STAFF REQUESTED.** | | | | | | | | |
| **NACS** | | | **LPNS** | | | **RNS** | | |
|  | | SHIFTS NEEDED:  DAY  EVENING  NIGHT |  | | SHIFTS NEEDED:  DAY  EVENING  NIGHT |  | | SHIFTS NEEDED:  DAY  EVENING  NIGHT |
| **Rapid Response Team 2 Management Notes** | | | | | | | | |
| COMMENTS  Priority 1  Priority 2  Priority 3 | | | | | | | | |
| RAPID RESPONSE TEAM 2 MANAGER’S SIGNATURE DATE | | | | | | MANAGER’S PRINTED NAME | | |