FORM 1. RESOURCE REQUEST FORM USED BY HEALTHCARE FACILITIES OR FIELD SITES

Instructions: Healthcare Facility should submit completed form to MHOAC Program.

Healthcare Facility Name	
Facility Type (Hospital, SNF, etc.)	
Address	
City	
County	
POC Name	
POC Phone #	
POC Email	
24 Hour POC (Name/Contact #)	

CHECK THE TYPE OF SUPPORT NEEDED:

- ☐ Patient Transportation ONLY (complete Section A)
- ☐ Patient Placement ONLY (complete Section B)
- ☐ Both Patient Transport & Placement (complete Sections A and B)

Section A – Patient Transport		
GROUND AMBULANCE Patient Types	**# of Patients/Passengers**	
# of stretcher patients needing ALS		
# of stretcher patients needing BLS		
# of bariatric patients (pt. weighs > 400lbs., extra wide stretcher). All bariatric units are ALS.		
PARATRANSIT Passenger Types		
# of passengers that are **ambulatory, do not require assistance** and can ride in a van or bus		
# of passengers that are "**ambulatory-with-assistance**" that can ride in a van or bus with assistance but do not require a wheelchair or stretcher		
# of **non-ambulatory passengers that may need a wheelchair** but do not require stretcher		
# of **caregivers** that will be provided **to accompany paratransit passengers**		
AIR AMBULANCE Patient Types (adult/child and neonatal)	**ADULT and CHILD**	**NEONATE**
# of patients requiring transportation by helicopter air ambulance		
# of patients requiring transportation by fixed-wing air ambulance		

Section B – Bed Types Needed		
Patient Type	**Bed Type**	**#**
Adult:	Med/Surgical	☐
	OB/LND	☐
	Psychiatric	☐
	Critical: Burn	☐
	Critical: ICU	☐
	Critical: CCU	☐
	Critical: Trauma	☐
Pediatric:	Ped Med/Surgical	☐
	PICU	☐
	NICU	☐