From: Miller, Carly <carly.miller@em.myflorida.com>
Sent: Friday, January 08, 2021 11:10 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Subject: 11:15 will be delayed at least 15 minutes

Please stand by, the 11:15 will be delayed at least 15 minutes today

Carly Miller FPEM, FCCM
Executive Assistant
Florida Division of Emergency Management
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Tallahassee, FL 32399
850-320-3613
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AMERICAN OVERSIGHT

From: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Sent: Friday, February 05, 2021 10:18 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Subject: Allocations

Allocations were just received and Ryan is feverously pushing out the survey shortly it will be due by 1430 today.

Kevin Guthrie, MA MEP CEM FPEM | Deputy Director
Office of the Director
Florida Division of Emergency Management
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AMERICAN OVERSIGHT

From: Lock, Ryan <Ryan.Lock@em.myflorida.com>
Sent: Thursday, December 31, 2020 2:14 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>; Dick, Cindy <Cindy.Dick@flhealth.gov>; Mahon, Jason <Jason.Mahon@em.myflorida.com>; Guidicelli, Ian <Ian.Guidicelli@em.myflorida.com>; SWO_COMMAND <SWO_COMMAND@em.myflorida.com>; EOC COSLogistics <EOC.COSLogistics@em.myflorida.com>; DeCastro, Kenneth <Kenneth.DeCastro@em.myflorida.com>; Plans Command <Plans_Command@em.myflorida.com>; Kitchen, Madison <Madison.Kitchen@em.myflorida.com>; Nagle, Taylor <Taylor.Nagle@em.myflorida.com>; Vaughn, Phyllis <Phyllis.Vaughn@em.myflorida.com>; McDaniel, Susanne <Susanne.McDaniel@em.myflorida.com>; Blake, Jessica <Jessica.Blake@em.myflorida.com>; Hunt, Kaitlyn <Kaitlyn.Hunt@em.myflorida.com>; Walters, Tara <Tara.Walters@em.myflorida.com>; McLeary, Allison <Allison.McLeary@em.myflorida.com>; Shirah, Melissa <Melissa.Shirah@em.myflorida.com>; Roberts, Douglas <Douglas.Roberts@em.myflorida.com>; Stachowicz, Stephanie <Stephanie.Stachowicz@em.myflorida.com>; Sayler, Erik <Erik.Sayler@em.myflorida.com>; Keenan, Gwen (FEMA) <Gwen.Keenan@fema.dhs.gov>; Williams, Paul (FEMA) <Paul.Williams6@fema.dhs.gov>; Peterson, Amy (FEMA) <Amy.Peterson@fema.dhs.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Hughes, Pamela <Pamela.Hughes@em.myflorida.com>; Bond, Megan <Megan.Bond@em.myflorida.com>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Courtney Coppola <Courtney.Coppola@flhealth.gov>; Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Otis, Aaron <Aaron.Otis@flhealth.gov>; StateESF8.Planning <StateESF8.Planning@flhealth.gov>; Bielling, Jeffery <Jeffery.Bielling@flhealth.gov>; Harris, Shevaun <Shevaun.Harris@ahca.myflorida.com>; McKinstry, Molly <Molly.McKinstry@ahca.myflorida.com>; Smoak, Kimberly <Kimberly.Smoak@ahca.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Lee Newsome <LNewsome@ERECinc.com>; madisoncountyem@gmail.com <madisoncountyem@gmail.com>; emergencymanagement@myescambia.com <emergencymanagement@myescambia.com>; Howell.Batts@flhealth.gov <Howell.Batts@flhealth.gov>; Margaret.Hart@osceola.org <Margaret.Hart@osceola.org>; Nicole Double <ndouble@scgov.net>; mcarmichael@fau.edu <mcarmichael@fau.edu>; rrodrigu@fgcu.edu <rrodrigu@fgcu.edu>; Kristina.Mathews@flhealth.gov <Kristina.Mathews@flhealth.gov>; Kristopher.Pickens@flhealth.gov <Kristopher.Pickens@flhealth.gov>; thomas.bowman@hhs.gov <thomas.bowman@hhs.gov>; Lock, Ryan <Ryan.Lock@em.myflorida.com>
CC: Bouler, Kimberlyn (Santa Rosa Co Alt EM) <kimberlynb@santarosa.fl.gov>; Anderson, Kristy (Taylor Co EM) <kristy.anderson@taylorsheriff.org>; Grant Geyer <grantgeyer@fdle.state.fl.us>; Larry Rogers (Seminole Tribe EM) <larryrogers@semtribe.com>; Rezola, Inaki (Hillsborough Co Alt EM) <rezolai@hillsboroughcounty.org>; John Kohnke (Office of the Chief Financial Officer) <John.Kohnke@myfloridacfo.com>; Rahming, Derrick <DerrickRahming@flhsmv.gov>; Bunker, Chuck <Chuck.Bunker@sbafla.com>; Gerrell, Traci <Traci.Gerrell@ahca.myflorida.com>; Howard, Matthew <matthew.howard@myflfamilies.com>; McCrane, Ed (Sarasota Co EM) <EMcCrane@scgov.net>; Brown, Curtis <curtis.brown@myfwc.com>; Watts, Wayne <wayne.watts@myfloridacfo.com>; Casto, David (Sumter Co EM) <David.Casto@sumtercountyfl.gov>; Womble, Paul (Polk Co EM) <paulwomble@polk-county.net>; Kostus, Spencer (Lake Co Alt EM) <skostus@lakecountyfl.gov>; Tucker, LeiAnna (FDACS) <LeiAnna.Tucker@fdacs.gov>; Bryan, Jeff <Jeffery.Bryan@fdc.myflorida.com>; Cleversy, Tommy <Tommy.cleversy@apdcares.org>; Thorpe, Paul <paul.thorpe@nwfwater.com>; Goldberg, Jeff (Walton Co EM) <jeff@waltoncountyem.org>; Peter Newman <Peter.Newman@fldoe.org>; Moulton, Diane <Diane.Moulton@eog.myflorida.com>; Register, Joshua (Elder Affairs) <registerj@elderaffairs.org>; Jones, Harvey <HarveyJones@fdle.state.fl.us>; Ward, John (Clay Co EM) <john.ward@claycountygov.com>; LoPresti, Etta (Indian River Co Alt EM) <ELoPresti@ircgov.com>; Lord, Jonathan (Flagler Co EM) <jlord@flaglercounty.org>; Halquist, Richard (Osceola Co Alt EM) <richard.halquist@osceola.org>; Abel, Lynn (Washington Co EM) <label@washingtonfl.com>; Cisco, Tom (Volusia Co Alt EM) <tcisco@volusia.org>; Hall, Steven <halls@flcourts.org>; Lumm, Frankie (Bay Co EM) <flumm@baycountyfl.gov>; Davis, Gregory (DJJ ECO) <Gregory.Davis@djj.state.fl.us>; Duffey, Mike <Mikeduffey@fdle.state.fl.us>; Litton, Bill (Osceola Co EM) <bill.litton@osceola.org>; Saur, Jacob (Manatee Co Alt EM) <jacob.saur@mymanatee.org>; Shuler, Lisa (Liberty Co Alt EM) <mashuler@fairpoint.net>; Tambasco, Jeffrey (DeSoto Co EM) <j.tambasco@desotobocc.com>; Holloman, Chris (Escambia Co Alt EM) <cjhollom@myescambia.com>; Evan, Chris (Citrus Co EM) <cevan@sheriffcitrus.org>; Miller, Anne (Sarasota County Alt. EM) <ammiller@scgov.net>; Lowers, Loren (Lottery Alt ECO) <lowersl@flalottery.com>; Durden, Carlos <carlos.durden@ocfl.net>; Foster, Greg (Nassau Co EM) <gfoster@nassauso.com>; Broadway, Patricia <Patricia.Broadway@myfloridalicense.com>; Waite, Sally (Martin Co EM) <swaite@martin.fl.us>; Owen, Adrienne (Holmes Co EM) <aowen@holmesem.org>; Harris, Eddie <eddie.harris@apdcares.org>; Wilson, Cindy (Holmes Co Alt EM) <cwilson@holmesem.org>; Rivera, Cesar (American Red Cross) <cesar.rivera@redcross.org>; Mason, Melanie <Melanie.Mason@fdacs.gov>; Andreasen, Rodney (Jackson Co EM) <andreasenr@jacksoncountyfl.gov>; Witt, Brad (Bradford Co EM) <brad_witt@bradfordsheriff.org>; Litschauer, Steve (Manatee Co EM) <steve.litschauer@mymanatee.org>; Guerrero, Ron <RAGUERRERO@broward.org>; Reiss, Latosha (Highlands Co EM) <Lreiss@highlandsfl.gov>; Giammanco, Joseph (St Johns Co EM) <jgiammanco@sjcfl.us>; Hagan, Karen (ARC-TLH) <Karen.Hagan@apdcares.org>; Carpenter, Thomas (Lake Co EM) <tcarpenter@lakecountyfl.gov>; Shedlock, Andrew <andrewshedlock@fdle.state.fl.us>; Zyvoloski, Richard (Collier Co Alt EM) <richard.zyvoloski@colliercountyfl.gov>; Vilchez, Gustavo (St Lucie Co Alt EM) <vilchezg@stlucieco.org>; Cabral, Irene <Irene.Cabral@dot.state.fl.us>; Pinder, Ellen (Charlotte Co Alt EM) <ellen.pinder@charlottecountyfl.gov>; Padgett, Jimmie <jimmie.padgett@myflfamilies.com>; Harris, Alan (Seminole Co EM) <aharris@seminolecountyfl.gov>; Rollason, Frank (Miami-Dade Co EM) <frank.rollason@miamidade.gov>; Johnson, Bill (Palm Beach Co EM) <wpjohnson@pbcgov.org>; Dilmore, Cory <Cory.Dilmore@FloridaDEP.gov>; Wolfe, Ken (Okaloosa Co Alt EM) <kwolfe@myokaloosa.com>; Oberdorfer, Martha (Nassau Co Alt EM) <MLOberdorfer@NassauSO.com>; Cyrille, Charles (Miami-Dade Co Alt EM) <charles.cyrille@miamidade.gov>; Lawrence, Liz (ARC) <Liz.lawrence@redcross.org>; Abes, Benjamin (Lee Co Alt EM) <benjamin.abes@leegov.com>; Carroll, Paula (Jefferson Co EM) <paula.carroll@jcso-fl.org>; Smeykal, Mitch (Okeechobee Co EM) <MSmeykal@co.okeechobee.fl.us>; Smith, Todd (Duval Co Alt EM) <todds@coj.net>; Roush, Deanna <deanna.roush@uss.salvationarmy.org>; Parker, Bek (Baker Co EM) <bek.parker@bakerso.com>; Herring, Matt (Gulf Co EM) <mherring@gulfcounty-fl.gov>; Gatlin, John <John.Gatlin@myfloridacfo.com>; Baker, Brad (Santa Rosa Co EM) <BradB@santarosa.fl.gov>; Lerner, Steven (Seminole Co Alt EM) <slerner@seminolecountyfl.gov>; Shaw, Barry

AMERICAN OVERSIGHT

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Hattaway <BCHATTAW@myescambia.com>; Jaeson Weber <jweber15@fau.edu>; Veneka EOC Brown <venekaeocbrown@tds.net>; Blevins, Allison M <Allison.Blevins@flhealth.gov>; Nolan Ristau <nristau@pascocountyfl.net>; AHCAEOC <ahcaeoc@ahca.myflorida.com>; Ashley Biegel <abiegel@fau.edu>; Fleischman, Jennifer <jfleischman@usf.edu>; yshapiro@ncf.edu <yshapiro@ncf.edu>; bbowers@uwf.edu <bbowers@uwf.edu>; Danial Bartle <dbartle@floridapoly.edu>; nmcdonald@uwf.edu <nmcdonald@uwf.edu>; psparks@uwf.edu <psparks@uwf.edu>; Greenlaw, Robert <r.greenlaw@unf.edu>; dfairclo@uwf.edu <dfairclo@uwf.edu>; Amy Aiken <abaiken@fiu.edu>; Smith, Brian <brian.smith@MyFWC.com>; Shpiner, Matthew V. <mshpiner@miami.edu>; Sasser, Billy E <billy.sasser@HQ.DHS.GOV>; Simko, Anna Christine <acs296@miami.edu>; Gulla, John Anthony <jgulla@miami.edu>; Rocks, Lance <lrocks@usf.edu>; McElheney, MaryAlice <MaryAlice.McElheney@FloridaDEP.gov>; HowardAmy <Amy.Howard@colliercountyfl.gov>; Cole, Conn <Conn.Cole@em.myflorida.com>; Steven Hartsook <Steven.Hartsook@uss.salvationarmy.org>; Valentine, Kathryn <kvalentine@seminolecountyfl.gov>; Gonzalez, Freddy <fgonzalez@seminolecountyfl.gov>; Claudia.Blackburn@flhealth.gov <Claudia.Blackburn@flhealth.gov>; Michael Denier <mdenier@fau.edu>; Hazel, Richard C <Richard.Hazel@flhealth.gov>; dennis.adams2@redcross.org <dennis.adams2@redcross.org>; bene.hunter2@redcross.org <bene.hunter2@redcross.org>; Shel.Seidman@redcross.org <Shel.Seidman@redcross.org>; Emergency Management <EMFRANKLIN@franklinemergencymanagement.com>; Kissler, Aaron X <Aaron.Kissler@flhealth.gov>; Pittzer, Kimberly <kpittzer@citrus.myflorida.com>; Bartels, Amy <Amy.Bartels@flhealth.gov>; Pepe, Joseph D <Joseph.Pepe@flhealth.gov>; Matt Lewis <malewis@fsu.edu>; EOC-COSLogistics <EOC-COSLogistics@em.myflorida.com>; Knox, Steven E LTC USARMY (USA) <steven.e.knox.mil@mail.mil>; Krista Ditoro <kditoro@pascocountyfl.net>; Johnson, Troy (MDFR) <troy.johnson@miamidade.gov>; Seth Imhof <simhof@baycountyfl.gov>; Candace Hill <candacehill@tds.net>; WU Opa-Locka <WU.Opa-Locka@erecinc.com>; DAVID DEES <david@deesmediation.com>; WU Miramar <WU.Miramar@erecinc.com>; CBTS Brevard PB <CBTS.BrevardPB@erecinc.com>; CBTS HardRock <CBTS.HardRock@erecinc.com>; WU Manatee <WU.Manatee@erecinc.com>; DuBois, Adam J <Adam.DuBois@flhealth.gov>; Sarah Salgado <ssalgado@pascocountyfl.net>; Stormant, Aaron <gregory.a.stormant@usace.army.mil>

Subject: Canceled: SERT-County Conference Call

There is no call on Jan 1.

The SERT-County Conference Calls will now occur daily M-F. Note that the link has changed:

–

https://fdem.webex.com/fdem/j.php?MTID=mdde3307d48f4e62329bd3cce13c900b7

Meeting Number: 179-323-8743

AMERICAN OVERSIGHT

SERT-County Conference Call

The Monday and Friday 11:15 Eastern Conference Calls have moved to a WebEx Webinar. Please see the link below to join.

https://fdem.webex.com/fdem/j.php?MTID=mdde3307d48f4e62329bd3cce13c900b7

Meeting Number: 179-323-8743

Rules for Entry

- **We will not admit individuals joining via phone**. Please login using the WebEx App.
- Users logging in should **sign-in with their full name and agency**. This will expedite entry into the Webinar.

Planning Section Staff will open the Webinar by 10:45 AM Eastern. Please try to enter by 11:10 AM to ensure you are admitted before 11:15.

Forward internally as appropriate, but attendance is limited to State and County emergency management partners.

Email eoc-plans@em.myflorida.com if there are questions or if you need technical assistance.

Ryan Lock | Florida Division of Emergency Management
State Emergency Response Team | Planning Section Chief
Preparedness Bureau | All-Hazards Preparedness Manager
Ryan.Lock@em.myflorida.com | 850-841-9484

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AMERICAN OVERSIGHT

From: EOC-Plans <EOC-Plans@em.myflorida.com>
Sent: Tuesday, February 02, 2021 6:22 PM EST
To: Grant, James <James.Grant@dms.fl.gov>; McWhorter, Linda <Linda.McWhorter@em.myflorida.com>; Culbreath, Erek <Erek.Culbreath@em.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Stephanie Murphy <smurphy@tidalbasin.rphc.com>; Melissa Gordon <mgordon@tidalbasin.rphc.com>; Douglass E Pace <dpace@stonehillinnovation.com>; Vasudev Bhat <Vasudev.Bhat@sharecare.com>; EOC-Plans <EOC-Plans@em.myflorida.com>
CC: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DLDOHCHDAdministrators_Directors@flhealth.gov <DLDOHCHDAdministrators_Directors@flhealth.gov>; Adkison, Kevin <Kevin.Adkison@em.myflorida.com>
Subject: Canceled: ShareCare Town Hall

This occurrence has been cancelled. The only afternoon Town Hall remaining will be Thursday at 3:00pm.

These meetings are to establish a communication platform for all counties who are using the Sharecare system.

The agenda for each meeting will follow the cadence below:

General updates
Summary of known issues/concerns still outstanding
Identification of new concerns

Meetings will occur daily at 3 p.m. M-F

This is in addition to the 9 AM Meetings

Microsoft Teams meeting

Join on your computer or mobile app
Click here to join the meeting
Or call in (audio only)
+1 914-294-5479,,653732008# United States, Yonkers
Phone Conference ID: 653 732 008#
Find a local number | Reset PIN
Learn More | Meeting options

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AMERICAN OVERSIGHT

From: Perry, Kaylynn <Kaylynn.Perry@em.myflorida.com>
Sent: Tuesday, February 02, 2021 6:04 PM EST
To: McWhorter, Linda <Linda.McWhorter@em.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; james.grant@dms.fl.gov <james.grant@dms.fl.gov>; Culbreath, Erek <Erek.Culbreath@em.myflorida.com>; Stephanie Murphy <smurphy@tidalbasin.rphc.com>; Melissa Gordon <mgordon@tidalbasin.rphc.com>; Perry, Kaylynn <Kaylynn.Perry@em.myflorida.com>
CC: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; Cintron, Morgan <Morgan.Cintron@em.myflorida.com>; Fiske, Jodie <Jodie.Fiske@em.myflorida.com>; Baker, Claudia <Claudia.Baker@em.myflorida.com>; Richardson, Kesley <Kesley.Richardson@em.myflorida.com>; Bradshaw, Brian <Brian.Bradshaw@em.myflorida.com>; Stachowicz, Stephanie <Stephanie.Stachowicz@em.myflorida.com>; Siddall, Paul <Paul.Siddall@em.myflorida.com>; Bergstrom, Pamela <Pamela.Bergstrom@em.myflorida.com>; Williams, Alicia (MDFR) <Alicia.Williams@miamidade.gov>; DLDOHCHDAdministrators_Directors@flhealth.gov <DLDOHCHDAdministrators_Directors@flhealth.gov>; Wolfe, Ken (Okaloosa Co Alt EM) <kwolfe@myokaloosa.com>; Smith, Todd (Duval Co Alt EM) <todds@coj.net>; Rezola, Inaki (Hillsborough Co Alt EM) <rezolai@hillsboroughcounty.org>; Hess, Erin E <Erin.Hess@flhealth.gov>; Johns, Amie G <Amie.Johns@flhealth.gov>; Mann, John D <John.Mann@flhealth.gov>; Carpenter, Thomas (Lake Co EM) <tcarpenter@lakecountyfl.gov>; Wegener-Vitani, Carol Ann <Carol.Wegener-Vitani@flhealth.gov>; Vasudev Bhat <Vasudev.Bhat@sharecare.com>; Douglass E Pace <dpace@stonehillinnovation.com>; Allen, Timothy (Union Co EM) <allentc@unionsheriff.us>; Evan, Chris (Citrus Co EM) <cevan@sheriffcitrus.org>; Pappa, John J <John.Pappa@flhealth.gov>; Erin Thomas <EThomas@co.hernando.fl.us>; Litschauer, Steve (Manatee Co EM) <steve.litschauer@mymanatee.org>; Rubio, Tito G. <Tito.Rubio@flhealth.gov>; Burns, Mary K <Mary.Burns@flhealth.gov>; Alexander, Jeffery <jaalexander@sjcfl.us>; Lord, Jonathan (Flagler Co EM) <jlord@flaglercounty.org>; Lumm, Frankie (Bay Co EM) <flumm@baycountyfl.gov>; O'Toole, Bryan (Putnam Co EM) <bryan.otoole@putnam-fl.com>; Abes, Benjamin (Lee Co Alt EM) <benjamin.abes@leegov.com>; Cyrille, Charles (Miami-Dade Co Alt EM) <charles.cyrille@miamidade.gov>; Hartl, Erik (Seminole Tribe Alt EM) <erikhartl@semtribe.com>; Halquist, Richard (Osceola Co Alt EM) <richard.halquist@osceola.org>; Gilmore, Eric (Escambia Co EM) <egilmore@myescambia.com>; 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Subject: Canceled: ShareCare Town Hall

This meeting occurrence has been cancelled. The only AM Townhall will be Friday.

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Subject: Canceled: ShareCare Town Hall

This meeting occurrence has been cancelled. The only AM Townhall will be Friday.

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From: EOC-Plans <EOC-Plans@em.myflorida.com>
Sent: Tuesday, February 02, 2021 12:09 PM EST
To: Grant, James <James.Grant@dms.fl.gov>; McWhorter, Linda <Linda.McWhorter@em.myflorida.com>; Culbreath, Erek <Erek.Culbreath@em.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Stephanie Murphy <smurphy@tidalbasin.rphc.com>; Melissa Gordon <mgordon@tidalbasin.rphc.com>; Douglass E Pace <dpace@stonehillinnovation.com>; Vasudev Bhat <Vasudev.Bhat@sharecare.com>; EOC-Plans <EOC-Plans@em.myflorida.com>
CC: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DLDOHCHDAdministrators_Directors@flhealth.gov <DLDOHCHDAdministrators_Directors@flhealth.gov>; Adkison, Kevin <Kevin.Adkison@em.myflorida.com>
Subject: Canceled: ShareCare Town Hall

The 3PM Town Hall has been cancelled. The Town Halls on Wednesday will continue as scheduled.

These meetings are to establish a communication platform for all counties who are using the Sharecare system.

The agenda for each meeting will follow the cadence below:

General updates
Summary of known issues/concerns still outstanding
Identification of new concerns

Meetings will occur daily at 3 p.m. M-F

This is in addition to the 9 AM Meetings

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From: Perry, Kaylynn <Kaylynn.Perry@em.myflorida.com>
Sent: Monday, February 01, 2021 5:51 PM EST
To: james.grant@dms.fl.gov <james.grant@dms.fl.gov>; Culbreath, Erek <Erek.Culbreath@em.myflorida.com>; Stephanie Murphy <smurphy@tidalbasin.rphc.com>; Melissa Gordon <mgordon@tidalbasin.rphc.com>; McWhorter, Linda <Linda.McWhorter@em.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Perry, Kaylynn <Kaylynn.Perry@em.myflorida.com>
CC: DLDOHCHDAdministrators_Directors@flhealth.gov <DLDOHCHDAdministrators_Directors@flhealth.gov>; Wolfe, Ken (Okaloosa Co Alt EM) <kwolfe@myokaloosa.com>; Smith, Todd (Duval Co Alt EM) <todds@coj.net>; Rezola, Inaki (Hillsborough Co Alt EM) <rezolai@hillsboroughcounty.org>; Hess, Erin E <Erin.Hess@flhealth.gov>; Johns, Amie G <Amie.Johns@flhealth.gov>; Mann, John D <John.Mann@flhealth.gov>; Carpenter, Thomas (Lake Co EM) <tcarpenter@lakecountyfl.gov>; Wegener-Vitani, Carol Ann <Carol.Wegener-Vitani@flhealth.gov>; Vasudev Bhat <Vasudev.Bhat@sharecare.com>; Douglass E Pace <dpace@stonehillinnovation.com>; Allen, Timothy (Union Co EM) <allentc@unionsheriff.us>; Evan, Chris (Citrus Co EM) <cevan@sheriffcitrus.org>; Pappa, John J <John.Pappa@flhealth.gov>; Erin Thomas <EThomas@co.hernando.fl.us>; Litschauer, Steve (Manatee Co EM) <steve.litschauer@mymanatee.org>; Rubio, Tito G. <Tito.Rubio@flhealth.gov>; Burns, Mary K <Mary.Burns@flhealth.gov>; Alexander, Jeffery <jaalexander@sjcfl.us>; Lord, Jonathan (Flagler Co EM) <jlord@flaglercounty.org>; Lumm, Frankie (Bay Co EM) <flumm@baycountyfl.gov>; O'Toole, Bryan (Putnam Co EM) <bryan.otoole@putnam-fl.com>; Abes, Benjamin (Lee Co Alt EM) <benjamin.abes@leegov.com>; Cyrille, Charles (Miami-Dade Co Alt EM) <charles.cyrille@miamidade.gov>; Hartl, Erik (Seminole Tribe Alt EM) <erikhartl@semtribe.com>; Halquist, Richard (Osceola Co Alt EM) <richard.halquist@osceola.org>; Gilmore, Eric (Escambia Co EM) <egilmore@myescambia.com>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Kretzer, Heather N <Heather.Kretzer@flhealth.gov>; Allbritton, Kimberly <Kimberly.Allbritton@flhealth.gov>; French, Katie L <Katie.French@flhealth.gov>; Hayes, Lisa B <Lisa.Hayes@flhealth.gov>; Zyvoloski, Richard (Collier Co Alt EM) <richard.zyvoloski@colliercountyfl.gov>; Otis, Aaron <Aaron.Otis@flhealth.gov>; Rolle, Pauline J <Pauline.Rolle@flhealth.gov>; Wadsworth, Lynn <Lynn.Wadsworth@flhealth.gov>; Myers, Paul D <Paul.Myers@flhealth.gov>; Casto, David (Sumter Co EM) <David.Casto@sumtercountyfl.gov>; Harris, Jim (Highlands Co Alt EM) <jharris@highlandsfl.gov>; Snyder, Robert E <Robert.Snyder@flhealth.gov>; Pinder, Ellen (Charlotte Co Alt EM) <ellen.pinder@charlottecountyfl.gov>; Eadie, Bob <Bob.Eadie@flhealth.gov>; Kostus, Spencer (Lake Co Alt EM) <skostus@lakecountyfl.gov>; Waite, Sally (Martin Co EM) <swaite@martin.fl.us>; Tambasco, Jeffrey (DeSoto Co EM) <j.tambasco@desotobocc.com>; Witt, Brad (Bradford Co EM) <brad_witt@bradfordsheriff.org>; Anderson, Kristy (Taylor Co EM) <kristy.anderson@taylorsheriff.org>; LangWilliam <William.Lang@colliercountyfl.gov>; Garcia, Mary L <Mary.Garcia2@flhealth.gov>; Johnson, Adam C <Adam.Johnson@flhealth.gov>; Cavillo, Laura (Hardee Co Alt EM) <Laura.calvillo@hardeecounty.net>; Moffses, Thomas P <Thomas.Moffses@flhealth.gov>; Holloman, Chris (Escambia Co Alt EM) <cjhollom@myescambia.com>; nixsa.serrano@miamidade.gov <nixsa.serrano@miamidade.gov>; Stahl, Maria A <Maria.Stahl@flhealth.gov>; Martin, Sandy K <Sandy.Martin@flhealth.gov>; Mott, Marie B <Marie.Mott@flhealth.gov>; Arista, Amalia (Hardee Co EM) <amalia.arista@hardeecounty.net>; Scurlock, Renee (Jackson Co EM) <scurlockr@jacksoncountyfl.gov>; Goldberg, Jeff (Walton Co EM) <jeff@waltoncountyem.org>; Baker, Brad (Santa Rosa Co EM) <BradB@santarosa.fl.gov>; Whitford, Amber A <Amber.Whitford@flhealth.gov>; Seibert, Patricia A <Patricia.Seibert@flhealth.gov>; Blitch, Brenda J <Brenda.Blitch@flhealth.gov>; Massingill, Tammy M <Tammy.Massingill@flhealth.gov>; Funk, Aaron (Seminole Co Alt EM) <afunk@seminolecountyfl.gov>; Stremmel, Anita R <Anita.Stremmel@flhealth.gov>; Speedling, Sandon S. <Sandon.Speedling@flhealth.gov>; Stilphen, Deborah P <Deborah.Stilphen@flhealth.gov>; Harris, Nicole E. <Nicole.Harris@flhealth.gov>; Foster, Greg (Nassau Co EM) <gfoster@nassauso.com>; Gowdy, Lucy (Wakulla Co Alt EM) <lgowdy@wcso.org>; Scott, John <john.scott@brevardfl.gov>; Walsh, Donna <Donna.Walsh@flhealth.gov>; Warren, Skyler C <Skyler.Warren@flhealth.gov>; Collins, Tiffany L <Tiffany.Collins@flhealth.gov>; Crews, Randy (Baker Co Alt EM) <rcrews@bakerso.com>; Larry Rogers (Seminole Tribe EM) <larryrogers@semtribe.com>; Siverling, TJ <TJ.Siverling@brevardfl.gov>; Carroll, Paula (Jefferson Co EM) <paula.carroll@jcso-fl.org>; Clanton, Mary B <Mary.Clanton@flhealth.gov>; MacKinnon, Alex (Leon Co Alt EM) <mackinnona@leoncountyfl.gov>; McKellips, Natalie D <Natalie.McKellips@flhealth.gov>; Giammanco, Joseph (St Johns Co EM) <jgiammanco@sjcfl.us>; Oberdorfer, Martha (Nassau Co Alt EM) <MLOberdorfer@NassauSO.com>; Litton, Bill (Osceola Co EM) <bill.litton@osceola.org>; Perkins, Catherine <cperkins@co.pinellas.fl.us>; Pino, Raul <Raul.Pino@flhealth.gov>; Fossa, Andrew (Pasco Co EM) <afossa@pascocountyfl.net>; Russell, Wendy (Bradford Co Alt EM) <wendy_russell@bradfordsheriff.org>; EmergencyManagementEmployees <EMP@colliercountyfl.gov>; Smith, Kathy J <Kathy.Smith@flhealth.gov>; Johnson3, Robert <Robert.Johnson3@flhealth.gov>; Hoskins, Ashley J <Ashley.Hoskins@flhealth.gov>; Pfalzgraf, Marisa <Marisa.Pfalzgraf@flhealth.gov>; Amandro, Frank (St Lucie Co Alt EM) <amandrof@stlucieco.org>; Lanier, Jeremy T <Jeremy.Lanier@flhealth.gov>; Maurice, Yvelle <Yvelle.Maurice@flhealth.gov>; Guidash, Gayle <Gayle.Guidash@flhealth.gov>; Graze, Laura G <Laura.Graze@flhealth.gov>; jason.gilmore@wheeleremc.com <jason.gilmore@wheeleremc.com>; McDougall, Ana L <Ana.McDougall@flhealth.gov>; Moore, Valarie E <Valarie.Moore@flhealth.gov>; Lauren Possinger <lpossinger@volusia.org>; Cisco, Tom (Volusia Co Alt EM) <tcisco@volusia.org>; Guerrero, Ron <RAGUERRERO@broward.org>; Rodriguez, Carolyn <CRODRIGUEZ@broward.org>; Smith, Angela M <Angela.Smith2@flhealth.gov>; Gonzalez, Tania E <Tania.Gonzalez@flhealth.gov>; Joseph, Jerry A. <Jerry.Joseph@flhealth.gov>; erinisaac1@gmail.com <erinisaac1@gmail.com>; lynne@latcreative.com <lynne@latcreative.com>; Hale, Chloe L <Chloe.Hale@flhealth.gov>; Savanah Lollie <slollie@washingtonfl.com>; Scott, Cynthia M <Cynthia.Scott@flhealth.gov>; Parker, Bek (Baker Co EM) <bek.parker@bakerso.com>; Simpson, Ryan (Flagler Co Alt EM) <RSimpson@FlaglerCounty.org>; Scott, Katie E <Katie.Scott@flhealth.gov>; Schwartz, Micheal (Okaloosa Co EM) <mschwartz@myokaloosa.com>; Waldron, Kerry S <Kerry.Waldron@flhealth.gov>; Parker, David <David.Parker@flhealth.gov>; Wilson, Cindy (Holmes Co Alt EM) <cwilson@holmesem.org>; Taylor-Bennett, Carla <CTBENNETT@broward.org>; Hickey, Tessa L <Tessa.Hickey@flhealth.gov>; Emergency Management <EMFRANKLIN@franklinemergencymanagement.com>; McMeekan, J Neil <Neil.McMeekan@flhealth.gov>; Miles, Leigh E <Leigh.Miles@flhealth.gov>; Rutledge, Laura X <Laura.Rutledge@flhealth.gov>; Sykes, Michael R <Michael.Sykes@flhealth.gov>; Bencie, Jennifer L <Jennifer.Bencie@flhealth.gov>; County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; Cintron, Morgan <Morgan.Cintron@em.myflorida.com>;

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Fiske, Jodie <Jodie.Fiske@em.myflorida.com>; Baker, Claudia <Claudia.Baker@em.myflorida.com>; Richardson, Kesley <Kesley.Richardson@em.myflorida.com>; Bradshaw, Brian <Brian.Bradshaw@em.myflorida.com>; Stachowicz, Stephanie <Stephanie.Stachowicz@em.myflorida.com>; Siddall, Paul <Paul.Siddall@em.myflorida.com>; Bergstrom, Pamela <Pamela.Bergstrom@em.myflorida.com>; Rubin, Gregory (MDFR) <Gregory.Rubin@miamidade.gov>; Alonso, Alina M <Alina.Alonso@flhealth.gov>; Lambert, Gina <Gina.Lambert@em.myflorida.com>; Miller, Carly <carly.miller@em.myflorida.com>; Shirah, Melissa <Melissa.Shirah@em.myflorida.com>; Hagan, Shannon <Shannon.Hagan@em.myflorida.com>; McLeary, Allison <Allison.McLeary@em.myflorida.com>; Adkison, Kevin <Kevin.Adkison@em.myflorida.com>
Subject: Canceled: ShareCare Town Hall

This occurrence of the town hall is cancelled, the rest will proceed as scheduled.
Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

AMERICAN OVERSIGHT

From: EOC-Plans <EOC-Plans@em.myflorida.com>
Sent: Tuesday, February 02, 2021 6:22 PM EST
To: Grant, James <James.Grant@dms.fl.gov>; McWhorter, Linda <Linda.McWhorter@em.myflorida.com>; Culbreath, Erek <Erek.Culbreath@em.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Stephanie Murphy <smurphy@tidalbasin.rphc.com>; Melissa Gordon <mgordon@tidalbasin.rphc.com>; Douglass E Pace <dpace@stonehillinnovation.com>; Vasudev Bhat <Vasudev.Bhat@sharecare.com>; EOC-Plans <EOC-Plans@em.myflorida.com>
CC: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DLDOHCHDAdministrators_Directors@flhealth.gov <DLDOHCHDAdministrators_Directors@flhealth.gov>; Adkison, Kevin <Kevin.Adkison@em.myflorida.com>
Subject: Canceled: ShareCare Town Hall

This occurrence has been cancelled. The only afternoon Town Hall remaining will be Thursday at 3:00pm.

These meetings are to establish a communication platform for all counties who are using the Sharecare system.

The agenda for each meeting will follow the cadence below:

General updates
Summary of known issues/concerns still outstanding
Identification of new concerns

Meetings will occur daily at 3 p.m. M-F

This is in addition to the 9 AM Meetings

Microsoft Teams meeting

Join on your computer or mobile app
Click here to join the meeting
Or call in (audio only)
+1 914-294-5479,,653732008# United States, Yonkers
Phone Conference ID: 653 732 008#
Find a local number | Reset PIN
Learn More | Meeting options

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AMERICAN OVERSIGHT

From: McLeary, Allison <Allison.McLeary@em.myflorida.com>
Sent: Thursday, January 14, 2021 5:15 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: Sapp, Wesley <Wesley.Sapp@em.myflorida.com>
Subject: CARES/CRF Extension

In an effort to keep you informed of information being sent to POCs for the County CARES program, please be advised that the email found below was sent out a few minutes ago. Please reach out to Wes and I with any questions.

****

Good Afternoon,

On December 27, 2020, President Trump signed the Consolidated Appropriations Act of 2021 into law which included an extension of the Coronavirus Relief Fund (CRF). Since that time, we have worked closely with the Governor's Office on this extension to find a solution that ensures communities are able to continue their response to COVID-19 through their use of CRF funding. Counties that wish to extend their Funding Agreement with the Division of Emergency Management to continue incurring costs related to the CRF into 2021 may opt-in for an extension to June 30, 2021.

Prior to executing an Amendment to the Funding Agreement, counties shall submit a revised spend plan that:

- Includes any modifications to Treasury Expenditure Categories
- Includes a timeline of when the County anticipates incurring the full allocation of CRF funding

We will be hosting a webinar next Wednesday, January 20, to discuss the details of this extension and answer any questions for those counties seeking to opt-in to an extension. Information on that webinar and the link to join will be forthcoming.

If you have any questions in the interim, please contact Wesley Sapp atWesley.Sapp@em.myflorida.com or me at Allison.McLeary@em.myflorida.com.

Thank you,

Allison McLeary, Esq.
Recovery Bureau Chief
Florida Division of Emergency Management

Rebuilding Together

(850) 509-8643 (Cell)
Allison.McLeary@em.myflorida.com

Please note that Florida has a broad public records law (Chapter 119, Florida Statutes). Most written communications to or from state employees are public records obtainable by the public upon request. Emails sent to me at this email address may be considered public and will only be withheld from disclosure if deemed confidential pursuant to the laws of the State of Florida.

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AMERICAN OVERSIGHT

From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Monday, December 14, 2020 9:27 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>
Subject: CDC COVID-19 Vaccination Communication Toolkit

FYSA –

Please see weblink for the CDC – COVID-19 Vaccination guidance communication guidance. Please use as you wish; the SERT will incorporate this guidance and modify as needed.

COVID-19 Vaccination Communication Toolkit

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AMERICAN OVERSIGHT

From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Wednesday, January 27, 2021 8:29 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>
Subject: CDC Updates Recommended Time Between Vaccines Doses

CDC Updates Recommended Time Between Vaccines Doses

- **Summary:** The CDC updated their interim clinical considerations on intervals between the first and second dose. The second dose should be administered as close to the recommended interval as possible. However, if it is not feasible to adhere to the recommended interval, the second dose of Pfizer-BioNTech and Moderna COVID-19 vaccines may be scheduled for administration up to 6 weeks (42 days) after the first dose.

Resource: Updated Interim Considerations.

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From: Cintron, Morgan <Morgan.Cintron@em.myflorida.com>
Sent: Friday, January 15, 2021 1:28 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Subject: Church Missions for this coming weekend

Good Afternoon,

Please see below for church missions that is happening around the state this weekend and into the middle of next week. Please let me know if there are any questions.

Event Day	Region	County	Event Time	Name	Street Address	City
01/16/2021 (Saturday)	Region 5	Brevard	9:00 AM	Mt Moriah Missionary Baptist Church	2295 Dr. Harvey Riley St NE	Palm Bay
01/16/2021 (Saturday)	Region 7	Palm Beach	9:00 AM	Tabernacle Missionary Baptist Church	801 8th St.	West Palm Beach
01/17/2021 (Sunday)	Region 7	Broward	9:00 AM	Hopewell Missionary Baptist Church	890 NW 15th St	Pompano Beach
01/17/2021 (Sunday)	Region 1	Escambia	8:00 AM	Brownsville Community Center	3200 W DeSoto St.	Pensacola
01/17/2021 (Sunday)	Region 7	Miami-Dade	1:00 PM	Bethel Evangelical Baptist Church	17601 NW 2nd Avenue	Miami Gardens
01/17/2021 (Sunday)	Region 7	Miami-Dade	9:00 AM	Second Baptist Church	11111 Pinkston Dr	Miami
01/17/2021 (Sunday)	Region 7	Palm Beach	9:00 AM	Wells Recreation Center	2409 Avenue H West	Riviera Beach
01/16/2021 (Saturday)	Region 4	Pinellas	9:00 AM	Mt. Zion Progressive Missionary Baptist Church	955 20th Street South	St. Petersburg
01/18/2021 (Monday)	Region 5	Osceola	8:00 AM	St. Rose of Lima Catholic Church	3880 Pleasant Hill Rd	Kissimmee
01/20/2021 (Wednesday)	Region 7	Miami-Dade	8:00 AM	San Lazaro Church	4400 W 18th Ave	Hialeah

Thanks!

Morgan L. Cintron, MECM
External Affairs Director
Office of the Director
Florida Division of Emergency Management
2555 Shumard Oak Boulevard
Tallahassee, FL 32399
C-850-755-2722
O-850-815-4013
Morgan.Cintron@em.myflorida.com
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AMERICAN OVERSIGHT

From: Perry, Kaylynn <Kaylynn.Perry@em.myflorida.com>
Sent: Tuesday, February 02, 2021 10:43 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: EOC-Plans <EOC-Plans@em.myflorida.com>
Subject: CORRECTED: County Vaccine Roll-Up 2-2-21
Attachment(s): "County Vaccine Site Roll-Up 2-2-21.pdf"

Attached is a corrected County Vaccine Site Roll-Up.

Sorry everyone, as before:

This is the first (well, second) iteration of this report, so if there are any errors or changes that need to be made let me know and we can work on them tomorrow. If there are any errors in the doses reported I can go in and change it on the back end. Once we establish county access you will be able to do this as well.
Additionally, if your to-date totals do not accurately reflect your site, you can change the date in the survey to enter vaccines administered for past days. This is the only way to enter back-dated information. If you need help establishing when your jurisdiction began reporting into salesforce I can look it up.

Please let me know if you need anything else.

Kaylynn Perry
Planning Section | State Emergency Response Team
Florida Division of Emergency Management
Kaylynn.perry@em.myflorida.com
PSC desk: (850) 815-4916
Mobile: (850) 254-5657

From: Perry, Kaylynn
Sent: Tuesday, February 2, 2021 10:27 PM
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Cc: EOC Plans <eoc-plans@em.myflorida.com>
Subject: RE: County Vaccine Roll-Up 2-2-21

All,

Several counties dropped of this report in filtering for County/CHD sites. I will send a corrected version shortly.

Kaylynn Perry
Planning Section | State Emergency Response Team
Florida Division of Emergency Management
Kaylynn.perry@em.myflorida.com
PSC desk: (850) 815-4916
Mobile: (850) 254-5657

From: Perry, Kaylynn
Sent: Tuesday, February 2, 2021 10:04 PM
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Cc: EOC Plans <eoc-plans@em.myflorida.com>
Subject: County Vaccine Roll-Up 2-2-21

Good evening,

Attached is the County Vaccine Roll-Up for 2-2-21.

This is the first iteration of this report, so if there are any errors or changes that need to be made let me know and we can work on them tomorrow. If there are any errors in the doses reported I can go in and change it on the back end. Once we establish county access you will be able to do this as well.
Additionally, if your to-date totals do not accurately reflect your site, you can change the date in the survey to enter vaccines administered for past days. This is the only way to enter back-dated information. If you need help establishing when your jurisdiction began reporting into salesforce I can look it up.

Please let me know if you need anything else.

Thanks,
Kaylynn Perry
Planning Section | State Emergency Response Team
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PSC desk: (850) 815-4916
Mobile: (850) 254-5657

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State Vaccine Site Roll-Up 2/02/2021

	2/2/2021	To-Date
Total Doses Administered:	**50,878**	**575,339**
Pharmacy	-	**-**
State-Run POD	3,627	**54,147**
55+ Community POD	3,167	**42,702**
County/CHD POD	44,084	**471,307**
Faith-Based POD	-	**7,183**
POD undefined	-	**-**

County	Site	POD Type	1st Dose	2nd Dose	Doses Administered Today	To-Date Administered
Alachua	DOH-Alachua County	County/CHD POD	5	327	332	7,150
Baker	DOH-Baker	County/CHD POD	-	-	-	580
Bay	DOH-Bay	County/CHD POD	267	21	288	1,222
Bradford	DOH-Bradford	County/CHD POD	240	-	240	881
Brevard	DOH-Brevard (Viera)	County/CHD POD	11	563	574	7,548
Broward	Coral Springs - Coral Square Mall	County/CHD POD	406	414	820	5,726
Broward	Coral Square Mall	County/CHD POD	-	-	-	-
Broward	Trade Winds Park	County/CHD POD	156	808	964	10,245
Broward	Holiday Park	County/CHD POD	224	1,018	1,242	9,883
Broward	Vista View Park	County/CHD POD	8	754	762	8,893
Broward	Markham Park	County/CHD POD	470	1,258	1,728	12,089
Broward	Central Broward Regional Park	County/CHD POD	540	588	1,128	10,775
Broward	DOH-Broward	County/CHD POD	173	49	222	2,362
Broward	Broward County Soccer Stadium	County/CHD POD	588	439	1,027	7,294
Broward	Sunrise Lakes	County/CHD POD	-	-	-	2,386
Calhoun	DOH-Calhoun	County/CHD POD	2	9	11	245
Charlotte	Harold Ave Park	County/CHD POD	-	-	-	2,424
Citrus	DOH-Citrus	County/CHD POD	-	-	-	4,353
Clay	DOH-Clay	County/CHD POD	-	-	-	2,679
Collier	North Collier Regional Park	County/CHD POD	-	-	-	6,673
Columbia	Southside Sports Complex	County/CHD POD	19	1,122	1,141	25,779
Desoto	Agri Turner Civic Center	County/CHD POD	-	-	-	764
Dixie	DOH-Dixie	County/CHD POD	-	-	-	201
Duval	Prime Osborn Convention Center	County/CHD POD	-	-	-	-
Escambia	DOH-Escambia	County/CHD POD	-	55	55	5,770
Flagler	Flagler County Fairgrounds	County/CHD POD	2	508	510	2,510
Franklin	DOH-Franklin	County/CHD POD	1	60	61	443
Gadsden	DOH-Gadsden / FLNG Gadsden Armory	County/CHD POD	-	-	-	523
Gilchrist	DOH-Gilchrist	County/CHD POD	106	88	194	773
Glades	DOH-Glades	County/CHD POD	-	-	-	230
Gulf	DOH-Gulf	County/CHD POD	-	70	70	713
Hamilton	DOH-Hamilton	County/CHD POD	998	-	998	7,866
Hardee	Vacant Building 1499 US 17	County/CHD POD	-	-	-	475
Hardee	DOH-Hardee	County/CHD POD	-	-	-	951
Hendry	DOH-Hendry Clewiston	County/CHD POD	-	293	293	892
Hendry	DOH-Hendry Labelle	County/CHD POD	-	-	-	150
Hernando	DOH-Hernando	County/CHD POD	743	105	848	4,007
Highlands	Lakeshore Mall	County/CHD POD	-	-	-	2,942
Holmes	DOH-Holmes	County/CHD POD	6	514	520	1,215
Indian River	IR Fairgrounds	County/CHD POD	-	450	450	3,675
Jackson	DOH-Jackson	County/CHD POD	-	-	-	1,249
Jefferson	DOH-Jefferson	County/CHD POD	291	1	292	553
Lafayette	DOH-Lafayette	County/CHD POD	1,130	-	1,130	6,998
Lake	Clermont Arts and Recreation Center	County/CHD POD	973	2,710	3,683	18,584
Lee	Southwest Florida International Airport	County/CHD POD	-	-	-	14,601
Leon	DOH-Leon	County/CHD POD	-	854	854	6,263
Levy	DOH-Levy	County/CHD POD	-	107	107	988
Liberty	DOH-Liberty	County/CHD POD	-	-	-	205
Madison	Van H Priest Auditorium	County/CHD POD	86	106	192	2,539
Manatee	Tom Bennett Park	County/CHD POD	-	1,453	1,453	12,204
Marion	Paddock Mall	County/CHD POD	-	-	-	13,145

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Marion	Heart of Florida Health Centers	County/CHD POD	-	-	-	-
Marion	DOH-Marion	County/CHD POD	-	-	-	-
Martin	DOH - Martin	County/CHD POD	-	211	211	2,317
Miami-Dade	Jackson Memorial (3 PODs)	County/CHD POD	1,195	2,103	3,298	46,401
Monroe	DOH-Monroe	County/CHD POD	-	-	-	253
Nassau	DOH-Nassau	County/CHD POD	-	-	-	2,423
Okaloosa	DOH-Okaloosa	County/CHD POD	2	428	430	5,343
Okeechobee	DOH-Okeechobee	County/CHD POD	-	-	-	653
Orange	Orange County Covention Center	County/CHD POD	-	-	-	18,061
Osceola	Centro Cristiano Dios De Pactos Church	County/CHD POD	9	811	820	7,254
Osceola	DOH-Osceola	County/CHD POD	-	-	-	533
Palm Beach	South Florida Fairgrounds	County/CHD POD	1,128	-	1,128	14,736
Pasco	St. Leo University	County/CHD POD	-	-	-	4,847
Pasco	Sears Gulf View Mall Location	County/CHD POD	1,032	81	1,113	3,740
Pasco	Pasco-Location Pending	County/CHD POD	-	-	-	-
Pinellas	Palm Harbor	County/CHD POD	358	-	358	4,269
Pinellas	DOH-Pinellas (Mid County)	County/CHD POD	-	111	111	111
Pinellas	Pinellas Park	County/CHD POD	-	-	-	-
Pinellas	DOH-Pinellas (Clearwater)	County/CHD POD	-	119	119	119
Pinellas	Highland Rec Complex	County/CHD POD	-	-	-	-
Pinellas	DOH-Pinellas (St. Petersburg)	County/CHD POD	-	119	119	119
Pinellas	Center for Health Equity	County/CHD POD	1,706	-	1,706	18,197
Polk	DOH-Polk	County/CHD POD	1,406	570	1,976	13,970
Putnam	Putnam County Fairgrounds	County/CHD POD	-	679	679	1,894
Santa Rosa	DOH-Santa Rosa	County/CHD POD	193	115	308	2,576
Sarasota	Twin Lakes Park	County/CHD POD	-	-	-	2,760
Sarasota	DOH-Sarasota	County/CHD POD	1,530	-	1,530	6,703
Seminole	Oveido Mall (Sears storefront)	County/CHD POD	729	1,080	1,809	21,440
St. Johns	Solomon Calhoun Community Center	County/CHD POD	-	225	225	10,712
St. Lucie	DOH-St. Lucie	County/CHD POD	-	2,234	2,234	11,763
St. Lucie	St. Lucie Fairgrounds	County/CHD POD	-	-	-	-
Sumter	DOH-Sumter (Villages)	County/CHD POD	-	-	-	-
Sumter	DOH-Sumter (Wildwood)	County/CHD POD	244	-	244	2,177
Suwannee	Suwannee County Health Department	County/CHD POD	-	-	-	5,415
Suwannee	DOH-Suwannee	County/CHD POD	1,985	132	2,117	9,576
Taylor	DOH-Taylor	County/CHD POD	-	-	-	400
Union	DOH-Union	County/CHD POD	210	-	210	500
Union	Union County Hospital	County/CHD POD	-	-	-	-
Volusia	Volusia County Fairgrounds	County/CHD POD	-	1,150	1,150	8,930
Wakulla	DOH-Wakulla	County/CHD POD	-	-	-	649
Walton	Gene Hurley Park	County/CHD POD	-	-	-	1,100
Washington	First Baptist Church of Chipley	County/CHD POD	-	-	-	750
Total			**19,172**	**24,912**	**44,084**	**471,307**

AMERICAN OVERSIGHT

From: McLeary, Allison <Allison.McLeary@em.myflorida.com>
Sent: Wednesday, December 16, 2020 8:47 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: DEM Recovery <DEM_Recovery@em.myflorida.com>
Subject: Cost of Assistance Estimates in the Disaster Declaration Process for the Public Assistance Program - Notice of Proposed Rulemaking
Attachment(s): "NPRM - Cost of Assistance Estimates in the Declaration Process for the PA Program.pdf"

Good morning:

FEMA is proposing to revise the “estimated cost of the assistance” disaster declaration factor that it uses to evaluate a Governor’s request for a major disaster under the Public Assistance Program.

The proposed revisions would assess states’ disaster response capabilities and would comply with the direction of Congress in the Disaster Recovery Reform Act of 2018, which requires FEMA to review and update its disaster declaration factors. The Notice of Proposed Rulemaking was published in the *Federal Register* (linked below and attached).

FEMA is seeking public comment on the rule until **February 12, 2021**. Comments may be submitted through www.Regulations.gov under docket ID FEMA-2020-0038. We encourage you to comment directly, or coordinate with FDEM to include your considerations in our comment.

https://www.federalregister.gov/documents/2020/12/14/2020-27094/cost-of-assistance-estimates-in-the-disaster-declaration-process-for-the-public-assistance-program

Thank you,

Allison McLeary, Esq.
Recovery Bureau Chief
Florida Division of Emergency Management

Rebuilding Together

(850) 509-8643 (Cell)
Allison.McLeary@em.myflorida.com

Please note that Florida has a broad public records law (Chapter 119, Florida Statutes). Most written communications to or from state employees are public records obtainable by the public upon request. Emails sent to me at this email address may be considered public and will only be withheld from disclosure if deemed confidential pursuant to the laws of the State of Florida.

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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raised. The comment period is extended until February 12, 2021.

Carolyn Hoskinson,

Director, Office of Resource Conservation and Recovery.

[FR Doc. 2020–27360 Filed 12–11–20; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 206

[Docket ID FEMA–2020–0038]

RIN 1660–AA99

Cost of Assistance Estimates in the Disaster Declaration Process for the Public Assistance Program

AGENCY: Federal Emergency Management Agency, Department of Homeland Security (DHS).

ACTION: Notice of proposed rulemaking.

SUMMARY: The Federal Emergency Management Agency (FEMA) is proposing a rule to substantively revise the ''Estimated cost of the assistance'' disaster declaration factor that FEMA uses to review a Governor's request for a major disaster under the Public Assistance Program. FEMA proposes revisions to this factor to more accurately assess the disaster response capabilities of the 50 States, the District of Columbia, and the U.S. territories (States), and to respond to the direction of Congress in the Disaster Recovery Reform Act of 2018, which requires FEMA to review its disaster declaration factors and update them via rulemaking, as appropriate.

DATES: All comments must be submitted by February 12, 2021.

ADDRESSES: You may submit comments on this proposed rule, identified by Docket ID FEMA–2020–0038, by the following method:

Federal eRulemaking Portal: http://www.regulations.gov. Follow the instructions for submitting comments.

Comments on the proposed information collections included in this proposed rule should be submitted both to FEMA, as indicated above, and to the Office of Information and Regulatory Affairs, Office of Management and Budget. Comments should be identified by the appropriate OMB Control Number(s), addressed to the Desk Officer for the Department of Homeland Security, Federal Emergency Management Agency, and sent via electronic mail to *dhsdeskofficer@omb.eop.gov.*

FOR FURTHER INFORMATION CONTACT: Tod Wells, Deputy Director of Public Assistance, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, 202–646–3936, *fema-recovery-pa-policy@fema.dhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Public Participation

We encourage you to participate in this rulemaking by submitting comments and related materials. We will consider all comments and material received during the comment period.

If you submit a comment, identify the agency name and the docket ID for this rulemaking, indicate the specific section of this document to which each comment applies, and give the reason for each comment. You may submit your comments and material by electronic means, mail, or delivery to the address under the **ADDRESSES** section. Please submit your comments and material by only one means.

Regardless of the method used for submitting comments or material, all submissions will be posted, without change, to the Federal e-Rulemaking Portal at *http://www.regulations.gov,* and will include any personal information you provide. Therefore, submitting this information makes it public. You may wish to read the Privacy and Security Notice that is available via a link on the homepage of *http://www.regulations.gov.*

Viewing comments and documents: For access to the docket to read supporting documents and comments received, go to the Federal e-Rulemaking Portal at *http://www.regulations.gov.* Background documents and submitted comments may also be inspected at FEMA, Office of Chief Counsel, 500 C Street SW, Washington, DC 20472–3100.

II. Executive Summary

Pursuant to 44 CFR 206.48(a), FEMA considers several factors when determining whether to recommend that the President declare a major disaster authorizing the Public Assistance (PA) program.[1] FEMA proposes to amend the factor in 44 CFR 206.48(a)(1) for ''estimated cost of the assistance,'' to raise the per capita indicator and the minimum threshold.[2]

Since 1986, FEMA has evaluated the estimated cost of Federal and non-Federal public assistance against the statewide population and used a per capita dollar amount (set at $1 in 1986) as an indicator that a disaster may warrant Federal assistance. The per capita indicator remained at $1 until 1999, when the Agency began adjusting the indicator for inflation in 1999 and annually thereafter.[3] Also in 1999, FEMA established a $1 million minimum threshold, meaning it would not recommend that the President authorize the PA program unless there was at least $1 million in damages resulting from the disaster and within the proposed area for Public Assistance. At the time, FEMA believed $1 million was a level of damage from which even the least populous States could recover with their own resources. FEMA has never increased the $1 million threshold. Additionally, FEMA also considers impacts at the local level and recent disasters in the 12 months prior to a declaration request to evaluate the impact to the State or locality.

In the Disaster Recovery Reform Act of 2018 (DRRA), Congress directed FEMA to give greater consideration to the recent multiple disasters and localized impacts factors when evaluating a request for a major disaster.[4] Congress also directed FEMA to generally review the factors it considers when considering a request for a major disaster, specifically the estimated cost of assistance factor, and to update the factors through rulemaking, as appropriate.[5]

The lack of increases to the per capita indicator from 1986 to 1999 has undercut the value of this factor as an indicator of State capacity given the 51 percent reduction in purchasing power during that time.[6] In addition, a State

[1] Under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act) (42 U.S.C. 5170), the President may declare that a major disaster exists after finding, upon request by a State governor, that such disaster is beyond the capabilities of the State and affected local governments, and that Federal assistance is needed. FEMA receives the governor's request and makes a recommendation to the President whether such a declaration is warranted. *See* 44 CFR 206.37.

[2] *See* 44 CFR 206.48(a). Other factors include: Insurance coverage in force, hazard mitigation, and other Federal assistance programs. *Id.*

[3] At the time of drafting this proposed rule, the indicator was $1.50 in fiscal year 2019. *See* FEMA, Notice of Adjustment of Statewide per Capita Impact Indicator, 83 FR 53279 (Oct. 22, 2018).

[4] Sec. 1232 of Public Law 115–254, 132 Stat. 3460 (Oct. 5, 2018). However, as discussed below, FEMA does not propose to substantively amend 44 CFR 206.48(a)(2) because that factor is already sufficiently flexible to address the requirements of section 1232 of the DRRA.

[5] Sec. 1239 of Public Law 115–254, 132 Stat. 3466 (Oct. 5, 2018).

[6] April 1986 CPI–U was 108.6 and January 1999 CPI–U was 164.3. (164.3 − 108.6)/108.6 = 51.29%. *See* Bureau of Labor Statistics, U.S. Department of Labor, ''Consumer Price Index, Archived Consumer Price Index Supplemental Files'': Historical CPI–U, November 2019, (available for download at *https://*

Continued

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fiscal capacity factor pegged to $1 per person in 1986 does not capture more sophisticated measurements of fiscal capacity available through consideration of a State's total taxable resources. Accordingly, the current per capita indicator and minimum threshold do not provide an accurate measure of States' capabilities to respond to disasters.

With respect to the minimum threshold, while FEMA determined in 1999 that every State could handle at least $1 million in damages with their own resources, that figure has also not increased with inflation or rising State budgets and expenditures.[7] As a result, FEMA may recommend that the President declare major disaster declarations for incidents that, with more accurate assessment, would be found to be well within a State's financial capabilities to respond to on its own. FEMA proposes to adjust these factors so that it may more closely adhere to the law which authorizes Federal disaster assistance only when an event "is beyond the capabilities" of the State and affected local governments.[8]

FEMA proposes to increase the per capita indicator to account for increases in inflation from 1986 to 1999, and to adjust the individual States' indicators by their total taxable resources (TTR). These changes will allow FEMA to more accurately gauge a State's fiscal capacity by accounting for taxable resources other than the State's population, such as business income, undistributed corporate profits, and out-of-state residents. FEMA also proposes to increase the minimum threshold by accounting for inflation from 1999 to 2019, and annually thereafter.

FEMA also proposes to use the U.S. Census Bureau's annual population estimates produced under the Population Estimates Program (PEP) instead of the decennial census population data produced every 10 years, which FEMA currently uses to calculate each State's Cost of Assistance (COA) Indicator. By increasing the per capita indicator and the minimum threshold, and using more current population data, FEMA's recommendation to the President will be a better informed and more accurate assessment of whether an incident exceeds State capabilities. The resulting reduction in disaster declarations for smaller incidents will allow FEMA to better focus its efforts and resources on larger disasters without the complications of reallocating resources from multiple smaller-scale commitments. Collectively, these changes would provide a better distribution of responsibilities between the States and the Federal Government, and will incentivize States to invest more in response, recovery, and mitigation capabilities, and lead to a more resilient and prepared Nation.

With respect to the recent multiple disasters and localized impacts factors, FEMA proposes not to substantively amend 44 CFR 206.48(a)(2) and (5). As is discussed below, these factors are already sufficiently flexible to address the requirements of section 1232 of the DRRA. FEMA also does not propose at this time to substantively amend the other declaration factors at 44 CFR 206.48(a)(3) ("Insurance coverage in force"), (4) ("Hazard mitigation"), and (6) ("Programs of other Federal assistance") because they already provide adequate consideration of important information for FEMA's assessment of a State's capabilities to respond to an event, while also providing sufficient flexibility for FEMA to account for a variety of circumstances across the States.

Importantly, this proposed rule will not affect FEMA's recommendations on direct requests for a major disaster declaration received from Tribal governments. For direct requests from Tribal governments, FEMA relies on the Tribal Declarations Pilot Guidance and criteria in that guidance instead of 44 CFR 206.48.[9]

FEMA also proposes minor technical and corresponding grammatical changes to 44 CFR 206.48 to ensure consistent language between the Public Assistance declaration factors in 44 CFR 206.48(a) and the Individual Assistance factors in 44 CFR 206.48(b).

III. Background

The Disaster Relief Act of 1974,[10] which was amended and renamed the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act) in 1988,[11] formally established the foundation of the current disaster assistance system. Generally, FEMA coordinates the Federal Government's response to major disasters and provides various forms of financial and direct assistance. One of the primary types of financial assistance FEMA provides is through the PA program.[12] FEMA provides financial assistance to States, Tribes, Territories, and local governments and certain private non-profit entities for debris removal,[13] emergency protective measures,[14] and the repair, restoration, and replacement of infrastructure damaged or destroyed by a disaster event.[15] Repair and replacement assistance, known as "permanent work," helps jurisdictions to repair or replace a wide variety of infrastructure including buildings, roads, bridges, and sewer and water systems.

Before an affected jurisdiction can receive funding through the PA program, the President of the United States must authorize it through a declaration of a major disaster or emergency.[16] To obtain a declaration, the Governor must make a request through FEMA.[17] Upon receipt, FEMA is responsible for evaluating the Governor's request and providing a recommendation to the President regarding its disposition.[18]

When considering a jurisdiction's request for a major disaster declaration authorizing the PA program, FEMA considers all relevant information including, but not limited to, six specific factors.[19] These specific factors are:

1. Estimated cost of the assistance; [20]
2. localized impacts; [21]

www.bls.gov/cpi/tables/supplemental-files/home.htm).

[7] *See* Government Accountability Office (GAO), Federal Disaster Assistance: Improved Criteria Needed to Assess Eligibility and a Jurisdiction's Capability to Respond and Recover On Its Own, GAO–12–838 (2012); Department of Homeland Security (DHS), Office of Inspector General (OIG), Opportunities to Improve FEMA's Public Assistance Preliminary Damage Assessment Process, OIG–12–79 (2012).

[8] *See* section 401 of the Stafford Act (42 U.S.C. 5170).

[9] See FEMA, Tribal Declarations Pilot Guidance, available at: *https://www.fema.gov/tribal-declarations-pilot-guidance*. Notice of availability published at 82 FR 3016 (Jan. 10, 2017).

[10] Disaster Relief Act of 1974, Public Law 93–288 (1974).

[11] Robert T. Stafford Disaster Relief and Emergency Assistance Act, Public Law 100–707 (1988); Public Law 93–288 (1974), as amended; 42 U.S.C. 5121 *et seq.*

[12] *See* 42 U.S.C. 5172.

[13] *See* 44 CFR 206.224.

[14] *See* 44 CFR 206.225.

[15] *See* 44 CFR 206.226.

[16] *See* 42 U.S.C. 5170b, 5192; *see also* 44 CFR 206.38 and 206.40.

[17] 42 U.S.C. 5170 & 5191. The Chief Executive of an Indian Tribal government may also request a major disaster declaration from the President under the Tribal Declarations Pilot Guidance. FEMA, Tribal Declarations Pilot Guidance, available at: *https://www.fema.gov/tribal-declarations-pilot-guidance*. Notice of availability published at 82 FR 3016 (Jan. 10, 2017). The factors FEMA considers when reviewing a request submitted under the Tribal Declarations Pilot Guidance are not a part of the factors FEMA considers under 44 CFR 206.48(a) and are outside the scope of this proposed rulemaking.

[18] *See* 44 CFR 206.37(c).

[19] *See* 44 CFR 206.48(a).

[20] *Id.* at § 206.48(a)(1).

[21] *Id.* at § 206.48(a)(2).

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3. insurance coverage in force; [22]
4. hazard mitigation; [23]
5. recent multiple disasters; [24] and
6. programs of other Federal assistance.[25]

FEMA evaluates every request with regard to each of these delineated factors, to the extent applicable. However, there is a strong correlation between the first factor, the estimated cost of the assistance, and the likelihood that FEMA will recommend that the President issue a major disaster declaration.

On October 5, 2018, the President signed the Disaster Recovery Reform Act (DRRA).[26] Section 1239 of the DRRA directs FEMA to review the factors it considers when evaluating a request for a major disaster declaration, specifically the estimated cost of assistance factor, and to initiate rulemaking to update the declaration factors. Further, Section 1232 of the DRRA directs the FEMA Administrator to give ''greater consideration'' to the localized impacts and recent multiple disasters factors and to make corresponding adjustments to FEMA policies and regulations. FEMA now proposes to amend 44 CFR 206.48(a) to make changes to the estimated cost of assistance factor. With respect to the recent multiple disasters and localized impacts factors, FEMA evaluated the provision of the DRRA as well as the current factors in regulation and determined that the regulation is sufficiently flexible to address the DRRA requirements. On May 1, 2019, FEMA issued guidance to Regional Administrators directing them to include in their recommendations appropriate and fulsome information regarding severe local impacts and the history of recent multiple disasters.[27] As is discussed below, FEMA requests comment on whether revisions to the recent multiple disasters factor are necessary.

A. Cost of Assistance Estimates

1. Creation of the Per Capita Indicator

Pursuant to 44 CFR 206.48(a)(1), FEMA evaluates the estimated cost of Federal and non-Federal public assistance resulting from an incident to inform its recommendation to the President of whether an incident is of such severity and magnitude that it is beyond the capabilities of the State and warrants Federal assistance under a major disaster declaration. To make this estimation, FEMA calculates the estimated cost of assistance, generally determined from joint FEMA-State Preliminary Damage Assessments, against the statewide population and if the estimated per capita dollar amount exceeds $1.50 (fiscal year (FY) 2019 per capita indicator),[28] FEMA considers this an indicator that the incident is of such a size and magnitude that it may warrant Federal assistance for the State under a major disaster declaration. In other words, FEMA relies on the per capita indicator to assess the financial impact of an incident on a State and as an indicator of whether the State is overwhelmed and unable to effectively respond to an event on its own.

FEMA publishes the updated per capita indicator in the **Federal Register** each year.[29] FEMA multiplies the indicator by the impacted State's most recent decennial population to determine the amount of damage that a State is expected to be able to independently manage without the need for supplemental Federal assistance (the State Cost of Assistance (COA) Indicator). For example, if an event occurred in FY2019 in a State with a 2010 decennial census population of 1,500,000, FEMA would multiply that population by the $1.50 indicator and arrive at a State COA indicator of $2,250,000.[30] If the estimated cost of assistance exceeds $2,250,000, FEMA would consider this a strong indicator that the State is overwhelmed and in need of supplemental Federal assistance.

Although FEMA considers every request for a Presidential major disaster declaration in light of each applicable regulatory factor, the probability of an incident being declared a major disaster and that incident having exceeded the State COA indicator in disaster damage between 2005 and 2014 was over 80 percent (494 of 589 declared major disasters).[31] In other words, whether damage assessments find an amount of damage that meets or exceeds the State COA indicator is highly correlated to whether that State will ultimately receive supplemental Federal assistance for that incident.

FEMA began informally using the per capita indicator in 1986 and set it at $1, based on the 1983 nationwide per capita personal income (PCPI), as $1 was determined to be a reasonable portion of PCPI for a State to contribute towards the cost of a disaster. This amount also correlated closely to about 0.1 percent of established General Fund expenditures by States. With the passage of time, however, the indicator lost its relation to both metrics upon which FEMA first calculated it. When FEMA began using a per capita indicator of $1 in 1986, the most recent PCPI data available was 1983 PCPI, which was $11,687.[32] By 1999, PCPI had risen 145 percent to $28,675.[33] Similarly, the per capita indicator also fell short of keeping pace with State general fund expenditures. Between 1986 and 1999, the national average increase in State general fund expenditures was 146 percent.[34] Despite these increases in PCPI and State general fund expenditures, FEMA did not increase the per capita indicator until 1999.

2. Changes to the Per Capita Indicator and Establishment of the Minimum Threshold

In 1999, FEMA issued a rule to codify the per capita indicator at $1 and establish, beginning in 1999, that FEMA would annually adjust the per capita indicator for inflation based on the Consumer Price Index for All Urban Consumers (CPI–U).[35] This rule, along with the failure to increase the indicator over the years, removed any remaining association the indicator had in the past

[22] *Id.* at § 206.48(a)(3).
[23] *Id.* at § 206.48(a)(4).
[24] *See* 44 CFR 206.48(a)(5).
[25] *Id.* at § 206.48(a)(6).
[26] Public Law 115–254, 132 Stat. 3438 (Oct. 5, 2018).
[27] Memorandum for Regional Administrators from Jeff Byard, Associate Administrator, Office of Response and Recovery, Declaration Factors for Local Impact and Recent Multiple Disasters (May 1, 2019).
[28] Since the drafting of this proposed rule, FEMA has published the FY 2020 per capita indicator of $1.53. However, for the purposes of this proposed rule and analysis, FEMA will continue to discuss the FY 2019 per capita of $1.50. *See* FEMA, Notice of Adjustment of Statewide per Capita Impact Indicator, 83 FR 53279 (Oct. 22, 2018).
[29] *See, e.g.*, 84 FR 55324 (Oct. 16, 2019).
[30] Per Capita Impact Indicator and Project Thresholds are published on FEMA's website, available at *https://www.fema.gov/public-assistance-indicator-and-project-thresholds.*
[31] 82 FR 4064, 4067 (Jan. 12, 2017).
[32] Disaster Assistance; Subpart C, the Declaration Process and State Commitments, 51 FR 13333, Apr. 18, 1986, found at *http://cdn.loc.gov/service/ll/fedreg/fr051/fr051075/fr051075.pdf.* Revisions were made to the BEA 1983 PCPI after publication of the proposed 1986 rule. FEMA used the PCPI of $11,687 to maintain consistency with the data used at the time of establishing the per capita indicator.
[33] Per Capita Personal Income (PCPI) is calculated annually by the United States Department of Commerce's Bureau of Economic Analysis. PCPI data is available for download at *https://apps.bea.gov/regional/downloadzip.cfm:* Download ''Annual Personal Income by State'' under ''State Personal Income Accounts.'' Historical PCPI data pulled from Excel sheet titled ''SAINC1_ALL_AREAS_1929_2018.''
[34] *Compare* National Association of State Budget Officers (NASBO), 1988 State Expenditure Report, *with* NASBO, 2000 State Expenditure Report (available for download at: *https://www.nasbo.org/reports-data/state-expenditure-report/state-expenditure-archives*). Actual fiscal total US expenditures were $880,252 million in 1999 (found page 6 of the 2000 report) and $358,277 million in 1986 (found page 5 of the 1988 report). Calculation: (($880,252 − $358,277)/$358,277) * 100 = 145.69 percent (146 percent rounded).
[35] 64 FR 47697 (Sept. 1, 1999).

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with PCPI or State general fund expenditures.

In setting the per capita indicator in 1999, FEMA chose not to retroactively account for inflation from 1986–1999.[36] Accordingly, FEMA did not, and to this date has not, accounted for the 51 percent increase in the CPI–U between April of 1986 (when the per capita indicator was first set at $1) and January of 1999 (when FEMA proposed to adjust the per capita indicator for inflation).[37] Consequently, since 1999, the per capita indicator has risen to its FY 2019 value of $1.50, rather than $2.32, which would be the value of the per capita indicator had FEMA accounted for inflation between 1986 and 1999.[38]

Also, in 1999, FEMA established, through regulation, a $1 million minimum threshold for any PA major disaster, regardless of the calculated State COA indicator.[39] FEMA set the threshold at $1 million because it believed that even the lowest population States could reasonably be expected to cover this level of public assistance damage.[40] Importantly, FEMA did not subject the $1 million floor to adjustments for inflation. FEMA has never raised the $1 million threshold.

3. Criticism of the Current Cost of Assistance Estimates Factor

In recent years, the Government Accountability Office (GAO),[41] the Department of Homeland Security Office of Inspector General (DHS OIG),[42] and Congress,[43] have criticized and called for changes to the way FEMA considers the estimated cost of assistance for a disaster. For example, the GAO found that the PA per capita indicator is artificially low because it does not reflect the rise in PCPI since 1986, or 13 years of inflation from 1986 to 1999, resulting in recommendations to the President that do not comprehensively assess a jurisdiction's capability to respond to and recover from a disaster on its own.[44] Similarly, the DHS OIG found that roughly one-third of FEMA-State Preliminary Damage Assessments used to estimate the damage of a given event would not have exceeded the States' COA indicators if the per capita indicator had been indexed to the Consumer Price Index since 1983.[45] Both GAO and the DHS OIG recommended that FEMA develop and implement a methodology that provides a better reflection of current economic conditions and a more comprehensive assessment of a jurisdiction's capability to respond and recover from a disaster without Federal assistance in order to decrease the frequency of disaster declarations and transfer some costs back to State and local jurisdictions.[46] Additionally, GAO and the DHS OIG recommended that FEMA supplement the per capita indicator with more complete data on a jurisdiction's financial resources (*i.e.,* its tax base), such as TTR, in order to obtain a more comprehensive assessment of the jurisdiction's ability to respond to a disaster on its own.[47]

More recently, in section 1239 of the DRRA, Congress directed FEMA to review the factors it considers when evaluating a request for a major disaster declaration, specifically the estimated cost of assistance factor, and to initiate rulemaking to update the declaration factors.[48]

4. Problems With the Current Cost of Assistance Estimates Factor

a. The Current Cost of Assistance Estimates Factor No Longer Provides an Accurate Measure of States' Capabilities To Respond to Disasters and Is No Longer Reflective of Current Economic Conditions

The lack of increases to the per capita indicator from 1986 to 1999 undercut the value of this factor as an indicator of State capacity given the reduction in purchasing power during that time. Similarly, on the minimum threshold, the lack of an increase since 1999 has prevented this factor from keeping pace with inflation, and rising State budgets and resources. For context, the lowest State budget for FY 2018 (Delaware) was just over $4 billion,[49] while its State COA indicator for FY 2018 was just over $1.31 million, or 0.032 percent of the State's budget. For comparison, in FY 1987, Delaware's budget was just under $1 billion,[50] while its State COA indicator was just under $595,000, or 0.063 percent of Delaware's FY 1987 State budget. Similarly, the lowest TTR amongst the States for FY 2016 (Vermont) was $36.1 billion,[51] while that State in FY 2016 was subject to the $1 million minimum threshold, or 0.0028 percent of the State's TTR. Because its State COA indicator was less than $1 million, Vermont would have been subject to the $1 million threshold in FY 2016. For comparison, Vermont's TTR in 1997 was $17.3 billion, while it was subject to the $1 million minimum threshold, or 0.0058 percent of its 1997 TTR. As shown from these figures, the ratio of the per capita indicator and the minimum threshold as a percentage of State budgets and TTR has decreased since FEMA began using the per capita indicator and minimum threshold. Moreover, as discussed in the Regulatory Impact Analysis (RIA) found in the docket of this rulemaking, since 1999, State gross domestic product (GDP), total State expenditures, and State TTR have increased, on a nationwide average, by approximately 113 percent, 131 percent, and 130

[36] In 1998, FEMA considered adjusting the per capita indicator to $1.51 to account for inflation since 1986, but because of input from state emergency management officials, FEMA decided not to do so. *See* GAO, GAO 12–838.

[37] *See* Historical CPI–U, April 2019 (available for download at *https://www.bls.gov/cpi/tables/supplemental-files/home.htm*). CPI–U in April 1986 was 108.6, CPI–U in January 1999 was 164.3. (164.3 − 108.6)/108.6 = 51.23%.

[38] FEMA, Notice of Adjustment of Statewide per Capita Impact Indicator, gave notice that the statewide per capita impact indicator increased to $1.50 for all disasters declared on or after October 1, 2018. 83 FR 53279 (Oct. 22, 2018). FEMA calculated inflation from between 1986 and 1999 by using the CPI–U from April 1986 to August 2018. Calculation: ((August 2018 CPI–U (252.146)—April 1986 CPI–U (108.6))/April 1986 CPI–U (108.6)) + $1 = $2.32 (rounded). FEMA uses the latest available month of CPI–U data to adjust the minimum threshold and per capita indicator each fiscal year, which is generally August CPI–U data. August 2018 CPI–U data was the latest available data when FEMA established the FY2019 per capita indicator and is used in this analysis to maintain consistency with FEMA practice.

[39] 44 CFR 206.48(a)(1).

[40] FEMA, Disaster Assistance; Factors Considered When Evaluating a Governor's Request for a Major Disaster Declaration, 64 FR 47697 (Sept. 1, 1999).

[41] *See, e.g.,* GAO, Disaster Assistance: Improvements Needed in Disaster Declaration Criteria and Eligibility Assurance Procedures, GAO 01–837 (2001); See also, GAO, GAO–12–838 at 29.

[42] *See* DHS OIG, OIG–12–79 at 3.

[43] *See, e.g.,* S.1960, Fairness in Federal Disaster Declarations Act of 2014, 113th Cong.; H.R. 3925, Fairness in Federal Disaster Declarations Act of 2014, 113th Cong. (establishing criteria for FEMA to incorporate in rulemaking with specific weighted factors); H.R. 1859, Disaster Declaration Improvement Act of 2013, 113th Cong. (requiring new regulations concerning major disaster declarations).

[44] GAO, GAO–12–838 at 48.

[45] DHS OIG, OIG–12–79 at 7.

[46] GAO, GAO 12–838 at 48–49; *See also* DHS OIG, OIG–12–79 at 7–8.

[47] GAO, GAO 12–838 at 48–49; *See also* DHS OIG, OIG–12–79 at 7–9.

[48] *See* Public Law 115–254, 132 Stat. 3466 (Oct. 5, 2018).

[49] Delaware General Assembly, Section 1, House Substitute No. 1 for House Bill No. 275 of 2017. p. 60. Retrieved 11 June 2018 (available for download at: *http://delcode.delaware.gov/sessionlaws/ga149/chp058.pdf*).

[50] NASBO, The State Expenditure Report, at 59 (July 1987) (available for download at: *https://www.nasbo.org/reports-data/state-expenditure-report/state-expenditure-archives*).

[51] U.S. Dept. of Treasury, 2018 Total Taxable Resources Estimates (Sept. 2018), (available for download at: *https://home.treasury.gov/system/files/226/TTR-tables-2018.pdf*) (last accessed Feb. 19, 2019). 2016 is the most recently reported year for TTR because there is a two-year lag in reporting.

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percent, respectively.[52] In comparison, since 1999, the per capita indicator and the minimum threshold have risen 50 percent and 0 percent, respectively.

Consequently, FEMA is relying upon per capita indicator and minimum threshold factors that are no longer adequate measures of a State's capability to respond to and recover from a disaster. The result is a greater likelihood that FEMA recommends major disaster declarations for relatively small incidents that a more accurate assessment would find is within a State's financial capabilities to respond to on its own. This result is counter to the intent of the Stafford Act that Federal assistance be supplemental, and only necessary for disasters that exceed a State's capabilities. In light of the rise in the costs to respond to and recover from a disaster (construction costs in particular), the lack of increases to the per capita indicator has led to outcomes, especially in less populous States, where minor, concentrated infrastructural damage (*e.g.,* a dirt road washout or damage to a single building) would result in costs sufficient to meet the per capita indicator and potentially result in a disaster declaration. While such incidents can certainly be disruptive and expensive, it is questionable whether such minor, concentrated damage really overwhelms a State and warrants a Presidential major disaster declaration.

In sum, the per capita indicator and minimum threshold are not reflective of the change in economic conditions since 1986 and 1999, respectively, and are no longer adequate measures of the States' capabilities to respond to, and recover from, incidents on their own. The increases in State resources and expenditures, and costs, generally, without corresponding increases to the per capita indicator and minimum threshold, has created a situation where Federal assistance is being provided for incidents which are more appropriately addressed by the States. This is counter to the intent of the Stafford Act that Federal assistance be provided only where State and local capabilities are overwhelmed.

b. The Current Cost of Assistance Estimates Factor Undermines FEMA's Mission to Better Prepare the Nation for Disasters by Disincentivizing States From Investing in Disaster Mitigation and Preparedness

The current per capita indicator and minimum threshold act as disincentives for States to invest in disaster response and recovery capabilities for incidents that should be within their capability to respond. Emergency management is a shared responsibility that is most effective when disaster operations are federally supported, State managed, and locally executed, where Federal support supplements, rather than supplants, State and local efforts.[53] In order to build a more prepared and resilient nation, it is essential that State, local, Tribal, and Territorial governments continually mitigate risk to hazards posed by natural disasters, and build their response and recovery capabilities for future incidents, including the creation of dedicated financial reserves to respond to incidents.

While State and local governments respond on their own to countless small incidents that do not reach the level of their current State COA indicator, there is little incentive for States to build their response and recovery capabilities beyond their current State COA indicator, since Federal assistance will be provided at that point, even though FEMA believes all States have financial capabilities beyond their current State COA indicator. For example, in a 2015 study of 10 States, the GAO found that some States reported that they could cover disaster costs without dedicated disaster reserves because they generally relied on the Federal Government to fund most of the costs associated with disaster response and recovery.[54] GAO ultimately concluded, in part, that given the fiscal challenges facing all levels of government, there may be increased pressure to consider whether the current State and Federal approach for providing disaster assistance balances responsibilities appropriately.[55]

The current situation is contrary to two of FEMA's primary objectives when FEMA first formally established the declaration factors in regulation in 1999: To encourage States to establish their own funded disaster assistance programs and to incentivize States to mitigate hazards and obtain insurance coverage, where possible.[56] Moreover, the status quo undermines FEMA's mission to build a more prepared and resilient nation by encouraging States to rely on Federal assistance when they are capable of being better prepared and more resilient on their own.

c. The Current Cost of Assistance Estimates Factor Undermines FEMA's Mission To Prepare for and Respond to the Worst Disasters Without Delay

FEMA's response and recovery operations for numerous and cumulative small disasters weaken its ability to quickly respond to and aid recovery efforts for larger, or concurrent catastrophic disasters. FEMA's incident workforce is historically over-committed to smaller disasters, leaving a fraction of the Agency's capacity to prepare for, respond to, and recover from complex catastrophes and national security emergencies.[57]

The constraints imposed by numerous and cumulative smaller disasters affect the Agency's readiness to support disaster recovery operations without unacceptable delays by consuming FEMA staff time and resources that would be better used for larger disasters. For example, FEMA began the 2017 disaster season with nearly 30 percent of its workforce deployed on numerous smaller disasters across the country, which then required extraordinary and disruptive measures to reallocate and redistribute employees to meet the evolving requirements for hurricanes Harvey, Irma, Maria, and the California Wildfires.[58] When Hurricane Harvey made landfall in Texas, FEMA already had 692 open disaster and emergency declarations.[59] Of that total, it had staff deployed to 32 disasters across 19 field offices.[60] Additionally, in anticipation of concurrent impacts from Hurricane Irma, FEMA transitioned 9 active field offices supporting 13 disasters to regional offices prior to their anticipated closure date. The respective FEMA regional offices assumed responsibility for supporting these operations once the field offices transitioned, requiring FEMA regional staff to aid recovery efforts for these disasters in addition to those disasters already overseen by the Regional offices, as well as the daily operations of the Regional offices.[61] Of the 298 staff that were demobilized from the 9 field offices, FEMA redeployed 182 personnel to Hurricanes Harvey, Irma, and Maria within 15 days, 223

[52] *See* Regulatory Impact Analysis (RIA) at 47. The RIA is available in the public docket for this proposed rule on *regulations.gov*.

[53] FEMA, 2018–2022 Strategic Plan at 8 (2018).

[54] GAO, Budgeting for Disasters: Approaches to Budgeting for Disasters in Selected States, GAO–15–424, at 17 (March 2015).

[55] *Id.* at 21.

[56] *See* FEMA, Disaster Assistance; Factors Considered When Evaluating a Governor's Request for a Major Disaster Declaration, 64 FR 47697 (Sept. 1, 1999). *See also,* FEMA, Disaster Assistance; Factors Considered When Evaluating a Governor's Request for a Major Disaster Declaration, 64 FR 3910, 3911 (Apr. 26, 1999).

[57] FEMA, 2017 Hurricane Season FEMA After-Action Report, at 23 (July 12, 2018).

[58] *Id.*

[59] This total includes emergency, major, and fire management assistance declarations.

[60] FEMA, 2017 Hurricane Season FEMA After-Action Report, at 14.

[61] *Id.* at 18.

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personnel within 30 days, and 242 personnel within 90 days.[62]

FEMA's responsibilities require it to have the capacity to respond in the shortest possible time, under all conditions, and to provide adequate staffing and resources for long-term recovery efforts for FEMA to successfully accomplish its mission. FEMA needs immediate operational availability because complex, no-notice or concurrent catastrophes do not provide time to maximize readiness by amassing a workforce and extracting response resources from multiple smaller-scale commitments. Moreover, FEMA needs proper staffing, resources, and focus for the long-term recovery operations for large disasters so that affected communities can be repaired and rebuilt and return to normal day-to-day life as soon as possible. FEMA is unable to properly meet these demands when such a large portion of FEMA's staffing and focus are committed to numerous and cumulative smaller disasters that are actually, or should be, within the States' capabilities to handle on their own.

As noted in FEMA's After-Action Report for the 2017 Hurricane Season, for FEMA to be better positioned for future challenges, State and territorial governments should be able to respond to and recover from smaller incidents within their capabilities either organically or through collaboration with neighboring states and territories. Strengthened States and territories, in turn, allow FEMA to preserve sufficient capacity to promptly respond to and recover from large, complex, or concurrent catastrophes and national security emergencies.[63] However, as noted above, the current per capita indicator and minimum threshold disincentivize States from building their capabilities to respond to smaller incidents on their own, which undermines FEMA's ability to respond to and recover from large, complex, or concurrent large disasters, and weakens the preparedness and resilience of the Nation. FEMA could be faster and more effective in planning for, responding to, and recovering from large catastrophic disasters if more of its workforce was able to focus on such large disasters, rather than being dispersed to numerous smaller incidents more appropriately handled by the States.

d. FEMA's Use of the Decennial Census as a Data Source for Population

FEMA has exclusively relied upon the U.S. Census Bureau's decennial census reports on population to calculate State COA indicators since the inception of the per capita indicator.[64] The decennial census is a major governmental undertaking that involves canvasing the nation and is considered the most-accurate account of the United States population at the time it is conducted.[65] However, the decennial survey is only conducted every 10 years. Meanwhile, populations constantly fluctuate due to changing circumstances, such as economic growth and downturn, relocations driven by disaster, and other factors. In many cases these fluctuations are rather de minimis, but occasionally they are not. In such instances, as more time elapses after the most recently completed decennial census survey, the data from that decennial survey census becomes a less and less accurate measure of the current populations. Therefore, the Census Bureau uses the Population Estimates Program (PEP) to update the populations since the decennial Census was collected.

Illustrative of how drastically the decennial census data can diverge from the PEP estimates are the cases of Nevada in 2000 and Puerto Rico in 2010, showing the greatest increase and greatest decrease in population in those periods, respectively. The 2000 decennial census reported the population of Nevada to be 1,998,257.[66] The 2001 PEP estimate for Nevada was 2,098,399. By 2009, the PEP estimate had risen to 2,684,665.[67] The 2010 decennial census reported Nevada's population at 2,700,551. Nevada's population grew by 35 percent between 2000 and 2010. Consequently, by 2010, the 2000 decennial census data showed a population for Nevada that was 35 percent lower than its 2010 population. Comparatively, the 2009 Nevada PEP estimate was off by only 0.6 percent from the actual population reported in the 2010 decennial survey. Similarly, the 2010 decennial census reported the population of Puerto Rico to be 3,725,789.[68] However, by July of 2018, the PEP estimate for Puerto Rico fell to 3,195,153, a 14 percent decrease.[69]

Despite the increasing divergence of past decennial data from current populations in out years, FEMA continues to utilize solely decennial data for purposes of calculating the State COA indicators. Under this approach, FEMA essentially locks-in the population of each State until the new decennial census data is collected, analyzed, and reported. In monetary terms, FEMA's choice to rely solely on decennial population values can impact the State COA indicator for a State whose population is quickly changing.

Nevada and Puerto Rico again provide illustrative examples of this effect. In 2009, the PA per capita indicator was $1.31.[70] Based on the 2000 decennial population that FEMA was still utilizing in 2009, Nevada's State COA indicator in 2009 was $2,617,717.[71] Even if FEMA made no changes to the underlying State COA indicator formula other than substituting the 2009 PEP population estimate for the 2000 decennial census population estimate, Nevada's State COA indicator would have risen to $3,516,911.[72] That results in a difference of $899,194. Thus, continuing to utilize the static 2000 decennial census figures in 2009 undervalues Nevada's State COA indicator by 34 percent. With respect to Puerto Rico, based on the 2010 decennial census data that FEMA currently utilizes, Puerto Rico's FY 2019 State COA indicator is $5,588,684.[73] Assuming no changes to the underlying per capita indicator

[62] *Id.*

[63] *Id.* at 23.

[64] The Census Bureau's Population Estimates Program (PEP) produces annual estimates for years after the last published decennial census 2010, as well as for past decades. Existing data series such as births, deaths, Federal tax returns, Medicare enrollment, and immigration, are used to update the decennial census base counts. PEP estimates are used in Federal funding allocations, in setting the levels of national surveys, and in monitoring recent demographic changes. U.S. Census Bureau, Population and Housing Units Estimates: Frequently Asked Questions (available at: *https://www.census.gov/programs-surveys/popest/about/faq.html*) (last accessed April 26, 2019).

[65] Also known as the Population and Housing Census, the Decennial U.S. Census counts every resident in the United States. It is mandated by Article I, Section 2 of the Constitution and takes place every 10 years. The data collected by the decennial census determine the number of seats each state has in the U.S. House of Representatives and is also used to distribute billions in Federal funds to local communities. U.S. Census Bureau, Our Surveys & Programs: Our Censuses (available at *https://www.census.gov/programs-surveys/censuses.html*) (last accessed June 26, 2019).

[66] U.S. Census Bureau, Report No. DP–1, Profiles of General Demographic Characteristics 2000: Census of Population and Housing: Nevada (May 2001) (available for download at: *https://www2.census.gov/library/publications/2001/dec/2kh32.pdf?#*) (last accessed April 26, 2019).

[67] *See* U.S. Census Bureau, Intercensal Estimates of the Resident Population by Sex, Race and Hispanic Origin for States and the United States: April 1, 2000 to July 1, 2010 (available for download at: *https://www.census.gov/data/tables/time-series/demo/popest/intercensal-2000-2010-state.html*) (last accessed April 26, 2019).

[68] *Id.*

[69] U.S. Census Bureau, Puerto Rico Commonwealth Population Totals and Components of change: 2010–2018: Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 2010 to July 2018 (available for download at: *https//www.census.gov/data/tables/time-series/demo/popest/2010s-total-puerto-rico.html*) (last accessed May 2, 2019).

[70] 73 FR 60303 (Oct. 10, 2008).

[71] Calculation: 1,998,257 × $1.31 = $2,617,717.

[72] Calculation: 2,684,665 × $1.31 = $3,516,911.

[73] Calculation: 3,725,789 × $1.50 = $5,588,684.

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formula other than substituting 2018 PEP population estimate for the 2010 decennial census population estimate, Puerto Rico's State COA indicator would be $4,792,730,[74] or a difference of $795,954. Thus, continuing to utilize the 2010 decennial census figures in 2019 overvalues Puerto Rico's State COA indicator by 14 percent.

As shown above, FEMA's reliance on population data from the most recent decennial survey can lead to an imprecise assessment of a State's population. Using PEP estimates will provide more up-to-date population information and allow for more accurate analysis.

B. Localized Impacts and Multiple Disasters

In addition to estimating the cost of assistance for a disaster, pursuant to 44 CFR 206.48(a)(1), FEMA also considers a variety of other factors when reviewing a request for a major disaster declaration authorizing PA. While the cost of assistance estimates factor is often the greatest indicator of whether FEMA will recommend that the President issue a major disaster declaration, that factor alone does not automatically mean a denial if the State does not meet it, nor does it guarantee a declaration if the State does meet it.[75] Rather, FEMA considers each factor to better evaluate the unique circumstances or needs created by each incident.[76]

Two of the factors that FEMA considers in reviewing a Governor's request are the recent disasters in an area, and the localized impacts of a disaster.[77] With respect to recent disasters, FEMA considers the disaster history within the last 12-month period to better evaluate the overall impact on the State or locality. FEMA considers declarations under the Stafford Act as well as declarations by the Governor and the extent to which the State has spent its own funds. With respect to localized impacts, FEMA considers the impact of the incident at the county and local government level, as well as impacts at the American Indian and Alaskan Native Tribal Government levels, because at times there are extraordinary concentrations of damages that might overwhelm State capabilities even if the State COA indicator is not met, especially where critical facilities are involved or where localized per capita impacts might be extremely high. For example, at times localized damage may be in the tens or even hundreds of dollars per capita, though the statewide per capita impact was low.

In recent years, some members of Congress have expressed concern that the President has denied declarations that were warranted because of other recent disasters in the area and localized impacts, particularly where the impact is limited to the rural or sparsely populated areas of a high population State and the estimated costs of the incident do not exceed the State COA indicator. Section 1232 of the DRRA requires the Administrator of FEMA to give greater consideration to recent multiple disasters or severe localized impacts when making disaster declaration recommendations to the President, and to make corresponding adjustments to FEMA's policies and regulations regarding such consideration.

The existing recent multiple disasters provision in FEMA's regulations is broad with respect to how much consideration the Administrator gives to disasters in the previous 12 months. Consistent with that provision and with FEMA's May 1 guidance to Regional Administrators, directing them to include in their recommendations appropriate and fulsome information regarding severe local impacts and the history of recent multiple disasters,[78] FEMA is giving greater consideration to these factors when making disaster declaration recommendations. Accordingly, FEMA does not propose to substantively amend 44 CFR 206.48(a)(5), but requests comment on whether the 12-month time limit currently in place is sufficient to address this factor as required by the DRRA. Similarly, FEMA proposes not to substantively amend the current regulatory text for the localized impacts factor in § 206.48(a)(2). FEMA believes that the current regulatory text enables FEMA to provide adequate consideration of local impacts while ensuring that FEMA does not over step the statutory requirement that an event be beyond State capability. FEMA also does not propose at this time to substantively amend the other declaration factors at 44 CFR 206.48(a)(3) ("Insurance coverage in force"), (4) ("Hazard mitigation"), and (6) ("Programs of other Federal assistance"). The current regulatory text for these factors already provides for adequate consideration of important information for FEMA assessment of a State's capabilities to respond to an event, while also providing sufficient flexibility for FEMA to account for a variety of circumstances across the States. However, FEMA is proposing minor technical and grammatical changes to all of § 206.48(a).

IV. Discussion of the Proposed Rule

FEMA proposes to revise the "Estimated cost of the assistance" factor in 44 CFR 206.48(a)(1) by increasing the per capita indicator to account for inflation from 1986 to 1999 and adjusting the individual States' indicators by their total taxable resources (TTR),[79] and by increasing the minimum threshold by accounting for inflation from 1999 to 2019, and annually thereafter. These changes would provide FEMA with a better informed and more accurate assessment of whether an incident has exceeded State capabilities when it makes its recommendations to the President; incentivize States to invest more in response, recovery, and mitigation capabilities, which would provide a better distribution of responsibilities between the States and the Federal Government and better overall national preparedness for disasters; and the associated reductions in declarations of small incidents would allow FEMA to better focus its efforts and resources on large disasters without the complications of reallocating resources from multiple smaller-scale commitments.

Additionally, FEMA also proposes to use the U.S. Census Bureau's annual population estimates produced under the Population Estimates Program (PEP) instead of the decennial census population data. Using the U.S. Census Bureau's annual PEP data instead of the decennial census data would ensure a more accurate assessment of an individual State's population, which would better enable FEMA to achieve its readiness and preparedness missions by allowing FEMA to expend more attention and resources on incidents that actually exceed the States' capabilities.

Importantly, this proposed rule does not affect disaster declaration requests received directly from Tribal governments under the Tribal

[74] Calculation: 3,195,153 × $1.50 = $4,792,730.

[75] 64 FR 47697. *See also* 64 FR 3911.

[76] 64 FR 47697. *See also* 64 FR 3911.

[77] 44 CFR 206.48(a)(2) & (5).

[78] Memorandum for Regional Administrators from Jeff Byard, Associate Administrator, Office of Response and Recovery, Declaration Factors for Local Impact and Recent Multiple Disasters (May 1, 2019).

[79] As discussed more below, FEMA will not adjust the District of Columbia's per capita indicator for TTR because of the unique tax and Federal funding circumstances in the District, as well as Congress' control over the ability of the District to manipulate its own revenues. Additionally, FEMA will not adjust the territories' per capita indicators for TTR because Treasury does not report TTR for the territories.

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Declarations Pilot Guidance, or any of the criteria contained in that guidance.[80]

FEMA also proposes minor technical and corresponding grammatical changes to the introductory paragraph of § 206.48 and all of paragraph (a) to ensure consistent language throughout this section.

A. 44 CFR 206.48(a)(1)—Adjusting the Per Capita Indicator

1. Increasing the Per Capita Indicator To Account for Inflation Between 1986 and 1999

FEMA proposes to increase the per capita indicator from a FY 2019 value of $1.50,[81] to $2.32 (rounded), to account for increases to the Consumer Price Index for All Urban Consumers (CPI–U) between 1986 and 1999.[82] FEMA would continue to adjust the per capita indicator annually to reflect changes in the CPI–U, as is current practice. This would establish the baseline per capita indicator which FEMA would further adjust for each State, as described below.

The CPI–U is calculated and published by the U.S. Department of Labor, Bureau of Labor Statistics,[83] and uses the period of 1982 to 1984 as the base level where the CPI–U = 100. Current FEMA practice is to update the per capita indicator each fiscal year using the latest available month of CPI–U data. Since the per capita indicator is reported for the fiscal year and is published each October, the latest available CPI–U data is August data published in September each year. To maintain consistency with how FEMA updates the per capita indicator, FEMA calculated the inflation adjustment by comparing the April CPI–U for the base year 1986 (108.60) with the August CPI–U for 2018 (252.146). At the time of this analysis, August 2018 CPI–U data was the most recently available August CPI–U data available. This resulted in an inflation adjustment factor of 2.322.[84] FEMA then multiplied the inflation adjustment factor of 2.322 by the original per capita indicator of $1.00 to find a base per capita indicator of $2.32 (rounded).

Moving forward, once FEMA increases the indicator for the 1986–1999 inflationary adjustments, the continued practice of adjusting the indicator to account for changes in the CPI–U would continue to ensure that the indicator keeps pace with inflation. This would lead to reductions in the number and frequency of future major disaster declarations, and decreases in Federal costs of disaster assistance, by having States take responsibility for costs that are within their capability to manage.

Much like FEMA's decision in 1999 to set the per capita indicator at $1 and begin adjusting for inflation, rather than PCPI,[85] the current proposed change (to increase the per capita indicator for inflation between 1986 and 1999) provides a simple, clear, consistent, and long standing means of evaluating the size of a disaster relative to the size of the State, while also decreasing the number and frequency of disaster declarations, and decreasing Federal disaster costs. Moreover, increasing the per capita indicator to account for inflation from 1986 to 1999 would be more reflective of current dollar values, and would better enable FEMA to achieve its readiness and preparedness missions because FEMA would be able to apply more attention and resources to large catastrophic incidents as less FEMA focus and resources would be needed for smaller incidents actually within the States' capabilities.

2. Adjusting the Increased Per Capita Indicator for Total Taxable Resources

In addition to increasing the per capita indicator to account for inflation from 1986 to 1999, FEMA proposes to adjust the increased, baseline per capita indicator for a State's TTR to set an indicator that better recognizes a State's actual fiscal capability.

The TTR of the State is a publicly available annual estimate of the relative fiscal capacity of a State, calculated by the U.S. Department of Treasury (Treasury).[86] Treasury defines TTR as the unduplicated sum of the income flows produced within a State and the income flows, received by its residents, which a State could potentially tax.[87] TTR includes much of the business income that does not become part of the income flow to jurisdiction residents, as well as undistributed corporate profits, and rents and interest payments made by businesses to out-of-jurisdiction real estate owners and lenders.[88] TTR does not consider the actual fiscal choices made by the States, but rather, it reflects their potential resources and is an indicator of a State's broader economy.[89] In summary, TTR is a flow concept, meaning it is a comprehensive measure of all the income flows a State can potentially tax.[90] Treasury bases its calculation of the TTR on the Gross State Product (GSP) and State personal income,[91] accounting for the earnings of State residents who work outside the State borders, dividend and monetary interest income earned from sources outside of the State, select transfers from the Federal Government, and net realized capital gains. The following components of GSP were not available to States to tax and hence subtracted from GSP: Federal indirect business taxes, employer and employee contributions to social insurance, and Federal civilian enterprises surplus/deficit.[92]

Consideration of TTR as an indicator of State fiscal capacity is also consistent with FEMA's recent rulemaking revising the factors considered when evaluating requests for Individual Assistance (IA). The revised regulations for evaluating requests for IA (44 CFR 206.48(b)) use TTR as the main indicator of a State's fiscal capacity to provide IA.[93]

FEMA considered other potential alternatives for adjusting the per capita indicator to better measure a State's financial capabilities, including State GDP (*i.e.,* the total value of the goods and services produced within the State in a particular year); State Total Actual Revenues (TAR) (*i.e.,* the amount of revenue a particular State actually raises in a typical year); and a composite index of per capita TTR, per capita surplus/deficit, per capita reserve funding, and the State's bond rating. State GDP and TAR are strongly correlated with TTR;

[80] FEMA, Tribal Declarations Pilot Guidance, available at: *https://www.fema.gov/tribal-declarations-pilot-guidance.* Notice of availability published at 82 FR 3016 (Jan. 10, 2017).

[81] The FY2019 per capita indicator was the most current per capita indicator at the time that this proposed rule was written.

[82] Using August 1986 and 1999 CPI–U historical data.

[83] BLS Archived Consumer Price Index Supplemental Files (available for download at: *https://www.bls.gov/CPI-U/tables/supplemental-files/home.htm*). Data was taken from the Historical CPI–U, February 2019 publication.

[84] Calculation: $1 + (252.146–108.60)/108.60 = $2.322 (rounded).

[85] *See* 64 FR 47697 (Sept. 1, 1999).

[86] Treasury updates TTR data annually with a 2-year lag in the data, available at *https://home.treasury.gov/policy-issues/economic-policy/total-taxable-resources.*

[87] Dep't of Treasury, Office of Economic Policy, Treasury Methodology for Estimating Total Taxable Resources, at 2 (Revised Nov. 2002) (available for download at: *https://www.treasury.gov/resource-center/economic-policy/Documents/nmpubsum.pdf*).

[88] *See Id.* at 1–4.

[89] *See Id.* at 2.

[90] *Id.*

[91] *Id.* at 2–3.

[92] *See Id.* at 1–4.

[93] FEMA, Factors Considered When Evaluating a Governor's Request for Individual Assistance for a Major Disaster, 84 FR 10632 (March 21, 2019). The revised IA regulations also allow States to submit information regarding State GDP and local per capita personal income, as well as other limiting factors, which FEMA may use as an alternative or supplemental evaluation method to TTR from which to measure a State's fiscal capacity to provide IA in response to a disaster. *See* 44 CFR 206.48(b)(1)(i)(A)–(C).

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however, TTR, as a measure of potential, does not suffer from complications of political choice in TAR or GDP that result from differences between States in State tax obligations and the services for which tax dollars are allocated. Accordingly, given the correlation between the three, and the policy-neutrality of TTR, FEMA believes that TTR is the best measure of a State's financial capabilities by which to adjust the baseline per capita indicator.

Under the composite index approach, FEMA would average the four fiscal capacity indices and use the final figure to adjust each State's per capita indicator. This type of analysis was previously considered for use in FEMA's Establishing a Deductible for FEMA's Public Assistance Program Supplemental Advance Notice of Proposed Rulemaking (Deductible ANPRM).[94] The Deductible ANPRM was an earlier attempt to address the issue of underestimating States' fiscal capacity when recommending disaster declarations, and the four-part composite index analysis was part of the reason the deductible was eventually rejected. Public comments received on the Deductible ANPRM made clear that State and local stakeholders were uncomfortable with the complexity of the four-factor analysis; although it is more in-depth and could potentially produce more accurate assessments of States' fiscal capacities, the analysis is also a substantially more complicated framework for States and PA sub-recipients to adapt to and plan around. FEMA decided against using it here for these same reasons. FEMA believes adjusting the per capita indicator only by TTR strikes an appropriate balance between improving the fiscal capacity analysis by considering more than simply a State's population, and not burdening States with an overly complicated formula that slows implementation of the new framework.

Based on the above, FEMA believes that adjusting the baseline per capita indicator for TTR would result in a more realistic estimate of a State's financial capability. As previously discussed, adjusting the per capita indicator to adjust for inflation using the CPI–U between 1986 and 1999 would provide a more accurate measurement of the current costs of response and recovery, as well as changing present value of the dollar. Adjusting the indicator based on a State's TTR would provide additional accuracy in gauging a State's fiscal capacity by accounting for taxable resources other than the State's population, such as business income, undistributed corporate profits, and resident earnings from out-of-state employment. This approach also aligns with the recommendations of DHS OIG and GAO, Congress' direction in section 1239 of the DRRA, as well as the Stafford Act and FEMA's Strategic Plan, by ensuring that Federal assistance supplements State and local efforts when State and local capabilities have been exceeded, rather than supplanting resources that a State is financially capable of providing on its own.

Treasury reports TTR in three formats: billions of dollars, dollars per capita, and the per capita index. To adjust for TTR, FEMA would use 1/100th of the TTR per capita index, which is calculated relative to the national average TTR for a given year, where a TTR per capita index of 100 represents the national average. For example, if a State had a TTR per capita index of 101, FEMA would multiply the baseline indicator by 1.01 to adjust (*e.g.*, $2.32 × 1.01 = $2.34). FEMA would use the most recent TTR data available. Using 2018 published data, the minimum per capita indicator adjusted for TTR would be $1.52 (Mississippi, $2.32 × .655 = $1.52) and the maximum per capita indicator adjusted for TTR would be $3.17 (Connecticut, $2.32 × 1.368 = $3.17).[95]

FEMA believes that this method is the clearest and simplest method of utilizing the reported formats of TTR.[96] If FEMA were to use one of the other reported formats of TTR, FEMA would need to set a percentage of State total TTR in billions of dollars or State TTR per capita that would be appropriate for measuring a State's fiscal capability for responding to an incident, or FEMA would need to devise a formula by which to obtain a number that would adjust the baseline per capita indicator. FEMA believes that such changes could be difficult to implement on an annual basis, would be overly complex, and could result in confusion for stakeholders.[97] In contrast, much like the adjustment to the baseline per capita indicator, FEMA believes that the proposed method of adjusting for TTR provides the simplest, clearest, and most workable method by which to adjust the per capita indicator in order to ensure that FEMA accurately measures a State's financial capabilities.

As shown in Table 1, the individual States' per capita indicators would range from $1.51 to $3.15. Every State's per capita indicator would increase due to the adjustment for increases to the CPI–U from 1986 and 1999. However, adjusting for TTR would decrease 29 States' per capita threshold from the base amount, 20 States would see an increase in their per capita indicator threshold, and 7 States would still have a $2.32 adjusted per capita indicator.[98]

FEMA proposes not to adjust the District of Columbia's per capita indicator for TTR. The complex tax and Federal appropriation circumstances in the District of Columbia, as well as Congress' control over the ability of the District to manipulate its own revenues, would require impractical and potentially inaccurate adjustments in the TTR method. For example, Federal law prohibits the District from taxing non-resident commuters. Additionally, evaluating the District of Columbia's TTR is further complicated by the direct Federal oversight and appropriation of the District's budget. Accordingly, TTR does not provide the additional accuracy in determining the District's financial capability as it does for the States. Therefore, FEMA would use the increased per capita indicator to determine the District's per capita threshold, without adjusting for TTR. FEMA specifically requests comment on possible alternatives to this approach that would improve the accuracy of FEMA's fiscal capacity analysis for the District.

Additionally, FEMA is not proposing to adjust the per capita indicator for TTR for the territories because Treasury

[94] 82 FR 4064, 4072 (Jan. 12, 2017).

[95] U.S Dept. of Treasury, 2018 Total Taxable Resources Estimates (2018), *https://home.treasury.gov/system/files/226/TTR-tables-2018.pdf.*

[96] The GAO recommended the same approach to use a fiscal index to adjust the per capita indicator. GAO, GAO 12–838 at 71–72.

[97] Notably, the revisions to the regulations governing requests for IA included the ability for States to submit information on their GDP and local per capita personal income (PCPI) which FEMA may use as a supplemental or alternative factor to TTR when measuring a State's fiscal capacity to provide IA. *See* 44 CFR 206.48(b)(1). While such data may be useful in the IA context, it is less so in the PA context. First, FEMA notes that the use of State GDP and local PCPI are only as potential supplemental or alternative data points for fiscal capacity; TTR is still the preeminent factor for determining fiscal capacity for IA requests. Second, the IA program does not use a per capita indicator like the PA program, nor does it use any adjustment factors such as the proposed rule. Accordingly, if FEMA were to incorporate State GDP and local PCPI, along with TTR, into its consideration of PA requests, it would need to create a formula to adjust the per capita indicator, which would add complexity to the per capita indicator with little benefit given that TTR already incorporates a measure of a State's GDP and personal income. Moreover, States may submit data on their GDP or local PCPI to supplement their request for a PA declaration, since FEMA may consider information in addition to the factors in 44 CFR 206.48(a) to the extent that it further informs FEMA's recommendation to the President.

[98] As noted above, FEMA is not proposing to use TTR data for the territories and DC. South Dakota had a TTR of 100 in 2018.

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does not report TTR for the territories.[99] This would result in the territories having the same per capita threshold as the average State, which may in practice be an over-estimation of the territories' fiscal capacity. However, without a published TTR to use, adopting the same approach proposed here for the States simply is not an option. FEMA requests comment on alternative approaches that would improve FEMA's fiscal capacity analysis for the territories. One such alternative, on which FEMA requests comment, would be to adjust the per capita indicator for the territories by the lowest TTR reported for any of the States.

3. Using Annual Population Data To Calculate the States' COA Indicator

FEMA proposes to use the U.S. Census Bureau's annual population estimates produced under PEP instead of the decennial census population data when calculating the State COA indicator. PEP produces annual estimates for years after the last published decennial census, as well as for past decades. The Census Bureau uses existing data series such as births, deaths, Federal tax returns, Medicare enrollment, and immigration to update the decennial census base counts. PEP estimates are used in Federal funding allocations, in setting the levels of national surveys, and in monitoring recent demographic changes.[100] As years pass since the most-recent decennial survey, the PEP estimates bear less relation to the previous numbers and adopt a stronger correlation to the results of the next decennial survey. In other words, as more time elapses between the most recently completed decennial survey and the next decennial survey, the PEP estimates become more current measures of the States' populations than the most recently conducted decennial survey.

Using the annual PEP data instead of data from the most recent decennial census would provide a more contemporaneous measure of a State's population to use in FEMA's calculation of State COA indicators. As shown in the examples of Nevada and Puerto Rico, use of decennial census data can lead to inaccurate assessments of a State's current population. Using the U.S. Census Bureau's annual PEP data instead of the decennial census data would ensure a more current assessment. Using the PEP data would better enable FEMA to achieve its readiness and preparedness missions because FEMA would be able to expend more attention and resources to large catastrophic incidents since less FEMA focus and resources would be needed for smaller incidents within the States' capabilities.

4. State COA Indicators After Accounting for Proposed Changes

The following table shows for each State: (1) The most recent TTR per capita index (2016),[101] (2) the proposed State per capita indicator after adjusting for inflation and TTR, (3) State population from the most recent PEP estimates (2018),[102] (4) the resultant proposed State COA indicators, (5) the FY2019 State COA indicators based on the FY2019 per capita indicator ($1.50) [103] and 2010 decennial census data, and (6) the difference between the proposed and baseline State COA indicators.

TABLE 1—PROPOSED STATE COA INDICATORS

State	2016 TTR (percentage)	Proposed state per capita indicator (2016 TTR * $2.32)	PEP population estimate (2018)	Proposed state COA indicators (A)	FY 2019 state COA indicators—baseline (B)	Difference (A – B)	Percent change
Alabama	73.7	$1.71	4,887,871	$8,358,259	$7,169,604	$1,188,655	16.6
Alaska	110.5	2.56	737,438	1,887,841	1,065,347	822,494	77.2
Arizona	76.6	1.78	7,171,646	12,765,530	9,588,026	3,177,504	33.1
Arkansas	74.2	1.72	3,013,825	5,183,779	4,373,877	809,902	18.5
California	114.2	2.65	39,557,045	104,826,169	55,880,934	48,945,235	87.6
Colorado	102	2.37	5,695,564	13,498,487	7,543,794	5,954,693	78.9
Connecticut	136.8	3.17	3,572,665	11,325,348	5,361,146	5,964,202	111.2
District of Columbia	100	2.32	967,171	2,243,837	902,585	1,341,252	148.6
Delaware	131.7	3.06	702,455	2,149,512	1,346,901	802,611	59.6
Florida	85.4	1.98	21,299,325	42,172,664	28,201,965	13,970,699	49.5
Georgia	87.3	2.03	10,519,475	21,354,534	14,531,480	6,823,054	47.0
Hawaii	99	2.30	1,420,491	3,267,129	2,040,452	1,226,677	60.1
Idaho	74.5	1.73	1,754,208	3,034,780	2,351,373	683,407	29.1
Illinois	108.4	2.51	12,741,080	31,980,111	19,245,948	12,734,163	66.2
Indiana	90.7	2.10	6,691,878	14,052,944	9,725,703	4,327,241	44.5
Iowa	102.5	2.38	3,156,145	7,511,625	4,569,533	2,942,092	64.4
Kansas	96.3	2.23	2,911,505	6,492,656	4,279,677	2,212,979	51.7
Kentucky	76.6	1.78	4,468,402	7,953,756	6,509,051	1,444,705	22.2
Louisiana	85.8	1.99	4,659,978	9,273,356	6,800,058	2,473,298	36.4
Maine	79.6	1.85	1,338,404	2,476,047	1,992,542	483,505	24.3
Maryland	117.2	2.72	6,042,718	16,436,193	8,660,328	7,775,865	89.8
Massachusetts	130.4	3.03	6,902,149	20,913,511	9,821,444	11,092,067	112.9
Michigan	85.6	1.99	9,995,915	19,891,871	14,825,460	5,066,411	34.2
Minnesota	105	2.44	5,611,179	13,691,277	7,955,888	5,735,389	72.1
Mississippi	65.5	1.52	2,986,530	4,539,526	4,450,946	88,580	2.0
Missouri	86.1	2.00	6,126,452	12,252,904	8,983,391	3,269,513	36.4
Montana	80.2	1.86	1,062,305	1,975,887	1,484,123	491,764	33.1
Nebraska	107.1	2.48	1,929,268	4,784,585	2,739,512	2,045,073	74.7

[99] The territories for which Treasury does not report TTR include: American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands.

[100] U.S. Census Bureau, Population and Housing Units Estimates: Frequently Asked Questions (available at: *https://www.census.gov/programs-surveys/popest/about/faq.html*) (accessed April 26, 2019).

[101] The Treasury Department publishes updated TTR per capita indices two years after the year in question. The most recent data available at the time of this analysis was 2016 data.

[102] PEP estimates are released in July each year covering the previous year and all other years back to the last decennial census. At the time of this analysis, the data for 2018 was the most recent data available.

[103] FEMA publishes updated per capita indicators in the **Federal Register** each year, with FY 2019 being the most recent data available at the time of this analysis. If this proposed change were adopted, FEMA's annual publication in the **Federal Register** would include a list of TTR-adjusted per capita indicators and COA indicators for each State.

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TABLE 1—PROPOSED STATE COA INDICATORS—Continued

State	2016 TTR (percentage)	Proposed state per capita indicator (2016 TTR * $2.32)	PEP population estimate (2018)	Proposed state COA indicators (A)	FY 2019 state COA indicators—baseline (B)	Difference (A − B)	Percent change
Nevada	91.9	2.13	3,034,392	6,463,255	4,050,827	2,412,428	59.6
New Hampshire	112.9	2.62	1,356,458	3,553,920	1,974,705	1,579,215	80.0
New Jersey	122.8	2.85	8,908,520	25,389,282	13,187,841	12,201,441	92.5
New Mexico	76	1.76	2,095,428	3,687,953	3,088,769	599,184	19.4
New York	132	3.06	19,542,209	59,799,160	29,067,153	30,732,007	105.7
North Carolina	86.4	2.00	10,383,620	20,767,240	14,303,225	6,464,015	45.2
North Dakota	119.8	2.78	760,077	2,113,014	1,008,887	1,104,127	109.4
Ohio	91.6	2.13	11,689,442	24,898,511	17,304,756	7,593,755	43.9
Oklahoma	80.7	1.87	3,943,079	7,373,558	5,627,027	1,746,531	31.0
Oregon	95.7	2.22	4,190,713	9,303,383	5,746,611	3,556,772	61.9
Pennsylvania	100.4	2.33	12,807,060	29,840,450	19,053,569	10,786,881	56.6
Rhode Island	101.9	2.36	1,057,315	2,495,263	1,578,851	916,412	58.0
South Carolina	75.5	1.75	5,084,127	8,897,222	6,938,046	1,959,176	28.2
South Dakota	100	2.32	882,235	2,046,785	1,221,270	825,515	67.6
Tennessee	84.9	1.97	6,770,010	13,336,920	9,519,158	3,817,762	40.1
Texas	96.6	2.24	28,701,845	64,292,133	37,718,342	26,573,791	70.5
Utah	87.4	2.03	3,161,105	6,417,043	4,145,828	2,271,215	54.8
Vermont*	91.7	2.13	626,299	1,334,017	938,612	395,405	42.1
Virginia	105.1	2.44	8,517,685	20,783,151	12,001,536	8,781,615	73.2
Washington	116	2.69	7,535,591	20,270,740	10,086,810	10,183,930	101.0
West Virginia	72	1.67	1,805,832	3,015,739	2,779,491	236,248	8.5
Wisconsin	95.4	2.21	5,813,568	12,847,985	8,530,479	4,317,506	50.6
Wyoming	117.9	2.74	577,737	1,582,999	845,439	737,560	87.2
Puerto Rico	100	2.32	3,195,153	7,412,755	5,588,684	1,824,071	32.6
American Samoa*	100	2.32	55,519	128,804	83,279	45,525	54.7
Guam*	100	2.32	159,358	369,711	239,037	130,674	54.7
Northern Mariana Islands*	100	2.32	44,943	104,268	67,415	36,853	54.7
Virgin Islands*	100	2.32	106,405	246,860	159,608	87,252	54.7

*These jurisdictions are subject to the current $1 million minimum threshold because the State COA indicator falls beneath the minimum threshold.

B. 44 CFR 206.48(a)(1)—Adjusting the $1 Million Minimum Threshold for Inflation

FEMA proposes to increase the minimum threshold in the cost of assistance estimates factor to account for inflation from 1999, and to adjust the threshold using CPI–U annually hereafter. The proposed rule would increase the current minimum threshold from $1 million to $1.535 million for FY 2019.[104] As noted above, FEMA has never increased the minimum threshold since it established the threshold in 1999, despite a 51 percent increase in the CPI–U and corresponding rises in the costs to respond to incidents, as well as rises in State GDP, expenditures, and TTR. Accordingly, while FEMA believed in 1999 that $1 million was a reasonable amount for even the least populous States and Territories to handle on their own, FEMA believes that the $1 million minimum threshold may no longer be an accurate benchmark of the least populous States' and Territories' capabilities to respond to incidents. Based on the rises in State and Territories' GDP, expenditures, and TTR, FEMA believes that States and Territories should be able to handle the increased minimum threshold.

With the proposed changes to the per capita indicator and the minimum threshold, Vermont, and the territories of the U.S. Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands would have State COA indicators that would fall below the proposed minimum threshold.[105] Accordingly, these jurisdictions would be subject to the $1.535 million minimum threshold.

Importantly, by accounting for increases to the CPI–U since 1999 and annually moving forward, the minimum threshold would be more representative of current dollar values and be a more accurate indicator of the least populous States' capabilities to respond to incidents. The reduction in disaster declarations would keep FEMA from expending resources and attention on incidents within the States' capabilities, allowing FEMA to better prepare for large, catastrophic incidents. A higher minimum threshold would incentivize less populous States and Territories to build their response and recovery capabilities and mitigate the hazards of future incidents.

In addition to analyzing the effects of increasing the minimum threshold to account for CPI–U from 1999, FEMA analyzed several alternatives to increasing the minimum threshold. The full results of the analysis are presented in the RIA. FEMA analyzed increases since 1999 in State general fund expenditures (which were used as a partial basis for the $1 per capita indicator set in 1986), State TTR, and State GDP, as potential alternatives to the proposed action.

FEMA also analyzed whether its administrative costs for past smaller disasters demonstrated a threshold for which FEMA's administrative burden exceeded the amount of Federal assistance provided. In other words, instances in which FEMA's cost to deliver the assistance may have exceeded the cost of the assistance provided. Administrative costs include

[104] FEMA calculated the inflation adjustment by comparing the January CPI–U for the base year 1999 (164.3) with the August CPI–U for 2018 (252.146). This resulted in an inflation adjustment factor of 1.535. FEMA then multiplied the inflation adjustment factor of 1.535 by the original minimum threshold of $1 million to find a minimum threshold of $1,535,000 (rounded).

[105] As shown in Table 1 above, with the proposed changes to the per capita indicator, Vermont's State COA indicator would be just over $1.30 million. Each of the noted territorial jurisdictions COA indicators fall well below the proposed $1.535 million minimum threshold. Therefore, under this proposed rule, in cases where the estimated cost of assistance meets or exceeds the COA indicators for Vermont or the territorial jurisdictions, but is less than the $1.535 million minimum threshold, the minimum threshold would apply, and the estimated cost of assistance for the State or Territory would have to meet this higher amount. FEMA anticipates that these territorial jurisdictions will generally be subject to the annual minimum threshold year to year due to their small populations.

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disaster-related personnel costs such as salaries, benefits, and travel; the cost of tasking another Federal agency to support operations (mission assignments); technical assistance contracts associated with the execution of the PA program; and, general administrative costs such as leases, communications, supplies, and equipment that are incurred from declaration to disaster closure.[106] Given the broad scope of items included in administrative costs, particularly related to personnel, administrative costs are a good representation of the overall Federal resources and attention that are expended on a given disaster.

Based on the analysis of alternatives, FEMA believes that increasing the minimum threshold to account for post-1999 increases to CPI–U is the best alternative for raising the minimum threshold because the other alternatives would increase the complexity of setting the minimum threshold, with few, if any, additional benefits. As explained in the stand-alone RIA found in the docket of this rulemaking,[107] while the other alternatives may result in modest gains in reducing disaster declarations and Federal expenditures, those gains would be outweighed by the complexity that FEMA and stakeholders would encounter in implementing these other alternatives. Importantly, however, in addition to increases in the CPI–U, the increases in State expenditures, GDP, and TTR, and FEMA's average administrative costs for small disasters collectively demonstrate that the current $1 million threshold is no longer an accurate benchmark for the States' capabilities to respond to disasters on their own. Therefore, based on the totality of this information, FEMA believes an increase to the minimum threshold is necessary.

Accordingly, FEMA proposes to amend the minimum threshold to account for increases to the CPI–U from 1999 to present, and annually thereafter. The proposed changes would provide the simplest and most certain means of increasing the minimum threshold, and for annual changes to the threshold. The proposed use of the CPI–U to increase the minimum threshold is also consistent with the adjustments to the per capita indicator. Additionally, adjusting the minimum threshold for changes to the CPI–U would better reflect current dollar values and the States' incident response capabilities, allow FEMA to be better prepared for larger, catastrophic incidents, and incentivize States to build their response capabilities and mitigate hazards posed by future incidents, thereby helping FEMA achieve its mission to make the nation better prepared and more resilient.

C. 44 CFR 206.48(a)(2)–(6)—Other Factors

Section 1232 of the DRRA requires the Administrator of FEMA to give greater consideration to recent multiple disasters or severe localized impacts when making disaster declaration recommendations to the President, and to make corresponding adjustments to FEMA's policies and regulations regarding such consideration. The current text of 44 CFR 206.48(a)(5) provides broad discretion for the consideration of multiple disasters occurring in the 12-month period prior to the event. Consistent with that provision and with FEMA's May 1 guidance to Regional Administrators, directing them to include in their recommendations appropriate and fulsome information regarding severe local impacts and the history of recent multiple disasters,[108] FEMA is giving greater consideration to these factors when making disaster declaration recommendations. Accordingly, FEMA is not proposing to substantively amend § 206.48(a)(5), but requests comment on whether a revision of the 12-month time limit currently in place is necessary to give greater consideration to this factor as required by the DRRA.

Similarly, FEMA proposes not to substantively amend the current regulatory text for the localized impacts factor in § 206.48(a)(2). As noted above, FEMA has instructed Regional staff to give greater consideration to local impacts moving forward [109] and FEMA believes that the current regulatory text provides FEMA sufficient flexibility to provide adequate consideration of local impacts while ensuring that FEMA does not over step the statutory requirement that an event be beyond State capability.[110]

Additionally, with regard to the requirements of section 1239 of the DRRA that FEMA review all of the declaration factors and update them as necessary, FEMA does not propose to substantively amend the other declaration factors at 44 CFR 206.48(a)(3) (''Insurance coverage in force''), (4) (''Hazard mitigation''), and (6) (''Programs of other Federal assistance'') at this time. FEMA believes that the regulatory text for these factors already provides adequate consideration of important information for FEMA's assessment of a State's capabilities to respond to an event, while also providing sufficient flexibility for FEMA to account for a variety of circumstances across the States. Notably, although FEMA is not proposing to substantively amend these factors, FEMA may consider relevant information submitted by a requesting State that is outside the scope of the declaration factors listed in 44 CFR 206.48(a).

D. 44 CFR 206.48—Minor Technical and Grammatical Edits

FEMA also proposes minor technical and corresponding grammatical changes to the undesignated introductory paragraph and to § 206.48(a) to ensure consistent language between the PA declaration factors in 44 CFR 206.48(a) and the IA factors in 44 CFR 206.48(b). FEMA proposes to replace all uses of the term ''we'' in 44 CFR 206.48 with ''FEMA''. This would be consistent with the IA declaration factors in 44 CFR 206.48(b). FEMA also proposes minor corresponding edits to account for the change to the use of ''FEMA'' to ensure proper grammar.

VI. Regulatory Analysis

A. Executive Order 12866, As Amended, Regulatory Planning and Review; Executive Order 13563, Improving Regulation and Regulatory Review; and Executive Order 13771, Reducing Regulation and Controlling Regulatory Costs

Executive Orders 12866 (Regulatory Planning and Review) and 13563 (Improving Regulation and Regulatory Review) direct agencies to assess the costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and

[106] Administrative costs do not include program costs associated with mission assignments for Direct Federal Assistance, Urban Search and Rescue costs, and all other program deliverables and assistance such as grants to survivors.

[107] *See* Regulatory Impact Analysis at 47–51.

[108] Memorandum for Regional Administrators from Jeff Byard, Associate Administrator, Office of Response and Recovery, Declaration Factors for Local Impact and Recent Multiple Disasters (May 1, 2019).

[109] Memorandum for Regional Administrators from Jeff Byard, Associate Administrator, Office of Response and Recovery, Declaration Factors for Local Impact and Recent Multiple Disasters (May 1, 2019).

[110] Importantly, the DRRA did not amend section 401 of the Stafford Act which requires that the President determine that an event, to qualify as a major disaster warranting Federal assistance, be beyond the capabilities of the State and the affected local governments. *See* 42 U.S.C. 5170(a). So, while the President must give consideration to the impact of an event on local governments, he must also determine that the event exceeds the capabilities of the State.

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equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. Executive Order 13771 (Reducing Regulation and Controlling Regulatory Costs) directs agencies to reduce regulation and control regulatory costs and provides that ''for every one new regulation issued, at least two prior regulations be identified for elimination, and that the cost of planned regulations be prudently managed and controlled through a budgeting process.''

The Office of Management and Budget (OMB) has designated this rule an ''economically significant regulatory action,'' under section 3(f)(1) of Executive Order 12866. Accordingly, this rule has been reviewed by OMB. This rule is exempt from the requirements of Executive Order 13771 because it has de minimis costs spread across all States and territories. See OMB's Memorandum ''Guidance Implementing Executive Order 13771, Titled 'Reducing Regulation and Controlling Regulatory Costs''' (April 5, 2017).

FEMA conducted a Regulatory Impact Analysis (RIA) to assess the potential costs, benefits, and transfers from this proposed rule, and it has been found to be economically significant under E.O. 12866. FEMA provides an executive summary of the RIA below. For the full analysis, please see the RIA posted in the docket of this proposed rule on *regulations.gov*.

FEMA proposes to amend one of the factors it considers when recommending a major disaster declaration that authorizes PA. Specifically, the proposed rule would update 44 CFR 206.48(a)(1), ''Estimated cost of the assistance.'' FEMA proposes four associated changes in 44 CFR 206.48(a) to conform regulations to Section 1239 of the Disaster Recovery Reform Act of 2018 (DRRA). Table 2 provides a summary of the impacts of the proposed rule. The four proposed changes are:

(1) Increase the per capita indicator from $1.50 to $2.32 to account for inflation using Consumer Price Index for All Urban Consumers (CPI–U) data from 1986 to 1999 because no inflation factor was applied during that time frame. Adjust the per capita indicator by each individual State's total taxable resources (TTR).

(2) Increase the minimum threshold for major disaster declarations that authorize PA from $1 million to $1.535 million to account for inflation since 1999 and to adjust the threshold by CPI–U annually thereafter.[111]

(3) Use the US Census Bureau's annual population estimates produced under the Population Estimates Program (PEP) when calculating the individual State's threshold. FEMA's current practice is to use the decennial census population data when calculating the State COA indicator.

(4) Make minor technical and corresponding grammatical changes to the undesignated introductory paragraph and to paragraph (a) of § 206.48.

TABLE 2—SUMMARY OF THE IMPACTS OF THE PROPOSED RULE (2018$)

Category	Summary
Proposed Changes	Replace the per capita indicator of $1.50 with $2.32 to account for inflation from 1986–1999 and then adjust by State TTR annually. Replace the minimum threshold of $1,000,000 with $1,535,000 and adjust by CPI–U annually. Use PEP annual population estimates instead of decennial census data to calculate the State COA indicators. Technical and grammatical changes to 44 CFR 206.48(a).
Affected Population	Applicants eligible to submit an application for a PA project, include 56 State and Territorial governments, 573 Federally recognized Indian Tribal governments, local governments, and certain private nonprofit organizations (PNPs). From 2008–2017, 7,456 Applicants would have been impacted by the proposed rule.
Transfers	$208.76 million annualized and $1.47 billion and $1.78 billion 10-year monetized reduction in transfers to the Applicants from FEMA at 7 and 3 percent discount rates, respectively.
Cost Savings (due to reduced disaster declaration requests and applications).	$62.71 million annualized and $440.45 million and $534.93 million 10-year monetized FEMA costs savings at 7 and 3 percent discount rates, respectively. $8.04 million annualized; and $56.44 million and $68.55 million 10-year monetized; Applicant cost savings at 7 and 3 percent discount rates, respectively.
Costs (quantitative)	$5,274 and $4,513 annualized; and $37,042 and $38,496 10-year monetized costs to Applicants and FEMA at 7 and 3 percent discount rates, respectively.
Costs (qualitative)	Applicants would need to invest more in response recovery, and mitigation capabilities. Damaged facilities may not be repaired or replaced and could be susceptible to future disasters.
Benefits (quantitative)	No quantitative benefits.
Benefits (qualitative)	Provide FEMA with a more accurate assessment of whether an incident has exceeded an Applicant's capabilities to respond to and recover from an incident. Incentivize Applicants to invest more in response, recovery, and mitigation capabilities, and increase overall national preparedness for incidents. Allow FEMA to refine its focus and resources on large-scale disasters.

[111] January 1999 CPI–U was 164.3 and August 2018 CPI–U was 252.146. Calculation: (252.14 − 164.3)/164.3 + 1 = 1.535 conversation factor (rounded). 1.535 × $1,000,000 = $1,535,000.

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Affected Population

The proposed rule would reduce the number of major disaster declarations authorizing PA and therefore affect all non-Federal entities that are eligible to request PA following a Federal major disaster declaration. Eligible applicants for PA include 50 State and 6 Territorial governments, and the District of Columbia as well as 573 Federally recognized Indian Tribal governments,[112] local governments, and certain PNPs. A disaster declaration is done at the State level, but the Applicants fill out the forms for PA eligibility and to receive funding once PA funding is made available through a declaration. For simplicity, FEMA refers to the affected population as Applicants throughout the RIA. If this proposed rule had been in effect from 2008–2017, 7,456 Applicants for 159 PA disasters would have been impacted by the proposed rule. These Applicants would have had a reduction in grant funding, including funding and management costs for PA, funding and management costs for HMGP, and funding and management costs for BRIC. These Applicants would have also had paperwork cost savings for not filling out the forms to determine eligibility and receive funding.

Reduction in Disaster Declarations

As discussed later in this analysis, FEMA used data for the PA disasters from fiscal years (FY) 2008–2017 to estimate how the proposed rule would impact the number of PA disasters and the funding and costs associated with those PA disasters. FEMA used historical data on the estimated impacts on PA disasters from 2008–2017 as a proxy to estimate the impacts over the next ten years after this rule becomes final and effective. FEMA found there were a total of 585 PA disasters over the 10-year period of analysis, an average of 59 disasters per year. FEMA estimates that there likely would be 159 PA disasters that would no longer be declared disasters under the proposed rule, an average of 16 fewer PA disasters declared per year as discussed further in the RIA. This represents a 27 percent reduction in PA disasters declared from 2008–2017 under this proposed rule.

Transfers

Transfer payments are monetary payments from one group to another that do not affect the total resources available to society. Transfers can have significant efficiency effects in addition to distributional effects and are not included in the estimates of the benefits and costs of a regulation. Transfers are analyzed in this RIA because grants, *i.e.* those grants made by FEMA for PA, are considered transfers.

The reduction in PA disasters would result in a reduction in grant funding to the PA Applicants. The reduction in funding from these programs equates to a reduction in transfers from FEMA to the Applicants. FEMA estimates the total 10-year undiscounted transfers of the proposed rulemaking would be $2.09 billion. The total 10-year discounted transfers would be $1.47 billion at a 7 percent discount rate and 1.78 billion at a 3 percent discount rate, with annualized transfers of $208.76 million at both 7 and 3 percent discount rates (Table 3).

TABLE 3—TOTAL ESTIMATED TRANSFERS OF THE PROPOSED RULE

[2018$]

Year	Total undiscounted reduction in transfers from FEMA to applicants	Discounted	
		7%	3%
1	$208,758,700	$195,101,589	$202,678,350
2	208,758,700	182,337,933	196,775,097
3	208,758,700	170,409,284	191,043,783
4	208,758,700	159,261,013	185,479,401
5	208,758,700	148,842,068	180,077,088
6	208,758,700	139,104,736	174,832,125
7	208,758,700	130,004,427	169,739,927
8	208,758,700	121,499,464	164,796,046
9	208,758,700	113,550,901	159,996,161
10	208,758,700	106,122,337	155,336,078
Total	2,087,587,000	1,466,233,752	1,780,754,055
Annualized		208,758,700	208,758,700

Cost Savings

The proposed rulemaking would result in administrative cost savings for FEMA, and paperwork cost savings for the Applicants and FEMA due to a decrease in the number of PA, BRIC, and HMGP applications resulting from fewer disaster declarations. A reduction in declarations would allow FEMA to focus its efforts and resources on larger disasters without the complications of reallocating response resources from multiple smaller scale commitments. The 10-year undiscounted FEMA cost savings resulting from the proposed rule would be $627.10 million ($440.45 million discounted at 7 percent discount rate and $534.92 million at a 3 percent discount rate; $62.71 million annualized at both 7 and 3 percent discount rates). FEMA estimates the 10-year undiscounted Applicant cost savings would be $73.30 million ($51.48 million at 7 percent and $62.53 million at 3 percent; $7.33 million annualized at both 7 and 3 percent). The total 10-year undiscounted cost savings for both FEMA and the Applicants would be $700.40 million, because there would be fewer requests for disasters to be declared and there would be fewer Applicants able to apply for relief. The

[112] As noted above, Tribal governments may directly submit a request for a major disaster declaration to FEMA under the Tribal Declarations Pilot Guidance, instead of requesting assistance through the State. The potential impacts of this proposed rule are discussed in more detail below and in the RIA. *See* Section 13 of the RIA.

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10-year total discounted cost savings would be $491.93 million at 7 percent and $597.46 million at 3 percent, with an annualized cost savings of $70.75 million (Table 4).

TABLE 4—TOTAL ESTIMATED COST SAVINGS OF THE PROPOSED RULE

[2018$]

Year	Applicant cost savings	FEMA cost savings	Total undiscounted cost savings	Discounted	
				7%	3%
1	$8,035,714	$62,710,053	$70,745,767	$66,117,539	$68,685,211
2	8,035,714	62,710,053	70,745,767	61,792,093	66,684,671
3	8,035,714	62,710,053	70,745,767	57,749,619	64,742,399
4	8,035,714	62,710,053	70,745,767	53,971,607	62,856,698
5	8,035,714	62,710,053	70,745,767	50,440,754	61,025,920
6	8,035,714	62,710,053	70,745,767	47,140,892	59,248,466
7	8,035,714	62,710,053	70,745,767	44,056,908	57,522,783
8	8,035,714	62,710,053	70,745,767	41,174,681	55,847,362
9	8,035,714	62,710,053	70,745,767	38,481,010	54,220,740
10	8,035,714	62,710,053	70,745,767	35,963,561	52,641,495
Total	80,357,140	627,100,530	707,457,670	496,888,663	603,475,742
Annualized				70,745,767	70,745,767

Costs

The proposed rule would substantively revise the estimated cost of the assistance disaster declaration factor. The proposed rule would not create new factors for FEMA to consider when reviewing a request for a PA disaster. FEMA would not change its current process for updating the per capita indicator or PA damage thresholds. FEMA's current practice is to update the per capita indicator each fiscal year to adjust for inflation using the for CPI–U and post the updated indicator on the **Federal Register** and FEMA website. The proposed rule would also require FEMA to update the minimum threshold every year to adjust for inflation. This is a new practice that FEMA is implementing to more accurately gauge a State's fiscal capacity to respond to disasters, as the threshold has not been updated since it was introduced in 1999. However, FEMA already calculates the change in CPI–U to apply to the per capita indicator each year. FEMA would apply the same change in CPI–U used to update the per capita indicator to the minimum threshold. The proposed rule would require FEMA to adjust the per capita indicator for each State's TTR, which is a new practice. FEMA estimates it would cost $12 per year for a FEMA employee to adjust the per capita indicator by TTR annually.

FEMA would continue to post the updated per capita indicator each fiscal year and would not require any additional annual calculations or data requirements from the Applicants. The proposed rule would impose a one-time cost of $39,545 to the Applicants to familiarize themselves with the proposed changes the first year (Table 5). The minimum threshold would now be published yearly along with the per capita indicator. Because Applicants already look up the per capita indicator, FEMA does not expect additional costs associated with also looking up the minimum threshold. The proposed changes could impose qualitative costs that FEMA was unable to quantify. Qualitative costs are discussed in the RIA. Transferring the costs of PA disasters to Applicants would require the Applicants to invest more in response, recovery, and mitigation capabilities. It is possible that without Federal assistance, Applicants may opt to not repair damaged facilities or pay for other recovery efforts. Damaged facilities that are not repaired or replaced could be more susceptible to subsequent incidents in the future. Additionally, damaged facilities that are not repaired or replaced may no longer be used, which could be a significant loss of infrastructure to small governments who might opt to not repair damaged facilities due to fiscal limitations.

TABLE 5—TOTAL ESTIMATED COSTS OF THE PROPOSED RULE

[2018$]

Year	Applicant costs	FEMA costs	Total undiscounted costs	Discounted	
				7%	3%
1	$39,545	$12	$39,557	$36,969	$38,405
2	0	12	12	10	11
3	0	12	12	10	11
4	0	12	12	9	11
5	0	12	12	9	10
6	0	12	12	8	10
7	0	12	12	7	10
8	0	12	12	7	9
9	0	12	12	7	9
10	0	12	12	6	9
Total	39,545	120	39,665	37,042	38,496

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TABLE 5—TOTAL ESTIMATED COSTS OF THE PROPOSED RULE—Continued

[2018$]

Year	Applicant costs	FEMA costs	Total undiscounted costs	Discounted	
				7%	3%
Annualized				5,274	4,513

Benefits

FEMA was unable to quantify benefits of the proposed regulatory changes due to a lack of data on future impacts of adjusting declaration factors. FEMA instead focused on proposed regulatory changes that would provide FEMA with a more accurate assessment of whether an incident has exceeded an Applicant's capabilities to respond to and recover from an incident. This is because the minimum threshold and per capita indicator have not consistently been updated to account for inflation, and not based on a State's fiscal capacity to respond. The proposed changes would ensure that these factors are taken into account. FEMA believes that the proposed changes also would incentivize Applicants to invest more in response, recovery, and mitigation capabilities, since Federal assistance would be focused on larger-scale disasters, and Applicants will have more responsibility to ensure they are adequately equipped to handle smaller disasters. This would provide a better distribution of responsibilities between the Applicants and the Federal Government. These incentives would increase overall national preparedness for incidents. In addition, FEMA believes these changes to the PA declaration factors would result in a reduction in the number of declarations for smaller incidents, allowing FEMA to refine its focus and resources on larger incidents without the complications of reallocating response resources from multiple smaller-scale commitments, that States and local governments would have the capacity to manage without Federal assistance. FEMA requests public comment on the ability of Applicants to invest more in response, recovery, and mitigation capabilities.

Summary

Table 6 provides a summary of the annual and total quantified costs, cost savings, and reduction in transfers by category after implementation of the proposed rule, and Table 7 provides the A–4 accounting summary.

TABLE 6—SUMMARY OF TRANSFERS AND COST SAVINGS OF THE PROPOSED RULE

Transfer, cost, or cost savings item	Annual undiscounted
Reduction in Transfers	
PA Funding	$144,534,939
HMGP Funding	33,330,171
BRIC Funding	7,267,390
PA Management Cost Funding	17,344,193
HMGP Management Cost	4,999,526
Funding	
BRIC Management Cost Funding	1,282,481
Total Reduction in Transfers	208,758,700
Cost Savings	
Applicant Paperwork Cost Savings	8,035,714
FEMA Administrative Cost	62,409,381
Savings	
FEMA Paperwork Cost Savings	300,672
Total FEMA Cost Savings	62,710,053
Total Cost Savings (Applicants and FEMA)	70,745,767
Costs	
Applicant Costs.	
Year 1	39,545
Years 2–10	0
FEMA Costs	12
Total Costs, Year 1	39,557
Total Costs, Years 2–10	12

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TABLE 7 A–4 ACCOUNTING STATEMENT

[$2018]

Period of Analysis: 2008 to 2017			
Category	7 percent discount rate	3 percent discount rate	Source citation (RIA, preamble, etc.)
BENEFITS:			
Annualized Quantified	N/A	N/A	
Qualitative	• Provide FEMA with a more accurate assessment of whether an incident exceeds Applicant capabilities. • Allow FEMA to focus efforts and resources on larger incidents. • Provide better distribution of responsibilities between Applicants and the Federal Government.		RIA Section 12.
COSTS:			
Annualized Monetized $millions/year	0.005274	0.004513	RIA Section 8.
Annualized quantified	N/A	N/A	
Qualitative	• Applicants would need to invest more in response, recovery, and mitigation capabilities. • Damaged facilities may not be repaired or replaced, and could be susceptible to future disasters.		
COST SAVINGS:			
Annualized Monetized $millions/year	70.75	70.75	RIA Section 8.
TRANSFERS:			
Annualized Monetized $millions/year	208.76	208.76	RIA Section 9.
From/To	Reduction in transfers from FEMA to PA Applicants		RIA Section 9.
Category	Effects		Source citation (RIA, preamble, etc.)
State, Local, and/or Tribal Government	Included in the Cost Savings is $5.88 million annual paperwork cost savings to Applicants. Included in the Transfers is $8.48 million in PA funding that Tribal Applicants would not have received from 2008–20187. However, $7.11 of that funding would have potentially been available for Tribal governments had that requested a disaster declaration under the Tribal Declarations Pilot Guidance.		RIA.
Small business	There were 7,456 unique Applicants for the 159 removed PA disasters from 2008–2017. Using a sample size of 380, FEMA found that 79% were likely to be small entities (5,890 Applicants). The average PA funding received per small entity in the sample was $168,046, with a range from a low of $0 to a high of $20.65 million. If the changes in the proposed rule were in effect, these entities would not have received this PA funding.		RFA (IRFA).
Wages	None.		
Growth	None.		

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B. Regulatory Flexibility Act

The Regulatory Flexibility Act of 1980 (5 U.S.C. 601 *et seq.*) requires agency review of proposed and final rules to assess their impact on small entities. When an agency promulgates a notice of proposed rulemaking under 5 U.S.C. 553, the agency must prepare an initial regulatory flexibility analysis (IRFA) unless it determines and certifies pursuant to 5 U.S.C. 605(b) that a rule, if promulgated, would not have a significant impact on a substantial number of small entities. However, FEMA is publishing this IRFA to aid the public in commenting on the potential small entity impacts of the proposed requirements in this NPRM. FEMA invites all interested parties to submit data and information regarding the potential direct economic impacts on small entities that would result from the adoption of this NPRM. FEMA will consider all comments received in the public comment process.

In accordance with the Regulatory Flexibility Act (RFA), 5 U.S.C. 601 *et seq.*, as amended by the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121, 110 Stat. 857), FEMA prepared this IRFA to examine the impacts of the proposed rule on small entities. A small entity may be: A small independent business, defined as independently owned and operated, is organized for profit, and is not dominant in its field per the Small Business Act (5 U.S.C. 632); a small not-for-profit organization (any not-for-profit enterprise which is independently owned and operated and is not dominant in its field); or a small governmental jurisdiction (locality with fewer than 50,000 people) per 5 U.S.C. 601–612.

FEMA has discussed most of these issues in other sections of the NPRM and in the stand-alone RIA found in the docket of this rulemaking. In this section, FEMA will address the issues specific to the analysis of small entities that have not been addressed elsewhere.

1. *A description of the reasons why action by the agency is being considered.*

FEMA is proposing to amend the estimated cost of the assistance factor, including the minimum threshold, in 44 CFR 206.48. Pursuant to 44 CFR 206.48, FEMA considers several factors when determining whether to recommend that the President declare a major disaster authorizing the PA program. Since 1986, FEMA has evaluated the estimated cost of Federal and non-Federal public assistance against the statewide population and used a per capita dollar amount (set at $1 in 1986) as an indicator that a disaster may warrant Federal assistance. FEMA did not increase the indicator until 1999, when it began adjusting for inflation in 1999 and annually thereafter. Also, in 1999, FEMA established a $1 million minimum threshold, meaning it would not recommend that the President authorize the PA program unless there was at least $1 million in PA damage, which FEMA believed was a level of damage even the least populous States could handle with their own resources. FEMA has never increased this threshold. The current per capita indicator and minimum threshold do not provide an accurate measure of States' capabilities to respond to disasters. The lack of increases to the per capita indicator from 1986 to 1999 undercut the value of this factor as an indicator of State capacity given the inflation increases during that time. With respect to the minimum threshold, a 1999 determination by FEMA that all States could handle at least $1.0 million in damages with their own resources is outdated given the 53.5 percent increase from 1999 in the inflation rate over the last 20 years and rising State budgets and expenditures.[113]

Additionally, FEMA proposes to use the U.S. Census Bureau's annual population estimates produced under the PEP instead of the decennial census population data when calculating the State COA indicators. These changes would ensure a more accurate assessment of an individual State's financial capability to respond to and recover from a disaster, which would better enable FEMA to achieve its readiness and preparedness missions by allowing FEMA to expend more attention and resources on disasters that exceed the States' capabilities.

2. *A succinct statement of the objectives of, and legal basis for, the proposed rule.*

Section 1239 of DRRA directs FEMA to review the factors it considers when evaluating a request for a major disaster declaration, specifically the estimated cost of assistance factor, and to initiate rulemaking to update the declaration factors. FEMA proposes to amend 44 CFR 206.48(a) to make changes to the estimated cost of assistance factor.

FEMA is proposing to revise the cost of assistance estimates factor in 44 CFR 206.48(a)(1) by increasing the per capita indicator to account for inflation from 1986 to 1999 and adjusting the individual States' indicators by their TTR, and by increasing the minimum threshold by accounting for inflation from 1999 to 2019, and annually thereafter. FEMA also proposes to use the U.S. Census Bureau's annual population estimates produced under PEP instead of the decennial census population data. These changes would provide FEMA with a better informed and more accurate assessment of whether an incident has exceeded State capabilities when it makes its recommendations to the President; incentivize States to invest more in response, recovery, and mitigation capabilities, which would provide a better distribution of responsibilities between the States and the Federal Government and better overall national preparedness for disasters; and the associated reductions in declarations of smaller incidents would allow FEMA to better focus its efforts and resources on large disasters without the complications of reallocating resources from multiple smaller-scale commitments.

3. *A description of and, where feasible, an estimate of the number of small entities to which the rule will apply.*

The proposed rule directly affects all Applicants that are eligible to request PA under a Federal major disaster declaration authorizing PA. Eligible Applicants for PA include: State and Territorial governments, including the District of Columbia, American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands; federally recognized Indian Tribal Governments, including Alaska Native villages and organizations; local governments; and certain private nonprofits.[114]

FEMA reviewed the PA disasters that it identified that likely would not have been declared from 2008–2017 due to the proposed rule, as presented in Table 8–1 in Section 8 of the stand-alone RIA found in the docket of this rulemaking, to estimate the number of small entities to which the proposed rule would apply. For each of the 159 PA disasters removed, FEMA used PA data in FEMA's Enterprise Data Warehouse (EDW) database to identify the Applicants for each of the PA disasters.

[113] January 1999 CPI–U of 164.3 and August 2018 CPI–U of 252.146. Calculation: (252.146 − 164.3)/164.3 = 53.5% (rounded).

[114] To be an eligible private nonprofit applicant, the private nonprofit must show that it has: A current ruling letter from the U.S. Internal Revenue Service granting tax exemption under sections 501(c), (d), or (e) of the Internal Revenue Code of 1954, or documentation from the State substantiating it is a non-revenue producing, nonprofit entity organized or doing business under State law. Additionally, prior to determining whether the private nonprofit is eligible, FEMA must first determine whether the private nonprofit owns or operates an eligible facility.

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FEMA found there were 7,456 unique Applicants for the 158 PA disasters.

FEMA selected a random sample of 383 Applicants from the 7,456 unique Applicants to estimate the percentage that are small entities.[115] The term ''small entities'' includes small businesses that meet the Small Business Administration (SBA) size standard for small business concerns at 13 CFR 121.201, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with population of less than 50,000. FEMA researched and found data and information on 383 randomly sampled Applicants. FEMA found that of the 383 Applicants, 25 were classified as State governments, 312 were local governments, 3 were Tribal governments, and 43 were nonprofits. FEMA removed the 3 Tribal governments from the sample as they are sovereign entities and are not covered by the RFA. State governments are not considered small entities because they have populations greater than 50,000. For the Applicants classified as local governments, FEMA used 2010 decennial Census Bureau population data to determine the Applicant population size. Of the 312 local governments, 259 (or 83 percent) had populations below 50,000 and would be considered as small entities. For nonprofit Applicants, FEMA reviewed the nonprofit's website utilizing an open source database (*Manta.com*) and any other publicly available information to determine the size of the nonprofit and ownership. FEMA researched the 43 private nonprofits and found that all of them were independently owned and operated and are not dominant in their field. Therefore, FEMA assumed all 43 private nonprofits were likely to be small entities. Table 8 summarizes the findings of the small entity threshold analysis.

TABLE 8—SUMMARY OF APPLICANTS IN SAMPLE

Type of recipient or subrecipient	Exceed small entity threshold	Below small entity threshold	Total
State Government	25	0	25
Local Government	53	259	312
Private Nonprofits	0	43	43
Total	78	302	380
Percentage	21%	79%	100%

Of the 380 Applicants, FEMA found that 302 entities were small as defined by the SBA thresholds. Therefore, FEMA estimates that 79% of the total 7,456 Applicants of PA were small entities (5,890 Applicants were small entities). The 302 sampled small entities received a total of $50.75 million in PA funding for the disasters removed from 2008–2017 according to FEMA's EDW database. If the changes in the proposed rule were in effect, these entities would not have received this PA funding. The average PA funding received per small entity in the sample was $168,046 over the 10-year period. The PA funding a small entity received ranged from a low of $0 to a high of $20.65 million. Of the 302 small entities, 4 received $0 in PA funding. FEMA welcomes any data or comments from the public on the number of small entities that may be impacted by this proposed rule an any impacts to those small entities.

4. *A description of the projected reporting, recordkeeping and other compliance requirements of the proposed rule, including an estimate of the classes of small entities which will be subject to the requirement and the type of professional skills necessary for preparation of the report or record.*

The proposed rule would call for a revision of a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520). This proposed rule would call for amendments to the existing collection requirements previously approved under the collections of information (COI) with OMB Control Numbers 1660–0009 and 1660–0017.[116] The costs associated with COI 1660–0009 include the time and cost burden for an Applicant to request a disaster declaration. A request for a disaster declaration comes from the State level. There is no burden for small entities included in COI 1660–0009, as the burden to complete FEMA form 010–0–13 is completed by the equivalent of a State Government Chief Executive and a State Administrative Support Worker. Therefore, there is no paperwork burden impact to small entities for COI 1660–0009.

The costs associated with COI 1660–0017 include the time and cost burden for Applicants to provide FEMA information that is required for PA program eligibility determinations, grants management, and compliance with other Federal laws and regulations. For the 159 PA disasters removed from 2008–2017 from this proposed rule, there would be a reduction in paperwork burden for Applicants that applied for the PA program, as covered by COI 1660–0017. There would be a reduction in respondents for FEMA Forms 009–0–49, 009–0–91, 009–0–91A, 009–0–91B, 009–0–91C, 009–0–91D, 009–0–120, 009–0–121, 009–0–123, 009–0–124, 009–0–125, 009–0–126, 009–0–127, 009–0–128, and 009–0–141. The number of respondents would not change for FEMA Form 009–0–111, State Administrative Plan and State Plan Amendments (no form), Request for Appeals and Recommendation (no form), and Requests for Arbitration and Recommendation resulting from Hurricanes Katrina or Rita (no form), as these forms are not impacted by the proposed rule.

The burden per response varies by form (see Table 9 in Section E, Paperwork Reduction Act of 1995). The number of forms each Applicant fills out varies by Applicant and by disaster. If an Applicant fills out every form impacted by this proposed rule, the maximum burden per Applicant is 11.4

[115] FEMA used Slovin's formula to determine the sample size. Using a 95 percent confidence interval, a sample size of 380 recipients and subrecipients is sufficient. Slovin's formula = N/(1+Ne^2) = 7,456/(1 + 7,456 * (0.05^2)) = 379.633, rounded up to 380.

[116] ''Public Assistance Program'', 1660–0017 can be found at *https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201902-1660-001*. The most recently approved ICR at the time of this analysis was ICR Reference Number 201902–1660–001. ''The Declaration Process: Requests for Preliminary Damage Assessment (PDA), Requests for Supplemental Federal Disaster Assistance, Appeals, and Requests for Cost Share Adjustments'', 1660–0009 can be found at *https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201905-1660-003*. The most recently approved ICR at the time of this analysis was ICR Reference Number 201905–1660–003.

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hours (found using the ''Average Hourly Burden'' column in Table 9, excluding those forms or items not impacted by the proposed rule). Therefore, small entities would have a maximum reduction of 11.4 hours of paperwork burden for each PA disaster removed due to the proposed rule. FEMA previously estimated that 79% of the total 7,456 Applicants of PA for the 159 removed PA disasters were small entities (5,890 Applicants were small entities). If all 5,890 small entity Applicants had filled out every form impacted by the proposed rule, there would have been a reduction in paperwork burden of 67,146 hours (5,890 small entities × 11.4 hours) from 2008–2017. There are no additional reporting, recordkeeping, or other compliance requirements resulting from this proposed rule.

5. *An identification, to the extent practicable, of all relevant Federal rules which may duplicate, overlap or conflict with the proposed rule.*

There are no relevant Federal rules that may duplicate, overlap, or conflict with this proposed rule.

6. *A description of any significant alternatives to the proposed rule which accomplish the stated objectives of applicable statutes and which minimize any significant economic impact of the proposed rule on small entities.*

FEMA considered several alternatives to the proposed changes to the per capita indicator and the minimum threshold. The alternatives are described in more detail in Section 15 of the stand-alone RIA found in the docket of this rulemaking. Because PA is approved at the State level, this proposed rule would only directly affect States. Small entities would be indirectly affected by a reduction in declared disasters at the State level, but FEMA is unable to address the impacts to small entities directly. A summary of those alternatives follows.

FEMA considered two alternatives to adjusting the per capita indicator: adjusting the per capita indicator by PCPI and adjusting the per capita indicator by PCPI and then adjusting by TTR. The preliminary estimate for 2018 US PCPI is $53,712.[117] FEMA established the per capita indicator at $1 in 1986 based on the 1983 US PCPI, which was the latest available published information at the time. The PCPI used to set the original per capita indicator was $11,687.[118] PCPI increased by 360 percent from 1983 to 2018 (($53,712–$11,687)/$11,687). FEMA used the PCPI estimate of $11,687 from the 1986 proposed rulemaking as this was the data FEMA used to set the original per capita indicator. Applying the increase in PCPI to the original per capita indicator of $1 would result in a per capita indicator of $4.60. The per capita indicator alternatives resulted in per capita indicators that were higher than the proposed changes, which would result in more PA disasters that would not have exceeded the proposed thresholds from 2008–2017. Fewer PA disasters would result in more small entities impacted by the proposed rule, since fewer declared disasters would lead to a reduction in Public Assistance provided to local governments and Private Non-Profits within each State. FEMA rejected the PCPI-based per capita indicator thresholds because FEMA believed the resulting per capita indicators may be too high for some States to meet. Moreover, the potentially large changes to PCPI from year to year, in comparison to changes to the CPI–U, could result in instability and uncertainty in what the per capita indicator may be each year for individual States and make it more difficult for States to plan.

FEMA considered four alternatives to adjusting the minimum threshold using CPI–U: Using the change in GDP, State expenditures, or TTR to adjust the minimum threshold, or using FEMA administrative costs to calculate a minimum threshold for which FEMA's administrative burden exceeded the amount of Federal assistance provided. The minimum threshold alternatives resulted in minimum thresholds that were higher than the proposed minimum threshold and would have led to a 1 percent increase in the PA disasters that would not have exceeded the thresholds. Fewer PA disasters could result in more small entities impacted by the proposed rule. FEMA rejected adjusting the minimum threshold using the change in GDP, State expenditures, or TTR because the alternatives increase the complexity of calculating the threshold, but have little additional impact on the reduction in total PA disasters.

FEMA rejected using administrative costs to calculate a minimum threshold because FEMA was unable to derive a specific dollar value of estimated PA obligations at which the proportion of administrative costs relative to PA obligations could justify that a prospective minimum threshold be set at that amount. Based on FEMA's analysis of available information across all PA disasters in the past ten years, there is no specific size of PA disaster at which point administrative costs exceed the amount of PA assistance, or where excessive administrative costs essentially renders such PA assistance ineffectual from a Federal cost standpoint.

FEMA considered the following two alternatives that would have a smaller impact on small entities.

(a) No Regulatory Action

FEMA considered not proposing the minimum threshold and per capita indicator regulatory changes in this proposed rule. FEMA rejected this alternative because section 1239 of the DRRA directs FEMA to review the factors it considers when evaluating a request for a major disaster declaration, specifically the estimated cost of assistance factor, and to initiate rulemaking to update the declaration factors. Additionally, the lack of increases to the per capita indicator from 1986 to 1999 undercuts the value of this factor as an indicator of State capacity given the increases in inflation during that time. For the minimum threshold, the lack of an increase since 1999 has prevented this factor from keeping pace with inflation, and rising State budgets and resources. By not proposing the per capita indicator and minimum threshold regulatory changes in the proposed rule, FEMA would be relying upon per capita indicator and minimum threshold factors that are no longer adequate measures of a State's capability to respond to and recover from a disaster. The no regulatory action alternative would result in a greater likelihood that the President declares major disaster declarations for relatively small incidents that a more accurate assessment would find is within a State's financial capabilities to respond to on its own.

(b) Population Alternative

FEMA considered continuing to use the US Census Bureau's decennial census population estimates instead of the proposed PEP annual estimates. FEMA found that using the decennial populations instead of the PEP annual estimates would have resulted in a reduction of 148 PA disasters from

[117] State Annual Personal Income, 2018 (Preliminary) and State Quarterly Personal Income, 4th Quarter 2018, Table 1: Personal Income, Population, and Per Capita Personal Income, by State and Region, 2017–2018, *https://www.bea.gov/system/files/2019-03/spi0319.pdf.*

[118] Disaster Assistance; Subpart C, the Declaration Process and State Commitments, 51 FR 13333, Apr. 18, 1986, found at *http://cdn.loc.gov/service/ll/fedreg/fr051/fr051075/fr051075.pdf.* FEMA began using $1 per capita informally in 1986. Revisions were made to the BEA 1983 PCPI after publication of the proposed 1986 rule. FEMA used the PCPI of $11,687 to maintain consistency with the data used at the time of establishing the per capita indicator.

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2008–2017, an average of 15 per year. This is a difference of 10 disasters from when FEMA used the proposed PEP annual populations in the analysis. This difference was a result of the States having a higher population with the PEP annual population estimates compared to the decennial population, and therefore a higher State COA indicator.

FEMA rejected this alternative because FEMA's reliance on population data from the most recent decennial survey can lead to an imprecise assessment of a State's capabilities to respond to and recover from a disaster on its own. Decennial population data can lead to an inaccurate per capita indicator for States experiencing rapid changes in population. This could result in a greater likelihood that the President declares major disaster declarations for relatively small incidents that are within a State's financial capabilities to respond to on its own after it has experienced rapid population growth, or, conversely, a likelihood that the President does not declare major disaster declarations for incidents that may actually exceed a State's capabilities to respond to on its own where that State's population has rapidly decreased.

More detailed information on the alternatives can be found in Section 15 of the stand-alone RIA found in the docket of this rulemaking.

7. Conclusion

FEMA is interested in the potential impacts of the proposed rule on small entities and requests public comment on these potential impacts. If you think that this rule will have a significant economic impact on you, your business, or your organization, please submit a comment to the docket at the address under **ADDRESSES** in the rule. In your comment, explain why, how, and to what degree you think this rule will have an economic impact on you. FEMA is also interested in less burdensome alternatives for small entities. If you know of less burdensome alternatives, please include them in your comment.

C. Unfunded Mandates Reform Act of 1995

Pursuant to Section 201 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4, 2 U.S.C. 1531), each Federal agency "shall, unless otherwise prohibited by law, assess the effects of Federal regulatory actions on State, local, and tribal governments, and the private sector (other than to the extent that such regulations incorporate requirements specifically set forth in law)." Section 202 of the Act (2 U.S.C. 1532) further requires that "before promulgating any general notice of proposed rulemaking that is likely to result in the promulgation of any rule that includes any Federal mandate that may result in expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year, and before promulgating any final rule for which a general notice of proposed rulemaking was published, the agency shall prepare a written statement" detailing the effect on State, local, and tribal governments and the private sector. FEMA has determined that this proposed rule can be excluded from this assessment as the proposed rule meets the criteria set forth in 2 U.S.C. 1503(4), which states, "This chapter shall not apply to . . . any provision in a proposed or final Federal regulation that— . . . (4) provides for emergency assistance or relief at the request of any State, local, or tribal government or any official of a State, local, or tribal government." Therefore, no actions are deemed necessary under the provisions of the Unfunded Mandates Reform Act of 1995.

D. National Environmental Policy Act of 1969 (NEPA)

Under the National Environmental Policy Act of 1969 (NEPA), as amended, 42 U.S.C. 42 U.S.C. 4321 *et. seq.*, an agency must prepare an environmental assessment or environmental impact statement for any rulemaking that significantly affects the quality of the human environment. FEMA has determined that this rulemaking does not significantly affect the quality of the human environment and consequently has not prepared an environmental assessment or environmental impact statement.

Rulemaking is a major Federal action subject to NEPA. Categorical exclusion A3 included in the list of exclusion categories at Department of Homeland Security Instruction Manual 023–01–001–01, Revision 01, Implementation of the National Environmental Policy Act, Appendix A, issued November 6, 2014, covers the promulgation of rules, issuance of rulings or interpretations, and the development and publication of policies, orders, directives, notices, procedures, manuals, and advisory circulars if they meet certain criteria provided in A3(a–f). This proposed rule amends an existing regulation without changing its environmental effect, which meets Categorical Exclusion A3(d). This proposed rule is a narrowly crafted revision to FEMA's existing regulations updating the criteria that FEMA considers when recommending an area eligible for PA under a major disaster declaration. The proposed rule is not part of any larger regulatory action. Further, there are no extraordinary circumstances present that would create the potential for a significant environmental impact. Therefore, each of the conditions for application of categorical exclusion A3(d) is satisfied, and this action is categorically excluded from further NEPA review.

Because no other extraordinary circumstances have been identified, this rule does not require the preparation of either an EA or an EIS as defined by NEPA. *See* Department of Homeland Security Instruction Manual 023–01–001–01, Revision 01, Implementation of the National Environmental Policy Act, section (V)(B)(2).

E. Paperwork Reduction Act of 1995

Under the Paperwork Reduction Act of 1995, as amended, 44 U.S.C. 3501–3520, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the agency obtains approval from the Office of Management and Budget (OMB) for the collection and the collection displays a valid OMB control number. *See* 44 U.S.C. 3506, 3507. This rulemaking contains a collection of information, as defined by the Paperwork Reduction Act of 1995, as amended, 44 U.S.C. 3501–3520. This action contains proposed amendments to the existing information collection requirements previously approved under OMB Control Number 1660–0009 and 1660–0017. As required by the Paperwork Reduction Act of 1995, FEMA has submitted these proposed collection amendments to OMB for its review.

Collection of Information Number 1660–0009

Title: The Declaration Process: Requests for Preliminary Damage Assessment (PDA), Requests for Supplemental Federal Disaster Assistance, Appeals, and Requests for Cost Share Adjustments.

OMB Control Number: 1660–0009.

Type of information collection: Revision of a currently approved collection.

Form Numbers: FEMA Forms 010–0–13 and 009–0–140 (used by FEMA personnel or contractors only).

Summary of the Collection of Information: When a disaster occurs in a State, the Governor of the State or the Acting Governor in his/her absence, may request a major disaster declaration or an emergency declaration using FEMA Form 010–0–13. The information obtained by joint Federal, State, and

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local preliminary damage assessments is analyzed by FEMA regional senior level staff. The regional summary and the regional analysis and recommendation will include a discussion of State and local resources and capabilities, and other assistance available to meet the disaster related needs. The Administrator of FEMA provides a recommendation and a copy of the Governor's request to the President. In the event the information required by law is not contained in the request, the Governor's request cannot be processed and forwarded to the White House.

Need for Information: The Stafford Act requires that all requests for a major disaster or emergency declaration be made by the Governor of the affected State or the Chief Executive of an affected Indian tribal government. Section 401(a) of the Stafford Act stipulates that such a request shall be based on a finding that the disaster is of such severity and magnitude that effective response is beyond the capabilities of the State and the affected local government, and that Federal assistance is necessary. Section 401(a) further stipulates that as a part of such request, and as a prerequisite to major disaster assistance under the Stafford Act, the Governor shall take appropriate response action under State law and direct the execution of the State's emergency plan and shall furnish specific information that must be included in a request for a major disaster declaration. Section 401(a) stipulates that the request must include specific information on the nature and amount of State and local resources which have been or will be committed to alleviate the results of the disaster. Section 501(a) requires the same information to be provided in requests for declarations of an emergency.

Use of Information: This collection includes FEMA Form 010–0–13, Request for Presidential Disaster Declaration Major Disaster or Emergency, which asks for the same data that were stated and required in the previous narrative Governor's requests to the President requesting supplemental Federal assistance, through the appropriate Regional Administrator, combined with the findings of a joint FEMA, State and local Preliminary Damage Assessment (PDA). The PDA is analyzed and provides the basis for a Regional Summary, Analysis, and Recommendation, which is submitted to the Assistant Administrator of the Disaster Assistance Directorate. The information is reviewed and evaluated, and the Administrator formulates a recommendation which is submitted to the President for consideration of a disaster or emergency declaration. The FEMA form eliminates the need for follow-up communications and reporting during a declaration request.

Description of the Respondents: State, local, or Tribal government.

Number of Respondents: The current OMB-approved number of respondents is 623 per year. The proposed rulemaking would not impact the number of respondents.

Number of Responses: FEMA estimates the number of responses would be 340 per year. This is a decrease of 16 responses from the OMB-approved number of responses of 356 per year.

Burden of Response: For each response, FEMA estimates it takes 9 hours to complete FEMA Form 010–0–13. In addition, FEMA estimates it takes 24.126 hours to gather information for the FEMA Form 010–0–13. The total burden for each response is 33.126 hours

Estimate of Total Annual Burden: The previously approved total annual burden was 11,792.8 hours. FEMA estimates that the number of responses would decrease by 16 per year. At 33.126 hours per response, the reduced burden for submitting the responses would be 530 hours (rounded). Based on the proposed rule's decrease in burden, the new estimated total annual burden is 11,262.8 hours.

Collection of Information Number 1660–0017

Title: Public Assistance Program,
OMB Control Number: 1660–0017,
Type of information collection: Revision of a currently approved collection.

Form Numbers: FEMA Forms 009–0–49, 009–0–91, 009–0–91A, 009–0–91B, 009–0–91C, 009–0–91D, 009–0–111, 009–0–120, 009–0–121, 009–0–123, 009–0–124, 009–0–125, 009–0–126, 009–0–127, 009–0–128, 055–0–0–1, and 009–0–141.

Summary of the Collection of Information: The Stafford Act authorizes grants to assist State, tribal, and local governments and certain Private Non-Profit entities with the response to and recovery from disasters following Presidentially declared major disasters and emergencies.

Need for Information: The information collected is required for the PA program eligibility determinations, grants management, and compliance with other Federal laws and regulations. Title 44 CFR part 206 specifies the information collections necessary to facilitate the provision of assistance under the PA program.

Use of Information: The information collected is utilized by FEMA to make determinations for PA grants based on the information supplied by the respondents.

Description of Respondents: State, local, or tribal government.

Number of Respondents: The current OMB-approved number of respondents is 56 per year for FEMA Forms 009–0–49, 009–0–91, 009–0–91A, 009–0–91B, 009–0–91C, 009–0–91D, 009–0–111, 009–0–120, 009–0–121, 009–0–123, 009–0–124, 009–0–125, 009–0–126, 009–0–127, 009–0–128, 009–0–141, State Administrative Plan and State Plan Amendments (no form), and Request for Appeals and Recommendation (no form); and 4 per year for Requests for Arbitration and Recommendation resulting from Hurricanes Katrina or Rita (no form). FEMA estimates the number of respondents would be 40 per year, a decrease of 16 respondents from the OMB-approved number of responses of 56 per year, for FEMA Forms 009–0–49, 009–0–91, 009–0–91A, 009–0–91B, 009–0–91C, 009–0–91D, 009–0–120, 009–0–121, 009–0–123, 009–0–124, 009–0–125, 009–0–126, 009–0–127, 009–0–128, and 009–0–141. The number of respondents would not change for FEMA Form 009–0–111, State Administrative Plan and State Plan Amendments (no form), Request for Appeals and Recommendation (no form), and Requests for Arbitration and Recommendation resulting from Hurricanes Katrina or Rita (no form).

Number of Responses: The number of responses per respondent varies by form (see Table 9). The number of responses per respondent (form) would not change due to the proposed rule. The decrease in the number of respondents for certain forms would result in a decrease in the total annual responses. FEMA estimates the total annual number of responses would be 284,564 per year. This is a decrease of 113,504 responses from the OMB-approved number of responses of 398,068 per year.

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TABLE 9—ESTIMATED ANNUALIZED BURDEN HOURS BY FORM

Form name/form No.	Respondents	Responses per respondent	Total annual responses	Average hourly burden per response	Total hourly annual burden
FEMA Form 009–0–49, Request for Public Assistance	40	129	5,160	0.25	1,290
FEMA Form 009–0–91, Project Worksheet (PW) and a Request for Time Extension	40	840	33,600	1.5	50,400
FEMA Form 009–0–91A Project Work Sheet (PW) Damage Description and Scope of Work	40	784	31,360	1.5	47,040
FEMA Form 009–0–91B, Project Worksheet (PW) Cost Estimate Continuation Sheet and Request for additional funding for Cost Overruns	40	784	31,360	1.3333	41,813
FEMA Form 009–0–91C Project Worksheet (PW) Maps and Sketches Sheet	40	728	29,120	1.5	43,680
FEMA Form 009–0–91D Project Worksheet (PW) Photo Sheet	40	728	29,120	1.5	43,680
FEMA Form 009–0–120, Special Considerations Questions	40	840	33,600	0.5	16,800
FEMA Form 009–0–128, Applicant's Benefits Calculation Worksheet	40	784	31,360	0.5	15,680
FEMA Form 009–0–121, PNP Facility Questionnaire	40	94	3,760	0.5	1,880
FEMA Form 009–0–123, Force Account Labor Summary Record	40	94	3,760	0.5	1,880
FEMA Form 009–0–124, Materials Summary Record	40	94	3,760	0.25	940
FEMA Form 009–0–125, Rented Equipment Summary Record	40	94	3,760	0.5	1,880
FEMA Form 009–0–126, Contract Work Summary Record	40	94	3,760	0.5	1,880
FEMA Form 009–0–127, Force Account Equipment Summary Record	40	94	3,760	0.25	940
State Administrative Plan and State Plan Amendments/No Form	56	1	56	8	448
FEMA Form 009–0–111, Quarterly Progress Report	56	4	224	100	22,400
Request for Appeals & Recommendation/No Forms	56	9	504	3	1,512
Request for Arbitration & Recommendation resulting from Hurricanes Katrina or Rita/No Form	4	5	20	3	60
FEMA Form 009–0–141, FAC–TRAX System	40	913	36,520	1.25	45,650
Total	.....	.....	284,564	126.3333	339,853

Burden of Response: The burden per response varies by form (see Table 9). The total burden per response varies by respondent, with a maximum burden per respondent of 126.3333 hours if a respondent completes every form and those items without forms. The burden per response would not change due to this rulemaking.

Estimate of Total Annual Burden: The previously approved total annual burden was 466,025 hours. FEMA estimates that the number of respondents would decrease by 16 per year for FEMA Forms 009–0–49, 009–0–91, 009–0–91A, 009–0–91B, 009–0–91C, 009–0–91D, 009–0–120, 009–0–121, 009–0–123, 009–0–124, 009–0–125, 009–0–126, 009–0–127, 009–0–128, and 009–0–141. Table 9 shows the resultant change in the total annual burden by form. Based on the proposed rule's decrease in burden, the new estimated total annual burden is 339,853 hours. This is a reduction of 126,172 hours per year.

TABLE 9—ITEMIZED CHANGES IN ANNUAL BURDEN HOURS

Data collection activity/instrument	Program change (burden currently on OMB Inventory)	Program change (new)	Difference
FEMA Form 009–0–49, Request for Public Assistance	1,806	1,290	−516
FEMA Form 009–0–91, Project Worksheet (PW) and a Request for Time Extension	70,560	50,400	−20,160
FEMA Form 009–0–91A Project Work Sheet (PW) Damage Description and Scope of Work	65,856	47,040	−18,816
FEMA Form 009–0–91B, Project Worksheet (PW) Cost Estimate Continuation Sheet and Request for additional funding for Cost Overruns	58,537	41,813	−16,724
FEMA Form 009–0–91C Project Worksheet (PW) Maps and Sketches Sheet	61,152	43,680	−17,472
FEMA Form 009–0–91D Project Worksheet (PW) Photo Sheet	61,152	43,680	−17,472
FEMA Form 009–0–120, Special Considerations Questions	23,520	16,800	−6,720
FEMA Form 009–0–128, Applicant's Benefits Calculation Worksheet	21,952	15,680	−6,272
FEMA Form 009–0–121, PNP Facility Questionnaire	2,632	1,880	−752
FEMA Form 009–0–123, Force Account Labor Summary Record	2,632	1,880	−752
FEMA Form 009–0–124, Materials Summary Record	1,316	940	−376.0
FEMA Form 009–0–125, Rented Equipment Summary Record	2,632	1,880	−752

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TABLE 9—ITEMIZED CHANGES IN ANNUAL BURDEN HOURS—Continued

Data collection activity/instrument	Program change (burden currently on OMB Inventory)	Program change (new)	Difference
FEMA Form 009–0–126, Contract Work Summary Record	2,632	1,880	−752
FEMA Form 009–0–127, Force Account Equipment Summary Record	1,316	940	−376
State Administrative Plan and State Plan Amendments/No Form	448	448	0
FEMA Form 009–0–111, Quarterly Progress Report	22,400	22,400	0
Request for Appeals & Recommendation/No Forms	1,512	1,512	0
Request for Arbitration & Recommendation resulting from Hurricanes Katrina or Rita/No Form	60	60	0
FEMA Form 009–0–141, FAC–TRAX System	63,910	45,650	−18,260
Total	466,025	339,853	−126,172

As required by 44 U.S.C. 3507(d), FEMA will submit a copy of the proposed rule to OMB for its review of the collection of information.

FEMA asks for public comment on the proposed collection of information to help determine how useful the information is, whether it can help FEMA perform its functions better, whether it is readily available elsewhere, how accurate the estimate of the burden of collection is, how valid the methods for determining burden are, how FEMA can improve the quality, usefulness, and clarity of the information, and how FEMA can minimize the burden of collection.

If you submit comments on the collection of information, submit them both to OMB and to the Docket Management Facility, where indicated under the **ADDRESSES** section of the proposed rule, by the date given under the **DATES** section.

You are not required to respond to a collection of information unless it displays a currently valid control number from OMB. Before FEMA could enforce the collection of information requirements in this proposed rule, OMB would need to approve FEMA's request to collect this information.

F. Privacy Act/E-Government Act

Under the Privacy Act of 1974, 5 U.S.C. 552a, an agency must determine whether implementation of a proposed regulation will result in a system of records. A "record" is any item, collection, or grouping of information about an individual that is maintained by an agency, including, but not limited to, his/her education, financial transactions, medical history, and criminal or employment history and that contains his/her name, or the identifying number, symbol, or other identifying particular assigned to the individual, such as a finger or voice print or a photograph. *See* 5 U.S.C. 552a(a)(4). A "system of records" is a group of records under the control of an agency from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual. An agency cannot disclose any record which is contained in a system of records except by following specific procedures.

The E-Government Act of 2002, 44 U.S.C. 3501 note, also requires specific procedures when an agency takes action to develop or procure information technology that collects, maintains, or disseminates information that is in an identifiable form. This Act also applies when an agency initiates a new collection of information that will be collected, maintained, or disseminated using information technology if it includes any information in an identifiable form permitting the physical or online contacting of a specific individual.

A Privacy Threshold Analysis for this proposed rule was approved on May 23, 2019. Any information will be collected in existing FEMA Form 010–0–13, and will still only include the Governor's point of contact and general office phone number as well as other State specific and disaster specific information of a non-personally-identifiable nature. The information received through the form is neither retrieved nor retrievable by personally identifiable information (PII). Any retrieval would be done by utilizing State specific or disaster specific information of a non-identifiable nature. This form and its contents are covered by a System of Records Notice, DHS/FEMA/PIA–013 Grant Management Programs and notice is provided by the DHS/FEMA–009 Hazard Mitigation Disaster Public Assistance and Disaster Loan Programs SORN. This rulemaking does not impact FEMA's collection of PII in the disaster declarations process and form and no Privacy Impact Assessment or System of Records Notice is required at this time.

G. Executive Order 13175, Consultation and Coordination With Indian Tribal Governments

Executive Order 13175, "Consultation and Coordination with Indian Tribal Governments," 65 FR 67249, November 9, 2000, applies to agency regulations that have Tribal implications, that is, regulations that have substantial direct effects on one or more Indian tribes, on the relationship between the Federal Government and Indian Tribes, or on the distribution of power and responsibilities between the Federal Government and Indian Tribes. Under this Executive order, to the extent practicable and permitted by law, no agency shall promulgate any regulation that has Tribal implications, that imposes substantial direct compliance costs on Indian Tribal governments, and that is not required by statute, unless funds necessary to pay the direct costs incurred by the Indian Tribal government or the Tribe in complying with the regulation are provided by the Federal Government, or the agency consults with Tribal officials.

FEMA has reviewed this proposed rule under Executive Order 13175 and believes that this proposed rule would not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian Tribes, or on the distribution of power and responsibilities between the Federal Government and Indian Tribes. The Sandy Recovery Improvement Act of 2013 requires the President when issuing regulations to "consider the unique conditions that affect the general welfare of Indian tribal governments." To this end, FEMA, in coordination

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with DHS, OMB and several tribes and tribal organizations, decided to develop the Tribal Declarations Pilot Guidance. The guidance underwent extensive and exhaustive tribal consultation for over 3 years, which included over 150 listening sessions across the country and the adjudication of over 2,000 comments. Under the Tribal Declarations Pilot Guidance, FEMA established separate factors for evaluating tribal governments' requests. These factors include (but are not limited to) a lower minimum damage amount for Public Assistance ($250,000) and the elimination of a per capita damage amount. These factors reflect the Agency's acknowledgement that tribal nations have different needs and capabilities than states. The factors listed in the Tribal Declarations Pilot Guidance will not be altered by this proposed rule, as the proposed rule only applies to States and Territories. Additionally, as noted in the RIA, Tribal applicants and subapplicants would have received $10.74 million less in PA funding between 2008 and 2017 had the proposed rule been in effect. However, $9 million of that funding would have been potentially available for some of those Tribal governments had they requested a major disaster declaration under the Tribal Declarations Pilot Guidance because those Tribal governments received more than $250,000 in PA assistance. Therefore, it is possible more Tribal governments may request disaster declarations through the Tribal Declarations Pilot Guidance as a result of the proposed rule. However, as discussed in the RIA, there are many other factors that affect whether a Tribal government requests a declaration through the Tribal Declarations Pilot Guidance.

The remaining $1.74 million of PA funding that Tribal governments would likely not have received resulted in an average of $36,192 per project for each of the 44 Tribal governments across the 29 disasters analyzed. While FEMA appreciates that some Tribal governments have limited financial capabilities, FEMA believes most Tribal governments could handle such costs in responding to an event on their own. Accordingly, FEMA does not believe that consultation under Executive Order 13175 is necessary; however, FEMA welcomes comments on the potential impacts of the proposed rule on Tribal governments. Additionally, in accordance with the requirement in section 1239 of the DRRA that FEMA meaningfully consult with State, local and Tribal governments, FEMA will conduct additional outreach with Tribal government stakeholders as well as representatives of State, regional and local governments.

H. Executive Order 13132, Federalism

Executive Order 13132, "Federalism," 64 FR 43255, August 10, 1999, sets forth principles and criteria that agencies must adhere to in formulating and implementing policies that have federalism implications, that is, regulations that have "substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government." Federal agencies must closely examine the statutory authority supporting any action that would limit the policymaking discretion of the States, and to the extent practicable, must consult with State and local officials before implementing any such action.

FEMA has reviewed this proposed rule under Executive Order 13132 believes that this proposed rule would not have substantial direct effects on the States, on the relationship between the National Government and the States, on the distribution of power and responsibilities among the various levels of government, or on the policymaking discretion of the States, and therefore does not have federalism implications as defined by the Executive order. The proposed rule substantively affects one of several factors that FEMA considers when determining whether to recommend that the President declare that a major disaster has occurred on the basis of a governor's request that such a declaration be made. Importantly, FEMA considers all of the factors in making a decision on a recommendation, as each disaster request involves circumstances unique to that disaster event, the State, and affected communities. Moreover, FEMA's recommendation to the President does not obligate the President to agree with FEMA's recommendation. Rather, the President may declare or not declare a disaster on their own accord. Furthermore, the proposed rule does not affect a State's ability or choice to request such a declaration, since disaster declaration requests are voluntary, and States choose whether or not to request Federal assistance. While FEMA hopes that the proposed rule will encourage States to invest more in mitigating future disasters and their consequences, such funding decisions are ultimately left to the States' discretion. Accordingly, the proposed rule does not have federalism implications as defined by the Executive order.

However, FEMA welcomes comments on the proposed rule's potential impacts on States and territories, and their relationships with the Federal Government. Additionally, in accordance with the requirement in section 1239 of the DRRA that FEMA meaningfully consult with State, local and Tribal governments, FEMA will conduct additional outreach with representatives of State, regional and local governments.

I. Executive Order 11988, Floodplain Management, as amended

Pursuant to Executive Order 11988, each agency is required to provide leadership and take action to reduce the risk of flood loss, to minimize the impact of floods on human safety, health and welfare, and to restore and preserve the natural and beneficial values served by floodplains in carrying out its responsibilities for (1) acquiring, managing, and disposing of Federal lands and facilities; (2) providing Federally undertaken, financed, or assisted construction and improvements; and (3) conducting Federal activities and programs affecting land use, including but not limited to water and related land resources planning, regulating, and licensing activities. In carrying out these responsibilities, each agency must evaluate the potential effects of any actions it may take in a floodplain; to ensure that its planning programs and budget requests reflect consideration of flood hazards and floodplain management; and to prescribe procedures to implement the policies and requirements of the Executive order.

Before promulgating any regulation, an agency must determine whether the proposed regulations will affect a floodplain(s), and if so, the agency must consider alternatives to avoid adverse effects and incompatible development in the floodplain(s). If the head of the agency finds that the only practicable alternative consistent with the law and with the policy set forth in Executive Order 11988 is to promulgate a regulation that affects a floodplain(s), the agency must, prior to promulgating the regulation, design or modify the regulation in order to minimize potential harm to or within the floodplain, consistent with the agency's floodplain management regulations and prepare and circulate a notice containing an explanation of why the action is proposed to be located in the floodplain.

The requirements of Executive Order 11988 apply in the context of the provision of Federal financial assistance

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relating to, among other things, construction and property improvement activities, as well as conducting Federal programs affecting a floodplain(s). The changes proposed in this rule would not have an effect on floodplain management. This proposed rule revises the criteria that FEMA considers when recommending a State eligible for PA under a major disaster declaration. A major disaster declaration recommendation to the President is an administrative action for FEMA's PA program. When FEMA undertakes specific actions in administering PA that may have effects on floodplain management, FEMA follows the procedures set forth in 44 CFR part 9 to assure compliance with this Executive order. This serves as the notice that is required by the E.O..

J. Executive Order 11990, Protection of Wetlands

Pursuant to Executive Order 11990, each agency must provide leadership and take action to minimize the destruction, loss or degradation of wetlands, and to preserve and enhance the natural and beneficial values of wetlands in carrying out the agency's responsibilities for (1) acquiring, managing, and disposing of Federal lands and facilities; and (2) providing Federally undertaken, financed, or assisted construction and improvements; and (3) conducting Federal activities and programs affecting land use, including but not limited to water and related land resources planning, regulating, and licensing activities. Each agency, to the extent permitted by law, must avoid undertaking or providing assistance for new construction located in wetlands unless the head of the agency finds (1) that there is no practicable alternative to such construction, and (2) that the proposed action includes all practicable measures to minimize harm to wetlands which may result from such use. In making this finding the head of the agency may take into account economic, environmental and other pertinent factors.

In carrying out the activities described in the Executive order, each agency must consider factors relevant to a proposal's effect on the survival and quality of the wetlands. Among these factors are: Public health, safety, and welfare, including water supply, quality, recharge and discharge; pollution; flood and storm hazards; and sediment and erosion; maintenance of natural systems, including conservation and long term productivity of existing flora and fauna, species and habitat diversity and stability, hydrologic utility, fish, wildlife, timber, and food and fiber resources; and other uses of wetlands in the public interest, including recreational, scientific, and cultural uses.

The requirements of Executive Order 11990 apply in the context of the provision of Federal financial assistance relating to, among other things, construction and property improvement activities, as well as conducting Federal programs affecting land use. The changes proposed in this rule would not have an effect on land use or wetlands. This proposed rule revises the criteria that FEMA considers when recommending a State eligible for PA under a major disaster declaration. A major disaster declaration recommendation to the President is an administrative action for FEMA's PA program. When FEMA undertakes specific actions in administering PA that may have such effects, FEMA follows the procedures set forth in 44 CFR part 9 to assure compliance with this Executive order.

K. Executive Order 12898, Environmental Justice

Pursuant to Executive Order 12898, "Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations," 59 FR 7629, February 16, 1994, as amended by Executive Order 12948, 60 FR 6381, February 1, 1995, FEMA incorporates environmental justice into its policies and programs. The Executive order requires each Federal agency to conduct its programs, policies, and activities that substantially affect human health or the environment in a manner that ensures that those programs, policies, and activities do not have the effect of excluding persons from participation in programs, denying persons the benefits of programs, or subjecting persons to discrimination because of race, color, or national origin.

This rulemaking will not have a disproportionately high or adverse effect on minority or low-income populations. The proposed rule substantively affects one of several factors that FEMA considers when determining whether to recommend that the President declare that a major disaster has occurred on the basis of a governor's request that such a declaration be made for PA. FEMA's PA program provides assistance to States, local governments, and private non-profits in repairing, restoring, and replacing facilities damaged by disasters, such as buildings, roads, bridges, and other infrastructure. FEMA's review of a governor's request for a major disaster declaration for PA only considers the relevant factors as they pertain to a disaster's impacts on those public or eligible private non-profit facilities covered by the PA program. Accordingly, no action that FEMA can anticipate under this rule will have a disproportionately high and adverse human health or environmental effect on any segment of the population.

L. Federal Participation in the Development and Use of Voluntary Consensus Standards and in Conformity Assessment Activities," OMB Circular A–119

"Voluntary consensus standards" are standards developed or adopted by voluntary consensus standards bodies, both domestic and international. These standards include provisions requiring that owners of relevant intellectual property have agreed to make that intellectual property available on a non-discriminatory, royalty-free or reasonable royalty basis to all interested parties. OMB Circular A–119 directs agencies to use voluntary consensus standards in their regulatory actions in lieu of government-unique standards except where inconsistent with law or otherwise impractical. The policies in the Circular are intended to reduce to a minimum the reliance by agencies on government-unique standards.

The proposed rule does not contain a "standard" as defined by OMB Circular A–119. This proposed rule revises the criteria that FEMA considers when recommending a State eligible for PA under a major disaster declaration. A major disaster declaration recommendation to the President is an administrative action for FEMA's PA program. Accordingly, an analysis under OMB Circular A–119 is not required.

M. Congressional Review of Agency Rulemaking

Under the Congressional Review of Agency Rulemaking Act (CRA), 5 U.S.C. 801–808, before a rule can take effect, the Federal agency promulgating the rule must submit to Congress and to the Government Accountability Office (GAO) a copy of the rule, a concise general statement relating to the rule, including whether it is a major rule, the proposed effective date of the rule, a copy of any cost-benefit analysis; descriptions of the agency's actions under the Regulatory Flexibility Act and the Unfunded Mandates Reform Act, and any other information or statements required by relevant Executive orders.

FEMA will send this rule to the Congress and to GAO pursuant to the CRA if the rule is finalized. The rule, as proposed, is a "major rule" within the meaning of the CRA. It will have an

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annual effect on the economy of $100,000,000 or more, and may result in a major increase in costs or prices for Federal, State, or local government agencies. It will not have significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States- based enterprises to compete with foreign-based enterprises in domestic and export markets.

List of Subjects in 44 CFR Part 206

Administrative practice and procedure, Coastal zone, Community facilities, Disaster assistance, Fire prevention, Grant programs—housing and community development, Housing, Insurance, Intergovernmental relations, Loan programs—housing and community development, Natural resources, Penalties, Reporting and recordkeeping requirements.

For the reasons stated in the preamble, the Federal Emergency Management Agency proposes to amend 44 CFR part 206, subpart B, as follows:

PART 206—FEDERAL DISASTER ASSISTANCE

■ 1. The authority citation for part 206 continues to read as follows:

Authority: Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 through 5207; Homeland Security Act of 2002, 6 U.S.C. 101 *et seq.;* Department of Homeland Security Delegation 9001.1.

■ 2. Revise § 206.48 introductory text and paragraph (a) to read as follows:

§ 206.48 Factors considered when evaluating a Governor's request for a major disaster declaration.

When FEMA reviews a Governor's request for major disaster assistance under the Stafford Act, these are the primary factors in making a recommendation to the President whether assistance is warranted. FEMA considers other relevant information as well.

(a) *Public Assistance Program.* FEMA evaluates the following factors to evaluate the need for assistance under the Public Assistance Program.

(1) *Estimated cost of the assistance.* FEMA evaluates the estimated cost of Federal and non-Federal public assistance against the statewide population to give some measure of the per capita impact within the State. FEMA uses a figure of $2.32 per capita as an indicator that the disaster is of such size that it might warrant Federal assistance, and will adjust this figure annually based on the Consumer Price Index for all Urban Consumers. With the exception of the District of Columbia, the Commonwealth of Puerto Rico, U.S. Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, and Guam, FEMA further adjusts each State's per capita indicator according to each State's Total Taxable Resources (TTR) as reported by the U.S. Department of Treasury. FEMA is establishing a minimum threshold of $1.535 million in public assistance damages per disaster in the belief that FEMA can reasonably expect even the lowest population States to cover this level of public assistance damage. FEMA will adjust this minimum threshold annually based on the Consumer Price Index for all Urban Consumers. FEMA will publish the adjusted figures annually in the **Federal Register**.

(2) *Localized impacts.* FEMA evaluates the impact of the disaster at the county and local government level, as well as impacts at the American Indian and Alaskan Native Tribal Government levels, because at times there are extraordinary concentrations of damages that might warrant Federal assistance even if the statewide per capita is not met. This is particularly true where critical facilities are involved or where localized per capita impacts might be extremely high. For example, FEMA has at times seen localized damages in the tens or even hundreds of dollars per capita though the statewide per capita impact was low.

(3) *Insurance coverage in force.* FEMA considers the amount of insurance coverage that is in force or should have been in force as required by law and regulation at the time of the disaster, and reduces the amount of anticipated assistance by that amount.

(4) *Hazard mitigation.* To recognize and encourage mitigation, FEMA considers the extent to which State and local government measures contributed to the reduction of disaster damages for the disaster under consideration. For example, if a State can demonstrate in its disaster request that a Statewide building code or other mitigation measures are likely to have reduced the damages from a particular disaster, FEMA considers that in the evaluation of the request. This could be especially significant in those disasters where, because of mitigation, the estimated public assistance damages fell below the per capita indicator.

(5) *Recent multiple disasters.* FEMA looks at the disaster history within the last 12-month period to better evaluate the overall impact on the State or locality. FEMA considers declarations under the Stafford Act as well as declarations by the Governor and the extent to which the State has spent its own funds.

(6) *Programs of other Federal assistance.* FEMA also considers programs of other Federal agencies because at times their programs of assistance might more appropriately meet the needs created by the disaster.

* * * * *

Pete Gaynor,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2020–27094 Filed 12–11–20; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

49 CFR Parts 385 and 391

[Docket No. FMCSA–2018–0224]

RIN 2126–AC15

Record of Violations

AGENCY: Federal Motor Carrier Safety Administration (FMCSA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: FMCSA proposes to eliminate the requirement that drivers operating commercial motor vehicles (CMVs) in interstate commerce prepare and submit a list of their convictions for traffic violations to their employers annually. This requirement is largely duplicative of a separate provision that requires each motor carrier to make an annual inquiry to obtain the motor vehicle record (MVR) for each driver it employs from every State in which the driver holds or has held a CMV operator's license or permit in the past year. To ensure motor carriers are aware of traffic violations for a driver who is licensed by a foreign authority rather than by a State, that provision would be amended to provide that motor carriers must make an annual inquiry to each driver's licensing authority where a driver holds or has held a CMV operator's license or permit. This change would require motor carriers to request the MVR equivalent from Canadian and Mexican driver's licensing authorities. FMCSA expects that removing the requirement for drivers to provide a list of their convictions for traffic violations to their employers annually would reduce the paperwork burden on drivers and motor carriers without adversely affecting CMV safety.

DATES: Comments on this notice of proposed rulemaking (NPRM) and information collection must be received on or before February 12, 2021.

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FL-DEM-21-0173-A-000050

From: Perry, Kaylynn <Kaylynn.Perry@em.myflorida.com>
Sent: Friday, February 05, 2021 1:51 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: EOC-Plans <EOC-Plans@em.myflorida.com>
Subject: County Salesforce Vaccine Site Management Tutorials

Good afternoon all,

Here is a short video outlining the functionalities available through the Salesforce Vaccine Site Management application:
County Salesforce Tutorial

Table of Contents:
:05 – Landing page and how to view vaccine sites
:52 – How to edit existing sites
2:30 – How to add a new site
5:12 – How to create a new Daily Result
6:18 – How to edit an existing Daily Result
6:53 – County Dashboard overview

If you have any further questions or need assistance please reach out to me, Ryan oreoc-plans@em.myflorida.com

Kaylynn Perry
Planning Section | State Emergency Response Team
Florida Division of Emergency Management
Kaylynn.perry@em.myflorida.com
PSC desk: (850) 815-4916
Mobile: (850) 254-5657

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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From: Mahon, Jason <Jason.Mahon@em.myflorida.com>
Sent: Friday, January 29, 2021 11:02 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Subject: County Toolkit
Attachment(s): "1.27.21 County FAQs.pdf","1.28.21 Press Release Template.pdf","1.28.21 Registration System Draft Social.pdf","Know Before You Go Graphic.png","Receiving Call Backs Graphic.png","Second Dose Appointments Graphic.png"

Good morning everyone,

As part of the statewide announcement for the preregistration COVID-19 vaccine system, the Division has prepared a Communications Toolkit to assist your announcement efforts.

Attached is language to frequently asked questions, draft social media posts, draft social media responses, graphics and a press release template.

Please let us know if you have any questions.

Best,

Jason

Jason Mahon
Communications Director
Florida Division of Emergency Management
850-815-4131 (desk)
850-294-2169 (cell)
Jason.Mahon@em.myflorida.com

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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Florida COVID-19 Vaccine Registration System

Questions regarding COVID-19, the safety of the vaccine, cases of COVID-19 in the state, etc. can be directed to the State of Florida COVID-19 Call Center: 866-779-6121

General

Who is eligible to receive a vaccine at this site?

At this time, the state is continuing to prioritize vaccines for frontline health care workers and individuals 65 and older to ensure that these populations have access to the vaccine. Individuals who are either frontline health care workers or are 65 and older are eligible to receive a vaccine at a state-supported site.

I have mobility issues, will there be accommodations at the vaccine site?

All state-supported vaccine sites can make accommodations for individuals on site. If an accommodation needs to be made, alert staff on the site when you arrive.

Will there be enough vaccines for my appointment?

The state is continuing to distribute vaccines statewide, daily. The state does not schedule appointments until it is guaranteed there will be enough vaccine on site.

I have a comorbidity/disability, but I'm younger than 65, can I get a vaccine?

Under Governor DeSantis' Executive Order 20-315, hospital providers may vaccinate individuals who they have deemed to be extremely vulnerable to COVID-19. Individuals with a comorbidity or disability who are under the age of 65 are encouraged to reach out to their health care provider to receive a vaccine.

When will I get a call back to schedule a vaccine appointment?

Once an individual calls their designated county number and provides their contact information and date of birth, they are placed in a queue for call backs. An individual will not directly speak with an operator until they receive a call back. Once the individual receives a call back, they will work with the operator to find an open appointment that works best with their schedule. Every eligible individual will receive a call back when appointments become available.

I called the appointment number but didn't speak to a person. How do I ensure I can contact someone to schedule a vaccine appointment?

Once an individual calls their designated county number and provides their contact information and date of birth, they are placed in a queue for call backs. An individual will not directly speak with an operator until they receive a call back. Once the individual receives a call back, they will work with the operator to find an open appointment that works best with their schedule. Every eligible individual will receive a call back when appointments become available.

Second Dose Appointment

I haven't been contacted for my second dose appointment yet. How do I schedule a second dose appointment?

The state is scheduling second dose appointments. Individuals who received their first dose at a state-supported vaccination site will receive a call directly to schedule their second dose appointment. If the operator cannot reach the individual, multiple attempts will be made. As we continue to schedule these appointments, we ask for your patience. All individuals who received a first dose at a state-supported site will be contacted for their second dose appointment.

Can I just show up to the vaccine site on the day listed on my CDC card?

In order to ensure the site can accommodate all individuals asking to receive a vaccine, we ask that you do not go to until you have been contacted. All individuals who received their first dose at a state-supported site will be contacted to schedule their second dose appointment.

I need to update my contact information for my second dose appointment. How do I do that?

We are happy to assist with this request. Please provide us with your updated contact information.

Why can't I make my second dose appointment on site?

The state is working toward a process that will allow individuals to schedule their booster shot appointment on site after receiving their first dose. This process will roll out as the state continues to receive additional vaccine.

Can I get my second dose at a different location?

We ask that individuals receive their second dose at the same location – especially if it is at a state-supported site. Not only does this ensure they receive the correct vaccine, but it assists the state in planning for allocations, staffing needs, appointments, etc.

My second dose appointment is after the day listed on my CDC card. Will the vaccine still be effective?

Per guidance issued by the CDC, the second dose should be administered as close to the recommended interval as possible. However, if it is not feasible to adhere to the recommended interval, the second dose of Pfizer-BioNTech and Moderna COVID-19 vaccines may be scheduled for administration up to 6 weeks (42 days) after the first dose.

What do I need to bring to my second dose appointment?

Individuals need to bring their CDC vaccination card, a form of identification and proof of residency to their second dose appointment.

What do I do if I lost my CDC vaccine card?

It is critical that individuals bring their CDC vaccine card to their second appointment. However, if you have lost this card, individuals on site can access your information. It is important to note, this will delay the process of receiving your second dose and may increase wait time at the site.

Residency

I'm a part-time resident, am I eligible to receive the vaccine?

As per a public health advisory issued by Surgeon General Scott Rivkees, part-time residents are eligible to receive a vaccine in Florida. A part-time resident is any person who temporarily resides in this state for a period of at least 31 consecutive days in each calendar year, maintains a temporary residence in this state, returns to the state or jurisdiction of his or her residence at least one time during each calendar year, and is registered to vote or pays income tax in another state or jurisdiction.

What proof of residency items do I need to bring?

We ask that all individuals bring proof of residency to their vaccine appointment. Examples of proof of residency include:

- A deed, mortgage, monthly mortgage statement, mortgage payment booklet or residential rental or lease agreement.
- One proof of residential address from the seasonal resident's parent, step-parent, legal guardian or other person with whom the seasonal resident resides and a statement from the person with whom the seasonal resident resides stating that the seasonal resident does reside with him or her.
- A utility hookup or work order
- A utility bill, not more than 2 months old
- Mail from a financial institution, including checking, savings, or investment account statements, not more than 2 months old.
- Mail from a federal, state, county, or municipal government agency, not more than 2 months old.

Do you have to be a resident of [County Name] to receive a vaccine?

No, you do not have be a resident of [County Name] to receive a vaccine at a state-supported site. Individuals only need to be a full-time or part-time resident of the state to receive a vaccine at a state-supported site.

Appointments

How do I make an appointment for a vaccine?

Appointments for a vaccine must be made by calling the designated number for your county. The numbers for each county are available here.

I missed the call to schedule my appointment, how do I call them back?

Operators will make multiple attempts to reach an individual. All operators will leave a voicemail indicating that they are calling to assist in scheduling an appointment. Please wait for the follow-up call.

What number will call me back?

The call center will make multiple attempts to reach the individual. Individuals will be called from a number with their county's area code. Operators will leave a voicemail and continue to attempt to reach the individual.

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I need to cancel or change my appointment; can you help me?

If you need to cancel or change your appointment, please call the designated appointment number for your county and wait for an operator to call you back. They will assist in changing your appointment.

I received a call from [number], is this the number that's supposed to call me back?

The call center will make multiple attempts to reach the individual. Individuals will be called from a number with their county's area code. Operators will leave a voicemail and continue to attempt to reach the individual. Remember - operators will never ask you to provide credit card or other financial information. If you are asked to provide this information to schedule a vaccine appointment, please hang up.

Can I schedule an appointment online?

Individuals can pre-register their information online by visiting myvaccine.fl.gov. This website will allow individuals who are eligible to receive the COVID-19 vaccine to be contacted directly when vaccine appointments are available in their area. On the site, residents can select their county and submit their contact information. Once appointments are available, individuals will be contacted by phone call, text or email and will be assisted in scheduling an appointment.

I can't drive myself, can someone come to my appointment with me?

Yes, individuals scheduled for a vaccine appointment can be accompanied by another individual.

What do I need to bring to my vaccine appointment?

Individuals are asked to bring a form of identification and proof of residency to vaccine appointments. Health care workers are asked to bring proof of employment (i.e., badge) and individuals 65 and older are asked to bring proof of birth date.

Can I schedule multiple individuals for an appointment on a phone call?

No. Each individual that needs to schedule an appointment should call the appointment line or visit the appointment website separately. This ensures every individual will be contacted and scheduled for an appointment.

Below is a press release template to use separately from the statewide release

[COUNTY NAME] Participates in Statewide Preregistration System for COVID-19 Vaccine Appointments

[CITY], Fla. - Today, [COUNTY] announced that the statewide preregistration system to schedule COVID-19 vaccine appointments for individuals 65 and older and frontline health care workers, is now available to [COUNTY] residents.

Individuals can now pre-register for vaccine appointments and be notified when appointments are available in their area by visiting myvaccine.fl.gov or by calling XXX-XXX-XXXX.

[QUOTE FROM LOCAL OFFICIALS HERE]

This website will allow individuals who are eligible to receive the COVID-19 vaccine to be proactively contacted when vaccine appointments are available in the county. On the site, residents can select [COUNTY NAME] and submit their contact information.

Once appointments are available, individuals will be contacted by phone call, text or email and will be assisted in scheduling an appointment.

Vaccine supply remains limited and appointments may not be available for several weeks.

Additionally, as part of the statewide preregistration system, each county has a designated number that individuals can call and pre-register with if they do not have Internet access. [COUNTY NAME]'s designated number is XXX-XXX-XXXX.

The statewide preregistration system also provides each county with a designated help line number. This help line will connect individuals directly with an operator an answer questions regarding the preregistration system. [COUNTY NAME]'s help line number is XXX-XXX-XXXX.

For additional information, please visit [COUNTY WEBSITE] and FloridaHealthCOVID19.gov.

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Below are suggested social media posts and responses for communication with constituents

Social Media Posts

- The state of Florida has developed a statewide COVID-19 vaccine registration system. To schedule a vaccine appointment, call xxx-xxx-xxxx or visit myvaccine.fl.gov. All eligible individuals will be contacted when appointments are available.

- ICYMI: Individuals can pre-register for vaccine appointments & be notified when appointments are available in their area by visiting myvaccine.fl.gov. On the site, residents can submit their contact information. Individuals will be contacted by phone call, text or email.

- As part of the statewide COVID-19 vaccine registration system, individuals without internet access can schedule an appointment by calling xxx-xxx-xxxx. All eligible individuals will receive a call back from an operator when appointments are available.

- If you have questions about the statewide vaccine registration system - call the help line. There is a separate phone number for questions that will connect you to an operator immediately. Help line number is available here - XXX-XXX-XXXX.

- [COUNTY NAME] is participating in the statewide COVID-19 vaccine registration system. Eligible individuals can make an appointment either by calling xxx-xxx-xxxx or by visiting myvaccine.fl.gov. Learn more - [LINK TO PRESS RELEASE]

- [COUNTY NAME] is participating in the statewide registration system. Below is helpful information to know before scheduling your appointment. – *Attach with Know Before You Call Graphic*

Social Media Responses

How can I make an appointment?

At this time, state-supported sites are vaccinating frontline health care workers & individuals 65 and older. To schedule an appointment, please call xxx-xxx-xxxx or visit myvaccine.fl.gov. You will receive a call back when appointments are available.

When will I receive a call back?

If you have pre-registered your information through the website or call center & you are eligible to receive a vaccine, you will be contacted when appointments are available in your area. We ask for your patience during this time as we continue to schedule more appointments.

I need to schedule my second dose appointment, when will someone contact me?

The call center is actively contacting individuals for their second dose appointments. All individuals who received their first dose will be contacted. If the operator cannot reach the individual, multiple attempts will be made.

I haven't been contacted to schedule my second dose appointment; can I just show up to the site?

Please do not go to the site without a confirmed appointment. If you show up without an appointment, you will not be able to receive a vaccine. All eligible individuals will be directly contacted to schedule their appointments.

Are part-time residents eligible to schedule an appointment?

Part-time residents are eligible to receive a vaccine in Florida. If you are a part-time resident, you will need to bring proof of residency to your appointment. Below is a graphic with examples of proof of residency. – *Attach with Proof of Residency Graphic*

Can I schedule my first dose & second dose appointment at the same time?

The state is working toward a process that will allow individuals to schedule their booster shot appointment on site after receiving their first dose. This process will roll out as the state continues to receive additional vaccine.

Why can't I talk to an operator?

Once an individual provides their contact information, they are placed in a queue for call backs. An individual won't speak with an operator until they receive a call back. Once the individual receives a call back, they will work with the operator to schedule an appointment.

Is the registration system available in Spanish?

Yes - the statewide registration system is available in English and Spanish. The state is continuing to add additional languages on a rolling basis.

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Do I need to be a resident of [COUNTY] to schedule an appointment?

No, you do not have be a resident of [County Name] to receive a vaccine at a state-supported site. Individuals only need to be a full-time or part-time resident of the state to receive a vaccine at a state-supported site.

My second dose appointment is after the day listed on my CDC card. Will the vaccine still be effective?

Per guidance issued by the CDC, the second dose should be administered as close to the recommended interval as possible. However, the second dose of Pfizer-BioNTech and Moderna COVID-19 vaccines may be scheduled for administration up to 6 weeks (42 days) after the first dose.

KNOW BEFORE YOU CALL

MAKING COVID-19 VACCINATION APPOINTMENTS AT STATE-SUPPORTED SITES

TO PREREGISTER, VISIT MYVACCINE.FL.GOV

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WAYS TO RECEIVE A CALL-BACK FOR VACCINE APPOINTMENT SCHEDULING

How eligible individuals will be contacted after pre-registering

WHEN VACCINE APPOINTMENTS ARE AVAILABLE

CALL

Several attempts will be made to call-back an individual for appointment scheduling. A voicemail will be left if the individual does not answer.

TEXT

Representatives may reach out to eligible individuals via text to assist in appointment scheduling.

EMAIL

Representatives may reach out to eligible individuals via email and provide a call-back number to assist in appointment scheduling.

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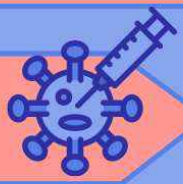
SECOND DOSE VACCINATION APPOINTMENT INFORMATION

Scheduling booster appointments at state-supported sites

All eligible individuals will be contacted via phone, text or email for second dose scheduling as appointments become available.

If you have not received a call-back, please remain patient. Do not arrive at the vaccination site prior to receiving a confirmed appointment.



Arrive at your second dose appointment on time. Remember to bring your CDC appointment card, a form of identification and proof of residency.

To preregister for available appointments, visit MyVaccine.FL.gov

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From: Perry, Kaylynn <Kaylynn.Perry@em.myflorida.com>
Sent: Tuesday, February 02, 2021 10:03 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: EOC-Plans <EOC-Plans@em.myflorida.com>
Subject: County Vaccine Roll-Up 2-2-21
Attachment(s): "County Vaccine Site Roll-Up 2-2-21.pdf"

Good evening,

Attached is the County Vaccine Roll-Up for 2-2-21.

This is the first iteration of this report, so if there are any errors or changes that need to be made let me know and we can work on them tomorrow. If there are any errors in the doses reported I can go in and change it on the back end. Once we establish county access you will be able to do this as well.
Additionally, if your to-date totals do not accurately reflect your site, you can change the date in the survey to enter vaccines administered for past days. This is the only way to enter back-dated information. If you need help establishing when your jurisdiction began reporting into salesforce I can look it up.

Please let me know if you need anything else.

Thanks,
Kaylynn Perry
Planning Section | State Emergency Response Team
Florida Division of Emergency Management
Kaylynn.perry@em.myflorida.com
PSC desk: (850) 815-4916
Mobile: (850) 254-5657

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

AMERICAN OVERSIGHT

State Vaccine Site Roll-Up 2/02/2021

	2/2/2021	To-Date
Total Doses Administered:	**50,878**	**575,339**
Pharmacy	-	**-**
State-Run POD	3,627	**54,147**
55+ Community POD	3,167	**42,702**
County/CHD POD	44,084	**471,307**
Faith-Based POD	-	**7,183**

County	Site	POD Type	1st Dose	2nd Dose	Doses Administered Today	To-Date Administered
Alachua	DOH-Alachua County	County/CHD POD	5	327	332	7,150
Baker	DOH-Baker	County/CHD POD	-	-	-	580
Bay	DOH-Bay	County/CHD POD	267	21	288	1,222
Bradford	DOH-Bradford	County/CHD POD	240	-	240	881
Brevard	DOH-Brevard (Viera)	County/CHD POD	11	563	574	7,548
Broward	Coral Springs - Coral Square Mall	County/CHD POD	406	414	820	5,726
Broward	Coral Square Mall	County/CHD POD	-	-	-	-
Broward	Trade Winds Park	County/CHD POD	156	808	964	10,245
Broward	Vista View Park	County/CHD POD	8	754	762	8,893
Broward	DOH-Broward	County/CHD POD	173	49	222	2,362
Broward	Sunrise Lakes	County/CHD POD	-	-	-	2,386
Calhoun	DOH-Calhoun	County/CHD POD	2	9	11	245
Charlotte	Harold Ave Park	County/CHD POD	-	-	-	2,424
Citrus	DOH-Citrus	County/CHD POD	-	-	-	4,353
Clay	DOH-Clay	County/CHD POD	-	-	-	2,679
Collier	North Collier Regional Park	County/CHD POD	-	-	-	6,673
Desoto	Agri Turner Civic Center	County/CHD POD	-	-	-	764
Dixie	DOH-Dixie	County/CHD POD	-	-	-	201
Duval	Prime Osborn Convention Center	County/CHD POD	-	-	-	-
Escambia	DOH-Escambia	County/CHD POD	-	55	55	5,770
Flagler	Flagler County Fairgrounds	County/CHD POD	2	508	510	2,510
Franklin	DOH-Franklin	County/CHD POD	1	60	61	443
Gadsden	DOH-Gadsden / FLNG Gadsden Armory	County/CHD POD	-	-	-	523
Gilchrist	DOH-Gilchrist	County/CHD POD	106	88	194	773
Glades	DOH-Glades	County/CHD POD	-	-	-	230
Gulf	DOH-Gulf	County/CHD POD	-	70	70	713
Hamilton	DOH-Hamilton	County/CHD POD	998	-	998	7,866
Hardee	Vacant Building 1499 US 17	County/CHD POD	-	-	-	475
Hardee	DOH-Hardee	County/CHD POD	-	-	-	951
Hendry	DOH-Hendry Clewiston	County/CHD POD	-	293	293	892
Hendry	DOH-Hendry Labelle	County/CHD POD	-	-	-	150
Hernando	DOH-Hernando	County/CHD POD	743	105	848	4,007
Highlands	Lakeshore Mall	County/CHD POD	-	-	-	2,942
Holmes	DOH-Holmes	County/CHD POD	6	514	520	1,215
Indian River	IR Fairgrounds	County/CHD POD	-	450	450	3,675
Jackson	DOH-Jackson	County/CHD POD	-	-	-	1,249
Jefferson	DOH-Jefferson	County/CHD POD	291	1	292	553
Lee	Southwest Florida International Airport	County/CHD POD	-	-	-	14,601
Leon	DOH-Leon	County/CHD POD	-	854	854	6,263
Levy	DOH-Levy	County/CHD POD	-	107	107	988
Liberty	DOH-Liberty	County/CHD POD	-	-	-	205
Madison	Van H Priest Auditorium	County/CHD POD	86	106	192	2,539
Marion	Paddock Mall	County/CHD POD	-	-	-	13,145
Marion	Heart of Florida Health Centers	County/CHD POD	-	-	-	-
Marion	DOH-Marion	County/CHD POD	-	-	-	-
Martin	DOH - Martin	County/CHD POD	-	211	211	2,317
Monroe	DOH-Monroe	County/CHD POD	-	-	-	253
Nassau	DOH-Nassau	County/CHD POD	-	-	-	2,423
Okaloosa	DOH-Okaloosa	County/CHD POD	2	428	430	5,343
Okeechobee	DOH-Okeechobee	County/CHD POD	-	-	-	653
Orange	Orange County Covention Center	County/CHD POD	-	-	-	18,061
Osceola	Centro Cristiano Dios De Pactos Church	County/CHD POD	9	811	820	7,254
Osceola	DOH-Osceola	County/CHD POD	-	-	-	533
Pasco	St. Leo University	County/CHD POD	-	-	-	4,847
Pinellas	Palm Harbor	County/CHD POD	358	-	358	4,269
Pinellas	DOH-Pinellas (Mid County)	County/CHD POD	-	111	111	111
Pinellas	Pinellas Park	County/CHD POD	-	-	-	-
Pinellas	DOH-Pinellas (Clearwater)	County/CHD POD	-	119	119	119
Pinellas	Highland Rec Complex	County/CHD POD	-	-	-	-

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Pinellas	DOH-Pinellas (St. Petersburg)	County/CHD POD	-	119	119	119
Putnam	Putnam County Fairgrounds	County/CHD POD	-	679	679	1,894
Santa Rosa	DOH-Santa Rosa	County/CHD POD	193	115	308	2,576
Sarasota	Twin Lakes Park	County/CHD POD	-	-	-	2,760
St. Johns	Solomon Calhoun Community Center	County/CHD POD	-	225	225	10,712
St. Lucie	St. Lucie Fairgrounds	County/CHD POD	-	-	-	-
Sumter	DOH-Sumter (Villages)	County/CHD POD	-	-	-	-
Sumter	DOH-Sumter (Wildwood)	County/CHD POD	244	-	244	2,177
Suwannee	Suwannee County Health Department	County/CHD POD	-	-	-	5,415
Taylor	DOH-Taylor	County/CHD POD	-	-	-	400
Union	DOH-Union	County/CHD POD	210	-	210	500
Union	Union County Hospital	County/CHD POD	-	-	-	-
Wakulla	DOH-Wakulla	County/CHD POD	-	-	-	649
Walton	Gene Hurley Park	County/CHD POD	-	-	-	1,100
Washington	First Baptist Church of Chipley	County/CHD POD	-	-	-	750
Total			**4,517**	**8,974**	**13,491**	**212,245**

AMERICAN OVERSIGHT

From: Perry, Kaylynn <Kaylynn.Perry@em.myflorida.com>
Sent: Thursday, February 04, 2021 8:37 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: EOC-Plans <EOC-Plans@em.myflorida.com>
Subject: County Vaccine Roll-Up 2-3-21
Attachment(s): "County Vaccine Site Roll-Up 2-3-21.pdf"

Good morning all,

Attached is the roll-up for county POD vaccinations for 2-3-21. We will be sending this out in the morning to allow sites more time to input results to be included in this report.

Additionally, the scope of this report has changed to become inclusive of ALL vaccine operations within the state. With that said, the SERT Planning Section will be working to enter daily vaccine numbers for sites prior to the implementation of this report and input sites that have not been included previously.

In order to assist with this, please:

- Review the attached document
- Email myself, Ryan or eoc-plans@em.myflorida.com letting us know any additional POD sites operational within your jurisdiction including the following:
  - Site Name
  - Site Type (CHD POD, Community POD, Mobile Clinic, Hospital POD)
  - Site POC
- Email myself, Ryan or eoc-plans@em.myflorida.com letting us know which sites the to-date counts are incomplete and include the following:
  - Site Name
  - Vaccinations by date, type (Moderna or Pfizer) and dose (first or second)

The county dashboard to access, review, and edit this data is in final review, so we would like to get it as complete as possible for you all prior to launch.

Thanks,

Kaylynn Perry
Planning Section | State Emergency Response Team
Florida Division of Emergency Management
Kaylynn.perry@em.myflorida.com
PSC desk: (850) 815-4916
Mobile: (850) 254-5657

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AMERICAN OVERSIGHT

State Vaccine Site Roll-Up 2/03/2021

	2/3/2021	To-Date
Total Doses Administered:	**55,736**	**703,236**
Pharmacy	-	**-**
State-Run POD	5,541	**60,998**
55+ Community POD	1,085	**43,787**
County/CHD POD	49,110	**590,698**
Faith-Based POD	-	**7,753**

County	Site	POD Type	1st Dose	2nd Dose	Doses Administered Today	To-Date Administered
Alachua	DOH-Alachua County	County/CHD POD	64	396	460	7,610
Baker	DOH-Baker	County/CHD POD	-	-	-	660
Bay	DOH-Bay	County/CHD POD	4	121	125	1,347
Bradford	DOH-Bradford	County/CHD POD	233	-	233	1,114
Brevard	DOH-Brevard (Viera)	County/CHD POD	311	716	1,027	8,575
Broward	Coral Springs - Coral Square Mall	County/CHD POD	432	544	976	6,702
Broward	Coral Square Mall	County/CHD POD	-	-	-	-
Broward	Trade Winds Park	County/CHD POD	150	800	950	11,195
Broward	Holiday Park	County/CHD POD	-	-	-	9,883
Broward	Vista View Park	County/CHD POD	569	612	1,181	10,074
Broward	Markham Park	County/CHD POD	18	1,488	1,506	13,595
Broward	Central Broward Regional Park	County/CHD POD	613	419	1,032	11,807
Broward	DOH-Broward	County/CHD POD	294	54	348	2,710
Broward	Broward County Soccer Stadium	County/CHD POD	506	482	988	8,282
Broward	Sunrise Lakes	County/CHD POD	-	-	-	2,386
Calhoun	DOH-Calhoun	County/CHD POD	273	3	276	521
Charlotte	Harold Ave Park	County/CHD POD	401	239	640	3,944
Citrus	DOH-Citrus	County/CHD POD	-	-	-	4,353
Clay	DOH-Clay	County/CHD POD	564	5	569	3,808
Collier	North Collier Regional Park	County/CHD POD	-	-	-	6,673
Collier	Physicians Regional Medical Center - Collier	County/CHD POD	-	-	-	677
Columbia	Southside Sports Complex	County/CHD POD	-	-	-	25,779
Desoto	Agri Turner Civic Center	County/CHD POD	-	-	-	1,664
Dixie	DOH-Dixie	County/CHD POD	-	-	-	463
Duval	Regency Mall (State Run Site)	State-Run POD	1,080	1	1,081	15,045
Duval	Prime Osborn Convention Center	County/CHD POD	-	-	-	-
Duval	Prime Osborne	County/CHD POD	-	1,000	1,000	1,000
Escambia	DOH-Escambia	County/CHD POD	-	43	43	5,813
Flagler	Flagler County Fairgrounds	County/CHD POD	397	-	397	2,907
Franklin	DOH-Franklin	County/CHD POD	-	70	70	513
Gadsden	DOH-Gadsden / FLNG Gadsden Armory	County/CHD POD	-	-	-	523
Gilchrist	DOH-Gilchrist	County/CHD POD	101	87	188	961
Glades	DOH-Glades	County/CHD POD	-	445	445	675
Gulf	DOH-Gulf	County/CHD POD	-	60	60	773
Hamilton	DOH-Hamilton	County/CHD POD	-	-	-	7,866
Hardee	Vacant Building 1499 US 17	County/CHD POD	-	-	-	475
Hardee	DOH-Hardee	County/CHD POD	22	135	157	1,108
Hendry	Labelle 250 and Clewiston 250	County/CHD POD	-	-	-	892
Hendry	DOH-Hendry Labelle	County/CHD POD	-	-	-	150
Hernando	DOH-Hernando	County/CHD POD	723	125	848	4,855
Highlands	Lakeshore Mall	County/CHD POD	-	-	-	2,942
Hillsborough	University Mall	State-Run POD	1,612	-	1,612	10,040
Holmes	DOH-Holmes	County/CHD POD	-	-	-	1,215
Indian River	IR Fairgrounds	County/CHD POD	-	491	491	4,166
Jackson	DOH-Jackson	County/CHD POD	15	235	250	1,499
Jefferson	DOH-Jefferson	County/CHD POD	107	195	302	855
Lafayette	DOH-Lafayette	County/CHD POD	1,293	109	1,402	8,400
Lake	Clermont Arts and Recreation Center	County/CHD POD	-	-	-	18,584
Lake	Lake Square Mall	County/CHD POD	916	3,458	4,374	4,374
Lee	Southwest Florida International Airport	County/CHD POD	-	3,284	3,284	17,885
Leon	DOH-Leon	County/CHD POD	-	-	-	6,263
Levy	DOH-Levy	County/CHD POD	-	101	101	1,089
Liberty	DOH-Liberty	County/CHD POD	250	-	250	455
Madison	Van H Priest Auditorium	County/CHD POD	92	126	218	2,757

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Manatee	Tom Bennett Park	County/CHD POD	1,682	4	1,686	17,533
Marion	Paddock Mall	County/CHD POD	845	-	845	14,899
Marion	Heart of Florida Health Centers	County/CHD POD	-	-	-	-
Marion	DOH-Marion	County/CHD POD	-	-	-	-
Marion	Advent Health Ocala	County/CHD POD	-	-	-	2,131
Marion	Ocala Health	County/CHD POD	-	-	-	4,189
Martin	DOH - Martin	County/CHD POD	-	180	180	2,497
Miami-Dade	Hard Rock	State-Run POD	948	810	1,758	24,344
Miami-Dade	Marlin Stadium	State-Run POD	1,089	1	1,090	11,569
Miami-Dade	Jackson Memorial (3 PODs)	County/CHD POD	1,282	2,319	3,601	50,002
Monroe	DOH-Monroe	County/CHD POD	6	246	252	816
Nassau	DOH-Nassau	County/CHD POD	51	51	102	2,525
Okaloosa	DOH-Okaloosa	County/CHD POD	167	177	344	5,687
Okeechobee	DOH-Okeechobee	County/CHD POD	-	290	290	943
Orange	Disney's Typhoon Lagoon	County/CHD POD	-	-	-	-
Orange	DOH-Orange	County/CHD POD	-	-	-	3,379
Orange	Orange County Covention Center	County/CHD POD	-	-	-	54,606
Osceola	Centro Cristiano Dios De Pactos Church	County/CHD POD	950	21	971	9,036
Osceola	DOH-Osceola	County/CHD POD	-	-	-	533
Palm Beach	South Florida Fairgrounds	County/CHD POD	1,556	-	1,556	16,292
Pasco	St. Leo University	County/CHD POD	685	-	685	5,532
Pasco	Sears Gulf View Mall Location	County/CHD POD	-	-	-	3,740
Pasco	Pasco-Location Pending	County/CHD POD	-	-	-	-
Pinellas	Palm Harbor	County/CHD POD	351	-	351	4,620
Pinellas	DOH-Pinellas (Mid County)	County/CHD POD	-	97	97	208
Pinellas	Pinellas Park	County/CHD POD	484	-	484	5,465
Pinellas	DOH-Pinellas (Clearwater)	County/CHD POD	-	121	121	240
Pinellas	Highland Rec Complex	County/CHD POD	359	-	359	4,314
Pinellas	DOH-Pinellas (St. Petersburg)	County/CHD POD	-	115	115	234
Pinellas	Center for Health Equity	County/CHD POD	851	-	851	10,466
Polk	DOH-Polk	County/CHD POD	588	450	1,038	15,008
Putnam	Putnam County Fairgrounds	County/CHD POD	-	499	499	2,393
Santa Rosa	DOH-Santa Rosa	County/CHD POD	213	131	344	2,920
Sarasota	Sarasota Square Mall	County/CHD POD	1,530	-	1,530	4,290
Sarasota	DOH-Sarasota	County/CHD POD	-	-	-	6,703
Seminole	Oveido Mall (Sears storefront)	County/CHD POD	662	1,252	1,914	23,354
St. Johns	Solomon Calhoun Community Center	County/CHD POD	1,248	-	1,248	11,960
St. Lucie	DOH-St. Lucie	County/CHD POD	3	1,849	1,852	13,615
St. Lucie	St. Lucie Fairgrounds	County/CHD POD	-	-	-	-
Sumter	DOH-Sumter (Villages)	County/CHD POD	-	-	-	-
Sumter	UF Health The Villages	County/CHD POD	-	-	-	1,240
Sumter	DOH-Sumter (Wildwood)	County/CHD POD	-	315	315	2,492
Suwannee	DOH-Suwannee	County/CHD POD	2,195	132	2,327	17,318
Taylor	DOH-Taylor	County/CHD POD	30	450	480	880
Union	DOH-Union	County/CHD POD	-	-	-	500
Union	Lake Butler Hospital	County/CHD POD	2	30	32	32
Volusia	Volusia County Fairgrounds	County/CHD POD	-	-	-	22,340
Wakulla	DOH-Wakulla	County/CHD POD	-	-	-	649
Walton	Gene Hurley Park	County/CHD POD	-	-	-	1,100
Washington	First Baptist Church of Chipley	County/CHD POD	7	443	450	1,200
Total			**28,824**	**25,827**	**54,651**	**651,696**

AMERICAN OVERSIGHT

From: Perry, Kaylynn <Kaylynn.Perry@em.myflorida.com>
Sent: Friday, February 05, 2021 8:58 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: EOC-Plans <EOC-Plans@em.myflorida.com>
Subject: County Vaccine Site Roll-Up 2-4-2021
Attachment(s): "County Vaccine Site Roll-Up 2-4-21.pdf"

Good morning all,

Attached is the County/CHD Site Roll-Up from Salesforce.

We are still working to back-date the data so if you have not reached out to us on any information missing from your jurisdiction, please do so we can get it entered.

Kaylynn Perry
Planning Section | State Emergency Response Team
Florida Division of Emergency Management
Kaylynn.perry@em.myflorida.com
PSC desk: (850) 815-4916
Mobile: (850) 254-5657

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AMERICAN OVERSIGHT

State Vaccine Site Roll-Up 2/04/2021

	2/4/2021	To-Date
Total Doses Administered:	**68,779**	**812,962**
Pharmacy	-	**10,582**
State-Run POD	4,708	**77,358**
55+ Community POD	1,076	**44,863**
County/CHD POD	60,959	**670,370**
Faith-Based POD	2,036	**9,789**

County	Site	POD Type	1st Dose	2nd Dose	Doses Administered Today	To-Date Administered
Alachua	DOH-Alachua County	County/CHD POD	613	1,212	1,825	21,882
Baker	DOH-Baker	County/CHD POD	40	-	40	700
Bay	DOH-Bay	County/CHD POD	231	35	266	1,613
Bradford	DOH-Bradford	County/CHD POD	-	-	-	1,114
Brevard	DOH-Brevard (Viera)	County/CHD POD	195	725	920	9,495
Broward	Coral Springs - Coral Square Mall	County/CHD POD	381	561	942	7,644
Broward	Trade Winds Park	County/CHD POD	59	949	1,008	12,203
Broward	Holiday Park	County/CHD POD	324	1,098	1,422	11,305
Broward	Vista View Park	County/CHD POD	512	958	1,470	11,544
Broward	Markham Park	County/CHD POD	5	1,297	1,302	14,897
Broward	Central Broward Regional Park	County/CHD POD	263	541	804	12,611
Broward	DOH-Broward	County/CHD POD	222	55	277	2,987
Broward	Broward County Soccer Stadium	County/CHD POD	371	685	1,056	11,953
Broward	Sunrise Lakes	County/CHD POD	-	-	-	2,386
Calhoun	DOH-Calhoun	County/CHD POD	82	273	355	876
Charlotte	Harold Ave Park	County/CHD POD	10	260	270	4,214
Citrus	DOH-Citrus	County/CHD POD	-	-	-	4,353
Clay	DOH-Clay	County/CHD POD	323	205	528	3,999
Collier	North Collier Regional Park	County/CHD POD	-	-	-	6,673
Collier	Physicians Regional Medical Center - Collier	County/CHD POD	-	-	-	677
Columbia	Southside Sports Complex	County/CHD POD	3,682	1,132	4,814	30,593
Desoto	Agri Turner Civic Center	County/CHD POD	-	540	540	2,204
Dixie	DOH-Dixie	County/CHD POD	-	-	-	463
Duval	Prime Osborn Convention Center	County/CHD POD	1	980	981	981
Duval	Prime Osborne	County/CHD POD	-	-	-	1,000
Escambia	DOH-Escambia	County/CHD POD	-	-	-	5,813
Flagler	Flagler County Fairgrounds	County/CHD POD	394	366	760	3,709
Franklin	DOH-Franklin	County/CHD POD	-	-	-	513
Gadsden	DOH-Gadsden / FLNG Gadsden Armory	County/CHD POD	-	-	-	523
Gilchrist	DOH-Gilchrist	County/CHD POD	97	81	178	1,139
Glades	DOH-Glades	County/CHD POD	-	-	-	675
Gulf	DOH-Gulf	County/CHD POD	446	135	581	1,354
Hamilton	DOH-Hamilton	County/CHD POD	998	-	998	8,864
Hardee	Vacant Building 1499 US 17	County/CHD POD	2	146	148	780
Hardee	DOH-Hardee	County/CHD POD	-	-	-	951
Hendry	Labelle 250 and Clewiston 250	County/CHD POD	-	-	-	892
Hendry	DOH-Hendry Labelle	County/CHD POD	240	140	380	530
Hernando	DOH-Hernando	County/CHD POD	-	-	-	5,354
Highlands	Lakeshore Mall	County/CHD POD	821	-	821	3,763
Holmes	DOH-Holmes	County/CHD POD	497	3	500	4,044
Indian River	IR Fairgrounds	County/CHD POD	-	462	462	4,628
Jackson	DOH-Jackson	County/CHD POD	461	2	463	5,755
Jefferson	DOH-Jefferson	County/CHD POD	47	138	185	1,040
Lafayette	DOH-Lafayette	County/CHD POD	-	-	-	8,400
Lake	Clermont Arts and Recreation Center	County/CHD POD	-	-	-	18,584
Lake	Lake Square Mall	County/CHD POD	3,450	1,108	4,558	8,932

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Lee	Southwest Florida International Airport	County/CHD POD	10	1,960	1,970	19,855
Leon	DOH-Leon	County/CHD POD	-	-	-	6,263
Levy	DOH-Levy	County/CHD POD	-	112	112	1,201
Liberty	DOH-Liberty	County/CHD POD	48	272	320	775
Madison	Van H Priest Auditorium	County/CHD POD	-	220	220	2,977
Manatee	Tom Bennett Park	County/CHD POD	1,652	1	1,653	19,186
Marion	Paddock Mall	County/CHD POD	201	848	1,049	15,948
Marion	Advent Health Ocala	County/CHD POD	-	-	-	2,131
Marion	Ocala Health	County/CHD POD	-	-	-	4,189
Martin	DOH - Martin	County/CHD POD	54	206	260	2,757
Miami-Dade	Jackson Memorial (3 PODs)	County/CHD POD	1,714	2,019	3,733	53,735
Monroe	DOH-Monroe	County/CHD POD	100	-	100	916
Nassau	DOH-Nassau	County/CHD POD	77	44	121	2,646
Okaloosa	DOH-Okaloosa	County/CHD POD	-	-	-	5,687
Okeechobee	DOH-Okeechobee	County/CHD POD	500	-	500	1,443
Orange	DOH-Orange	County/CHD POD	-	-	-	3,379
Orange	Orange County Covention Center	County/CHD POD	571	1,763	2,334	56,940
Osceola	Centro Cristiano Dios De Pactos Church	County/CHD POD	-	780	780	9,816
Osceola	DOH-Osceola	County/CHD POD	-	-	-	533
Palm Beach	South Florida Fairgrounds	County/CHD POD	1,542	-	1,542	17,834
Pasco	St. Leo University	County/CHD POD	-	-	-	5,532
Pasco	Sears Gulf View Mall Location	County/CHD POD	-	1,247	1,247	4,987
Pasco	Pasco-Location Pending	County/CHD POD	1	54	55	99
Pinellas	Palm Harbor	County/CHD POD	355	-	355	4,975
Pinellas	DOH-Pinellas (Mid County)	County/CHD POD	-	119	119	2,089
Pinellas	Pinellas Park	County/CHD POD	452	-	452	5,917
Pinellas	DOH-Pinellas (Clearwater)	County/CHD POD	-	114	114	2,377
Pinellas	Highland Rec Complex	County/CHD POD	368	-	368	4,682
Pinellas	DOH-Pinellas (St. Petersburg)	County/CHD POD	-	112	112	346
Pinellas	Center for Health Equity	County/CHD POD	865	-	865	11,331
Polk	DOH-Polk	County/CHD POD	2,849	428	3,277	18,285
Putnam	Putnam County Fairgrounds	County/CHD POD	481	3	484	2,877
Santa Rosa	DOH-Santa Rosa	County/CHD POD	200	174	374	3,294
Sarasota	Sarasota Square Mall	County/CHD POD	10	1,860	1,870	6,160
Sarasota	DOH-Sarasota	County/CHD POD	-	-	-	6,703
Seminole	Oveido Mall (Sears storefront)	County/CHD POD	692	642	1,334	24,688
St. Johns	Solomon Calhoun Community Center	County/CHD POD	-	389	389	12,349
St. Lucie	DOH-St. Lucie	County/CHD POD	-	151	151	13,766
Sumter	DOH-Sumter (Villages)	County/CHD POD	456	-	456	456
Sumter	UF Health The Villages	County/CHD POD	-	-	-	1,240
Sumter	DOH-Sumter (Wildwood)	County/CHD POD	-	-	-	2,492
Suwannee	DOH-Suwannee	County/CHD POD	2,278	254	2,532	19,850
Taylor	DOH-Taylor	County/CHD POD	-	-	-	880
Union	DOH-Union	County/CHD POD	-	-	-	705
Union	Lake Butler Hospital	County/CHD POD	-	-	-	32
Volusia	Volusia County Fairgrounds	County/CHD POD	1,050	900	1,950	15,360
Wakulla	DOH-Wakulla	County/CHD POD	423	4	427	1,076
Walton	Gene Hurley Park	County/CHD POD	-	-	-	1,100
Washington	First Baptist Church of Chipley	County/CHD POD	479	1	480	3,151
Washington	DOH-Washington	County/CHD POD	-	-	-	750
Total			**32,195**	**28,764**	**60,959**	**670,370**

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From: Godsey, Amy <Amy.Godsey@em.myflorida.com>
Sent: Wednesday, December 23, 2020 1:14 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: DEM FL State Agency ECOs <ECO_Agency@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>; DEM All Staff <DEM@em.myflorida.com>
Subject: Courtesy Copy: ***FYI: Severe Weather Possible Thursday***
Attachment(s): "12-23-20 Severe Weather Update.pdf"

AMERICAN OVERSIGHT

FDEM Header

This update is intended for government and emergency response officials, and is provided for informational and situational awareness purposes only. Forecast conditions are subject to change based on a variety of environmental factors. For additional information, or for any life safety concerns with an active weather event please contact your local National Weather Service forecast office.

New users wishing to subscribe (approval pending) to this list can click here: https://public.govdelivery.com/accounts/FLDEM/subscriber/new?topic_id=Weather_Briefing_Packets

You are subscribed to Non-Tropical Weather Briefing Packets for Florida Division of Emergency Management. This information has recently been updated, and is now available.

spc1	spc2

- **12-23-20 Severe Weather Update.pdf**

•**What**: A strong cold front will bring a threat of severe weather, including damaging wind gusts, heavy rainfall, and isolated tornadoes. Coldest air of the season so far moves in behind the front.
•**Where**: Slight Risk (level 2 of 5) for the western Panhandle, Marginal Risk (level 1 of 5) for the eastern Panhandle, Big Bend, Northeast Florida, Central Florida and South Florida (generally north of Alligator Alley).
•**When**: Panhandle – Thursday morning; Big Bend – Thursday afternoon; Peninsula – Thursday evening
•**Potential Impacts**:

- •Damaging wind gusts around 45-65mph and a couple of tornadoes may cause power outages, downed trees/limbs, and damage to weak structures (such as mobile/manufactured homes). Temporary structures will be more susceptible to the severe weather.
- •Heavy rain could cause temporary flooding of roadways and rising of creeks and rivers.
- •Cold air could harm animals and sensitive vegetation such as flowers and citrus.

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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WEATHER UPDATE

1:00 PM EST

Wednesday, December 23, 2020

Severe Weather Threat Thursday

Statewide

This update is intended for government and emergency response officials, and is provided for informational and situational awareness purposes only. Forecast conditions are subject to change based on a variety of environmental factors. For additional information, or for any life safety concerns with an active weather event please contact your County Emergency Management or Public Safety Office, local National Weather Service forecast office at www.weather.gov, or visit the Storm Prediction Center website at spc.noaa.gov.

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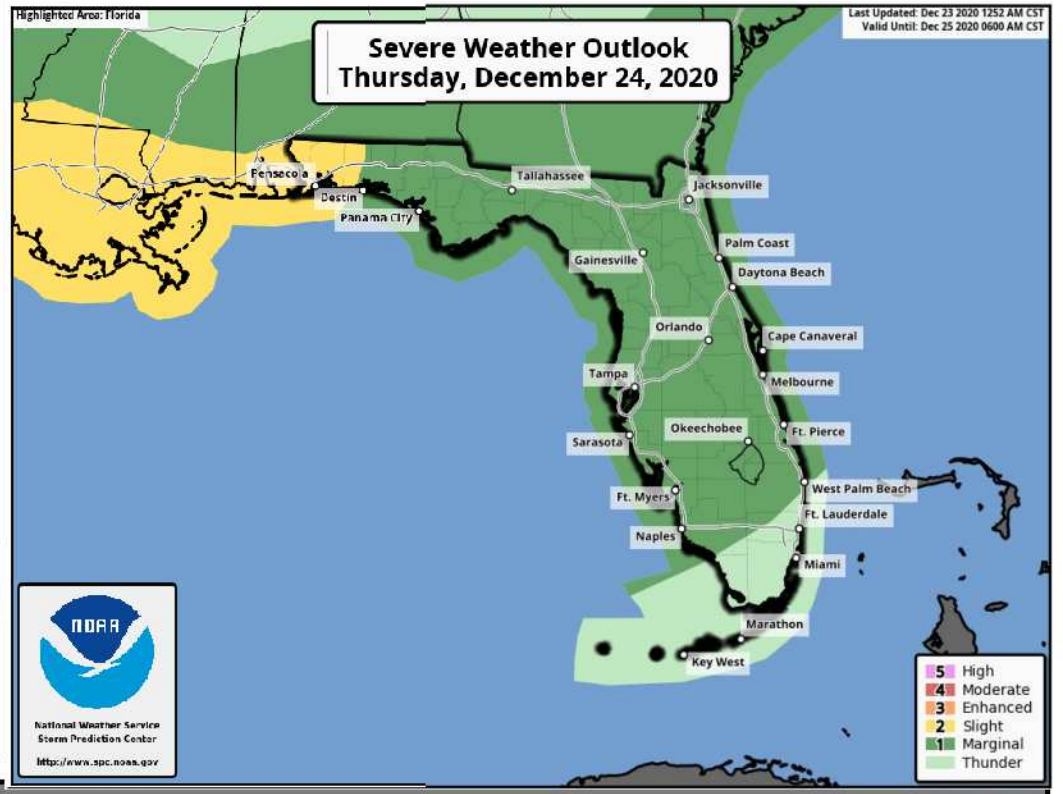
Severe Threat Overview

Florida Threats & Summary

	Marginal	Slight	Enhanced	Moderate	High
Severe Risk					
Tornado	Eastern Panhandle	Western Panhandle			
Damaging Winds	Elsewhere	Western Panhandle			
Hail					

	Marginal	Slight	Moderate	High
Flash Flooding				

Storm Prediction Center Map



Overview/Recent Changes:

A strong cold front will move through the Panhandle Thursday morning and through the Peninsula in the afternoon/evening. The primary hazard is damaging wind gusts (50-65mph) and brief heavy rainfall, but isolated tornadoes are also possible in the Panhandle and Big Bend.

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Severe Thunderstorm Risk Categories

Understanding the Storm Prediction Center Risk Scale

Understanding Severe Thunderstorm Risk Categories

THUNDERSTORMS (no label)	1 - MARGINAL (MRGL)	2 - SLIGHT (SLGT)	3 - ENHANCED (ENH)	4 - MODERATE (MDT)	5 - HIGH (HIGH)
No severe* thunderstorms expected	**Isolated severe thunderstorms possible**	**Scattered severe storms possible**	**Numerous severe storms possible**	**Widespread severe storms likely**	**Widespread severe storms expected**
Lightning/flooding threats exist with <u>all</u> thunderstorms	Limited in duration and/or coverage and/or intensity	Short-lived and/or not widespread, isolated intense storms possible	More persistent and/or widespread, a few intense	Long-lived, widespread and intense	Long-lived, very widespread and particularly intense

* NWS defines a severe thunderstorm as measured wind gusts to at least 58 mph, and/or hail to at least one inch in diameter, and/or a tornado. All thunderstorm categories imply lightning and the potential for flooding. Categories are also tied to the probability of a severe weather event within 25 miles of your location.

National Weather Service

www.spc.noaa.gov

Thunderstorms (no label)

No severe* thunderstorms expected
Lightning/flooding threat exists with <u>all</u> thunderstorms
Winds to 40 mph and small hail possible

1 Marginal Risk (MRGL)

Isolated severe thunderstorms possible
Limited in duration and/or coverage and/or intensity
Wind to 40-60 mph, hail up to 1", and low tornado risk

2 Slight Risk (SLGT)

Scattered severe storms possible
Short-lived and/or not widespread, isolated intense storms
One or two tornadoes
Reports of strong winds and wind damage
Hail ~1", isolated 2"

3 Enhanced Risk (ENH)

Numerous severe storms possible
More persistent and/or widespread, a few intense
A few tornadoes
Several wind damage reports
Damaging hail, 1"-2"

4 Moderate Risk (MDT)

Widespread severe storms likely
Long-lived, widespread and intense
Strong tornadoes
Widespread wind damage
Destructive hail, 2" or greater

5 High Risk (HIGH)

Widespread severe storms expected
Long-lived, very widespread and particularly intense
Tornado outbreak
Derecho

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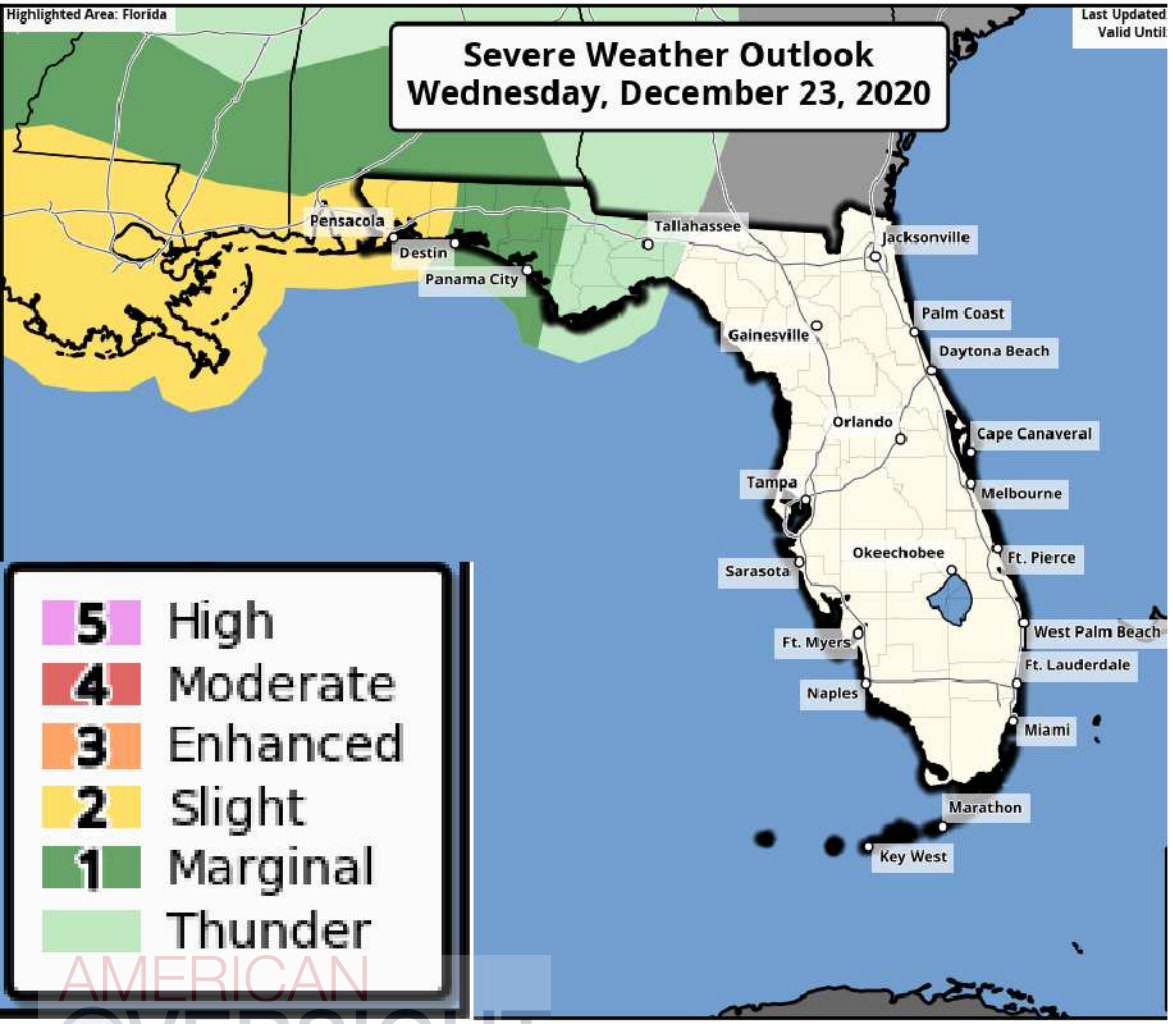
Severe Weather Outlook- Early Thursday

From the Storm Prediction Center



A line of strong thunderstorms will develop tonight along a cold front and move eastward into the western Panhandle Thursday morning just before sunrise. Scattered storms could form ahead of this main line and impact Panhandle areas as after midnight.

Storm both along and ahead of the main line have the potential to produce **damaging wind gusts and isolated tornadoes**.

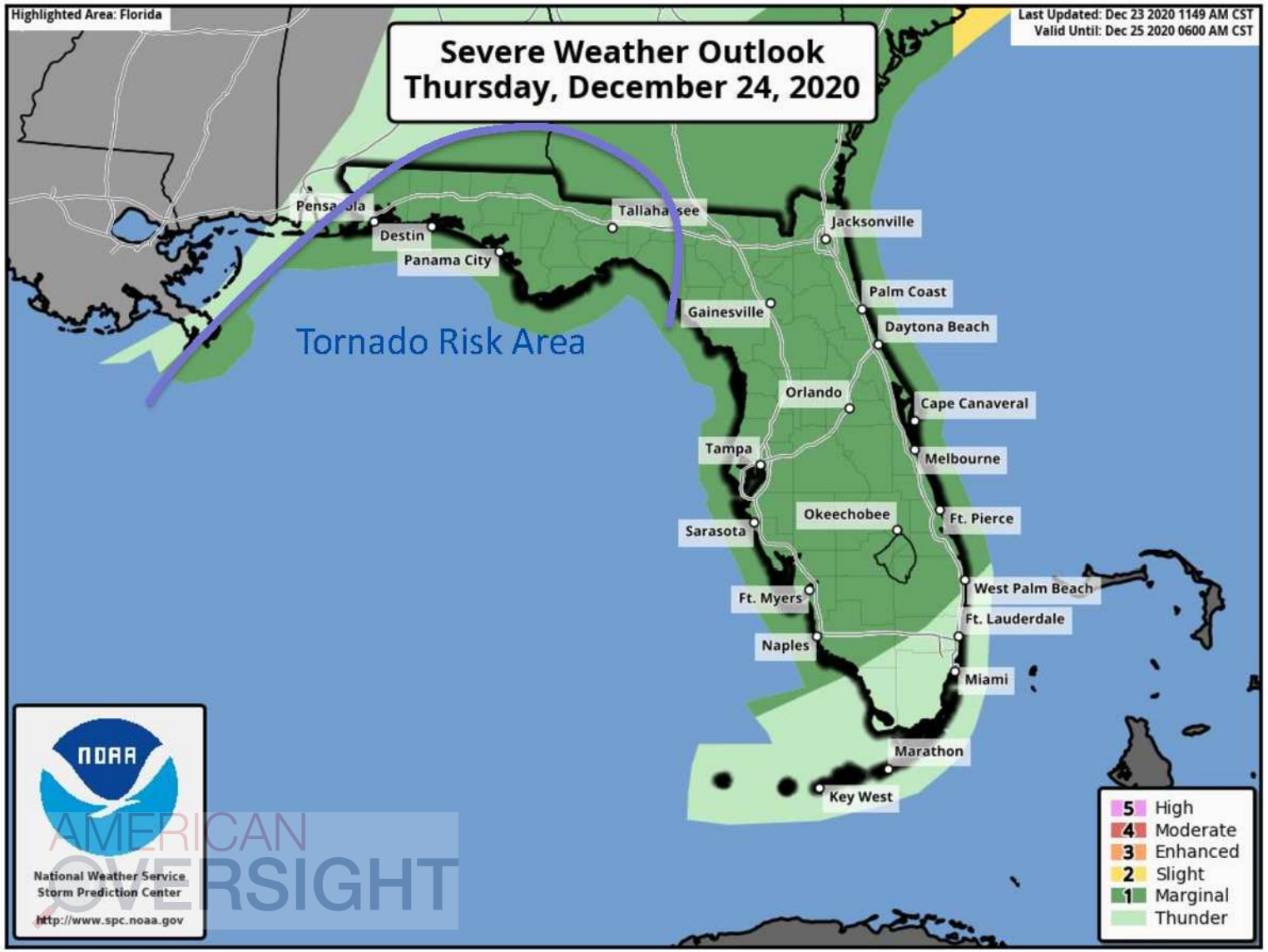
There is a **Slight Risk** (level 2 of 5) of severe weather for the western Panhandle and a **Marginal Risk** (level 1 of 5) of Severe Weather for the eastern Florida Panhandle.

Note: This outlook covers the period before 6 am CST.

AMERICAN OVERSIGHT

Severe Weather Outlook- Thursday

From the Storm Prediction Center



The line of thunderstorms will continue to move eastward across the Panhandle and Big Bend during the day on Thursday, then affecting the Peninsula later in the day and during the evening before weakening and moving offshore around midnight.

There is a **Marginal Risk** (level 1 of 5) of severe weather for nearly the entire state. The primary severe weather threat statewide is damaging wind gusts (45-65 mph), but isolated tornadoes will also be possible in the Panhandle and Big Bend.

Note: This outlook covers the period after 6 am CST / 7 am EST.

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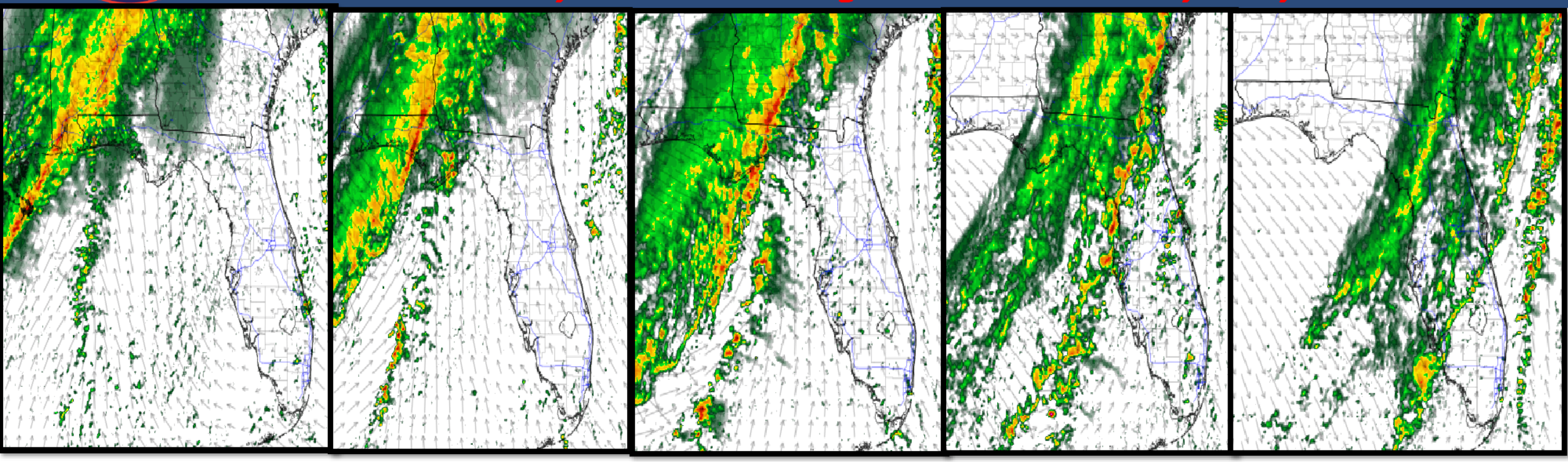
Model Forecast Radar

Guidance Only – Exact Timing and Position May Vary



7 AM ET / 6 AM CT	12 PM ET / 11 AM CT	3 PM ET / 2 PM CT	6 PM ET / 5 PM CT	10 PM ET / 9 PM CT
Thursday	Thursday	Thursday	Thursday	Thursday

The line of thunderstorms is forecast to move into the western Panhandle around sunrise Thursday and continue eastward during the morning hours, moving across Big Bend during the midday-mid afternoon, and then into the northern Peninsula mid-afternoon through early evening. The line should begin to weaken as it moves south of I-4 after sunset, with storms ending around midnight-2am Friday.

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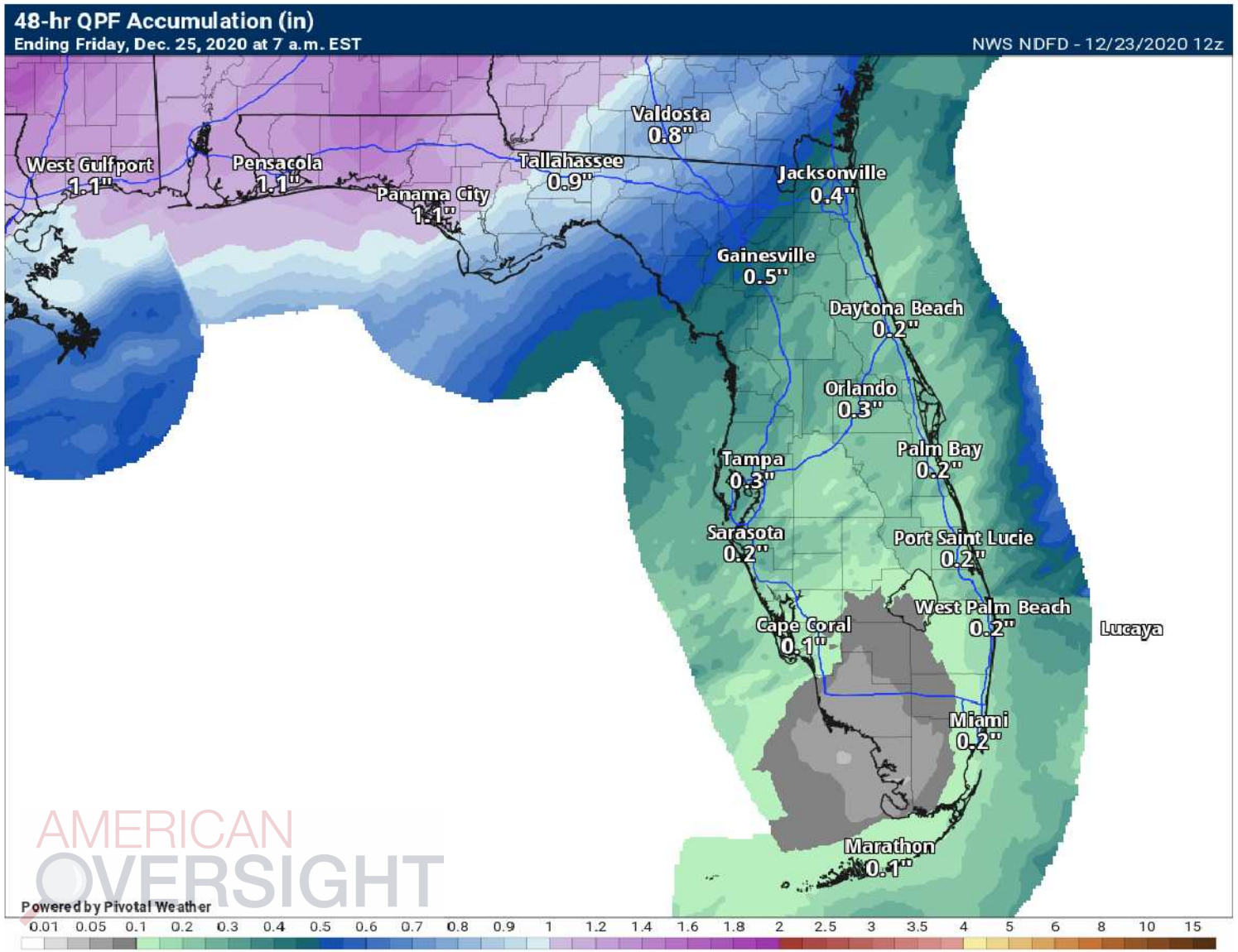
Rainfall Totals Next 48 Hours

Ending 7 AM ET Friday



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These storms could also produce brief heavy rainfall totals of 1-2” across the Panhandle and western Big Bend. Lower amounts of ¼” to 1” is expected across the eastern Big Bend and Peninsula.

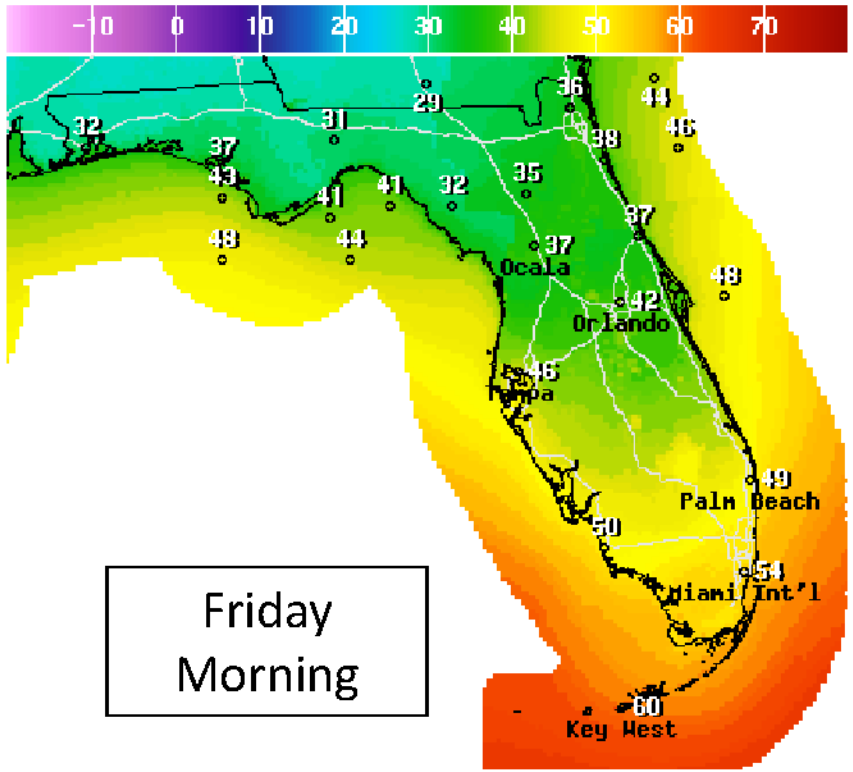
The flash flood risk is very low, but ponding of water on roadways and minor flooding of poor-drainage areas is possible during the heaviest rain.

At this time, river flooding is not forecast. However, some Panhandle rivers are forecast to reach Action Stage (bank full).

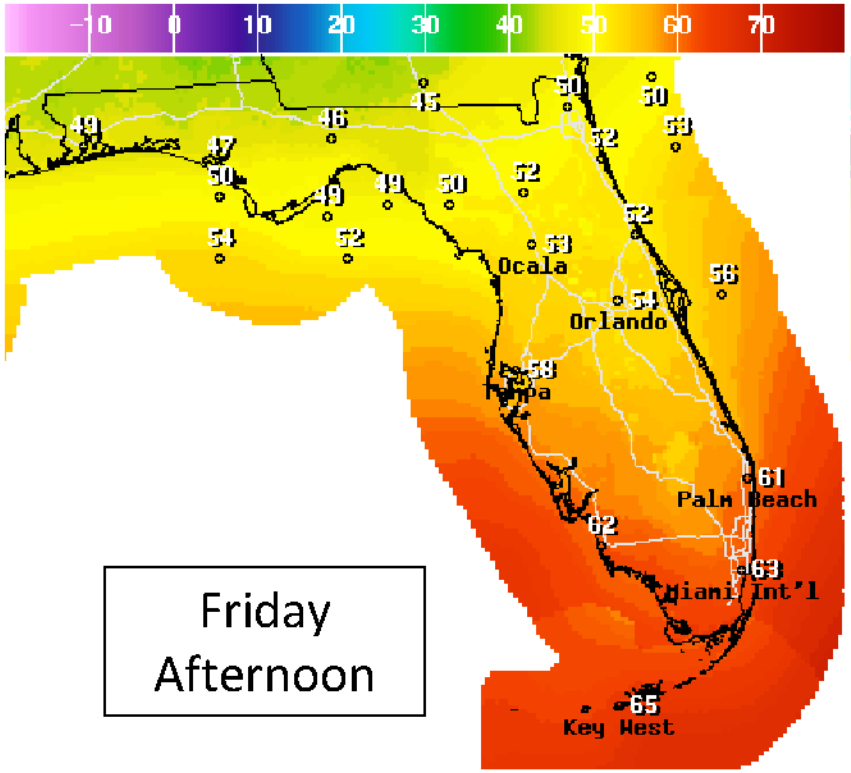
FL-DEM-21-0173-A-000082

Forecast Temperatures

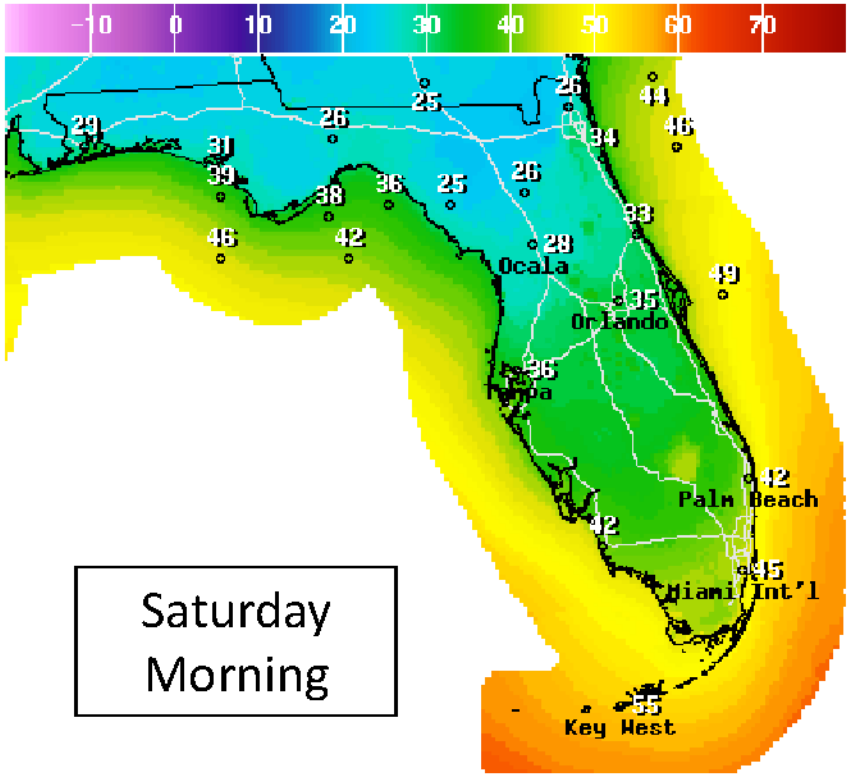
Behind the Cold Front



Friday Morning



Friday Afternoon



Saturday Morning

Freezing temperatures move in behind the cold front

A brief **light freeze** is expected across inland areas of the Panhandle and Big Bend early Friday morning (icing on roads should not occur), with a **freeze likely** across much of North Florida and the Nature Coast Saturday morning. Frost is possible in Central Florida. Afternoon highs on Friday will only reach the mid-40s to low 50s across North Florida, with highs ranging from the mid 50s across Central Florida to mid 60s across South Florida. Additionally, winds of 10-20mph will make it feel even colder. This forecast would make this the coldest Christmas Day since 2004 for North Florida and 1995 for Central and South Florida.

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Summary

- **What**: A strong cold front will bring a threat of severe weather, including damaging wind gusts, heavy rainfall, and isolated tornadoes. Coldest air of the season so far moves in behind the front.
- **Where**: Slight Risk (level 2 of 5) for the western Panhandle, Marginal Risk (level 1 of 5) for the eastern Panhandle, Big Bend, Northeast Florida, Central Florida and South Florida (generally north of Alligator Alley).
- **When**: Panhandle – Thursday morning; Big Bend – Thursday afternoon; Peninsula – Thursday evening
- **Potential Impacts**:
  - Damaging wind gusts around 45-65mph and a couple of tornadoes may cause power outages, downed trees/limbs, and damage to weak structures (such as mobile/manufactured homes). Temporary structures will be more susceptible to the severe weather.
  - Heavy rain could cause temporary flooding of roadways and rising of creeks and rivers.
  - Cold air could harm animals and sensitive vegetation such as flowers and citrus.

This will the only briefing package for this event unless there are significant changes in the forecast. For the latest severe weather updates, see products from your local National Weather Service office and the Storm Prediction Center.

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WEATHER UPDATE

Created by:

Amy Godsey, Chief State Meteorologist

Amy.Godsey@em.myflorida.com

State Meteorological Support Unit

Florida Division of Emergency Management

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AMERICAN OVERSIGHT

From: McLeary, Allison <Allison.McLeary@em.myflorida.com>
Sent: Wednesday, January 13, 2021 9:23 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: DEM Recovery <DEM_Recovery@em.myflorida.com>
Subject: COVID FEMA Declaration: Project Activity Completion Deadlines/Extensions
Attachment(s): "Coronavirus (COVID-19) Pandemic-Purchase and Distribution of Food Eligible for Public Assistance.pdf","COVID-19 Contractor POC List.pdf","Recovery_Contractors_Covid.pdf"

Good morning:

We have received questions lately about the period of time in which to incur eligible costs and perform eligible work under the FEMA PA program for the COVID declaration. (Typically Applicants have 6 months in which to perform Emergency Protective Measures, and we are well beyond the 6 month mark for the COVID declaration.) Please be advised, these time frames are being automatically extended by FEMA Headquarters in 90 day increments to correspond with the extension of the national public health emergency (link). As of today, the period of performance has been extended through March 24, 2021.

As such, for COVID projects Applicants do not need to and should not request individual PW time extensions via FEMA Grants Portal or FDEM's www.floridaPA.org

There are some types of activities that require specific approval and are notable exceptions.

1. If your organization incurred or will incur **costs related to the purchase and distribution of food** for a duration beyond 30 days, you will need a Time Extension approved by the FEMA Regional Administrator, per the attached policy. This is NOT a new policy and those of you with large scale feeding operations have been in compliance with this policy.
2. For **Non-Congregate Sheltering**, the State continues to obtain programmatic statewide approval. No individual requests for time extensions for NCS activities are needed, however Applicants must continue to report NCS activities to FDEM for reporting to FEMA per prior guidance.

FDEM contract staff are available to assist with developing feeding program Time Extensions that conform with FEMA requirements and can offer technical assistance. A map of which contractor is assigned to which Region is attached as well as a POC list for these contractors. If you're unsure whether your project needs a time extension or if you have other COVID-19 Public Assistance questions, please contact them for clarification. You can also, as always, reach out to FDEM Recovery and we are happy to assist as well.

Thank you,

Allison McLeary, Esq.
Recovery Bureau Chief
Florida Division of Emergency Management

Rebuilding Together

(850) 509-8643 (Cell)
Allison.McLeary@em.myflorida.com

Please note that Florida has a broad public records law (Chapter 119, Florida Statutes). Most written communications to or from state employees are public records obtainable by the public upon request. Emails sent to me at this email address may be considered public and will only be withheld from disclosure if deemed confidential pursuant to the laws of the State of Florida.

From: Smit, John <John.Smit@em.myflorida.com>
Sent: Tuesday, January 12, 2021 4:02 PM
To: Adkison, Kevin <Kevin.Adkison@em.myflorida.com>; Dickinson, Buck <Frederick.Dickinson@em.myflorida.com>; Shirah, Melissa <Melissa.Shirah@em.myflorida.com>
Subject: FW: Project Activity Completion Deadline Extensions - Food Distribution Ext. Requests

Kevin,

Looks good my review is complete.

Name	Task	Complete
Kevin	Draft	Draft

AMERICA OVERSIGHT

John	Review	Reviewed
Buck	Review	
Shirah	Review	
McLeary	Finalize	

From: Adkison, Kevin <Kevin.Adkison@em.myflorida.com>
Sent: Tuesday, January 12, 2021 2:54 PM
To: Dickinson, Buck <Frederick.Dickinson@em.myflorida.com>; Shirah, Melissa <Melissa.Shirah@em.myflorida.com>; Smit, John <John.Smit@em.myflorida.com>
Subject: RE: Project Activity Completion Deadline Extensions - Food Distribution Ext. Requests

This copy includes the FEMA policy...

From: Adkison, Kevin
Sent: Tuesday, January 12, 2021 2:53 PM
To: Dickinson, Buck <Frederick.Dickinson@em.myflorida.com>; Shirah, Melissa <Melissa.Shirah@em.myflorida.com>; Smit, John <John.Smit@em.myflorida.com>
Subject: RE: Project Activity Completion Deadline Extensions - Food Distribution Ext. Requests

Please see draft message below and let me know of any necessary changes. I'll send to Allison when I hear back – thanks

Subject: COVID-19 DR-4486 Time Extensions

Good afternoon,

Regarding the need for Time Extensions (period of performance extensions) for the COVID-19 DR-4486 event, projects are being automatically extended by FEMA Headquarters in 90 day increments to correspond with the extension of the national public health emergency (link). As of today, the period of performance has been extended through March 24, 2021. As such, Applicants do not need to and should not request individual time extensions in the FEMA Grants Portal or floridaPA.org. However, if your organization incurred costs related to the purchase and distribution of food for a duration beyond 30 days, you will need a Time Extension approved by the FEMA Regional Administrator, per the attached policy. FDEM contract staff are available to assist with developing an extension that conforms with FEMA requirements and can offer technical assistance; please see attached POC list and county assignment listing for more information. If you're unsure whether your project needs a time extension or if you have other COVID-19 Public Assistance questions, please contact them for clarification.

Thank you,

Kevin Adkison | Programmatic Reviewer
Bureau of Recovery, Florida Division of Emergency Management
Cell: (850) 570-7073 | Email: Kevin.Adkison@em.myflorida.com
www.FloridaPA.org | www.FloridaDisaster.org

From: McLeary, Allison <Allison.McLeary@em.myflorida.com>
Sent: Tuesday, January 12, 2021 12:41 PM
To: Dickinson, Buck <Frederick.Dickinson@em.myflorida.com>; Adkison, Kevin <Kevin.Adkison@em.myflorida.com>; Shirah, Melissa <Melissa.Shirah@em.myflorida.com>; Morales, Jose <Jose.Morales@em.myflorida.com>; Smit, John <John.Smit@em.myflorida.com>
Subject: RE: Project Activity Completion Deadline Extensions - Food Distribution Ext. Requests

To clarify. Mostly would be cut and paste out of what is already here- just a quick paragraph to send out later today.. Thanks

---

From: Dickinson, Buck <Frederick.Dickinson@em.myflorida.com>
Sent: Tuesday, January 12, 2021 12:21 PM
To: McLeary, Allison <Allison.McLeary@em.myflorida.com>; Adkison, Kevin <Kevin.Adkison@em.myflorida.com>; Shirah, Melissa <Melissa.Shirah@em.myflorida.com>; Morales, Jose <Jose.Morales@em.myflorida.com>; Smit, John <John.Smit@em.myflorida.com>
Subject: RE: Project Activity Completion Deadline Extensions - Food Distribution Ext. Requests

Name	Task	Complete
Kevin	Draft	
John	Review	

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Buck	Review	
Shirah	Review	
McLeary	Finalize	

Buck Dickinson | State Public Assistance Officer
Bureau of Recovery
Florida Division of Emergency Management
Rebuilding Together
(850) 815-4447
(850) 591-4381 (cell)

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From: McLeary, Allison <Allison.McLeary@em.myflorida.com>
Sent: Tuesday, January 12, 2021 12:16 PM
To: Adkison, Kevin <Kevin.Adkison@em.myflorida.com>; Shirah, Melissa <Melissa.Shirah@em.myflorida.com>; Dickinson, Buck <Frederick.Dickinson@em.myflorida.com>; Morales, Jose <Jose.Morales@em.myflorida.com>; Smit, John <John.Smit@em.myflorida.com>
Subject: RE: Project Activity Completion Deadline Extensions - Food Distribution Ext. Requests

Please draft up language that I can send to County EM's on this point. Send to me and Shirah for review, then can send out to counties thereafter.

Thanks

From: Adkison, Kevin <Kevin.Adkison@em.myflorida.com>
Sent: Tuesday, January 12, 2021 12:12 PM
To: McLeary, Allison <Allison.McLeary@em.myflorida.com>; Shirah, Melissa <Melissa.Shirah@em.myflorida.com>; Dickinson, Buck <Frederick.Dickinson@em.myflorida.com>; Morales, Jose <Jose.Morales@em.myflorida.com>; Smit, John <John.Smit@em.myflorida.com>
Subject: FW: Project Activity Completion Deadline Extensions - Food Distribution Ext. Requests

We've received confirmation from FEMA regarding how COVID-19 time extensions are being processed by HQ

John – please let the contractors know

Kevin Adkison | Programmatic Reviewer
Bureau of Recovery, Florida Division of Emergency Management
Cell: (850) 570-7073 | Email: Kevin.Adkison@em.myflorida.com
www.FloridaPA.org | www.FloridaDisaster.org

From: Brown, Casey <casey.brown.2@fema.dhs.gov>
Sent: Tuesday, January 12, 2021 10:15 AM
To: Adkison, Kevin <Kevin.Adkison@em.myflorida.com>
Subject: Project Activity Completion Deadline Extensions - Food Distribution Ext. Requests

Good morning Kevin,

Regarding the question you had about the period of performance extensions being requested by the applicants, I've received the following information:

The Period of Performance for the COVID-19 Events and projects are currently being controlled by Headquarters and are extended by HQ in 90 day increments to correspond with the extension of the national public health emergency. As of now, the POP has been extended through March 24, 2021. As such, applicants do not need to and should not request individual extensions for periods of performance for the COVID-19 event. If there is an issue with the dates being reflected incorrectly/inconsistently across applicants, please let me know.

However, at this time, pre-approval extensions are still required every 30 days for projects involving the purchase and distribution of

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food. RIV has asked HQ to eliminate this requirement, but as of now, the requirement stands.

Saidat advised that it may be prudent for the State to deliver consistent messaging to all applicants that time extensions for the period of performance for COVID-19 projects do not need to be requested individually, with the exception of the food distribution, despite Grants Portal's automatically generated reminders to do so.

Please let me know if you have any further questions.

Thanks,

Casey Brown
Public Assistance | Program Delivery Manager
Mobile: (202) 672-3239
Casey.brown.2@fema.dhs.gov
FEMA Grants Portal Hotline: (866) 337-8448

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AMERICAN OVERSIGHT

Coronavirus (COVID-19) Pandemic: Purchase and Distribution of Food Eligible for Public Assistance

FEMA Policy FP 104-010-03

BACKGROUND

Under the President's March 13, 2020, COVID-19 emergency declaration[1] and subsequent major disaster declarations for COVID-19, state, local, tribal, and territorial (SLTT) government entities and certain private non-profit (PNP) organizations are eligible to apply for assistance under the FEMA Public Assistance (PA) Program. This policy is applicable to eligible PA applicants only and is exclusive to emergency and major disaster declarations for the COVID-19 pandemic.

As of April 9, 2020, 51 states and territories had "stay at home" orders in place.[2] The population at high-risk for severe illness from COVID-19 includes people 65 years and older and people of any age who have serious underlying medical conditions, including people with chronic lung disease or moderate to severe asthma, people with serious heart conditions, people who are immunocompromised (e.g., those undergoing cancer treatment, smokers, those with HIV or AIDs), and people with severe obesity, diabetes, or liver disease, and people undergoing kidney dialysis.[3] Due to the impact of the COVID-19 pandemic, there may be areas where it will be necessary as an emergency protective measure to provide food to meet the immediate needs of those who do not have access to food as a result of COVID-19 and to protect the public from the spread of the virus.

PURPOSE

This policy defines the framework, policy details, and requirements for determining eligible work and costs for the purchase and distribution of food in response to the COVID-19 Public Health Emergency to ensure consistent and appropriate implementation across all COVID-19 emergency and major disaster declarations. Except where specifically stated otherwise in this policy, assistance is subject to PA Program requirements as defined in Version 3.1 of the Public Assistance Program and Policy Guide (PAPPG).[4]

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[1] Proclamation 9994 of March 13, 85 FR 15337 (Mar. 18, 2020); *see also* www.fema.gov/news-release/2020/03/13/covid-19-emergency-declaration.

[2] https://www.nga.org/coronavirus/#states

[3] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html.

[4] The current version of the Public Assistance Program and Policy Guide (PAPPG), Version 3.1, is available on the FEMA website at www.fema.gov/media-library/assets/documents/111781.

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FL-DEM-21-0173-A-000090

PRINCIPLES

A. FEMA will provide flexibility to applicants to protect the health and safety of impacted communities in response to the COVID-19 Public Health Emergency through the purchase and distribution of food.

B. FEMA will responsibly implement this policy and any assistance provided in a consistent manner through informed decision-making and accountable documentation.

C. FEMA will engage with interagency partners, including the U.S. Department of Agriculture (USDA), the U.S. Department of Health and Human Services (HHS), and U.S. Department of Housing and Urban Development (HUD), to ensure this assistance does not duplicate other available assistance. Engagement with USDA will include coordination with USDA's efforts on food bank response.

REQUIREMENTS

A. APPLICABILITY

Outcome: To establish the parameters of this policy and ensure it is implemented in a manner consistent with program authorities and appropriate to the needs of the COVID-19 Public Health Emergency.

1. This policy applies to:

    a. All Presidential emergency and major disaster declarations under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act), as amended, issued for the COVID-19 Public Health Emergency.

    b. Eligible PA applicants under the COVID-19 emergency declaration or any subsequent COVID-19 major disaster declaration.

    c. This policy does not apply to any other emergency or major disaster declaration.

B. GENERAL ELIGIBILITY CONSIDERATIONS

Outcome: To define the overarching eligibility framework for purchasing and distributing food in response to COVID-19 declarations.

1. Legal Responsibility.

    a. To be eligible for PA, an item of work must be the legal responsibility of an eligible applicant.[5] Measures to protect life, public health, and safety are generally the responsibility of state, local, tribal, and territorial (SLTT) governments.

[5] 44 CFR §206.223.

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b. Legally responsible SLTT governments may enter into formal agreements or contracts with private organizations, including private nonprofit (PNP) organizations such as food banks, to purchase and distribute food when necessary as an emergency protective measure in response to the COVID-19 Public Health Emergency. In these cases, PA funding is provided to the legally responsible government entity, which would then reimburse the private organization for the cost of providing those services under the agreement or contract.

2. Work Eligibility.

a. In accordance with sections 403 and 502 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 et seq. (the "Stafford Act"), emergency protective measures necessary to save lives and protect public health and safety, including the purchase and distribution of food, may be reimbursed under the PA program.

b. When necessary as an emergency protective measure, eligible work related to the purchase and distribution of food in response to the COVID-19 pandemic includes:
   i. Purchasing, packaging, and/or preparing food, including food commodities, fresh foods, shelf-stable food products, and prepared meals;
   ii. Delivering food, including hot and cold meals if necessary, to distribution points and/or individuals, when conditions constitute a level of severity that food is not easily accessible for purchase; and
   i. Leasing distribution and storage space, vehicles, and necessary equipment.

c. Several indicators may demonstrate the need to purchase and distribute food in response to the COVID-19 pandemic:
   i. Reduced mobility of people in need due to government-imposed restrictions, including "stay-at-home" orders, which prevent certain populations from accessing food;
   ii. Marked increase or atypical demand for feeding resources; or
   iii. Disruptions to the typical food supply chain within a given jurisdiction.

d. Populations in an impacted community that may need the provision of food as a lifesaving and life-sustaining commodity, may include:
   i. Those who test positive for COVID-19 or have been exposed to COVID-19, but who do not require hospitalization;[6]
   ii. High-risk individuals, such as people over 65 or with certain underlying health conditions;[7] and

[6] Any collection or handling of information with regard to the health status of individuals must be compliance with applicable privacy laws, including the Health Insurance Portability and Accountability Act of 1996. FEMA will not be collecting any health information.

[7] The distribution of supplies and other relief and assistance activities shall be accomplished without discrimination on the grounds of race, color, religion, nationality, sex, age, disability, English proficiency, or economic status. Section 308 of the Stafford Act, 42 U.S.C. § 5151, as amended.

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iii. Other populations based on the direction or guidance of the appropriate public health official.

3. Cost Eligibility.

a. All claimed costs must be necessary and reasonable in order to respond to the COVID-19 Public Health Emergency and are subject to standard program eligibility and other Federal requirements, including the prevailing cost-share for the respective declaration.[8]

b. Applicants must follow applicable cost principles and procurement requirements.[9]

i. Costs claimed by SLTT governments must be reasonable pursuant to Federal regulations and Federal cost principles.[10] A cost is considered reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost.

ii. States and territorial governments are required to follow their own procurement procedures, comply with 2 CFR §200.322, and include any clauses required by 2 CFR §200.326. Local and tribal governments must follow their own procedures and comply with 2 CFR §200.318.

iii. In accordance with the March 17, 2020, memorandum from David Bibo, Acting Associate Administrator for the Office of Response and Recovery, and Bridget E. Bean, Assistant Administrator for the Grants Program Directorate, for the duration of the Public Health Emergency, as determined by U.S. Department of Health and Human Services (HHS), local governments, tribal governments, PNPs, and other non-state entities may proceed with new and existing non-competitively procured contracts. The March 17, 2020 memorandum and other information related to procurement specific to COVID-19 declarations are available on the FEMA website at www.fema.gov/media-library/assets/documents/186350.

c. Pursuant to Section 312 of the Stafford Act, FEMA is prohibited from providing financial assistance where such assistance would duplicate funding available from another program, insurance, or any other source for the same costs.[11]

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[8] In certain circumstances, the Regional Administrator may require the submission of an internal control plan, pursuant to 2 CFR §200.303, in particular when the SLTT government is implementing residential delivery of meals to targeted groups of individuals who are need of such assistance.
[9] *See. COVID-19 Guidance: Procurements Under Grants During Periods of Exigent or Emergency Circumstances,* March 17, 2020. (https://www.fema.gov/media-library/assets/documents/186350.)
[10] 2 CFR §200.404; OMB Circular 87.
[11] 42 U.S.C. § 5155.

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4. Time Limitations.

   a. FEMA may provide funding for an initial 30-day time period.

   b. SLTT governments may request a 30-day time extension from the Regional Administrator (RA) with documentation showing continued need.

   c. Work may not extend beyond the duration of the COVID-19 Public Health Emergency, as determined by HHS.

Keith Turi
Assistant Administrator, Recovery Directorate

April 11, 2020
Date

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ADDITIONAL INFORMATION

REVIEW CYCLE

This policy will be reviewed periodically during the COVID-19 Public Health Emergency. The Assistant Administrator of Recovery is responsible for authorizing any changes or updates. This policy will sunset with the closure of the national emergency for COVID-19 and any subsequent major disaster declarations for COVID-19.

AUTHORITIES and REFERENCES

Authorities

- Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. § 5121, et seq., as amended
- Title 44 of the Code of Federal Regulations, Part 206, Subparts G and H

References

- Public Assistance Program and Policy Guide, Version 3.1

MONITORING AND EVALUATION

FEMA will closely monitor the implementation of this policy through close coordination with regional and field staff, as appropriate, as well as interagency partners and SLTT stakeholders. Various planning calls are conducted daily related to COVID-19 declarations. Additionally, FEMA has set up a mailbox for COVID-19 questions and concerns at covid19paoperations@fema.dhs.gov.

QUESTIONS

Direct questions to covid19paoperations@fema.dhs.gov.

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COVID-19 Contractor POC Listing

Ernst and Young

Joseph F Alonso - joseph.alonso@ey.com

Reena Panchal - reena.panchal@ey.com

Tidal Basin

Laura DeLoach - LDeLoach@tidalbasin.rphc.com

Karla Reale - KReale@rphc.com

Robert 'Bob" Wright - Rwright@tidalbasin.rphc.com

IEM

Charlie Axton - Charlie.Axton@iem.com

Kimberly Prosser - Kimberly.Prosser@iem.com

Atkins

Jamelyn Trucks - Jamelyn.Trucks@atkinsglobal.com

Lourdes Fernandez - Lourdes.Fernandez@atkinsglobal.com

Charlotte Maddox - Charlotte.Maddox@atkinsglobal.com

Hagerty

Chris Thomas - chris.thomas@hagertyconsulting.com

Katie Grasty - katie.grasty@hagertyconsulting.com

Kalie Burke - katie.grasty@hagertyconsulting.com

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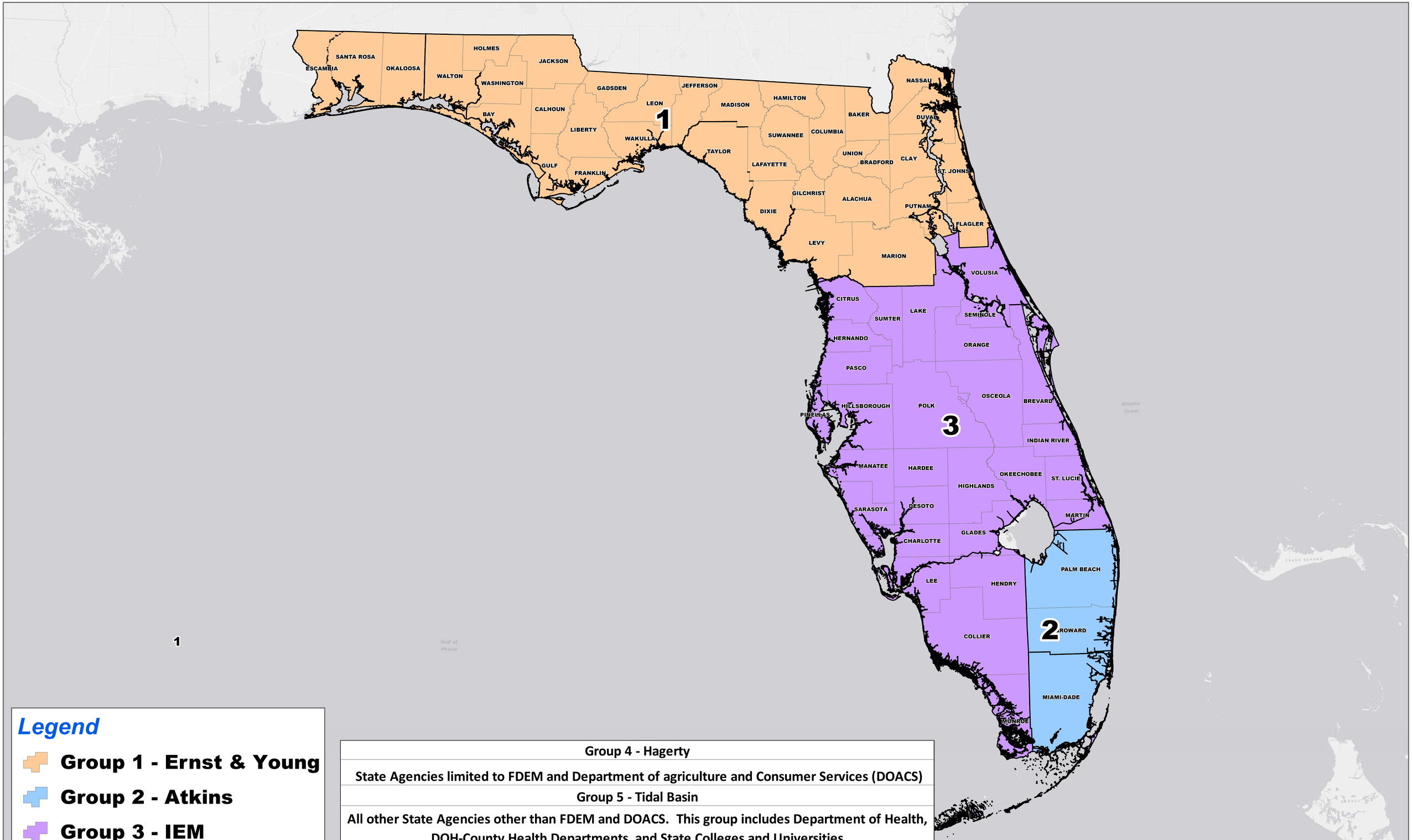

Legend

- Group 1 - Ernst & Young
- Group 2 - Atkins
- Group 3 - IEM

Group 4 - Hagerty
State Agencies limited to FDEM and Department of agriculture and Consumer Services (DOACS)
Group 5 - Tidal Basin
All other State Agencies other than FDEM and DOACS. This group includes Department of Health, DOH-County Health Departments, and State Colleges and Universities

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Disclaimer: Map is intended for reference only
No warranty for accuracy provided

Created By: GIS Section
Requested By: Wes Maul
Date: 6/17/2020
Time: 5:25:44 PM

Path: S:\Events\2020_03_07_COVID-19\MXD\Recovery_Contractors_Covid.mxd

RECOVERY CONTRACTORS

COVID-19

0 6.5 13 19.5 26 Miles

From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Thursday, January 28, 2021 11:51 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>
Subject: COVID-19 State Profile Report - Florida

Based on the call and requested, see below.

https://beta.healthdata.gov/Community/COVID-19-State-Profile-Report-Florida/ht94-9tjc

---

From: Edward McCrane <emccrane@scgov.net>
Sent: Thursday, January 28, 2021 11:40 AM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Subject: report mentioned during call

Ash

This may be the article about a WH report mentioned in our local media

https://www.firstcoastnews.com/article/news/health/coronavirus/white-house-task-force-reports-that-florida-should-close-down-gym-bars-and-restaurants/77-12b70228-8f9e-49ec-bd7f-cb51b097fdac

Ed

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From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Sunday, December 13, 2020 9:39 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>
Subject: COVID-19 Vaccine: What Every Clinician Should Know

Per HHS/CDC:

What Every Clinician Should Know about COVID-19 Vaccine Safety

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From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Thursday, December 17, 2020 2:00 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
Subject: EEOC materials related to COVID-19 (updated)

What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws.

Please note, check CDC guidance as dates are subject to change.

Thanks Frank!

From: Rollason, Frank (MDFR) <Frank.Rollason@miamidade.gov>
Sent: Thursday, December 17, 2020 10:36 AM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Cc: Cyrille, Charles (Miami-Dade Co Alt EM) <charles.cyrille@miamidade.gov>

You may want to blast out to the Counties, Frank.

Frank Rollason,
Director, Office of Emergency Management
Miami-Dade Fire Rescue Department
Office: (305) 468-5405
E-mail: frank.rollason@miamidade.gov
www.miamidade.gov/oem
readysouthflorida.org
facebook.com/MiamiDadeCountyEM
twitter.com/MiamiDadeEM
"Delivering Excellence Every Day"

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From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Friday, December 18, 2020 3:04 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>; DEM All Staff <DEM@em.myflorida.com>
Subject: Emergency Rule 64DER20-44

FYSA

From: Mahon, Jason <Jason.Mahon@em.myflorida.com>
Subject: Emergency Rule

Emergency Rule 64DER20-44 has been published on the Department of Health Website here - https://floridahealthcovid19.gov/wp-content/uploads/2020/12/64DER20-44.pdf.

This rule applies to the redistribution of COVID-19 vaccines.

Jason Mahon
Communications Director
Florida Division of Emergency Management
& Communications Director (Interim)
Florida Department of Health
Jason.Mahon@em.myflorida.com

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From: Stachowicz, Stephanie <Stephanie.Stachowicz@em.myflorida.com>
Sent: Wednesday, December 30, 2020 9:08 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Subject: EO 20-316
Attachment(s): "EO_20-316.pdf"

Please see attached. Thank you.

Very Respectfully,

Stephanie Stachowicz

Stephanie Stachowicz, Esq.
Deputy General Counsel
Florida Division of Emergency Management
Cell: (850) 815-5762
Direct: (850) 815-4160
Stephanie.Twomey@em.myflorida.com

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STATE OF FLORIDA

OFFICE OF THE GOVERNOR

EXECUTIVE ORDER NUMBER 20-316

(Emergency Management -Extension of Executive Order 20-52-COVID-19)

WHEREAS, on March 9, 2020, I issued Executive Order 20-52, declaring a state of emergency for the entire state due to COVID-19; and

WHEREAS, no state of emergency declared pursuant to the Florida Emergency Management Act may continue for more than 60 days unless renewed by the Governor; and

WHEREAS, the impact of COVID-19 poses a continuing threat to the health, safety and welfare of the State of Florida and its residents; and

WHEREAS, as Florida recovers and re-launches its economy, I am committed to providing all available resources to assist Floridians and local communities with their efforts.

NOW, THEREFORE, I, RON DESANTIS, as Governor of Florida, by virtue of the authority vested in me by Article IV, Section 1(a) of the Florida Constitution and by the Florida Emergency Management Act, as amended, and all other applicable laws, promulgate the following Executive Order, to take immediate effect:

Section 1. The state of emergency declared in Executive Order 20-52, as extended by Executive Orders 20-114, 20-166, 20-192, 20-213, and 20-276 will be extended for 60 days following the issuance of this order for the entire State of Florida.

Section 2. All actions taken by the Director of the Division of Emergency Management as the State Coordinating Officer with respect to this emergency before the issuance of this Executive Order are ratified, and he is directed to continue to execute the State's Comprehensive Emergency Management Plan and other response, recovery, and mitigation

AMERICAN OVERSIGHT

plans necessary to cope with the emergency.

Section 3. Except as amended herein, Executive Order 20-52, extended by Executive Orders 20-114, 20-166, 20-192, 20-213, and 20-276 is ratified and reaffirmed.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Florida to be affixed, at Tallahassee, this 29th day of December, 2020.

RON DESANTIS, GOVERNOR

ATTEST:

SECRETARY OF STATE

FILED
2020 DEC 29 PM 3:29
DEPARTMENT OF STATE
TALLAHASSEE, FLORIDA

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From: Stachowicz, Stephanie <Stephanie.Stachowicz@em.myflorida.com>
Sent: Tuesday, January 12, 2021 8:31 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Subject: Executive Order 21-10
Attachment(s): "Executive Order 21-10.pdf"

Good morning,

Please see attached regarding Sally SOE.

Very Respectfully,

Stephanie Stachowicz

Stephanie Stachowicz, Esq.
Deputy General Counsel
Florida Division of Emergency Management
Cell: (850) 815-5762
Direct: (850) 815-4160
Stephanie.Twomey@em.myflorida.com

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STATE OF FLORIDA

OFFICE OF THE GOVERNOR
EXECUTIVE ORDER NUMBER 21-10

(Extending Executive Order 20-224, Emergency Management – Hurricane Sally)

WHEREAS, on September 14, 2020 and September 15, 2020 I declared a state of emergency in multiple Florida counties in preparation for Hurricane Sally; and

WHEREAS, on September 16, 2020, Hurricane Sally made landfall at 5:45 AM EST at Gulf Shores, Alabama, with hurricane conditions reported in Northwest Florida; and

WHEREAS, Northwest Florida counties are still recovering following the damage caused by Hurricane Sally's dangerous storm surge, flooding, and rainfall; and

WHEREAS, I, as Governor of the State of Florida, am committed to providing every available resource for our residents, businesses and communities in Northwest Florida to recover and rebuild; and

WHEREAS, no state of emergency declared pursuant to the Florida Emergency Management Act may continue for more than 60 days unless renewed by the Governor.

NOW, THEREFORE, I, RON DESANTIS, as Governor of Florida, by virtue of the authority vested in me by Article IV, Section 1(a) of the Florida Constitution and by the Florida Emergency Management Act, as amended, and all other applicable laws, promulgate the following Executive Order, to take immediate effect:

Section 1. The state of emergency declared in Executive Order 20-224, as amended by Executive Orders 20-248 and 20-279, will be extended for 60 days following the issuance of this order.

Section 2. All actions taken by the Director of the Division of Emergency Management as the State Coordinating Officer with respect to this emergency before the issuance of this Executive

AMERICAN OVERSIGHT

Order are ratified, and he is directed to continue to execute the State's Comprehensive Emergency Management Plan and other response, recovery and mitigation plans necessary to cope with the emergency.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Florida to be affixed, at Tallahassee, this 11th day of January, 2021.

RON DESANTIS, GOVERNOR

ATTEST:

SECRETARY OF STATE

FILED
2021 JAN 11 PM 5:40
DEPARTMENT OF STATE
TALLAHASSEE, FL

AMERICAN OVERSIGHT

From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Friday, December 18, 2020 3:30 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>
Subject: Fact sheet has FDA official language for the additional dose

Per HHS

Fact sheet has FDA official language for the additional dose

Q: Some vials of the Pfizer-BioNTech COVID-19 vaccine have contained extra product after five doses is obtained. Can the extra be used?
A: FDA is aware of the issue and working with Pfizer to determine the best path forward, and will share additional updates as we have them. At this time, given the public health emergency, FDA is advising that it is acceptable to use every full dose obtainable (the sixth, or possibly even a seventh) from each vial, pending resolution of the issue. However, since the vials are preservative free, it is critical to note that any further remaining product that does not constitute a full dose should not be pooled from multiple vials to create one.

EUA links also below. Sent to state leads and I forwarded it to MCM coordinators as well

Here are the links to the translated fact sheets: https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine

Here is the EUA table link: https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization#coviddrugs

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From: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Sent: Tuesday, February 02, 2021 1:21 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM Bureau Chiefs and Director's Section Heads <DEM_Bureau_Chiefs_List@em.myflorida.com>
Subject: FEMA 100% Retro to Jan 2020 - FLNG and Emergency Costs

From NEMA:

++++++++

Increasing Funding to States: Central to the Biden-Harris Administration's COVID-19 National Strategy is ensuring states, Tribes, territories, and jurisdictions have the resources they need to defeat the virus. That's why, in his second day in office, President Biden directed the Federal Emergency Management Agency (FEMA) to fully reimburse states for the cost of National Guard Personnel and emergency costs. Today, President Biden is announcing that the administration will go even further, retroactively reimbursing states fully for the FEMA-eligible services – including masks, gloves, emergency feeding actions, sheltering at risk populations and mobilization of the National Guard - back dated to the beginning of the pandemic in January 2020.

--
Sarah Montell
Director of Intergovernmental Affairs | FEMA
Mobile: (202) 262-1723
Sarah.Montell@fema.dhs.gov

Kevin Guthrie, MA MEP CEM FPEM | Deputy Director
Office of the Director
Florida Division of Emergency Management
2555 Shumard Oak Blvd
Tallahassee, FL 32399-2100
Office: (850) 815-4101
Cell: (850) 294-8250
Kevin.Guthrie@em.myflorida.com
www.floridadisaster.org

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From: McLeary, Allison <Allison.McLeary@em.myflorida.com>
Sent: Monday, January 25, 2021 11:04 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: DEM Recovery <DEM_Recovery@em.myflorida.com>
Subject: FEMA PA Cost Share for Vaccination Costs
Attachment(s): "COVID-19 Contractor POC List.pdf","Recovery_Contractors_Covid.pdf","01222021 - 100% Federal Cost Share for COVID-19 Vaccine Distribution and Administration.pdf"

Good morning:
While FEMA is still developing guidance to implement the attached memorandum, they are leaning forward to ensure vaccine distribution and administration is expedited to the greatest extent possible. **Therefore, FEMA will fund vaccine distribution and administration-related project worksheets and approved requests for vaccine-related direct federal assistance at 100 percent federal cost share for work conducted on and after January 21, 2021, until September 30, 2021.**

If you would like to explore requesting an expedited project for these costs, FDEM contract staff are available to assist and offer technical assistance. A map of which contractor is assigned to which Region is attached as well as a POC list for these contractors. If you're unsure whether you would benefit from an expedited project or if you have other COVID-19 Public Assistance questions, please contact them for clarification. You can also, as always, reach out to FDEM Recovery and we are happy to assist as well.

Thank you,

Allison McLeary, Esq.
Recovery Bureau Chief
Florida Division of Emergency Management

Rebuilding Together

(850) 509-8643 (Cell)
Allison.McLeary@em.myflorida.com

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U.S. Department of Homeland Security
Washington, DC 20472

FEMA

January 22, 2021

MEMORANDUM FOR: Regional Administrators
Regions I – X

FROM: Keith Turi
Assistant Administrator
Recovery Directorate

SUBJECT: 100 Percent Federal Cost Share for COVID-19 Vaccine Distribution and Administration

On January 21, 2021, the President issued a ***Memorandum to Extend Federal Support to Governors' Use of the National Guard to Respond to COVID-19 and to Increase Reimbursement and Other Assistance Provided to States***. This memorandum includes provisions related to the cost share for FEMA assistance under Public Assistance, Category B Emergency Protective Measures.

While we are still developing guidance to implement this memorandum, FEMA is leaning forward to ensure vaccine distribution and administration is expedited to the greatest extent possible. Therefore, FEMA will fund vaccine distribution and administration-related project worksheets and approved requests for vaccine-related direct federal assistance at 100 percent federal cost share for work conducted on and after January 21, 2021, until September 30, 2021.

Additional policy guidance implementing the Presidential Memorandum will be made available as soon as possible. For any questions about this memorandum, please contact Tod Wells, Deputy Director, Policy and Strategy, Public Assistance Division (tod.wells@fema.dhs.gov).

cc: David Bibo, Associate Administrator (Acting), Office of Response and Recovery
Melissa Forbes, Deputy Assistant Administrator, Recovery Directorate
Ana Montero, Director, Public Assistance Division
Tod Wells, Deputy Director, Policy and Strategy, Public Assistance Division
Frank Matranga, Deputy Director, Operations, Public Assistance Division

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FL-DEM-21-0173-A-000111

COVID-19 Contractor POC Listing

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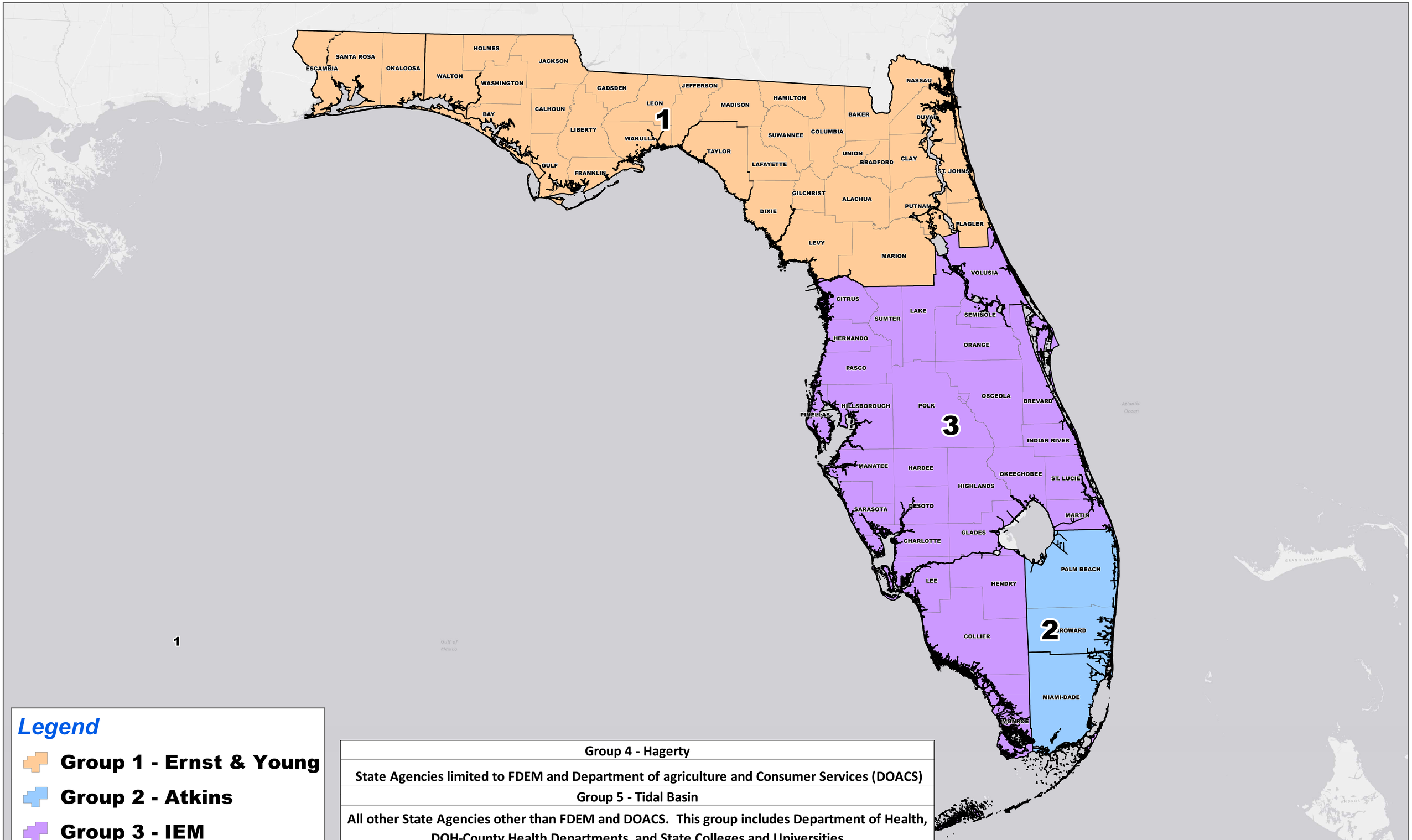

Legend

- Group 1 - Ernst & Young
- Group 2 - Atkins
- Group 3 - IEM

Group 4 - Hagerty
State Agencies limited to FDEM and Department of agriculture and Consumer Services (DOACS)
Group 5 - Tidal Basin
All other State Agencies other than FDEM and DOACS. This group includes Department of Health, DOH-County Health Departments, and State Colleges and Universities

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Disclaimer: Map is intended for reference only
No warranty for accuracy provided

Created By: GIS Section
Requested By: Wes Maul
Date: 6/17/2020
Time: 5:25:44 PM

Path: S:\Events\2020_03_07_COVID-19\MXD\Recovery_Contractors_Covid.mxd

RECOVERY CONTRACTORS

COVID-19

0 6.5 13 19.5 26 Miles

FLDEM:21-0173-A-000113

From: McLeary, Allison <Allison.McLeary@em.myflorida.com>
Sent: Sunday, December 13, 2020 6:12 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: DEM Recovery <DEM_Recovery@em.myflorida.com>
Subject: FEMA PA Eligibility of Vaccination Related Costs
Attachment(s): "fema_covid-19-vaccination-planning_faq_11-19-2020.pdf"

Good evening everyone:

We are getting lots of follow up questions about the guidance FDEM provided this past week as to eligibility of immunization support activities, specifically freezers and fridges- whether purchased or leased.

Generally: Are costs incurred by SLTT governments for the distribution and administration ofCOVID-19 vaccines eligible for FEMA PA?

FEMA's response (found in the attached guidance): Work and associated costs to support the distribution and administration of COVID-19 vaccines may be eligible for PA. The work and associated costs must be in accordance with PA program eligibility requirements as outlined in the Public Assistance Program and Policy Guide (PAPPG). For example, costs covered by another source of federal funding or insurance are not eligible for PA. The cost of the vaccine itself will be covered by the Federal government and Operation Warp Speed is providing vaccination kits with supplies to support the administration of the vaccine. The vaccine will be made available through established healthcare delivery and reimbursement systems and HHS has established mechanisms and program funding to support the COVID-19 vaccination effort. There may be additional costs incurred by SLTTs to support the distribution and administration of the vaccine. Such costs may be eligible for PA funding when they are necessary to effectively distribute and administer COVID-19 vaccines consistent with CDC guidance and PA program requirements.

All of the underlined caveats found in the attached FEMA policy are potential issues re: the eligibility of immunization support expenses. Specifically FEMA is going to analyze:

- Was the expenditure required as a result of the event?
- Was it reasonable to buy or incur those expenses under the circumstances and were the costs themselves reasonable?
- Was it the legal responsibility of the entity incurring the cost to undertake those support activities and incur those costs?
-

The previous guidance sent out by FDEM regarding freezers and refrigeration was provided out of an abundance of caution. County governments and political subdivisions may be purchasing items in support of immunization activities that FEMA may not ultimately deem eligible. Some concerns additionally include:

- Was the support already provided by another federal program, and therefore not "necessary" ?
- Were the items or services used in support of the immunization activities?

With there being uncertainty early on as to the scope and nature of what was being provided with the immunization "packages" and what additional support may be needed, the advice was provided. As always, it is just our "take" on the guidance and you must make decisions in the best interest of your constituents. We have asked FEMA Region some questions on behalf of specific counties as to specific aspects of their plan and are willing to do the same for any of you. Please reach out to the FDEM Recovery Bureau for additional guidance.

Thank you,

Allison McLeary, Esq.
Recovery Bureau Chief
Florida Division of Emergency Management

Rebuilding Together

(850) 509-8643 (Cell)
Allison.McLeary@em.myflorida.com

Please note that Florida has a broad public records law (Chapter 119, Florida Statutes). Most written communications to or from state employees are public records obtainable by the public upon request. Emails sent to me at this email address may be considered public and will only be withheld from disclosure if deemed confidential pursuant to the laws of the State of Florida.

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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COVID-19 Pandemic: Vaccination Planning FAQ

November 19, 2020

The U.S. government must ensure access to a COVID-19 vaccine that meets FDA's rigorous and science based standards, for all people in the United States who wish to be vaccinated. The U.S. Department of Health and Human Services (HHS), the U.S. Department of Defense (DOD), and other Federal partners are coordinating support requirements for the distribution, storage, and administration of COVID-19 vaccines. Details on the requirements associated with the distribution and administration of the vaccine are based on the vaccines that are expected to be reviewed, and potentially authorized, by the U.S. Food and Drug Administration (FDA).[1] Such requirements include the type of storage and handling necessary for each approved vaccine, transportation and distribution needs, and specific requirements for properly administering the vaccine. Links are provided at the end of this FAQ for more information and resources about general vaccine planning and support mechanisms.

1. How is the Federal government coordinating support for COVID-19 vaccination across departments and agencies?

Following FDA's determination that the vaccine has met the agency's rigorous and science based standards for quality, safety, and effectivenss, Operation Warp Speed[2] is planning to deliver authorized COVID-19 vaccines to Americans as expeditiously as possible. Successful implementation of a national COVID-19 vaccination program requires precise and close coordination across the Federal government, as well as state, local, territorial, and tribal (SLTT) governments and among many public and private partners. Operation Warp Speed is a partnership among components of HHS, including the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), the HHS Assistant Secretary for Preparedness and Response (ASPR), and Biomedical Advanced Research and Development Authority (BARDA), as well as DOD, with the objective of a unified government approach in response to the ongoing COVID-19 pandemic. The goal is to produce and deliver 300 million doses

[1] The FDA is expected to authorize COVID-19 vaccines for use under an Emergency Use Authorization or licensed through the Biologics License Application process.

[2] Fact Sheet: Explaining Operation Warp Speed available at www.hhs.gov/coronavirus/explaining-operation-warp-speed/index.html.

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of authorized vaccines, with the initial doses available by January 2021 (if not sooner) as part of a broader strategy to accelerate the development, manufacturing, and distribution of COVID-19 vaccines and therapeutics.[3] The Federal Emergency Management Agency (FEMA) is also able to provide supplemental funding through the Public Assistance (PA) Program for eligible work and associated costs when necessary for the distribution and administration of COVID-19 vaccines.[4]

2. What sources of Federal funding are available for COVID-19 vaccines?

COVID-19 vaccines will be procured and distributed by the Federal government at no cost to enrolled COVID-19 vaccine providers.[5] The vaccine will be administered primarily through established healthcare systems and distribution points approved by Operation Warp Speed. The cost for vaccine administration will be covered by private and public healthcare providers, most insurance, TRICARE, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and/or other HHS funding sources. Healthcare providers may be reimbursed for administering COVID-19 vaccines to uninsured individuals through HHS's COVID-19 Uninsured Program. Additionally, vaccine providers will be able to charge an administration fee to the program or entity providing reimbursement for COVID-19 vaccines.[6] However, the CDC Provider Agreement[7] states that participating providers must administer COVID-19 vaccines regardless of the vaccine recipient's insurance coverage status or ability to pay COVID-19 vaccine administration fees.[8] Vaccine providers may seek appropriate reimbursement from a program or health plan that covers COVID-19 vaccine administration fees for the individual receiving the vaccine[9] (e.g., private insurance, Medicare, Medicaid, CHIP, etc.).

Operation Warp Speed is also providing vaccination kits,[10] at no cost, which includes the needles, syringes, and Personal Protective Equipment (PPE) needed for safe administration of COVID-19 vaccines. CDC has also allocated funding through established mechanisms to support the distribution of COVID-19 vaccines to SLTT

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[3] Id.

[4] Work and costs must in accordance with PA program eligibility requirements as outlined in the Public Assistance Program and Policy Guide (PAPPG). Version 3.1 of the PAPPG is applicable to all COVID-19 declarations and is available on the FEMA website at www.fema.gov/sites/default/files/2020-03/public-assistance-program-and-policy-guide_v3.1_4-26-2018.pdf.

[5] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations, page 30. www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf.

[6] Getting Vaccinated: www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html.

[7] The CDC COVID-19 Vaccination Program Provider Agreement is available at www.mhanet.com/mhaimages/COVID-19/COVID%20Vaccine%20Provider%20Agreement_Fillable.pdf.

[8] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations, number 4 at page 21. www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf.

[9] COVID-19 Vaccine Implementation Planning Update, page 14: www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-10/COVID-Routh.pdf.

[10] Each ancillary supply kit will contain enough supplies to administer up to 100 doses of vaccine. For a list of items, please visit www.hhs.gov/about/news/2020/10/30/trump-administration-producing-supply-kits-safely-administer-covid-19-vaccines-americans.html.

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public health departments and the SLTT plans for their administration. FEMA is also able to provide supplemental funding through the PA Program for eligible work and costs necessary for the distribution and administration of COVID-19 vaccines and consistent with PA program authorities. Funding may also be available through the FY 2020 Emergency Management Performance Grant Program – COVID-19 Supplemental (EMPG-S). Funding availability is dependent on the eligibility requirements of each program. With the support of interagency partners, FEMA has developed the COVID-19 Healthcare Recovery Resource Roadmap to assist SLTT leaders and stakeholders with navigating some of the challenges, as well as the resources, associated with the COVID-19 pandemic.

3. Are costs incurred by SLTT governments for the distribution and administration of COVID-19 vaccines eligible for FEMA PA?

Work and associated costs to support the distribution and administration of COVID-19 vaccines may be eligible for PA. The work and associated costs must be in accordance with PA program eligibility requirements as outlined in the Public Assistance Program and Policy Guide (PAPPG).[11] For example, costs covered by another source of federal funding or insurance are not eligible for PA. The cost of the vaccine itself will be covered by the Federal government and Operation Warp Speed is providing vaccination kits with supplies to support the administration of the vaccine. The vaccine will be made available through established healthcare delivery and reimbursement systems and HHS has established mechanisms and program funding to support the COVID-19 vaccination effort. There may be additional costs incurred by SLTTs to support the distribution and administration of the vaccine. Such costs may be eligible for PA funding when they are necessary to effectively distribute and administer COVID-19 vaccines consistent with CDC guidance and PA program requirements.

4. What kinds of work and associated costs may be eligible under FEMA PA for COVID-19 vaccines?

Examples of eligible work and costs under FEMA PA include, but are not limited to:

- Personal protective equipment (PPE),[12] other equipment, and supplies required for storing, handling, distributing/transporting, and administering COVID-19 vaccines.
    - PPE includes items necessary for proper handling and administration of vaccines as well as handling dry ice for storage and transportation needs.
    - Equipment includes, coolers, freezers, temperature monitoring devices, and portable vaccine storage units for transportation.

[11] Version 3.1 of the PAPPG is applicable to all COVID-19 declarations and is available on the FEMA website at www.fema.gov/sites/default/files/2020-03/public-assistance-program-and-policy-guide_v3.1_4-26-2018.pdf.

[12] PPE includes items such as N95 and other filtering respirators, surgical masks, gloves, protective eyewear, face shields, and protective clothing (e.g., gowns).

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    - Supplies include emergency medical supplies (for emergency medical care needs that may arise in the administration of the vaccine), sharps containers (for medical waste), and supplies necessary for proper storage like cannisters of liquid nitrogen or dry ice.
    - Transportation support includes refrigerated trucks and transport security when reasonable and necessary.
- Facility support costs, including leasing space for storage and/or administration of vaccines, utilities, maintenance, and security.
- Additional staff if necessary, including medical and support staff not paid for by another funding source, consistent with FEMA PA labor policies (see *Chapter 2:V.A. Applicant (Force Account) Labor* of the PAPPG (V3.1)).
- Onsite infection control measures including PPE for staff as well as cloth face coverings for patients, temperature scanners, physical barriers (e.g., plexiglass dividers), and disinfection of the facility in accordance with CDC guidance.
- Emergency medical care associated with vaccine administration (e.g., to address allergic reactions to the vaccine or other emergency medical needs that arise in the administration of the vaccine).
- Medical waste disposal.
- Communications to disseminate public information regarding vaccinations.[13]

5. Are there work and associated costs eligible for FEMA PA that are also eligible from other sources of Federal funding?

Eligibility among various programs of Federal assistance depends on the specific statutory and regulatory provisions and criteria that apply to each program. In some cases, there may be overlap among programs regarding what is eligible. FEMA will allow costs that are eligible under PA that are also eligible under other Federal programs as long as funding for the same item of work and associated costs is not provided by another source of Federal funding, insurance, or any other funding source. The FEMA fact sheet Coronavirus Disease 2019 (COVID-19) Public Health Emergency: Coordinating Public Assistance and Other Sources of Federal Funding provides information regarding the coordination of COVID-19 funding between FEMA PA and other sources of Federal funding.

6. Will FEMA require SLTT applicants to seek reimbursement of costs through insurance?

Costs for administering the vaccine to individuals may be covered by other mechanisms, including health insurance, TRICARE, Medicare, Medicaid, and other HHS funding sources for uninsured individuals (*i.e.*, HHS COVID-19 Uninsured Program). Costs for which providers have received or will receive payments from health insurance, TRICARE, Medicare, Medicaid, CHIP, or other Federal programs are not eligible under PA. Applicants

[13] Dissemination of public information should be consistent with Chapter 2:VI.B of the PAPPG (V3.1) which lists "dissemination of information to the public to provide warnings and guidance about health and safety hazards using various strategies, such as flyers, public service announcements, or newspaper campaigns" as an eligible emergency protective measure.

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should follow their normal billing practices and must certify that they have not received and do not anticipate receiving assistance from these sources or any other source for the same work or costs.

7. If obtaining required resources is beyond a SLTT government's capability, can it request Direct Federal Assistance for those resources?

When a SLTT government is unable to secure resources that are necessary to effectively distribute and administer COVID-19 vaccines, it may request the resources directly from the Federal government through Direct Federal Assistance (DFA). FEMA will evaluate such requests to determine if those resources are beyond the capability of SLTT jurisdictions and, if so, the best method of securing those resources. Vaccine distribution and administration activities are also an allowable activity under existing Title 32 Mission Assignments to Department of Defense for Title 32 National Guard deployments in response to the COVID-19 pandemic until the President's authorization expires.

8. What is the best source of information for SLTT emergency managers regarding Federal support for COVID-19 vaccine distribution and administration?

SLTT emergency management agencies should coordinate communications, planning, and logistics for vaccine distribution and administration with their public health director and through existing immunization programs. CDC is providing frequent updates to SLTTs and other jurisdictions through engagement with jurisdictional public health and emergency management staff. SLTT health departments have conducted pandemic vaccination planning with immunization and preparedness funding from CDC for over a decade and have been updating those plans specifically for COVID-19. HHS has also been holding regular calls with intergovernmental partners at the SLTT level with robust dialogue on how the Federal government will successfully partner with them on the COVID-19 vaccination program. At the Federal level, emergency managers may contact their regional HHS/ASPR point of contact for more information:

Region 1: ASPR.R1@hhs.gov
Region 2: ASPR.R2@hhs.gov
Region 3: ASPR.R3@hhs.gov
Region 4: ASPR.R4@hhs.gov
Region 5: ASPR.R5@hhs.gov
Region 6: ASPR.R6@hhs.gov
Region 7: ASPR.R7@hhs.gov
Region 8: ASPR.R8@hhs.gov
Region 9: ASPR.R9@hhs.gov
Region 10: ASPR.R10@hhs.gov

Additional Federal information related to COVID-19 vaccine planning and distribution are provided below:

1. CDC Interim Playbook (provides vaccination response planning for SLTT partners)
2. Operation Warp Speed Fact Sheet and Vaccine Distribution Strategy
3. CDC COVID-19 Vaccine FAQ
4. CDC: 8 Things to Know About Vaccine Planning
5. COVID-19 Recovery Resource Roadmaps

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From: McLeary, Allison <Allison.McLeary@em.myflorida.com>
Sent: Tuesday, January 26, 2021 1:38 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: DEM Recovery <DEM_Recovery@em.myflorida.com>
Subject: FEMA Policy re: Labor Eligibility
Attachment(s): "PAPPG V3.1 Labor Eligibility (pages 34-37).pdf"

As a follow-up to today's call, please find FEMA's labor eligibility policy attached/below. The use of Force Account Labor to support vaccination sites must comply with these FEMA policies in order to be eligible. You can also link to PAPPG V3.1, here

In this policy there is a helpful chart summarizing the eligibility of these costs:

Emergency Work Labor Eligibility		
Budgeted Employees	**Overtime**	**Straight-Time**
Permanent employee	☑	
Seasonal employee working during normal season of employment	☑	
Unbudgeted Employees	**Overtime**	**Straight-Time**
Essential employee called back from administrative leave	☑	☑
Permanent employee funded from external source	☑	☑
Temporary employee hired to perform eligible work	☑	☑
Seasonal employee working outside normal season of employment	☑	☑

Thank you,

Allison McLeary, Esq.
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Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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FEMA may disallow all or part of the costs by adjusting eligible funding to an amount it determines to be reasonable.

A. Applicant (Force Account) Labor

FEMA refers to the Applicant's personnel as "force account." FEMA reimburses force account labor based on actual hourly rates plus the cost of the employee's actual fringe benefits. FEMA calculates the fringe benefit cost based on a percentage of the hourly pay rate. Because certain items in a benefit package are not dependent on hours worked (e.g., health insurance), the percentage for overtime is usually different than the percentage for straight-time. Fringe benefits may include:

- Holiday leave
- Accrued vacation leave
- Sick leave
- Social security matching
- Medicare matching
- Unemployment insurance
- Workers compensation
- Retirement
- Health insurance
- Life and disability insurance
- Administrative leave

1. Labor Policies

FEMA determines the eligibility of overtime, premium pay, and compensatory time costs based on the Applicant's pre-disaster written labor policy, provided the policy:

- Does not include a contingency clause that payment is subject to Federal funding;
- Is applied uniformly regardless of a Presidential declaration; and
- Has set non-discretionary criteria for when the Applicant activates various pay types.

If these requirements are not met, FEMA limits PA funding to the Applicant's non-discretionary, uniformly applied pay rates.

All costs must be reasonable and equitable for the type of work being performed.

FEMA will determine whether the number of hours claimed are reasonable and necessary by evaluating:

- The severity of the incident;
- Whether the work was performed at a time when it was necessary to work extraordinary hours based on the circumstances of the incident;
- The function of the employee for which the hours are claimed; and
- The number of consecutive hours the employee worked.

2. Eligibility Criteria Based on Type of Employee and Work Performed

FEMA's criteria for reimbursing straight-time labor costs differ depending on the type of employee and whether that employee is performing Emergency Work or Permanent Work.

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For Permanent Work, both straight-time and overtime labor costs are eligible for both budgeted and unbudgeted employees.[86] For Emergency Work, only overtime labor is eligible for budgeted employees.[87] For unbudgeted employees performing Emergency Work, both straight-time and overtime labor are eligible. Figure 11 indicates different types of budgeted and unbudgeted employees.

Regular Time for Debris Removal Projects

- Alternative Procedures: Eligible
- Standard Program: Ineligible

Under the alternative procedures authorized by Section 428 of the Stafford Act, if the Applicant opts to participate in the straight-time procedure for debris removal, straight-time labor costs are eligible for budgeted employees conducting eligible debris removal (Category A) activities. See Chapter 2:VI.A.1(b) for further information.

Emergency Work Labor Eligibility		
Budgeted Employees	**Overtime**	**Straight-Time**
Permanent employee	☑	
Seasonal employee working during normal season of employment	☑	
Unbudgeted Employees	**Overtime**	**Straight-Time**
Essential employee called back from administrative leave	☑	☑
Permanent employee funded from external source	☑	☑
Temporary employee hired to perform eligible work	☑	☑
Seasonal employee working outside normal season of employment	☑	☑

Figure 11. Emergency Work Labor Eligibility

Reassigned Employees

The Applicant may assign an employee to perform work that is not part of the employee's normal job. For example, a police officer may clear debris. FEMA provides PA funding based on the reassigned employee's normal pay rate, not the pay level appropriate to the work, because the Applicant's incurred cost is the employee's normal pay rate.

Straight-time of a permanent employee funded from an external source (such as a grant from a Federal agency or statutorily dedicated funds) is eligible if the employee is reassigned to perform eligible Emergency Work that the external source does not fund. FEMA must confirm that no duplication of funding exists prior to approval.

Backfill Employees

The Applicant may need to temporarily replace an employee who is responding to the incident. Overtime costs for the backfill employee are eligible even if the backfill employee is not performing eligible work as long as the employee that he/she is replacing is performing eligible Emergency Work.

[86] Stafford Act § 406(a)(2)(C), 42 U.S.C. § 5172, and 44 CFR § 206.228(a)(2)(i).
[87] Stafford Act § 403(d)(1)(B), 42 U.S.C. § 5170b, and 44 CFR § 206.228(a)(2)(iii).

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FEMA also provides PA funding for straight-time if the backfill employee is a:

- Contracted or temporary employee; or
- Permanent employee called in on a normally scheduled day off (weekend or other off day).

If the backfill employee is called in from scheduled leave, only overtime is eligible.

Supervisors

Second-level supervisors and above (e.g., commissioners, mayors, department directors, police and fire chiefs) are usually exempt employees[88] and are not directly involved in the performance of a specific project. Therefore, they are not eligible for overtime, unless the Applicant:

- Demonstrates that the employee was directly involved with a specific project;
- Normally charges that individual's time to specific projects regardless of Federal funding; and
- Incurs overtime costs for the employee in accordance with a labor policy that meets the criteria in Chapter 2:V.A.1.

Other

Extraordinary costs (such as call-back pay, night-time and weekend differential pay, and hazardous duty pay) for essential employees who are called back to duty during administrative leave to perform eligible Emergency Work are eligible if costs are paid in accordance with a labor policy that meets the criteria above.

Administrative leave or similar labor costs incurred for employees sent home or told not to report due to emergency conditions are not eligible.

Stand-by Time

Subject to the provisions of labor cost eligibility criteria, FEMA also provides PA funding for costs related to stand-by time incurred in preparation for and directly related to actions necessary to save lives and protect public health and safety. To be eligible, stand-by time must be reasonable, necessary, and consistent with the Applicant's practice in non-federally declared incidents. Examples of when FEMA may reimburse costs for stand-by time include, but are not limited to:

- When bus drivers are prudently deployed to transport evacuees, even if the bus is not ultimately used for evacuations
- When first responders are prudently deployed for the purpose of evacuating or providing emergency medical care to survivors in order to save lives or protect health and safety, even if the employee does not ultimately perform eligible Emergency Work
- When a contract or union agreement requires payment for stand-by time

FEMA will determine whether any stand-by time claimed is reasonable and necessary based on whether:

- There is a contractual obligation to pay for stand-by time based on a labor agreement

[88] These employees are exempt from the overtime pay requirements set forth in the Fair Labor Standards Act.

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- The stand-by time occurred when it was necessary to have resources available to save lives and protect health and safety

For instance, the Applicant may be required to pay firefighter costs from portal-to-portal, which may result in paying for 24-hour shifts with periods of rest. FEMA will reimburse costs based on such requirements. However, FEMA limits its reimbursement to that which is reasonable and necessary, not to exceed 14 calendar days from the start of the incident period.

B. Applicant (Force Account) Equipment and Purchased Equipment

FEMA provides PA funding for the use of Applicant-owned equipment (force account equipment), including permanently mounted generators, based on hourly rates.[89] FEMA may provide PA funding based on mileage for vehicles, if the mileage is documented and is less costly than hourly rates.

There are instances when an Applicant does not have sufficient equipment to effectively respond to an incident. If the Applicant purchases equipment that it justifiably needs to respond effectively to the incident, FEMA provides PA funding for both the purchase price and either:

- The use of the equipment based on equipment rates (without the ownership and depreciation components); or
- The actual fuel and maintenance costs.

FEMA only applies equipment rates to the time the Applicant is actually operating equipment. Although costs associated with mobilizing equipment to a project site are eligible, costs for standby time (time spent on hold or in reserve) are not eligible unless the equipment operator uses the equipment intermittently for more than half of the working hours for a given day. In this case the intermittent standby time is eligible.

Executive Order (EO) 13688, Federal Support for Local Law Enforcement Equipment Acquisition, requires Federal agencies to ensure careful coordination and oversight of providing military and military-styled equipment, firearms, and tactical vehicles, including property covered under 22 CFR Part 121, The United States Munitions List, and 15 CFR Part 774, The Commerce Control List, (collectively "controlled equipment"), to State, Territorial, Tribal, and local law enforcement agencies. FEMA must comply with this EO when providing PA funding for purchase of this type of equipment.[90] The PA Division at FEMA Headquarters provides specific guidance when an Applicant seeks PA funding for law enforcement equipment.[91]

FEMA provides PA funding for force account equipment usage based on FEMA, State, Territorial, Tribal, or local equipment rates in accordance with the specific criteria noted below.

FEMA Rates

FEMA publishes equipment rates applicable on a national basis.[92] FEMA's rate schedule includes any item powered by fuel or attached to any item powered by fuel. FEMA develops equipment rates based on all costs associated with ownership and operation of equipment, with

[89] 44 CFR § 206.228(a)(1).
[90] Executive Order (EO) 13688, 80 *Fed. Reg.* 3451 (January 22, 2015).
[91] As of the date of this publication, FEMA policy to meet the requirements of EO 13688 is under development. Absent publication of a specific policy, Recipients and Applicants must obtain specific guidance from FEMA.
[92] www.fema.gov/schedule-equipment-rates.

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FL-DEM-21-0173-A-000124

From: McLeary, Allison <Allison.McLeary@em.myflorida.com>
Sent: Monday, January 04, 2021 3:12 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: DEM Recovery <DEM_Recovery@em.myflorida.com>
Subject: FEMA Vaccination FAQ/Planning Guidance
Attachment(s): "Vaccination FAQ- FEMA.pdf"

Happy New Year and good afternoon:

There have been discussions recently about whether funding is available to local governments to support vaccination efforts. Comprehensive guidance on "new" funding sources is not yet available, however FEMA has previously issued the attached planning document that discusses available sources of funding. Please read this document carefully.

Specific to the sources currently administered by FDEM (FEMA PA):
Work and associated costs to support the distribution and administration of COVID-19 vaccines may be eligible for FEMA PA. The work and associated costs must be in accordance with PA program eligibility requirements as outlined in the Public Assistance Program and Policy Guide (PAPPG). Link here: https://www.fema.gov/sites/default/files/2020-03/public-assistance-program-and-policy-guide_v3.1_4-26-2018.pdf

Costs covered by another source of federal funding or insurance are not eligible for PA. The cost of the vaccine itself will be covered by the Federal government and Operation Warp Speed is providing vaccination kits with supplies to support the administration of the vaccine. The vaccine will be made available through established healthcare delivery and reimbursement systems and HHS has established mechanisms and program funding to support the COVID-19 vaccination effort. There may be additional costs incurred by SLTTs to support the distribution and administration of the vaccine. Such costs may be eligible for PA funding when they are necessary to effectively distribute and administer COVID-19 vaccines consistent with CDC guidance and PA program requirements.

Examples of eligible work and costs under FEMA PA include, but are not limited to:
•Personal protective equipment (PPE), other equipment, and supplies required for storing, handling, distributing/transporting, and administering COVID-19 vaccines.
-PPE includes items necessary for proper handling and administration of vaccines as well as handling dry ice for storage and transportation needs.
- Equipment includes, coolers, freezers, temperature monitoring devices, and portable vaccine storage units for transportation.
- Supplies include emergency medical supplies (for emergency medical care needs that may arise in the administration of the vaccine), sharps containers (for medical waste), and supplies necessary for proper storage like cannisters of liquid nitrogen or dry ice
- Transportation support includes refrigerated trucks and transport security when reasonable and necessary.
•Facility support costs, including leasing space for storage and/or administration of vaccines, utilities, maintenance, and security.
•Additional staff if necessary, including medical and support staff not paid for by another funding source, consistent with FEMA PA labor policies (see *Chapter 2:V.A. Applicant (Force Account) Labor* of the PAPPG(V3.1)).
•Onsite infection control measures including PPE for staff as well as cloth face coverings for patients, temperature scanners, physical barriers (e.g., plexiglass dividers), and disinfection of the facility in accordance with CDC guidance.
•Emergency medical care associated with vaccine administration (e.g., to address allergic reactions to the vaccine or other emergency medical needs that arise in the administration of the vaccine).
•Medical waste disposal.
•Communications to disseminate public information regarding vaccinations.

If you would like to explore FEMA PA funding for your vaccination support efforts on an expedited basis, please contact FDEM Recovery Bureau via reply email or reach out to the staff augmentation contractors assigned to your entity for this event, and they can help you develop FEMA PA expedited project request.

Thank you,

Allison McLeary, Esq.
Recovery Bureau Chief
Florida Division of Emergency Management

Rebuilding Together

(850) 509-8643 (Cell)
Allison.McLeary@em.myflorida.com

Please note that Florida has a broad public records law (Chapter 119, Florida Statutes). Most written communications to or from state employees are public records obtainable by the public upon request. Emails sent to me at this email address may be considered public and will only be withheld from disclosure if deemed confidential pursuant to the laws of the State of Florida.

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COVID-19 Pandemic: Vaccination Planning FAQ

November 19, 2020

The U.S. government must ensure access to a COVID-19 vaccine that meets FDA's rigorous and science based standards, for all people in the United States who wish to be vaccinated. The U.S. Department of Health and Human Services (HHS), the U.S. Department of Defense (DOD), and other Federal partners are coordinating support requirements for the distribution, storage, and administration of COVID-19 vaccines. Details on the requirements associated with the distribution and administration of the vaccine are based on the vaccines that are expected to be reviewed, and potentially authorized, by the U.S. Food and Drug Administration (FDA).[1] Such requirements include the type of storage and handling necessary for each approved vaccine, transportation and distribution needs, and specific requirements for properly administering the vaccine. Links are provided at the end of this FAQ for more information and resources about general vaccine planning and support mechanisms.

1. How is the Federal government coordinating support for COVID-19 vaccination across departments and agencies?

Following FDA's determination that the vaccine has met the agency's rigorous and science based standards for quality, safety, and effectivenss, Operation Warp Speed[2] is planning to deliver authorized COVID-19 vaccines to Americans as expeditiously as possible. Successful implementation of a national COVID-19 vaccination program requires precise and close coordination across the Federal government, as well as state, local, territorial, and tribal (SLTT) governments and among many public and private partners. Operation Warp Speed is a partnership among components of HHS, including the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), the HHS Assistant Secretary for Preparedness and Response (ASPR), and Biomedical Advanced Research and Development Authority (BARDA), as well as DOD, with the objective of a unified government approach in response to the ongoing COVID-19 pandemic. The goal is to produce and deliver 300 million doses

[1] The FDA is expected to authorize COVID-19 vaccines for use under an Emergency Use Authorization or licensed through the Biologics License Application process.

[2] Fact Sheet: Explaining Operation Warp Speed available at www.hhs.gov/coronavirus/explaining-operation-warp-speed/index.html.

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of authorized vaccines, with the initial doses available by January 2021 (if not sooner) as part of a broader strategy to accelerate the development, manufacturing, and distribution of COVID-19 vaccines and therapeutics.[3] The Federal Emergency Management Agency (FEMA) is also able to provide supplemental funding through the Public Assistance (PA) Program for eligible work and associated costs when necessary for the distribution and administration of COVID-19 vaccines.[4]

2. What sources of Federal funding are available for COVID-19 vaccines?

COVID-19 vaccines will be procured and distributed by the Federal government at no cost to enrolled COVID-19 vaccine providers.[5] The vaccine will be administered primarily through established healthcare systems and distribution points approved by Operation Warp Speed. The cost for vaccine administration will be covered by private and public healthcare providers, most insurance, TRICARE, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and/or other HHS funding sources. Healthcare providers may be reimbursed for administering COVID-19 vaccines to uninsured individuals through HHS's COVID-19 Uninsured Program. Additionally, vaccine providers will be able to charge an administration fee to the program or entity providing reimbursement for COVID-19 vaccines.[6] However, the CDC Provider Agreement[7] states that participating providers must administer COVID-19 vaccines regardless of the vaccine recipient's insurance coverage status or ability to pay COVID-19 vaccine administration fees.[8] Vaccine providers may seek appropriate reimbursement from a program or health plan that covers COVID-19 vaccine administration fees for the individual receiving the vaccine[9] (e.g., private insurance, Medicare, Medicaid, CHIP, etc.).

Operation Warp Speed is also providing vaccination kits,[10] at no cost, which includes the needles, syringes, and Personal Protective Equipment (PPE) needed for safe administration of COVID-19 vaccines. CDC has also allocated funding through established mechanisms to support the distribution of COVID-19 vaccines to SLTT

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[3] Id.

[4] Work and costs must in accordance with PA program eligibility requirements as outlined in the Public Assistance Program and Policy Guide (PAPPG). Version 3.1 of the PAPPG is applicable to all COVID-19 declarations and is available on the FEMA website at www.fema.gov/sites/default/files/2020-03/public-assistance-program-and-policy-guide_v3.1_4-26-2018.pdf.

[5] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations, page 30. www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf.

[6] Getting Vaccinated: www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html.

[7] The CDC COVID-19 Vaccination Program Provider Agreement is available at www.mhanet.com/mhaimages/COVID-19/COVID%20Vaccine%20Provider%20Agreement_Fillable.pdf.

[8] COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations, number 4 at page 21. www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf.

[9] COVID-19 Vaccine Implementation Planning Update, page 14: www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-10/COVID-Routh.pdf.

[10] Each ancillary supply kit will contain enough supplies to administer up to 100 doses of vaccine. For a list of items, please visit www.hhs.gov/about/news/2020/10/30/trump-administration-producing-supply-kits-safely-administer-covid-19-vaccines-americans.html.

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public health departments and the SLTT plans for their administration. FEMA is also able to provide supplemental funding through the PA Program for eligible work and costs necessary for the distribution and administration of COVID-19 vaccines and consistent with PA program authorities. Funding may also be available through the FY 2020 Emergency Management Performance Grant Program – COVID-19 Supplemental (EMPG-S). Funding availability is dependent on the eligibility requirements of each program. With the support of interagency partners, FEMA has developed the COVID-19 Healthcare Recovery Resource Roadmap to assist SLTT leaders and stakeholders with navigating some of the challenges, as well as the resources, associated with the COVID-19 pandemic.

3. Are costs incurred by SLTT governments for the distribution and administration of COVID-19 vaccines eligible for FEMA PA?

Work and associated costs to support the distribution and administration of COVID-19 vaccines may be eligible for PA. The work and associated costs must be in accordance with PA program eligibility requirements as outlined in the Public Assistance Program and Policy Guide (PAPPG).[11] For example, costs covered by another source of federal funding or insurance are not eligible for PA. The cost of the vaccine itself will be covered by the Federal government and Operation Warp Speed is providing vaccination kits with supplies to support the administration of the vaccine. The vaccine will be made available through established healthcare delivery and reimbursement systems and HHS has established mechanisms and program funding to support the COVID-19 vaccination effort. There may be additional costs incurred by SLTTs to support the distribution and administration of the vaccine. Such costs may be eligible for PA funding when they are necessary to effectively distribute and administer COVID-19 vaccines consistent with CDC guidance and PA program requirements.

4. What kinds of work and associated costs may be eligible under FEMA PA for COVID-19 vaccines?

Examples of eligible work and costs under FEMA PA include, but are not limited to:

- Personal protective equipment (PPE),[12] other equipment, and supplies required for storing, handling, distributing/transporting, and administering COVID-19 vaccines.
    - PPE includes items necessary for proper handling and administration of vaccines as well as handling dry ice for storage and transportation needs.
    - Equipment includes, coolers, freezers, temperature monitoring devices, and portable vaccine storage units for transportation.

[11] Version 3.1 of the PAPPG is applicable to all COVID-19 declarations and is available on the FEMA website at www.fema.gov/sites/default/files/2020-03/public-assistance-program-and-policy-guide_v3.1_4-26-2018.pdf.

[12] PPE includes items such as N95 and other filtering respirators, surgical masks, gloves, protective eyewear, face shields, and protective clothing (e.g., gowns).

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    - Supplies include emergency medical supplies (for emergency medical care needs that may arise in the administration of the vaccine), sharps containers (for medical waste), and supplies necessary for proper storage like cannisters of liquid nitrogen or dry ice.
    - Transportation support includes refrigerated trucks and transport security when reasonable and necessary.
- Facility support costs, including leasing space for storage and/or administration of vaccines, utilities, maintenance, and security.
- Additional staff if necessary, including medical and support staff not paid for by another funding source, consistent with FEMA PA labor policies (see *Chapter 2:V.A. Applicant (Force Account) Labor* of the PAPPG (V3.1)).
- Onsite infection control measures including PPE for staff as well as cloth face coverings for patients, temperature scanners, physical barriers (e.g., plexiglass dividers), and disinfection of the facility in accordance with CDC guidance.
- Emergency medical care associated with vaccine administration (e.g., to address allergic reactions to the vaccine or other emergency medical needs that arise in the administration of the vaccine).
- Medical waste disposal.
- Communications to disseminate public information regarding vaccinations.[13]

5. Are there work and associated costs eligible for FEMA PA that are also eligible from other sources of Federal funding?

Eligibility among various programs of Federal assistance depends on the specific statutory and regulatory provisions and criteria that apply to each program. In some cases, there may be overlap among programs regarding what is eligible. FEMA will allow costs that are eligible under PA that are also eligible under other Federal programs as long as funding for the same item of work and associated costs is not provided by another source of Federal funding, insurance, or any other funding source. The FEMA fact sheet Coronavirus Disease 2019 (COVID-19) Public Health Emergency: Coordinating Public Assistance and Other Sources of Federal Funding provides information regarding the coordination of COVID-19 funding between FEMA PA and other sources of Federal funding.

6. Will FEMA require SLTT applicants to seek reimbursement of costs through insurance?

Costs for administering the vaccine to individuals may be covered by other mechanisms, including health insurance, TRICARE, Medicare, Medicaid, and other HHS funding sources for uninsured individuals (*i.e.*, HHS COVID-19 Uninsured Program). Costs for which providers have received or will receive payments from health insurance, TRICARE, Medicare, Medicaid, CHIP, or other Federal programs are not eligible under PA. Applicants

[13] Dissemination of public information should be consistent with Chapter 2:VI.B of the PAPPG (V3.1) which lists "dissemination of information to the public to provide warnings and guidance about health and safety hazards using various strategies, such as flyers, public service announcements, or newspaper campaigns" as an eligible emergency protective measure.

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should follow their normal billing practices and must certify that they have not received and do not anticipate receiving assistance from these sources or any other source for the same work or costs.

7. If obtaining required resources is beyond a SLTT government's capability, can it request Direct Federal Assistance for those resources?

When a SLTT government is unable to secure resources that are necessary to effectively distribute and administer COVID-19 vaccines, it may request the resources directly from the Federal government through Direct Federal Assistance (DFA). FEMA will evaluate such requests to determine if those resources are beyond the capability of SLTT jurisdictions and, if so, the best method of securing those resources. Vaccine distribution and administration activities are also an allowable activity under existing Title 32 Mission Assignments to Department of Defense for Title 32 National Guard deployments in response to the COVID-19 pandemic until the President's authorization expires.

8. What is the best source of information for SLTT emergency managers regarding Federal support for COVID-19 vaccine distribution and administration?

SLTT emergency management agencies should coordinate communications, planning, and logistics for vaccine distribution and administration with their public health director and through existing immunization programs. CDC is providing frequent updates to SLTTs and other jurisdictions through engagement with jurisdictional public health and emergency management staff. SLTT health departments have conducted pandemic vaccination planning with immunization and preparedness funding from CDC for over a decade and have been updating those plans specifically for COVID-19. HHS has also been holding regular calls with intergovernmental partners at the SLTT level with robust dialogue on how the Federal government will successfully partner with them on the COVID-19 vaccination program. At the Federal level, emergency managers may contact their regional HHS/ASPR point of contact for more information:

Region 1: ASPR.R1@hhs.gov
Region 2: ASPR.R2@hhs.gov
Region 3: ASPR.R3@hhs.gov
Region 4: ASPR.R4@hhs.gov
Region 5: ASPR.R5@hhs.gov
Region 6: ASPR.R6@hhs.gov
Region 7: ASPR.R7@hhs.gov
Region 8: ASPR.R8@hhs.gov
Region 9: ASPR.R9@hhs.gov
Region 10: ASPR.R10@hhs.gov

Additional Federal information related to COVID-19 vaccine planning and distribution are provided below:

1. CDC Interim Playbook (provides vaccination response planning for SLTT partners)
2. Operation Warp Speed Fact Sheet and Vaccine Distribution Strategy
3. CDC COVID-19 Vaccine FAQ
4. CDC: 8 Things to Know About Vaccine Planning
5. COVID-19 Recovery Resource Roadmaps

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From: McLeary, Allison <Allison.McLeary@em.myflorida.com>
Sent: Friday, January 22, 2021 12:19 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: DEM Recovery <DEM_Recovery@em.myflorida.com>
Subject: FEMA Webinars- Week of 1/25-1/29
Attachment(s): "FEMA PA Webinars 2021-1.25 to 1.29 FINAL.pdf"

Please find next week's FEMA webinar schedule attached. It will also be posted on www.floridaPA.org

Webinars are designed to train State, Local, Tribal, and Territorial (SLTT) stakeholders, but are open to all who want to learn about the Public Assistance (PA) grant process and the FEMA Grants Portal website that is used for PA grants. No preregistration is required. Sessions may be recorded.

To watch these webinars and other on-demand videos, visit FEMA's Grants Manager/Grants Portal YouTube Channel or the Support Center in Grants Portal (https://www.youtube.com/channel/UCIJp91Ds2IaVlR1t8uXcEKg)

Thank you,

Allison McLeary, Esq.
Recovery Bureau Chief
Florida Division of Emergency Management

Rebuilding Together

(850) 509-8643 (Cell)
Allison.McLeary@em.myflorida.com

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FEMA Public Assistance Training Section – SLTT Team

Recipient and Applicant Webinars

Week of January 25 - 29, 2021

Recipient and Applicant Webinars are designed to train State, Local, Tribal, and Territorial (SLTT) stakeholders, but are open to all who want to learn about the Public Assistance (PA) grant process and the FEMA Grants Portal website that is used for PA grants. No preregistration is required. Sessions may be recorded. To watch these webinars and other on-demand videos, visit our other platforms, the FEMA's Grants Manager/Grants Portal YouTube Channel or the Support Center in Grants Manager and Grants Portal.

Request for Public Assistance and Applicant Impact Survey [RPA and AIS]	**Management Costs and Category Z Streamlined Project Application [Cat Z]**	**Streamlined Project Application [SPA]**	**Updated - COVID-19 Streamlined Project Application [COVID SPA]**
• An overview of the updated RPA submission process • Applicant Impact Survey in the Grants Portal	• An overview of Management Costs • Documenting costs • Category Z Streamlined Project Application in Grants Portal	• Streamlined Process Flow for Non-COVID-19 Streamlined Declarations • Category B Streamlined Project Application in Grants Portal • Documentation/Forms	• Streamlined Project Application in Grants Portal and discussion of new additions to the form • COVID-19 Documentation / Forms

All sessions are approximately an hour unless otherwise noted

All times are listed in Eastern Daylight Time (EDT), please convert to your local time zone

Monday 1/25	Tuesday 1/26	Wednesday 1/27	Thursday 1/28	Friday 1/29
• **12:00 pm:** RPA and AIS	• **12:00 pm:** SPA • **6:00 pm:** Cat Z	• **11:00 am:** Cat Z • **2:00 pm:** COVID SPA	• **11:00 am:** COVID SPA • **6:00 pm:** RPA and AIS	• **2:00 pm:** SPA
Link to attend: https://fema.zoomgov.com/j/1600760821 **Password:** PA2021 Meeting ID if requested: 160 076 0821				

New Zoom Link and Password for the 2021

To join a webinar, click the corresponding link above at the designated time and enter the meeting password. **Please sign in with your full name, organization, state, tribe, and/or territory** for tracking purposes.

Trouble Shooting: If you have trouble logging in using the link provided, visit https://fema.zoomgov.com/. Choose "Join Meeting," enter the meeting ID and then the password when prompted. You may sign into Zoom as a guest. Your Zoom log-in information is not the same as your Grants Portal log-in information.

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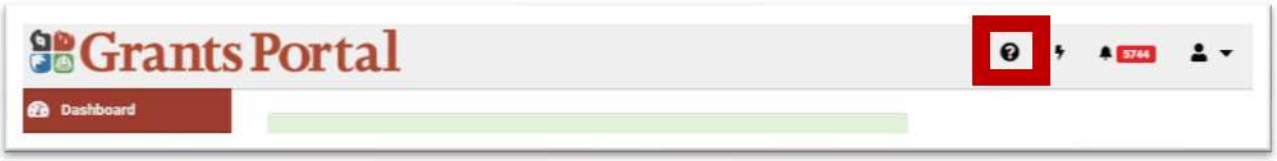
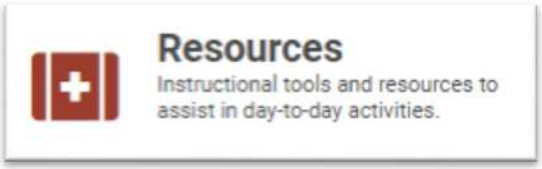
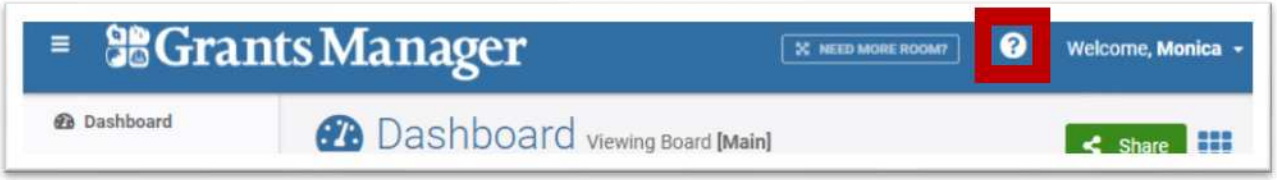
Have an Old Schedule?

- The schedule for the current week is available in the Support Center of both Grants Manager and Grants Portal. Check the current schedule to make sure you have the most updated link

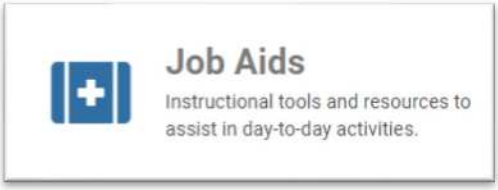


- Grants Portal Support Center under Resources





- Grants Manager Support Center under Job Aids



Can't attend the webinar at the offered time?

- All previous webinars have been recorded and are available either as parts or as whole videos on both YouTube and in the Support Center of Grants Manager and Grants Portal.
- To watch these webinars and other on-demand videos anytime, visit FEMA's Grants Manager Grants Portal YouTube Channel - https://www.youtube.com/channel/UCIJp91Ds2IaVlR1t8uXcEKg
- New webinars take about three weeks to get uploaded onto these platforms.

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From: McLeary, Allison <Allison.McLeary@em.myflorida.com>
Sent: Friday, January 08, 2021 2:16 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: DEM Recovery <DEM_Recovery@em.myflorida.com>
Subject: FEMA Webinars
Attachment(s): "FEMA PA Webinars 2021-1.11 to 1.15.pdf"

Please find next week's FEMA webinar schedule attached. It will also be posted on www.floridaPA.org

Webinars are designed to train State, Local, Tribal, and Territorial (SLTT) stakeholders, but are open to all who want to learn about the Public Assistance (PA) grant process and the FEMA Grants Portal website that is used for PA grants. No preregistration is required. Sessions may be recorded.

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Thank you,

Allison McLeary, Esq.
Recovery Bureau Chief
Florida Division of Emergency Management

Rebuilding Together

(850) 509-8643 (Cell)
Allison.McLeary@em.myflorida.com

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FEMA Public Assistance Training Section – SLTT Team

Recipient and Applicant Webinars

Week of January 11 - 15, 2021

Recipient and Applicant Webinars are designed to train State, Local, Tribal, and Territorial (SLTT) stakeholders, but are open to all who want to learn about the Public Assistance (PA) grant process and the FEMA Grants Portal website that is used for PA grants. No preregistration is required. Sessions may be recorded. To watch these webinars and other on-demand videos, visit our other platforms, the FEMA's Grants Manager/Grants Portal YouTube Channel or the Support Center in Grants Manager and Grants Portal

Emergency Protective Measures & Donated Resources [EPM & DR] ***Video available on all platforms***	**Management Costs and Category Z Streamlined Project Application [Cat Z]**	**Grants Portal Overview: "I'm Logged in Now what?" [Overview]** ***Video available on all platforms***	**COVID-19 Streamlined Project Application [COVID SPA]** ***Video available on all platforms***
• Understand and document your protective measures and purchases • Learn how donated resources can reduce cost shares	• An overview of Management Costs • Documenting costs • Category Z Streamlined Project Application in Grants Portal	• An overview of quick actions and Grants Portal functionality that applicants and recipients will use while navigating Grants Portal	• Streamlined Process Flow for COVID-19 Declarations • Streamlined Project Application in Grants Portal • COVID-19 Documentation / Forms

All sessions are approximately an hour unless otherwise noted

All times are listed in Eastern Daylight Time (EDT), please convert to your local time zone

Monday 1/11	Tuesday 1/12	Wednesday 1/13	Thursday 1/14	Friday 1/15
• **12:00 pm:** Cat Z	• **9:00 am:** Overview • **2:00 pm:** EPM & DR	• **4:00 pm:** Overview	• **12:00 pm:** EPM & DR • **6:00 pm:** COVID SPA	• **12:00 pm:** COVID SPA
Link to attend: https://fema.zoomgov.com/j/1600760821 **Password:** PA2021 Meeting ID if requested: 160 076 0821				

New Zoom Link and Password for the 2021

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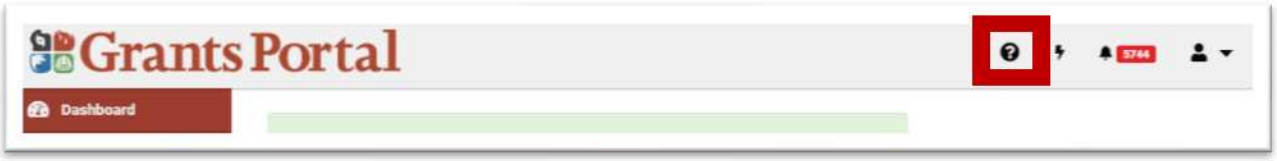
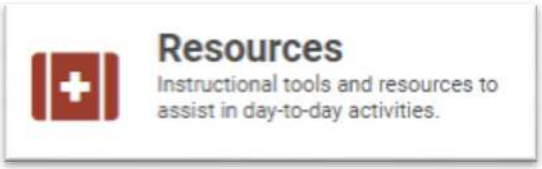
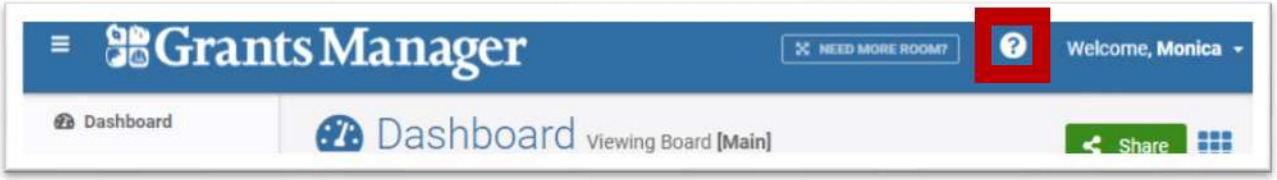


- Grants Portal Support Center under Resources





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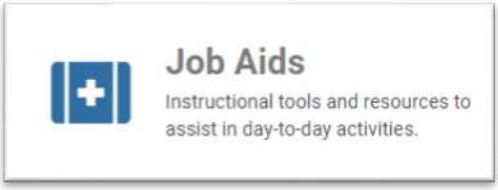

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- New webinars take about three weeks to get uploaded onto these platforms.

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From: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Sent: Monday, December 14, 2020 5:12 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: Phillips, Mike <mikephillips@fdle.state.fl.us>
Subject: FSA Email

Good evening,

Many of you have emailed me regarding an email that was sent today by the FSA that we were not aware of until after it went out. We are currently working with FSA and FDOC as to the email and attached plan.

We will update you as soon as we can.

Sent from my iPhone
Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Monday, January 11, 2021 10:52 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>
Subject: FW: *NEW CALL INFORMATION* CDC COVID-19 All State Update Call series (3)
Attachment(s): "January 11 All State Agenda_participants.docx","January 4 2021 All State Summary _ Final.docx"

Per HHS/CDC.

Subject: *NEW CALL INFORMATION* CDC COVID-19 All State Update Call series (3)

FYI…
Due to the large number of recipients thus has been sent via blind copied

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****NEW CALL INFORMATION****

CDC's 2019 Novel Coronavirus (COVID-19) response team will continue to host a national call series from 2 p.m. to 2:45 p.m. EST every Monday, to provide state and local partners with the latest information on the novel coronavirus outbreak and U.S. preparedness efforts.

Invited participants include state, local, and territorial preparedness directors, state epidemiologists, state health officials, public health laboratory directors, and nongovernmental partners. Participant information can be found below.

Participant Information

Bridgeline: 1(888) 455-8370
Passcode: 5206512

Thank you,

Health Department Task Force
Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24/7
PROTECTING AMERICA'S SAFETY, HEALTH, AND SECURITY

(Sent to PHEP directors & secondary POCs, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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CDC COVID-19 All State Update Call

Monday, January 11, 2021; 2:00-2:45

Participant Bridgeline: 1-888-455-8370 Participant Passcode: 5206512

Audience: State, Local, and territorial Preparedness Directors, State Epidemiologists, State Health Officials, Public Health Laboratory Directors, Big City Health Coalition, Nongovernmental partners, and Immunization Services Division Awardees.

Welcome & Introductions – Dr. Mark Anderson

- *Purpose of Call*
- *Remind participants this call is NOT for the media*
- *Non-vaccine related questions should be directed to: eocevent424@cdc.gov.*
- *Vaccine related question should be directed to: eocevent480@cdc.gov.*
- *Due to the Birthday of Martin Luther King, Jr. Holiday on Monday, January 18, next week's call is scheduled for Tuesday, January 19 from 2:00 – 2:45 pm.*

Incident Manager's Update – Dr. Henry Walke

Updates

- Racial and Ethnic Health Disparities Web Resources – Terica Scott, CHEO Partnership Lead supporting the Chief Health Equity Officer
- Vaccine Task Force Update – Dr. Janell Routh, Co-Lead, Vaccine Implementation Unit
- Variant Update – Dr. Greg Armstrong, Director, Advanced Molecular Detection Program
    - Web resources
        - New COVID-19 Variants
        - Emerging SARS-CoV-2 Variants
        - Interim: Implications of the Emerging SARS-CoV-2 Variant
        - CDC's Advanced Molecular Detection Program

Questions and Answers

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CDC COVID-19 All State Update Call

Monday, January 4, 2021; 2:00-3:00 pm

Incident Manager's Update - Dr. Henry Walke

- Over the past week, increases in cases, deaths, and hospitalizations:
  - 205,000 + cases/day
  - 2600 + deaths/day
- Up-to-date tracking via CDC COVID DATA TRACKER with an expanded jurisdiction view for VACCINE DISTRIBUTION AND ADMINISTRATION
- CDC has 57 deployments, 28 teams supporting various jurisdictions
- Seven MMWR articles planned for release this week:
  - All COVID-19 MMWR articles can be found here

Vaccine Task Force Update – Dr. Leanne Fox, Co-lead Vaccine Implementation Unit

- Several factors contributed to jurisdictions taking a more measured approach to vaccine administration:
  - These are new vaccines using new platforms with complex requirements for storage, handling, and administration.
  - The vaccination campaign launched in the midst of a pandemic, with strained health care providers and public health departments balancing vaccine administration with caring for increasing numbers of COVID-19 patients.
  - The vaccination campaign also began during the winter holidays.
- CDC is encouraged that since December 14th, over 4.8 million individuals have received the vaccine with an expected rapid increase in January
- Many jurisdictions have also set aside vaccines for the long-term care pharmacy program:
  - Over 3.2 million vaccines distributed to the program
  - 429,000+ individuals have been vaccinated via the program
- CDC was appropriated $8.75 billion in COVID-19 supplemental funding for domestic and international efforts
  - Minimum of $4.5 billion for States, Tribes, Localities, and Territories for implementation of the COVID-19 vaccine program
  - Not less than $300 million for high-risk and underserved populations to include racial and ethnic minority populations in rural communities
  - At least $1 billion is to be made available within 21 days of enactment
- CDC is currently working to obligate COVID-19 supplemental funding where it is most needed. Additional information forthcoming as details are available.
- Jurisdictions will receive a survey and be contacted for an interview to:
  - Assess readiness to administer
  - Address any gaps and challenges
  - Identify ways CDC can provide support with preparation for upcoming funding

Healthcare Resilience Working Group Surge Roadmap Webinar - CDR Chitra Mahadevan, External Engagement Lead, Healthcare Resilience Working Group

- The Healthcare Resilience Working Group (HRWG) created Strategies for Managing a Surge in COVID-19 cases, which we refer to as the Surge Roadmap, to provide guidance to various jurisdictions on how to enhance health care capabilities in response to a surge in COVID-19 cases.
  - This resource consolidates multiple resources related to healthcare workforce staffing, PPE preservation, and establishing a Medical Operations Coordination Cell (MOCC) and Alternate Care Site (ACS). HRWG recently recorded a Surge Roadmap Webinar to share this resource with stakeholders, which is available on ASPR TRACIE.
- The links to access the slides and recording are listed below:

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CDC COVID-19 All State Update Call

Monday, January 4, 2021; 2:00-3:00 pm

1. Recording: https://attendee.gotowebinar.com/recording/1700367656049205264
2. Slides: https://files.asprtracie.hhs.gov/documents/patient-surge-management-resources-webinar-slides.pdf

- For inquiries, contact the Healthcare Resilience Working Group at: COVID-Healthcare-RFI@hhs.gov

Ventilation Guidance – Dr. Stephen Martin, Senior Research Engineer, NIOSH Ventilation Team

- CDC Workers Safety and Health team provides guidance for employees and employers across multiple workplaces and industry sectors during the COVID-19 pandemic:
  - Recommendations for Ventilation in Buildings
  - Ventilation FAQs
  - Resuming Business Toolbox

COVID-19 case surveillance microdata: restricted access and public use datasets (data.cdc.gov) – Dr. Paula Yoon, Data, Analytics & Visualization Task Force

- CDC offers several tools and datasets for public use including the COVID-19 Data Tracker, COVIDView, and COVID-19 case surveillance microdata (line-level data from the case reports that jurisdictions share with CDC).
- Microdata is published in two formats (updated monthly):
  - Public-use file https://data.cdc.gov/Case-Surveillance/COVID-19-Case-Surveillance-Public-Use-Data/vbim-akqf
  - Restricted access file https://data.cdc.gov/Case-Surveillance/COVID-19-Case-Surveillance-Restricted-Access-Detai/mbd7-r32t
    - ☐ This file includes 31 data elements including county and state of residence
    - ☐ Data suppression has been applied to protect individual privacy
    - ☐ Access is granted after completing an easy online registration process including a data use agreement
  - To support CDC's goal of increasing the public's ongoing access to COVID-19 data, CDC is engaged in several data privacy activities including:
    - ☐ Key informant interviews with data privacy experts
    - ☐ Systematic review of data privacy literature
    - ☐ Data privacy reviews of selected data sets by an external organization

Variant Update – Dr. Greg Armstrong, CDC Advanced Molecular Detection Program

- Two new variants of concern have surfaced around November 2019
  - Appears to be about 50% more transmissible than the older variant
  - More vigilance in following public health measures to slow the spread of this variant is needed.
  - Does not appear to cause more severe or less severe symptoms
- Access the links below for variant updates:
  - New COVID-19 Variants
  - Emerging SARS-CoV-2 Variants
  - Implications of the Emerging SARS-CoV-2 Variant
  - CDC's Advanced Molecular Detection Program

Q&A:

MMWR

1. **Q:** Can you share more about the MMWR papers coming out that support the quarantine options?

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A: Two new MMWRs are looking at testing at 7 days and then looking at 10 days without testing. It is not zero risk, but the rates are under 5% after 10 days. All COVID-19 MMWR articles can be found here

2. **Q:** Are the 7-day (with negative test) and 10-day quarantine options applicable to households given the January 1st MMWR on shortened quarantine among household? Will the guidelines be updated for household contacts compared to other contacts?
   A: It is important to recognize that households and congregate settings are different than an individual in quarantine. Guidance will continue to update as we learn more information.

Vaccines

3. **Q:** For discussion: Has CDC considered using funds to add to what insurance pays to providers for vaccine administration to get more entities involved?
   A: CDC does not have guidance on this.

4. **Q:** Are there any plans for vaccine finder tools online for individuals to find vaccination locations?
   A: CDC does not currently have a tool for individuals to find COVID-19 vaccination locations. There are two separate VaccineFinder systems: one is for routine and seasonal vaccines and that does not include COVID-19 at this time: https://vaccinefinder.org/. The other is for COVID-19 vaccine providers and is accessible by invite only. If there are providers in your state who have received or are receiving COVID-19 vaccine in the next two weeks, please let us know and we will set them for onboarding to the COVID-19 VaccineFinder. Additional information can be found on CDC's VaccineFinder resource page.

5. **Q:** Clinical considerations for vaccination say that the vaccines don't interfere with TB test results, but then says you should change timing of TB testing – can you help clarify this?
   A: Please see the full guidance here: https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html

6. **Q:** Do we know if the vaccine will be effective for the new variants?
   A: We don't have a definitive answer at this time, but it is expected that the antibodies from vaccinations will still be effective. More data will be needed to confirm this. It should also be noted that due to the potential increased transmissibility of the new variants, higher vaccine coverage will be needed to shut down transmission.

7. **Q:** Does CDC still encourage states to stay in phase 1a if it's not yet feasible to move into 1b and 1c at this time?
   A: CDC recommends beginning vaccination under phase 1a, and then moving to subsequent phases. Interim Considerations for Phased Implementation of COVID-19 Vaccination and Sub-Prioritization Among Recommended Populations includes considerations for moving from one phase to the next. CDC emphasizes the phased approach but recognizes that some jurisdictions may need to make local decisions based on supply and vaccine uptake. Initiation of phases is likely to be overlapping. Administration of all available doses is encouraged to increase update and avoid wastage. Therefore, vaccination of populations in subsequent phases may occur.

Ventilation

8. **Q:** Does CDC have guidance on maintaining humidity levels?
   A: CDC does not currently have guidance on humidity but will share if new guidance becomes available.

Variant

9. **Q:** If a state finds their first cases of a new variant through testing, should it be reported to the CDC before going public?
   A: CDC would appreciate knowing if states would like to share this information. States can contact the Labs Task Force Strain Surveillance inbox: eocevent506@cdc.gov

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10. **Q:** Do the current diagnostic tests still detect the new variants?
    A: CDC expects that the current tests are effective in detecting the new variants.

11. **Q:** Does CDC recommend that states test people that have recently traveled to the UK based on Epi-X alerts?
    A: There is no expectation, but we will circle back with the travel group on this.

12. **Q:** Are there plans for guidance on surveillance or case investigation for the B.1.1.7 variant?
    A: Currently, CDC does not have guidance on this. CDC will be in contact with states and to discuss a plan for moving forward.

        Follow up Q: Would you recommend sequencing the cases that have recently travel to the UK?
        A: We don't have enough information to provide guidance currently. It may be a useful strategy for states that have capacity for sequencing. For other states that have cases of interest, please reach out to CDC for sequencing support that may be available.

As a reminder, if you have other questions, please send non-vaccine related questions to **eocevent424@cdc.gov** and vaccine-related questions **eocevent480@cdc.gov**.

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From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Thursday, December 17, 2020 4:16 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>
Subject: FW: CDC COCA Call Friday, December 18: What Clinicians Need to Know About the Pfizer-BioNTech and Moderna COVID-19 Vaccines

Per HHS.

What Clinicians Need to Know About the Pfizer-BioNTech and Moderna COVID-19 Vaccines

Overview

This COCA Call will give clinicians an overview of the Pfizer-BioNTech and Moderna COVID-19 vaccines. Clinicians will learn about vaccine characteristics and administration, vaccinating special populations, and contraindications. They will also get answers to a number of clinical questions CDC has received about these new vaccines.

If you are unable to attend the live COCA Call, the recording will be available for viewing on the COCA

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Call webpage a few hours after the live event ends.

The slide set will be available under "Call Materials" on the COCA Call webpage.

Advanced registration is not required.

Date: Friday, December 18, 2020

Time: 2:00 pm - 3:00 pm (ET)

A few minutes before the webinar starts, please click on the Zoom link below to join:
https://www.zoomgov.com/j/1606816862?pwd=NFFBS0ErU09BOVB5UlpOZzg2SjRwUT09

Or iPhone one-tap:
US:
+16692545252,,1606816862#,,,,,,0#,,105116#
or
+16468287666,,1606816862#,,,,,,0#,,105116#

Or Telephone: Dial (for higher quality, dial a number based on your current location):
US: +1 669 254 5252 or +1 646 828 7666

Webinar ID: 160 681 6862
Passcode: 105116

Due to the high demand we anticipate for this COCA Call, we encourage participants to consider viewing it on U.S. Stream TV.

Watch via U.S. Stream TV:
https://www.ustream.tv/channel/dwxer96bR7q

International numbers available:
https://www.zoomgov.com/zoomconference?m=LQrypUYZ2oBE1q6VNVpum7gKGSpbqzqM

COCA Call Objectives

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At the conclusion of the session, the participant will be able to accomplish the following—

1. Cite background information on the topic covered during the presentation.
2. Discuss CDC's role in the topic covered during the presentation.
3. Describe the topic's implications for clinicians.
4. Discuss concerns and/or issues related to preparedness for and/or response to urgent public health threats.
5. Promote health improvement, wellness, and disease prevention in cooperation with patients, communities, at-risk populations, and other members of an interprofessional team of healthcare providers.

Presenters

Amanda Cohn, MD
CAPT, U.S. Public Health Service
Lead, Vaccine Planning Unit
COVID-19 Response
Centers for Disease Control and Prevention

Sarah Mbaeyi, MD, MPH
CDR, U.S. Public Health Service
Medical Officer
National Center for Immunization and Respiratory Diseases
Centers for Disease Control and Prevention

Sara Oliver, MD
LCDR, U.S. Public Health Service
Co-lead, Advisory Committee for Immunization Practices COVID-19 Vaccines Work Group
COVID-19 Response
Centers for Disease Control and Prevention

The Emergency Risk Communication Branch in the Division of Emergency Operations, Center for Preparedness and Response is responsible for the management of all COCA products.

For information about this update or other clinical issues, or to send your feedback, please contact us at coca@cdc.gov

- CDC Clinician Outreach and Communication Activity Facebook page—connect with COCA on Facebook
- Clinician Outreach and Communication Activity—resources for healthcare providers
- COCA RSS Feed—subscribe to be notified of conference calls, updates, and CDC guidance for health providers
- Crisis & Emergency Risk Communication Training—training program that draws from lessons learned during public health emergencies, and incorporates best practices from the fields of risk and crisis communication
- Health Alert Network—CDC's primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, territorial, and local public health practitioners; clinicians; and public health laboratories

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Centers for Disease Control and Prevention

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Questions or Problems | Unsubscribe

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From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Tuesday, December 15, 2020 9:25 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>
Subject: FW: CDC communications and items of interest
Attachment(s): "COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations_V2.pdf","Pharmacy Partnerships for Longterm Care_12.01.2020.docx"

FYSA – per CDC/HHS.

General COVID messages that states can adapt

- https://www.cdc.gov/coronavirus/2019-ncov/communication/index.html
- https://www.cdc.gov/coronavirus/2019-ncov/community/communication-plan.html
    - Section 3: Communication resources – with resources already translated in multiple languages
- https://www.cdc.gov/coronavirus/2019-ncov/communication/social-media-toolkit.html
    - Social media toolkit

Vaccine communication messages

- https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html
- https://www.cdc.gov/coronavirus/2019-ncov/vaccines/8-things.html

COVID-19 Grant Opportunities and Guidance

- https://www.hhs.gov/coronavirus/grants/index.html
- https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html

Additionally, the Vaccination Playbook from CDC (v2) is attached – **Note that section 12 is all on communications**. The pharmacy partnership documents provided to jurisdictions is attached too.

V/r,
Ash

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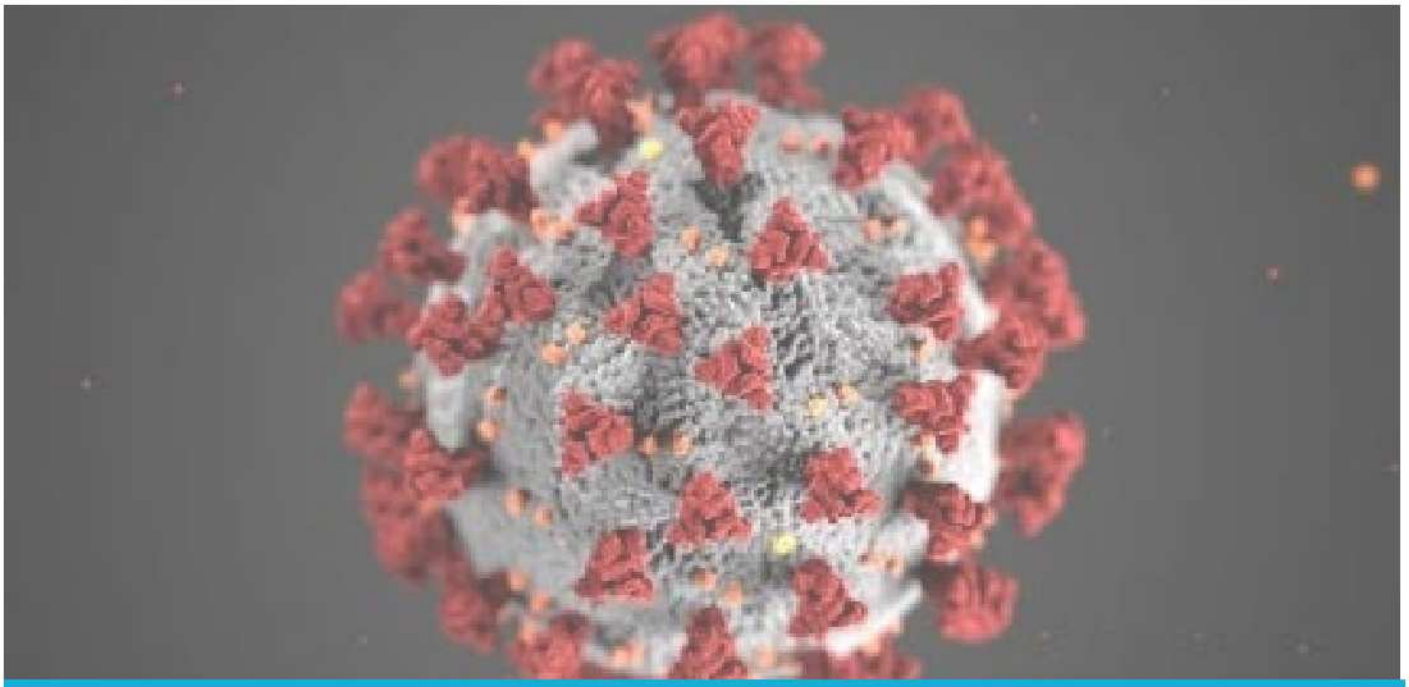

COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations

Centers for Disease Control and Prevention (CDC)

October 29, 2020

Version 2.0

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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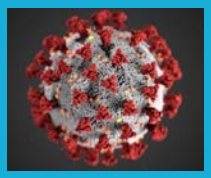
COVID-19 VACCINATION PROGRAM INTERIM PLAYBOOK FOR JURISDICTION OPERATIONS – October 29, 2020



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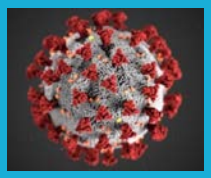

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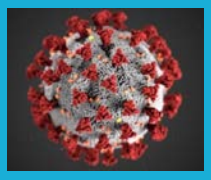

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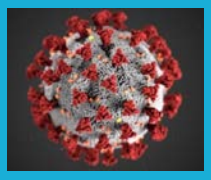
FL-DEM-21-0173-A-000153



Executive Summary

Immunization with a safe and effective COVID-19 vaccine is a critical component of the United States strategy to reduce COVID-19-related illnesses, hospitalizations, and deaths and to help restore societal functioning. The goal of the U.S. government is to have enough COVID-19 vaccine for all people in the United States who wish to be vaccinated. Early in the COVID-19 Vaccination Program, there may be a limited supply of COVID-19 vaccine, and vaccination efforts may focus on those critical to the response, providing direct care, and maintaining societal function, as well as those at highest risk for developing severe illness from COVID-19.

This document serves as an interim playbook for state, territorial (including the US-affiliated Pacific Islands [USAPI] of American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau), tribal, and local public health programs and their partners on how to plan and operationalize a vaccination response to COVID-19 within their jurisdictions. The document's sections cover specific areas of COVID-19 vaccination program planning and implementation and provide key guidance documents and links to resources to assist those efforts. Many, but not all, of the COVID-19 Vaccination Program activities described may overlap with routine activities; routine immunization and pandemic influenza program activities can serve as a foundation for COVID-19 vaccination planning.

Centers for Disease Control and Prevention (CDC) Immunization and Vaccines for Children Cooperative Agreement funding recipients (i.e., "awardees") should use this document to develop and update their COVID-19 vaccination plans. Within their vaccination plans, awardees must address all requirements outlined in the playbook and clearly describe their responsibility for ensuring activities are implemented. All awardees have submitted their interim plans to their CDC project officer.

Information in this interim playbook will be updated as new information (e.g., recommendations for pregnant women or pediatric populations) becomes available.

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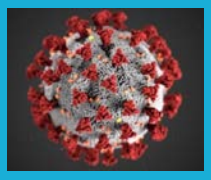
FL-DEM-21-0173-A-000154



Section 1: Public Health Preparedness Planning

Pandemic vaccination response planning requires collaboration among a wide range of public- and private-sector partners, including immunization and public health emergency preparedness programs, emergency management agencies, healthcare organizations, industry groups that include critical infrastructure sectors, policy makers, and community vaccination providers (e.g., pharmacies, occupational health settings, doctors' offices). Many of these partners are engaged regularly in seasonal influenza and other outbreak vaccination campaigns, and many served as vaccination providers[1] during the 2009 H1N1 pandemic. However, significant additional planning is needed to operationalize a vaccination response to COVID-19, which is much larger in scope and complexity than seasonal influenza or other previous outbreak-related vaccination responses. Following the planning and improvement guidance below can assist in developing a jurisdiction's baseline readiness to launch the COVID-19 Vaccination Program.

Improvement Planning

Improvement planning is the identification of strengths, areas for improvement, and corrective actions that results from workshops, exercises, or real-world events. Jurisdictions should use a consistent approach for improvement-related activities across each of their COVID-19 vaccination preparedness planning components. Gaps in program planning are often identified when plans are tested, whether through a real event, such as a hepatitis A outbreak, or a full-scale vaccination exercise. Jurisdictions should test their COVID-19 vaccination program plans, and after testing, assign roles and responsibilities with target completion dates for specific tasks to ensure that corrective actions are fully implemented. Periodic review and revision of plans are integral to the improvement process. Jurisdictions should support continuous quality improvement as they move through different phases of workshops, exercises, and actual COVID-19 vaccination program implementation, making and operationalizing improvements in an ongoing manner.

COVID-19 Vaccination Program Planning

Prior to plan development, it is important for jurisdictions to have full situational awareness. There are many unknowns and unanswered questions at this time. For example, it is not yet known which vaccines will be available, in what volumes, at what time, with what efficacy, and with what storage and handling requirements. However, jurisdictions should review all current planning assumptions to assist with early planning efforts. (See *Appendix A: COVID-19 Vaccination Planning Assumptions for Jurisdictions.*)

In addition to current situational awareness, there is much to learn from past experiences. Jurisdictions may find it helpful to review their 2009 H1N1 pandemic vaccination response plans and lessons learned. After-action reports and improvement plans from that time provide an opportunity for jurisdictions to build on prior strengths and determine any gaps that may need to be addressed.

After plans have been drafted, it is important to identify any weaknesses by conducting exercises, including workshops or tabletop, functional, or full-scale exercises. This may be particularly valuable for any activities planned with external partners. For example, vaccination clinics in temporary or off-site settings, such as those planned for essential workers, are an excellent opportunity for exercises. Specific procedures to assess could

[1] For the purposes of this document, "vaccination provider" refers to any facility, organization, or healthcare provider licensed to possess/administer vaccine or provide vaccination services. A "COVID-19 vaccination provider" is any vaccination provider who has been enrolled in the COVID-19 Vaccination Program.

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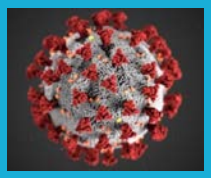

include cold chain management, vaccine administration and documentation, traffic flow, or social distancing and sanitation measures. The Federal Emergency Management Agency (FEMA) has posted information on its Homeland Security Exercise and Evaluation program that jurisdictions may find useful as they plan their own exercises.

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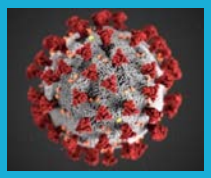

Section 2: COVID-19 Organizational Structure and Partner Involvement

Pandemic vaccination planning is a combined state, territorial, tribal, and local responsibility that requires close collaboration between public health, external agencies, and community partners. Depending on the specific jurisdiction's governance structure, the jurisdiction may play a key role in ensuring readiness at all levels. It is imperative that state and local jurisdictions, tribal nations, and their planning partners clearly understand each other's roles and responsibilities in the COVID-19 Vaccination Program.

Planning and Coordination Team (Internal)

An internal COVID-19 Vaccination Program planning and coordination team is critical to ensure the vaccination response to COVID-19 is thoughtfully planned and successfully executed. A wide array of expertise should be represented among team members. Jurisdictions should consider broad inclusion from the immunization program, preparedness program, legal affairs, media/public affairs, and crisis and emergency risk communication (see *Section 12: COVID-19 Vaccination Program Communication* for additional information on crisis communication planning). In addition, the team should include clinical expertise as well as representatives of programs that serve the early populations of focus (e.g., Bureau of Aging, state licensing board, HIV/AIDS program, rural health office). It may even be helpful to include representation from a local public health jurisdiction for implementation perspective. Team members should be assigned responsibilities based on their individual expertise to best enhance plan development and activities coordination before and during the response. To mitigate any unexpected situations affecting a team member, each team member should have a backup representative to ensure coverage of each specialty area remains intact throughout the COVID-19 Vaccination Program. For any roles that are not adequately staffed, efforts should be made to recruit for and fill any team member vacancies as early as possible.

State-Local Coordination

State governance structures vary from centralized to decentralized. In a centralized state, legal authority is concentrated in the central state government, which makes decisions and performs most functions. Conversely, in a decentralized state, authority and responsibilities are dispersed and distributed across regions and areas. Regardless of the jurisdiction's governance structure, it is imperative that state and local authorities combine and coordinate efforts. State-level personnel must closely monitor activities at the local level to ensure the COVID-19 Vaccination Program is implemented throughout the jurisdiction in adherence with federal guidance and requirements, and that there is equitable access to COVID-19 vaccination across all areas. Local personnel likely have a better understanding of perceptions, unique challenges, and successful mitigation strategies within their communities. Aligning areas of responsibility as well as specific tasks can help to complement rather than duplicate efforts at either level, maximizing the efficient use of resources and overall quality of the COVID-19 Vaccination Program.

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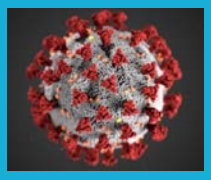

Tribal Nations and Tribal Communities

While engaging with tribal leaders, jurisdictional[2] immunization programs must remember each tribal nation has the sovereign authority to provide for the welfare of its people and, therefore, has the authority to:

- Choose among the jurisdiction or Indian Health Service (IHS) options for accessing vaccine.
- Determine the population(s) it chooses to serve.
- Choose how vaccines are distributed to its community.
- Establish priority groups when there is a limited supply of COVID-19 vaccine or other accompanying resources.

For the COVID-19 Vaccination Program, tribal nations have two options for receiving vaccine:

1. Through the jurisdiction's allocation and distribution mechanism
2. Through the IHS allocation and distribution mechanism

State and local jurisdictions do not possess legal authority over tribal nations directly providing vaccine to their service populations. However, if a tribal nation or any of the health facilities serving that tribal nation receive vaccine from the jurisdiction's allocation, they are responsible for adhering to vaccine storage, handling, distribution, and reporting requirements outlined in the *CDC COVID-19 Vaccination Program Provider Agreement.*

Jurisdictions should reach out to tribal nations within their respective areas for involvement in planning efforts. Jurisdictions must include each tribe's preference for COVID-19 vaccine distribution to ensure vaccine is effectively delivered to tribal nations and their communities. State and local jurisdictions should also engage with Urban Indian Health Centers (UIHCs). IHS may be able to support distribution to UIHCs and is planning to formally confer with UHICs to solicit their feedback. Additionally, awardee jurisdictions should reach out to UIHCs as part of the planning process to determine their preference for vaccine access. Details of engagement with tribal nations and other tribal entities should be included in jurisdiction COVID-19 vaccination plans.

The jurisdictional planning process should include state-recognized tribes, unrecognized tribes, and American Indian/Alaska Native individuals who are included in state-recognized tribes because the option to access COVID-19 vaccine through IHS may not be possible for these communities.

COVID-19 Vaccination Program Implementation Committee (Internal and External)

Reaching intended vaccine recipients is essential to achieving desired levels of COVID-19 vaccination coverage. To ensure equitable access to vaccinations, information about populations within a jurisdiction and the logistical requirements for providing them access to COVID-19 vaccination services will require collaboration with external entities and community partners who are familiar with how they obtain healthcare and other essential services. Jurisdictions should establish a COVID-19 Vaccination Program implementation committee to enhance development of plans, reach of activities, and risk/crisis response communication messaging and delivery. Committee membership should include leadership from the jurisdiction's COVID-19 planning and coordination team as well as representatives from key COVID-19 vaccination providers for critical population groups

[2] "Jurisdiction/jurisdictional," as used in this document, refers to the federal immunization funding awardees described in the Executive Summary and their state public health emergency preparedness counterparts who are tasked with developing COVID-19 vaccination plans for submission to CDC.

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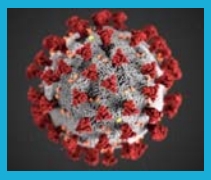

identified by CDC (see *Section 4: Critical Populations*), as well as representatives from other sectors within the community, such as:

- Emergency management agencies
- Healthcare coalitions
- Immunization coalitions
- Local health departments
- Health systems and hospitals (including critical access hospitals for rural areas, in-patient psychiatric facilities)
- Community health centers
- Rural Health Clinics (RHCs)
- Pharmacies
- Long-term care facilities (LTCFs; includes nursing homes/skilled nursing facilities, assisted living facilities, intermediate care facilities for individuals with intellectual and developmental disabilities, and independent/retirement communities
- Businesses and occupational health organizations
- Health insurance issuers and plans
- Education agencies and providers
- Correctional facilities
- Churches or religious leaders and institutions
- Tribal leaders
- Organizations serving racial and ethnic minority groups
- Organizations serving people with disabilities
- Organizations serving people with limited English proficiency
- Community representatives
- Entities involved in COVID-19 testing center organization

This committee will be helpful in advocating for and developing strategies to ensure equitable access to COVID-19 vaccination services. If needed, a Memorandum of Understanding (MOU) between the jurisdiction and partners can help to cement roles, responsibilities, and the level of support to be provided.

Related Guidance and Reference Materials

CDC's public health preparedness resources can assist jurisdictions and tribal organizations with strategic planning to strengthen their public health capabilities.

Pandemic influenza-specific resources on vaccine and other medical countermeasures may be helpful in strategizing for other COVID-19-related situations.

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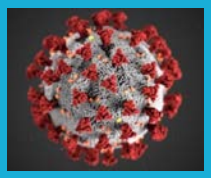

Section 3: Phased Approach to COVID-19 Vaccination

Due to changing vaccine supply levels at various points during the COVID-19 Vaccination Program, planning needs to be flexible but as specific as possible to accommodate a variety of scenarios. A key point to consider is that vaccine supply will be limited at the beginning of the program, so the allocation of doses must focus on vaccination providers and settings for vaccination of limited critical populations as well as outreach to these populations. The vaccine supply is projected to increase quickly over the proceeding months, allowing vaccination efforts to be expanded to additional critical populations and the general public. It is important to note that recommendations on the various population groups to receive initial doses of vaccine could change after vaccine is available, depending on each vaccine's characteristics, vaccine supply, disease epidemiology, and local community factors.

Final decisions are being made about use of initially available supplies of COVID-19 vaccines. These decisions will be partially informed by the proven efficacy of the vaccines coming out of Phase 3 trials, but populations of focus for initial COVID-19 vaccination may include: (see *Section 4: Critical Populations*)

- Healthcare personnel (paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials)
- Non-healthcare essential workers
- Adults with high-risk medical conditions who possess risk factors for severe COVID-19 illness
- People 65 years of age and older (including those living in LTCFs)

Jurisdictions should be planning in terms of three phases:

1. **Phase 1: Potentially limited supply of COVID-19 vaccine doses available**
    - Concentrate efforts on reaching the initial populations of focus for COVID-19 vaccination listed above, including those who may be part of other critical populations that might require additional vaccination efforts to ensure access to vaccine. Ensure vaccination locations selected can reach populations, manage cold chain requirements, and meet reporting requirements for vaccine supply and uptake.
2. **Phase 2: Large number of vaccine doses available**
    - Focus on ensuring access to vaccine for all critical populations who were not vaccinated in Phase 1, as well as for the general population; expand provider network.
3. **Phase 3: Sufficient supply of vaccine doses for entire population (surplus of doses)**
    - Focus on ensuring equitable vaccination access across the entire population. Monitor vaccine uptake and coverage; reassess strategy to increase uptake in populations or communities with low coverage.

The following graph illustrates the three phases of the COVID-19 Vaccine Program and populations of focus in each phase.

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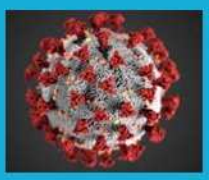

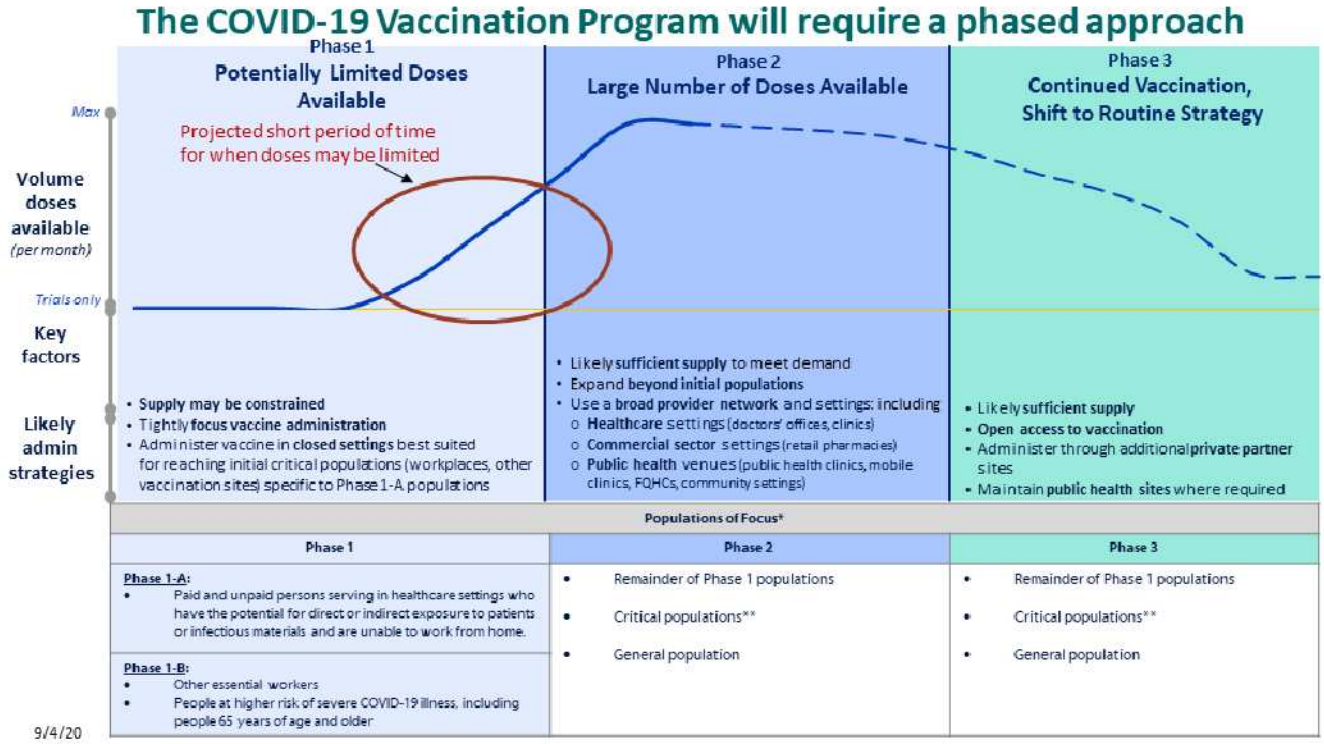

Planning should consider that there may be initial age restrictions for vaccine products.

***See Section 4: Critical Populations for information on Phase 1 subset and other critical population groups.*

Phase 1: Potentially Limited COVID-19 Vaccine Doses Available

In the initial phase, or Phase 1, of the COVID-19 Vaccination Program, initial doses of vaccine will likely be distributed in a limited manner, with the goal of maximizing vaccine acceptance and public health protection while minimizing waste and inefficiency. The key considerations in planning for this phase are:

- COVID-19 vaccine supply may be limited.
- COVID-19 vaccine administration efforts must concentrate on the initial populations of focus to achieve vaccination coverage in those groups.
- Inventory, distribution, and any repositioning of vaccine will be closely monitored through reporting to ensure end-to-end visibility of vaccine doses.

Jurisdictions can employ strategies to address these constraints, including:

- Concentrating early COVID-19 vaccine administration efforts on the initial critical populations identified above and in *Section 4: Critical Populations*.
- Providing COVID-19 vaccination services in closed point-of-dispensing (POD) settings that allow for the maximum number of people to be vaccinated while maintaining social distancing and other infection control procedures (e.g., large hospitals and satellite, temporary, or off-site settings)

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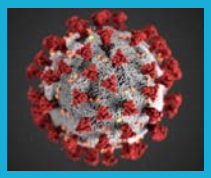

Jurisdictions should prioritize enrollment activities for vaccination providers and settings who will administer COVID-19 vaccine to the populations of focus for Phase 1, considering those who live in remote, rural areas and may have difficulty accessing vaccination services. Simultaneously, jurisdictions should develop operational procedures for any temporary or mobile clinics planned for Phase 1 prior to receipt of vaccine. Additional information on COVID-19 vaccination provider outreach and clinic settings is located in *Section 5: COVID-19 Provider Recruitment and Enrollment.*

Three scenarios are provided in *Appendix B: COVID-19 Vaccination Scenarios for Jurisdictional Planning – Phase 1, Q4 2020* to assist with planning for Phase 1. Each hypothetical scenario presents variations in product availability, number of vaccine doses allocated, storage and handling requirements, and administration by theoretical vaccine product. These three scenarios may be especially helpful in conducting any workshops or exercises.

As jurisdictions are performing Phase 1 activities, they should be thinking ahead to Phase 2. Jurisdictions may consider the need for additional vaccinators to staff PODs, contract needs for vaccination services, and reviewing state practice acts to allow for expanded professional practice, if necessary.

Phase 2: Large Number of Doses Available; Supply Likely to Meet Demand

As the supply of available vaccine increases, distribution will expand, increasing access to vaccination services for a larger population. When larger quantities of vaccine become available, there will be two simultaneous objectives:

1. Provide equitable access to COVID-19 vaccination for all critical populations to achieve high COVID-19 vaccination coverage in these populations in the jurisdiction.
2. Ensure high uptake in specific populations, particularly in groups that are higher risk for severe outcomes from COVID-19.

The key considerations in planning for Phase 2 are:

- COVID-19 vaccine supply will likely be sufficient to meet demand for critical populations as well as the general public.
- Additional COVID-19 vaccine doses available will permit an increase in vaccination providers and locations.
- A surge in COVID-19 vaccine demand is possible, so a broad vaccine administration network for surge capacity will be necessary.
- Low COVID-19 vaccine demand is also a possibility, so jurisdictions should monitor supply and adjust strategies to minimize vaccine wastage.

Jurisdictions should adapt to the increase in COVID-19 vaccine supply levels by:

- Expanding vaccination efforts beyond initial population groups in Phase 1 with emphasis on equitable access for all populations.
- Administering vaccine through:
    - Commercial and private sector partners (pharmacies, doctors' offices, clinics)
    - Public health sites (mobile clinics, Federally Qualified Health Centers [FQHCs], RHCs, public health clinics, temporary/off-site clinics, and federal, tribal, and Urban Indian health facilities)

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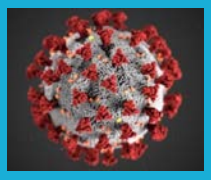

Phase 3: Likely Sufficient Supply

Ultimately, COVID-19 vaccine will be widely available and integrated into routine vaccination programs, run by both public and private partners.

The key considerations in planning for Phase 3 are:

- Likely sufficient COVID-19 vaccine supply where supply might exceed demand
- Broad vaccine administration network for increased access

Strategies that jurisdictions should consider:

- Continuing to focus on equitable vaccination access to vaccination services
- Monitoring COVID-19 vaccine uptake and coverage in critical populations and enhancing strategies to reach populations with low vaccination uptake or coverage
- Partnering with commercial and private entities to ensure COVID-19 vaccine and vaccination services are widely available
- Monitoring supply and repositioning refrigerated vaccine products to minimize vaccine wastage

Related Guidance and Reference Materials

CDC's Roadmap to Implementing Pandemic Influenza Vaccination of Critical Workforce provides additional information and tools for state and local planners on how to operationalize and implement specific plans for targeting critical workforce groups during an influenza pandemic response. The document also includes tools and resources for tracking progress on critical workforce vaccination planning and activities within a jurisdiction. Though currently specific to an influenza pandemic, it may help to inform the approach for COVID-19 vaccination planning for critical workforce.

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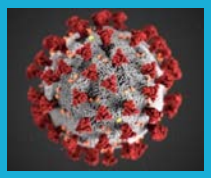

Section 4: Critical Populations

CDC's Advisory Committee on Immunization Practices (ACIP), the National Institutes of Health, and the National Academies of Sciences, Engineering, and Medicine (NASEM) are working to determine populations of focus for COVID-19 vaccination and ensure equity in access to COVID-19 vaccination availability across the United States. CDC has established an ACIP work group to review evidence on COVID-19 epidemiology and burden as well as COVID-19 vaccine safety, vaccine efficacy, evidence quality, and implementation issues to inform recommendations for COVID-19 vaccination policy. A key policy goal is to determine critical populations for COVID-19 vaccination, including those groups identified to receive the first available doses of COVID-19 vaccine when supply is expected to be limited.

After a short period of potentially limited vaccine supply, supply will likely increase quickly, allowing vaccination efforts to be expanded to include additional critical populations as well as the general public. Jurisdictions should develop plans to ensure equitable access to vaccination for each of the critical populations identified below.

Identifying and Estimating Critical Populations

The first step in planning is to identify and estimate the critical populations within a jurisdiction. These populations (listed in no particular order) may include but are not limited to:

- Critical infrastructure workforce
    - Healthcare personnel (i.e., paid and unpaid personnel working in healthcare settings, which may include vaccinators, pharmacy staff, ancillary staff, school nurses, and EMS personnel)
    - Other essential workers (see additional guidance from the Cybersecurity and Infrastructure Security Agency [CISA])

  Note: The critical infrastructure workforce varies by jurisdiction. Each jurisdiction must decide which groups to focus on when vaccine supply is limited by determining key sectors that may be within their populations (e.g., port-related workers in coastal jurisdictions)
- People at increased risk for severe COVID-19 illness
    - LTCF residents (i.e., residents of nursing homes and assisted living facilities)
    - People with underlying medical conditions that are risk factors for severe COVID-19 illness
    - People 65 years of age and older
- People at increased risk of acquiring or transmitting COVID-19
    - People from racial and ethnic minority groups
    - People from tribal communities
    - People who are incarcerated/detained in correctional facilities
    - People experiencing homelessness/living in shelters
    - People attending colleges/universities
    - People who work in educational settings (e.g., early learning centers, schools, and colleges/universities)
    - People living and working in other congregate settings
- People with limited access to routine vaccination services
    - People living in rural communities
    - People with disabilities
    - People who are under- or uninsured

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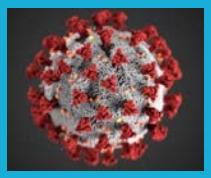

Estimates of these groups should be as accurate as possible to minimize potential waste of vaccine, constituent products, or ancillary supplies. Partner agencies and organizations may be helpful in determining accurate estimates of these population groups. Such organizations might include the jurisdiction's emergency management agency, labor department, chamber of commerce, healthcare coalitions, and chronic disease/nutrition groups, as well as the U.S. Department of the Interior, federal executive boards, and the Association of Continuity Professionals.

Estimating Population Groups for Initial COVID-19 Vaccine Distribution During Phase 1

In the event that the jurisdiction's allocation during Phase 1 is insufficient to vaccinate all those included in the initial populations of focus, it is important for jurisdictions to identify and estimate the subset groups (i.e., Phase 1-A, Phase 1-B) within these initial populations of focus to determine who will receive the first available doses of COVID-19 vaccine. Jurisdictions can review current ACIP work group considerations for assistance in identifying, prioritizing, and estimating Phase 1 sub-population groups.

Jurisdictional considerations for Phase 1 subset groups may include, for example:

- **Phase 1-A**: Paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials
- **Phase 1-B**: People who play a key role in keeping essential functions of society running and cannot socially distance in the workplace (e.g., emergency and law enforcement personnel not included in Phase 1-A, food packaging and distribution workers, teachers/school staff, childcare providers), adults with high-risk medical conditions who possess risk factors for severe COVID-19 illness, and people 65 years of age or older (including those living in LTCFs)

There may be insufficient COVID-19 vaccine supply initially to vaccinate all those who fall into the Phase 1-A subset, so jurisdictions should plan for additional subsets within that group (see CISA guidance for categories of healthcare personnel). Phase 1-B and Phase 2 planning may also benefit from identifying subsets of population groups if there is high demand for vaccine. The U.S. Department of Labor's Occupational Safety and Health Administration has information on classifying workers at risk (low to very high based on position within an organization) for exposure to SARS-CoV-2. This information could prove helpful to jurisdictions in determining subsets of critical populations for vaccination.

Describing and Locating Critical Populations

To improve vaccination among critical population groups, jurisdictions must ensure these groups have access to vaccination services. To inform COVID-19 vaccination provider outreach efforts, jurisdictions need to know where these groups are located. Jurisdictions should create visual maps of these populations, including places of employment for the critical infrastructure workforce category, to assist in COVID-19 vaccination clinic planning, especially for satellite, temporary, or off-site clinics. Certain jurisdictions have critical infrastructure workforces, such as healthcare personnel, that cross jurisdictional boundaries to get to their workplaces. Rather than try to enumerate these populations by place of residence, jurisdictions should consider enumeration by place of employment. Enumeration by health system to estimate its workforce may include both inpatient and outpatient facilities as well as any satellite clinics. The shift between daytime and nighttime essential worker populations is most pronounced in the mid- and northeastern jurisdictions. Accounting for workers by place of employment will help to minimize underestimation of these critical populations. The convenience of receiving vaccination at the place of employment may also result in increased vaccination coverage. Public health

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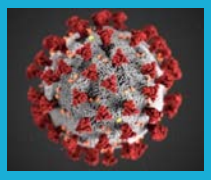

programs should establish procedures to communicate key messages and coordinate vaccination logistics for these groups.

Programs should establish points of contact (POCs) for each organization, employer, or community (as appropriate) within the critical population groups. Partnerships with trusted community organizations can facilitate early agreement on communication channels and methods for rapidly disseminating information and ultimately ensuring these groups have access to vaccination. (See *Section 12: COVID-19 Vaccination Program Communication.*) Some of these partners could include:

- Community health centers
- FQHCs
- RHCs
- Critical access hospitals
- Pharmacies
- Organizations and businesses that employ critical workforce
- First responder organizations
- Tribal health or community centers
- Non-traditional providers (e.g., community health workers, doulas, promotoras) and locations (e.g., dialysis centers, community centers) serving people at higher risk for severe illness
- Other locations or facilities for shared or congregate housing serving people at higher risk for COVID-19 illness (e.g., homeless shelters, group housing, correctional facilities, senior living facilities)
- Locations where people 65 years of age and older gather (e.g., senior centers, food pantries)
- Religious groups and other community groups
- In-home care organizations
- Schools and institutions of higher learning

Additional strategies for jurisdictions to consider when planning to vaccinate critical populations are listed in *Appendix G: Vaccination Implementation Strategies to Consider for Critical Populations*.

Jurisdictions should prioritize describing and locating the Phase 1 initial populations of focus (see above) in their planning efforts, as these groups will be the first to be vaccinated before other critical populations.

A sample worksheet for collecting critical population POCs and other pertinent information is in *Appendix C: Phase 1 Population Group Worksheet Example.*

Related Guidance and Reference Materials

Advisory Committee on Immunization Practices

NASEM Preliminary Framework for Equitable Allocation of COVID-19 Vaccine

Johns Hopkins Center for Health Security Interim Framework for COVID-19 Vaccine Allocation and Distribution in the United States

The HHS Office for Civil Rights (OCR) webpage on Civil Rights and COVID-19 has several resources, including:

- BULLETIN: Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19)
- BULLETIN: Ensuring the Rights of Persons with Limited English Proficiency in Health Care During COVID-19

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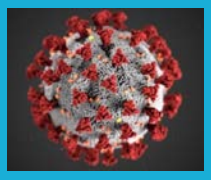

- BULLETIN: Civil Rights Protections Prohibiting Race, Color, and National Origin Discrimination During COVID-19: Application of Title VI of the Civil Rights Act of 1964
- Information on the resolution of complaints filed with HHS OCR such as those that allege age and disability discrimination due to a state's crisis standards of care guidelines, etc.

Mapping Medicare Disparities Tool can be used to identify areas of disparities between subgroups of Medicare beneficiaries in health outcomes, utilization, and spending. It can assist with investigating geographic and racial and ethnic differences in health outcomes and inform decisions to focus on certain populations and geographies.

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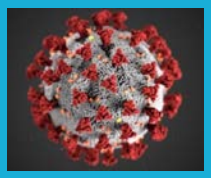

Section 5: COVID-19 Vaccination Provider Recruitment and Enrollment

An adequate network of trained, technically competent COVID-19 vaccination providers in accessible settings is critical to COVID-19 Vaccination Program success. For this reason, COVID-19 vaccination provider recruitment and enrollment may be the most critical activity conducted before vaccine becomes available. Jurisdictions and tribal organizations should concentrate early planning efforts on engaging those vaccination providers and services that can rapidly vaccinate initial populations of focus (see *Section 4: Critical Populations*) as soon as a COVID-19 vaccine is available (Phase 1). Subsequent planning should include measures for recruiting and enrolling enough providers to vaccinate additional critical populations and eventually the general population when sufficient vaccine supply is available (Phases 2 and 3).

Vaccination Provider Recruitment

Jurisdictions are encouraged to immediately reach out to potential COVID-19 vaccination providers and target the appropriate settings so that COVID-19 vaccination services are accessible to the initial populations of focus when the first COVID-19 vaccine doses arrive. Providers and settings that maximize the number of people who can be vaccinated should be prioritized for enrollment; however, jurisdictions should ensure social distancing and other infection control procedures can be maintained in selected settings (see *CDC guidance on vaccination during a pandemic*). All providers/settings, especially those enrolled for Phase 1, must be able to meet the reporting requirements discussed in *Section 9: COVID-19 Vaccine Administration Documentation and Reporting* and *Section 11: COVID-19 Requirements for Immunization Information Systems or Other External Systems*. Jurisdictions should consider partnering with the private sector and with local hospitals or health systems to provide COVID-19 vaccination in the closest proximity possible to the initial populations of focus. For example, partnering with critical access hospitals will be key to vaccinating Phase 1 populations in rural areas. Suggested early COVID-19 vaccination providers/settings include:

- Large hospitals and health systems
- Commercial partners* (e.g., pharmacies)
- Mobile vaccination providers
- Occupational health settings for large employers
- Critical access hospitals, RHCs, community health centers, or other central locations that can provide vaccination services for a broad area

  **CDC has agreements with CVS and Walgreens to assist with on-site vaccination in LTCFs. These partners have existing distribution (including cold chain), administration, and reporting infrastructure and relationships with some LTCFs to provide medication and, in some cases, vaccination services (e.g., seasonal influenza) for staff and residents; this may reduce burden on jurisdictional health departments. CDC will ensure jurisdictions have visibility on this work with retail pharmacy partners.*

Jurisdictions should recruit additional COVID-19 vaccination providers to expand equitable access to COVID-19 vaccination when vaccine supply increases. Enrollment activities should be tracked so vaccination providers are not approached multiple times. Establishing and building upon existing relationships with community partners and collaborating with medical societies, state licensing boards, the state Medicaid agency, state rural health office, IHS/tribal health entities, and health insurance issuers and plans in the area, may assist jurisdictions in identifying COVID-19 vaccination providers and the population groups they serve. Jurisdictions should consider engaging both traditional and nontraditional vaccination providers and settings, including:

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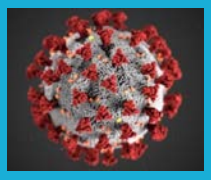

- In-patient healthcare facilities
    - Large hospitals could potentially operate as open PODs.
- LTCFs (e.g., nursing homes/skilled nursing facilities, assisted living facilities)
- Doctors' offices and other outpatient facilities (particularly those treating patients at higher risk of severe COVID-19 illness)
- Pharmacies
- Occupational health settings
- Organizations serving people at higher risk for severe illness from COVID-19 (e.g., dialysis centers, social service organizations)
- In-home care provider organizations
- Congregate settings (e.g., correctional facilities)
- Colleges and universities
- Homeless shelters
- Locations where people 65 years of age and older gather (e.g., senior centers, food pantries, retirement/independent living communities)
- FQHCs and RHCs

Jurisdictions and tribal nations should determine the need for additional vaccination services such as satellite, temporary, or off-site clinics to meet demand/need not met by other enrolled COVID-19 vaccination providers. These clinics may operate as either closed or open PODs.

It is important to consider infection control measures that are currently necessary when selecting COVID-19 vaccination clinic settings:

- Providing specific appointment times or other strategies to manage patient flow and avoid crowding and long lines.
- Ensuring sufficient staff and resources to help move patients through the clinic flow as quickly as possible
- Limiting the overall number of clinic attendees at any given time, particularly for people at higher risk for severe illness from COVID-19
- Setting up a unidirectional site flow with signs, ropes, or other measures to direct site traffic and ensure physical distancing between patients
- When feasible, arranging a separate vaccination area or separate hours for people at increased risk for severe illness from COVID-19, such as older adults and people with underlying medical conditions
- Making available a point of contact for any reasonable accommodation needs for people with disabilities
- Ensuring vaccination locations are accessible to individuals with disabilities consistent with disability rights statutes such as the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973
- Selecting a space large enough to ensure a minimum distance of 6 feet between patients in line or in waiting areas for vaccination, between vaccination stations, and in postvaccination monitoring areas. *Note: ACIP recommends that providers consider observing patients for 15 minutes after vaccination to decrease the risk for injury should they faint. For mobile or drive-through vaccination clinics, it is important to assess parking to accommodate vaccine recipients as they wait after vaccination.*

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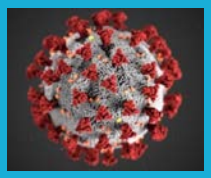

Vaccination Provider Enrollment

To receive/administer COVID-19 vaccine, constituent products, and ancillary supplies, vaccination provider facilities/organizations must enroll in the federal COVID-19 Vaccination Program coordinated through their jurisdiction's immunization program. Enrolled COVID-19 vaccination providers must be credentialed/licensed in the jurisdiction where vaccination takes place, and sign and agree to the conditions in the *CDC COVID-19 Vaccination Program Provider Agreement*. These conditions are detailed in the agreement itself:

1. Administer COVID-19 vaccine in accordance with ACIP recommendations. (*Note: ACIP will review data on the safety and efficacy of each available COVID-19 vaccine and vote on recommendations for use.)*
2. Within 24 hours of administering a dose of COVID-19 vaccine and adjuvant (if applicable), record in the vaccine recipient's record and report required information to the relevant state, local, or territorial public health authority. (See *Appendix D: CDC IIS Data Requirements for COVID-19 Vaccine Monitoring*). The provider must maintain the vaccine administration records for at least 3 years following vaccination, or longer if required by state, local, or territorial law. These records must be made available to any federal, state, local, or territorial public health department to the extent authorized by law.
3. Not sell or seek reimbursement for COVID-19 Vaccine and any diluent, syringes, needles, or other constituent products and ancillary supplies provided by the federal government.
4. Administer COVID-19 vaccine regardless of the vaccine recipient's ability to pay.
5. Provide an Emergency Use Authorization (EUA) fact sheet for recipients or vaccine information statement (VIS), as applicable, to each vaccine recipient/parent/legal representative prior to vaccination.
6. Comply with CDC requirements for vaccine management, including storage and handling, temperature monitoring at all times, complying with jurisdiction's instructions for dealing with temperature excursions, and monitoring expiration dates. Providers must keep all records related to COVID-19 vaccine management for a minimum of 3 years, or longer if required by law.
7. Report COVID-19 vaccines and diluents that were unused, spoiled, expired, or wasted as required by the jurisdiction's immunization program.
8. Comply with federal instruction regarding disposal of unused COVID-19 vaccine and diluent.
9. Report vaccine administration errors (whether associated with an adverse event [AE]) or not, serious AEs (irrespective of attribution to vaccination),[3] multisystem inflammatory syndrome (MIS) in children or adults, and cases of COVID-19 that result in hospitalization or death to the Vaccine Adverse Event Reporting System (VAERS). Report any additional AEs and adhere to any revised safety reporting requirements per the U.S. Food and Drug Administration's (FDA) conditions of authorized vaccine use posted on FDA's website throughout the duration of the EUA, as applicable. Healthcare providers should also report any additional clinically significant adverse events following COVID-19 vaccination to VAERS, even if they are not sure if the vaccination caused the event.
10. Provide a completed COVID-19 vaccination record card to every vaccine recipient/parent/legal representative.

[3] Serious AEs are defined as: death, a life-threatening AE, inpatient hospitalization or prolongation of existing hospitalization, persistent or significant incapacity or substantial disruption of the ability to conduct normal life functions, a congenital anomaly/birth defect, or an important medical event that may not result in death, be life-threatening, or require hospitalization when, based upon appropriate medical judgment, it may jeopardize the individual and may require medical or surgical intervention to prevent one of the outcomes listed above. Serious AEs should be reported regardless of causality.

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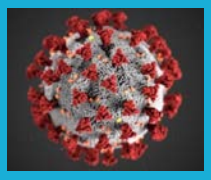

11. Comply with FDA's requirements, including EUA-related requirements described in FDA's Letter of Authorization, as applicable. Providers must also administer COVID-19 vaccine in compliance with all applicable state and territorial vaccine laws.

Failure of any enrolled COVID-19 vaccination provider organization or vaccination location under its authority to meet the conditions of the agreement may impact whether COVID-19 vaccine product orders are fulfilled and may result in legal action by the federal government.

Enrolled COVID-19 vaccination providers must also fully complete the *CDC COVID-19 Vaccination Provider Profile* form for each location where COVID-19 vaccine will be administered. The profile form collects the following variables for each location:

- Address and contact information
- Days and hours of operation
- Vaccination provider type (e.g., medical practice, pharmacy, LTCF)
- Settings where vaccine will be administered (e.g., hospital, university, temporary or off-site clinic)
- Number of patients/clients served
- Influenza vaccination capacity during the peak week of the prior (2019–2020) influenza season
- Populations served (e.g., pediatric, adult, military, pregnant women)
- Current IIS reporting status
- Vaccine storage unit capacity in volume and ability to maintain required temperatures

The profile form includes a field where the brand/model/type of storage unit is to be listed, requiring an attestation from the medical/pharmacy director or vaccine coordinator that each unit will maintain the relevant required temperatures (i.e., refrigerated [2°C to 8°C], frozen [-15° to -25°C], ultra-cold [-60° to -80°C]. If desired, the immunization program may request photos of vaccine storage units for confirmation.

Both forms (agreement and profile) may be submitted to the jurisdiction electronically, and it is permissible for an immunization program to develop and administer these forms in the IIS or other system.

*Note: A **vaccine coordinator** is the POC for receiving vaccine shipments, monitoring storage unit temperatures, managing vaccine inventory, etc. Immunization programs should encourage enrolled facilities/organizations to designate a vaccine coordinator role at each location as well as a back-up vaccine coordinator.*

Provider enrollment activities that immunization programs must complete include:

- Ensure provider agreement, profile form, and redistribution agreement (if applicable) are thoroughly and accurately completed by each enrolled provider, retained on file for a minimum of 3 years, and made available to CDC upon request
- Verify COVID-19 vaccination providers) have active, valid licensure/credentials to possess and administer vaccine. This licensure verification is needed only for those with prescribing authority [e.g., MD, DO, RPh, NP, PA] who will oversee COVID-19 vaccine administration. Credential verification is not required for vaccinators who work under the authority of someone with a higher level of licensure (i.e., not required for pharmacy techs/interns, RNs, LPNs, medical assistants, etc.).
- Onboard COVID-19 vaccination providers to the jurisdiction's IIS or other external system using an expedited process.
- Enter ship-to site information for each enrolled COVID-19 vaccination provider location in the Vaccine Tracking System (VTrckS) via direct upload or extensible XML information set (ExIS). *(Note: To support*

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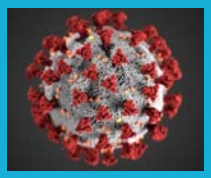

more efficient distribution of vaccine, locations should offer full-day receiving hours to the extent possible. When that is not possible, COVID-19 vaccination providers must be available to receive vaccine shipments during a 4-hour window on a weekday other than Monday.)

- Report COVID-19 vaccination provider enrollment data electronically to CDC twice a week (i.e., Monday and Thursday by 9:00pm EST), using CDC-provided Comma Separated Values (CSV) and JavaScript Object Notation (JSON) templates to report via a Security Access Management Services (SAMS)–authenticated mechanism. CDC will monitor provider enrollment progress (see *Section 15: COVID-19 Vaccination Program Monitoring*).
- Ensure that all COVID-19 vaccination providers have been trained appropriately and have the appropriate equipment at their location to manage any serious adverse events. (*Note: For new vaccination providers and nontraditional provider settings, it will be helpful to furnish vaccination clinic planning guidance to ensure optimum staffing, layout, supplies, and infection control procedures are in place.*)

COVID-19 Vaccination Provider Training

Training of COVID-19 vaccination providers is vital to ensure the success of the COVID-19 Vaccination Program. CDC will have many educational resources available for use (even some for co-branding), but immunization programs may develop or use other materials in conjunction with CDC materials. Jurisdictions should determine the most efficient methods for training delivery and tracking. Online videos may be particularly useful for convenient access and standardization of instruction. Jurisdictions will not be required to provide training for federal entities and commercial partners receiving direct vaccine allocations from CDC.

COVID-19 vaccination providers must understand the following:

- ACIP COVID-19 vaccine recommendations, when available
- How to order and receive COVID-19 vaccine
- COVID-19 vaccine storage and handling (including transport requirements)
- How to administer vaccine, including mixing with diluent, appropriate needle size, anatomic sites for vaccine administration, avoiding shoulder injury with vaccine administration, etc.
- How to document and report vaccine administration via the jurisdiction's IIS or other external system
- How to manage vaccine inventory, including accessing and managing product expiration dates (see *Section 7: COVID-19 Vaccine Allocation, Ordering, Distribution, and Inventory Management*)
- How to report vaccine inventory
- How to manage temperature excursions
- How to document and report vaccine wastage/spoilage
- Procedures for reporting adverse events as well as vaccine administration errors to VAERS
- Providing EUA fact sheets or VISs to vaccine recipients
- How to submit facility information and daily vaccine inventory reports for COVID-19 vaccination clinics to CDC's VaccineFinder (particularly for pharmacies or other high-volume vaccination providers/settings)

CDC is developing and updating a variety of clinical educational and training resources for healthcare professionals related to COVID-19 vaccine(s). Some of these materials will soon be available to assist with planning for vaccine implementation. Other materials will become available as regulatory authorization or approval from FDA for each vaccine candidate is acquired. Each manufacturer is also developing educational and training resources for its individual vaccine candidate. The list may change or be updated as appropriate.

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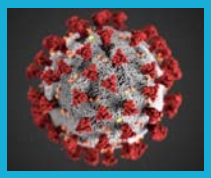

PRODUCT	NEW/UPDATE	ADDITIONAL INFORMATION
Vaccine Storage and Handling Toolkit	Update	An addendum with general COVID-19 vaccine storage, handling and transport information will be added, and the addendum will be updated as COVID-19 vaccine products are approved. A fully updated toolkit, incorporating COVID-19 information into the actual toolkit will not be issued until 2022.
COVID-19 training module	New	Under development is a web-based module. Topics will include storage/handing, vaccine indications, contraindications/precautions, administration, and documentation. It will not have CE and will be amended as new COVID-19 vaccine products are introduced.
Vaccine product summary sheets	New	Fact sheets with storage, handling, preparation, indications, contraindications/precautions, and administration will be developed for each vaccine
Additional immunization guidance materials	New	More extensive information related to storage, handling, preparation, administration, shipping, packaging, and transport will be provided as necessary (not all vaccines will need additional guidance)
Comprehensive table of vaccine products	New	A table of COVID-19 vaccine products with key information will be updated as vaccines are approved.
Beyond use dates and expiration date tracking tools	New	A resource will be provided to track BUD and expiration dates, for use early in vaccine distribution process.
ACIP recommendation summary information	New	Conduct webinar, slide deck for use by awardees and other partners
You Call the Shots web-based Training	Update	Updates to the You Call the Shots Vaccine Administration and Storage and Handling modules to refer users to appropriate COVID-19 vaccine websites. Information will be updated more extensively in early 2021 based on continuing education timelines.
Healthcare personnel FAQs	New	Web-based FAQ document
Providing vaccinations Safely during a pandemic	Update	CDC has developed this website to provide guidance about safely providing vaccines during COVID 19. The website will be updated as appropriate.

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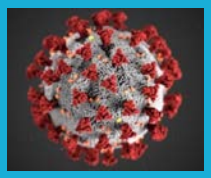

Role of Commercial and Federal Partners

Some multijurisdictional vaccination providers (e.g., select large drugstore chains, some IHS locations, Veterans Administration clinics and hospitals, and other federal providers) will enroll directly with CDC to order and receive COVID-19 vaccine. CDC will notify jurisdictions of any entities receiving direct allocations within their areas. These direct partners will be required to report vaccine supply and uptake information to each respective jurisdiction. Jurisdictions may partner with commercial entities that are enrolled directly with CDC to reach their populations. Large drugstore chains, for example, may be particularly helpful in conducting PODs as well as vaccinating LTCF residents and staff. Health insurance issuers and plans may also assist in informing their enrollees about vaccination efforts.

Federal Direct Allocation to Federal Entities

Outlined below are the federal entities (and their respective populations) that will receive a direct allocation of COVID-19 vaccine.

Federal Entity	Population Served
Bureau of Prisons (BoP)	• All BoP-managed facilities: facility staff and inmates • Private contracted facilities and contracted residential reentry centers (RRCs) not included
Department of Defense (DoD)	• Active duty personnel and their dependents • Retirees (does not include their dependents) • U.S. Coast Guard (does not include their dependents) • DoD civilian and contractor employees (those who regularly receive care through DoD as well as those who don't) • To be determined: Reserves and National Guard (including those not activated)
Department of State (DoS)	• All personnel under Chief of Mission eligible to receive care through DoS • Stateside civil service employees
Indian Health Service (IHS)	• Tribal nations selecting IHS for vaccine allocation (see page 12: Tribal Nations and Tribal Communities) • Potentially includes IHS/Tribal/Urban facility staff and individuals served
Veterans Health Administration (VHA)	• VA staff (including volunteers and trainees) and veterans regularly receiving care at VHA facilities (State Veterans Homes not included)

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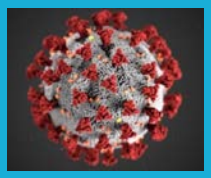

Federal Pharmacy Partnership for COVID-19 Vaccination in Long-Term Care Facilities

CDC will collaborate with CVS and Walgreens to provide on-site vaccination clinics for LTCF residents. CDC is working closely with LTCFs, jurisdictions, Centers for Medicare and Medicaid Services (CMS), professional trade organizations that serve nursing homes and assisted living facilities, and pharmacy partners to inform facilities of their options to receive COVID-19 vaccine. Depending on when LTCF staff is prioritized to receive vaccine, they will be covered under this plan (if prioritized at the same time as residents) or covered under jurisdiction plans for vaccinating healthcare workers/essential populations (if prioritized before residents). If staff is prioritized before residents, any staff not already vaccinated may be vaccinated through the on-site clinics offered by pharmacy partners. (See *Appendix H: Pharmacy Partnership for Long-Term Care Program for COVID-19 Vaccination.*)

Federal Direct Allocation to Pharmacy Partners (Phase 2)

To vaccinate a broader population group in Phase 2, vaccine will be allocated and distributed directly from the federal government to select pharmacy partners. Direct allocation opportunities will be provided to retail chain pharmacies and networks of independent and community pharmacies[4] (those with a minimum of 200 stores). All partners must sign a pharmacy provider agreement with the federal government. As part of such agreement, before receiving COVID-19 vaccine, the partner must propose, in writing, its minimum capacity for vaccine administration, including a) the number and location of facilities that will administer COVID-19 vaccine, b) the estimated number of COVID-19 vaccine doses that each facility will be able to administer within defined periods, and c) estimated cold chain storage capacity.

On a daily basis, pharmacy partners must report to CDC via designated methods the number of doses of COVID-19 vaccine a) ordered by store location; and b) on hand in each store reported through VaccineFinder. Pharmacy providers will also be required to report CDC-defined data elements related to vaccine administration to jurisdiction IISs. CDC will provide information on these data elements and reporting methods if stores are not able to directly provide data to jurisdiction IISs.

Partnerships with pharmacies will need to be synchronized with jurisdictions to improve vaccination coverage and ensure transparency across the COVID-19 Vaccination Program. Jurisdictions will be provided an opportunity to opt out of having pharmacies in their area receive direct allocations. Once a jurisdiction opts out, it will not be able to opt back into the program. All jurisdictions participating in this program will have visibility on vaccine supply and uptake data by store within their respective areas. (See *Appendix I: Federal Pharmacy Partnership Strategy for COVID-19 Vaccination Program*.)

Related Guidance and Reference Materials

HHS authorization for state-licensed pharmacists to administer vaccines

[4] Pharmacy services administrative organizations, or PSAOs

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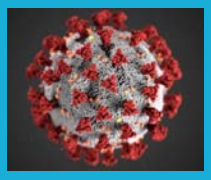

Section 6: Understanding a Jurisdiction's COVID-19 Vaccine Administration Capacity

Occupational health settings, temporary vaccination clinics, and closed PODs may be particularly useful for vaccination of critical infrastructure workers and other select critical populations early in the COVID-19 vaccination response when vaccine supply may be limited. However, once vaccine supply increases, leveraging a wide variety of potential community COVID-19 vaccination providers and settings is essential to providing equitable access to COVID-19 vaccination for all people in all communities. Public health programs should understand their jurisdiction's overall potential COVID-19 vaccine administration capacity, using a variety of COVID-19 vaccination provider types and settings.

"Vaccine administration capacity" is defined as the maximum achievable vaccination throughput regardless of public demand for vaccination. If a jurisdiction has a good understanding of its COVID-19 vaccination providers and locations and their vaccine administration capacities, then planners can generate rough estimates of COVID-19 vaccine administration capacity in their jurisdiction and their ability to reach various COVID-19 vaccination coverage goals.

Box 1: Key Public and Private Sector Vaccination Settings

- Healthcare provider offices and other outpatient clinics
- Public health clinics
- Chain and independent pharmacies
- School-based health centers
- Worksites and other occupational health clinics
- Hospitals
- Temporary or off-site vaccination clinics*
- Mobile vaccinators

**Community locations where state and local agencies dispense and administer medical countermeasures [MCMs] to the public, also known as "points of dispensing" [PODs])*

Important elements to consider in estimating vaccination capacity:

- Estimated number of existing vaccination provider locations in the jurisdiction, by type or vaccination setting, and the populations served (e.g., adults, children)
- Estimated potential weekly COVID-19 vaccine administration capacity (throughput)
- Estimated vaccination provider participation rate in the COVID-19 Vaccination Program

When assessing vaccine administration capacity, other important factors to consider include:

- COVID-19 vaccine storage capacity at a given location (e.g., quantity of COVID-19 vaccine that can be stored, storage equipment and temperature monitoring devices that meet CDC requirements)
- Existing vaccine administration capacity during seasonal influenza or other high vaccination periods
- Current staffing levels
- Routine immunization programs being conducted simultaneously that may affect throughput for COVID-19 vaccination in certain vaccination provider settings
- Infection control measures (i.e., scheduling, distancing, donning and doffing personal protective equipment, cleaning/sanitation procedures) that may slow the vaccination process
- Timing and duration of COVID-19 vaccination provider participation due to changes in staffing or other resources throughout the response
- Clinic closure due to environmental or other factors (e.g., seasonal weather, wildfires, holidays)

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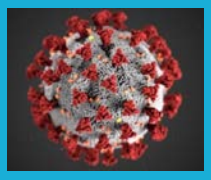

Jurisdictions should seek input from a variety of COVID-19 vaccination providers to inform this process. Previous vaccination exercises or campaigns may also provide helpful information.

Related Guidance and Reference Materials

CDC has developed a tool to assist with estimating vaccination capacity. The newest version of this tool, the PanVax Tool for Pandemic Vaccination Planning (version 3.3), is available on the CDC website.

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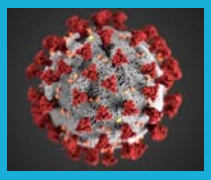

Section 7: COVID-19 Vaccine Allocation, Ordering, Distribution, and Inventory Management

Initial supplies of COVID-19 vaccine may be available in fall 2020. Early dose distribution will be limited; therefore, phased allocation of early vaccine doses will likely be necessary. Populations of focus for initial COVID-19 vaccine doses are expected to include healthcare workers (including ancillary staff, vaccinators, and staff in LTCFs), other essential workers, and people at higher risk for severe COVID-19 illness [5]. See *Section 4: Critical Populations* for more information. Jurisdictions should anticipate allocations to shift during the response based on supply, demand, vaccine characteristics, and disease epidemiology and should plan for high-demand and low-demand scenarios.

Allocation

The federal government will determine the amount of COVID-19 vaccine designated for each jurisdiction. The jurisdiction's immunization program will then be responsible for managing and approving orders from enrolled providers within their jurisdiction using this allotment. The amount allotted will change over time, which may be based on critical populations recommended for vaccination by ACIP (with input from NASEM), COVID-19 vaccine production and availability, and overall population of the jurisdiction.

Federal agencies and additional commercial partners will also receive allocations directly from CDC once larger volumes of vaccine are available. CDC is currently developing procedures to ensure that jurisdictions have full visibility of COVID-19 vaccine supply and vaccination activities among these entities located within their boundaries.

Immunization programs should develop allocation methods for critical populations of focus in early- and limited-supply scenarios. Prior to receiving an initial vaccine supply, jurisdictions should determine COVID-19 vaccine order allowances among their vaccination providers based on the critical populations they serve. Allotments of doses to vaccination providers within a jurisdiction should be based on:

- ACIP recommendations (when available)
- Estimated number of doses allocated to the jurisdiction and timing of availability
- Populations served by vaccination providers and geographic location to ensure distribution throughout the jurisdiction
- Vaccination provider site vaccine storage and handling capacity
- Minimizing the potential for wastage of vaccine, constituent products, and ancillary supplies
- Other local factors

See *Section 4: Critical Populations* for more information.

Ordering

COVID-19 vaccination providers enrolled by the jurisdiction will order COVID-19 vaccine through their jurisdiction's immunization program. Most jurisdictions will ask COVID-19 vaccination providers to place orders using systems and procedures routinely used for ordering publicly funded vaccines (e.g., IIS/ExIS upload to CDC's VTrckS for provider direct order entry), though some jurisdictions may have augmented systems.

[5] Subject to any vaccine product-specific age restrictions

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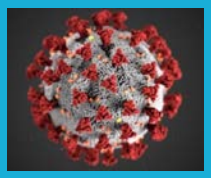

CDC will provide jurisdictions with regular updates on the available vaccine supply and their assigned vaccine product-specific allocations in VTrckS. During Phase 1 of the vaccination program, when there is limited vaccine supply for critical populations, immunization programs should approve orders based on the likely populations served by a vaccination provider, the provider's capability to store and handle various COVID-19 vaccine products, and existing inventory. The minimum order size and increment for centrally distributed vaccines will be 100 doses per order; though early in the response, ultra-cold (-60°C to -80°C) vaccine (if authorized for use or approved) may be shipped directly from the manufacturer in 975-dose increments. CDC will share more information on these shipments as it becomes available.

Ancillary supplies will be packaged in kits and will be automatically ordered in amounts to match vaccine orders in VTrckS.

A. For centrally distributed vaccines, each kit will contain supplies to administer 100 doses of vaccine, including:
   - Needles, 105 per kit (various sizes for the population served by the ordering vaccination provider)
     - 25-gauge, 1" (if vaccination indicated for pediatric population)
     - 22–25-gauge, 1-1.5" (adult)
   - Syringes, 105 per kit (ranging from 1–3 mL)
   - Alcohol prep pads, 210 per kit
   - 4 surgical masks and 2 face shields for vaccinators per kit
   - COVID-19 vaccination record cards for vaccine recipients, 100 per kit
   - Vaccine needle guide detailing the appropriate length/gauge for injections based on route, age (for children), gender, and weight (for adults)

   If a COVID-19 vaccine that requires mixing with diluent is ordered and shipped from CDC's centralized distributor, a mixing kit that includes the necessary needles, syringes, and alcohol prep pads will also be automatically added to the order. For centrally distributed vaccines, providers will have the option to submit the order in a way that opts out of receiving the administration and mixing kits.

B. For vaccines that are shipped directly from the manufacturer, a combined kit will be included. This combined kit will include administration supplies (as noted above), mixing supplies, and vials of diluent to prepare the vaccine for use. Because it contains diluent, providers will not have the option to opt out of requesting this combined ancillary kit.

Ancillary supply kits will not include sharps containers, gloves, and bandages. Additional personal protective equipment (PPE) may be needed depending on vaccination provider site needs.

Facilities ordering outside of their jurisdiction's allocation (i.e., commercial and federal entities with federal MOUs in place) will order directly from CDC, and CDC will be responsible for approval of those orders.

Distribution

COVID-19 vaccines and ancillary supplies will be procured and distributed by the federal government at no cost to enrolled COVID-19 vaccination providers. CDC will use its centralized distribution contract to fulfill orders for most vaccine products and associated ancillary supplies. Some vaccine products, such as those with ultra-cold temperature requirements, will be shipped directly from the manufacturer to the vaccination provider site.

Jurisdictions should ensure accurate and complete shipping information (e.g., shipment address, provider contact information, shipping hours) is available in VTrckS for all vaccine shipments to enrolled vaccination

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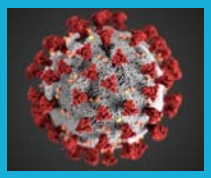

providers. To support more efficient distribution of vaccine, locations should offer full-day receiving hours to the extent possible. When that is not possible, locations identified to receive vaccine and ancillary supply shipments must be available during a 4-hour window on a weekday other than Monday to receive those shipments.

COVID-19 vaccine (and diluent, if required) will be shipped to vaccination provider sites enrolled by the jurisdiction's immunization program within 48 hours of order approval. Because of cold chain requirements, ancillary supply kits (and diluent, if applicable) will ship separately from vaccine but should arrive before or on the same day as vaccine.

The federally contracted vaccine distributor uses validated shipping procedures to maintain COVID-19 vaccine cold chain and minimize the likelihood of vaccine loss or damage during shipment. Once a vaccine product has been shipped to a COVID-19 vaccination provider site, the federal government will neither redistribute the product nor take financial responsibility for its redistribution. (See *Section 8: COVID-19 Vaccine Storage and Handling* for more information.)

Whenever possible, vaccine should be shipped to the location where it will be administered to minimize potential breaks in the cold chain. However, there may be circumstances where COVID-19 vaccine needs to be redistributed beyond the identified primary CDC ship-to sites (i.e., for orders smaller than the minimum order size or for large organizations whose vaccine is shipped to a central depot and requires redistribution to additional clinic locations). In these instances, vaccination provider organizations/facilities, third-party vendors, and other vaccination providers may be allowed, if approved by the jurisdiction's immunization program, to redistribute COVID-19 vaccine, if validated cold-chain procedures are in place in accordance with the manufacturer's instructions and CDC's guidance on COVID-19 vaccine storage and handling. These entities must sign and agree to conditions in the *CDC COVID-19 Vaccine Redistribution Agreement* for the sending facility/organization and have a fully completed and signed *CDC COVID-19 Vaccination Provider Profile* form for each receiving location. Jurisdictions should be extremely judicious in allowing redistribution and limit any redistribution to refrigerated vaccines only.

Immunization programs may occasionally allow local transport of vaccines from one location to another within their jurisdictions, if adherence to cold chain and tracking requirements are maintained. CDC does not pay for or reimburse jurisdictions, COVID-19 vaccination provider organizations, facilities, or other entities for any redistribution beyond the initial designated primary CDC ship-to location, or for any vaccine-specific portable refrigerators and/or qualified containers and pack-outs. (See *Section 8: COVID-19 Vaccine Storage and Handling* for more information.)

Inventory Management

COVID-19 vaccination providers will be required to report COVID-19 vaccine inventory daily using VaccineFinder. Once providers are enrolled in VTrckS, they will be preregistered for a VaccineFinder account and provided instructions via email on how to submit daily supply information. Jurisdictions may also require that providers submit inventory on hand when placing an order for more vaccine to help inform their allocation decisions. However, submission of this information into VTrckS is optional. All inventory should be managed in accordance with storage and handling requirements specific to each vaccine.

It is anticipated that COVID-19 vaccines will initially be authorized under an EUA. Vial and carton labels for vaccines *authorized* under an EUA will contain slight variations from labels typical of *approved* Food and Drug Administration (FDA) products, including:

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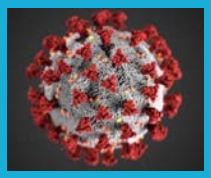

- **Expiration Date:** The vaccine vials and cartons may not contain a printed expiration date. Expiration dates may be updated based on vaccine stability studies occurring simultaneously with COVID-19 vaccine distribution and administration. Additional information will be provided about how to access expiry information for individual vaccines. To ensure that information systems continue to work as expected, CDC has worked with FDA and the manufacturers to include a two-dimensional (2D) barcode on the vaccine vial (if possible) and carton (required) labels that includes a National Drug Code (NDC), lot number, and a placeholder expiration date of 12/31/2069 to be read by a scanner. The placeholder 12/31/2069 expiration date is not visible on the vaccine packaging nor found anywhere else; it is only to facilitate information system compatibility. CDC is developing "beyond use date" (BUD) tracker labels to assist clinicians with tracking expiration dates at the point of vaccine administration. The label templates will be available on the CDC website.
- **Manufactured Date:** A manufactured date will be on the packaging and should not be used as the expiration date when documenting vaccine administration. This date is provided to help with managing stock rotations; however, expiration dates should also be considered (see above) as using manufactured date alone could have some limitations.
- **2D Barcode:** The 2D barcode available on the vaccine carton (also on the vials for some vaccines) will include NDC, lot number, and a placeholder expiration date of 12/31/2069.
- **QR Code:** Each vaccine manufacturer will include a Quick Response (QR) code on the vaccine carton for accessing FDA-authorized, vaccine product-specific EUA fact sheets for COVID-19 vaccination providers and COVID-19 vaccine recipients.

A list of authorized COVID-19 vaccine products with corresponding EUA fact sheets for healthcare providers and vaccine recipients, and up-to-date expiration information by vaccine lot will be available on an HHS website.

COVID-19 Vaccine Recovery

Details of COVID-19 vaccine recovery are still being finalized and will be communicated when available.

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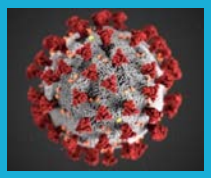

Section 8: COVID-19 Vaccine Storage and Handling

COVID-19 vaccine products are temperature-sensitive and must be stored and handled correctly to ensure efficacy and maximize shelf life. Proper storage and handling practices are critical to minimize vaccine loss and limit risk of administering COVID-19 vaccine with reduced effectiveness. Jurisdictions should work with staff at each COVID-19 vaccination provider site to ensure appropriate vaccine storage and handling procedures are established and followed.

It is expected that cold chain storage and handling requirements for COVID-19 vaccine products will vary in temperature from refrigerated (2°C to 8°C) to frozen (-15°C to -25°C) to ultra-cold (-60°C to -80°C) in the freezer or within the dry ice thermal shipper in which product was received. Ongoing stability testing may impact these requirements. *Note: These temperatures are based on information available as of 10/29/2020. Updated information will be provided as it becomes available.*

For a reliable cold chain, three elements must be in place:

- Well-trained staff
- Reliable storage and temperature monitoring equipment
- Accurate vaccine inventory management

The cold chain begins at the COVID-19 vaccine manufacturing plant, includes delivery to and storage at the COVID-19 vaccination provider site, and ends with administration of COVID-19 vaccine to a person. Jurisdictions and vaccination providers are responsible for maintaining vaccine quality from the time a shipment arrives at a vaccination provider site until the dose is administered. To minimize opportunities for breaks in the cold chain, most COVID-19 vaccine will be delivered from CDC's centralized distributor directly to the location where the vaccine will be stored and administered, although some vaccine may be delivered to secondary depots for redistribution. Certain COVID-19 vaccine products, such as those with ultra-cold temperature requirements, will be shipped directly from the manufacturer to the vaccination provider site. If redistributing vaccine, jurisdictions must adhere to all cold chain requirements and should limit transport of frozen or ultra-cold vaccine products.

Every vaccine storage unit/container must have a temperature monitoring device. CDC recommends digital data loggers (DDLs). One vaccine product is stored at ultra-cold temperatures and will require a DDL that can register these temperatures. CDC is currently exploring options to support acquisition of DDLs for use with ultra-cold vaccines. However, jurisdictions should continue to identify options to obtain DDLs for use with ultra-cold vaccines, in addition to the DDLs needed for storage of refrigerated and frozen (-20°C) vaccines. DDLs using a buffered temperature probe provide the most accurate measurement of vaccine temperatures. However, many manufacturers use pure propylene glycol (freezing point -59°C) or a glycol mixture with a warmer freezing point in their probes. For accurate temperature monitoring of ultra-cold vaccines, it is essential that an air-probe or a probe designed specifically for ultra-cold temperatures is used with the DDL.

An addendum to the *Vaccine Storage and Handling Toolkit* that specifically addresses COVID-19 vaccines is currently being developed in addition to other training materials.

Satellite, Temporary, and Off-Site Clinic Storage and Handling Considerations

Satellite, temporary, or off-site clinics in collaboration with community or mobile vaccinators may assist jurisdictions in providing equitable access for COVID-19 vaccination. However, these situations require additional oversight and enhanced storage and handling practices, including:

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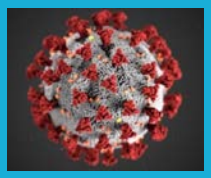

- The quantity of COVID-19 vaccine transported to a satellite, temporary, or off-site COVID-19 vaccination clinic should be based on the anticipated number of COVID-19 vaccine recipients and the ability of the vaccination provider to store, handle, and transport the vaccine appropriately. This is essential to minimizing the potential for vaccine wastage and spoilage.
- COVID-19 vaccines may be transported—not shipped—to a satellite, temporary, or off-site COVID-19 vaccination clinic setting using vaccine transportation procedures outlined in the upcoming COVID-19 addendum to CDC's *Vaccine Storage and Handling Toolkit*. The procedures will include transporting vaccines to and from the provider site at appropriate temperatures, using appropriate equipment, as well as monitoring and documenting temperatures.
- Upon arrival at the COVID-19 vaccination clinic site, vaccines must be stored correctly to maintain appropriate temperature throughout the clinic day.
- Temperature data must be reviewed and documented according to guidance in the upcoming COVID-19 addendum to CDC's *Vaccine Storage and Handling Toolkit*.
- At the end of the clinic day, temperature data must be assessed prior to returning vaccine to fixed storage units to prevent administration of vaccines that may have been compromised.
- As with all vaccines, if COVID-19 vaccines are exposed to temperature excursions[6] at any time, the temperature excursion should be documented and reported according to the jurisdiction immunization program's procedures. The vaccines that were exposed to out-of-range temperatures must be labeled "do not use" and stored at the required temperature until further information on usability can be gathered or further instruction on disposition or recovery is received.

Jurisdictions and tribal organizations should review CDC's revised Guidance for Planning Vaccination Clinics Held at Satellite, Temporary, or Off-Site Locations as well as Vaccination Guidance During a Pandemic. These resources provide information on additional considerations that are necessary during the COVID-19 pandemic, including social distancing, PPE use, and enhanced sanitation efforts.

[6] *A "temperature excursion" is an event in which the COVID-19 vaccine is exposed to temperatures outside the range(s) prescribed for storage and/or transport.*

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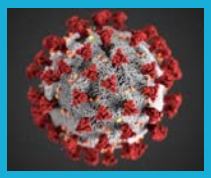

Section 9: COVID-19 Vaccine Administration Documentation and Reporting

CDC requires that vaccination providers enrolled in the COVID-19 Vaccination Program report certain data elements for each dose administered within 24 hours of administration. (See *Appendix D: CDC IIS Data Requirements for COVID-19 Vaccine Monitoring).* Jurisdictions should assess the capability of COVID-19 vaccination providers to meet federal and jurisdiction-specific reporting requirements before or upon enrollment. The required data elements are located on the ISD Awardees SharePoint site. COVID-19 vaccination providers may view the data requirements on CDC's IIS website. Jurisdictions should be prepared to provide additional support or technical assistance for smaller vaccination providers or rural clinic settings.

Jurisdictions must facilitate and monitor IIS reporting by enrolled vaccination providers. Each vaccination location should be ready (including trained staff, necessary equipment, and internet access) to report vaccine administration data to the IIS or other external system at the time of vaccination. If data will be entered off site, vaccination providers must ensure the required data are reported to the IIS or other designated system within 24 hours. Reporting data may be transmitted daily from the jurisdiction's designated system to the CDC via the IZ Gateway[7] "Connect" component. Additional information on the reporting process and specifications will be shared as soon as they have been finalized. Jurisdictions will not be responsible for reporting data from federal agencies or commercial partners who receive vaccine allocations directly from CDC.

In addition to reporting vaccine administration, jurisdictions must put processes in place to match first and second doses including addressing the need to exchange data with or query other jurisdiction's systems and/or the Immunization Data Lake[8] to obtain immunization history, if applicable.

Jurisdictions should ensure redundant measures and procedures are in place for recording vaccine administration data in instances of connectivity problems or failures in the jurisdiction's IIS or other system. The jurisdiction's IIS should collect, report, and submit data directly to CDC's Immunization Data Lake and jurisdictional reporting requirements. (Additional information on CDC data requirements is forthcoming.) Planning activities should include onboarding to IZ Gateway Connect and Share[9] (if feasible) components;

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[7] The Immunization Gateway (IZ Gateway) facilitates electronic messaging of vaccination records in a secure infrastructure allowing IIS systems across the nation to share vaccine administration data not only between jurisdictions, but also with provider organizations (e.g., Department of Defense, Federal Bureau of Prisons, IHS, Department of Veterans Affairs) that do not exchange data with the IIS today.

[8] The Immunization Data Lake is a cloud-hosted data repository to receive, store, and manage COVID-19 vaccination data for doses administered, vaccination coverage, ordering, inventory, and distribution. The Data Lake will provide a catalogue of different COVID-19 vaccine-related data sources that can be used to aid in monitoring COVID-19 vaccine ordering, distribution, coverage, and uptake. Data streams currently being onboarded to the Data Lake include provider enrollment data, VTrckS, and VaccineFinder.

[9] There are multiple ways to onboard to the IZ Gateway, including Connect and Share.

- **Connect** enables large national and non-traditional vaccination systems for satellite/temporary/off-site clinic settings to report and query immunization data with IISs, using the gateway's centralized data exchange, avoiding multiple individual, and point-to-point connections.
- **Share** allows exchange of immunization data between IIS jurisdictions by automating message triggers through the

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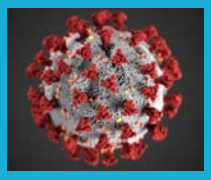

exchanging data with other jurisdictions through the IZ Gateway; generating coverage reports for use within the jurisdiction; and providing data to CDC that meet defined standards.

IIS for patients immunized outside of their jurisdiction, to route messages to the patient's state of residence through the IZ Gateway.

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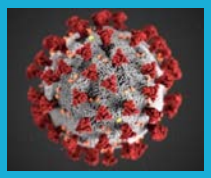

Section 10: COVID-19 Vaccination Second-Dose Reminders

For most COVID-19 vaccine products, two doses of vaccine, separated by 21 or 28 days, will be needed. Because different COVID-19 vaccine products will not be interchangeable, a vaccine recipient's second dose must be from the same manufacturer as their first dose. Second-dose reminders for vaccine recipients will be critical to ensure compliance with vaccine dosing intervals and achieve optimal vaccine effectiveness. COVID-19 vaccination providers should make every attempt to schedule a patient's second-dose appointment when they get their first dose.

COVID-19 vaccination record cards will be provided as part of vaccine ancillary kits. Vaccination providers must complete these cards with accurate vaccine information (i.e., vaccine manufacturer, lot number, date of first dose administration, and second dose due date), and give them to each patient who receives vaccine to ensure a basic vaccination record is provided. Vaccination providers should encourage vaccine recipients to keep the card in case the IIS or other system is not available when they return for their second dose. The card provides room for a written reminder for a second-dose appointment. If vaccine recipients have a smartphone, they may consider documenting their vaccine administration with a photo of their vaccination record and entering the date the next vaccine dose is due on their electronic calendar.

Redundant methods and systems should be used to remind vaccine recipients about their need for second doses. Jurisdictions should assess current practices for patient reminder/recall in existing healthcare provider organizations. Public health programs should work with occupational health providers and partners to consider the most appropriate and effective method of issuing second-dose reminders. A jurisdiction's IIS can be particularly useful for centralized reminder/recall (see *Section 11: COVID-19 Requirements for IIS or Other External Systems*). Many pharmacies and healthcare systems have their own systems for patient notifications and reminders, some using functionality within their electronic health record (EHR) systems. Jurisdictions may consider exploring the use of automated patient phone calls ("robocalls"), emails, and SMS text message-based systems. Health plans may also help to notify their enrollees about second doses based on claims information.

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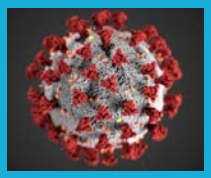

Section 11: COVID-19 Requirements for Immunization Information Systems or Other External Systems

Immediate Priorities for Immunization Programs Related to Data Reporting:

- Determine and implement a solution for documenting vaccine administration in temporary or high-volume settings (e.g., VAMS or similar application, IIS or module that interfaces with the IIS, or other jurisdiction-based solution)
- Ensure system capacity for data exchange, security, storage, and reporting
- Enroll vaccination provider facilities/organizations anticipated to vaccinate essential workers
- Connect IIS to the IZ Gateway
- Establish required data use agreements
- Assess and improve data quality
  - Ensure data are available, secure, complete, timely, valid, accurate, consistent, and unique

IISs, also known as "vaccine registries," are confidential, population-based, computerized databases for recording information on vaccine doses. IISs are maintained by a jurisdiction's immunization program.

IISs have a range of capabilities. Many IISs can exchange data with EHRs, so that documentation of vaccine administration is automatically uploaded through bidirectional data exchange between EHRs and the IIS. EHRs that interface with jurisdiction IISs may improve the pace and accuracy of vaccine administration data capture. Some EHRs may leverage 2D barcoding technology on vaccine vials and VISs to allow for rapid, accurate, and automatic capture of vaccine administration data, such as vaccine lot number, vaccine manufacturer, and expiration date. In many jurisdictions, routine vaccination providers enroll in public vaccine programs, order vaccines, report inventory, document vaccine spoilage/wastage, and remind patients when vaccine doses are due using the IIS.

Using the IIS to document COVID-19 vaccine dose administration is beneficial on many fronts. When using the IIS, vaccination providers are able to determine if a patient is due for the first or second dose of vaccine. This is especially helpful in a pandemic situation when people may receive first and second vaccine doses at different locations. The IIS will also help to ensure that first and second doses are administered using the same vaccine product and appropriately spaced according to ACIP-recommended intervals. Based on a jurisdiction's discretion and IIS functionality, COVID-19 vaccination providers may use IISs to:

- Preregister or enroll in the COVID-19 vaccination program
- Place orders for COVID-19 vaccine
- Document vaccine administration
- Manage and report vaccine inventory
- Report vaccine spoilage/wastage
- Provide reminders to COVID-19 vaccine recipients indicating when the next dose of a multidose vaccine is due

CDC is making available a vaccination clinic mobile application, Vaccine Administration Management System (VAMS), that may be used to register patients and record dose-level vaccination data that meets CDC reporting requirements. IIS and other external systems that support COVID-19 response efforts must have solid

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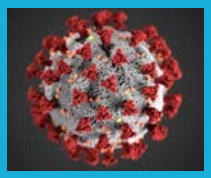

infrastructure, engaged partners, high-quality data, and efficient processes for managing vaccination. The objectives for these areas are described below.

System Infrastructure

Jurisdictions should take certain steps to ensure the IIS or other external system's infrastructure is ready to support the COVID-19 Vaccination Program. Each jurisdiction should ensure their IIS infrastructure meets COVID-19 response data exchange, storage, and reporting requirements. The hardware and software on which the IIS depends should be up to date. For IISs that use a vendor platform, the IIS should be on the latest version of the platform.

The jurisdiction's IIS must operate as expected to appropriately support COVID-19 vaccination tracking efforts. The jurisdiction should prioritize testing and implement fixes for defects and enhancements that impact the IIS's ability to support COVID-19 response efforts.

The jurisdiction must use a system that supports dose-level accountability—from the time vaccine leaves the distributor until the vaccine is administered or unused vaccine is returned—and provides data to CDC that meet defined standards. Jurisdictions will need to have a solution (either leveraging existing or new) for extracting required data from their IIS as a contingency for network outages. The specifications to support the data extracts will be provided by CDC to ensure data submissions align with the format required for submission to the COVID-19 clearing house (a secure data lake). Jurisdictions should also develop and test backup solutions for offline use if the internet is unavailable.

Jurisdictions should explore and implement available IIS functionality for sending second-dose reminders to vaccine recipients via email and/or text messages (see *Section 10: COVID-19 Vaccination Second-Dose Reminders*). This will be critical to ensure recipients complete the COVID-19 vaccine series.

COVID-19 Vaccination Provider Preparation

As jurisdictions enroll providers in the COVID-19 Vaccination Program (see *Section 5: COVID-19 Vaccination Provider Recruitment and Enrollment*), it is critical that they onboard providers to the IIS. Jurisdictions should have expedited processes in place to rapidly onboard vaccination providers expected to support Phase 1 activities and efficient processes to onboard vaccination providers expected to support expanded efforts in Phases 2 and 3.

Jurisdictions may conduct nontraditional COVID-19 vaccination clinics, such as temporary, off-site, or mobile vaccination clinics to reach critical populations, particularly during early vaccination efforts. This may require jurisdictions to identify, enroll, and train additional partners to report doses administered in the system designated to support those efforts.

Data Management

The jurisdiction's IIS should collect and report data to satisfy CDC and jurisdictional reporting requirements. (Additional information on CDC data requirements is forthcoming.) Planning activities should include onboarding COVID-19 providers to the IIS, ensuring adequate IIS capacity, and establishing processes to ensure provider reporting within 24 hours of administration. IISs should also consider leveraging the IZ Gateway **Connect** and **Share** (if feasible) components for exchanging data with and/or querying other jurisdictions to obtain a consolidated vaccination record; using systems designed to support satellite, temporary, or off-site vaccination clinics; and generating coverage reports for use within the jurisdiction. Jurisdictions should be prepared to

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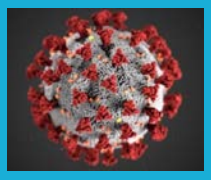

update their Clinical Decision Support (CDS) systems when CDC CDSi (Clinical Decision Support for immunizations) resources are updated.

Jurisdictions must have necessary policies in place to facilitate data collection and sharing with CDC and other jurisdictions. Jurisdictions onboarding to the IZ Gateway will be required to sign the Data Use Agreement (DUA) with Association of Public Health Laboratories (APHL) to participate in both IZ Gateway **Connect** and IZ Gateway **Share.** Jurisdictions will also need to execute the MOU to share data with other jurisdictions through the IZ Gateway.

- **APHL – Jurisdiction DUA IZ Gateway (3August2020revision)** When executed, the APHL and jurisdiction DUA allows for the jurisdiction to participate in the Connect component and to identify which (if any) other components to enable (*Share, Provider-initiated Multi-jurisdictional Data Exchange, Access* and/or *Access: Consumer-initiated Multi-jurisdictional Data Exchange*). This document was updated Aug 3, 2020 for this expanded use.

- **Memorandum of Understanding between Jurisdictions to Exchange Data** The Share component enables the exchange of immunization information across IIS jurisdictions. To enable the Share component, a jurisdiction must execute an Interjurisdictional MOU with jurisdictions with which it will exchange data. The MOU allows data exchange to occur through the IZ Gateway or an alternative mechanism with any state or jurisdiction that signed the MOU.

Jurisdictions will also need to execute a DUA with CDC so CDC can access their IIS data for national coverage data analysis.

Ordering and Inventory

Jurisdictions must have processes in place for managing and tracking COVID-19 vaccine ordering and inventory. Planning activities should include reviewing business processes and IIS functionality to identify and implement improvements; developing a plan to order, monitor, and manage COVID-19 vaccine inventory in the IIS using CDC standards; and exploring opportunities to adopt 2D barcoding technology to improve data quality.

Related Guidance and Reference Materials

CDC Vaccination Clinic Mobile Application: Vaccine Administration Management System (VAMS)

- VAMS: An overview of the functionality of the four VAMS modules: IIS jurisdictions, employers/organizations, clinics, and vaccine recipients. *(Located in SharePoint)*

Provider Onboarding

- CDC Provider IIS Participation Community of Practice: An overview of the CDC Provider IIS Participation Community of Practice and ideas for addressing important provider IIS participation issues, including onboarding, EHR assistance, data quality, and provider training and outreach presented as a webinar on April 10, 2019.
- American Immunization Registry Association (AIRA Data Validation Guide – for the IIS Onboarding Process (2017): A guide with recommendations on the data validation process within onboarding
- Onboarding Consensus-Based Recommendations (2018): A guide for improving and standardizing onboarding intended for technical and programmatic staff that make up IIS onboarding teams and for program administrators responsible for allocation of onboarding resources

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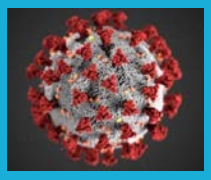

Data Quality

- IIS Data Quality Blueprint — A guide to help immunization program awardees address and advance data quality within IISs
- Data Quality Assurance in Immunization Information Systems: Incoming Data (2008): A summary of best practice guidelines and immediate actions an IIS can take to improve data quality
- IIS Data Quality Practices to Monitor and Evaluate Data at Rest (2018): Practical guidance on techniques, methodologies, and processes for IISs to use in assessing the quality of data at rest, including demographic and immunization record information that is currently in the live, production environment (e.g., database or other data store). The primary audience for the guide includes IIS managers and staff with responsibility for ensuring IIS data quality.
- Consolidating Demographic Records and Vaccination Event Records (2017): Consensus-based best practice recommendations to support the process of consolidating demographic and vaccination event records.

Immunization Gateway (IZ Gateway)

- Immunization Gateway Information Sheet *(Located in SharePoint available to immunization programs)*
- Immunization Gateway Overview *(Located in SharePoint available to immunization programs)*
- Immunization Gateway Q&As for IIS Awardees *(Located in SharePoint available to immunization programs)*

Ordering and Inventory

- Immunization Information System Inventory Management Operations (2012): Consensus-based best practice recommendations for IISs to support immunization program requirements for provider organizations' vaccine inventory management and associated IIS reports that support the vaccine inventory management needs of provider organizations and grantee immunization programs.
- Decrementing Inventory via Electronic Data Exchange (2016): Consensus-based best practice recommendations to support the process of decrementing inventory via electronic data exchange.
- Guidance on Unit of Sale/Unit of Use Lot Numbers (2018): Clarifications to the process and expectations for management of vaccine lot numbers.
- Vaccine Code Set Considerations (2020): A general overview of vaccine code sets and brief description of how code sets support multiple and varied IIS functions, including electronic data exchange with EHRs and other health information systems and vaccine ordering and inventory management.

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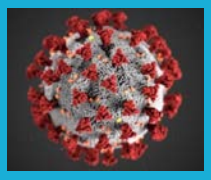

Section 12: COVID-19 Vaccination Program Communication

Starting before COVID-19 vaccines are available, clear, effective communication will be essential to implementing a successful COVID-19 Vaccination Program. Building vaccine confidence broadly and among groups anticipated to receive early vaccination, as well as dispelling vaccine misinformation, are critical to ensure vaccine uptake.

A successful COVID-19 Vaccination Program will have lasting effects on the nation's immunization system and overall vaccination efforts in the future. Using risk communication principles along with the CDC's recently developed Vaccinate with Confidence framework, jurisdictions can develop and implement timely, evolving plans as the foundation for their overall COVID-19 vaccination communication efforts.

COVID-19 Vaccination Communication Objectives

- Educate the public about the development, authorization, distribution, and execution of COVID-19 vaccines and that situations are continually evolving.
- Ensure public confidence in the approval or authorization process, safety, and efficacy of COVID-19 vaccines.
- Help the public to understand key differences in FDA emergency use authorization and FDA approval (i.e., licensure).
- Engage in dialogue with internal and external partners to understand their key considerations and needs related to COVID-19 vaccine program implementation.
- Ensure active, timely, accessible, and effective public health and safety messaging along with outreach to key state/local partners and the public about COVID-19 vaccines.
- Provide guidance to local health departments, clinicians, and other hosts of COVID-19 vaccination provider locations.
- Track and monitor public receptiveness to COVID-19 vaccination messaging.

Key Audiences

Messaging should be tailored for each audience to ensure communication is effective.

- Healthcare personnel (i.e., organizations and clinicians who will receive information about receiving and administering vaccine)
- Health insurance issuers and plans (coverage for vaccine, in-network providers)
- Employers
- Government and community partners and stakeholders
- Public/consumers
    - Essential workers
    - Those in groups at risk for severe outcomes from COVID-19 infection
    - Those in groups at increased risk of acquiring or transmitting COVID-19
    - Those with limited access to vaccination services

Broad Communication Planning Phases

Messaging should be timely and applicable for the current phase of the COVID-19 Vaccination Program.

- Before vaccine is available
- Vaccine is available in limited supply for certain populations of early focus (Phase 1)

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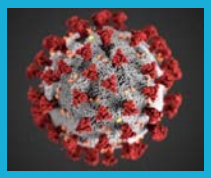

- Vaccine is increasing and available for other critical populations and the general public (Phase 2)
- Vaccine is widely available (Phase 3)

Communication Activities

- Communicate early about the safety of vaccines in general and have easily accessible, government information to address myths, questions, and concerns.
- Keep the public, public health partners, and healthcare providers well-informed about COVID-19 vaccine(s) development, recommendations, and public health's efforts.
- Engage and use a wide range of partners, collaborations, and communication and news media channels to achieve communication goals, understanding that channel preferences and credible sources vary among audiences and people at higher risk for severe illness and critical populations, and channels vary in their capacity to achieve different communication objectives.
- Communicate proactively whenever possible, anticipating issues and forecasting possible problems before they reach broad awareness.
- Ensure that communications meet the requirements of the Americans with Disabilities Act, the Rehabilitation Act, the Patient Protection and Affordable Care Act, the Plain Language Act, and other applicable disability rights laws for accessibility.
- Use information and education campaigns to extend reach and increase visibility of vaccine recommendations and resources.
- Work closely with partner agencies, representatives of local communities with critical populations, and intermediaries to achieve consensus on actions, consistency in messages, and coordinated communication activities.
- Communicate transparently about COVID-19 vaccine risks and recommendations, immunization recommendations, public health recommendations, and prevention measures.

Messaging Considerations

Public health messages and products should be tailored for each audience and developed with consideration for health equity. It is important to use plain language that is easily understood. Information should be presented in culturally responsive language and available in languages that represent the communities. Jurisdictions should be careful to address all people inclusively, with respect, using non-stigmatizing, bias-free language. Insufficient consideration of culture in developing materials may unintentionally result in misinformation, errors, confusion, or loss of credibility. When developing/utilizing materials, jurisdictions should check for the following:

- Are there words, phrases, or images that could be offensive to or stereotypical of the cultural or religious traditions, practices, or beliefs of the intended audience?
- Are there words, phrases, or images that may be confusing, misleading, or have a different meaning for the intended audience (e.g., if abstract images are used, will the audience interpret them as intended)?
- Are there images that do not reflect the look or lifestyle of the intended audience or the places where they live, work, or worship?
- Are there health recommendations that may be inappropriate or prohibited for the social, economic, cultural, or religious context of the intended audience?
- Are any toll-free numbers or reference web pages in the message in the language of the intended audience?

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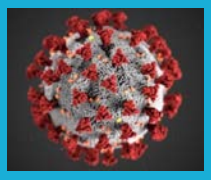

These considerations and any others that emerge during message development and deployment should be reviewed again when material is translated.

Communication Channels

Even perfectly developed messages and materials will provide no benefit if they are not received by the intended audience. Jurisdictions and tribal organizations should explore how specific groups are most likely to access information with the communication methods available to them. Feedback mechanisms such as a web page or e-mail account to allow the audience to express concerns, ask questions, and request assistance are extremely important, and creating such mechanisms should be a priority for jurisdictions.

Traditional media channels

- Print
- Radio
- TV

Digital media

- Internet
- Social media
- Text messaging

Partners and Trusted Sources

Working to engage and empower partners is critical to reinforcing COVID-19 vaccination messages. Efforts with partners and trusted sources should be integrated into other channels in addition to programmatic and community engagement efforts. These partners include:

- State and local government
- Employers
- Healthcare providers (including federally funded safety net and in-home care providers)
- Health insurance issuers and plans
- Educators
- Unions and professional organizations
- Organizations serving minority populations and people with disabilities
- Community and faith-based groups
- Organizations serving tribal nations

Crisis and Risk Communication

Crisis and emergency risk communication (CERC) is the application of evidence-based principles to effectively communicate during emergencies. These principles are used by public health professionals and public information officers to provide information that helps people, stakeholders, and entire communities make the best possible decisions for themselves and their loved ones. CERC recognizes that during emergencies, we work under impossible time constraints and must accept the imperfect nature of our choices.

CERC principles include:

- Be First
- Be Right

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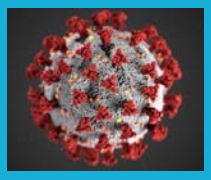

- Be Credible
- Express Empathy
- Show Respect

Jurisdictions must have communication messaging before, during, and after COVID-19 vaccine is available to help communities understand the importance of vaccination as well as the benefits and risks. Communicating what is currently known, regularly updating this information, and continuing dialogue with media and other partners throughout the vaccine distribution and administration process is essential to establish and maintain trust and credibility.

Related Guidance and Reference Materials

Jurisdictions should regularly review available CDC COVID-19 Communication Resources. CDC has developed COVID-19 One-Stop Shop Toolkits for communication, including toolkits tailored for different populations as well as a social media toolkit. To reach essential workers for vaccination, jurisdictions may need to assist industry and businesses in communicating with employees about vaccination clinics. CDC's COVID-19 Communications Plan for Select Non-Healthcare Critical Infrastructure Employers may be helpful for this purpose.

CDC's CERC manual is available online, including online trainings, and examples of how CERC is applied during emergencies, at https://emergency.cdc.gov/cerc/manual/index.asp.

The World Health Organization has developed a guide that provides strategies and tools to support effective communication planning and management in response to vaccine safety events.

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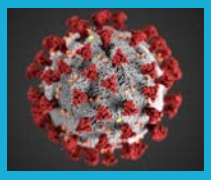

Section 13: Regulatory Considerations for COVID-19 Vaccination

Initially available COVID-19 vaccines may be authorized for use under an EUA issued by FDA or approved as licensed vaccines.

Emergency Use Authorization Fact Sheets

The EUA authority allows FDA to authorize either (a) the use of an unapproved medical product (e.g., drug, vaccine, or diagnostic device) or (b) the unapproved use of an approved medical product during an emergency based on certain criteria. The EUA will outline how the COVID-19 vaccine should be used and any conditions that must be met as requirements of authorized vaccine use. FDA will coordinate with CDC to confirm these "conditions of authorization." Vaccine conditions of authorization are expected to include distribution requirements, reporting requirements, and safety and monitoring requirements. The EUA would be terminated when either the HHS Secretary determines that circumstances justifying authorization of emergency use of the COVID-19 vaccine have ceased or there is a change in the approval status of the vaccine such that an EUA is no longer necessary. Additional information on EUAs, including guidance and frequently asked questions, is located on the FDA website.

Product-specific EUA fact sheets for COVID-19 vaccination providers will be made available that will include information on the specific vaccine product and instructions for its use. An **EUA fact sheet for vaccine recipients** will also be developed, and both will be made available on the FDA and CDC websites. Jurisdictions should ensure providers know where to find both the provider and recipient fact sheets, have read and understand them, and are clear on the requirement to provide the recipient fact sheet to each client/patient prior to administering vaccine.

Vaccine Information Statements

VISs are required by law for certain licensed vaccines and only if a vaccine is added to the Vaccine Injury Table. Optional VISs may be produced, but only after a vaccine has been licensed. Plans for developing a VIS for COVID-19 vaccine are not known at this time but will be communicated as additional information becomes available.

Additional information on VISs is located at https://www.cdc.gov/vaccines/hcp/vis/current-vis.html.

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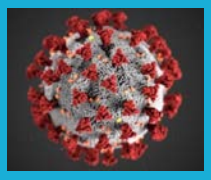

Section 14: COVID-19 Vaccine Safety Monitoring

An "adverse event (AE) following immunization" is an adverse health problem or condition that happens after vaccination (i.e., a temporally associated event). It might be truly caused by the vaccine or it might be purely coincidental and not related to vaccination.

CDC continuously monitors the safety of vaccines given to children and adults in the United States. VAERS, co-administered by CDC and FDA, is the national frontline monitoring system for vaccine safety.

Vaccine Adverse Event Reporting System

VAERS is a national early warning system to detect possible safety problems with vaccines. Anyone—a doctor, nurse, pharmacist, or any member of the general public—can submit a report to VAERS. VAERS is not designed to detect whether a vaccine caused an adverse event, but it can identify "signals" that might indicate possible safety problems requiring additional investigation.

Per the *CDC COVID-19 Vaccination Program Provider Agreement*, COVID-19 vaccination providers are required to report the following to VAERS:

- vaccine administration errors (whether associated with an AE or not),
- serious AEs (even if they are not sure if the vaccination caused the event),[10]
- multisystem inflammatory syndrome (MIS) in children or adults, and
- cases of COVID-19 that result in hospitalization or death to VAERS.

They are also required to report to VAERS any additional AEs and/or adhere to any revised safety reporting requirements per FDA's conditions of authorized vaccine use posted on FDA's website throughout the duration of the EUA, as applicable. Vaccination providers should also report any additional clinically significant adverse events following COVID-19 vaccination to VAERS, even if they are not sure if the vaccination caused the event. Jurisdictions should ensure that enrolled COVID-19 vaccination providers understand the procedures for reporting adverse events to VAERS. More information on submitting a VAERS report electronically can be found at https://vaers.hhs.gov/reportevent.html.

v-safe

CDC will implement **v-safe**, a new smartphone-based tool that uses text messaging and web surveys to check in with vaccinated individuals for adverse events after a COVID-19 vaccination. **v-safe** will also provide second-dose reminders (if needed) and live telephone follow up by CDC if vaccinated individuals report a medically significant event during a **v-safe** check-in. **v-safe** asks questions that help CDC monitor the safety of COVID-19 vaccines. Medically significant events will be identified if the vaccinated individual reports that they missed work, were unable to complete normal daily activities, or had to seek care from a health provider or healthcare professional. The information will be used to analyze common side effects (soreness in the arm, muscle aches, etc.) and to detect unexpected, serious health problems if they occur.

[10] Serious AEs are defined as: death, a life-threatening AE, inpatient hospitalization or prolongation of existing hospitalization, persistent or significant incapacity or substantial disruption of the ability to conduct normal life functions, a congenital anomaly/birth defect, or an important medical event that may not result in death, be life-threatening, or require hospitalization when, based upon appropriate medical judgment, it may jeopardize the individual and may require medical or surgical intervention to prevent one of the outcomes listed above. Serious AEs should be reported regardless of causality.

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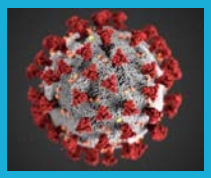

CDC will create a **v-safe** information sheet that contains background on the **v-safe** program and instructions for enrolling. Healthcare professionals and healthcare facilities that are giving COVID-19 vaccines are asked to provide printed hard copies of the **v-safe** information sheet to each vaccinated individual and counsel them on the importance of enrolling in **v-safe**. The **v-safe** information sheet and counseling script are in development and will be made available electronically when competed. It is critically important for vaccine safety monitoring and assessment that healthcare professionals give each patient a **v-safe** information sheet at the time of vaccination and encourage patients to enroll.

The following two vaccine safety monitoring programs require no actions from jurisdictions, but descriptions are provided for informational purposes to help in fielding questions about COVID-19 vaccine safety monitoring.

Vaccine Safety Datalink

The Vaccine Safety Datalink (VSD) is a collaboration between CDC's Immunization Safety Office and nine healthcare organizations. This active surveillance system monitors electronic health data on vaccination and medical illnesses diagnosed in various healthcare settings and conducts vaccine safety studies based on questions or concerns raised from medical literature and findings from VAERS monitoring.

Clinical Immunization Safety Assessment Project

CDC's Clinical Immunization Safety Assessment (CISA) Project is a national network of vaccine safety experts from CDC's Immunization Safety Office and seven medical research centers. This project conducts clinical research, assesses complex events following vaccination, and provides consultations to U.S. healthcare providers and public health partners.

Healthcare providers or health departments in the United States can request a consultation from CISA for a complex COVID-19 vaccine safety question that is (1) about an individual patient residing in the United States or vaccine safety issue and (2) not readily addressed by Centers for Disease Control and Prevention (CDC) or Advisory Committee on Immunization Practices (ACIP) guidelines. CISA consultations can be requested by calling CDC-INFO at 800-CDC-INFO (800-232-4636) or using the CDC-INFO webform. Please indicate that the request is for a CISA evaluation. The request will be forwarded to the CISA Project clinicians for review.

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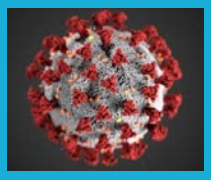

Section 15: COVID-19 Vaccination Program Monitoring

Continuous monitoring for situational awareness throughout the COVID-19 Vaccination Program is crucial for a successful outcome. Prior to receiving COVID-19 vaccine, jurisdictions should establish procedures for monitoring various critical program planning and implementation elements, including performance targets, resources, staffing, and activities.

CDC Dashboards

To provide situational awareness for jurisdictions and the general public throughout the COVID-19 vaccination response, two dashboards will be available.

CDC's **Weekly Flu Vaccination Dashboard** will include weekly estimates of influenza vaccination for adults, children, and pregnant women using existing (National Immunization Survey [NIS]-Flu) data sources. Data and estimates from additional sources will be added, as available.

An additional dashboard, the Operation Warp Speed (OWS) Tiberius platform, is a COVID-19 vaccine distribution planning, tracking, modeling, and analysis application that provides flexible, real-time, data-backed processes so users of all types can make data-driven decisions. Tiberius will integrate data sources from federal agencies, state and local partners, private-sector partners, and other data providers to create a comprehensive common operating picture for the COVID-19 vaccine planning, distribution, and administration effort that awardees can use to support the COVID-19 vaccine response. Awardees can reach out to their OWS point of contact or POB project officer to request access.

Resources

Jurisdictions and tribal nations should regularly monitor their resources to avoid unexpected obstacles to the progress of their COVID-19 Vaccination Programs.

Staffing

Having enough adequately trained staff with current situational awareness is key to a successful COVID-19 Vaccination Program. Specialized expertise is required, and it is important to have backups in each specialty area to guard against interruption of activities because of illness or other personal situations. For example, if staff are supporting temporary or off-site COVID-19 vaccination clinics, the hours are likely to be long and physically taxing. Managers and supervisors need to regularly check in with and support assigned staff's wellness and overall resilience to perform the assigned tasks.

Inventory

Important activities during the COVID-19 Vaccination Program might be halted if certain supplies are depleted without replenishment. Jurisdictions may find it helpful to develop lists and track inventory for various program components (e.g., temporary/off-site clinics, vaccination provider enrollment and training, vaccine management). Regular monitoring of such records will foster early prompts to order and replenish supplies and ensure availability as needed. For example, jurisdictions will need to project and monitor use of PPE throughout the response and have ordering and procurement protocols in place for securing additional supplies.

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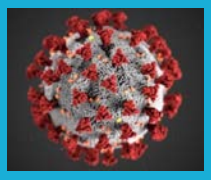

Messaging

CDC will provide timely messaging throughout the COVID-19 vaccination response via all-jurisdiction calls, regular e-mail communication, and website updates. Jurisdictions and Tribal Nations should routinely monitor both CDC and local-level messaging to inform their communications efforts. Variations in messaging can create confusion and hamper the effective implementation of the vaccination program. Messaging must be clear, current, and received as intended by the audience. Monitoring social media can be helpful in assessing message delivery and reception and dispelling inaccurate information.

Local Jurisdictions

Constant communication and coordination with local jurisdictions and Tribal Nations are instrumental during all phases of the COVID-19 Vaccination Program in both centralized and decentralized operational structures. Long before the vaccination program begins, roles and responsibilities should be established and well understood at all levels. This will help avoid misperceptions as well as gaps in planning and implementation. Throughout the COVID-19 Vaccination Program, jurisdictions should monitor and maintain awareness of local-level strategies and activities, providing technical assistance as needed. This visibility can help ensure local jurisdictions and providers adhere to recommendations and guidance from CDC and state, local, and tribal authorities.

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Appendix A: COVID-19 Vaccination Planning Assumptions for Jurisdictions (revised 10/29/2020)

Many COVID-19 vaccine candidates are in development, and clinical trials are being conducted simultaneously with large-scale manufacturing. It is not known which vaccines may be authorized or approved for use by FDA or when such EUA authorizations or approvals will take place. COVID-19 Vaccination Program plans must be flexible and accommodate multiple scenarios. For the purpose of initial planning, consider the following assumptions.

COVID-19 VACCINE

- Limited COVID-19 vaccine doses may be available by mid November 2020 if a COVID-19 vaccine is authorized or licensed by FDA by that time, but COVID-19 vaccine supply may increase substantially in 2021.
- Initially available COVID-19 vaccines are anticipated to be authorized for use under Emergency Use Authorization (EUA) issued by the U.S. Food and Drug Administration.
- Cold chain storage and handling requirements for each COVID-19 vaccine product will vary from refrigerated (2°C to 8°C) to frozen (-15°C to -25°C) to ultra-cold (-60°C to -80°C) temperatures, and ongoing stability testing may impact these requirements. *Note: These temperatures are based on information available as of October 29, 2020. Updated information will be provided as it becomes available.*
- Jurisdictions should develop strategies to ensure the correct match of COVID-19 vaccine products and dosing intervals. Once authorized or approved by the FDA, two doses of COVID-19 vaccine, separated by either 21 or 28 days, will be needed for most COVID-19 vaccine products, and second-dose reminders for patients will be necessary. Both doses will need to match each other (i.e., be the same vaccine product).
- Some COVID-19 vaccine products will likely require mixing with diluent at the point of administration.

COVID-19 VACCINE ALLOCATION

- Final decisions are being made about use of initially available supplies of COVID-19 vaccines. These decisions will be partially informed by the proven efficacy of the vaccines coming out of Phase 3 trials, but populations of focus for initial COVID-19 vaccination may include:
    - Healthcare personnel (paid and unpaid people serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials and are unable to work from home)
    - Non-healthcare essential workers
    - Adults with underlying medical conditions that are risk factors for severe COVID-19 illness
    - People 65 years of age or older
- Allocation of COVID-19 vaccine to jurisdictions will be based on multiple factors, including:
    - Critical populations recommended by the Advisory Committee on Immunization Practices (with input from the National Academies of Sciences, Engineering, and Medicine)
    - Current local spread/prevalence of COVID-19
    - COVID-19 vaccine production and availability
- Jurisdictions should anticipate that allocations may shift during the response based on supply, demand, and risk.
- Each jurisdiction should plan for high-demand and low-demand scenarios.

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COVID-19 VACCINATION PROVIDER OUTREACH AND ENROLLMENT

- To receive and administer COVID-19 vaccine and ancillary supplies, vaccination providers must enroll in the federal government (USG) COVID-19 Vaccination Program, coordinated through their jurisdiction's immunization program, by signing and agreeing to conditions outlined in the *CDC COVID-19 Vaccination Program Provider Agreement*.
- CDC will make this agreement available to each jurisdiction's immunization program for use in conducting outreach and enrolling vaccination providers. Jurisdictions will be required to maintain these agreements on file for a minimum of 3 years.
- Jurisdictions will be required to collect and submit to CDC information on each enrolled vaccination provider/site, including provider type and setting, patient population (i.e., number and type of patients served), refrigerated/frozen/ultra-cold temperature storage capacity, and logistical information for receiving COVID-19 vaccine shipments.
- Some multijurisdictional vaccination providers (e.g., select retail pharmacy chains, the Indian Health Service, other federal entities) will enroll directly with CDC to order and receive COVID-19 vaccine. These direct partners will be required to report vaccine supply and uptake information back to each respective jurisdiction. CDC will share additional information when available on these procedures to ensure jurisdictions have full visibility for planning and documentation purposes.
- Jurisdictions may choose to partner with commercial entities to reach the initial populations of focus.
- Routine immunization programs will continue.

COVID-19 VACCINE ORDERING AND DISTRIBUTION

- COVID-19 vaccine and ancillary supplies will be procured and distributed by the federal government at no cost to enrolled COVID-19 vaccination providers. CDC will share more information about reimbursement claims for administration fees as it becomes available.
- CDC will use its current centralized distribution contract to fulfill orders for most COVID-19 vaccine products as approved by jurisdiction immunization programs. Some vaccine products, such as those with ultra-cold temperature requirements, will be shipped directly from the manufacturer.
- Jurisdiction-enrolled vaccination providers will follow the jurisdiction's vaccine ordering procedures.
- COVID-19 vaccination providers will be required to report COVID-19 vaccine inventory each time a COVID-19 vaccine order is placed.
- Vaccine orders will be approved and transmitted in CDC's Vaccine Tracking System (VTrckS) by jurisdiction immunization programs for vaccination providers they enroll.
- Vaccine (and diluent, if required) will be shipped to provider sites within 48 hours of order approval by the immunization program, if supply is available. Ancillary supply kits and diluent (if required) will ship separately from the vaccine due to different cold chain requirements, but shipment will be timed to arrive with or before the vaccine.
- Ancillary supply kits will include needles, syringes, alcohol prep pads, COVID-19 vaccination record cards for each vaccine recipient, and a minimal supply of personal protective equipment (PPE), including surgical masks and face shields, for vaccinators.
    - Each kit will include supplies needed to administer 100 doses of vaccine.
    - Jurisdictions may need to plan for additional PPE, depending on vaccination site needs.

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- For COVID-19 vaccines that require mixing with diluent at the point of administration, these ancillary supply kits will include additional necessary syringes, needles, and other supplies for this purpose.
- Sharps containers, gloves, bandages, and other supplies will not be included.

- Minimum order size for CDC centrally distributed vaccines will be 100 doses per order for most vaccines. Minimum order size for direct-ship vaccines will be 975 doses. CDC will provide more detail as it becomes available.
- Vaccine will be sent directly to vaccination provider locations for administration or designated depots for secondary distribution to administration sites (e.g., chain drugstores' central distribution).
- Once vaccine products have been shipped to a provider site, the federal government will not redistribute product.
- Jurisdictions will be allowed to redistribute vaccines while maintaining the cold chain. However, with the challenge of meeting cold chain requirements for frozen or ultra-cold vaccines, jurisdictions should be judicious in their use of redistribution and limit any redistribution to refrigerated vaccines only.
- Jurisdictions are **not** advised to purchase ultra-cold storage equipment at this time. Ultra-cold vaccine may be shipped from the manufacturer in coolers that are packed with dry ice. These coolers should be repacked with dry ice within 24 hours of receipt of shipment (day 0) and repacked again every 5 days to maintain required temperature. On day 15, the vaccine should be moved into the refrigerator, stored at 2°C to 8°C, and used within 5 days (120 hours).

To be determined:

- *Vaccine disposal/recovery procedures*

COVID-19 VACCINE ADMINISTRATION DATA REPORTING

- Jurisdictions will be required to report CDC-defined data elements related to vaccine administration daily (i.e., every 24 hours). CDC will provide information on these data elements to jurisdictions.
- All vaccination providers may be required to report and maintain their COVID-19 vaccination inventory information in CDC's VaccineFinder daily.
- CDC has prioritized jurisdiction onboarding to the Immunization (IZ) Gateway* to allow Immunization Information Systems (IISs) to receive data directly from national providers, nontraditional vaccination providers, and other external systems, as well as to report vaccine administration data to CDC.
- Data Use Agreements (DUAs) will be required for data sharing via the IZ Gateway and other methods of vaccine administration data sharing with CDC and will be coordinated by each jurisdiction's immunization program.

COMMUNICATION

- CDC will develop communication resources for jurisdictions and tribal organizations to use with key audiences. These resources will be available on a public-facing website currently under development, but jurisdictions and tribal organizations will likely need to tailor messaging and resources specific to special populations in their communities.
- CDC will work with national organizations to disseminate key messages.
- Communication and educational materials about COVID-19 vaccination provider enrollment, COVID-19 vaccine ordering, COVID-19 vaccine storage, handling, administration (i.e., mixing with diluent, administration techniques), etc. will be available in a variety of formats.

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- When vaccine supply is available for expanded groups among the general population, a national COVID-19 vaccine finder will be available on the public-facing VaccineFinder.
- A screening tool on the CDC website will help people determine their own eligibility for COVID-19 vaccine and direct them to VaccineFinder.

COVID-19 VACCINE SAFETY

- Vaccine safety monitoring is required under the EUA(s) for COVID-19 vaccine. Select adverse events are required to be reported to the Vaccine Adverse Event Reporting System (VAERS) (i.e., vaccine administration errors, serious adverse events, multisystem inflammatory syndrome (MIS) in children or adults, and cases of COVID-19 that result in hospitalization or death). Any revised safety reporting requirements should also be adhered to. FDA's EUA website containing letter(s) of authorization and fact sheets should be checked for any updates that may occur.
- Any additional clinically significant adverse events following vaccination should be reported to the VAERS.
- Adverse events will also be monitored through electronic health record- and claims-based systems (e.g., Vaccine Safety Datalink).

[*] The IZ Gateway is a portfolio of project components that share a common IT infrastructure. The IZ Gateway aims to rapidly onboard IISs to support readiness for COVID-19 vaccine response through data exchange, both among IIS and between IIS and federal providers, mass vaccination reporting, and consumer access tools. The IZ Gateway aims to increase the availability and volume of complete and accurate immunization data stored within IIS and available to providers and consumers regardless of their jurisdictional boundaries.

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Appendix B: COVID-19 Vaccination Scenarios for Jurisdictional Planning—Phase 1, Q4 2020 (updated 10/29/2020)

The planning scenarios described below should be used by state and local jurisdictions to develop operation plans for early COVID-19 vaccination when vaccine supply may be constrained. The scenarios describe potential COVID-19 vaccine requirements, early supply estimates in the event that a vaccine is authorized under EUA, and populations that may be recommended for vaccination during this early period. These scenarios are designed to support jurisdictional, federal, and partner planning, but they are still considered hypothetical. The COVID-19 vaccine landscape is evolving and uncertain, and these scenarios may change as more information is available.

Planners should assume that by January 2021, significantly more COVID-19 vaccine may be available for distribution and plans will need to evolve to address additional vaccine availability. Please refer to COVID-19 vaccine planning assumptions and additional guidance from the Centers for Disease Control and Prevention.

Scenario 1: FDA has authorized vaccine A for Emergency Use Authorization (EUA) in 2020

Availability Assumptions

	Vaccine availability under EUA by		
Candidate	**End of Nov 2020**	**End of Dec 2020**	**Notes**
Vaccine A	10M–20M doses	20M–30M doses	Ultra-cold (-70°C) storage requirements, for large sites only

Distribution, Storage, Handling, and Administration Assumptions

Vaccine A

SHIPMENT

3 separately acquired components (mixed on site)

1. Vaccine
   - 2 mL multidose vials (5 doses/vial)
   - Direct to site from manufacturer (on dry ice) in thermal shipping container
   - Thermal shipper estimated specs: 400 mm X 400 mm X 560 mm, (15.75” X 15.75” X 22.0”)
   - Each shipper can hold up to 5 trays, and each tray will hold up to 195 vials.
   - Tray (i.e., “pizza box”) estimated specs: 229 mm X 229 mm X 40 mm (9” X 9” X 1.6”)
2. Diluent and ancillary supply kits (for administration and mixing)
   - Direct to site from the federal government (at room temperature)
3. Thermal shipper should be returned after use. Instructions for mail-back and labels will be forthcoming.

ON-SITE VACCINE STORAGE

Ultra-Cold Temp Frozen (-60°C to -80°C)

- Freezer units capable of ultra-cold temperatures (UCTs)
- The shipping container (thermal shipper) may be used to store vaccines:
  - Once received (day 1), the thermal shipper should be replenished with pelleted dry ice within 24 hours.
  - Shippers should be replenished with dry ice every 5 days thereafter to maintain required temperature.
  - Total amount of dry ice needed per thermal shipper “recharge” is ~23 kg.
  - On day 15, transfer the vaccine to refrigerated temperatures (2–8°C). Use within 5 days (120 hours).
  - Shippers may only be opened two times a day.
- Temperature monitoring must be in alignment with CDC guidance, irrespective of re-icing.
  - Thermal shipper may be monitored using a temperature probe on the container, in alignment with guidance provided by CDC and information provided by the manufacturer.
  - Direct handling of dry ice needed for recharging the containers will require the use of appropriate PPE.

Thawed but NOT diluted (2°C to 8°C)

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	• Product may be removed from ultra-cold storage or thermal shipper, thawed, and stored at 2°C–8°C for up to 5 days (discard unused doses after 5 days). • Cannot return to ultra-cold storage or thermal shipper once thawed ***Diluted (room temperature)*** • If removed directly from ultra-cold temperatures, vaccine must be thawed ~30 minutes at room temperature before dilution. • Once vaccine is thawed, it must be diluted within 2 hours. If unable to dilute within 2 hours, store at 2°C–8°C. • Must use diluted vaccine within 6 hours (discard any unused, diluted vaccine after 6 hours)
ORDERS ***Large quantities, to large provider sites only*** • Minimum order: ~1,000 doses • Maximum order: ~5,000 doses	**ADMINISTRATION** ***2-dose series (21 days between doses)*** • On-site mixing required; dilute with diluent just prior to administration; all 5 doses must be administered within 6 hours of dilution; remainder of diluted vaccine should be discarded. • Administer by intramuscular (IM) injection.
INITIAL POPULATIONS OF FOCUS AND ANTICIPATED VACCINATION PROVIDER SITES ***NOTE: Primary vaccination provider sites may consider providing vials to other sites. HOWEVER, all cold chain requirements should be maintained and logged in accordance with the information provided above.*** ***Healthcare personnel*** — public health clinics, closed points of dispensing (PODs), temporary/off-site vaccination clinics + potential for mobile clinics ***Other essential workers*** — public health clinics, closed PODs, temporary/off-site vaccination clinics + potential for mobile clinics ***Adults with underlying medical conditions and people 65 years of age and older*** — open PODs in strategic locations, potential for mobile clinics at long-term care facilities (LTCFs) or partnership with pharmacy on-site clinics for LTCFs, correctional/detention facilities, and other congregate settings	

Additional Considerations for Early Vaccination Planning

- "Healthcare personnel" includes paid or unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to people with COVID-19 or infectious materials.
- Jurisdictions should plan for real-time shipment of doses.
- Vaccination provider sites (during Phase 1) will not be required to store vaccine products beyond the period of time. Vaccine A can be stored in the ultra-cold thermal shipper or at refrigerated temp (2°C–8°C, see "Thawed but NOT diluted" section).
- Given the challenging storage, handling, and administration requirements, early vaccination should focus on vaccination provider sites that can reach critical populations with as much throughput as possible.
- Stability testing is ongoing for Vaccine A; the storage and handling requirements presented here may shift. The requirements in these scenarios are likely the strictest set of requirements for which planning is needed.
- Jurisdictions should consider partnering with the private sector and with local hospital systems to provide vaccine in closest proximity to the critical populations as possible, given vaccine product storage and handling requirements. For example, Vaccine A may be administered by mobile clinics if multiple mobile clinics are planned over a short period of time to ensure sufficiently high throughput. Vaccine A may also be placed in healthcare systems and support multiple clinics in one system (where product can be shared and repositioned from one site to another at 2°C–8°C).
- Ensure equitable access for adults with underlying medical conditions and people 65 years of age and older who are part of other critical populations. Additional vaccination provider sites may be required to reach these populations.

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Scenario 2: FDA has authorized vaccine B for EUA in 2020

Availability Assumptions

Vaccine availability under EUA by			
Candidate	**End of Nov 2020**	**End of Dec 2020**	**Notes**
Vaccine B	~10M doses	~15M doses	Central distributor capacity required (-20°C)

Distribution, Storage, Handling, and Administration Assumptions

Vaccine B

SHIPMENT

2 separately shipped components

Vaccine

- To central distributor (at -20°C)
- Multidose vials (10 doses/vial)

Ancillary supply kits

- Direct to site from USG (at room temperature)

ON-SITE VACCINE STORAGE

Frozen (-25°C to -15°C until ready for use)

Note: This is a narrower range than for varicella-containing vaccines.

Refrigerated (2°C to 8°C)

- Must use within 7 days if the vial has not been entered
- Thaw before use:
  - Thaw in refrigerated conditions between 2°C to 8°C for 2 hours. Let vial stand at room temperature for 15 minutes before administering.
  - Alternatively, thaw at room temperature between 20°C to 25°C for 1 hour.
  - After thawing, do not return vial to the freezer.

Room temperature

- The total time between removal from refrigeration and administration should be no more than 12 hours.
- Once the vial has been entered, it must be used within 6 hours (discard any unused vaccine after 6 hours).

ORDERS

Central distribution capacity

- Required by Dec 2020
- Maintained at -20°C

ADMINISTRATION

2-dose series (1 month between doses)

- No on-site mixing required
- Once thawed, swirl vaccine gently prior to withdrawing a dose. Do NOT shake.
- Administer by intramuscular (IM) injection.

INITIAL POPULATIONS OF FOCUS AND ANTICIPATED VACCINATION PROVIDER SITES

Healthcare personnel — healthcare clinics + healthcare occupational health clinics + public health clinics, closed PODs, temporary/off-site vaccination clinics + mobile clinics

Other essential workers (specifics TBA) — occupational health clinics + hospital clinics + public health clinics, closed PODs, temporary/off-site vaccination clinics

Adults with underlying medical conditions and people 65 years of age and older — commercial pharmacy partners + mobile clinics

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Additional Considerations for Early Vaccination Planning

- "Healthcare personnel" includes paid or unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to people with COVID-19 or infectious materials.
- Jurisdictions should plan for real-time shipment of doses.
- Administration sites (during Phase 1) will not be required to store vaccine products beyond the period of time Vaccine B can be stored at 2–8°C.
- Given the challenging storage, handling, and administration requirements, early vaccination should focus on administration sites that can reach critical populations with as much throughput as possible.
- Stability testing is ongoing for Vaccine B; the storage and handling requirements presented here may shift. The requirements in these scenarios are likely the strictest set of requirements for which planning is needed.
- Jurisdictions should consider partnering with the private sector and with local hospital systems to provide vaccine in closest proximity to the prioritized populations as possible, given limitations with the product.
- Ensure equitable access for adults with underlying medical conditions and people 65 years of age and older who are part of other critical populations. Additional vaccination provider sites may be required to reach these populations.

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Scenario 3: FDA has authorized vaccines A and B for EUA in 2020

Availability Assumptions

Vaccine availability under EUA by			
Candidate	**End of Nov 2020**	**End of Dec 2020**	**Notes**
Vaccine A	10M–20M doses	20M–30M doses	Ultra-cold (-70°C), for large sites only
Vaccine B	~10M doses	~15M doses	Central distribution capacity required (-20°C)
Total	**20M–30M doses**	**35M–45M doses**	

Distribution, Storage, Handling, and Administration Assumptions

Vaccine A

SHIPMENT

3 separately acquired components (mixed on site)

1. Vaccine
   - 2 mL multidose vials (5 doses/vial)
   - Direct to site from manufacturer (on dry ice) in thermal shipping container
   - Thermal shipper estimated specs: 400 mm X 400 mm X 560 mm (15.75" X 15.75" X 22.0")
   - Each shipper can hold up to 5 trays, and each tray will hold up to 195 vials.
   - Tray (i.e., "pizza box") estimated specs: 229 mm X 229 mm X 40 mm (9" X 9" X 1.6")
2. Diluent and ancillary supply kits (for administration and mixing)
   - Direct to site from the federal government (at room temperature)
3. Thermal shipper should be returned after use. Instructions for mail-back and labels will be forthcoming.

ON-SITE VACCINE STORAGE

Ultra-Cold Temp Frozen (-60°C to -80°C)

- Freezer units capable of ultra-cold temperatures (UCTs)
- The shipping container (thermal shipper) may be used to store vaccines:
  - Once received (day 1), the thermal shipper should be replenished with pelleted dry ice within 24 hours.
  - Shippers should be replenished with dry ice every 5 days thereafter to maintain required temperature.
  - Total amount of dry ice needed per thermal shipper "recharge" is ~23 kg.
  - On day 15, transfer the vaccine to refrigerated temperatures (2°C to 8°C). Use within 5 days (120 hours).
  - Shippers may only be opened two times a day.
- Temperature monitoring must be in alignment with CDC guidance, irrespective of re-icing.
  - Thermal shipper may be monitored using a temperature probe on the container, in alignment with guidance provided by CDC and information provided by the manufacturer.
  - Direct handling of dry ice needed for re-icing the containers will require the use of appropriate PPE.

Thawed but NOT diluted (2°C to 8°C)

- Product may be removed from the ultra-cold storage or thermal shipper, thawed, and stored at 2°C to 8°C for up to 5 days (discard unused doses after 5 days).
- Cannot return to ultra-cold storage or thermal shipper once thawed

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	Diluted (room temperature) • If removed directly from ultra-cold storage, vaccine must be thawed ~30 minutes at room temperature before dilution. • Once vaccine is thawed, it must be diluted within 2 hours. If unable to dilute within 2 hours, store at 2°C–8°C. • Must use diluted vaccine within 6 hours (discard any unused diluted vaccine after 6 hours)
ORDERS ***Large quantities, to large provider sites only*** Minimum order: ~1,000 doses Maximum order: ~5,000 doses	**ADMINISTRATION** ***2-dose series (21 days between doses)*** • On-site mixing required; dilute with diluent just prior to administration; all 5 doses must be administered within 6 hours of dilution; remainder of diluted vaccine should be discarded. • Administer by IM injection.
PRIORITIZED POPULATIONS AND ANTICIPATED VACCINATION PROVIDER SITES ***Healthcare personnel*** — public health clinics, closed PODs, temporary/off-site vaccination clinics + potential for mobile clinics ***Other essential workers (specifics TBA)*** — public health clinics, closed PODs, temporary/off-site vaccination clinics + potential for mobile clinics ***Adults with underlying medical conditions and people 65 years of age and older*** — commercial pharmacy partners, open PODs in strategic locations, potential for mobile clinics at LTCFs, correctional/detention facilities, and other congregate settings	
Vaccine B	

SHIPMENT
2 separately shipped components
Vaccine
• To central distributor (at -20°C)
• Multidose vials (10 doses/vial)
Ancillary supply kits
• Direct to site from USG (at room temperature)
	ON-SITE VACCINE STORAGE
	Frozen (-25°C to15°C until ready for use)
	Note: This is a narrower range than for varicella-containing vaccines.
	Refrigerated (2°C to 8°C)
	• Must use within 7 days if the vial has not been entered.
	• Thaw before use:
	  • Thaw in refrigerated conditions between 2°C to 8°C for 2 hours. Let vial stand at room temperature for 15 minutes before administering.
	  • Alternatively, thaw at room temperature between 20°C to 25°C for 1 hour.
	  • After thawing, do not return vial to the freezer.
	Room temperature
	• The total time before administration and after removal from the refrigerator should be no more than 12 hours.
	• Once the vial has been entered, it must be used within 6 hours (discard any unused vaccine after 6 hours).

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ORDERS	ADMINISTRATION
Central distribution capacity • Required by Dec 2020 • Maintained at -20°C	***2-dose series (1 month between doses)*** • No on-site mixing required • Once thawed, swirl vaccine gently prior to withdrawing a dose. Do NOT shake. • Administer by intramuscular (IM) injection

INITIAL POPULATIONS OF FOCUS AND ANTICIPATED VACCINATION PROVIDER SITES

Healthcare personnel — healthcare clinics + healthcare occupational health clinics + public health clinics, closed PODs, temporary/off-site vaccination clinics + mobile clinics

Other essential workers (specifics TBA) —occupational health clinics + hospital clinics + public health clinics, closed PODs, temporary/off-site vaccination clinics

Adults with underlying medical conditions and people 65 years of age and older — commercial pharmacy partners + mobile clinics

Additional Considerations for Early Vaccination Planning

- "Healthcare personnel" includes paid or unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to people with COVID-19 or infectious materials.
- Jurisdictions should plan for real-time shipment of doses.
- Administration sites (during Phase 1) will not be required to store vaccine products beyond the period of time Vaccine A can be stored in the ultra-cold shipment box or Vaccine B can be stored at 2–8°C.
- Given the challenging storage, handling, and administration requirements, early vaccination should focus on administration sites that can reach prioritized populations with as much throughput as possible.
- Stability testing is ongoing for Vaccine A and Vaccine B; the storage and handling requirements presented here may shift. The requirements in these scenarios are likely the strictest set of requirements for which planning is needed.
- Jurisdictions should consider partnering with the private sector and with local hospital systems to provide vaccine in closest proximity to the prioritized populations as possible, given the limitations with the product. For example: Vaccine A may be administered through mobile clinics if multiple mobile clinics are planned over a short period of time to ensure sufficiently high throughput.
- Ensure equitable access for adults with underlying medical conditions and people 65 years of age and older who are part of other critical populations. Additional vaccination provider sites may be required to reach these populations.

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Appendix C: Phase 1 Population Group Worksheet Example

PHASE 1-A POPULATION GROUP: HEALTHCARE PERSONNEL

Sub-Group	Agency/Organization	Point of Contact (POC)	POC Number	Contact e-mail	Key Group	Estimate # in Key Group
Long-Term Care	*Town Nursing Home*	*Jane Smith*	*123-456-7899*	townnh@gmail.com	*Direct Care Staff*	*50*
	County Nursing Home	*John White*	*123-789-1234*	conursinghome@co.gov	*Direct Care Staff*	*50*
Hospitals	*ABC Hospital*	*Joe Admin*	*123-555-6666*	jadmin@abchosp.com	*ICU Staff*	*50*
					Direct Care Staff	*200*
	City X Hospital	*Sue Jones*	*123-666-5555*	cityx@hospital.com	*Direct Care Staff*	*300*
Public Health	*Anywhere Health Dept.*	*Ann Stewart*	*123-222-1234*	astewart@cohd.gov	*Clinic Staff*	*50*
					Staff Providing Direct Care	*40*
Other Healthcare Essential Workers	*County Emergency Services*	*Sam Stone*	*123-555-9876*	sstone@coems.gov	*Ambulance Staff*	*25*
	Medical Reserve Corp	*Mike Reserve*	*123-777-8888*	mrcmike@mrc.com	*Clinic Volunteers*	*30*

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Appendix D: CDC IIS Data Requirements for COVID-19 Vaccine Monitoring

CDC IIS Data Requirements for COVID-19 Vaccine Administration

Background and Purpose

The ongoing, rapid monitoring of COVID-19 vaccine uptake will be a critical part of the nation's COVID-19 response efforts. Immunization programs and immunization information systems (IIS) will play a critical role in vaccine delivery, the monitoring of vaccine doses administered, and generation of vaccination coverage estimates among several different population groups.

A strong, nationally coordinated approach is critical to collecting, tracking, and analyzing vaccination data, especially in early phases of vaccine administration, which is expected to occur in non-traditional settings. This document outlines the anticipated vaccine administration data elements IIS will report to CDC. The required data elements in this document represent demographic and vaccination information routinely captured by an IIS during a vaccination event. In addition to the ability to collect and report these data elements, IIS will also be required to report information from these data elements 1) in a timely fashion (within 24 hours of administration) and 2) through a connection to the Immunization Gateway (IZ Gateway) or data lake. This will enable CDC to reliably track COVID-19 vaccinations and analyze vaccination coverage by demographic factors once vaccine supplies are available. The vaccine administration data elements in this document will continue to evolve to include inventory and distribution elements as those parameters are finalized.

Discrete Data Elements

Table 1 includes each data element that IIS will be required to report to CDC. Table 2 includes each data element that will be optional for IIS to report to CDC. Optional data requirements will support additional national coverage analysis and vaccination monitoring efforts. Data elements are also categorized as "Mass Vaccination" or "Standard." Standard data elements are likely already collected by IIS, whereas Mass Vaccination data elements are likely to require enhancements or a Mass Vaccination module for data collection and reporting. Any identifiable data elements will be used to facilitate deduplication of data within the Immunization Data Lake, an analytic environment that will be used to consolidate, deduplicate, and reconcile vaccine administration information from multiple sources (e.g. jurisdictional immunization programs, pharmacies, Department of Defense, Veterans Affairs, Bureau of Prisons, Indian Health Service). Identifiable elements will not be stored in the Data Lake environment.

Table 1. Required Data Elements

Required Data Element	Mass Vaccination or Standard
Data elements required for IIS to report	***Mass Vaccination = may require mass vaccination module or enhancement*** ***Standard = IIS Core Data Element commonly collected during routine vaccination***
Administered at location: facility name/ID	Standard
Administered at location: type	Standard
Administration address (including county)	Standard
Administration date	Standard
CVX (Product)	Standard

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Dose number	Standard
Recipient race	Standard
Recipient ethnicity	Standard
IIS recipient ID*	Standard
IIS vaccination event ID	Standard
Lot number: unit of use and/or unit of sale	Standard
MVX (manufacturer)	Standard
Recipient address*	Standard
Recipient date of birth*	Standard
Recipient name*	Standard
Recipient sex	Standard
Sending organization	Standard
Vaccine administering provider suffix	Standard
Vaccine administering site (on the body)	Standard
Vaccine expiration date	Standard
Vaccine route of administration	Standard
Vaccination series complete	Mass Vaccination

**Identifiable information*

Table 2. Optional Data Elements

Optional Data Element	Mass Vaccination or Standard
Data elements optional for IIS to report (e.g., state mass vaccination tool collects this information)	***Mass Vaccination = may require mass vaccination module or enhancement*** ***Standard = IIS Core Data Element commonly collected during routine vaccination***
Comorbidity status (Y/N)	Mass Vaccination
Recipient missed vaccination appointment (Y/N)	Mass Vaccination
Serology results (Presence of Positive Result, Y/N)	Mass Vaccination
Vaccination Refusal (Y/N)	Standard

**Identifiable Information*

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Appendix E: Countermeasures Injury Compensation Program

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the Countermeasures Injury Compensation Program (CICP) to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of covered countermeasures identified in and administered or used under a PREP Act declaration. The CICP also may provide benefits to certain survivors of individuals who die as a direct result of the administration or use of such covered countermeasures. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are:

- Any antiviral, any other drug, any biologic, any diagnostic, any other device, any respiratory protective device, or any vaccine, used:
  - To treat, diagnose, cure, prevent, mitigate, or limit the harm from COVID-19, or the transmission of SARS-CoV-2 or a virus mutating therefrom, or
  - To limit the harm that COVID-19, or the transmission of SARS-CoV-2 or a virus mutating therefrom, might otherwise cause; or

- Any device used in the administration of any such product, and all components and constituent materials of any such product.

Covered Countermeasures must be ''qualified pandemic or epidemic products,'' or ''security countermeasures,'' or drugs, biological products, or devices authorized for investigational or emergency use, as those terms are defined in the PREP Act, the Federal Food, Drug, and Cosmetic Act (FD&C Act), and the Public Health Service Act, or a respiratory protective device approved by National Institute for Occupational Safety and Health (NIOSH) under 42 CFR part 84, or any successor regulations, that the Secretary of the Department of Health and Human Services determines to be a priority for use during a public health emergency declared under section 319 of the Public Health Service Act.

For more information about the CICP, visit the program's website at www.hrsa.gov/cicp, email cicp@hrsa.gov, or call 1-855-266-CICP (1-855-266-2427).

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Appendix F: Liability Immunity for Covered Persons

The Declaration Under the Public Readiness and Emergency Preparedness Act (PREP Act) for Medical Countermeasures Against COVID-19 provides liability immunity to covered persons. The third amendment to the declaration defines "covered persons" as follows:

> "V. Covered Persons
>
> 42 U.S.C. 247d–6d(i)(2), (3), (4), (6), (8)(A) and (B)
>
> Covered Persons who are afforded liability immunity under this Declaration are ''manufacturers,'' ''distributors,'' ''program planners,'' ''qualified persons,'' and their officials, agents, and employees, as those terms are defined in the PREP Act, and the United States.
>
> In addition, I [the Secretary] have determined that the following additional persons are qualified persons:
>
> (a) Any person authorized in accordance with the public health and medical emergency response of the Authority Having Jurisdiction to prescribe, administer, deliver, distribute or dispense the Covered Countermeasures, and their officials, agents, employees, contractors and volunteers, following a Declaration of an emergency;
>
> (b) any person authorized to prescribe, administer, or dispense the Covered Countermeasures or who is otherwise authorized to perform an activity under an Emergency Use Authorization in accordance with Section 564 of the FD&C Act;
>
> (c) any person authorized to prescribe, administer, or dispense Covered Countermeasures in accordance with Section 564A of the FD&C Act; and
>
> (d) a State-licensed pharmacist who orders and administers, and pharmacy interns who administer (if the pharmacy intern acts under the supervision of such pharmacist and the pharmacy intern is licensed or registered by his or her State board of pharmacy), vaccines that the Advisory Committee on Immunization Practices (ACIP) recommends to persons ages three through 18 according to ACIP's standard immunization schedule.
>
> Such State-licensed pharmacists and the State-licensed or registered interns under their supervision are qualified persons only if the following requirements are met:
>
> • The vaccine must be FDA authorized or FDA-approved.
>
> • The vaccination must be ordered and administered according to ACIP's standard immunization schedule.

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• The licensed pharmacist must complete a practical training program of at least 20 hours that is approved by the Accreditation Council for Pharmacy Education (ACPE). This training program must include hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines.

• The licensed or registered pharmacy intern must complete a practical training program that is approved by the ACPE. This training program must include hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines.

• The licensed pharmacist and licensed or registered pharmacy intern must have a current certificate in basic cardiopulmonary resuscitation.

• The licensed pharmacist must complete a minimum of two hours of ACPE-approved, immunization-related continuing pharmacy education during each State licensing period.

• The licensed pharmacist must comply with recordkeeping and reporting requirements of the jurisdiction in which he or she administers vaccines, including informing the patient's primary-care provider when available, submitting the required immunization information to the State or local immunization information system (vaccine registry), complying with requirements with respect to reporting adverse events, and complying with requirements whereby the person administering a vaccine must review the vaccine registry or other vaccination records prior to administering a vaccine.

• The licensed pharmacist must inform his or her childhood-vaccination patients and the adult caregiver accompanying the child of the importance of a well-child visit with a pediatrician or other licensed primary care provider and refer patients as appropriate.

Nothing in this Declaration shall be construed to affect the National Vaccine Injury Compensation Program, including an injured party's ability to obtain compensation under that program. Covered countermeasures that are subject to the National Vaccine Injury Compensation Program authorized under 42 U.S.C. 300aa–10 et seq. are covered under this Declaration for the purposes of liability immunity and injury compensation only to the extent that injury compensation is not provided under that Program. All other terms and conditions of the Declaration apply to such covered countermeasures."

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Appendix G: Vaccination Implementation Strategies to Consider for Critical Populations

(New)

Vaccinating the critical infrastructure workforce, people at increased risk for severe COVID-19 illness, people at increased risk of acquiring or transmitting COVID-19, and people with limited access to routine vaccination services may be challenging for several reasons. Various strategies, some with commonality across groups and others unique to certain populations, should be considered to reach these critical populations for COVID-19 vaccination.

Provider Recruitment and Enrollment	• **Communicate vaccination provider requirements and enrollment procedures widely throughout jurisdiction**, including to all long-term care and correctional/detention facilities. • **Enroll a variety of providers throughout jurisdiction,** especially those serving critical populations, such as: ○ Health departments ○ Health clinics (including federally qualified health centers and community health centers) ○ Health Care for Homeless clinics ○ Physicians' offices ○ Hospitals (emergency departments) ○ Home healthcare providers ○ Employers/occupational health clinics ○ College/university health services/clinics that serve young adults ○ Pharmacies ○ Long-term care facilities ○ Correctional/detention facilities ○ Mobile clinics ○ Points of dispensing (PODs)

Enumerating and Locating Populations	• **Map distribution of critical populations** or the facilities/locations they live or work in (e.g., long-term care facilities, correctional/detention facilities, homeless shelters or encampments, colleges, and universities). • **Map location of enrolled providers** and their capacity. • **Compile and maintain critical points of contact** for reaching critical populations, for example: ○ Large healthcare systems operating within the jurisdiction ○ Large retail pharmacies serving people within the jurisdiction ○ Large employers of critical workers within the jurisdiction ○ Home healthcare providers ○ Long-term care facilities ○ Correctional/detention facilities ○ College and university presidents

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	○ Tribal leaders and local Indian Health Service administrators ○ Homeless shelters, soup kitchens, syringe service programs, and Continuum of Care Homeless Assistance programs ○ Intermediate care facilities, group homes, and paratransit services for people with disabilities • **Utilize electronic health records or administrative data** for estimating critical population size/location (e.g., CMS, trade group databases, point-in-time estimates and housing inventory count data, college/university student enrollment records).

Vaccine Administration	• **Ensure social distancing, mask use,** and/or other preventive measures by enrolled providers. • Encourage vaccination providers to **schedule clinic visits** to prevent congregation of individuals. • Consider utilizing **risk-specific vaccination options/events** (e.g., events specifically and only for people ≥65 years of age). • Consider establishing **institutional standing orders** where possible. • Ensure consent is obtained ahead of time if **medical proxy** is in place. • For people living in institutions, consider **vaccinating at intake**; for people attending colleges/universities, vaccinate at enrollment. • **Engage community members from the critical populations** for planning (e.g., people with disabilities). • **Engage trusted sources** to educate about vaccine recommendations and availability and to address hesitancy. For example: ○ Professional organizations, state licensure boards, and healthcare coalitions ○ Critical workforce employers and union representatives ○ Specific critical populations health advocacy organizations ○ College/university presidents, athletic coaches, and other student/campus organizations ○ Homeless shelter/soup kitchen/syringe service program managers ○ Social workers ○ Faith leaders • Ensure vaccination clinics are available during different times of day/evening to **accommodate different schedules.** • **Conduct mobile clinics in multiple locations** at non-traditional sites, such as: ○ Small health clinics not enrolled as providers ○ Intermediate care facilities and group homes for people with disabilities ○ Long-term care facilities ○ Correctional/detention facilities ○ Employers and job fairs ○ College/university parking lots, gyms, dining halls, faculty buildings, and residence halls ○ Homeless shelters, soup kitchens, syringe service programs, homeless encampments ○ Faith-based organizations ○ Public libraries, public parks ○ Community fairs • Leverage **ongoing seasonal influenza vaccination clinics.**

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Second-Dose Reminders	• Use a **variety of methods to send second-dose reminders** to recipients and/or medical proxies, including:
	  ○ Vaccination cards
	  ○ Electronic health records/patient portals
	  ○ Text messaging
	  ○ Phone calls
	  ○ Email
	  ○ Mail
	  ○ Peer navigators/mentors
	• For people living in institutions who are moved after receipt of first dose, **link them to vaccination providers in the community** or **send reminders to the receiving facility.**

Documentation and Reporting	• Provide training to qualified vaccination providers on use of the jurisdiction's **immunization information system (IIS)** or other external tracking system. • Leverage various **other administrative systems**, as able (e.g., employer systems, Homeless Management Information system).

Provider/ Administrator Communications	• Educate healthcare providers throughout jurisdiction about recommendations to vaccinate critical populations and, if not an enrolled provider, **where to refer patients for free vaccination.**
	• **Educate nonclinical facility administrators** about recommendations to vaccinate critical populations, such as:
	  ○ Employer human resource staff
	  ○ Correctional/detention facility wardens, leadership, and health services
	  ○ College/university administrators, faculty, and staff
	  ○ Homeless shelter staff
	• **Ensure providers have information needed on vaccine recommendations to counsel patients**, including relevant contraindications or potential lower efficacy in certain groups.
	• For people in institutions, train providers to ensure **transfer of vaccination records** to receiving facility or request vaccination records from previous facility.
	• **Message directly to caretakers,** medical proxies, or parents of college/university students to encourage uptake.

Critical Population Communications	• Develop **diverse communication materials** on vaccine recommendations and where to get vaccinated for people in critical population groups, such as:
	  ○ Flyers/posters at:
	  ▪ Healthcare provider facilities (e.g., physicians' offices, health centers, hospital emergency departments)
	  ▪ Large employers
	  ▪ Pharmacies
	  ▪ Long-term care facilities

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	▪ Correctional/detention facilities ▪ College/university campuses ▪ Homeless shelters, homeless encampments, soup kitchens, syringe service programs ▪ Retail stores ▪ Bus stations ▪ Public parks and libraries ○ Newspaper (print and online) advertisements ○ Online/social media advertisements, including on advocacy organization websites ○ Mail/postcards ○ Population-specific communications (e.g., employer communications, trade magazines, senior-focused publications, college/university newspapers, or other communications) • Ensure all communication materials are **culturally and linguistically appropriate**, including messaging with American Sign Language, large print, and braille. • Create **low-literacy messages**, including those for people with severe intellectual disabilities. • Ensure all messaging **complies with ADA regulations.**

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Appendix H: Pharmacy Partnership for Long-Term Care Program for COVID-19 Vaccination *(New)*

HHS is partnering with **CVS and Walgreens** to offer on-site COVID-19 vaccination services for residents of nursing homes and assisted living facilities once vaccination is recommended for them.

The **Pharmacy Partnership for Long-term Care (LTC) Program** provides end-to-end management of the COVID-19 vaccination process, including cold chain management, on-site vaccinations, and fulfillment of reporting requirements, to facilitate safe vaccination of this patient population, while reducing burden on LTC facilities and jurisdictional health departments. LTCF staff who have not received COVID-19 vaccine can also be vaccinated as part of the program. This program provides critical vaccination services and is free of charge to facilities. This effort will require extensive coordination with jurisdictions, long-term care facilities (LTCFs), federal partners, including the Centers for Medicare and Medicaid Services (CMS), and professional organizations, including American Health Care Association (AHCA) and Leading Age, which include members across both nursing homes and assisted living facilities.

As part of this program, which is free of charge to facilities, the pharmacy will:

- Schedule and coordinate on-site clinic date(s) directly with each facility. Three visits over approximately two months will likely be needed to administer both doses of vaccine and vaccinate any new residents and staff.
- Order vaccines and associated supplies (e.g., syringes, needles, personal protective equipment).
- Ensure cold chain management for vaccine.
- Provide on-site administration of vaccine.
- Report required vaccination data (approximately 20 data fields) to the local, state/territorial, and federal jurisdictions within 72 hours of administering each dose.
- Adhere to all applicable Centers for Medicare & Medicaid (CMS) COVID-19 testing requirements for LTCF staff.

If interested in participating, LTCFs should sign up (or opt out) starting October 19. Sign up will remain open for two weeks.

- Skilled nursing facilities (SNFs) will make their selection through the National Healthcare Safety Network (NHSN). An "alert" will be incorporated into the NHSN LTCF COVID-19 module to guide users to the form.
- Assisted living facilities (ALFs) will make their selection via an online REDCap (https://redcap.link/LTCF) sign-up form.
- Facilities will indicate which pharmacy partner (one of two large retail pharmacies or existing LTC pharmacy) they prefer to have on site.
- Online sign-up information will be distributed through ALF and SNF partner communication channels (email, social media, web).
- Indicating interest in participating is non-binding and facilities may change their selection or opt in or out via email after the online survey closes.

Once the sign-up period has closed, no changes can be made via the online form, and the facility must coordinate directly with the selected pharmacy provider to change any requested vaccination supplies and services.

HHS will communicate preferences to CVS and Walgreens and will try to honor facility preferences but may reassign facilities depending on vaccine availability and distribution considerations and to minimize vaccine wastage.

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HHS expects the program services to continue on site at participating facilities for approximately two months. After the initial phase of vaccinations, each facility can choose to continue working with CVS or Walgreens or can work with a pharmacy provider of its choice.

For questions about the Pharmacy Partnership for Long-term Care Program, please contact eocevent494@cdc.gov.

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Appendix I: Federal Pharmacy Partnership for COVID-19 Vaccination Program *(New)*

HHS is partnering with pharmacies to increase access to COVID-19 vaccine once a vaccine is authorized or approved and recommended for use in the United States. Through the **Federal Pharmacy Partnership Strategy for COVID-19 Vaccination**, select pharmacy partners will receive a direct allocation of COVID-19 vaccine. This will help jurisdictions augment access to vaccine when supply increases and vaccine is recommended beyond the initial critical populations. With more than 86% of people living within five miles of a community pharmacy, pharmacies have unique reach and ability to provide access to COVID-19 vaccine and support broad vaccination efforts. This program will provide critical vaccination services for the U.S. population, with vaccine administered at retail locations at no cost to recipients. The program will be implemented in close coordination with jurisdictions to ensure optimal COVID-19 vaccination coverage and vaccine access nationwide.

The federal allocation to pharmacies will not cover every pharmacy in the United States. Pharmacies not included in the federal allocation program are still encouraged to be part of the vaccination program and should coordinate with their jurisdictions to become COVID-19 vaccination providers.

Program Benefits

Once we have an adequate supply of COVID-19 vaccine to support broader vaccination efforts, it will be important to swiftly increase access to COVID-19 vaccine for the general population (Phase 2, COVID –19 implementation planning). Partnerships with retail chain pharmacies and networks of community pharmacists in the United States will increase the general population's access to COVID-19 vaccine.

Pharmacists can be crucial public health partners to increase access and convenience of COVID-19 vaccines.

- Pharmacists are trained to provide vaccinations and are important immunizers in their communities.
- Pharmacists are a trusted health resource in their communities and play a vital role in the public health response to COVID-19 by counseling patients and administering tests.
- Pharmacies have the capability to quickly surge and meet demand nationwide because of existing infrastructure and the large number of pharmacists who can administer vaccines.
- CDC has worked extensively with pharmacy chains to improve pandemic preparedness, conduct vaccine throughput exercises, and assess store and organizational response capabilities.

Program Participants

Retail chain pharmacies and networks of community pharmacists are being considered for this program. As of Monday, October 29, the following pharmacy partners have signed on to participate in this program:

- Walgreens
- CVS Health Corporation
- Walmart Stores, Inc (including Sam's)
- Rite Aid Corp
- The Kroger Co (i.e., Kroger, Harris Teeter, Fred Meyer, Frys, Ralphs, King Soopers, Smiths, City Market, Dillons, Marianos, Pick-n-Save, Copps, Metro Market)
- Publix
- Costco

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- Albertsons Companies (i.e., Osco, Jewel-Osco, Albertsons, Albertsons Market, Safeway, Tom Thumb, Star Market, Shaws, Haggen, Acme, Randalls, Carrs, Market Street, United, Vons, Pavilions, Amigos, Lucky's, Pak n Save, Sav-On)
- Hy-Vee
- Meijer
- H-E-B
- Retail Business Services (i.e., Food Lion, Giant Food, The Giant Company, Hannaford Bros Co, Stop & Shop)

Together, these pharmacy partners will extend the COVID-19 vaccination provider network to over 35,000 store locations. Store lists for each of these partners will be shared with jurisdictions. Additional partners are also expected to sign on, further expanding the program. Details on additional partners will be shared with jurisdictions as soon as they are available.

Based on their (1) size and reach, (2) capability to store vaccines and ensure cold chain management, (3) ability to meet data reporting requirements to jurisdictions and CDC, and (4) estimated daily number of doses each facility is able to administer, these partners stand ready to assist jurisdictions in COVID-19 vaccination efforts.

Program Implementation

Pharmacy partners must sign a COVID-19 pharmacy partner agreement to participate. Before receiving COVID-19 vaccine, the partner must propose, in writing, its minimum capacity for vaccine administration, including a) the number and location of facilities that will administer COVID-19 vaccine, b) the estimated number of COVID-19 vaccine doses that each facility will be able to administer within defined periods, and c) estimated cold chain storage capacity.

- Pharmacy partners will directly order and receive allocation of COVID-19 vaccine from the federal government.
- Vaccine will be provided at no cost to the pharmacy chain and will be administered at retail locations at no cost to vaccine recipients.
- On a daily basis, pharmacy partners must report to CDC the number of doses of COVID-19 vaccine a) ordered by store location in VTrcks and b) on hand in each store reported through VaccineFinder. Pharmacy providers will also be required to report CDC-defined data elements related to vaccine administration to jurisdiction IISs or through other agreed upon methods (e.g., formatted data extracts) to jurisdictions if IIS reporting is not available.
- Pharmacy partners will provide a point of contact for reach jurisdiction for questions related to allocation of vaccine in store locations in their jurisdiction area.
- Jurisdictions may choose to opt out of having pharmacies in their area receive allocations through this program.

For questions about the Federal Pharmacy Partnership Strategy for COVID-19 Vaccination Program, please contact eocevent481@cdc.gov.

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Pharmacy Partnership for LTC Program Updates for Jurisdictions

Anita Patel, Ruth Link-Gelles

AWARDEE MEETING DECEMBER 1ST, 2020

Including pharmacies in pandemic vaccine planning has been a collaborative effort over the last decade

NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

NCPA NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

astho™

AHCA AMERICAN HEALTH CARE ASSOCIATION

AIM ASSOCIATION OF IMMUNIZATION MANAGERS

NACCHO National Association of County & City Health Officials

APhA AMERICAN PHARMACISTS ASSOCIATION Improving medication use. Advancing patient care.

LeadingAge™

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

CSTE

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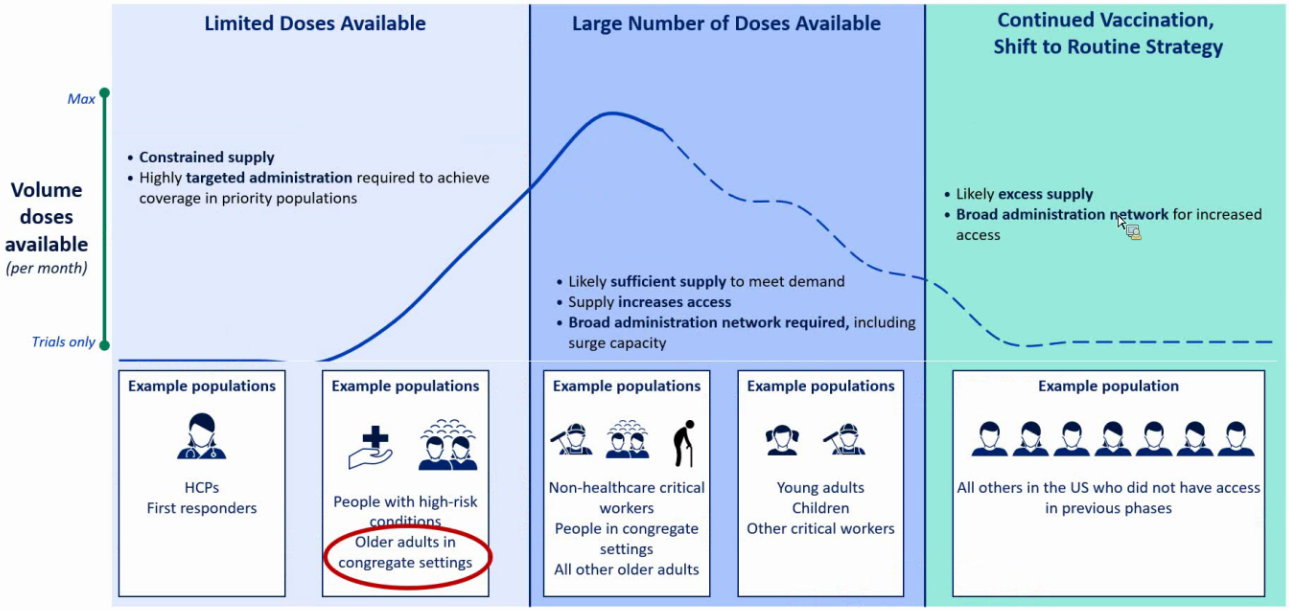
Illustrative scenario for planning purposes; will be adapted based on clinical / manufacturing information on all OWS candidates & vaccine prioritization

Planning considers various possible priority groups and supply



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Illustrative example populations; final prioritization to be decided by ACIP

11/3/20

Share - Ruth Link-Gelles

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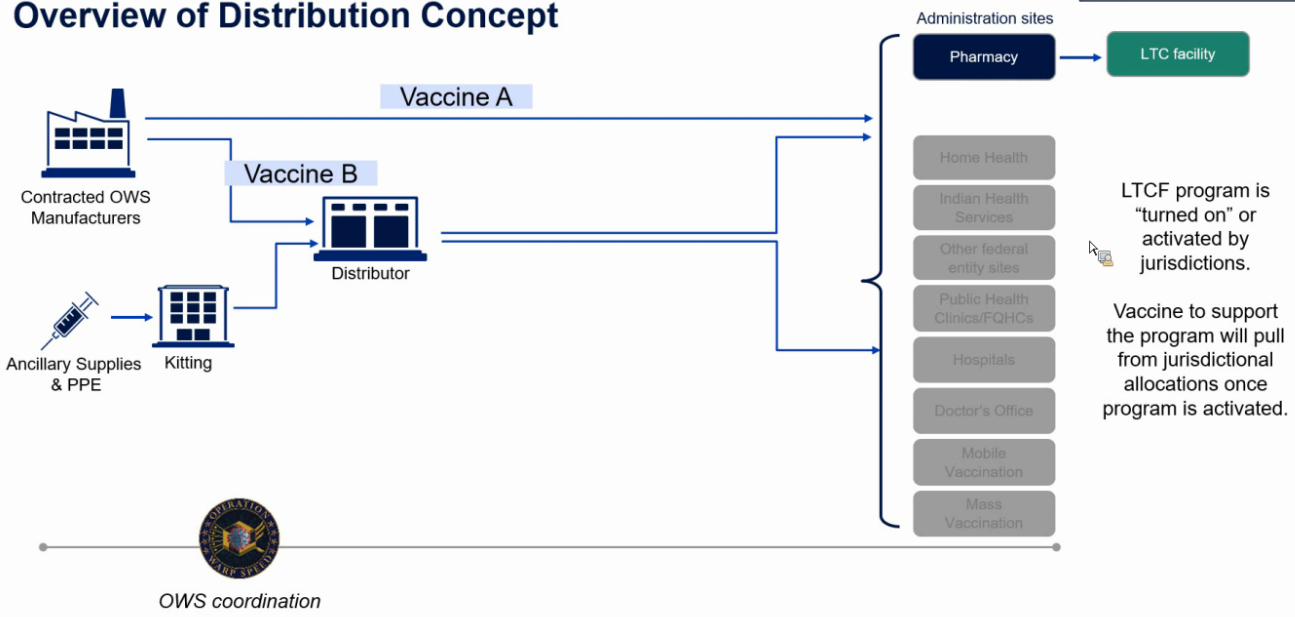
Overview of Distribution Concept



LTCF program is "turned on" or activated by jurisdictions.

Vaccine to support the program will pull from jurisdictional allocations once program is activated.

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Pharmacy Partnership for LTC Program Overview

- Program is designed to support jurisdictions, reach critical populations
- Provides end-to-end management of the COVID-19 vaccination for enrolled LTCFs
  - Increases access to COVID vaccine for LTCF residents
  - Provides cold chain management, on-site vaccinations, and fulfillment of reporting requirements
  - No cost to facilities or jurisdictions
  - LTCF staff who have not received COVID-19 vaccine can also be vaccinated as part of the program.

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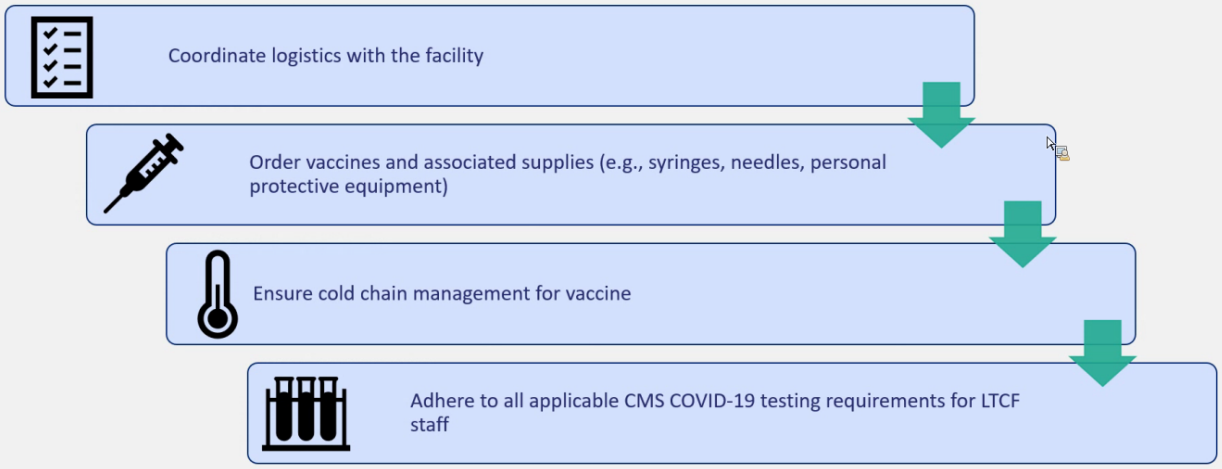
Federal pharmacy partners will:



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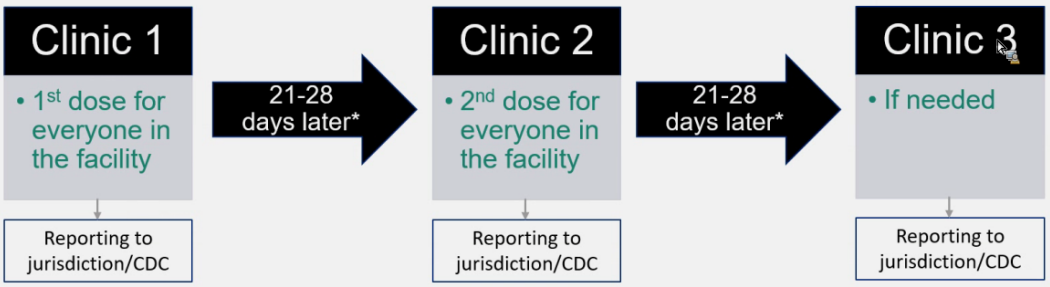
Onsite clinics



* Depending on vaccine product

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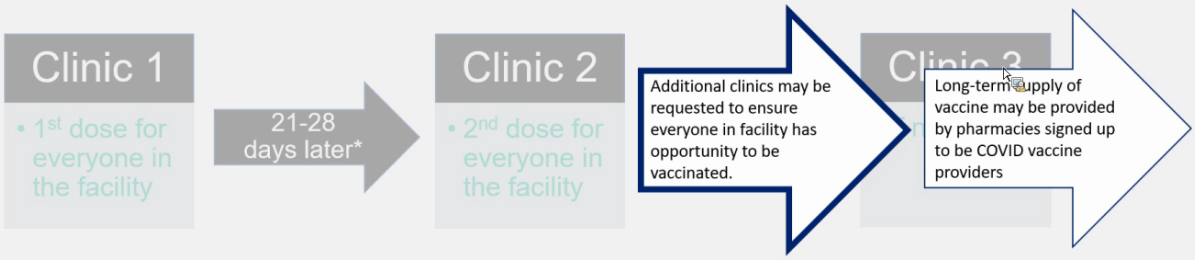
After the onsite clinics



* Depending on vaccine product

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Sign-up and next steps

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Lots of progress made to date!

- In October, CDC worked with AIM and ASTHO to socialize the idea of a LTCF program with jurisdictions
- In November, CDC partnered with AHCA and Leading Age to conduct outreach to LTC facilities
  - Facilities had the opportunity to sign up for the program and select a pharmacy partner
- Over the last 3 weeks, CDC shared the facility lists with jurisdictions, adjusted lists, and worked with jurisdictions to added facilities as needed
- **On Dec 4th, the list of facilities that will be served by the program will be 'locked'**

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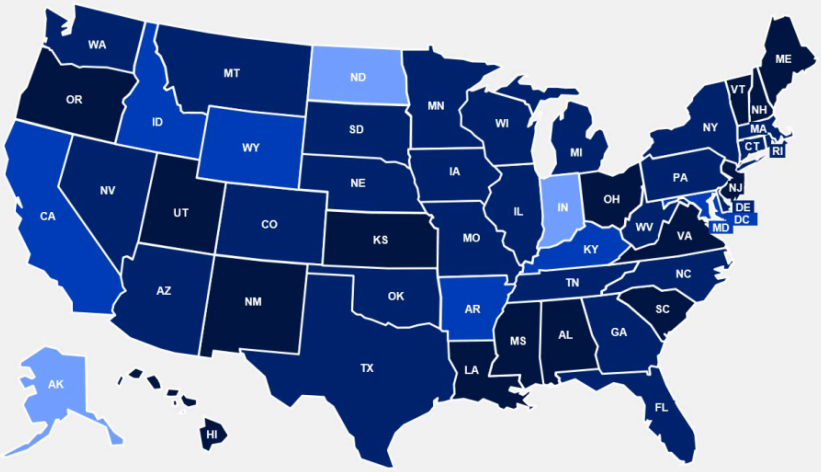
Skilled Nursing Facilities (SNFs) Enrolled in Pharmacy Partnership for Long-Term Care Program



- 100% of SNFs enrolled
- 95-99% of SNFs enrolled
- 90-94% of SNFs enrolled
- 80-89% of SNFs enrolled
- <80% of SNFs enrolled

99% of total SNFs nationwide have enrolled (N=15,353)

States with 100%+* enrollment: AL, DE, HI, KS, LA, ME, MS, NH, NJ, NM, OH, OR, SC, UT, VA, VT

Lowest enrollment:
AK (85%)
ND (83%)
Puerto Rico (67%)

* States >100% enrollment: Numerator may include non-CMS-certified SNFs. Denominator is only CMS-certified.

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Facility/Pharmacy Matching

First choice	Contingency	Matched result
CVS/Walgreens	N/A	CVS/Walgreens
Partner pharmacy (onboarded into federal pharmacy program per jurisdiction request)	CVS/Walgreens	Federal partner pharmacy (through partnership with MHA)
Partner pharmacy (onboarded by jurisdiction and communicated to CDC)	CVS/Walgreens	Jurisdiction partner pharmacy
Partner pharmacy (not federal or jurisdictional partner)	CVS/Walgreens	CVS/Walgreens
Partner pharmacy (not federal or jurisdictional partner)	Opt-out	Unable to match
Opt-out	N/A	Opt-out – jurisdiction TBD

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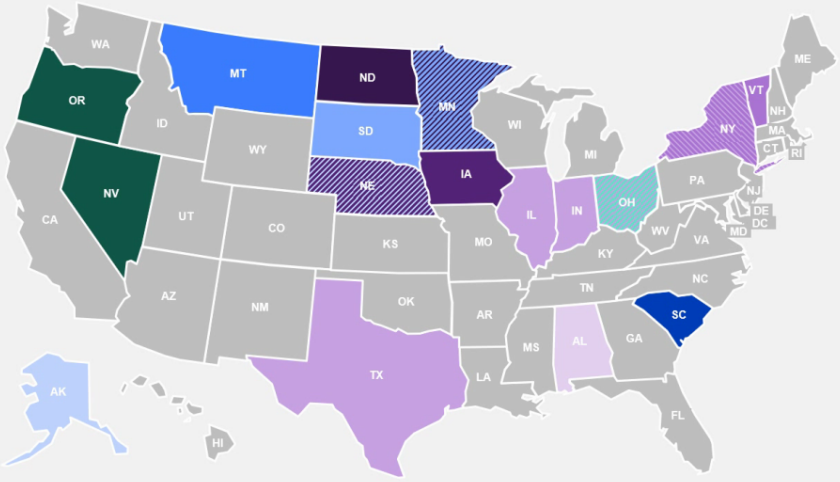
Jurisdictions with LTC Pharmacies Engaged Beyond CVS/Walgreens



Federal partners:

- CVS/Walgreens

Federal partners: via MHA

- Thrifty White
- Community Pharmacy LTC
- HealthDirect
- Pharmscript
- Senior Care
- Consonus
- Absolute

Jurisdictional partners

- PruittHealth
- Big Sky Pharmacy
- Lewis Drug
- Various partners

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Next steps for CDC

- Email to ineligible facilities (will be posted on Sharepoint for jurisdictions to see):
  - Adult day care, independent living, facilities for children or adolescents, psychiatric rehabilitation or behavioral treatment, substance abuse rehabilitation, independent low-income housing (not HUD-202, which was included), domestic violence shelter, homeless shelters, convents, churches, schools, individual houses (i.e., not a congregate living facility), miscellaneous “community programs,” correctional facilities, home health agencies
- Finalizing datasets for pharmacy partner outreach
- Loading sign-up data into Tiberius for easier access for jurisdictions and pharmacies.
  - Tiberius will provide specific views for the LTCF program for each jurisdiction

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Program Activation

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Jurisdictional considerations for program activation

In early stages of vaccine roll out, many factors will need to be considered when turning on the program including:

- Goals and desired impacts of immunization program
- Priority groups for vaccination
- Supply:
  - Having enough allocation available for vaccination of LTCFs without delaying vaccination for other essential healthcare personnel

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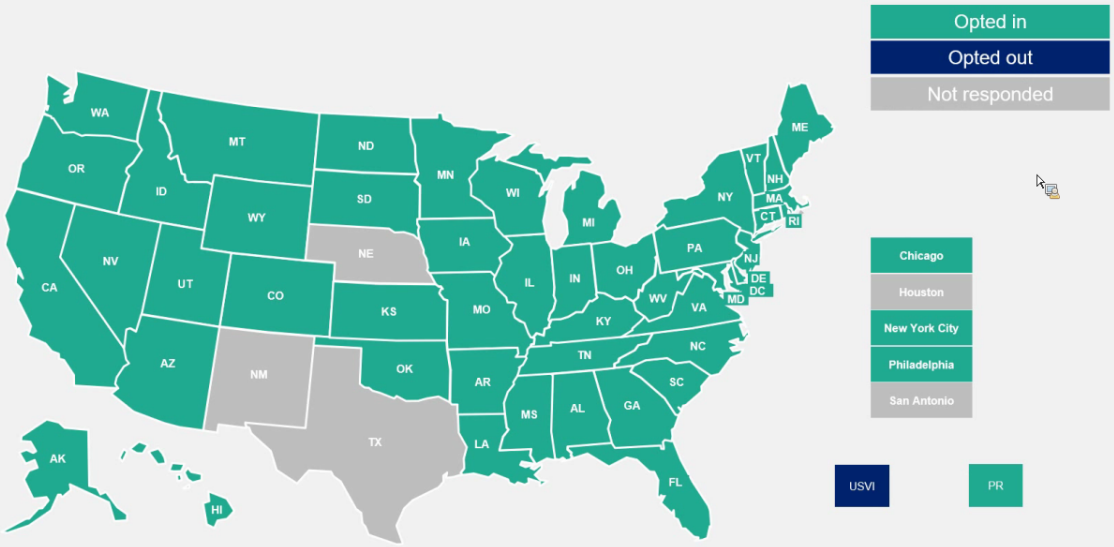
Activation: Opt in by SHOs this week (REDCap survey)



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Activation of the Federal Pharmacy Partnership for LTC Program

- SHOs will opt in on behalf of jurisdiction this week (via survey)
- Jurisdictions will need to provide a **two week notice** to begin the LTCF program
  - Allows for participating pharmacy partners to prepare to administer vaccine and coordinate vaccination activities with facilities assigned to them.
- The program is split into two components.
  - Part A includes vaccination of skilled nursing facilities, and
  - Part B includes vaccination of the remaining facilities enrolled in the program*
  - CDC will provide each jurisdiction with an estimated number of doses needed to cover Part A and Part B

*Includes: assisted living facilities, continuing care residential communities, residential care communities/adult family homes, HUD 202 low-income senior housing, intermediate care facilities for individuals with developmental disabilities, state-run veterans' homes

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Steps to Activate

1. **NOTICE**: Once a jurisdiction is ready to start the LTCF program, the state health officer or designee must email CDC's pharmacy team (eocevent494@cdc.gov) to provide notice. Let us know if you will activate Part A; or Part A&B

2. **TRANSFER DOSES**: CDC will work with the jurisdiction to begin transferring vaccine doses from state allocation to the LTCF program and its pharmacy partners.
   - CDC will coordinate with each jurisdiction to transfer the right amount of doses in Tiberius every week that they are needed to support the program.
   - Jurisdictions will be **required to have at least 50% of the needed doses available to cover the program (Part A or Part A&B) within a week after providing notice to activate**.
   - After the program starts, over the following two weeks, jurisdictions will need to ensure the remaining doses are available for transfer.

3. **ONSITE VACCINATION:** Pharmacy partners vaccinate facilities

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*** REMEMBER***

Program is meant to be turn-key with some key instructions:

- Consider when to activate, and if you will activate:
  - Part A only (SNF)*
  - Part A/B together (SNF and other facilities)

- Give a 2- week notice via email

- Vaccine will come from your jurisdiction's allocation
  - 50% of doses needed one week after notice
  - Remaining doses (50%) needed two weeks after program starts
  - CDC will help you with this 'dose transfer' step

* Part B (other facilities may be activated at a later date)

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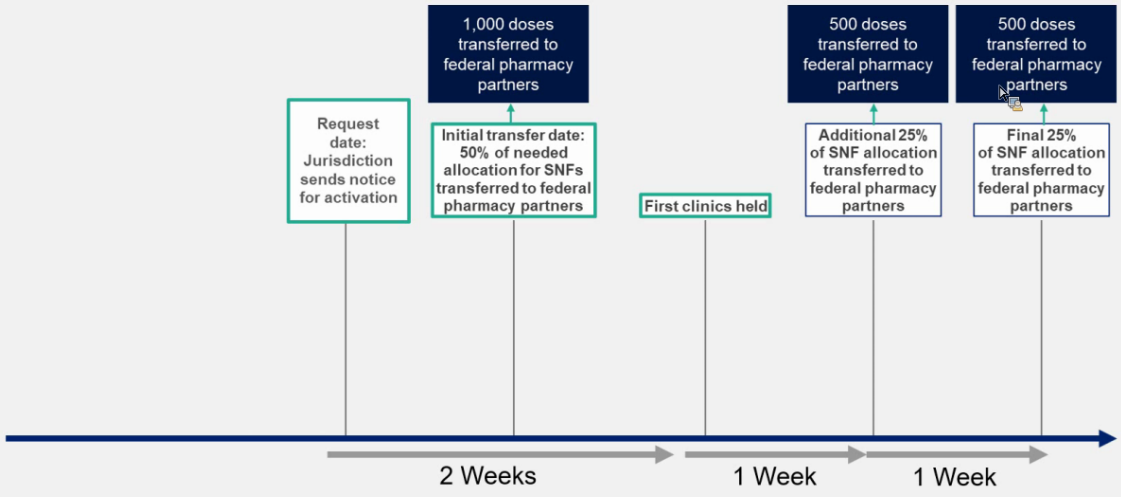
Example program activation timeline

Total estimated 1st dose allocation = 1,000 x 2 [to account for staff] = 2,000 doses



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Estimated amount of volume of vaccine needed

	A Skilled nursing facilities			B Other eligible facility types*		
Jurisdiction	# of facilities signed up	# of certified beds reported	Estimated allocation (# of certified beds x 2 [to account for staff])	# of facilities signed up	# of certified beds reported	Estimated allocation (# of certified beds x 2 [to account for staff])
AK	13	707	1,414	377	3,315	6,630
AL	227	26,945	53,890	270	12,687	25,374
AR	220	23,323	46,646	122	8,638	17,276
AZ	146	16,142	32,284	622	33,708	67,416
CA	1,173	88,922	177,844	4,092	186,431	372,862
CO	224	20,736	41,472	678	32,786	65,572
CT	208	25,048	50,096	429	28,118	56,236
DC	16	2,050	4,100	14	1,198	2,396
DE	49	5,140	10,280	95	4,957	9,914
FL	708	85,098	170,196	2,205	124,143	248,286
GA	342	37,827	75,654	650	38,940	77,880
HI	46	4,314	8,628	31	2,670	5,340
IA	419	29,328	58,656	769	23,597	47,194
ID	76	6,089	12,178	195	9,250	18,500
IL	699	87,344	174,688	1,429	75,275	150,550
IN	466	47,292	94,584	814	44,753	89,506

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Next steps from federal pharmacy partners

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CVS

- Initial outreach from CVS Health via centralized email to facility administrators (timing: **TBD based on CDC clearance**, this week likely). Initial outreach will include:
  - Link to vaccine clinic website (www.omnicare.com/covid-19-vaccine-resource)
  - Link to download the facility-facing process overview (PDF that will walk the facility step-by-step through the entire clinic experience)
  - Link to submit updated contact information (https://info.omnicare.com/Update-Contact-Info.html)
  - Calendar hold for SNF webinar (timing: **TBD**, ~48 hours after release of initial communication)
- LTCF receives live outreach call from CVS personnel to introduce themselves, address open questions, and review the clinic processes (plus/minus 3-5 days surrounding webinar)
- Once the date / time for each facility's clinics are scheduled, an acknowledgement email will be sent to the facility to provide this information
- Additional points of engagement are planned, ranging from direct phone calls to automated emails. These interventions are aligned with key activities occurring prior to the clinic, during the clinic, and after the clinic.

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MHA

Includes the following pharmacies brought into the federal program:
Absolute Pharmacy (Ohio), Community Pharmacy (Iowa & Nebraska), Consonus (Nevada & Oregon), HealthDirect (New York & Vermont), Pharmscript (Illinois, Indiana, New York, Ohio, & Texas), Senior Care (Alabama), and Thrifty White (Minnesota & North Dakota)

- Facilities will receive a unique email and print-memo communicating that their matched pharmacy will be conducting their clinics and we will be contacting them directly (via conference call/webinar/info on portal) for coordination and next steps
- Facility Specific Communication Plan will be scheduled shortly after to include discussion of general information such as vaccine clinic overview, clinic days, times, clinic flow, and documentation required, including consent forms and recommendations for communicating with family members and facility staff
- Scheduled meeting with the Pharmacy and Facility will be 7 – 3 – 1 day(s) prior to clinic to ensure appropriate communications and to validate operational plan

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DRAFT – PRE-DECISIONAL & DELIBERATIVE

Walgreens

- Introductory email to go out to LTCFs to notify them that Walgreens is assigned as their vaccine healthcare partner. The communication includes materials to enable LTCFs to begin preparing for vaccine administration, including:
  1. Clinic Overview Webinar
  2. Consent Form
  3. Resident Handout
  4. COVID Clinic Tip Sheet
- Walgreens Point of Contact
  Walgreens will assign each facility a point of contact (POC) from our pharmacy team.
- Personalized Outreach
  Long-term care facilities can expect to hear from their Walgreens POC as soon as their state grants authority to start immunizations at LTCF. In this outreach, LTCFs will receive additional guidance:
  - *Webinar - Resident Data Upload Portal Tutorial*
  - *Additional Clinic Preparation Guide*
- Ongoing Scheduling & Preparation
  All 3 clinics dates will be scheduled within 2 weeks of the initial outreach from the Walgreens POC. This will open a dialogue with the LTCF to determine the best person to serve as the clinic coordinator – this person will facilitate the agreement, scheduling, and clinic preparation process on behalf of the facility.

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From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Monday, January 04, 2021 3:00 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>
Subject: FW: CDC COVID-19 Weekly Digest of Resources

Per HHS.

CDC COVID-19 Science Update: No new science updates were released between 12/26 and 1/1 in observation of winter holidays. Previous science updates can be viewed at ***https://www.cdc.gov/library/covid19*.**

MMWR Articles: Below are links to recent COVID MMWR articles

1. **January 1, 2021** Implications of Shortened Quarantine Among Household Contacts of Index Patients with Confirmed SARS-CoV-2 Infection — Tennessee and Wisconsin, April–September 2020
2. **January 1, 2021** Performance of an Antigen-Based Test for Asymptomatic and Symptomatic SARS-CoV-2 Testing at Two University Campuses — Wisconsin, September–October 2020
3. **January 1, 2021** Impact of COVID-19 Pandemic on Global Poliovirus Surveillance
4. **January 1, 2021** The Advisory Committee on Immunization Practices' Interim Recommendation for Use of Moderna COVID-19 Vaccine — United States, December 2020
5. **January 1, 2021** The Advisory Committee on Immunization Practices' Updated Interim Recommendation for Allocation of COVID-19 Vaccine — United States, December 2020
6. **January 1, 2021** *COVID-19 Stats*: COVID-19 Incidence, by Age Group — United States, March 1–November 14, 2020

*Older MMWR COVID-19 Reports can be viewed at https://www.cdc.gov/mmwr/Novel_Coronavirus_Reports.html

CDC Website Updates: Please find updated CDC website pages for 12/26-1/1

Response Website Updates (12/26/20- 01/01/21)
1. Information about the Moderna COVID-19 Vaccine Friday, January 01, 2021
2. Information about the Pfizer-BioNTech COVID-19 Vaccine Friday, January 01, 2021
3. Impact of COVID-19 Pandemic on Global Poliovirus Surveillance Thursday, December 31, 2020
4. COVID-19 Stats: COVID-19 Incidence, by Age Group - United States, March 1-November 14, 2020 Thursday, December 31, 2020
5. Performance of an Antigen-Based Test for Asymptomatic and Symptomatic SARS-CoV-2 Testing at Two University Campuses - Wisconsin, September-October 2020 Thursday, December 31, 2020
6. Implications of Shortened Quarantine Among Household Contacts of Index Patients with Confirmed SARS-CoV-2 Infection - Tennessee and Wisconsin, April-September 2020 Thursday, December 31, 2020
7. The Advisory Committee on Immunization Practices' Updated Interim Recommendation for Allocation of COVID-19 Vaccine - United States, December 2020 Thursday, December 31, 2020
8. The Advisory Committee on Immunization Practices' Interim Recommendation for Use of Moderna COVID-19 Vaccine - United States, December 2020 Thursday, December 31, 2020
9. Raising Defenses against the COVID-19 "Tsunami" Thursday, December 31, 2020
10. Resources for Teachers and Staff Thursday, December 31, 2020
11. COVID-19 Vaccines and Severe Allergic Reactions Thursday, December 31, 2020
12. When Vaccine is Limited, Who Gets Vaccinated First? Thursday, December 31, 2020
13. What to Expect at Your Appointment to Get Vaccinated for COVID-19 Thursday, December 31, 2020
14. Things to Know about the COVID-19 Pandemic Thursday, December 31, 2020
15. Vaccines Thursday, December 31, 2020
16. Holiday Celebrations Thursday, December 31, 2020
17. Federal Register Notice: Temporary Halt in Residential Evictions to Prevent the Further Spread of COVID-19 Thursday, December 31, 2020
18. Playing Sports Thursday, December 31, 2020
19. Returning to Work Thursday, December 31, 2020
20. Considerations for Non-emergency Vehicle Transportation for Tribal Communities During COVID-19 Thursday, December 31, 2020
21. Living in or Visiting Retirement Communities or Independent Living Facilities Thursday, December 31, 2020
22. Considerations for Retirement Communities and Independent Living Facilities Thursday, December 31, 2020
23. Youth Sports Program FAQs Thursday, December 31, 2020
24. Food and Coronavirus Disease 2019 (COVID-19) Thursday, December 31, 2020
25. Considerations for Casinos and Gaming Operations Thursday, December 31, 2020
26. Crew Disembarkations through Commercial Travel Thursday, December 31, 2020
27. Personal and Social Activities Thursday, December 31, 2020
28. Considerations for Community-Based Organizations Thursday, December 31, 2020
29. COVID-19 in Newly Resettled Refugee Populations Thursday, December 31, 2020
30. Help Children Learn at Home Thursday, December 31, 2020

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31. Considerations for Institutes of Higher Education Thursday, December 31, 2020
32. Considerations for Youth Sports Thursday, December 31, 2020
33. Considerations for Public Pools, Hot Tubs, and Water Playgrounds During COVID-19 Thursday, December 31, 2020
34. COVID-19 Guidance for Shared or Congregate Housing Thursday, December 31, 2020
35. COVID-19 Employer Information for Bus Transit Operators Thursday, December 31, 2020
36. Running Essential Errands Thursday, December 31, 2020
37. Guidance for Child Care Programs that Remain Open Thursday, December 31, 2020
38. Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities Thursday, December 31, 2020
39. What To Do if You Are Sick Thursday, December 31, 2020
40. Caring for Someone Sick at Home Thursday, December 31, 2020
41. How to Protect Yourself & Others Thursday, December 31, 2020
42. Frequently Asked Questions Thursday, December 31, 2020
43. Previous Forecasts of Total Deaths Wednesday, December 30, 2020
44. Healthcare Facilities That Have Implemented COVID-19 Electronic Case Reporting Wednesday, December 30, 2020
45. Interim Guidance for Case Investigation and Contact Tracing in K-12 Schools Wednesday, December 30, 2020
46. Guidance for SARS-CoV-2 Point-of-Care Testing Wednesday, December 30, 2020
47. How CDC Is Making COVID-19 Vaccine Recommendations Wednesday, December 30, 2020
48. Previous COVID-19 Forecasts: Cases Wednesday, December 30, 2020
49. COVID-19 Forecasts: Cases Wednesday, December 30, 2020
50. School Decision-Making Tool for Parents, Caregivers, and Guardians Wednesday, December 30, 2020
51. Considerations for Traveling Amusement Parks and Carnivals Wednesday, December 30, 2020
52. Considerations for Public Beaches Wednesday, December 30, 2020
53. Support For Teens and Young Adults Wednesday, December 30, 2020
54. Previous COVID-19 Forecasts: Hospitalizations Wednesday, December 30, 2020
55. Considerations for Communities of Faith Wednesday, December 30, 2020
56. COVID-19 Forecasts: Hospitalizations Wednesday, December 30, 2020
57. Operating schools during COVID-19: CDC's Considerations Wednesday, December 30, 2020
58. Shared and Congregate Housing Wednesday, December 30, 2020
59. General Business Frequently Asked Questions Wednesday, December 30, 2020
60. COVID-19 Forecasts: Deaths Wednesday, December 30, 2020
61. Information for Pediatric Healthcare Providers Wednesday, December 30, 2020
62. Event Planning and COVID-19: Questions and Answers Wednesday, December 30, 2020
63. Cleaning And Disinfecting Your Home Wednesday, December 30, 2020
64. Schools and Childcare Programs Wednesday, December 30, 2020
65. Science Briefs Tuesday, December 29, 2020
66. COVID-19 Vaccination Considerations for Persons with Underlying Medical Conditions Tuesday, December 29, 2020
67. Implications of the Emerging SARS-CoV-2 Variant VUI 202012/01 Tuesday, December 29, 2020
68. Toolkit for Clinicians Tuesday, December 29, 2020
69. 10 Things Healthcare Professionals Need to Know about U.S. COVID-19 Vaccination Plans Tuesday, December 29, 2020
70. Frequently Asked Questions about COVID-19 Vaccination Tuesday, December 29, 2020
71. COVID-19 Published Science and Research Tuesday, December 29, 2020
72. Operational Considerations for Schools Tuesday, December 29, 2020
73. Summary for Healthcare Facilities: Strategies for Optimizing the Supply of PPE during Shortages Tuesday, December 29, 2020
74. Isolate If You Are Sick Tuesday, December 29, 2020
75. People with Certain Medical Conditions Tuesday, December 29, 2020
76. Support for Veterans Tuesday, December 29, 2020
77. Considerations for Events and Gatherings Tuesday, December 29, 2020
78. Summary for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response Tuesday, December 29, 2020
79. SARS-CoV-2 Viral Culturing at CDC Tuesday, December 29, 2020
80. Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for COVID-19 Tuesday, December 29, 2020
81. Colleges, Universities, and Higher Learning Tuesday, December 29, 2020
82. At-Home Testing Monday, December 28, 2020
83. Social Media Toolkit: COVID-19 & Mental Health Monday, December 28, 2020
84. The Importance of COVID-19 Vaccination for Healthcare Personnel Monday, December 28, 2020

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85. Importance of COVID-19 Vaccination for Residents of Long-term Care Facilities Monday, December 28, 2020
86. Different COVID-19 Vaccines Monday, December 28, 2020
87. Coronavirus Self-Checker Monday, December 28, 2020
88. Considerations for Use of SARS-CoV-2 Antigen Testing in Nursing Homes Monday, December 28, 2020
89. COVID-19 Parental Resources Kit – Young Adulthood Monday, December 28, 2020
90. COVID-19 Parental Resources Kit – Adolescence Monday, December 28, 2020
91. COVID-19 Parental Resources Kit Monday, December 28, 2020
92. National Wastewater Surveillance System (NWSS) Monday, December 28, 2020
93. Toolkit for Correctional and Detention Facilities Monday, December 28, 2020
94. COVID-19 Questions and Answers: For People Who Use Drugs or Have Substance Use Disorder Monday, December 28, 2020
95. Daily Activities and Going Out Monday, December 28, 2020
96. What Construction Workers Need to Know about COVID-19 Monday, December 28, 2020
97. Suggestions for Youth and Summer Camps Monday, December 28, 2020
98. Funeral Guidance for Individuals and Families Monday, December 28, 2020
99. How to Report COVID-19 Laboratory Data Monday, December 28, 2020
100. Data Visualization Monday, December 28, 2020
101. COVIDView Weekly Summary Monday, December 28, 2020
102. Training for Healthcare Professionals Monday, December 28, 2020
103. Cleaning and Disinfecting Your Facility Monday, December 28, 2020
104. Public Service Announcements (PSAs) Monday, December 28, 2020
105. If You Are Pregnant, Breastfeeding, or Caring for Young Children Monday, December 28, 2020
106. Clinical Questions about COVID-19: Questions and Answers Monday, December 28, 2020
107. Information for Healthcare Professionals about Coronavirus (COVID-19) Monday, December 28, 2020
108. Federal Coordination and Partnering for Wastewater Surveillance Saturday, December 26, 2020

Daily website updates are now viewable at https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html

CDC Webinars of Interest:
CMEs for Providers for Vaccine Education:
Vaccine Courses, Broadcasts, Webcasts and Self Study Training | CDC

You can access training materials for VaccineFinder here. These materials will also be added to the VaccineFinder website next week

COVID-19 UK Variant in Colorado: Updated Talking Points
You have already received the most recently updated talking points regarding the first reported U.S. case of the new variant first identified in the UK. These TPs will continue to evolve as we learn more. Meanwhile, please be sure to bookmark the CDC web content on COVID-19 variants, which will be updated frequently.

COVID-19 Vaccine Resources
1. Translated Pfizer-BioNTech EUA Recipient/Caregiver Fact Sheet
2. Factsheets and Manufacturer Instructions for Authorized Vaccines
3. V-SAFE
    1. For all V-SAFE inquiries contact: eocevent523@cdc.gov
4. COVID Data Tracker
5. Vaccine factsheets in multiple languages:
    1. Moderna
    2. Pfizer-BioNTech
6. COVID-19 Vaccine Clinical FAQs
7. Expiration date tracker
8. Beyond use date tracking labels for refrigerator storage
9. Vaccine storage and handling summary
10. Vaccine storage and handling labels
11. You can access the redistribution guidance for the Moderna vaccine here.
12. Ad Council COVID-19 Youtube playlist:
    1. Developed in partnership with leading health organizations and Dr. Anthony Fauci, this new educational content from the Ad Council and COVID Collaborative is designed to help healthcare providers better understand and answer common questions about COVID-19 vaccination.

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Thursday, December 17, 2020 4:12 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>; DEM All Staff <DEM@em.myflorida.com>
Subject: FW: CDC Help Contact Info, EUA Info Sheets, IIS Vaccine Code Sets
Attachment(s): "Awardee Email-Help Contacts_EUA Info Sheets_IIS Vax Code Sets_2.14.2020.pdf"

FYSA – per HHS

Good afternoon Awardees,

This email covers 3 important topics for awardees:
- Contacts for Technical Assistance
- EUA Fact Sheets
- CDC IIS Vaccine Codes

The content of the email includes links and tables that may not appear correctly in this email. The attached PDF includes the same content with functional links and formatted tables.

Contacts for Technical Assistance
Please see below for a list of support contacts for the systems being used for the COVID-19 vaccine response. In addition, CDC has a centralized call center available for awardees and system users; the caller's question will be answered or triaged as appropriate to meet the caller's needs. Phone numbers are listed below the specific contacts.

I need help with…	Contact…
General Inquiries	IIS Support: IISInfo@cdc.gov
Provider Enrollment Data	IZ Data Lake Support: IZDLhelpdesk@cdc.gov
VTrckS Ordering, Provider Master Data, Returns & Wastage Extracts	VTrckS ExIS Support: VTrckSExIS@cdc.gov VPoP (Federal Partners): VTrckSExIS@cdc.gov
VTrckS Allocations, Tracking and Shipment	Vaccine Order Management Contact Center: Vaccineordermgmt@cdc.gov
Inventory Data	VaccineFinder: Eocevent522@cdc.gov ****NEW ADDRESS****
Reporting Administration Data via CVRS Data Extract	CVRS Support: IZGateway@hhs.gov Data Clearinghouse: DCHInfo@cdc.gov Pharmacy Liaison: eocevent481@cdc.gov
VAMS	VAMS Help Desk: 1-833-957-1100 **preferred contact method** VAMS Help: VAMSHelp@cdc.gov These help options are **only** for jurisdictions and providers using VAMs.
v-safe	eocevent416@cdc.gov
Operation Warp Speed Tiberius	Log-in: Protect-ServiceDesk@hhs.gov Platform: ows-support@palantir.com Microplanning: ows-support-microplanning@palantir.com

The Vaccine Coordination Center at CDC has a Jurisdictional Watch Desk to provide technical assistance related to the COVID-19 vaccine for the 64 funded jurisdictions and 5 federal entities. The help desk will operate 24 hours a day, 7 days a week. The call center is not intended to disrupt the existing relationship jurisdictions have with their regional support team and other direct technical support they have been receiving. It is anticipated that, especially near-term, many jurisdictions will reach directly to their CDC regional teams; however, we encourage use of the call center as much as possible to help CDC provide the best service in the most efficient manner and track questions from awardees.

Call Center Numbers		
Regions 1-4	Toll-Free: Local:	1(833) 731 - 5110 (404) 718 - 8110
Regions 5-7	Toll-Free: Local:	1(833) 348 - 7409 (404) 718 - 8111
Regions 8-10	Toll-Free: Local:	1(833) 896 - 8952 (404) 718 - 8112

EUA Fact Sheets
FDA issued Emergency Use Authorization for the Pfizer BioNTech COVID-19 vaccine on Friday December 11, 2020. Information regarding that vaccine as well as the EUA Provider Fact Sheet and the EUA Recipient and Caregiver Fact Sheets are available on FDA web page (or https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine).

EUA Recipient Caregiver Fact Sheet Codes
To help facilitate documentation of having provided the EUA Recipient Caregiver Fact Sheet in electronic medical records/immunization information systems, the CDC is leveraging the existing Vaccine Information Statement (VIS) Code Set infrastructure, including barcoding, and URLs to provide the information needed for various systems, analogous to electronic system and workflow documentation of VIS.

The codes below were developed in advance of the EUA decision by FDA for each vaccine. Codes can be downloaded from the CDC IIS Vaccine Code Sets web pages (https://www.cdc.gov/vaccines/programs/iis/code-sets.html).

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EUA Recipient/Caregiver Fact Sheet Description	Document Barcode String	Edition Date	Edition Status	HTML URL	PDF URL	VIS GDTI document code
COVID-19 Moderna Vaccine EUA Recipient-Caregiver Fact Sheet	25308869830003491120120l	12/01/2020	Current	https://www.cdc.gov/vaccines/covid-19/eua/modernatx.html	https://www.cdc.gov/vaccines/covid-19/eua/modernatx.pdf	0886983000349
COVID-19 Pfizer BioNTech Vaccine EUA Recipient-Caregiver Fact Sheet	25308869830003321120120l	12/01/2020	Current	https://www.cdc.gov/vaccines/covid-19/eua/pfizer.html	https://www.cdc.gov/vaccines/covid-19/eua/pfizer.pdf	0886983000332

Note: *The URL document links shown above will not be activated until FDA EUA authorization and the final FDA approved EUA Recipient/Caregiver Fact Sheet is available.*

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The edition date is the barcode generated-date and does not reflect the exact date of the EUA-issued Recipient/Caregiver Fact Sheet.

CDC IIS Vaccine Codes

The codes shown below were developed in advance of potential EUA decision by FDA for each vaccine and can be downloaded from the CDC IIS Vaccine Code Sets web pages (or https://www.cdc.gov/vaccines/programs/iis/code-sets.html).

Preview Posting of COVID-19 Vaccine Codes and Crosswalk. Provided in anticipation of potential vaccine availability under Emergency Use Authorization (EUA). Data as of 11/11/2020. Codes will become effective only upon EUA issuance of COVID-19 vaccine(s) by the Food and Drug Administration (FDA). All CVX Codes are association to the new Vaccine Group "COVID-19"

CVX Code	CVX Long Description	CVX Short Description	Sale Proprietary Name	Sale Labeler	MVX Code	Unit of Sale NDC10 (UOS)	UoS Package	Unit of Use NDC10 (UOU)	Presentation	CPT Code	CPT Description
207	SARS-COV-2 (COVID-19) vaccine, mRNA, spike protein, LNP, preservative free, 100 mcg/0.5mL dose	COVID-19, mRNA, LNP-S, PF, 100 mcg/ 0.5 mL dose	Moderna COVID-19 Vaccine	Moderna US, Inc.	MOD	80777-273-99	CARTON, 10 MULTI-DOSE VIALS	80777-273-10	MULTI-DOSE VIAL, 10 DOSES	91301	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use
208	SARS-COV-2 (COVID-19) vaccine, mRNA, spike protein, LNP, preservative free, 30 mcg/0.3mL dose	COVID-19, mRNA, LNP-S, PF, 30 mcg/0.3 mL dose	Pfizer COVID-19 Vaccine	Pfizer-BioNTech	PFR	59267-1000-2	CARTON, 195 MULTI-DOSE VIALS	59267-1000-1	MULTI-DOSE VIAL, 5 DOSES	91300	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use
208	SARS-COV-2 (COVID-19) vaccine, mRNA, spike protein, LNP, preservative free, 30 mcg/0.3mL dose	COVID-19, mRNA, LNP-S, PF, 30 mcg/0.3 mL dose	Pfizer COVID-19 Vaccine	Pfizer-BioNTech	PFR	59267-1000-3	CARTON, 25 MULTI-DOSE VIALS	59267-1000-1	MULTI-DOSE VIAL, 5 DOSES	91300	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use

CPT Codes

- The Current Procedural Terminology (CPT) code effective date for the Pfizer COVID-19 Vaccine is 12/11/2020.
- The (CPT) code effective date for the Moderna COVID-19 Vaccine is pending EUA approval.

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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This document (email) covers 3 important topics for awardees.

- Contacts for Technical Assistance
- EUA Fact Sheets
- CDC IIS Vaccine Codes

Contacts for Technical Assistance

Please see below for a list of support contacts for the systems being used for the COVID-19 vaccine response. In addition, CDC has a centralized call center available for awardees and system users; the caller's question will be answered or triaged as appropriate to meet the caller's needs. Phone numbers are listed below the specific contacts.

I need help with…	Contact…
General Inquiries	IIS Support: IISInfo@cdc.gov
Provider Enrollment Data	IZ Data Lake Support: IZDLhelpdesk@cdc.gov
VTrckS Ordering, Provider Master Data, Returns & Wastage Extracts	VTrckS ExIS Support: VTrckSExIS@cdc.gov VPoP (Federal Partners): VTrckSExIS@cdc.gov
VTrckS Allocations, Tracking and Shipment	Vaccine Order Management Contact Center: Vaccineordermgmt@cdc.gov
Inventory Data	VaccineFinder: Eocevent522@cdc.gov ****NEW ADDRESS****
Reporting Administration Data via CVRS Data Extract	CVRS Support: IZGateway@hhs.gov Data Clearinghouse: DCHInfo@cdc.gov Pharmacy Liaison: eocevent481@cdc.gov
VAMS	VAMS Help Desk: 1-833-957-1100 **preferred contact method** VAMS Help: VAMSHelp@cdc.gov These help options are **only** for jurisdictions and clinics/providers using VAMs.
v-safe	eocevent416@cdc.gov
Operation Warp Speed Tiberius	Log-in: Protect-ServiceDesk@hhs.gov Platform: ows-support@palantir.com Microplanning: ows-support-microplanning@palantir.com

The Vaccine Coordination Center at CDC has a Jurisdictional Watch Desk to provide technical assistance related to the COVID-19 vaccine for the 64 funded jurisdictions and 5 federal entities. The help desk will operate 24 hours a day, 7 days a week. The call center is not intended to disrupt the existing relationship jurisdictions have with their regional support team and other direct technical support they have been

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FL-DEM-21-0173-A-000243

receiving. It is anticipated that, especially near-term, many jurisdictions will reach directly to their CDC regional teams; however, we encourage use of the call center as much as possible to help CDC provide the best service in the most efficient manner and track questions from awardees.

Call Center Numbers		
Regions 1-4	Toll-Free: Local:	1(833) 731 - 5110 (404) 718 - 8110
Regions 5-7	Toll-Free: Local:	1(833) 348 - 7409 (404) 718 - 8111
Regions 8-10	Toll-Free: Local:	1(833) 896 - 8952 (404) 718 - 8112

EUA Fact Sheets

FDA issued Emergency Use Authorization for the Pfizer BioNTech COVID-19 vaccine on Friday December 11, 2020. Information regarding that vaccine as well as the EUA Provider Fact Sheet and the EUA Recipient and Caregiver Fact Sheets are available on FDA web page (or https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine).

EUA Recipient Caregiver Fact Sheet Codes

To help facilitate documentation of having provided the EUA Recipient Caregiver Fact Sheet in electronic medical records/immunization information systems, the CDC is leveraging the existing Vaccine Information Statement (VIS) Code Set infrastructure, including barcoding, and URLs to provide the information needed for various systems, analogous to electronic system and workflow documentation of VIS.

The codes below were developed in advance of the EUA decision by FDA for each vaccine. Codes can be downloaded from the CDC IIS Vaccine Code Sets web pages (https://www.cdc.gov/vaccines/programs/iis/code-sets.html).

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EUA Recipient/Caregiver Fact Sheet Description	Document Barcode String	Edition Date	Edition Status	HTML URL	PDF URL	VIS GDTI document code
COVID-19 Moderna Vaccine EUA Recipient-Caregiver Fact Sheet	25308869830003491120120 1	12/01/2020	Current	https://www.cdc.gov/vaccines/covid-19/eua/modernatx.html	https://www.cdc.gov/vaccines/covid-19/eua/modernatx.pdf	0886983000349
COVID-19 Pfizer BioNTech Vaccine EUA Recipient-Caregiver Fact Sheet	25308869830003321120120 1	12/01/2020	Current	https://www.cdc.gov/vaccines/covid-19/eua/pfizer.html	https://www.cdc.gov/vaccines/covid-19/eua/pfizer.pdf	0886983000332

Note: *The URL document links shown above will not be activated until FDA EUA authorization and the final FDA approved EUA Recipient/Caregiver Fact Sheet is available. The edition date is the barcode generated-date and does not reflect the exact date of the EUA-issued Recipient/Caregiver Fact Sheet.*

CDC IIS Vaccine Codes

The codes shown below were developed in advance of potential EUA decision by FDA for each vaccine and can be downloaded from the CDC IIS Vaccine Code Sets web pages (or https://www.cdc.gov/vaccines/programs/iis/code-sets.html).

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Preview Posting of COVID-19 Vaccine Codes and Crosswalk. Provided in anticipation of potential vaccine availability under Emergency Use Authorization (EUA). Data as of 11/11/2020. Codes will become effective only upon EUA issuance of COVID-19 vaccine(s) by the Food and Drug Administration (FDA). All CVX Codes are association to the new Vaccine Group "COVID-19"											
CVX Code	**CVX Long Description**	**CVX Short Description**	**Sale Proprietary Name**	**Sale Labeler**	**MVX Code**	**Unit of Sale NDC10 (UOS)**	**UoS Package**	**Unit of Use NDC10 (UOU)**	**Presentation**	**CPT Code**	**CPT Description**
207	SARS-COV-2 (COVID-19) vaccine, mRNA, spike protein, LNP, preservative free, 100 mcg/0.5mL dose	COVID-19, mRNA, LNP-S, PF, 100 mcg/ 0.5 mL dose	Moderna COVID-19 Vaccine	Moderna US, Inc.	MOD	80777-273-99	CARTON, 10 MULTI-DOSE VIALS	80777-273-10	MULTI-DOSE VIAL, 10 DOSES	91301	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use
208	SARS-COV-2 (COVID-19) vaccine, mRNA, spike protein, LNP, preservative free, 30 mcg/0.3mL dose	COVID-19, mRNA, LNP-S, PF, 30 mcg/0.3 mL dose	Pfizer COVID-19 Vaccine	Pfizer-BioNTech	PFR	59267-1000-2	CARTON, 195 MULTI-DOSE VIALS	59267-1000-1	MULTI-DOSE VIAL, 5 DOSES	91300	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL_dosage, diluent reconstituted, for intramuscular use
208	SARS-COV-2 (COVID-19) vaccine, mRNA, spike protein, LNP, preservative free, 30 mcg/0.3mL dose	COVID-19, mRNA, LNP-S, PF, 30 mcg/0.3 mL dose	Pfizer COVID-19 Vaccine	Pfizer-BioNTech	PFR	59267-1000-3	CARTON, 25 MULTI-DOSE VIALS	59267-1000-1	MULTI-DOSE VIAL, 5 DOSES	91300	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL_dosage, diluent reconstituted, for intramuscular use

CPT Codes

- The Current Procedural Terminology (CPT) code effective date for the Pfizer COVID-19 Vaccine is 12/11/2020.
- The (CPT) code effective date for the Moderna COVID-19 Vaccine is pending EUA approval.

AMERICAN OVERSIGHT

From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Wednesday, December 23, 2020 8:17 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>; Otis, Aaron <Aaron.Otis@flhealth.gov>; Dick, Cindy <Cindy.Dick@flhealth.gov>
Subject: FW: CDC Vaccine Cards
Attachment(s): "2020-COVID-19-shot-card-2b.pdf"

FYSA – CDC vaccine cards are attached.

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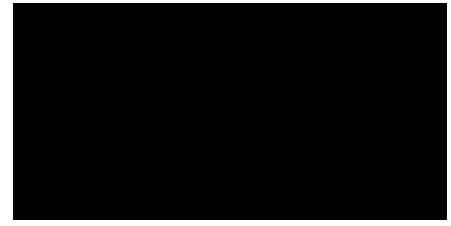
COVID-19 Vaccination Record Card



Please keep this record card, which includes medical information about the vaccines you have received.

Por favor, guarde esta tarjeta de registro, que incluye información médica sobre las vacunas que ha recibido.

Last Name | First Name | MI

Date of birth | Patient number *(medical record or IIS record number)*

Vaccine	Product Name/Manufacturer Lot Number	Date	Healthcare Professional or Clinic Site
1st Dose COVID-19		___/___/___ *mm dd yy*	
2nd Dose COVID-19		___/___/___ *mm dd yy*	
Other		___/___/___ *mm dd yy*	
Other		___/___/___ *mm dd yy*	

FL-DEM-21-0173-A-000248

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Reminder! Return for a second dose!

¡Recordatorio! ¡Regrese para la segunda dosis!

Vaccine	Date / Fecha
COVID-19 vaccine Vacuna contra el COVID-19	_____/_____/_____ mm dd yy
Other Otra	_____/_____/_____ mm dd yy

Bring this vaccination record to every vaccination or medical visit. Check with your health care provider to make sure you are not missing any doses of routinely recommended vaccines.

For more information about COVID-19 and COVID-19 vaccine, visit **cdc.gov/coronavirus/2019-ncov/index.html**.

You can report possible adverse reactions following COVID-19 vaccination to the Vaccine Adverse Event Reporting System (VAERS) at **vaers.hhs.gov**.

Lleve este registro de vacunación a cada cita médica o de vacunación. Consulte con su proveedor de atención médica para asegurarse de que no le falte ninguna dosis de las vacunas recomendadas.

Para obtener más información sobre el COVID-19 y la vacuna contra el COVID-19, visite **espanol.cdc.gov/coronavirus/2019-ncov/index.html**.

Puede notificar las posibles reacciones adversas después de la vacunación contra el COVID-19 al Sistema de Notificación de Reacciones Adversas a las Vacunas (VAERS) en **vaers.hhs.gov**.

FL-DEM-21-0173-A-000240
AMERICAN OVERSIGHT

From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Wednesday, December 16, 2020 8:59 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>; DEM All Staff <DEM@em.myflorida.com>
Subject: FW: CMS info - helpful links

Per HHS

Several helpful links of information about COVID-19 from CMS. Please share.

https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page

https://www.cms.gov/covidvax

https://www.cms.gov/medicare/covid-19/coding-covid-19-vaccine-shots

https://www.cms.gov/medicare/covid-19/medicare-billing-covid-19-vaccine-shot-administration

https://www.cms.gov/medicare/covid-19/medicare-covid-19-vaccine-shot-payment

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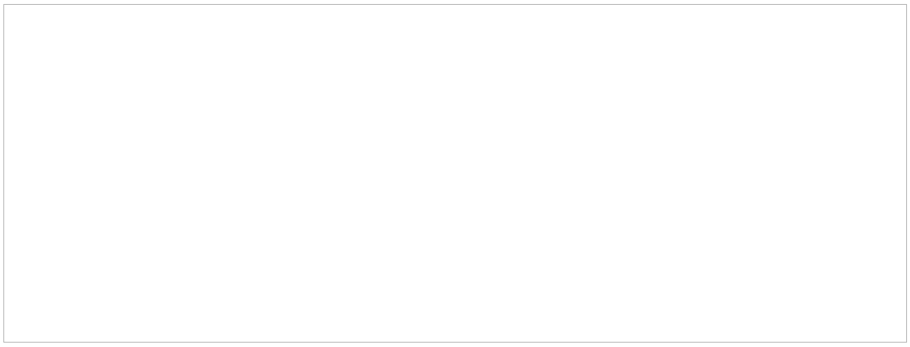
From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Monday, January 04, 2021 8:30 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>
Subject: FW: COVID-19 Clinical Rounds: Weekly Training Opportunities

Per HHS.

Subject: COVID-19 Clinical Rounds: Weekly Training Opportunities



Regional Ebola and Other Special Pathogen Treatment Centers*

COVID-19 CLINICAL ROUNDS

A Peer to Peer Virtual Community of Practice

Weekly Training Opportunities

EMS Medical Director Perspectives
Monday, January 4, 12:00pm EST
Click here for registration

Update on Critical Care Challenges and Successes
Tuesday, January 5, 12:00pm EST
Click here for registration

HHS COVID-19 Outpatient Therapeutics Miniseries
Wednesday, January 6, 12:00pm EST
Click here for registration

Emergency Department: Update on Emergency Physicians
Thursday, January 7, 12:00pm EST
Click here for registration

Resources from past sessions are below

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***Regional Ebola and Other Special Pathogen Treatment Centers**
Massachusetts General Hospital (Boston, Massachusetts)
New York City Health and Hospitals Corporation/HHC Bellevue Hospital Center (New York City, New York)
Johns Hopkins Hospital (Baltimore, Maryland)
Emory University Hospital and Children's Healthcare of Atlanta/Egleston Children's Hospital (Atlanta, Georgia)
University of Minnesota Medical Center (Minneapolis, Minnesota)
University of Texas Medical Branch at Galveston (Galveston, Texas)
Nebraska Medicine – Nebraska Medical Center (Omaha, Nebraska)
Denver Health Medical Center (Denver, Colorado)
Cedars-Sinai Medical Center (Los Angeles, California)
Providence Sacred Heart Medical Center and Children's Hospital (Spokane, Washington)

Please join us for a new series:

HHS/ASPR COVID-19 Outpatient Therapeutics Mini-Series

Wednesdays 12:00 PM - 1:00 PM EST
Next session is January 6, 2021

For Registration and Connection Information
Please Click Here

This mini-series will provide a deep dive on new and emerging COVID-19 outpatient therapeutics, including monoclonal antibodies. The goal of this mini-series is to equip clinicians with the appropriate knowledge, resources, and tools needed to initiate and scale administration of these therapies and reduce strain on the U.S. healthcare system.

Topics to be covered include:

- Clinical trials and drug efficacy
- Best practices from the field (e.g., workflows, training, IT)
- Priority settings (e.g., nursing homes, federally qualified health centers)
- Ethical issues (e.g., equitable access, prioritization of highest-risk patients)
- Considerations for use of vaccine and therapeutics

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Resources

AAMC COVID-19 Clinical Guidance Repository:
https://www.aamc.org/covid-19-clinical-guidance-repository

ASPR's Technical Resources, Assistance Center, and Information Exchange (TRACIE) Novel Coronavirus Resources:
https://asprtracie.hhs.gov/covid-19

CDC COVID-19 Resources for Health Care Professionals:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html

NETEC, the National Emerging Special Pathogen Training and Education Center:
https://netec.org/

SCCM COVID-19 Guidelines:
https://www.sccm.org/SurvivingSepsisCampaign/Guidelines/COVID-19

WHO COVID-19 Technical Guidance:
https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance

WHO COVID-19 Situation Reports:
https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports

Please be mindful of COVID-2019 infection prevention and control, try to limit numbers of people joining this learning session from one gathering place and practice social distancing.
WHO guidance on getting workplaces ready for COVID-2019

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Special Sessions

Pediatrics - May 22

- Evelina Children's Hospital Presentation
- Emory University Presentation
- Session Recording

Innovative PPE Preservation Strategies - May 8

- Mount Sinai Presentation
- University of Nebraska Presentation
- Session Recording

Long Term Care Facilities - May 1

- FutureCare Presentation
- Pittsburgh/VA Presentation
- Session Recording

Ventilation Support Strategies - April 10

- Providence Presentation
- LSU Presentation
- Session Recording

Dexamethasone and Other Steroids - July 2

- Bellevue Presentation
- Session Recording

Transitions of Care - August 4

- Bellevue Presentation
- AMDA Presentation
- Session Recording

Update on Remdesivir and Dexamethasone - Oct 1

- Emory Presentation
- Massachusetts General Presentation
- Session Recording

Home Health, EMS, Emergency Department and Critical Care - Oct 29

- Dignity Health Presentation
- VNA Presentation
- Session Recording

Monoclonal Antibodies - Dec 3

- OSUMC Presentation
- Session Recording

Crisis Care Update - Dec 10

- University of Minnesota Presentation
- Session Recording

100th Session - Dec 15

- Session recording

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COVID-19 Clinical Rounds: Critical Care Resources

Dec 8 - Update on Long Term Patient Care Challenges

- Emory Presentation
- Session Recording (coming soon)

Dec 1 - Medical Operations Coordination

- University of Nebraska Presentation
- Session Recording

Nov 17 - Update on Convalescent Plasma

- Mount Sinai Presentation
- Session Recording

For earlier presentations and recordings, please visit the Project ECHO COVID-19 Webpage

COVID-19 Clinical Rounds: Emergency Department Resources

Dec 17 - Innovative PPE Strategies

- Get Us PPE Presentation
- Session Recording

Nov 19 - Javits Center - Alternate Care Sites Revisited

- Javits Center Presentation
- Session Recording

Nov 12 - All India Institute of Medical Sciences

- India Presentation
- Session Recording

For earlier presentations and recordings, please visit the Project ECHO COVID-19 Webpage

COVID-19 Clinical Rounds: EMS Resources

Dec 14 - EMS Crisis Care

- Colorado Presentation
- Session Recording

Dec 7 - Vaccination and Infusion Activities

- Florida Presentation
- Medstar Presentation
- Session Recording (coming soon)

Nov 30 - Complacency: COVID breach at a rural fire department

- Upper Pine River FD Presentation
- Session Recording

For earlier presentations and recordings, please visit theProject ECHO COVID-19 Webpage

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Please direct any additional questions or concerns to

C19echo@salud.unm.edu

For help with connecting, please call (505) 750-4897 or email echoit@salud.unm.edu

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ECHO is a movement to demonopolize knowledge and amplify the capacity to provide best practice care for underserved people all over the world.

Project ECHO® collects registration, participation, questions/answers, chat comments, and poll responses for some teleECHO® programs. Your individual data will be kept confidential. These data may be used for reports, maps, communications, surveys, quality assurance, evaluation, research, and to inform new initiatives.

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https://www.facebook.com/UNMProjectECHO https://twitter.com/ProjectECHO

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AMERICAN OVERSIGHT

From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Thursday, January 07, 2021 5:56 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: Molly.McKinstry@ahca.myflorida.com <Molly.McKinstry@ahca.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
Subject: FW: COVID-19 Vaccinations for Assisted Living Facilities

---

From: McKinstry, Molly <Molly.McKinstry@ahca.myflorida.com>
Sent: Thursday, January 7, 2021 5:46 PM
To: Rosenstein, Jared <Jared.Rosenstein@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>
Subject: FW: COVID-19 Vaccinations for Assisted Living Facilities

fyi

From: McKinstry, Molly
Sent: Thursday, January 7, 2021 4:01 PM
To: Cindy Dick (Cindy.dick@flhealth.gov) <cindy.dick@flhealth.gov>; Courtney Coppola (Courtney.Coppola@flhealth.gov) <Courtney.Coppola@flhealth.gov>; Bussey, Jon <jon.bussey@em.myflorida.com>; Tina Vidal <Tina.Vidal@cdrmaguire.com>; McCoy, Steve <steve.mccoy@flhealth.gov>; aaron.otis@flhealth.gov
Subject: FW: COVID-19 Vaccinations for Assisted Living Facilities

Please see eblast sent to all ALFs today -thanks – Molly

From: State of Florida Agency for Health Care Administration <AHCANotice@ahca.myflorida.com>
Sent: Thursday, January 7, 2021 3:56 PM
Subject: [External] COVID-19 Vaccinations for Assisted Living Facilities

RON DESANTIS
GOVERNOR

SHEVAUN L. HARRIS
ACTING SECRETARY

AMERICAN OVERSIGHT

January 7, 2021

COVID-19 Vaccinations for Assisted Living Facilities

In accordance with Governor DeSantis' efforts to expedite vaccinations for assisted living facility residents and staff, the Division of Emergency Management has contracted with CDR Health to vaccinate assisted living facilities that are not scheduled for their initial vaccine clinic with CVS or Walgreens on or before January 23. CDR Health will be contacting assisted living facilities to make arrangements for vaccinations.

Assisted living facilities will receive three clinic dates from CDR Health –

- Clinic 1: Initial vaccinations of staff and resident
- Clinic 2: Second dose vaccinations for those who were vaccinated at Clinic 1, and initial vaccinations for additional/new staff and residents
- Clinic 3: Second dose vaccinations for those who received initial vaccinations during Clinic 2

All second doses will be fulfilled by the provider of the first dose, so any ALF served by CVS or Walgreens will finish second doses with that same provider.

CDR Health will provide all consent forms to be used and share this information when initial contact is made to arrange an onsite clinic.

A representative from CDR Health will join the weekly Long-Term Care 4:15 call to discuss the program. Questions of CDR Health may be submitted to Ltcvaccines@cdrmaguire.com.

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The Agency for Health Care Administration is committed to better health care for all Floridians. The Agency administers Florida's Medicaid program, licenses and regulates more than 44,000 health care facilities and 53 health plans, and publishes health care data and statistics at www.FloridaHealthFinder.gov. Additional information about Agency initiatives is available via Facebook (AHCAFlorida), Twitter (@AHCA_FL) and YouTube (/AHCAFlorida).

Agency for Health Care Administration | 2727 Mahan Drive, Tallahassee, FL 32308 | http://ahca.myflorida.com

This message was sent to Matthew.Ward@ahca.myflorida.com from:

State of Florida Agency for Health Care Administration |AHCANotice@ahca.myflorida.com | AHCA | 2727 Mahan Drive, Ft. Knox Bldg. #1, Room 136 | Tallahassee, FL 32308

Manage Your Subscription

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AMERICAN OVERSIGHT

From: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Sent: Saturday, January 16, 2021 7:59 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Subject: FW: CVS dashboard

Kevin Guthrie | Deputy Director
Office: (850) 815-4101
Cell: (850) 294-8250
Kevin.Guthrie@em.myflorida.com

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Friday, January 15, 2021 9:24 PM
To: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>; DeCastro, Kenneth <Kenneth.DeCastro@em.myflorida.com>; Dick, Cindy <Cindy.Dick@flhealth.gov>; Molly McKinstry <Molly.McKinstry@ahca.myflorida.com>; Scott A Rivkees <Scott.Rivkees@flhealth.gov>; Courtney F. Coppola <Courtney.Coppola@flhealth.gov>; Aaron Otis <aaron.otis@flhealth.gov>
Subject: CVS dashboard

Earlier today the link was asked for, just in case it has not been received.

CVS does currently have a publicly available breakdown on their website https://cvshealth.com/covid-19/vaccine-information/vaccination-data and announced in attached press release. I have not seen anything on Walgreens and just checked their website and didn't see anything either.

Jeanne

Sent from my iPhone

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From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Thursday, December 17, 2020 4:14 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>
Subject: FW: Everyone Can Make Winter Holiday Celebrations Safer

FYSA – Per HHS/CDC.

This message includes updates on the COVID-19 response from CDC. This is a rapidly evolving situation and information will be updated as it becomes available.

Received this email from a friend? Sign up now

View this email in your web browser

Coronavirus Disease 2019 (COVID-19)

December 17, 2020

This message includes updates on the COVID-19 response from CDC. The COVID-19 Outbreak is a rapidly evolving situation and information will be updated as it becomes available.

A home is shown with a few individuals outdoors in a snowy setting. Individuals are all maintaining distance from each other.

The safest way to celebrate winter holidays is at home with the people who live with you. Travel and gatherings with family and friends who do not live with you can increase your chances of getting or spreading COVID-19 or the flu.

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Everyone Can Make Winter Holiday Celebrations Safer

Celebrating virtually or with the people you live with is the safest choice this winter. If you do gather with people who don’t live with you, gatherings and activities held outdoors are safer than indoor gatherings.

- Wear a mask indoors and outdoors
- Stay at least 6 feet away from others who do not live with you
- Avoid crowded, poorly ventilated indoor spaces
- Wash your hands
- Get a flu shot as soon as possible

Safer Celebrations

Celebrating virtually or with the people you live with is the safest choice this winter.

If you do gather with people who don’t live with you, gatherings and activities held outdoors are safer than indoor gatherings.

Attending a Winter Holiday Celebration

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Celebrating virtually or with the people you live with is the safest choice this winter. If you do gather with people who don't live with you, gatherings and activities held outdoors are safer than indoor gatherings.

Hosting a Winter Holiday Celebration

If you choose to have guests at your home, you can make it safer by

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If you choose to have guests at your home, you can make your celebration safer by

- Limit the number of guests.
- Have a small, outdoor celebration with family and friends who live in your community, weather-permitting.
- Have extra unused masks available for your guests and encourage everyone to wear them inside and outside.
- Clean and disinfect frequently touched surfaces and items between use.
- Use single-use options, like salad dressing and condiment packets, and disposable items like food containers, plates, and utensils.
- Use a touchless garbage can, if available.
- Cancel your gathering if you or someone who lives with you is sick or has been near someone who thinks they have or has COVID-19.

Consider Other Winter Holiday Activities

- Schedule a time to eat a meal together virtually.
- Host a virtual “ugly” holiday sweater contest.
- Schedule a time to meet virtually to open gifts together.
- Build gingerbread houses, decorate cookies, or make holiday crafts and decorations.
- Drive or walk around your community to look at decorations from a safe distance or drive through a local holiday light display.
- Throw a virtual dance party.

Enjoy the winter weather, if you live somewhere with snow

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- Hold a snowman or snow angel contest with neighbors or friends in your community.
- Build a snow fort or other snow structure.

Volunteer to help others in need

- Reach out to your local community service organizations to get involved and give back. Make sure to ask about their safety precautions in advance.
- Find virtual opportunities to contribute.

Coronavirus Disease 2019 (COVID-19) in the U.S.

As of December 16, 2020

In the United States, there have been 16,519,668 confirmed cases of COVID-19 detected through U.S. public health surveillance systems in 50 states and the District of Columbia, Puerto Rico, Guam, the Northern Marianas Islands, and U.S. Virgin Islands.

CDC provides updated U.S. case information online daily.

In addition to cases, deaths, and laboratory testing, CDC's COVID Data Tracker now has a County View to help make decisions about everyday activities.

U.S. Cases

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FL-DEM-21-0173-A-000265

1600 Clifton Rd Atlanta, GA 30329 1-800-CDC-INFO (800-232-4636) TTY: 888-232-6348
Questions or Problems | Unsubscribe

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From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Tuesday, February 02, 2021 2:39 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>; Bureau Response <BureauResponse@em.myflorida.com>
Subject: FW: FACT SHEET: President Biden Announces Increased Vaccine Supply, Initial Launch of the Federal Retail Pharmacy Program, and Expansion of FEMA Reimbursement to States

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Sent: Tuesday, February 2, 2021 2:27 PM
Subject: FW: FACT SHEET: President Biden Announces Increased Vaccine Supply, Initial Launch of the Federal Retail Pharmacy Program, and Expansion of FEMA Reimbursement to States

The White House Logo

FACT SHEET: President Biden Announces Increased Vaccine Supply, Initial Launch of the Federal Retail Pharmacy Program, and Expansion of FEMA Reimbursement to States

States, Tribes, and territories will receive a 5 percent supply increase this week, and Americans will soon have easier access to vaccinations through local pharmacies

As the U.S. surpasses 26 million COVID-19 infections, President Biden took additional steps today to implement his comprehensive National Strategy to combat the COVID-19 pandemic. These steps include increasing the vaccine supply to states, Tribes, and territories and increasing funding to jurisdictions to help turn vaccines into vaccinations. And, the President announced that starting next week, the first phase of the federal pharmacy program will launch and select pharmacies nationwide will start offering vaccinations for their communities.

These new steps will help meet the President's goal of administering 100 million shots in 100 days and expand access to vaccines to more Americans in the coming weeks.

The President is taking the following actions today:

Expanding Vaccine Supply: Building on last week's announcement, the Biden-Harris Administration will increase overall, weekly vaccine supply to states, Tribes, and territories to 10.5 million doses nationwide beginning this week. This is a 22% increase since taking office on January 20. The Administration is committing to maintaining this as the minimum supply level for the next three weeks, and we will continue to work with manufacturers in their efforts to ramp up supply.

Launching First Phase of the Federal Retail Pharmacy Program for COVID-19 Vaccination: As part of the Biden-Harris Administration's efforts to increase access to COVID-19 vaccines, starting on February 11, those eligible for the vaccine will have the opportunity to be vaccinated at select pharmacies across the country through the Federal Retail Pharmacy Program for COVID-19 Vaccination. This program is a public-private partnership with 21 national pharmacy partners and networks of independent pharmacies representing over 40,000 pharmacy locations nationwide (listed below). It is a key component of the Administration's National Strategy to expand equitable access to vaccines for the American public.

As the first phase of this program launches, select retail pharmacies nationwide will receive limited vaccine supply to vaccinate priority groups at no cost. The Centers for Disease Control and Prevention (CDC) worked with states to select initial pharmacy partners based on a number of factors including their ability to reach some of the populations most at risk for severe illness from COVID-19. Americans should check their pharmacy's website to find out if vaccine is available as supply will be limited in the initial phase. More information is available at cdc.gov/covid19.

Increasing Reimbursements to States: Central to the Biden-Harris Administration's COVID-19 National Strategy is ensuring states, Tribes, territories, and jurisdictions have the resources they need to defeat the virus. That's why, in his second day in office, President Biden directed the Federal Emergency Management Agency (FEMA) to fully reimburse states for the cost of National Guard Personnel and emergency costs. Today, President Biden is announcing that the administration will go even further, retroactively reimbursing states fully for FEMA-eligible services – including masks, gloves, emergency feeding actions, sheltering at risk populations, and mobilization of the National Guard - back dated to the beginning of the pandemic in January 2020. This reimbursement is estimated to total $3-5 billion and is only a small share of the resources that states need to fight this pandemic — including for testing, genomic sequencing, and mass vaccination centers. To fully support states, Tribes, and territories' needs to contain the pandemic and vaccinate their populations, President Biden is requesting $350 billion from Congress in American Rescue Plan.

Participating Federal Pharmacy Partners (not all will be active in every state in initial phase)

Chain Pharmacies **Network Administrators**

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1. Walgreens (including Duane Reade)
2. CVS Pharmacy, Inc. (including Long's)
3. Walmart, Inc. (including Sam's Club)
4. Rite Aid Corp.
1. The Kroger Co. (including Kroger, Harris Teeter, Fred Meyer, Fry's, Ralphs, King Soopers, Smiths, City Market, Dillons, Mariano's, Pick-n-Save, Copps, Metro Market)
2. Publix Super Markets, Inc.
3. Costco Wholesale Corp.
4. Albertsons Companies, Inc. (including Osco, Jewel-Osco, Albertsons, Albertsons Market, Safeway, Tom Thumb, Star Market, Shaw's, Haggen, Acme, Randalls, Carrs, Market Street, United, Vons, Pavilions, Amigos, Lucky's, Pak n Save, Sav-On)
5. Hy-Vee, Inc.
1. Meijer Inc.
2. H-E-B, LP
3. Retail Business Services, LLC (including Food Lion, Giant Food, The Giant Company, Hannaford Bros Co, Stop & Shop)
4. Winn-Dixie Stores Inc. (including Winn-Dixie, Harveys, Fresco Y Mas)
1. Topco Associates, LLC (including Acme Fresh Markets, Associated Food Stores, Big-Y Pharmacy and Wellness Center, Brookshire's Pharmacy, Super One Pharmacy, FRESH by Brookshire's Pharmacy, Coborn's Pharmacy, Cash Wise Pharmacy, MarketPlace Pharmacy, Giant Eagle, Hartig Drug Company, King Kullen, Food City Pharmacy, Ingles Pharmacy, Raley's, Bel Air, Nob Hill Pharmacies, Save Mart Pharmacies, Lucky Pharmacies, SpartanNash, Price Chopper, Market 32, Tops Friendly Markets, ShopRite, Wegmans, Weis Markets, Inc.)
2. CPESN USA, LLC
3. GeriMed (long-term care and retail pharmacies)
4. Good Neighbor Pharmacy and AmerisourceBergen Drug Corporation's pharmacy services administrative organization (PSAO), Elevate Provider
5. Health Mart Systems, Inc.
6. Innovatix (long-term care pharmacies)
7. LeaderNET and Medicine Shoppe, Cardinal Health's PSAOs
8. Managed Health Care Associates (retail and long-term care pharmacies)

Eduardo Cisneros

COVID-19 Intergovernmental Affairs Director

The White House

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AMERICAN OVERSIGHT

From: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Sent: Thursday, February 04, 2021 7:12 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Subject: FW: FEMA Statement on 100% Cost Share

Kevin Guthrie | Deputy Director
Office: (850) 815-4101
Cell: (850) 294-8250
Kevin.Guthrie@em.myflorida.com

From: Szczech, Gracia <Gracia.Szczech@fema.dhs.gov>
Sent: Wednesday, February 3, 2021 9:18 PM
To: Hastings, Brian <brian.hastings@ema.alabama.gov>; McCraney, Stephen <smccraney@mema.ms.gov>; Moskowitz, Jared <Jared.Moskowitz@em.myflorida.com>; James.stallings@gema.ga.gov; michael.e.dossett@ky.gov; Sprayberry, Mike A <mike.sprayberry@ncdps.gov>; Kstenson@emd.sc.gov; Sheehan, Patrick (TN) <patrick.sheehan@tn.gov>; Dawson, Charlie (GEMA) <charlie.dawson@gema.ga.gov>; Gaddy, Jonathan <Jonathan.Gaddy@ema.alabama.gov>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Ray, William C. (Will) <will.ray@ncdps.gov>; Melisa Hucks <Melisa.Hucks@tn.gov>; Batson, Steven <sbatson@emd.sc.gov>; Hewings, Matthew <mhewings@mema.ms.gov>
Cc: Samaan, Robert <Robert.Samaan@fema.dhs.gov>; Terry, Quarles (FEMA) <Terry.Quarles@fema.dhs.gov>; Gary, Bruey (FEMA) <Gary.Bruey@fema.dhs.gov>; Hudak, Mary <Mary.Hudak@fema.dhs.gov>; Baker, Stuart <Stuart.Baker@fema.dhs.gov>; Toro, Manny J <Manny.Toro@fema.dhs.gov>; Sachtleben, Glen <Glen.Sachtleben@fema.dhs.gov>; Strouse, Philip <Philip.Strouse@fema.dhs.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Bowman, Thomas (OGA) <thomas.bowman@hhs.gov>
Subject: FEMA Statement on 100% Cost Share

State Directors,

FEMA is committed to supporting our state, local, tribal and territorial partners responding to the COVID-19 pandemic.

On Feb. 2, the President issued a directive allowing FEMA to pay 100% federal funding for the costs of previously eligible activities from the beginning of the pandemic in January 2020 to Sept. 30, 2021. No action will be required by applicants.

This directive also allows FEMA to expand the activities eligible for reimbursement for work conducted after Jan. 21, 2021 and until Sept. 30, 2021.

Visit FEMA Statement on 100% Cost Share | FEMA.gov for more information about these changes.

Terry Quarles will be prepared to answer any questions on our 1 PM Eastern State Director call tomorrow.

Thank you,

Gracia and Robert

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From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Wednesday, February 03, 2021 2:09 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>
Subject: FW: HHS COVID-19 Update 2/2

Per HHS

==========

Dear Partner,

HHS Intergovernmental and External Affairs Update for February 2, 2021:

COVID-19 Updates from the White House

COVID-19 Response Team Update and Information on the Launch of the Federal Retail Pharmacy Program: Jeff Zients, COVID-19 Response Team coordinator provided an update today on steps being taken to enact President Biden's National Action Strategy to change the course of this pandemic. During the briefing, he highlighted recent actions to further increase vaccine supply, expansions to the number of sites for vaccinations, and additional support for states. "Starting February 11, the Federal Government will supply vaccines directly to select pharmacies across the country. This will provide more sites for people to get vaccinated in their communities and it's an important component to delivering vaccines equitably," Zients noted. "Equity is at the core of how the CDC is working with states to select pharmacy partners for this first phase. Sites are selected based on their ability to reach some of the populations most at risk for severe illness from COVID-19, including socially vulnerable communities." The pharmacies participating will initially have limited supply and will be rollout out to 6,500 stores nationwide prior to expansion.

Maximizing Assistance from FEMA to Provide Additional Funding and Support to States: The White House released a memo on Maximizing Assistance from the Federal Emergency Management Agency. President Biden noted that "it is the policy of my Administration to combat and respond to COVID-19 with the full capacity and capability of the Federal Government to protect and support our families, schools, and businesses, and to assist State, local, Tribal, and territorial governments to do the same, including through emergency and disaster assistance available from the Federal Emergency Management Agency (FEMA)." As part of the memo, states, Territories and tribes will be fully reimbursed retroactively from January 20, 2020 and going forward for FEMA-eligible services – including masks, gloves, emergency feeding actions, sheltering at risk populations, and mobilization of the National Guard.

Additional Details on Increasing Vaccine Supply, Initial Launch of the Federal Retail Pharmacy Program, and Expansion of FEMA Reimbursement to States: The Biden Administration released a Fact Sheet on the additional steps announced today to implement his comprehensive National Strategy to combat the COVID-19 pandemic. These steps include increasing the vaccine supply to states, Tribes, and territories to 10.5 million doses nationwide and securing the equipment to extract a 6th dose from Pfizer's vials , and increasing funding to jurisdictions to help turn vaccines into vaccinations. And, the President announced that starting next week on February 11, the first phase of the federal pharmacy program will launch and select pharmacies nationwide will start offering vaccinations for their communities.

State Profile Reports: HHS and the White House COVID-19 response team have released the weekly state profile snapshot. The purpose of this report is to develop a shared understanding of the current status of the pandemic at the national, regional, state, and local levels.

Testing and Treatment

Rapid, Over-the-Counter in Vitro Diagnostic Test For influenza A/B and SARS-CoV-2: BARDA and Visby Medical partner to develop a rapid, hand-held, point-of-care and over-the-counter in vitro diagnostic test for influenza A/B and SARS-CoV-2. The Visby Personal PCR test is being developed to help diagnose and distinguish rapidly between cases of influenza A, influenza B and SARS-CoV-2 viral infections from a single nasal swab sample, facilitating decisions about appropriate patient care and management including quarantine, as necessary.

Text-based Virtual Care to Assess, Diagnose and Treat COVID-19: BARDA released an innovation project spotlight on 98point6, which developed a program that records de-identified, suspected COVID-19 cases, and uses this information to better understand disease transmission, potential hot spots, incidence of COVID-19 cases among different population groups, and self-reported vaccination status. Initially developed as a data analytics tool for treating and reporting influenza, BARDA has worked with 98point6's primary care telemedicine platform to expand screening and reporting of COVID-19. This tool combines their on-demand, text-based telemedicine services with automated COVID-19 screening via a questionnaire for patients experiencing fever or respiratory symptoms. 98point6 then creates daily and weekly reports of respiratory illness activity by zip code locations, which helps to identify near real-time hot spots as they are developing.

Antibody Tests to Test for Past Infection: CDC updated information on antibody or serology tests. Antibody and serology tests look for antibodies in your blood to determine if you had a past infection with the virus that causes COVID-19. Antibody tests should not be used to diagnose a current infection with the virus that causes COVID-19, except in instances in which viral testing is delayed. An antibody test may not show if you have a current infection because it can take 1–3 weeks after the infection for your body to make antibodies.

Blood Thinners and COVID-19: NIH Director Collins posted a blog on blood thinners and COVID-19. Interim findings based on

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more than 1,000 moderately ill patients suggest that individuals hospitalized, but not severely ill, with COVID-19 who received a full intravenous dose of the common blood thinner heparin were less likely to need vital organ support, including mechanical ventilation, compared to those who received the lower "prophylactic" subcutaneous dose. More study is needed to sort out all the details about when more aggressive blood thinning treatment is warranted. Trial investigators are now working to make the full results available to help inform a doctor's decisions about how to best to treat their patients hospitalized with COVID-19.

Laboratories: CDC has updated their information for laboratories about COVID-19. This page provides resources on testing, FAQs and much more.

Healthcare Workers: CDC has updated their information on COVID-19 for healthcare workers. This page provides guidance for managing patients with COVID-19, vaccine administration, and much more.

Travel Updates

Travel: CDC has updated their resource page on all things travel related. View CDC's travel FAQs. Find all current travel heath notices here.

Testing and International Air Travel: Air travel requires spending time in security lines and airport terminals, which can bring you in close contact with other people and frequently touched surfaces. Testing before and after travel can reduce the risk of spreading COVID-19. Testing does not eliminate all risk, but when paired with a period of staying at home and everyday precautions like wearing masks and social distancing, it can make travel safer by reducing spread on planes, in airports, and at destinations. As a reminder, all air passengers coming to the United States, including U.S. citizens, are **required** to have a negative COVID-19 test result or documentation of recovery from COVID-19 before they board a flight to the United States and masks are required.

When to Delay Travel: Travel increases your chance of spreading and getting COVID-19. CDC recommends that you do not travel at this time. Postpone travel and stay home to protect yourself and others from COVID-19.

Know Your Travel Risk: If you must travel, learn which travel activities are safer and take the following steps to protect yourself and others from COVID-19. Keep in mind that getting from one place to another is just one piece of the travel risk. Your activities and who you interact with before, during, and after travel may increase your risk.

Cruise Ship Travel: CDC recommends that all people avoid travel on cruise ships, including river cruises, worldwide. That's because the chance of getting COVID-19 on cruise ships is high, since the virus appears to spread more easily between people in close quarters aboard ships.

Returning from International Travel: You may have been exposed to COVID-19 on your travels. You may feel well and not have any symptoms, but you can be contagious without symptoms and spread the virus to others. You and your travel companions (including children) pose a risk to your family, friends, and community for 14 days after you travel.

Road Travel Toolkit for Transportation Partners: v CDC created this road travel toolkit for transportation departments and other partners to help reach domestic travelers with COVID-19 prevention messaging during road travel.

Information for Specific Populations

COVID-19 FAQs: CDC updated their frequently asked questions regarding COVID-19.

People with Certain Medical Conditions: Adults of any age with certain underlying medical conditions are at increased risk for severe illness from the virus that causes COVID-19. It is especially important for people at increased risk of severe illness from COVID-19, and those who live with them, to protect themselves from getting COVID-19.

Masks: CDC updated their resource page on masks.

Returning to Work: In general, the more closely you interact with others and the longer that interaction, the higher the risk of COVID-19 spread. If you return to work, continue to protect yourself by practicing everyday preventive actions. Keep these items on hand when returning to work: a mask, tissues, and hand sanitizer with at least 60% alcohol, if possible.

Agriculture Workers and Employers: Farm operations vary across regions of the country. This guidance provides a template of action to protect agriculture workers from coronavirus disease 2019 (COVID-19). Agricultural employers can adapt these recommendations to protect workers at their particular work sites or in specific work operations.

Meat and Poultry Processors: Meat and poultry processing facilities are a component of the critical infrastructure within the food and agriculture sector. CDC's guidance advises that critical infrastructure workers may be permitted to continue work following potential exposure to COVID-19, provided they remain asymptomatic, have not had a positive test result for COVID-19, and additional precautions are implemented to protect them and the community.

Manufacturing Workers and Employers: Manufacturing facilities are an integral part of the United States' supply chain. This document provides guidance for manufacturing workers and employers. All manufacturing facilities developing plans for continuing operations during the COVID-19 pandemic.

Employer Information for Transit Maintenance Workers: As a transit maintenance employer, your workforce might come into contact with the virus when: in close contact (within about 6 feet) with other people at the worksite, which can include passengers, coworkers, transit station workers, and transit operators, touching or handling high-contact surfaces and equipment, and then

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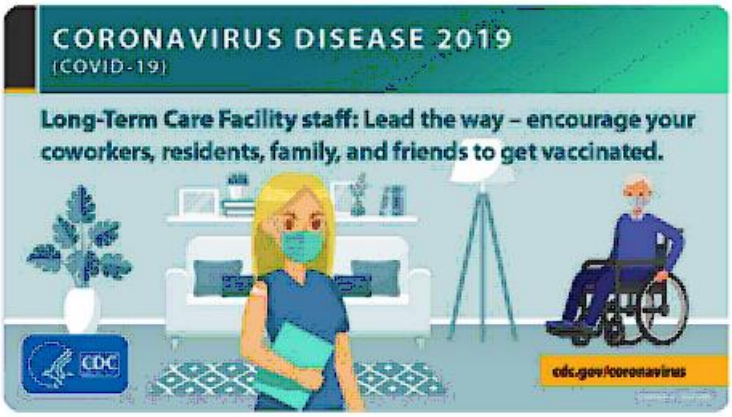
touching their face, mouth, nose, or eyes. Review the CDC resources for transit employers to ensure you protect your employees.

Newly Resettled Refugee Populations: Refugees to the United States, especially those who are recently resettled, may experience living arrangements or working conditions that put them at greater risk of getting COVID-19. Some refugees also have limited access to health care, as well as certain underlying medical conditions that put them at increased risk of severe illness from COVID-19, compared to the rest of the U.S. population.

Message to Long-Term Care Facility Workers and Vaccinations: In response to the CDC MMWR research findings of low rates of vaccination among staff in skilled nursing facilities, CDC posted a message for Long-Term Care facility staff: You have an essential role in fighting COVID-19. Your decision to get vaccinated can help protect more than just your health. You can lead the way for residents, colleagues, and others. Learn more: here.



Marvin Figueroa, Director
Office of Intergovernmental and External Affairs
U.S. Department of Health and Human Services
Washington, D.C.

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From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Tuesday, January 12, 2021 5:24 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>
Subject: FW: HHS OWS Briefing January 12, 2021

Per HHS – good intel on vaccine ops.

Subject: HHS OWS Briefing January 12, 2021

Here is a recording of the HHS Secretary OWS Briefing earlier today.
The recording will begin to play upon clicking the link. Secretary Azar begins at the 2:00 mark.

https://www.youtube.com/watch?v=UESMEGVoTsA

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From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Monday, January 04, 2021 2:30 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>
Subject: FW: HPH Sector Engagement Opportunities- January 4, 2021

Subject: HPH Sector Engagement Opportunities- January 4, 2021

Per HHS

Web Version

ASPR Masthead

The HPH Sector Engagement Opportunities

January 4, 2021

To Keep Stakeholders and Partners apprised of information sharing opportunities and resource webinars relevant to the Healthcare and Public Health community, this bulletin product is **shared twice weekly on Monday and Thursday.**

Monday, January 4

HHS/ASPR COVID-19 Clinical Rounds Learning Series
EMS: Patient Care and Operations
Monday, January 4, at 12:00 - 1:00 pm ET Click here for registration
Join EMS providers from across the country to discuss challenges faced in the COVID-19 response and what can be done to enhance patient care and emergency operations. The HHS/ASPR COVID-19. If you miss a session find the recordings online on the University of New Mexico's Project ECHO website . Click to join the HHS/ASPR COVID-19 Clinical Rounds email list .

Tuesday, January 5

HHS/ASPR COVID-19 Clinical Rounds Learning Series
Critical Care: Lifesaving Treatment and Clinical Operations
Tuesday, January 5 at 12:00 - 1:00 pm ET Click here for registration
This resource webinar is intended for consultant physicians involved in critical care practice, fellows, residents, pharmacists, nursing staff, nurse practitioners, physician assistants, respiratory therapists, & allied health staff. If you miss a session find the recordings online on the University of New Mexico's Project ECHO website . Click to join the HHS/ASPR COVID-19 Clinical Rounds email list .

Wednesday, January 6

HHS/ASPR COVID-19 Clinical Rounds Learning Series
COVID-19 Outpatient Therapeutics Mini-Series: Equitable Access
Wednesday, January 6 at 12:00 - 1:00 pm ET Click here for registration
This mini-series will provide a deep dive on new and emerging COVID-19 outpatient therapeutics, including monoclonal antibodies. The goal of this mini-series is to equip clinicians with the appropriate knowledge, resources, and tools needed to initiate and scale administration of these therapies and reduce strain on the U.S. healthcare system. If you miss a session find the recordings online on the University of New Mexico's Project ECHO website . Click to join the HHS/ASPR COVID-19 Clinical Rounds email list .

U.S. Food and Drug Administration (FDA)
Virtual Town Hall Series - Coronavirus (COVID-19) Test Development and Validation
Wednesday, January 6, at 12:15 pm ET Click here for connection information
FDA will host a virtual Town Hall for SARS-CoV-2 test developers. The purpose of this Town Hall is to help answer technical questions about the development and validation of tests for SARS-CoV-2.

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Thursday, January 7

HHS/ASPR COVID-19 Clinical Rounds Learning Series
Emergency Department: Patient Care and Clinical Operations
Thursday, January 7, at 12:00 - 1:00 pm ET Click here for registration
Join presenters to discuss emergency management resources and information that can be utilized to improve effective hospital and emergency department function during the COVID-19 pandemic. If you miss a session find the recordings online on the University of New Mexico's Project ECHO website . Click to join the HHS/ASPR COVID-19 Clinical Rounds email list .

Tuesday, January 19

U.S. Food and Drug Administration (FDA)
FDA Drug Topics: Biosimilar and Interchangeable Biological Products: An Updated Review of Scientific Concepts and Practical Resources
Tuesday, January 19, at 1:00 pm ET Click here for connection information
This webinar will provide an intermediate overview of the scientific concepts about biological products and the scientific and regulatory basis for the biosimilar pathway. In addition, we will review practical information regarding the use of these products, such as labeling, terminology, and pharmacy substitution. Lastly, the webinar will also demonstrate the functionality of the enhanced Purple Book resource that is available to health care professionals.

Wednesday, January 27

U.S. Food and Drug Administration (FDA)
OTC Monograph Reform in the CARES Act: Safety Orders
Wednesday, January 27, at 1:00 – 2:00 pm ET Click here for connection information
This webinar will provide an overview of nonprescription drugs, Over-the-Counter (OTC) Monograph Reform, and how FDA identifies and evaluates safety issues. Additionally, it will also explain the procedure for FDA-initiated administrative orders to address safety issues and how the public can participate in the administrative order process.

Friday, January 29

U.S. Food and Drug Administration (FDA)
Regulatory Perspectives for Development of Drugs for Treatment of NASH
Friday, January 29, at 1:00 – 2:30 pm ET Click here for connection information
This FDA will provide a summary of FDA's current thinking on the published draft guidance documents: Non-cirrhotic Non-alcoholic Steatohepatitis (NASH): Developing Drugs for Treatment, and Non-alcoholic Steatohepatitis in Compensated Cirrhosis: Developing Drugs for Treatment.

Friday, February 12

U.S. Food and Drug Administration (FDA)
Over-the-Counter Monograph Drug User Fee Program (OMUFA): Understanding User Fees Webinar
Friday, February 12, at 1:00 pm ET Click here for connection information
FDA will provide an overview of the Over-the-Counter Drug User Fee Program (OMUFA) and describe the key elements of the program as it relates to OMUFA user fees.

Comments and Questions

If you have comments or questions, send an email to CIP@hhs.gov. The CIP team will work to answer your inquiries or connect you to the proper entity.

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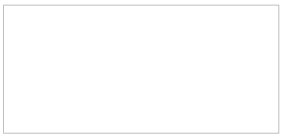

U.S. Department of Health & Human Services, Office of the Assistant Secretary for Preparedness & Response
200 C Street, SW
Washington, DC 20024

This email was sent by: U.S. Department of Health and Human Services
200 Independence Avenue, S.W., Washington, DC, 20201 US

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From: EOC-Plans <EOC-Plans@em.myflorida.com>
Sent: Wednesday, January 20, 2021 8:12 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Subject: Second Dose Planning Survey

Good morning County EM Directors,

In an effort to identify any potential operational needs related to second dose administration, please fill out the following survey on county second dose planning. Thank you.

https://www.surveymonkey.com/r/SecondDosePlanning

As possible and reasonable, please try and respond today.

Contact eoc-plans@em.myflorida.com for any questions.

Respectfully,

Ryan Lock
SERT Planning Section
EOC-Plans@em.myflorida.com

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From: Lock, Ryan <Ryan.Lock@em.myflorida.com>
Sent: Wednesday, January 20, 2021 1:01 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Subject: Second Dose Timelines

Good afternoon all,

Per the email below from Aaron Otis: "Second dose will be ordered this week for distribution next week. Once we submit we can provide a better timeline for delivery. However the earliest would be this Friday."

Respectfully,

Ryan Lock | Florida Division of Emergency Management
State Emergency Response Team | Planning Section Chief
Preparedness Bureau | All-Hazards Preparedness Manager
Ryan.Lock@em.myflorida.com | 850-841-9484

From: Otis, Aaron <Aaron.Otis@flhealth.gov>
Sent: Wednesday, January 20, 2021 11:58 AM
To: Lock, Ryan <Ryan.Lock@em.myflorida.com>
Subject: Second Dose

Ryan,

Please distribute to the county emergency managers. Follow-up from today's county call. Second dose will be ordered this week for distribution next week. Once we submit we can provide a better timeline for delivery. However the earliest would be this Friday. I have sent this to the health officers via blind copy.

Aaron

CDR Aaron B. Otis
Assistant Deputy Secretary County Health Systems
Florida Department of Health

United States Public Health Service
CDC Public Health Advisor

4052 Bald Cypress Way Bin A23
Tallahassee, Florida 32399

aaron.otis@flhealth.gov
850-445-1380 Mobile

DOH Mission Statement: To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.

PLEASE NOTE: Florida has very broad public records laws. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to disclosure.

How am I doing? Please let me know by taking this short survey. Thank you!
http://survey.doh.state.fl.us/survey/entry.jsp?id=1389303062486

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From: Lock, Ryan <Ryan.Lock@em.myflorida.com>
Sent: Saturday, January 16, 2021 1:09 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: Plans Command <Plans_Command@em.myflorida.com>; EOC-Plans <EOC-Plans@em.myflorida.com>
Subject: SEOC COVID-19 Reporting Requirements

Good afternoon all,

Per yesterday's 11:15 Call, please see the three reporting sources for vaccine information. For most counties, only the Salesforce Survey will be a nightly report.

SEOC COVID-19 Reporting Requirements

Salesforce Survey

- **Frequency:** Nightly – by 8:00pm, when sites are operational.
- **Completed for:** All State-Supported Sites
- **Completed by:** Site Staff, EM, or CHD. May vary site by site.
- **Reviewed by:** SERT Planning Section for Nightly EOG Vaccine Roll-Up
- **Description:** ***_This survey replaces the daily vaccination reporting in WebEOC_***. The Salesforce Survey is a nightly summary of activities that occurred at the vaccine site up until 8:00pm. It provides space to provide updates on vaccinations given, logistical supplies, and staffing. However, only vaccination information is required.
- **How to Access:** https://fdemgrantsmanagement.force.com/vaccinedailyresults/s/. The survey can be submitted without logging into Salesforce. Submissions can be edited. More guidance on this will be provided.
- **POC for More Info:** eoc-plans@em.myflorida.com and Kaylynn.Perry@em.myflorida.com

WebEOC Vaccination Site Board

- **Frequency:** As needed.
- **Completed for:** All vaccination sites
- **Completed by:** POD Primary Agency
- **Reviewed by:** Self-Reported, routinely reviewed by SEOC.
- **Description:** WebEOC Vaccination Site Board in WebEOC is an adapted view of the Emergency Sites Board.*The SERT is no longer asking sites to report vaccines in the board.* This board is automatically integrated into ArcGIS, and is used for general situational awareness.
- **How to Access:** WebEOC Board.
- **POC for More Info:** Ian.Guidicelli@em.myflorida.com for Operational concerns. Colby.Maxwell@em.myflorida.com for technical concerns.

FLSHOTS Upload Template

ShareCare will automatically report to FLSHOTS. Sites using ShareCare will not need to do Excel Spreadsheet.

- **Frequency:** Nightly – when doses are administered.
- **Completed for:** All vaccination sites not utilizing ShareCare for vaccination tracking.
- **Completed by:** Healthcare provider for site (County Health Department, for example).
- **Reviewed by:** FDOH
- **Description:** Nightly report of individuals that have been vaccinated. This information is sent to FDOH to be entered into FLSHOTS. This information becomes the official statistics that are sent to the federal government.
- **How to Access:** Excel Template. Contact County Health Department / State ESF-8 for more information.
- **POC for More Info:** State ESF-8 StateESF8.Planning@flhealth.gov

Ryan Lock | Florida Division of Emergency Management
State Emergency Response Team | Planning Section Chief
Preparedness Bureau | All-Hazards Preparedness Manager
Ryan.Lock@em.myflorida.com | 850-841-9484

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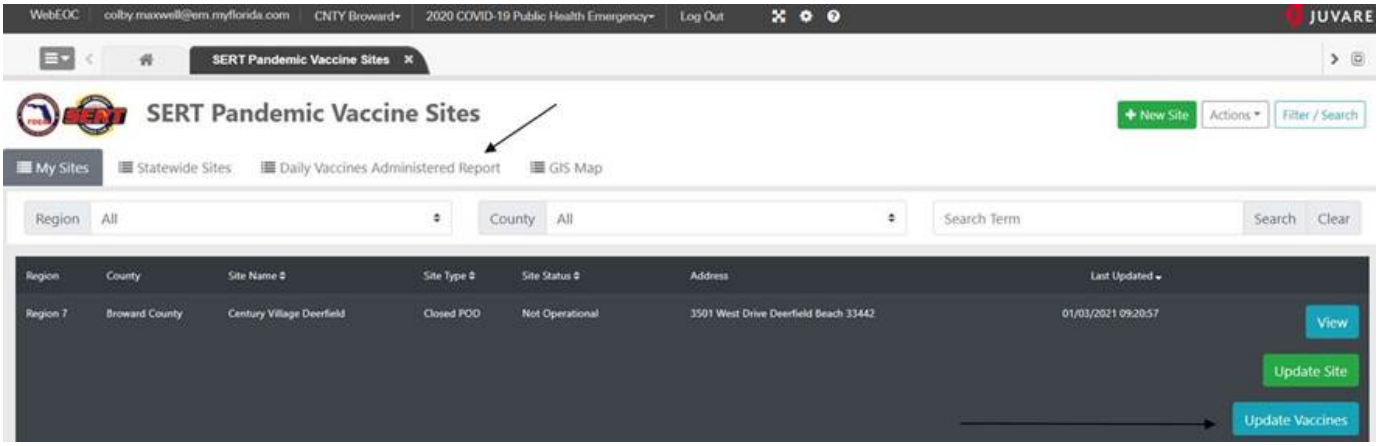
From: Ray, Jason <Jason.Ray@em.myflorida.com>
Sent: Sunday, January 03, 2021 1:10 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: EOC-Plans <EOC-Plans@em.myflorida.com>; Maxwell, Colby <Colby.Maxwell@em.myflorida.com>
Subject: SERT Pandemic Sites Board - Additional Buildout for Hours of Operations and Daily Vaccination Counts

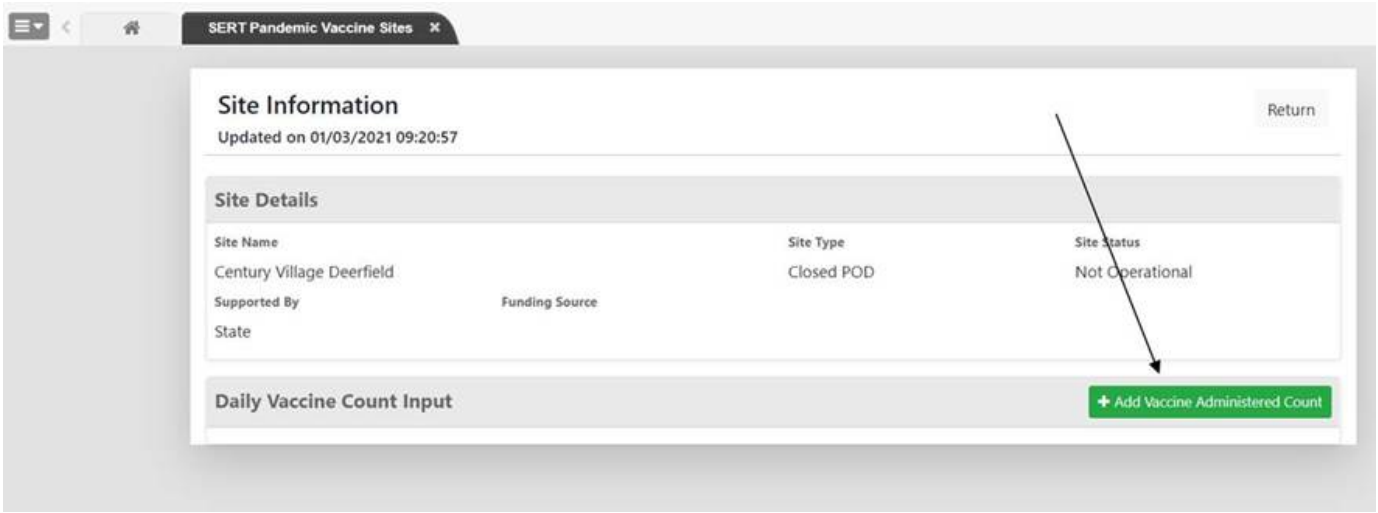
Director's,

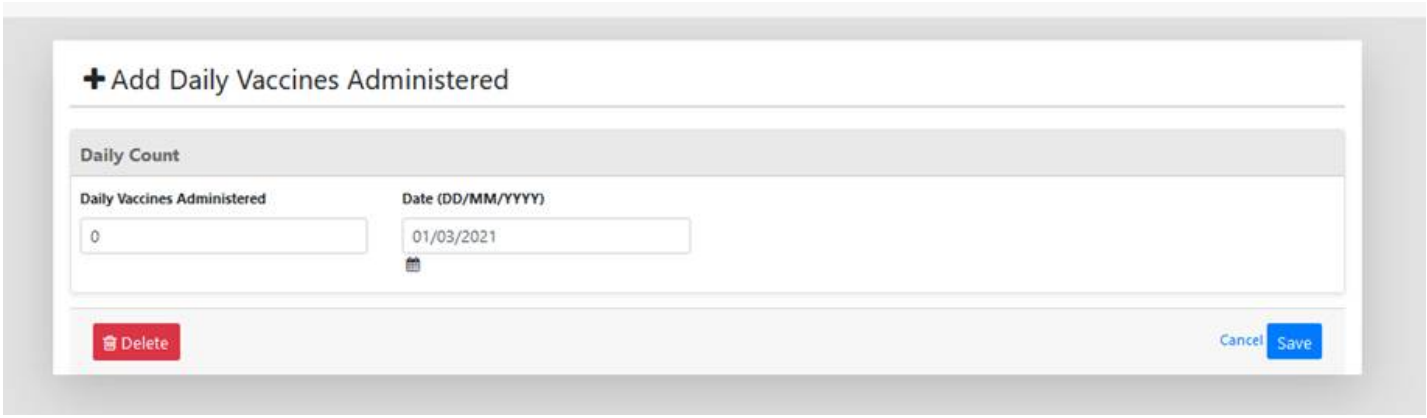
We have expanded the build out of the SERT Pandemic Vaccine Sites Board in the State WebEOC instance to include:

- Hours of Operations similar to the Pandemic Testing Sites Board
- Additional functionality to submit your Daily Vaccines Count throughput. As visualized below, select the Update Vaccines button next to your Site and then select the Add Vaccine Administered Count button to submit your daily vaccination count for that day.
- There is also a "Daily Vaccines Administered Report" available as a tab across the top of the Board for State or County use showing each day's vaccination count submissions that can be exported to a spreadsheet.

We would request that you update your Sites with the Hours of Operation and separately the Daily Vaccination Count each day, so the SERT can ascertain the County and Statewide daily throughput as we move forward.







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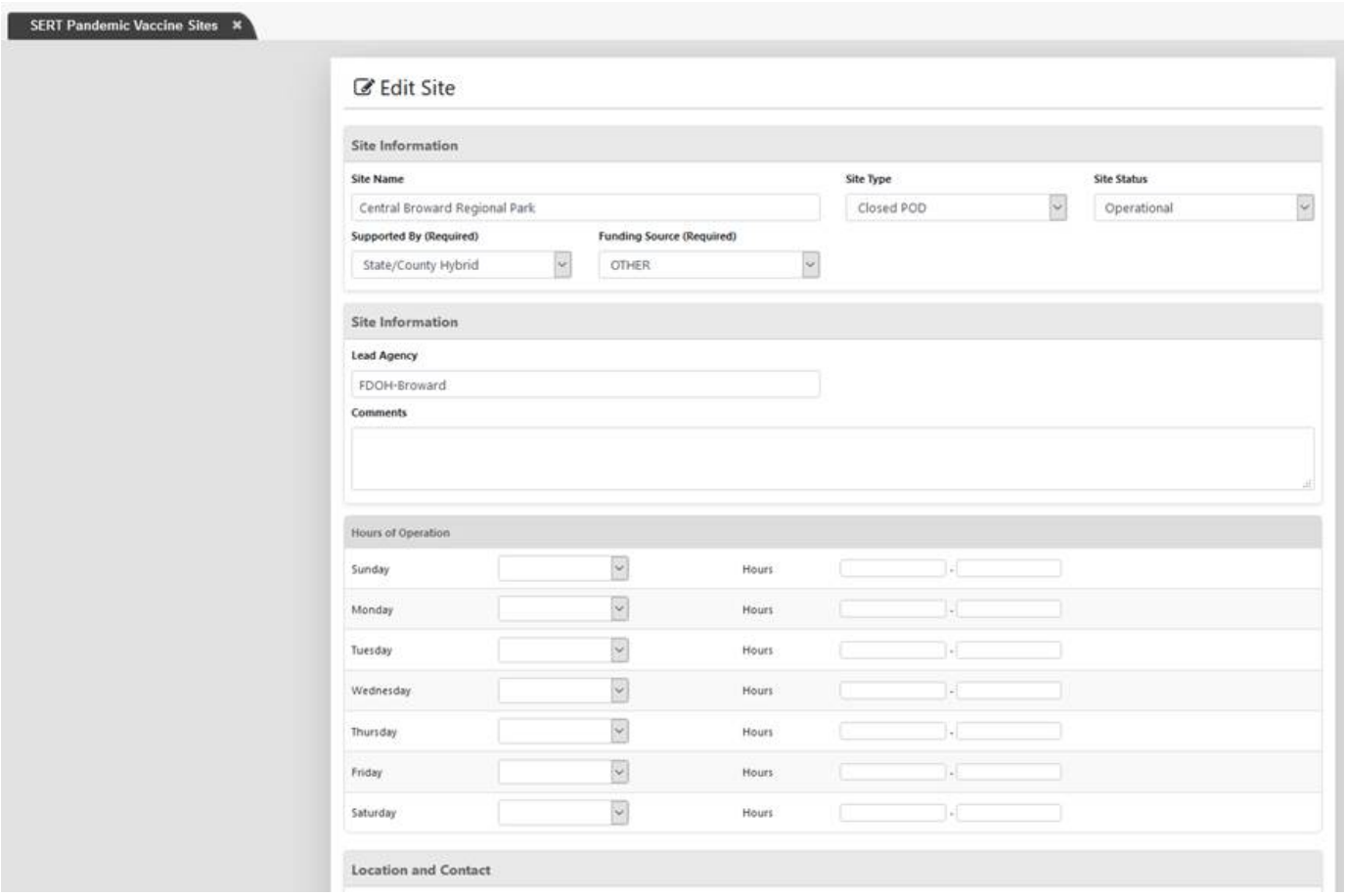

As always, if you have any questions regarding this Board or the additional buildout, please feel free to reach out to myself or Colby Maxwell, FDEM WebEOC Admin.

Thanks.

Jason Ray
GIS Administrator
Interim ITM Bureau Chief/Acting CIO
Florida Division of Emergency Management
jason.ray@em.myflorida.com
850-815-4730 (Office)
850-443-0170 (Mobile)

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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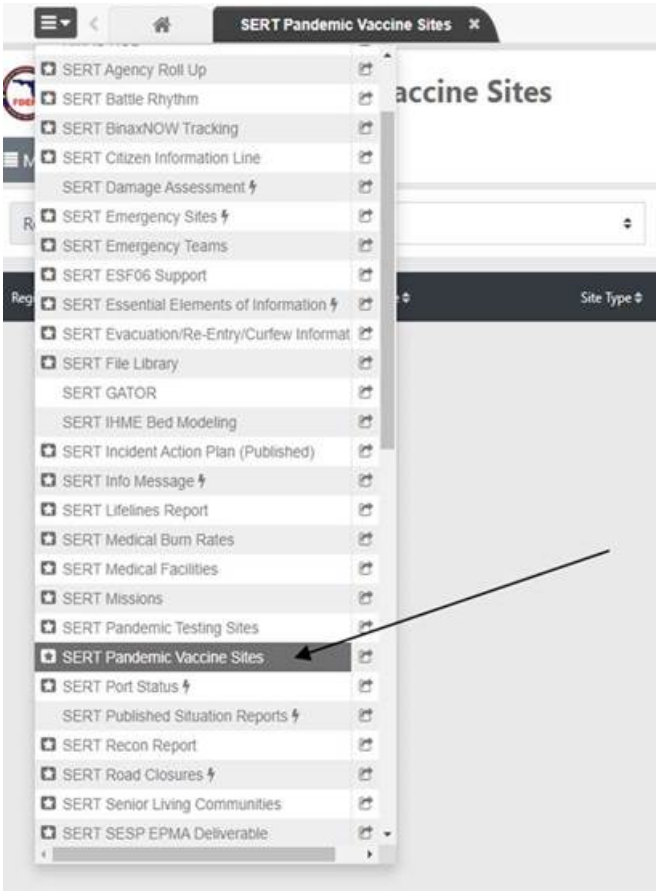
From: Ray, Jason <Jason.Ray@em.myflorida.com>
Sent: Monday, December 28, 2020 10:19 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: Maxwell, Colby <Colby.Maxwell@em.myflorida.com>
Subject: SERT Pandemic Vaccine Sites Board

Good Morning Directors,

For tracking purposes, the SERT Pandemic Vaccine Sites board is now available in the FDEM instance of WebEOC. You will have the ability to enter and track vaccination POD locations and details for vaccination sites in your County.

Please note, similar to the Pandemic Testing Sites Board, we are requiring that you provide information on whom the site is Supported By and the Funding Source, i.e. Cares Act, Stafford Act, Other. If Other, please note in the Comments Section.

Site Types include Open POD vs. Closed POD and Site Status includes Operational vs. Not Operational.



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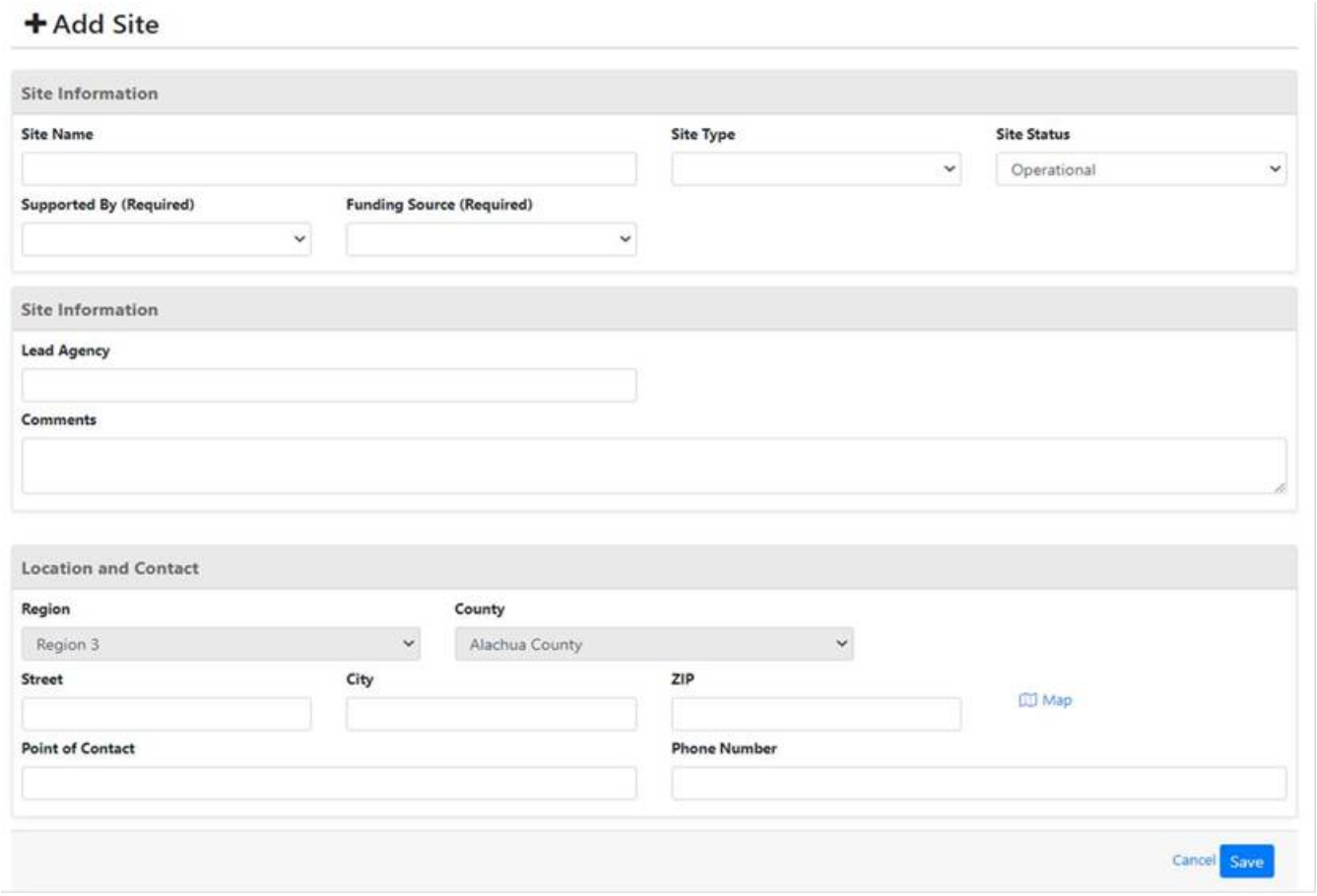

We appreciate your assistance on tracking these locations.

If you have any questions, please feel free to contact myself orColby Maxwell, FDEM WebEOC Administrator.

Jason Ray
GIS Administrator
Interim ITM Bureau Chief/Acting CIO
Florida Division of Emergency Management
jason.ray@em.myflorida.com
850-815-4730 (Office)
850-443-0170 (Mobile)

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Subject: SERT-County Conference Call
Location: WebEx: https://fdem.webex.com/fdem/j.php?MTID=mdde3307d48f4e62329bd3cce13c900b7

Start: Monday, January 04, 2021 11:15 AM EST
End: Monday, January 04, 2021 12:15 PM EST
Show Time As: Tentative

Recurrence: None

Meeting Status: Not yet responded

Organizer: Lock, Ryan
Required Attendees: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>; Dick, Cindy <Cindy.Dick@flhealth.gov>; Mahon, Jason <Jason.Mahon@em.myflorida.com>; Guidicelli, Ian <Ian.Guidicelli@em.myflorida.com>; SWO_COMMAND <SWO_COMMAND@em.myflorida.com>; EOC COSLogistics <EOC.COSLogistics@em.myflorida.com>; DeCastro, Kenneth <Kenneth.DeCastro@em.myflorida.com>; Plans Command <Plans_Command@em.myflorida.com>; Kitchen, Madison <Madison.Kitchen@em.myflorida.com>; Nagle, Taylor <Taylor.Nagle@em.myflorida.com>; Vaughn, Phyllis <Phyllis.Vaughn@em.myflorida.com>; McDaniel, Susanne <Susanne.McDaniel@em.myflorida.com>; Blake, Jessica <Jessica.Blake@em.myflorida.com>; Hunt, Kaitlyn <Kaitlyn.Hunt@em.myflorida.com>; Walters, Tara <Tara.Walters@em.myflorida.com>; McLeary, Allison <Allison.McLeary@em.myflorida.com>; Shirah, Melissa <Melissa.Shirah@em.myflorida.com>; Roberts, Douglas <Douglas.Roberts@em.myflorida.com>; Stachowicz, Stephanie <Stephanie.Stachowicz@em.myflorida.com>; Sayler, Erik <Erik.Sayler@em.myflorida.com>; Keenan, Gwen (FEMA) <Gwen.Keenan@fema.dhs.gov>; Williams, Paul (FEMA) <Paul.Williams6@fema.dhs.gov>; Peterson, Amy (FEMA) <Amy.Peterson@fema.dhs.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Hughes, Pamela <Pamela.Hughes@em.myflorida.com>; Bond, Megan <Megan.Bond@em.myflorida.com>; Kristina.Mathews@flhealth.gov <Kristina.Mathews@flhealth.gov>; Kristopher.Pickens@flhealth.gov <Kristopher.Pickens@flhealth.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Courtney Coppola <Courtney.Coppola@flhealth.gov>; Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Otis, Aaron <Aaron.Otis@flhealth.gov>; StateESF8.Planning <StateESF8.Planning@flhealth.gov>; Bielling, Jeffery <Jeffery.Bielling@flhealth.gov>; Harris, Shevaun <Shevaun.Harris@ahca.myflorida.com>; McKinstry, Molly <Molly.McKinstry@ahca.myflorida.com>; Smoak, Kimberly <Kimberly.Smoak@ahca.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Lee Newsome <LNewsome@ERECinc.com>; madisoncountyem@gmail.com <madisoncountyem@gmail.com>; emergencymanagement@myescambia.com <emergencymanagement@myescambia.com>; Howell.Batts@flhealth.gov <Howell.Batts@flhealth.gov>; Margaret.Hart@osceola.org <Margaret.Hart@osceola.org>; Nicole Double <ndouble@scgov.net>; mcarmichael@fau.edu <mcarmichael@fau.edu>; rrodrigu@fgcu.edu <rrodrigu@fgcu.edu>; thomas.bowman@hhs.gov <thomas.bowman@hhs.gov>
Optional Attendees: Bouler, Kimberlyn (Santa Rosa Co Alt EM) <kimberlynb@santarosa.fl.gov>; Anderson, Kristy (Taylor Co EM) <kristy.anderson@taylorsheriff.org>; Grant Geyer <grantgeyer@fdle.state.fl.us>; Larry Rogers (Seminole Tribe EM) <larryrogers@semtribe.com>; Rezola, Inaki (Hillsborough Co Alt EM) <rezolai@hillsboroughcounty.org>; John Kohnke (Office of the Chief Financial Officer) <John.Kohnke@myfloridacfo.com>; Rahming, Derrick <DerrickRahming@flhsmv.gov>; Bunker, Chuck <Chuck.Bunker@sbafla.com>; Gerrell, Traci <Traci.Gerrell@ahca.myflorida.com>; Howard, Matthew <matthew.howard@myflfamilies.com>; McCrane, Ed (Sarasota Co EM) <EMcCrane@scgov.net>; Brown, Curtis <curtis.brown@myfwc.com>; Watts, Wayne <wayne.watts@myfloridacfo.com>; Casto, David (Sumter Co EM) <David.Casto@sumtercountyfl.gov>; Womble, Paul (Polk Co EM) <paulwomble@polk-county.net>; Kostus, Spencer (Lake Co Alt EM) <skostus@lakecountyfl.gov>; Tucker, LeiAnna (FDACS) <LeiAnna.Tucker@fdacs.gov>; Bryan, Jeff <Jeffery.Bryan@fdc.myflorida.com>; Cleversy, Tommy <Tommy.cleversy@apdcares.org>; Thorpe, Paul <paul.thorpe@nwfwater.com>; Goldberg, Jeff (Walton Co EM) <jeff@waltoncountyem.org>; Peter Newman <Peter.Newman@fldoe.org>; Moulton, Diane <Diane.Moulton@eog.myflorida.com>; Register, Joshua (Elder Affairs) <registerj@elderaffairs.org>; Jones, Harvey <HarveyJones@fdle.state.fl.us>; Ward, John (Clay Co EM) <john.ward@claycountygov.com>; LoPresti, Etta (Indian River Co Alt EM) <ELoPresti@ircgov.com>; Lord, Jonathan (Flagler Co EM) <jlord@flaglercounty.org>; Halquist, Richard (Osceola Co Alt EM) <richard.halquist@osceola.org>; Abel, Lynn (Washington Co EM) <label@washingtonfl.com>; Cisco, Tom (Volusia Co Alt EM) <tcisco@volusia.org>; Hall, Steven <halls@flcourts.org>; Lumm, Frankie (Bay Co EM) <flumm@baycountyfl.gov>; Davis, Gregory (DJJ ECO) <Gregory.Davis@djj.state.fl.us>; Duffey, Mike <Mikeduffey@fdle.state.fl.us>; Litton, Bill (Osceola Co EM) <bill.litton@osceola.org>; Saur, Jacob (Manatee Co Alt EM) <jacob.saur@mymanatee.org>; Shuler, Lisa (Liberty Co Alt EM) <mashuler@fairpoint.net>; Tambasco, Jeffrey (DeSoto Co EM) <j.tambasco@desotobocc.com>; Holloman, Chris (Escambia Co Alt EM) <cjhollom@myescambia.com>; Evan, Chris (Citrus Co EM) <cevan@sheriffcitrus.org>; Miller, Anne (Sarasota County Alt. EM) <ammiller@scgov.net>; Lowers, Loren (Lottery Alt ECO) <lowersl@flalottery.com>; Durden, Carlos <carlos.durden@ocfl.net>; Foster, Greg (Nassau Co EM) <gfoster@nassauso.com>; Broadway, Patricia <Patricia.Broadway@myfloridalicense.com>; Waite, Sally (Martin Co EM) <swaite@martin.fl.us>; Owen, Adrienne (Holmes Co EM) <aowen@holmesem.org>; Harris, Eddie <eddie.harris@apdcares.org>; Wilson, Cindy (Holmes Co Alt EM) <cwilson@holmesem.org>; Rivera, Cesar (American Red Cross) <cesar.rivera@redcross.org>; Mason, Melanie <Melanie.Mason@fdacs.gov>; Andreasen, Rodney (Jackson Co EM) <andreasenr@jacksoncountyfl.gov>; Witt, Brad (Bradford Co EM) <brad_witt@bradfordsheriff.org>; Litschauer, Steve (Manatee Co EM) <steve.litschauer@mymanatee.org>; Guerrero, Ron <RAGUERRERO@broward.org>; Reiss, Latosha (Highlands Co EM) <Lreiss@highlandsfl.gov>; Giammanco, Joseph (St Johns Co EM) <jgiammanco@sjcfl.us>; Hagan, Karen (ARC-TLH) <Karen.Hagan@apdcares.org>; Carpenter, Thomas (Lake Co EM) <tcarpenter@lakecountyfl.gov>; Shedlock, Andrew <andrewshedlock@fdle.state.fl.us>; Zyvoloski, Richard (Collier Co Alt EM) <richard.zyvoloski@colliercountyfl.gov>; Vilchez, Gustavo (St Lucie Co Alt EM) <vilchezg@stlucieco.org>; Cabral, Irene <Irene.Cabral@dot.state.fl.us>; Pinder, Ellen

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(Charlotte Co Alt EM) <ellen.pinder@charlottecountyfl.gov>; Padgett, Jimmie <jimmie.padgett@myflfamilies.com>; Harris, Alan (Seminole Co EM) <aharris@seminolecountyfl.gov>; Rollason, Frank (Miami-Dade Co EM) <frank.rollason@miamidade.gov>; Johnson, Bill (Palm Beach Co EM) <wpjohnson@pbcgov.org>; Dilmore, Cory <Cory.Dilmore@FloridaDEP.gov>; Wolfe, Ken (Okaloosa Co Alt EM) <kwolfe@myokaloosa.com>; Oberdorfer, Martha (Nassau Co Alt EM) <MLOberdorfer@NassauSO.com>; Cyrille, Charles (Miami-Dade Co Alt EM) <charles.cyrille@miamidade.gov>; Lawrence, Liz (ARC) <Liz.lawrence@redcross.org>; Abes, Benjamin (Lee Co Alt EM) <benjamin.abes@leegov.com>; Carroll, Paula (Jefferson Co EM) <paula.carroll@jcso-fl.org>; Smeykal, Mitch (Okeechobee Co EM) <MSmeykal@co.okeechobee.fl.us>; Smith, Todd (Duval Co Alt EM) <todds@coj.net>; Roush, Deanna <deanna.roush@uss.salvationarmy.org>; Parker, Bek (Baker Co EM) <bek.parker@bakerso.com>; Herring, Matt (Gulf Co EM) <mherring@gulfcounty-fl.gov>; Gatlin, John <John.Gatlin@myfloridacfo.com>; Baker, Brad (Santa Rosa Co EM) <BradB@santarosa.fl.gov>; Lerner, Steven (Seminole Co Alt EM) <slerner@seminolecountyfl.gov>; Shaw, Barry <barry.shaw@myfwc.com>; Sharpe, Todd <todd.sharpe@fdc.myflorida.com>; Dawson, Slivester (SCOF) <dawson@flcourts.org>; Jackson, Tracy (Broward Co EM) <tjackson@broward.org>; Brunelle, Karen (FHWA) <karen.brunelle@dot.gov>; Parrish, Ron (St Lucie Co EM) <parrishr@stlucieco.org>; Gardner, Patrick <Patrick.Gardner@FloridaRevenue.com>; Fossa, Andrew (Pasco Co EM) <afossa@pascocountyfl.net>; Land, Henry (Hamilton Co EM) <hland@hamiltoneoc.com>; Judge II, James (Volusia Co EM) <jjudge@volusia.org>; Amandro, Frank (St Lucie Co Alt EM) <amandrof@stlucieco.org>; Tammi, Canelli <TCanelli@scgov.net>; Peaton, David (Levy Co Alt EM) <davidpeaton@levydisaster.com>; Schwartz, Micheal (Okaloosa Co EM) <mschwartz@myokaloosa.com>; Yown, Cara <Cara.Yown@MyFloridaCFO.com>; Susich, Jessica (Gulf Co Alt EM) <jsusich@gulfcounty-fl.gov>; Allen, Timothy (Union Co EM) <allentc@unionsheriff.us>; Arista, Amalia (Hardee Co EM) <amalia.arista@hardeecounty.net>; Whaley, Tashonda (Gadsden Co Alt EM) <tashondawhaley@tds.net>; Tompkins, Travis (Escambia Co Alt EM) <TDTOMPKINS@myescambia.com>; Land, Marc (Lafayette Co EM) <MLand@lafayetteso.org>; Davis, Joyce (Suwannee Co Alt EM) <joyce.davis@suwanneesheriff.com>; bbowers@uwf.edu <bbowers@uwf.edu>; Crews, Randy (Baker Co Alt EM) <rcrews@bakerso.com>; Alexander, Jeffery <jaalexander@sjcfl.us>; Walters, Sam <Sam.Walters@em.myflorida.com>; Baker, Claudia <Claudia.Baker@em.myflorida.com>; Perry, Kaylynn <Kaylynn.Perry@em.myflorida.com>; Wiggins, James <James.Wiggins@fdacs.gov>; Hendrix, Stephanie M <shendrix@co.pinellas.fl.us>; Smith, Derek A. <dasmith@lakecountyfl.gov>; Howard, Virgil <Virgil.Howard@dms.fl.gov>; Etienne, Debbie <DETIENNE@broward.org>; Lambert, Gina <Gina.Lambert@em.myflorida.com>; Kawika J. Bailey <Kawika.Bailey@swfwmd.state.fl.us>; Taylor-Bennett, Carla <CTBENNETT@broward.org>; ODell, Jeremy <Jeremy.ODell@em.myflorida.com>; Bradshaw, Brian <Brian.Bradshaw@em.myflorida.com>; McWhorter, Linda <Linda.McWhorter@em.myflorida.com>; Williams, Summer <Summer.Williams@fdacs.gov>; Morrow, Nick <Nicholas.Morrow@fdacs.gov>; LangWilliam <William.Lang@colliercountyfl.gov>; Cintron, Morgan <Morgan.Cintron@em.myflorida.com>; Fiske, Jodie <Jodie.Fiske@em.myflorida.com>; Anderson, Miles <Miles.Anderson@em.myflorida.com>; Bergstrom, Pamela <Pamela.Bergstrom@em.myflorida.com>; Siddall, Paul <Paul.Siddall@em.myflorida.com>; Justice, Zoie <Zoie.Justice@fldoe.org>; Erin Thomas <EThomas@co.hernando.fl.us>; Richardson, Kesley <Kesley.Richardson@em.myflorida.com>; Brevard County Emergency Operations Center <EOC1@brevardfl.gov>; Roberts, James <Jim.Roberts@em.myflorida.com>; Perkel, Richard <RPerkel@broward.org>; Scott Montgomery <smontgo@scgov.net>; Tristan Morath <tristan.morath@mymanatee.org>; Joel Richmond <joel.richmond@mymanatee.org>; Hagan, Shannon <Shannon.Hagan@em.myflorida.com>; Sperber, Clint J. <Clint.Sperber@flhealth.gov>; EmergencyManagementEmployees <EMP@colliercountyfl.gov>; Richardson, Brian <Brian.Richardson@dot.state.fl.us>; Rajyaguru, Jay <RajyaguruJ@hillsboroughcounty.org>; Stickley, Lynne <Lynne.Stickley@charlottecountyfl.gov>; Pengler, Regina <PenglerR@HillsboroughCounty.ORG>; Smart, Kayla <SmartK@hillsboroughcounty.org>; Charlene Borden <crborden@pascocountyfl.net>; Brad C. Hattaway <BCHATTAW@myescambia.com>; Jaeson Weber <jweber15@fau.edu>; Veneka EOC Brown <venekaeocbrown@tds.net>; Simpson, Ryan (Flagler Co Alt EM) <RSimpson@FlaglerCounty.org>; Blevins, Allison M <Allison.Blevins@flhealth.gov>; Nolan Ristau <nristau@pascocountyfl.net>; Cavillo, Laura (Hardee Co Alt EM) <Laura.calvillo@hardeecounty.net>; AHCAEOC <ahcaeoc@ahca.myflorida.com>; Ashley Biegel <abiegel@fau.edu>; Fleischman, Jennifer <jfleischman@usf.edu>; Sommerhoff, Curt <csommerhoff@fsu.edu>; yshapiro@ncf.edu <yshapiro@ncf.edu>; Danial Bartle <dbartle@floridapoly.edu>; nmcdonald@uwf.edu <nmcdonald@uwf.edu>; psparks@uwf.edu <psparks@uwf.edu>; Greenlaw, Robert <r.greenlaw@unf.edu>; dfairclo@uwf.edu <dfairclo@uwf.edu>; Amy Aiken <abaiken@fiu.edu>; Smith, Brian <brian.smith@MyFWC.com>; Shpiner, Matthew V. <mshpiner@miami.edu>; Sasser, Billy E <billy.sasser@HQ.DHS.GOV>; Simko, Anna Christine <acs296@miami.edu>; Gulla, John Anthony <jgulla@miami.edu>; Rocks, Lance <lrocks@usf.edu>; McElheney, MaryAlice <MaryAlice.McElheney@FloridaDEP.gov>; HowardAmy <Amy.Howard@colliercountyfl.gov>; Pandolfi, Roland <rolandp@miccosukeetribe.com>; Harrison, Tammy <Tammy.Harrison@tsa.dhs.gov>; Manning, Jeff <manning-jeff@monroecounty-fl.gov>; Cole, Conn <Conn.Cole@em.myflorida.com>; Steven Hartsook <Steven.Hartsook@uss.salvationarmy.org>; Valentine, Kathryn <kvalentine@seminolecountyfl.gov>; Gonzalez, Freddy <fgonzalez@seminolecountyfl.gov>; Claudia.Blackburn@flhealth.gov <Claudia.Blackburn@flhealth.gov>; Michael Denier <mdenier@fau.edu>; Hazel, Richard C <Richard.Hazel@flhealth.gov>; dennis.adams2@redcross.org <dennis.adams2@redcross.org>; bene.hunter2@redcross.org <bene.hunter2@redcross.org>; Shel.Seidman@redcross.org <Shel.Seidman@redcross.org>; Emergency Management <EMFRANKLIN@franklinemergencymanagement.com>; Kissler, Aaron X <Aaron.Kissler@flhealth.gov>; Pittzer, Kimberly <kpittzer@citrus.myflorida.com>; Bartels, Amy <Amy.Bartels@flhealth.gov>; Pepe, Joseph D <Joseph.Pepe@flhealth.gov>; nixsa.serrano@miamidade.gov <nixsa.serrano@miamidade.gov>; Matt Lewis <malewis@fsu.edu>; EOC-COSLogistics <EOC-COSLogistics@em.myflorida.com>; Knox, Steven E LTC USARMY (USA) <steven.e.knox.mil@mail.mil>; Krista Ditoro <kditoro@pascocountyfl.net>; Johnson, Troy (MDFR) <troy.johnson@miamidade.gov>; Guthrie, Ben (Gulf Co Alt EM) <bguthrie@gulfcounty-fl.gov>; Seth Imhof <simhof@baycountyfl.gov>; Scurlock, Renee (Jackson Co EM) <scurlockr@jacksoncountyfl.gov>; Candace Hill <candacehill@tds.net>; WU Opa-Locka <WU.Opa-Locka@erecinc.com>; Garner, Scott (Dixie Co EM) <scott.garner@dixie.fl.gov>; DAVID DEES <david@deesmediation.com>; WU Miramar <WU.Miramar@erecinc.com>; CBTS Brevard PB <CBTS.BrevardPB@erecinc.com>; CBTS HardRock <CBTS.HardRock@erecinc.com>; Woodard, Steven (Duval Co EM) <swoodard@coj.net>; WU Manatee <WU.Manatee@erecinc.com>; DuBois, Adam J <Adam.DuBois@flhealth.gov>

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The SERT-County Conference Calls will now occur daily M-F. Note that the link has changed:

https://fdem.webex.com/fdem/j.php?MTID=mdde3307d48f4e62329bd3cce13c900b7
Meeting Number: 179-323-8743

SERT-County Conference Call

The Monday and Friday 11:15 Eastern Conference Calls have moved to a WebEx Webinar. Please see the link below to join.

https://fdem.webex.com/fdem/j.php?MTID=mdde3307d48f4e62329bd3cce13c900b7

Meeting Number: 179-323-8743

Rules for Entry

- **We will not admit individuals joining via phone**. Please login using the WebEx App.
- Users logging in should **sign-in with their full name and agency**. This will expedite entry into the Webinar.

Planning Section Staff will open the Webinar by 10:45 AM Eastern. Please try to enter by 11:10 AM to ensure you are admitted before 11:15.

Forward internally as appropriate, but attendance is limited to State and County emergency management partners.

Email eoc-plans@em.myflorida.com if there are questions or if you need technical assistance.

Ryan Lock | Florida Division of Emergency Management
State Emergency Response Team | Planning Section Chief
Preparedness Bureau | All-Hazards Preparedness Manager
Ryan.Lock@em.myflorida.com | 850-841-9484

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Subject: SERT-County Conference Call
Location: WebEx: https://fdem.webex.com/fdem/j.php?MTID=mdde3307d48f4e62329bd3cce13c900b7

Start: Monday, December 14, 2020 6:15 AM EST
End: Monday, December 14, 2020 7:15 AM EST
Show Time As: Tentative

Recurrence: Weekly

Meeting Status: Not yet responded

Organizer: Lock, Ryan
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The SERT-County Conference Calls will now occur daily M-F. Note that the link has changed:

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https://fdem.webex.com/fdem/j.php?MTID=mdde3307d48f4e62329bd3cce13c900b7
Meeting Number: 179-323-8743

SERT-County Conference Call

The Monday and Friday 11:15 Eastern Conference Calls have moved to a WebEx Webinar. Please see the link below to join.

https://fdem.webex.com/fdem/j.php?MTID=mdde3307d48f4e62329bd3cce13c900b7

Meeting Number: 179-323-8743

Rules for Entry

- **We will not admit individuals joining via phone**. Please login using the WebEx App.
- Users logging in should **sign-in with their full name and agency**. This will expedite entry into the Webinar.

Planning Section Staff will open the Webinar by 10:45 AM Eastern. Please try to enter by 11:10 AM to ensure you are admitted before 11:15.

Forward internally as appropriate, but attendance is limited to State and County emergency management partners.

Email eoc-plans@em.myflorida.com if there are questions or if you need technical assistance.

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State Emergency Response Team | Planning Section Chief
Preparedness Bureau | All-Hazards Preparedness Manager
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Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

Appointment Recurrence Exception

Start: Monday, December 14, 2020 11:15 AM EST
End: Monday, December 14, 2020 12:15 PM EST

Required Attendees: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Courtney Coppola <Courtney.Coppola@flhealth.gov>; Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Dick, Cindy <Cindy.Dick@flhealth.gov>; Otis, Aaron <Aaron.Otis@flhealth.gov>; StateESF8.Planning <StateESF8.Planning@flhealth.gov>; Bielling, Jeffery <Jeffery.Bielling@flhealth.gov>; Harris, Shevaun <Shevaun.Harris@ahca.myflorida.com>; McKinstry, Molly <Molly.McKinstry@ahca.myflorida.com>; Smoak, Kimberly <Kimberly.Smoak@ahca.myflorida.com>; Mahon, Jason <Jason.Mahon@em.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Guidicelli, Ian <Ian.Guidicelli@em.myflorida.com>; SWO_COMMAND <SWO_COMMAND@em.myflorida.com>; EOC COSLogistics <EOC.COSLogistics@em.myflorida.com>; DeCastro, Kenneth <Kenneth.DeCastro@em.myflorida.com>; Plans Command <Plans_Command@em.myflorida.com>; Kitchen, Madison <Madison.Kitchen@em.myflorida.com>; Nagle, Taylor <Taylor.Nagle@em.myflorida.com>; Vaughn, Phyllis <Phyllis.Vaughn@em.myflorida.com>; McDaniel, Susanne <Susanne.McDaniel@em.myflorida.com>; Blake, Jessica <Jessica.Blake@em.myflorida.com>; Hunt, Kaitlyn <Kaitlyn.Hunt@em.myflorida.com>; Walters, Tara <Tara.Walters@em.myflorida.com>; McLeary, Allison <Allison.McLeary@em.myflorida.com>; Shirah, Melissa <Melissa.Shirah@em.myflorida.com>; Roberts, Douglas <Douglas.Roberts@em.myflorida.com>; Stachowicz, Stephanie <Stephanie.Stachowicz@em.myflorida.com>; Sayler, Erik <Erik.Sayler@em.myflorida.com>; Keenan, Gwen (FEMA) <Gwen.Keenan@fema.dhs.gov>; Williams, Paul (FEMA) <Paul.Williams6@fema.dhs.gov>; Peterson, Amy (FEMA) <Amy.Peterson@fema.dhs.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Lee Newsome <LNewsome@ERECinc.com>; madisoncountyem@gmail.com <madisoncountyem@gmail.com>; emergencymanagement@myescambia.com <emergencymanagement@myescambia.com>; Hughes, Pamela <Pamela.Hughes@em.myflorida.com>; Bond, Megan <Megan.Bond@em.myflorida.com>; Howell.Batts@flhealth.gov <Howell.Batts@flhealth.gov>; Margaret.Hart@osceola.org <Margaret.Hart@osceola.org>; Nicole Double <ndouble@scgov.net>; mcarmichael@fau.edu <mcarmichael@fau.edu>;

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Appointment Recurrence Exception

Start: Friday, December 18, 2020 11:15 AM EST
End: Friday, December 18, 2020 12:15 PM EST

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Appointment Recurrence Exception

Start: Monday, December 21, 2020 11:15 AM EST
End: Monday, December 21, 2020 12:15 PM EST

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Appointment Recurrence Exception

Start: Friday, December 25, 2020 11:15 AM EST
End: Friday, December 25, 2020 12:15 PM EST

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Appointment Recurrence Exception

Start: Monday, December 28, 2020 11:15 AM EST
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Appointment Recurrence Exception
Location: WebEx: https://fdem.webex.com/fdem/j.php?MTID=m38e77b28fe2fc2905679d03b385cbaaf

Start: Wednesday, December 30, 2020 11:15 AM EST
End: Wednesday, December 30, 2020 12:15 PM EST

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Appointment Recurrence Exception

Start: Monday, January 04, 2021 11:15 AM EST
End: Monday, January 04, 2021 12:15 PM EST

Required Attendees: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Courtney Coppola <Courtney.Coppola@flhealth.gov>; Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Dick, Cindy <Cindy.Dick@flhealth.gov>; Otis, Aaron <Aaron.Otis@flhealth.gov>; StateESF8.Planning <StateESF8.Planning@flhealth.gov>; Bielling, Jeffery <Jeffery.Bielling@flhealth.gov>; Harris, Shevaun <Shevaun.Harris@ahca.myflorida.com>; McKinstry, Molly <Molly.McKinstry@ahca.myflorida.com>; Smoak, Kimberly <Kimberly.Smoak@ahca.myflorida.com>; Mahon, Jason <Jason.Mahon@em.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Guidicelli, Ian <Ian.Guidicelli@em.myflorida.com>; SWO_COMMAND <SWO_COMMAND@em.myflorida.com>; EOC COSLogistics <EOC.COSLogistics@em.myflorida.com>; DeCastro, Kenneth <Kenneth.DeCastro@em.myflorida.com>; Plans Command <Plans_Command@em.myflorida.com>; Kitchen, Madison <Madison.Kitchen@em.myflorida.com>; Nagle, Taylor <Taylor.Nagle@em.myflorida.com>; Vaughn, Phyllis <Phyllis.Vaughn@em.myflorida.com>; McDaniel, Susanne <Susanne.McDaniel@em.myflorida.com>; Blake, Jessica <Jessica.Blake@em.myflorida.com>; Hunt, Kaitlyn <Kaitlyn.Hunt@em.myflorida.com>; Walters, Tara <Tara.Walters@em.myflorida.com>; McLeary, Allison <Allison.McLeary@em.myflorida.com>; Shirah, Melissa <Melissa.Shirah@em.myflorida.com>; Roberts, Douglas <Douglas.Roberts@em.myflorida.com>; Stachowicz, Stephanie <Stephanie.Stachowicz@em.myflorida.com>; Sayler, Erik <Erik.Sayler@em.myflorida.com>; Keenan, Gwen (FEMA) <Gwen.Keenan@fema.dhs.gov>; Williams, Paul (FEMA) <Paul.Williams6@fema.dhs.gov>; Peterson, Amy (FEMA) <Amy.Peterson@fema.dhs.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Lee Newsome <LNewsome@ERECinc.com>; madisoncountyem@gmail.com <madisoncountyem@gmail.com>; emergencymanagement@myescambia.com <emergencymanagement@myescambia.com>; Hughes, Pamela <Pamela.Hughes@em.myflorida.com>; Bond, Megan <Megan.Bond@em.myflorida.com>; Howell.Batts@flhealth.gov <Howell.Batts@flhealth.gov>; Margaret.Hart@osceola.org <Margaret.Hart@osceola.org>; Nicole Double <ndouble@scgov.net>; mcarmichael@fau.edu <mcarmichael@fau.edu>; rrodrigu@fgcu.edu <rrodrigu@fgcu.edu>; Kristina.Mathews@flhealth.gov <Kristina.Mathews@flhealth.gov>; Kristopher.Pickens@flhealth.gov <Kristopher.Pickens@flhealth.gov>; thomas.bowman@hhs.gov <thomas.bowman@hhs.gov>
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Subject: SERT-County Conference Call
Location: WebEx: https://fdem.webex.com/fdem/j.php?MTID=m38e77b28fe2fc2905679d03b385cbaaf

Start: Wednesday, December 30, 2020 11:15 AM EST
End: Wednesday, December 30, 2020 12:15 PM EST
Show Time As: Tentative

Recurrence: None

Meeting Status: Not yet responded

Organizer: Lock, Ryan
Required Attendees: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>; Dick, Cindy <Cindy.Dick@flhealth.gov>; Mahon, Jason <Jason.Mahon@em.myflorida.com>; Guidicelli, Ian <Ian.Guidicelli@em.myflorida.com>; SWO_COMMAND <SWO_COMMAND@em.myflorida.com>; EOC COSLogistics <EOC.COSLogistics@em.myflorida.com>; DeCastro, Kenneth <Kenneth.DeCastro@em.myflorida.com>; Plans Command <Plans_Command@em.myflorida.com>; Kitchen, Madison <Madison.Kitchen@em.myflorida.com>; Nagle, Taylor <Taylor.Nagle@em.myflorida.com>; Vaughn, Phyllis <Phyllis.Vaughn@em.myflorida.com>; McDaniel, Susanne <Susanne.McDaniel@em.myflorida.com>; Blake, Jessica <Jessica.Blake@em.myflorida.com>; Hunt, Kaitlyn <Kaitlyn.Hunt@em.myflorida.com>; Walters, Tara <Tara.Walters@em.myflorida.com>; McLeary, Allison <Allison.McLeary@em.myflorida.com>; Shirah, Melissa <Melissa.Shirah@em.myflorida.com>; Roberts, Douglas <Douglas.Roberts@em.myflorida.com>; Stachowicz, Stephanie <Stephanie.Stachowicz@em.myflorida.com>; Sayler, Erik <Erik.Sayler@em.myflorida.com>; Keenan, Gwen (FEMA) <Gwen.Keenan@fema.dhs.gov>; Williams, Paul (FEMA) <Paul.Williams6@fema.dhs.gov>; Peterson, Amy (FEMA) <Amy.Peterson@fema.dhs.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Hughes, Pamela <Pamela.Hughes@em.myflorida.com>; Bond, Megan <Megan.Bond@em.myflorida.com>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Courtney Coppola <Courtney.Coppola@flhealth.gov>; Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Otis, Aaron <Aaron.Otis@flhealth.gov>; StateESF8.Planning <StateESF8.Planning@flhealth.gov>; Bielling, Jeffery <Jeffery.Bielling@flhealth.gov>; Harris, Shevaun <Shevaun.Harris@ahca.myflorida.com>; McKinstry, Molly <Molly.McKinstry@ahca.myflorida.com>; Smoak, Kimberly <Kimberly.Smoak@ahca.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Lee Newsome <LNewsome@ERECinc.com>; madisoncountyem@gmail.com <madisoncountyem@gmail.com>; emergencymanagement@myescambia.com <emergencymanagement@myescambia.com>; Howell.Batts@flhealth.gov <Howell.Batts@flhealth.gov>; Margaret.Hart@osceola.org <Margaret.Hart@osceola.org>; Nicole Double <ndouble@scgov.net>; mcarmichael@fau.edu <mcarmichael@fau.edu>; rrodrigu@fgcu.edu <rrodrigu@fgcu.edu>; Kristina.Mathews@flhealth.gov <Kristina.Mathews@flhealth.gov>; Kristopher.Pickens@flhealth.gov <Kristopher.Pickens@flhealth.gov>
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THE COUNTY CALL SCHEDULED FOR 01/01/2021 WILL TAKE PLACE ON WEDNESDAY, 12/30/2020.

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SERT-County Conference Call

The Monday and Friday 11:15 Eastern Conference Calls have moved to a WebEx Webinar. Please see the link below to join.

https://fdem.webex.com/fdem/j.php?MTID=m38e77b28fe2fc2905679d03b385cbaaf

Rules for Entry

- **We will not admit individuals joining via phone**. Please login using the WebEx App.
- Users logging in should **sign-in with their full name and agency**. This will expedite entry into the Webinar.

Planning Section Staff will open the Webinar by 10:45 AM Eastern. Please try to enter by 11:10 AM to ensure you are admitted before 11:15.

Forward internally as appropriate, but attendance is limited to State and County emergency management partners.

Email eoc-plans@em.myflorida.com if there are questions or if you need technical assistance.

Ryan Lock | Florida Division of Emergency Management
State Emergency Response Team | Planning Section Chief
Preparedness Bureau | All-Hazards Preparedness Manager
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Subject: SERT-County Conference Call
Location: WebEx: https://fdem.webex.com/fdem/j.php?MTID=mdde3307d48f4e62329bd3cce13c900b7

Start: Monday, December 14, 2020 6:15 AM EST
End: Monday, December 14, 2020 7:15 AM EST
Show Time As: Tentative

Recurrence: Weekly

Meeting Status: Not yet responded

Organizer: Lock, Ryan
Required Attendees: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Courtney Coppola <Courtney.Coppola@flhealth.gov>; Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Dick, Cindy <Cindy.Dick@flhealth.gov>; Otis, Aaron <Aaron.Otis@flhealth.gov>; StateESF8.Planning <StateESF8.Planning@flhealth.gov>; Bielling, Jeffery <Jeffery.Bielling@flhealth.gov>; Harris, Shevaun <Shevaun.Harris@ahca.myflorida.com>; McKinstry, Molly <Molly.McKinstry@ahca.myflorida.com>; Smoak, Kimberly <Kimberly.Smoak@ahca.myflorida.com>; Mahon, Jason <Jason.Mahon@em.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Guidicelli, Ian <Ian.Guidicelli@em.myflorida.com>; SWO_COMMAND <SWO_COMMAND@em.myflorida.com>; EOC COSLogistics <EOC.COSLogistics@em.myflorida.com>; DeCastro, Kenneth <Kenneth.DeCastro@em.myflorida.com>; Plans Command <Plans_Command@em.myflorida.com>; Kitchen, Madison <Madison.Kitchen@em.myflorida.com>; Nagle, Taylor <Taylor.Nagle@em.myflorida.com>; Vaughn, Phyllis <Phyllis.Vaughn@em.myflorida.com>; McDaniel, Susanne <Susanne.McDaniel@em.myflorida.com>; Blake, Jessica <Jessica.Blake@em.myflorida.com>; Hunt, Kaitlyn <Kaitlyn.Hunt@em.myflorida.com>; Walters, Tara <Tara.Walters@em.myflorida.com>; McLeary, Allison <Allison.McLeary@em.myflorida.com>; Shirah, Melissa <Melissa.Shirah@em.myflorida.com>; Roberts, Douglas <Douglas.Roberts@em.myflorida.com>; Stachowicz, Stephanie <Stephanie.Stachowicz@em.myflorida.com>; Sayler, Erik <Erik.Sayler@em.myflorida.com>; Keenan, Gwen (FEMA) <Gwen.Keenan@fema.dhs.gov>; Williams, Paul (FEMA) <Paul.Williams6@fema.dhs.gov>; Peterson, Amy (FEMA) <Amy.Peterson@fema.dhs.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Lee Newsome <LNewsome@ERECinc.com>; madisoncountyem@gmail.com <madisoncountyem@gmail.com>; emergencymanagement@myescambia.com <emergencymanagement@myescambia.com>; Hughes, Pamela <Pamela.Hughes@em.myflorida.com>; Bond, Megan <Megan.Bond@em.myflorida.com>; Howell.Batts@flhealth.gov <Howell.Batts@flhealth.gov>; Margaret.Hart@osceola.org <Margaret.Hart@osceola.org>; Nicole Double <ndouble@scgov.net>; mcarmichael@fau.edu <mcarmichael@fau.edu>; rrodrigu@fgcu.edu <rrodrigu@fgcu.edu>; Kristina.Mathews@flhealth.gov <Kristina.Mathews@flhealth.gov>; Kristopher.Pickens@flhealth.gov <Kristopher.Pickens@flhealth.gov>; thomas.bowman@hhs.gov <thomas.bowman@hhs.gov>
Optional Attendees: Walters, Sam <Sam.Walters@em.myflorida.com>; Bouler, Kimberlyn (Santa Rosa Co Alt EM) <kimberlynb@santarosa.fl.gov>; Anderson, Kristy (Taylor Co EM) <kristy.anderson@taylorsheriff.org>; Grant Geyer <grantgeyer@fdle.state.fl.us>; Larry Rogers (Seminole Tribe EM) <larryrogers@semtribe.com>; Baker, Claudia <Claudia.Baker@em.myflorida.com>; Rezola, Inaki (Hillsborough Co Alt EM) <rezolai@hillsboroughcounty.org>; John Kohnke (Office of the Chief Financial Officer) <John.Kohnke@myfloridacfo.com>; Rahming, Derrick <DerrickRahming@flhsmv.gov>; Bunker, Chuck <Chuck.Bunker@sbafla.com>; Gerrell, Traci <Traci.Gerrell@ahca.myflorida.com>; Howard, Matthew <matthew.howard@myflfamilies.com>; McCrane, Ed (Sarasota Co EM) <EMcCrane@scgov.net>; Brown, Curtis <curtis.brown@myfwc.com>; Watts, Wayne <wayne.watts@myfloridacfo.com>; Casto, David (Sumter Co EM) <David.Casto@sumtercountyfl.gov>; Womble, Paul (Polk Co EM) <paulwomble@polk-county.net>; Kostus, Spencer (Lake Co Alt EM) <skostus@lakecountyfl.gov>; Perry, Kaylynn <Kaylynn.Perry@em.myflorida.com>; Wiggins, James <James.Wiggins@fdacs.gov>; Tucker, LeiAnna (FDACS) <LeiAnna.Tucker@fdacs.gov>; Bryan, Jeff <Jeffery.Bryan@fdc.myflorida.com>; Cleversy, Tommy <Tommy.cleversy@apdcares.org>; Hendrix, Stephanie M <shendrix@co.pinellas.fl.us>; Thorpe, Paul <paul.thorpe@nwfwater.com>; Goldberg, Jeff (Walton Co EM) <jeff@waltoncountyem.org>; Peter Newman <Peter.Newman@fldoe.org>; Moulton, Diane <Diane.Moulton@eog.myflorida.com>; Register, Joshua (Elder Affairs) <registerj@elderaffairs.org>; Jones, Harvey <HarveyJones@fdle.state.fl.us>; Ward, John (Clay Co EM) <john.ward@claycountygov.com>; LoPresti, Etta (Indian River Co Alt EM) <ELoPresti@ircgov.com>; Lord, Jonathan (Flagler Co EM) <jlord@flaglercounty.org>; Halquist, Richard (Osceola Co Alt EM) <richard.halquist@osceola.org>; Smith, Derek A. <dasmith@lakecountyfl.gov>; Abel, Lynn (Washington Co EM) <label@washingtonfl.com>; Cisco, Tom (Volusia Co Alt EM) <tcisco@volusia.org>; Hall, Steven <halls@flcourts.org>; Howard, Virgil <Virgil.Howard@dms.fl.gov>; Lumm, Frankie (Bay Co EM) <flumm@baycountyfl.gov>; Davis, Gregory (DJJ ECO) <Gregory.Davis@djj.state.fl.us>; Etienne, Debbie <DETIENNE@broward.org>; Duffey, Mike <Mikeduffey@fdle.state.fl.us>; Litton, Bill (Osceola Co EM) <bill.litton@osceola.org>; Saur, Jacob (Manatee Co Alt EM) <jacob.saur@mymanatee.org>; Shuler, Lisa (Liberty Co Alt EM) <mashuler@fairpoint.net>; Lambert, Gina <Gina.Lambert@em.myflorida.com>; Tambasco, Jeffrey (DeSoto Co EM) <j.tambasco@desotobocc.com>; Holloman, Chris (Escambia Co Alt EM) <cjhollom@myescambia.com>; Evan, Chris (Citrus Co EM) <cevan@sheriffcitrus.org>; Miller, Anne (Sarasota County Alt. EM) <ammiller@scgov.net>; Kawika J. Bailey <Kawika.Bailey@swfwmd.state.fl.us>; Lowers, Loren (Lottery Alt ECO) <lowersl@flalottery.com>; Durden, Carlos <carlos.durden@ocfl.net>; Taylor-Bennett, Carla <CTBENNETT@broward.org>; Foster, Greg (Nassau Co EM) <gfoster@nassauso.com>; ODell, Jeremy <Jeremy.ODell@em.myflorida.com>; Bradshaw, Brian <Brian.Bradshaw@em.myflorida.com>; McWhorter, Linda <Linda.McWhorter@em.myflorida.com>; Williams, Summer <Summer.Williams@fdacs.gov>; Broadway, Patricia <Patricia.Broadway@myfloridalicense.com>; Waite, Sally (Martin Co EM) <swaite@martin.fl.us>; Morrow, Nick <Nicholas.Morrow@fdacs.gov>; Owen, Adrienne (Holmes Co EM) <aowen@holmesem.org>; LangWilliam <William.Lang@colliercountyfl.gov>; Harris, Eddie <eddie.harris@apdcares.org>; Wilson, Cindy (Holmes Co Alt EM) <cwilson@holmesem.org>; Cintron, Morgan <Morgan.Cintron@em.myflorida.com>;

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The SERT-County Conference Calls will now occur daily M-F. Note that the link has changed:

https://fdem.webex.com/fdem/j.php?MTID=mdde3307d48f4e62329bd3cce13c900b7
Meeting Number: 179-323-8743

SERT-County Conference Call

The Monday and Friday 11:15 Eastern Conference Calls have moved to a WebEx Webinar. Please see the link below to join.

https://fdem.webex.com/fdem/j.php?MTID=mdde3307d48f4e62329bd3cce13c900b7

Meeting Number: 179-323-8743

Rules for Entry

- **We will not admit individuals joining via phone**. Please login using the WebEx App.
- Users logging in should **sign-in with their full name and agency**. This will expedite entry into the Webinar.

Planning Section Staff will open the Webinar by 10:45 AM Eastern. Please try to enter by 11:10 AM to ensure you are admitted before 11:15.

Forward internally as appropriate, but attendance is limited to State and County emergency management partners.

Email eoc-plans@em.myflorida.com if there are questions or if you need technical assistance.

Ryan Lock | Florida Division of Emergency Management
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From: EOC-Plans <EOC-Plans@em.myflorida.com>
Sent: Tuesday, January 19, 2021 3:51 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: EOC-Plans <EOC-Plans@em.myflorida.com>
Subject: Share Care Questions and Answers
Attachment(s): "Share Care QA.pdf"

Good afternoon,

Thank you all for your patience while the Share Care Team worked to ensure your questions were answered; the response to chat questions from the demonstration last week can be found attached to this email. A Demonstration Video and the Presentation can also be downloaded at the link below.

Demo Video
https://www.dropbox.com/s/4t1sxaj9uqtfnzf/florida-vaccine-assistant.m4v?dl=0

PDF Presentation
https://www.dropbox.com/s/uihd8ur2o9b4inz/sc_healthsecurity_vaccinesupport_FDEM.pdf?dl=0

Respectfully,

Ryan Lock
SERT Planning Section
EOC-Plans@em.mylorida.com

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1. Is there a cost to the county for use of this system?

   A: This system is provided free of charge to the county, on behalf of the state. Counties will not be asked to pay for the use of this system.

2. Is the person able to make a second dose appointment?

   A: If an individual has registered in the system and agreed to receive email or text messages, they will be sent a second dose reminders in the appropriate timeframe.

3. Will there be a separate webinar for the Tidal Basin Platform?

   A: No. Scheduling and vaccine platforms are managed by ShareCare. Tidal Basin is providing consulting, staffing and call center services, in coordination with ShareCare.

4. We typically send out a message with the link to the site. What is the first thing an individual sees once they click the link?

   A: After clicking on the link, individuals will be redirected to the state's landing page for vaccinations. From there, they can schedule appointments via the website or find additional information on how to schedule an appointment over the phone. After this appointment is made, individuals will receive an email or text message to confirm the appointment. They will also have the option to pre-register with the vaccine assistant.

5. Can you also attach the two presentations that were shown?

   A: Yes, the video and slide presentation will be provided.

6. Can the clients we have pre-registered be imported into the system?

   A: The state will work with each county to import existing information and transition to the statewide system.

7. Is the call center prepared to handle the volume of calls statewide?

   A: The state is committed to ensuring counties have every resource they need to respond to COVID-19 in their communities and is planning for the high volume of calls the system will receive once it's launched. The state is prepared to staff the call center by hiring additional personnel, as needed.

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8. Is the service ADA compliant, especially to the blind, etc.?

   A: Yes. The call center has TTY capability and additional accommodations can be made, as needed.

9. If an individual has already received their first dose, and enters their information into the system, is there an option to select second dose appointments?

   A: Yes. When the individual logs on for the first time, they will be asked to confirm if this is their first or second shot.

10. Does the system allow you to register multiple people (husband/wife/mother)?

    A: The system allows multiple data inputs during one session; however, separate appointments and registrations must be created.

11. With the FLSHOTS integration, will this reduce the amount of data entry for our staff? Or will staff still need to enter in the data into FLSHOTS?

    A: The system will be connected to automatically deliver data into FLSHOTs. If a site does not utilize the Sharecare service, SHOTS entries would still be required.

12. Can signatures be captured electronically for consent forms?

    A: Yes, the system can receive electronic signatures for the consent forms.

13. What type of equipment will be needed at the vaccination clinic/site?

    iPad tablets with internet provide the simplest, most secure workflow, although other devices with QR scanning capability. In addition to the tablets, it is recommended that window paint pens/window markers be used to mark vehicle windshields at drive through sites to identify transition between different stations.

14. Does the form/site provide information to people to advise the vaccine manufacturer?

    A: The system integrates the State FDOH vaccine forms

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15. Is an agreement needed between the vendor and counties or is the agreement with the State?

    A: Counties are not required to enter an agreement with the vendor. The agreement is with the state and the service is provided by the state.

16. What are the hours for tech support?

    A: The hours of standard tech support are [DAYS], [TIMES]. For after hours emergencies, on-call contact information will be provided.

17. Will this be offered in a culturally and linguistically competent manner? I.E. Spanish, Creole, reading level?

    A: The Vaccine Assistant tool will be available in English, Spanish and Creole.

18. What is the implementation timeline?

    A: The state is preparing to launch this system gradually. A typical onboarding process can take up to 72 hours.

19. Will the client be able to cancel appointments and re-schedule for another day base on their needs?

    A: Yes, cancellation and rescheduling options are available. However, it's important to note, that due to high demand, additional appointment times may not be available.

20. Are people going to have to go in every day until they are successful in getting an appointment or will they be on a list and notified when one is available?

    A: All available appointments will be displayed when individuals log in. Open appointments are added on a rolling basis, as they become available.

21. How easy is it to change the schedule every few days? Our schedule changes almost daily based on amount of staff available to give vaccines.

    A: Scheduling volume and operating hours can fluctuate from day-to-day, but appointment block volume must remain consistent throughout the operating day. For example, if booking 100 vaccines per hour, scheduling can be configured allow 25 every 15 minutes. We cannot configure 100 vaccines in one hour and 75 in the next hour.

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22. Can we split appointments between phone calls and online (if we had 200 appointments, we allocate 100 to phone and 100 to online)?

    A: Yes, counties are able to adapt the system to best fit the needs of their communities.

23. How are the appointments/locations generated? Do we have local control of this i.e.) an administrative level of access for the county?

    A: The county determines locations, schedule, and number of vaccinations. The ShareCare team works to update the system and call center to ensure all available appointments are available and displayed.

24. Is this all using cellular data if in remote areas?

    A: Internet connection is required for an all-digital process and for drive-thru sites. It is recommended that sites utilize the pre-registration process, to avoid unstable internet connections in the field.

25. Is there a way to control appointment time slots? Example, priority given to health care workers when scheduling. Or hold slots for some period before making them available to the public?

    A: There are multiple configuration options for priority populations within the system that will allow the county to control appointment slots.

26. What if the client does not bring the paperwork with the QR code?

    A: Pre-registered individuals can access the QR code onsite via phone or tablet. If the individual is not pre-registered, full-service registration can be completed on site.

27. Will the scanners that were sent from the State work to scan the QR codes?

    A: The scanners will not work for QR codes. However, the state is providing tablets to sites with capabilities to read QR codes.

28. What access level do the CHD personnel have to edit things in the system, such as the Lot number on the forms?

    A: The provider portal allows any individual with a provider pin to make necessary edits within the system.

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29. How easy is it to cancel or reschedule appointments?

    A: Technically simple, intuitive registration process that prompts the individual at each step. However, due to the demand of appointments, if an individual cancels an appointment, there may not be an available appointment to reschedule to.

30. Can you put limits on registrations per day (in the system build) to ensure it aligns with allotted vaccines your site has?

    A: Yes, schedules are set based on vaccine allocations provided. Capturing this information is part of the onboarding process prior to launch.

31. Is there a validation that the user meets the proper criteria , i.e. 65+, health care worker?

    B: The scheduling system is based on user response. However, sites should require proof of employment or age when the individual arrive on site.

32. What technology platform is running this software, has it been tested for statewide load testing?

    A: Microsoft Azure is the operating software. Microsoft Azure has been extensively tested by the state and continues to be tested to identify potential problems ahead of time.

33. How does the system work for people that do not have a device?

    A: If an individual does not have a device with internet capabilities, they can schedule an appointment with the call center and registration can be performed on site.

34. Will it check for duplication request for time periods?

    A: To allow all-inclusive participation of registered and unregistered residents and out-of-state visitors, the platform does not verify the identity of the user at this point. Therefore, it cannot prevent multiple schedules. (Our experience so far has been that the number of duplicate bookings is under 1.5%. To avoid wasted appointments the number of “overbookings” can be increased by 1.5%)

AMERICAN OVERSIGHT

35. How will someone, who makes a phone call appointment be validate upon arrival at the site, if they don't have a printout or mobile phone

    A: When confirming an appointment, online or via the call-center, individuals receive a confirmation email with their name and time. The site can request to present a printout of this email and validate the name on the appointment with an ID (DL, passport, or other). Additionally, lists of scheduled appointments can be provided to the sites.

36. Monroe County can really use this tool! Do we know what agencies will be receiving access this week?

    A: The state is rolling the system out gradually, to prevent an overload of the software. Counties will be notified of when they will be receiving access, once it is available.

37. Will it automatically schedule the second vaccine? And make sure the 2nd vaccine is the same as the first?

    A: Individuals will receive a notification to schedule their second appointment via second dose reminders. Individuals will need to schedule their second appointment at the time they receive the notification. Additionally, individuals will be given the same vaccine as the first. Information regarding type of vaccine an individual received will be available within the system for the sites.

38. Does it connect to the CDC's V-safe program for tracking of side effects?

    A: Yes, the system allows for data integration with VAERS.

39. What form is generated for them, the Moderna form or the Pfizer form?

    A: The form contains information for both vaccine types. The individual will be notified of what type of vaccine they received and will be able to reference the form.

AMERICAN OVERSIGHT

Subject: ShareCare Orientation Training
Location: Microsoft Teams Webinar

Start: Thursday, January 28, 2021 2:00 PM EST
End: Thursday, January 28, 2021 2:45 PM EST
Show Time As: Tentative

Recurrence: None

Meeting Status: Not yet responded

Organizer: EOC-Plans
Optional Attendees: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>; DEM All Staff <DEM@em.myflorida.com>

County EM Directors: Please feel free to join the SEOC for an orientation training on the ShareCare system.

Each timeslot offers the same training, so no need to join more than one. The training is 45 minutes.

Offerings

1. **Wednesday** 1/27 at 2PM
2. **Wednesday** 1/27 at 3PM

3. **Thursday** 1/28 at 2PM
4. **Thursday** 1/28 at 3PM

Meeting Information is below:

Microsoft Teams meeting

Join on your computer or mobile app
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Ryan Lock | Florida Division of Emergency Management
State Emergency Response Team | Planning Section Chief
Preparedness Bureau | All-Hazards Preparedness Manager
Ryan.Lock@em.myflorida.com | 850-841-9484

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AMERICAN OVERSIGHT

Subject: ShareCare Orientation Training
Location: Microsoft Teams Webinar

Start: Wednesday, January 27, 2021 3:00 PM EST
End: Wednesday, January 27, 2021 3:45 PM EST
Show Time As: Tentative

Recurrence: None

Meeting Status: Not yet responded

Organizer: EOC-Plans
Optional Attendees: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>; DEM All Staff <DEM@em.myflorida.com>

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Start: Wednesday, January 27, 2021 2:00 PM EST
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Organizer: EOC-Plans
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Start: Thursday, January 28, 2021 3:00 PM EST
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Show Time As: Tentative

Recurrence: None

Meeting Status: Not yet responded

Organizer: EOC-Plans
Optional Attendees: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>; DEM All Staff <DEM@em.myflorida.com>

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From: EOC-Plans <EOC-Plans@em.myflorida.com>
Sent: Friday, January 29, 2021 10:11 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Miller, Carly <carly.miller@em.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Guidicelli, Ian <Ian.Guidicelli@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>; Otis, Aaron <Aaron.Otis@flhealth.gov>; james.grant@dms.fl.gov <james.grant@dms.fl.gov>; Culbreath, Erek <Erek.Culbreath@em.myflorida.com>; Melissa Gordon <mgordon@tidalbasin.rphc.com>
Subject: ShareCare POD Appointment Survey

Good morning County Emergency Managers,

Counties who have chosen to use ShareCare for POD appointments are required to notify ShareCare every Friday of their PODs' hours of operation and appointments available per day for Wednesday though Tuesday of the following week. Once this information is received, ShareCare developers will work over the weekend to ensure appointments ae ready to be booked by residents.

Counties will use this survey to submit the required information: https://www.surveymonkey.com/r/ShareCarePODs.

A survey needs to be submitted for *each site* the county plans on utilizing ShareCare. Surveys must be submitted by 1:00 p.m. Friday to ensure ShareCare has time to configure their system.

Kaylynn Perry
Planning Section | State Emergency Response Team
Florida Division of Emergency Management
Kaylynn.perry@em.myflorida.com
PSC desk: (850) 815-4916
Mobile: (850) 254-5657

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AMERICAN OVERSIGHT

Subject: ShareCare Town Hall
Location: Webinar

Start: Tuesday, February 09, 2021 12:15 PM EST
End: Tuesday, February 09, 2021 1:15 PM EST
Show Time As: Tentative

Recurrence: None

Meeting Status: Not yet responded

Organizer: EOC-Operations
Required Attendees: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DLDOHCHDAdministrators_Directors@flhealth.gov <DLDOHCHDAdministrators_Directors@flhealth.gov>; james.grant@dms.fl.gov <james.grant@dms.fl.gov>; jennifer.cooke@dms.fl.gov <jennifer.cooke@dms.fl.gov>; mgordon@tidalbasin.rphc.com <mgordon@tidalbasin.rphc.com>; mmatthews@tidalbasin.rphc.com <mmatthews@tidalbasin.rphc.com>; phagopian@aarete.com <phagopian@aarete.com>; nblaszko@aarete.com <nblaszko@aarete.com>; McWhorter, Linda <Linda.McWhorter@em.myflorida.com>

These meetings are to establish a communication platform for all counties who are using the ShareCare system.
The agenda for each meeting will follow the cadence below:
·General updates
·Summary of known issues/concerns still outstanding
·Identification of new concerns

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AMERICAN OVERSIGHT

Subject: ShareCare Town Hall
Location: Microsoft Teams

Start: Monday, February 01, 2021 10:00 AM EST
End: Monday, February 01, 2021 11:00 AM EST
Show Time As: Tentative

Recurrence: Weekly

Meeting Status: Not yet responded

Organizer: EOC-Plans
Required Attendees: Grant, James <James.Grant@dms.fl.gov>; McWhorter, Linda <Linda.McWhorter@em.myflorida.com>; Culbreath, Erek <Erek.Culbreath@em.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Stephanie Murphy <smurphy@tidalbasin.rphc.com>; Melissa Gordon <mgordon@tidalbasin.rphc.com>; Douglass E Pace <dpace@stonehillinnovation.com>; Vasudev Bhat <Vasudev.Bhat@sharecare.com>
Optional Attendees: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DLDOHCHDAdministrators_Directors@flhealth.gov <DLDOHCHDAdministrators_Directors@flhealth.gov>

These meetings are to establish a communication platform for all counties who are using the Sharecare system.

The agenda for each meeting will follow the cadence below:

General updates
Summary of known issues/concerns still outstanding
Identification of new concerns

Meetings will occur daily at 3 p.m. M-F

This is in addition to the 9 AM Meetings

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AMERICAN OVERSIGHT

Subject: ShareCare Town Hall
Location: Webinar

Start: Monday, February 01, 2021 4:00 AM EST
End: Monday, February 01, 2021 5:00 AM EST
Show Time As: Tentative

Recurrence: Weekly

Meeting Status: Not yet responded

Organizer: Perry, Kaylynn
Required Attendees: james.grant@dms.fl.gov <james.grant@dms.fl.gov>; McWhorter, Linda <Linda.McWhorter@em.myflorida.com>; Culbreath, Erek <Erek.Culbreath@em.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Stephanie Murphy <smurphy@tidalbasin.rphc.com>; Melissa Gordon <mgordon@tidalbasin.rphc.com>
Optional Attendees: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DLDOHCHDAdministrators_Directors@flhealth.gov <DLDOHCHDAdministrators_Directors@flhealth.gov>

These meetings are to establish a communication platform for all counties who are using the Sharecare system.

The agenda for each meeting will follow the cadence below:

General updates
Summary of known issues/concerns still outstanding
Identification of new concerns

Meetings will occur daily at 9 a.m. M-F

Microsoft Teams meeting

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AMERICAN OVERSIGHT

Subject: ShareCare Town Hall
Location: Webinar

Start: Thursday, February 11, 2021 12:15 PM EST
End: Thursday, February 11, 2021 1:15 PM EST
Show Time As: Tentative

Recurrence: None

Meeting Status: Not yet responded

Organizer: EOC-Operations
Required Attendees: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DLDOHCHDAdministrators_Directors@flhealth.gov <DLDOHCHDAdministrators_Directors@flhealth.gov>; james.grant@dms.fl.gov <james.grant@dms.fl.gov>; jennifer.cooke@dms.fl.gov <jennifer.cooke@dms.fl.gov>; mgordon@tidalbasin.rphc.com <mgordon@tidalbasin.rphc.com>; mmatthews@tidalbasin.rphc.com <mmatthews@tidalbasin.rphc.com>; phagopian@aarete.com <phagopian@aarete.com>; nblaszko@aarete.com <nblaszko@aarete.com>; McWhorter, Linda <Linda.McWhorter@em.myflorida.com>

These meetings are to establish a communication platform for all counties who are using the ShareCare system.
The agenda for each meeting will follow the cadence below:
·General updates
·Summary of known issues/concerns still outstanding
·Identification of new concerns

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From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Sunday, December 13, 2020 9:37 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>
Subject: The Advisory Committee on Immunization Practices' Interim Recommendation for Use of Pfizer-BioNTech COVID-19 Vaccine
Attachment(s): "ACIPMMWRDec132020.pdf"

FYSA per HHS. See attached.

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Early Release / Vol. 69
December 13, 2020

The Advisory Committee on Immunization Practices' Interim Recommendation for Use of Pfizer-BioNTech COVID-19 Vaccine — United States, December 2020

Sara E. Oliver, MD[1]; Julia W. Gargano, PhD[1]; Mona Marin, MD[1]; Megan Wallace, DrPH[1,2]; Kathryn G. Curran, PhD[1]; Mary Chamberland, MD[1,3]; Nancy McClung, PhD[1]; Doug Campos-Outcalt, MD[4]; Rebecca L. Morgan, PhD[5]; Sarah Mbaeyi, MD[1]; José R. Romero, MD[6]; H. Keipp Talbot, MD[7]; Grace M. Lee, MD[8]; Beth P. Bell, MD[9]; Kathleen Dooling, MD[1]

On December 11, 2020, the Food and Drug Administration (FDA) issued an Emergency Use Authorization (EUA) for the Pfizer-BioNTech COVID-19 (BNT162b2) vaccine (Pfizer, Inc; Philadelphia, Pennsylvania), a lipid nanoparticle-formulated, nucleoside-modified mRNA vaccine encoding the prefusion spike glycoprotein of SARS-CoV-2, the virus that causes coronavirus disease 2019 (COVID-19) (*1*). Vaccination with the Pfizer-BioNTech COVID-19 vaccine consists of 2 doses (30 μg, 0.3 mL each) administered intramuscularly, 3 weeks apart. On December 12, 2020, the Advisory Committee on Immunization Practices (ACIP) issued an interim recommendation* for use of the Pfizer-BioNTech COVID-19 vaccine in persons aged ≥16 years for the prevention of COVID-19. To guide its deliberations regarding the vaccine, ACIP employed the Evidence to Recommendation (EtR) Framework,† using the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) approach.§ The recommendation for the Pfizer-BioNTech COVID-19 vaccine should be implemented in conjunction with ACIP's interim recommendation for allocating initial supplies of COVID-19 vaccines (*2*). The ACIP recommendation for the use of the Pfizer-BioNTech COVID-19 vaccine under EUA is interim and will be updated as additional information becomes available.

Since June 2020, ACIP has convened nine public meetings to review data on the epidemiology of COVID-19 and the potential use of COVID-19 vaccines, including the Pfizer-BioNTech COVID-19 vaccine (*3*). Within the EtR Framework, ACIP considered the importance of the public health problem of COVID-19, as well as issues of resource use, benefits and harms, patients' values and preferences, acceptability, feasibility, and equity for the Pfizer-BioNTech COVID-19 vaccine. To inform the EtR Framework, the COVID-19 Vaccines Work Group, comprising experts in infectious disease, vaccinology, vaccine safety, public health, and ethics, held 27 meetings to review COVID-19 surveillance data, evidence for vaccine efficacy and safety, and implementation considerations for COVID-19 vaccines, including the Pfizer-BioNTech COVID-19 vaccine. After a systematic review of the literature, the Work Group used the GRADE approach to assess the certainty of evidence for outcomes related to the vaccine, rated on a scale of 1 (high certainty) to 4 (very low certainty) (*4*). Work Group conclusions regarding the evidence for the Pfizer-BioNTech COVID-19 vaccine were presented to ACIP at public meetings.

The body of evidence for the Pfizer-BioNTech COVID-19 vaccine was primarily informed by one large, randomized, double-blind, placebo-controlled Phase II/III clinical trial that enrolled >43,000 participants (median age = 52 years, range = 16–91 years) (*5*,*6*). Interim findings from this clinical trial, using data from participants with a median of 2 months of follow-up, indicate that the Pfizer-BioNTech COVID-19 vaccine was 95.0% effective (95% confidence interval = 90.3%–97.6%) in preventing symptomatic laboratory-confirmed COVID-19 in persons without evidence of previous SARS-CoV-2 infection. Consistent high efficacy (≥92%) was observed across age, sex, race, and ethnicity categories and among persons with underlying medical conditions as well as among participants with evidence of previous SARS-CoV-2 infection. Although numbers of observed hospitalizations and deaths were low, the available data were consistent with reduced risk for these severe outcomes among vaccinated persons compared with that among placebo

* On December 12, 2020, ACIP voted 11–0 (three recusals) in favor of the interim recommendation for use of Pfizer-BioNTech COVID-19 vaccine. Three ACIP members recused themselves because of participation in clinical trials and/or other studies involving companies producing COVID-19 vaccines.
† https://www.cdc.gov/vaccines/acip/recs/grade/downloads/ACIP-evidence-recframe-508.pdf.
§ https://www.cdc.gov/vaccines/acip/recs/grade/about-grade.html.

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FL-DEM-21-0173-A-000326

recipients. Among vaccine recipients, reactogenicity symptoms, defined as solicited local injection site or systemic reactions during the 7 days after vaccination, were frequent and mostly mild to moderate. Systemic adverse reactions were more commonly reported after the second dose than after the first dose and were generally more frequent and severe in persons aged 18–55 years than in those aged >55 years. Systemic adverse reactions had a median onset of 1–2 days after vaccine receipt and resolved in a median of 1 day. Severe local and systemic adverse reactions (grade ≥3, defined as interfering with daily activity) occurred more commonly in vaccine recipients than in placebo recipients. Among vaccine recipients, 8.8% reported any grade ≥3 reaction; the most common symptoms were fatigue (4.2%), headache (2.4%), muscle pain (1.8%), chills (1.7%), and injection site pain (1.4%). Generally, grade ≥3 reactions were more commonly reported after the second dose than after the first dose and were less prevalent in older than in younger participants. Serious adverse events[¶] were observed in a similar proportion of vaccine (0.6%) and placebo (0.5%) recipients and encompassed medical events occurring at a frequency similar to that within the general population (*6*). No specific safety concerns were identified in subgroup analyses by age, race, ethnicity, underlying medical conditions, or previous SARS-CoV-2 infection. A detailed summary of safety data, including information on reactogenicity, is available at https://www.cdc.gov/vaccines/covid-19/info-by-manufacturer/pfizer/reactogenicity.html.

From the GRADE evidence assessment, the level of certainty for the benefits of the Pfizer-BioNTech COVID-19 vaccine was type 1 (high certainty) for the prevention of symptomatic COVID-19. Evidence was type 3 (low certainty) for the estimate of prevention of COVID-19–associated hospitalization and type 4 (very low certainty) for the estimate of prevention of death. Data on hospitalizations and deaths are limited at this time, but a vaccine that effectively prevents symptomatic infection is expected to also prevent hospitalizations and deaths. Regarding potential harms after vaccination, evidence was type 2 (moderate certainty) for serious adverse events and type 1 (high certainty) for reactogenicity. No data were available to assess the efficacy for prevention of asymptomatic SARS-CoV-2 infection. Data reviewed within the EtR Framework supported the use of the Pfizer-BioNTech COVID-19 vaccine. ACIP determined that COVID-19 is a major public health problem and that use of the Pfizer-BioNTech COVID-19 vaccine is a reasonable and efficient allocation of resources. Whereas there might be uncertainty in how all populations value the vaccine, it was determined that for most populations, the desirable effects outweigh the undesirable effects. The vaccine is probably acceptable to implementation stakeholders and feasible to implement in spite of difficult ultracold-chain storage and requirements for handling and administration. These requirements could limit the availability of the Pfizer-BioNTech COVID-19 vaccine to some populations thereby negatively impacting health equity. Therefore, efforts should be made to overcome these challenges and advance health equity. The GRADE evidence profile and EtR supporting evidence are available at https://www.cdc.gov/vaccines/acip/recs/grade/covid-19-pfizer-biontech-vaccine.html and https://www.cdc.gov/vaccines/acip/recs/grade/covid-19-pfizer-biontech-etr.html.

Before vaccination, the EUA Fact Sheet should be provided to recipients and caregivers. Providers should counsel Pfizer-BioNTech COVID-19 vaccine recipients about expected systemic and local reactogenicity. Additional clinical considerations, including details of administration and use in special populations (e.g., persons who are pregnant or immunocompromised or who have severe allergies) are available at https://www.cdc.gov/vaccines/covid-19/info-by-manufacturer/pfizer/clinical-considerations.html. Additional studies of safety and effectiveness are planned after authorization and will be important to inform future ACIP recommendations as well as increase public confidence in the COVID-19 vaccination program. The interim recommendation and clinical considerations are based on use of the Pfizer-BioNTech COVID-19 vaccine under an EUA and might change as more evidence becomes available. ACIP will continue to review additional data as they become available; updates to recommendations or clinical considerations will be posted on the ACIP website (https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html).

Reporting of Vaccine Adverse Events

Adverse events that occur in a recipient after receipt of COVID-19 vaccine should be reported to the Vaccine Adverse Events Reporting System (VAERS). FDA requires that vaccination providers report vaccination administration errors, serious adverse events, cases of multisystem inflammatory syndrome, and cases of COVID-19 that result in hospitalization or death after administration of COVID-19 vaccine under EUA. Reporting is encouraged for any clinically significant adverse event, whether or not it is clear that a vaccine caused the adverse event. Information on how to submit a report to VAERS is available at https://vaers.hhs.gov/index.html or 1-800-822-7967. In addition, CDC has developed a new, voluntary smartphone-based tool, v-safe, that uses text messaging and web surveys to provide near real-time health check-ins after patients receive COVID-19 vaccination. The CDC/v-safe call center follows up on reports to v-safe that indicate a medically significant health impact to collect additional information for completion of a VAERS report. Information on v-safe is available at https://www.cdc.gov/vsafe.

[¶] Serious adverse events are defined as any untoward medical occurrence that results in death, is life-threatening, requires inpatient hospitalization or prolongation of existing hospitalization, or results in persistent disability/incapacity.

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FL-DEM-21-0173-A-000327

Summary

What is already known about this topic?

On December 11, 2020, the Food and Drug Administration issued an Emergency Use Authorization for the Pfizer-BioNTech COVID-19 vaccine.

What is added by this report?

On December 12, 2020, after an explicit, evidence-based review of all available data, the Advisory Committee on Immunization Practices (ACIP) issued an interim recommendation for use of the Pfizer-BioNTech COVID-19 vaccine in persons aged ≥16 years for the prevention of COVID-19.

What are the implications for public health practice?

The recommendation for the Pfizer-BioNTech COVID-19 vaccine should be implemented in conjunction with ACIP's interim recommendation for allocating initial supplies of COVID-19 vaccines.

Acknowledgments

Voting members of the Advisory Committee on Immunization Practices: Robert L. Atmar, Baylor College of Medicine; Kevin A. Ault, University of Kansas Medical Center; Lynn Bahta, Minnesota Department of Health; Henry Bernstein, Zucker School of Medicine at Hofstra/Northwell Cohen Children's Medical Center; Sharon E. Frey, Saint Louis University Medical School; Paul Hunter, City of Milwaukee Health Department; Veronica V. McNally, Franny Strong Foundation; Katherine A. Poehling, Wake Forest School of Medicine; Pablo J. Sánchez, The Research Institute at Nationwide Children's Hospital; Peter Szilagyi, University of California, Los Angeles. Members of the Advisory Committee on Immunization Practices COVID-19 Vaccines Work Group: Edward Belongia, Center for Clinical Epidemiology & Population Health, Marshfield Clinic Research Institute; Dayna Bowen Matthew, George Washington University Law School; Oliver Brooks, National Medical Association; Matthew Daley, Institute for Health Research, Kaiser Permanente Colorado; Jillian Doss-Walker, Indian Health Service; Marci Drees, Society for Healthcare Epidemiology of America; Jeffrey Duchin, Infectious Diseases Society of America; Kathy Kinlaw, Center for Ethics, Emory University; Doran Fink, Food and Drug Administration; Sandra Fryhofer, American Medical Association; Jason M. Goldman, American College of Physicians; Michael Hogue, American Pharmacists Association; Denise Jamieson, American College of Obstetricians and Gynecologists; Jeffery Kelman, Centers for Medicare & Medicaid; David Kim, U.S. Department of Health and Human Services; Susan Lett, Council of State and Territorial Epidemiologists; Kendra McMillan, American Nurses Association; Kathleen Neuzil, Center for Vaccine Development and Global Health, University of Maryland School of Medicine; Sean O'Leary, American Academy of Pediatrics; Christine Oshansky, Biomedical Advanced Research and Development Authority; Stanley Perlman, Department of Microbiology and Immunology, University of Iowa; Marcus Plescia, Association of State and Territorial Health Officials; Chris Roberts, National Institutes of Health; William Schaffner, National Foundation for Infectious Diseases; Kenneth Schmader, American Geriatrics Society; Bryan Schumacher, Department of Defense; Rob Shechter, Association of Immunization Managers; Jonathan Temte, American Academy of Family Physicians; Matthew Tunis, National Advisory Committee on Immunization Secretariat, Public Health Agency of Canada; Thomas Weiser, Indian Health Service; Matt Zahn, National Association of County and City Health Officials; Rachel Zhang, Food and Drug Administration.

Corresponding author: Sara E. Oliver, yxo4@cdc.gov.

[1]CDC COVID-19 Response Team; [2]Epidemic Intelligence Service, CDC; [3]General Dynamics Information Technology, Falls Church, Virginia; [4]University of Arizona College of Medicine, Phoenix, Arizona; [5]Department of Health Research Methods, Evidence, and Impact, Hamilton, Ontario; [6]Arkansas Department of Health; [7]Vanderbilt University School of Medicine, Nashville, Tennessee; [8]Stanford University School of Medicine, Stanford, California; [9]University of Washington, Seattle, Washington.

All authors have completed and submitted the International Committee of Medical Journal Editors form for disclosure of potential conflicts of interest. No potential conflicts of interest were disclosed.

References

1. Food and Drug Administration. Pfizer-BioNTech COVID-19 Vaccine Emergency Use Authorization. Silver Spring, MD: US Department of Health and Human Services, Food and Drug Administration; 2020. https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine
2. Dooling K, McClung N, Chamberland M, et al. The Advisory Committee on Immunization Practices' interim recommendation for allocating initial supplies of COVID-19 vaccine—United States, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1857–9. PMID:33301429 https://doi.org/10.15585/mmwr.mm6949e1
3. Advisory Committee on Immunization Practices. ACIP meeting information. Atlanta, GA: US Department of Health and Human Services, CDC; 2020. https://www.cdc.gov/vaccines/acip/meetings/index.html
4. Advisory Committee on Immunization Practices. Advisory Committee on Immunization Practices (ACIP): GRADE (grading of recommendations, assessment, development and evaluation). Atlanta, GA: US Department of Health and Human Services, CDC; 2020. https://www.cdc.gov/vaccines/acip/recs/grade
5. Vaccines and Related Biological Products Advisory Committee. Vaccines and Related Biological Products Advisory Committee December 10, 2020, meeting: sponsor briefing document. Silver Spring, MD: US Department of Health and Human Services, Food and Drug Administration; 2020. https://www.fda.gov/media/144246/download
6. Vaccines and Related Biological Products Advisory Committee. Vaccines and Related Biological Products Advisory Committee December 10, 2020, meeting: FDA briefing document. Silver Spring, MD: US Department of Health and Human Services, Food and Drug Administration; 2020. https://www.fda.gov/media/144245/download

Readers who have difficulty accessing this PDF file may access the HTML file at https://www.cdc.gov/mmwr/volumes/69/wr/mm6950e2.htm?s_cid=mm6950e2_w. Address all inquiries about the *MMWR* Series, including material to be considered for publication, to Editor, *MMWR* Series, Mailstop E-90, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30329-4027 or to mmwrq@cdc.gov.

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FL-DEM-21-0173-A-000328

From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Thursday, December 17, 2020 9:46 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>
Subject: UPDATE -- CDC COVID-19 Vaccination Communication Toolkit

FYI

https://www.cdc.gov/vaccines/covid-19/health-systems-communication-toolkit.html

Please continue to monitor this website for new guidance.

From: Davis, Ashley
Sent: Monday, December 14, 2020 9:28 AM
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
Cc: DEM All Staff <DEM@em.myflorida.com>
Subject: CDC COVID-19 Vaccination Communication Toolkit

FYSA –

Please see weblink for the CDC – COVID-19 Vaccination communication guidance. Please use as you wish; the SERT will incorporate this guidance and modify as needed.

COVID-19 Vaccination Communication Toolkit

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Monday, January 04, 2021 1:26 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>
Subject: Update -- CDC's COVID-19 weekly call at 1400

Per HHS.

Subject: **NEW CALL INFORMATION** CDC's COVID-19 weekly call

****NEW CALL INFORMATION****

CDC's 2019 Novel Coronavirus (COVID-19) response team will continue to host a national call series from 2 p.m. to 2:45 p.m. EST every Monday, to provide state and local partners with the latest information on the novel coronavirus outbreak and U.S. preparedness efforts.

Invited participants include state, local, and territorial preparedness directors, state epidemiologists, state health officials, public health laboratory directors, and nongovernmental partners. Participant information can be found below.

Participant Information

Bridgeline: 1(888) 455-8370
Passcode: 5206512

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From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Wednesday, December 23, 2020 2:28 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>
Subject: UPDATE -- Severe Weather Possible Thursday
Attachment(s): "12-23-20_Severe_Weather_Update.pdf"

Team, good afternoon:

We have been watching this cold front for several days. The NWS heightened the advisory category to "Slight" in the Panhandle and **"Marginal"** across the Peninsula.

SWO Actions:

1. Preparing and distributing messaging to the counties, ECOs, and our staff – see below for additional details.
2. SWO Meteorology has been participating in NWS conference calls.
3. The SWO has reviewed it's staffing to ensure we can handle the anticipated advisories.
4. **ECOs** – please ensure the SWO/Branch Directors have the correct POC for the holiday.

Per the 5 day outlook packet – *"behind the cold front, a strong surge of cold air will push into the state overnight, leading to what could be the coldest Christmas Day across North Florida since 2004 and coldest Christmas Day across Central and South Florida since 1995!"*

Please be vigilant and monitor the weather. Wishing you, your family, a safe and happy holiday!

V/r,
Ash

Ashley H. Davis, FPEM, CEM | Bureau Chief of Response
Florida Division of Emergency Management
Ashley.Davis@em.myflorida.com

From: Florida Division of Emergency Management <FDEM@public.govdelivery.com>
Sent: Wednesday, December 23, 2020 1:13 PM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Subject: ***FYI: Severe Weather Possible Thursday***

FDEM Header

This update is intended for government and emergency response officials, and is provided for informational and situational awareness purposes only. Forecast conditions are subject to change based on a variety of environmental factors. For additional information, or for any life safety concerns with an active weather event please contact your local National Weather Service forecast office.

New users wishing to subscribe (approval pending) to this list can click here: https://public.govdelivery.com/accounts/FLDEM/subscriber/new?topic_id=Weather_Briefing_Packets

You are subscribed to Non-Tropical Weather Briefing Packets for Florida Division of Emergency Management. This information has recently been updated, and is now available.

spc1 | spc2

- **12-23-20 Severe Weather Update.pdf**

•**What**: A strong cold front will bring a threat of severe weather, including damaging wind gusts, heavy rainfall, and isolated tornadoes. Coldest air of the

AMERICAN OVERSIGHT

season so far moves in behind the front.

•**Where**: Slight Risk (level 2 of 5) for the western Panhandle, Marginal Risk (level 1 of 5) for the eastern Panhandle, Big Bend, Northeast Florida, Central Florida and South Florida (generally north of Alligator Alley).

•**When**: Panhandle – Thursday morning; Big Bend – Thursday afternoon; Peninsula – Thursday evening

•**Potential Impacts**:

- •Damaging wind gusts around 45-65mph and a couple of tornadoes may cause power outages, downed trees/limbs, and damage to weak structures (such as mobile/manufactured homes). Temporary structures will be more susceptible to the severe weather.
- •Heavy rain could cause temporary flooding of roadways and rising of creeks and rivers.
- •Cold air could harm animals and sensitive vegetation such as flowers and citrus.

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This email was sent to ashley.davis@em.myflorida.com using GovDelivery Communications Cloud on behalf of: Florida Division of Emergency Management · 2555 Shumard Oak Boulevard · Tallahassee, FL 32399-2100

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WEATHER UPDATE

1:00 PM EST

Wednesday, December 23, 2020

Severe Weather Threat Thursday

Statewide

This update is intended for government and emergency response officials, and is provided for informational and situational awareness purposes only. Forecast conditions are subject to change based on a variety of environmental factors. For additional information, or for any life safety concerns with an active weather event please contact your County Emergency Management or Public Safety Office, local National Weather Service forecast office at www.weather.gov, or visit the Storm Prediction Center website at spc.noaa.gov.

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FL-DEM-21-0173-A-000333

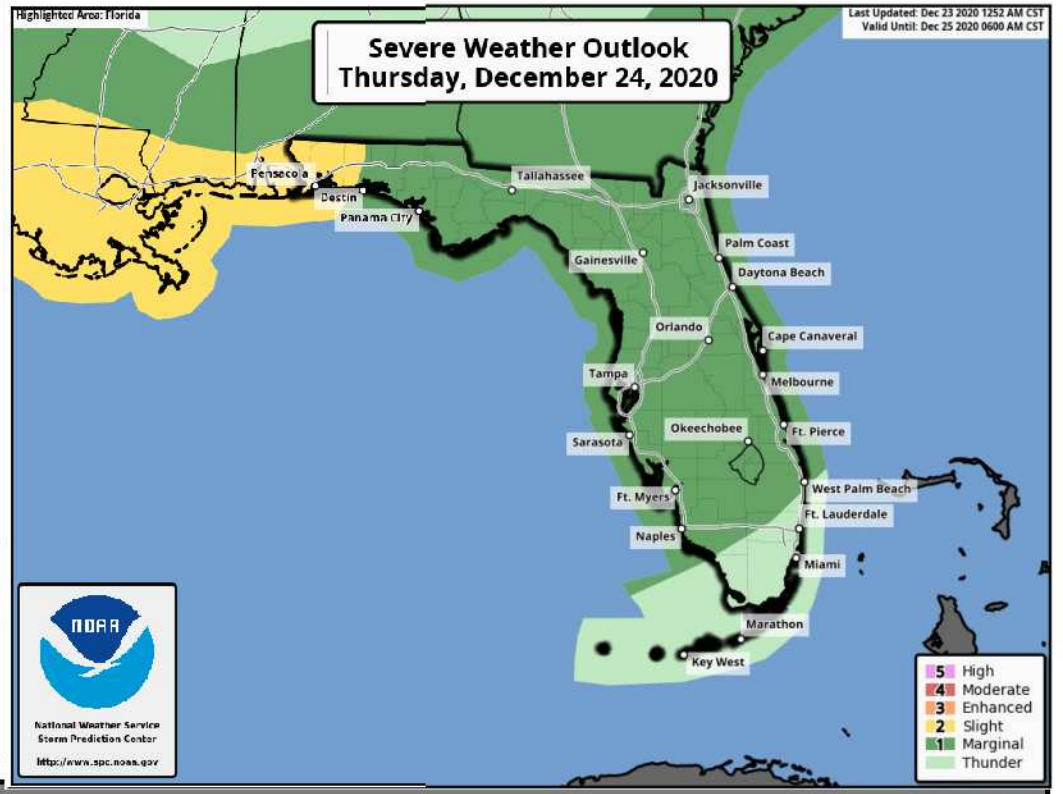
Severe Threat Overview

Florida Threats & Summary

	Marginal	Slight	Enhanced	Moderate	High
Severe Risk					
Tornado	Eastern Panhandle	Western Panhandle			
Damaging Winds	Elsewhere	Western Panhandle			
Hail					

	Marginal	Slight	Moderate	High
Flash Flooding				

Storm Prediction Center Map



Overview/Recent Changes:

A strong cold front will move through the Panhandle Thursday morning and through the Peninsula in the afternoon/evening. The primary hazard is damaging wind gusts (50-65mph) and brief heavy rainfall, but isolated tornadoes are also possible in the Panhandle and Big Bend.

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Severe Thunderstorm Risk Categories

Understanding the Storm Prediction Center Risk Scale

Understanding Severe Thunderstorm Risk Categories

THUNDERSTORMS (no label)	1 - MARGINAL (MRGL)	2 - SLIGHT (SLGT)	3 - ENHANCED (ENH)	4 - MODERATE (MDT)	5 - HIGH (HIGH)
No severe* thunderstorms expected	**Isolated severe thunderstorms possible**	**Scattered severe storms possible**	**Numerous severe storms possible**	**Widespread severe storms likely**	**Widespread severe storms expected**
Lightning/flooding threats exist with <u>all</u> thunderstorms	Limited in duration and/or coverage and/or intensity	Short-lived and/or not widespread, isolated intense storms possible	More persistent and/or widespread, a few intense	Long-lived, widespread and intense	Long-lived, very widespread and particularly intense

* NWS defines a severe thunderstorm as measured wind gusts to at least 58 mph, and/or hail to at least one inch in diameter, and/or a tornado. All thunderstorm categories imply lightning and the potential for flooding. Categories are also tied to the probability of a severe weather event within 25 miles of your location.

National Weather Service
www.spc.noaa.gov

Thunderstorms (no label)
No severe* thunderstorms expected
Lightning/flooding threat exists with <u>all</u> thunderstorms
Winds to 40 mph and small hail possible

1 Marginal Risk (MRGL)
Isolated severe thunderstorms possible
Limited in duration and/or coverage and/or intensity
Wind to 40-60 mph, hail up to 1", and low tornado risk

2 Slight Risk (SLGT)
Scattered severe storms possible
Short-lived and/or not widespread, isolated intense storms
One or two tornadoes
Reports of strong winds and wind damage
Hail ~1", isolated 2"

3 Enhanced Risk (ENH)
Numerous severe storms possible
More persistent and/or widespread, a few intense
A few tornadoes
Several wind damage reports
Damaging hail, 1"-2"

4 Moderate Risk (MDT)
Widespread severe storms likely
Long-lived, widespread and intense
Strong tornadoes
Widespread wind damage
Destructive hail, 2" or greater

5 High Risk (HIGH)
Widespread severe storms expected
Long-lived, very widespread and particularly intense
Tornado outbreak
Derecho

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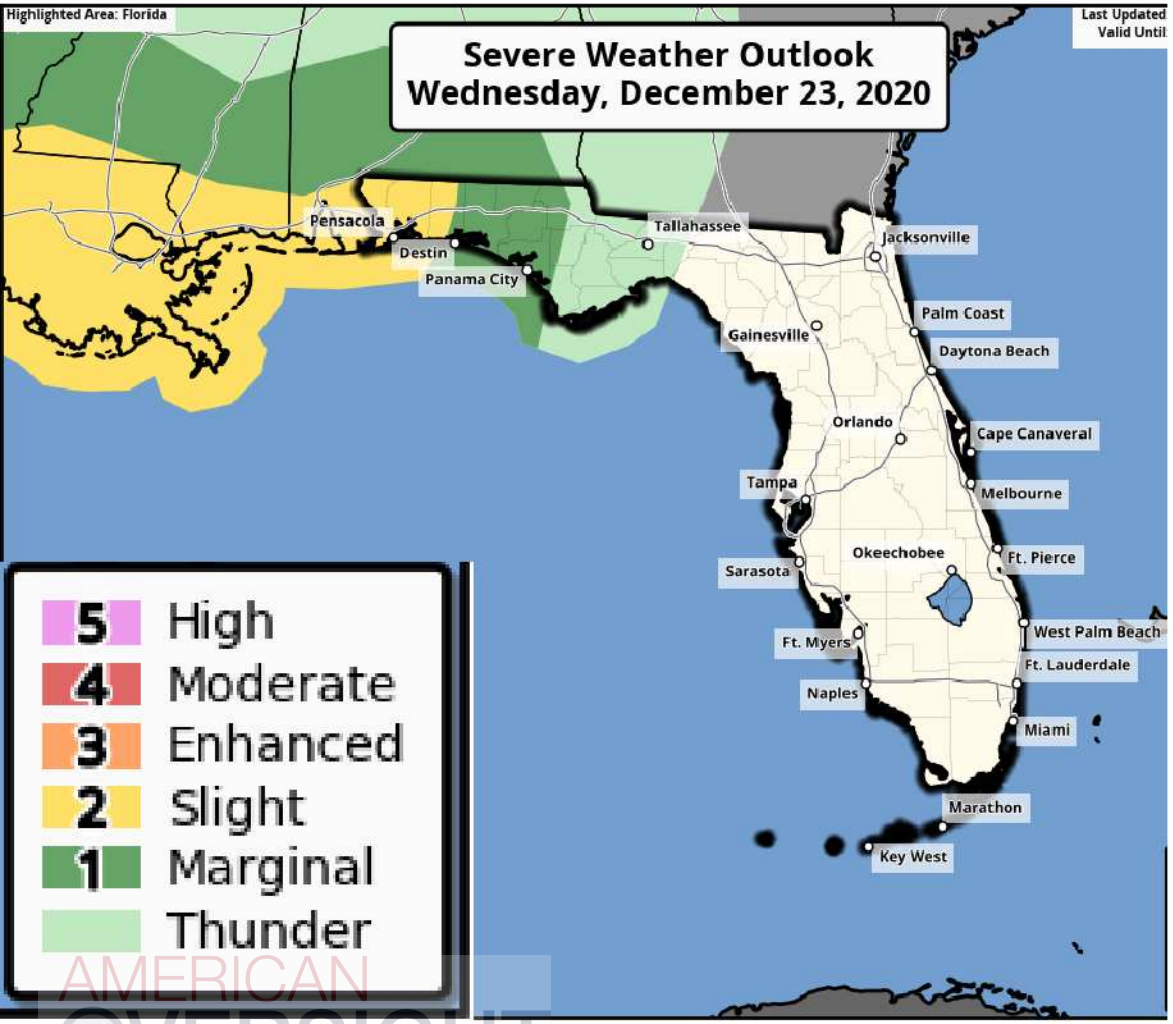
FL-DEM-21-0173-A-000335

Severe Weather Outlook- Early Thursday

From the Storm Prediction Center



A line of strong thunderstorms will develop tonight along a cold front and move eastward into the western Panhandle Thursday morning just before sunrise. Scattered storms could form ahead of this main line and impact Panhandle areas as after midnight.

Storm both along and ahead of the main line have the potential to produce **damaging wind gusts and isolated tornadoes**.

There is a **Slight Risk** (level 2 of 5) of severe weather for the western Panhandle and a **Marginal Risk** (level 1 of 5) of Severe Weather for the eastern Florida Panhandle.

Note: This outlook covers the period before 6 am CST.

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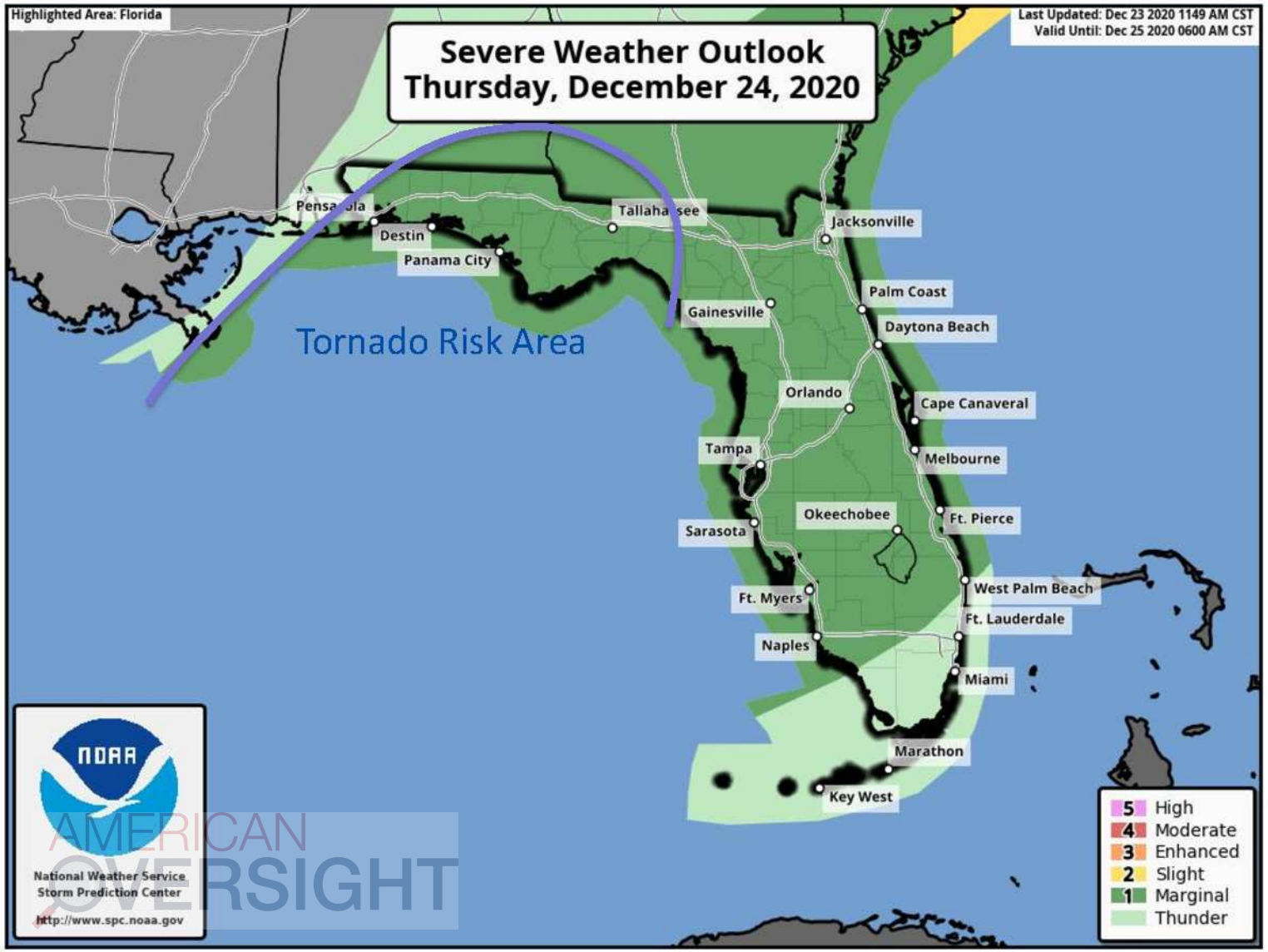
Severe Weather Outlook- Thursday

From the Storm Prediction Center



The line of thunderstorms will continue to move eastward across the Panhandle and Big Bend during the day on Thursday, then affecting the Peninsula later in the day and during the evening before weakening and moving offshore around midnight.

There is a **Marginal Risk** (level 1 of 5) of severe weather for nearly the entire state. The primary severe weather threat statewide is damaging wind gusts (45-65 mph), but isolated tornadoes will also be possible in the Panhandle and Big Bend.

Note: This outlook covers the period after 6 am CST / 7 am EST.

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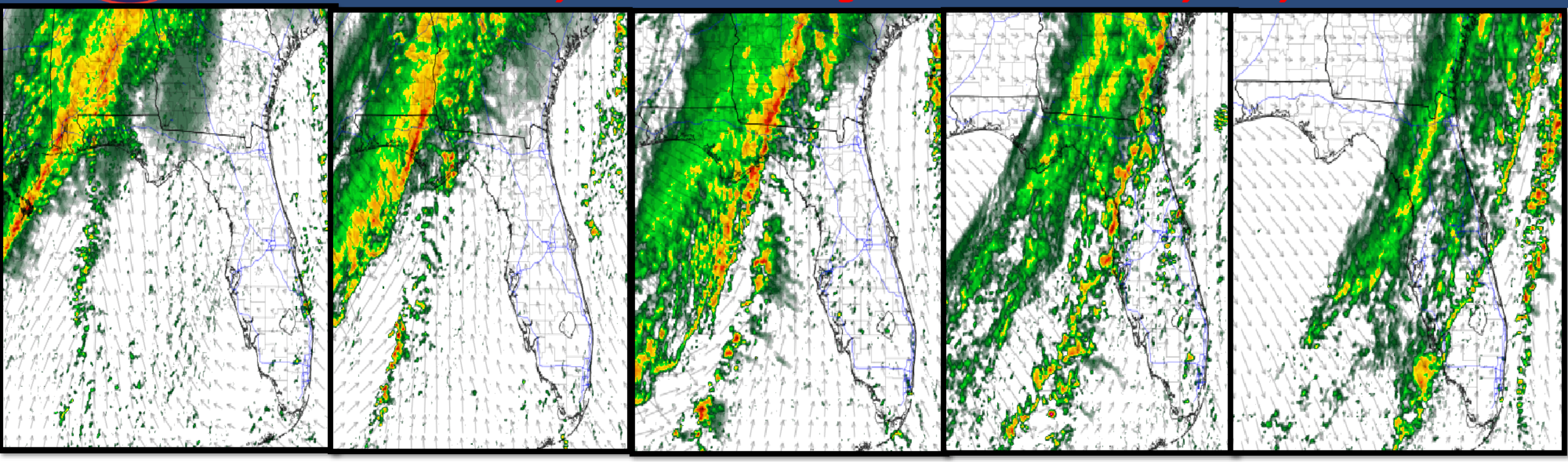
Model Forecast Radar

Guidance Only – Exact Timing and Position May Vary



7 AM ET / 6 AM CT	12 PM ET / 11 AM CT	3 PM ET / 2 PM CT	6 PM ET / 5 PM CT	10 PM ET / 9 PM CT
Thursday	Thursday	Thursday	Thursday	Thursday

The line of thunderstorms is forecast to move into the western Panhandle around sunrise Thursday and continue eastward during the morning hours, moving across Big Bend during the midday-mid afternoon, and then into the northern Peninsula mid-afternoon through early evening. The line should begin to weaken as it moves south of I-4 after sunset, with storms ending around midnight-2am Friday.

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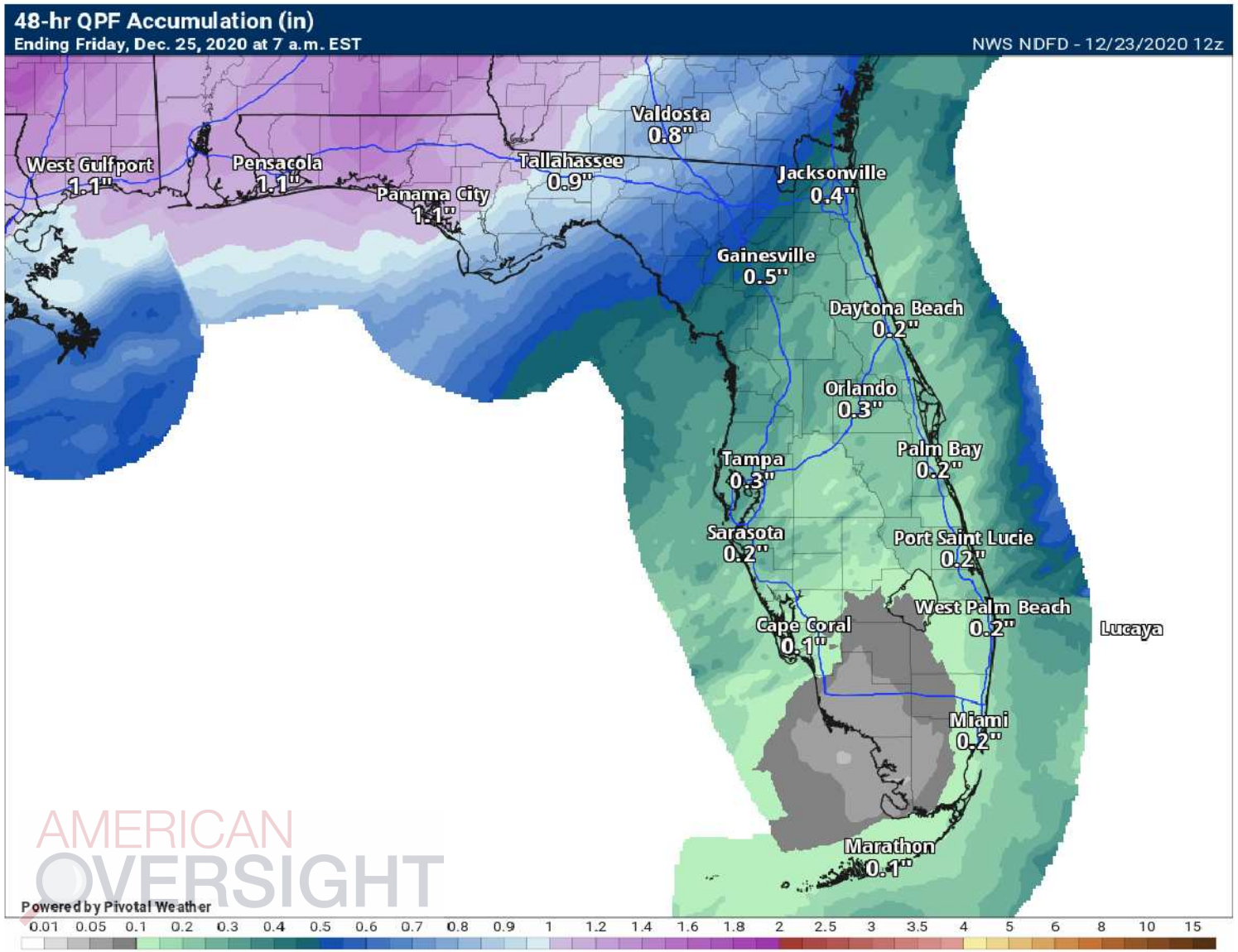
Rainfall Totals Next 48 Hours

Ending 7 AM ET Friday



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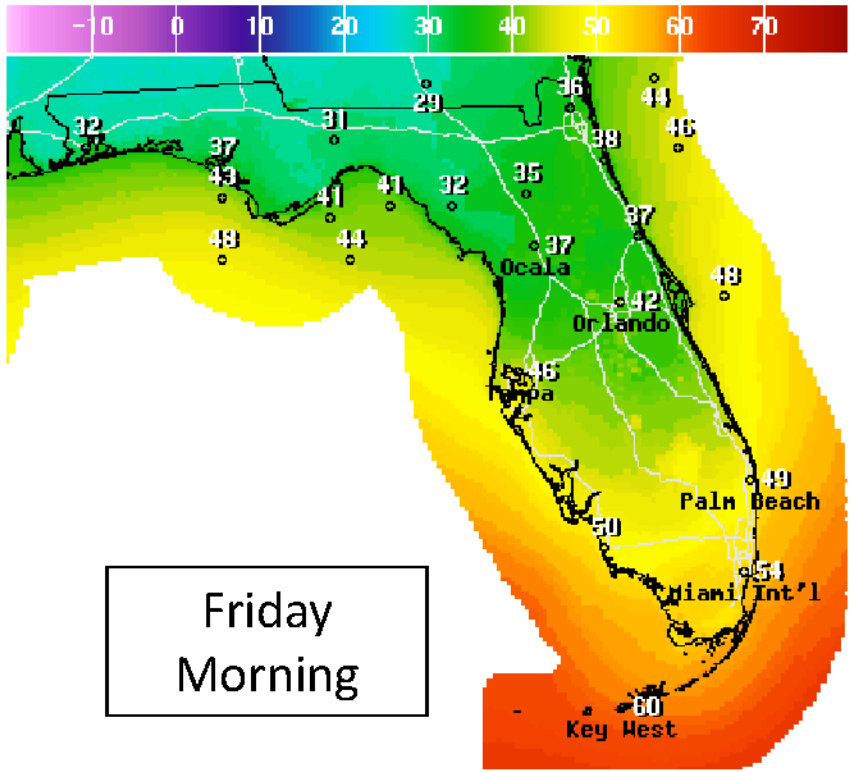
These storms could also produce brief heavy rainfall totals of 1-2” across the Panhandle and western Big Bend. Lower amounts of ¼” to 1” is expected across the eastern Big Bend and Peninsula.

The flash flood risk is very low, but ponding of water on roadways and minor flooding of poor-drainage areas is possible during the heaviest rain.

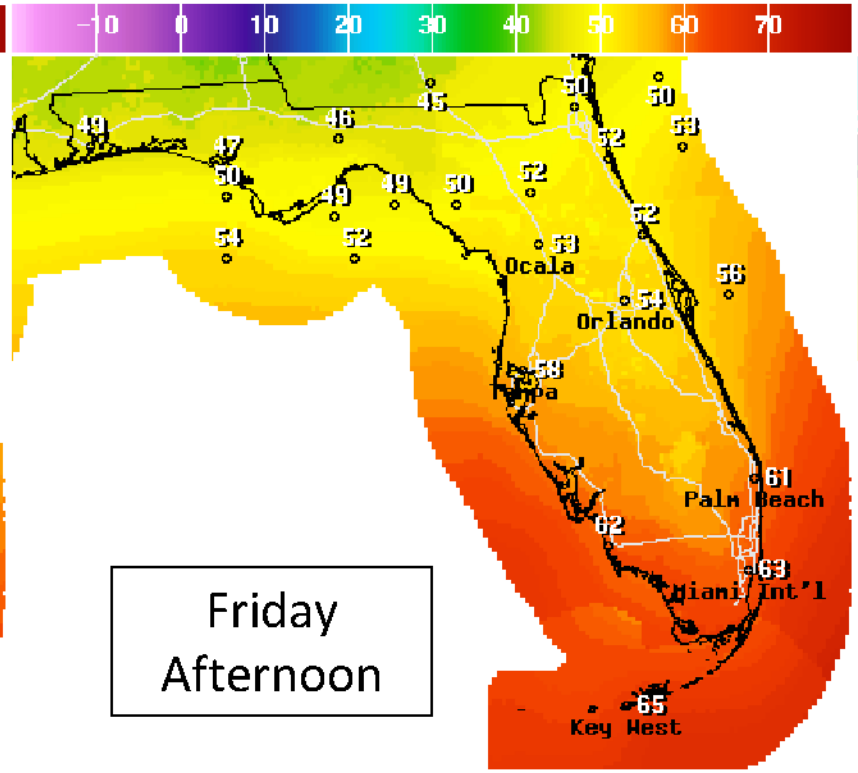
At this time, river flooding is not forecast. However, some Panhandle rivers are forecast to reach Action Stage (bank full).

Forecast Temperatures

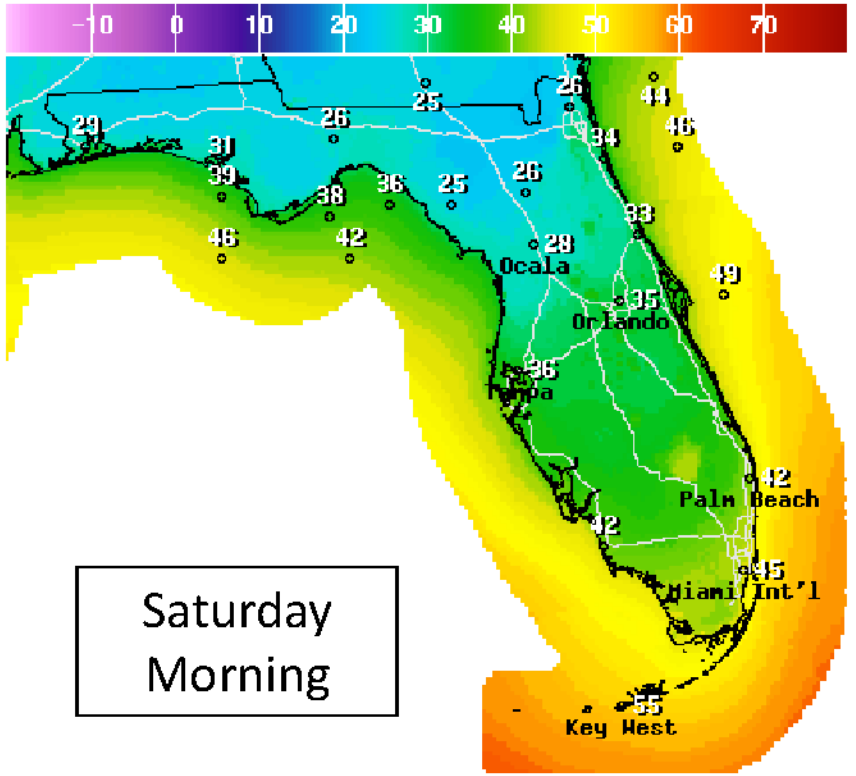
Behind the Cold Front



Friday Morning



Friday Afternoon



Saturday Morning

Freezing temperatures move in behind the cold front

A brief **light freeze** is expected across inland areas of the Panhandle and Big Bend early Friday morning (icing on roads should not occur), with a **freeze likely** across much of North Florida and the Nature Coast Saturday morning. Frost is possible in Central Florida. Afternoon highs on Friday will only reach the mid-40s to low 50s across North Florida, with highs ranging from the mid 50s across Central Florida to mid 60s across South Florida. Additionally, winds of 10-20mph will make it feel even colder. This forecast would make this the coldest Christmas Day since 2004 for North Florida and 1995 for Central and South Florida.

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Summary

- **What**: A strong cold front will bring a threat of severe weather, including damaging wind gusts, heavy rainfall, and isolated tornadoes. Coldest air of the season so far moves in behind the front.
- **Where**: Slight Risk (level 2 of 5) for the western Panhandle, Marginal Risk (level 1 of 5) for the eastern Panhandle, Big Bend, Northeast Florida, Central Florida and South Florida (generally north of Alligator Alley).
- **When**: Panhandle – Thursday morning; Big Bend – Thursday afternoon; Peninsula – Thursday evening
- **Potential Impacts**:
  - Damaging wind gusts around 45-65mph and a couple of tornadoes may cause power outages, downed trees/limbs, and damage to weak structures (such as mobile/manufactured homes). Temporary structures will be more susceptible to the severe weather.
  - Heavy rain could cause temporary flooding of roadways and rising of creeks and rivers.
  - Cold air could harm animals and sensitive vegetation such as flowers and citrus.

This will the only briefing package for this event unless there are significant changes in the forecast. For the latest severe weather updates, see products from your local National Weather Service office and the Storm Prediction Center.

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WEATHER UPDATE

Created by:

Amy Godsey, Chief State Meteorologist

Amy.Godsey@em.myflorida.com

State Meteorological Support Unit

Florida Division of Emergency Management

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From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Thursday, January 28, 2021 4:52 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>
CC: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; DeCastro, Kenneth <Kenneth.DeCastro@em.myflorida.com>; EOC-COSLogistics <EOC-COSLogistics@em.myflorida.com>; Bussey, Jon <Jon.Bussey@em.myflorida.com>
Subject: UPDATE -- Vendor List for PPE and other resources 1/28/21
Attachment(s): "PPE Vendor List 1_28_2021.xlsx"

Updated – see attached.

From: Davis, Ashley
Sent: Tuesday, November 17, 2020 1:48 PM
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Cc: Kevin Guthrie (Kevin.Guthrie@em.myflorida.com) <Kevin.Guthrie@em.myflorida.com>; DeCastro, Kenneth <Kenneth.DeCastro@em.myflorida.com>; EOC-COSLogistics <EOC-COSLogistics@em.myflorida.com>; Bussey, Jon <Jon.Bussey@em.myflorida.com>
Subject: UPDATE -- Vendor List for PPE and other resources 11/17/20

FYI -updated vendor list is attached. Thanks, Ash

From: Davis, Ashley
Sent: Wednesday, November 4, 2020 8:13 AM
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Subject: UPDATE -- Vendor List for PPE and other resources 11/04/20

FYI -updated vendor list is attached. Thanks, Ash

From: Davis, Ashley
Sent: Tuesday, September 29, 2020 3:27 PM
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Cc: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; DeCastro, Kenneth (Kenneth.DeCastro@em.myflorida.com) <Kenneth.DeCastro@em.myflorida.com>; EOC-COSLogistics <EOC-COSLogistics@em.myflorida.com>; Bussey, Jon <Jon.Bussey@em.myflorida.com>; McLeary, Allison <Allison.McLeary@em.myflorida.com>
Subject: UPDATE -- Vendor List for PPE and other resources 9/29/20

FYI -updated vendor list is attached. Thanks, Ash

From: Davis, Ashley
Sent: Tuesday, August 25, 2020 11:35 AM
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Cc: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; DeCastro, Kenneth (Kenneth.DeCastro@em.myflorida.com) <Kenneth.DeCastro@em.myflorida.com>; EOC-COSLogistics <EOC-COSLogistics@em.myflorida.com>; Bussey, Jon <Jon.Bussey@em.myflorida.com>; McLeary, Allison <Allison.McLeary@em.myflorida.com>
Subject: UPDATE -- Vendor List for PPE and other resources 8/25/20

FYI – updated vendor list is attached.

Thanks,
Ash

From: Davis, Ashley
Sent: Wednesday, August 12, 2020 9:06 AM
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Cc: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; DeCastro, Kenneth (Kenneth.DeCastro@em.myflorida.com) <Kenneth.DeCastro@em.myflorida.com>; EOC-COSLogistics <EOC-COSLogistics@em.myflorida.com>; Bussey, Jon <Jon.Bussey@em.myflorida.com>; McLeary, Allison <Allison.McLeary@em.myflorida.com>
Subject: UPDATED -- Vendor List for PPE and other resources 8/12/20

Team:

Please find the attached updated vendor list. Feel free to utilize the attached vendors and continue to exercise due diligence when contacting any vendors.

Thank you,
Ash

From: Davis, Ashley
Sent: Tuesday, July 28, 2020 5:07 PM
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>

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Cc: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; DeCastro, Kenneth (Kenneth.DeCastro@em.myflorida.com) <Kenneth.DeCastro@em.myflorida.com>; EOC-COSLogistics <EOC-COSLogistics@em.myflorida.com>; Bussey, Jon <Jon.Bussey@em.myflorida.com>; McLeary, Allison <Allison.McLeary@em.myflorida.com>
Subject: UPDATED -- Vendor List for PPE and other resources

Team:

Please find the attached updated vendor list. Feel free to utilize the attached vendors and continue to exercise due diligence when contacting any vendors.

Thank you,
Ash

From: Davis, Ashley
Sent: Tuesday, July 14, 2020 6:24 PM
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Cc: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; DeCastro, Kenneth (Kenneth.DeCastro@em.myflorida.com) <Kenneth.DeCastro@em.myflorida.com>; EOC-COSLogistics <EOC-COSLogistics@em.myflorida.com>; Bussey, Jon <Jon.Bussey@em.myflorida.com>; McLeary, Allison <Allison.McLeary@em.myflorida.com>
Subject: UPDATED -- Vendor List for PPE and other resources

Team, good evening:

We have updated the vendor list. Feel free to utilize the attached vendors and continue to exercise due diligence when contacting any vendors.

Thanks,
Ash

From: Davis, Ashley
Sent: Tuesday, June 9, 2020 10:03 AM
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Cc: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; DeCastro, Kenneth (Kenneth.DeCastro@em.myflorida.com) <Kenneth.DeCastro@em.myflorida.com>; EOC-COSLogistics <EOC-COSLogistics@em.myflorida.com>; Bussey, Jon <Jon.Bussey@em.myflorida.com>; McLeary, Allison <Allison.McLeary@em.myflorida.com>
Subject: Vendor List for PPE and other resources

Team, good morning:

Several County EM have requested a list of vendors the SERT has used throughout the COVID-19 response. Please note, FDEM does not promote these vendors, but we have done business with each of them throughout this event and had no issues. Most of these vendors are 3M or Honeywell distributors who offer PPE, Decon equipment, and have proven to be reliable.

Feel free to utilize the attached vendors and continue to exercise due diligence when contacting any vendors.

Thank you,
Ash

Ashley H. Davis, FPEM, CEM | Bureau Chief of Response
State Logistics for COVID-19
Florida Division of Emergency Management
Ashley.Davis@em.myflorida.com

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

AMERICAN OVERSIGHT

	A	B	C	D	E
1	**Vendor**	**POC**	**Phone**	**E-Mail**	**Website**
2	AA Mills	Grant Neel	770-312-5794	grant@aamills.com	www.aamills.com
3	Advantage Relocation, Inc	Ricky Abernathy	678-520-3930	abernathy.ricky@gmail.com	www.N95-US.com
4	Advanced Shelter Systems, Inc	Christian Weber	512-508-1228	govsales@assi.global	www.advancedsh
5	ALLSTATES MEDICAL	Ty Akbasli, Josino “Jo	305-929-3088	tyakbasli@gmail.com, sales@allstatesmed.com	www.allstatesmed
6	Biomax Solutions	Bruce Powell	612-804-9264	bpowell@biomaxsystems.com	www.exhibitmax.r
7	Cartagena Sun DBA Be Ready Medic	Jeff Su, RN	(206) 914-0874	jeff@cartagenasunshine.com, jeff@bereadymedical.com	http://www.bereac
8	D&W Sourceall	Barry Wood	561-352-5438	bwsource@bellsouth.net	www.dwsourceall
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AMERICAN OVERSIGHT

	F	G	H	I
1	**Items**	**Quantity**	**Lead Time**	My Florida Marketplace Registration
2	Gowns (33 GSM)	2,000	1-2 days	
3	Gowns (72 GSM)	5,000	1-2 days	
4	Hand Sanitizer	60,000	1-2 days	
5	Masks - 3-Ply Level 2	1,107,700	1-2 days	Yes
6	Masks - 3-Ply Level 3	15,000	1-2 days	
7	Masks - KN95	57,000	1-2 days	
8	Gloves - TDE	700,000 boxes (100 pcs box)	1-2 days (2 weeks out 1/27)	
9	Gowns - Level 2	50,000	1-2 days	
10	Hand Sanitizer (16oz)	100,000	1-2 days	Yes
11	Masks - 3ply Level 2	25M	1-2 days	
12	Masks - KN95 (3M)	25,000	1-2 days	
13	Face Shields	12,000	1 day	
14	Gloves - OTG Nitrile	500,000	1 day	Yes
15	Masks - KN95	10M	1 day	
16	Face Shields	Thousands	1-3 days	
17	Gloves - Latex	Thousands	1-3 days	
18	Gowns Level 2	Thousands	1-3 days	
19	Hand Sanitizer	Thousands	1-3 days	Yes
20	Masks - 3-Ply Level 1	Thousands	1-3 days	
21	Masks - 3-Ply Level 3	Thousands	1-3 days	
22	Masks - KN95	Thousands	1-3 days	
23	Sanitizing Wipes	Thousands	1-3 days	
24	Face Shields	1M	2-4 days	
25	Gown - Level 1	900,000	2-4 days	
26	Gown - Level 2	500,000	2-4 days	
27	Gown - Level 3	200,000	18-27 days	Yes
28	Masks - N95 folding style	9.5M	2-4 days	
29	Masks - Level 2	1.5M	2-4 days	
30	Masks - Level 3	10M	2-4 days	
31	Masks - N95 cup style	100,000	2-4 days	
32	Boot Covers	200,000	5 days	
33	Caps	80,000	5 days	
34	Gowns - Level 2	99,000	5 days	
35	Gowns - Level 3	210,000	6 days	Yes
36	Gowns Level 3	330,000	5 days	
37	Masks - 3-Ply Level 1	2.5M	5 days	
38	Masks - 3-Ply Level 3	1M	5 days	
39	Masks - N95	12M	5 days	
40	Face Shields	25,152	1-2 days	
41	Hand Sanitizer - Free Standing Dispensers	4,100	1-2 days	
42	Hand Sanitizer - Wall unit dispensers	7,000	1-2 days	
43	Hand Sanitizer (1 Gallon)	1,088	1-2 days	
44	Hand Sanitizer (16.9 oz)	19,840	1-2 days	Yes
45	Masks - 3 Ply General	78,400	1-2 days	
46	Masks - KN95	28,000	1-2 days	
47	Masks - 3 Ply Medical	75,800	1-2 days	
48	Thermometer - DET-306 Infrared Forehead	2,980	1-2 days	
49	Caps	10K Cases	3-7 days	
50	Gloves - Chemo	5K Cases	3-7 days	
51	Gown - Chemo Level 2	5-10K Cases	3-7 days	
52	Gowns - Surgical Level 1,2,3	5-10K Cases	3-7 days	
53	Masks - KN95	10K Cases	3-7 days	
54	Masks - 3 Ply Level 4 Medical	7K Cases	3-7 days	

AMERICAN OVERSIGHT

	A	B	C	D	E
55	Digital Dolphin	Daniel Fernandez	424-309-7650 x332	dfernandez@digitaldolphinsupplies.com	www.digitaldolphi
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63	Ever Win International Corp.	Robert Stern	714-296-3370	robert.stern@everwin.com	www.everwin.com
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67	Exiom Health	Erik Paul	808-651-1562	erik@exiomhealth.com	www.exiomhealth
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74	Fersten International	Mitchell Fersten	800-565-7462 x 110	mitchell@fersten.com	www.fersten.com/
75					
76					
77	FORSUPPLIES INCORPORATED	Jose lopez	(850) 635-0361	josel@forsupplies.com	www.forsupplies.c
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87	Galls	Billy DeVault	904-426-8236	deVault-billy@galls.com	www.galls.com
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96	Globaltek	Devyn Germia	603-842-5608	devyn@gtcusa.com	www.globaltekcor
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MERICAN
OVERSIGHT

	F	G	H	I
55	Masks - N95 1870+ 3M	5-10K Cases	3-7 days	Yes
56	Masks - N95 1860 3M	16K Cases	3-7 days	
57	Masks - N95 3M	3K Cases	3-7 days	
58	Masks - N95 8210 3M	5-10K Cases	3-7 days	
59	Masks - N95 8210V 3M	5-10K Cases	3-7 days	
60	Masks - N95 9205+ 3M	3-5K Cases	3-7 days	
61	Masks 3 Ply Level 1,2,3	50K Cases	3-7 days	
62	Shoe Covers	10-15K Cases	3-7 days	
63	Gowns - Level 2 Iso (AAMI Level 2)	20,000	5-7 days	Yes
64	Masks - 3-Ply Medical	2M (50 pcs box)	5-7 days	
65	Masks - N95 Resp	500,000 cup style (10 pcs box)	5-7 days	
66	Masks - N95 vfold	1.4M (10 pcs box)	5-7 days	
67	Disninfectant Wipes	Few Thousand	1-2 days	Yes
68	Face Shields	Few Thousand	1-2 days	
69	Gloves - Nitrile	Few Thousand	1-2 days	
70	Gowns	Few Thousand	1-2 days	
71	Hand Sanitizer	Few Thousand	1-2 days	
72	Masks - N95	Few Thousand	1-2 days	
73	Masks - 3-Ply Medical	Few Thousand	1-2 days	
74	Gloves - Nitrile	3.3M	45 Days	Yes
75	Masks - Level 1Disposable ASTM	1.1M	3-5 Dyas	
76	Masks - N95 Flat-fold	1.2M	3-5 Days	
77	Face Shields	5000	5-7 days	Yes
78	Gloves - Latex	700	5-7 days	
79	Gloves - Nitrile	600	5-7 days	
80	Gloves - Vinyl	1,200	5-7 days	
81	Gowns	4000	5-7 days	
82	Hand Sanitizer	2000	5-7 days	
83	Masks - 3-Ply Level 3	3300	5-7 days	
84	Masks - KnN95	38,000	5-7 days	
85	Masks - N95 Cup	46,000	5-7 days	
86	Sneeze Guard	300	5-7 days	
87	Face Shields	200000	10 days	Yes
88	Gloves - Latex	13,000	12 days	
89	Gloves - Nitrile	435,000	11 days	
90	Gowns	150000	13 days	
91	Hand Sanitizer	30,000	15 days	
92	Masks - 3-Ply Level 2 (2500 per case)	2623	9 days	
93	Masks - KN95 (1000 per case)	140000	7 days	
94	Masks - N95 (300 per case)	132	8 days	
95	Sanitizing Wipes	1M	14 days	
96	Face Shields	1,000-5,000	7 days	Yes
97	Gowns - Level 2-3	100,000	1-7 days	
98	Hand Sanitizer	100-500	8 days	
99	Masks - N95 cup style	50,000-100,000	14 days	
100	Masks - Surgical	100,000	1-7 days	
101	Sanitizer stands/dispensers	Non-Stock/Production Capable	7 days	
102	Sharps hazard containers	500-2000	3-4 days	
103	Temperature scanners	Non-Stock/Production Capable	7 days	
104	Caps - Surgical	20000	5-7 days	
105	Gloves - Nitrile	3000	5-7 days	
106	Gloves - TPE Stretch Hybrid	35000	5-7 days	
107	Gown - Surgical	200000	7-10 days	
108	Hand Sanitizer - 16oz	37000	5-7 days	

OVERSIGHT

	A	B	C	D	E
109	Guardia Medical	Zach Smith	719-396-9165	zsmith@youarebright.com	www.guardiamed
116	Jamestown Plastics, Inc.	Craig Zwilling	320-491-2918	czwilling@jamestownplastics.com	www.jamestownp
119	Merrow Sewing Machine Co., Inc	Kasey Hereth, Sierra	(508) 689-4095, 508-287-5899	k.hereth@merrow.com	www.merrow.com
122	NJF Worldwide	Alex Donofrio	908-839-3705	alex@njfworldwide.com	www.55industries
123					www.55industries
127	Plush Apparel	Jennifer Newton	844-384-5592	jennifer@plush-apparel.com	www.Plush-Appa
137	PPE Logistics	Ken Chu	646-200-2626	ken@ppelogistic.com	www.ppelogistic.c
145	Siyasebenza Manufacturing CC	Sarah Morrison	(+27) 794-03-1217	esjaymorrison@gmail.com	https://siyasebenz
150	Social6Solutions	Robert William Kuype	954-595-4799	RWKuypers@social6solutions.com	Social6Solutions.
154	United Medco	Heather DiMauro	954-947-4391	hdimauro@unitedmedco.com	www.unitedmedc
157	Vital Sourcing Co	Dean Siokas	(516) 965-3748	dean@vitalsourcingco.com	www.vitalsourcing

AMERICAN OVERSIGHT

	F	G	H	I
109	Masks - N95 1869 3M	1500	5-7 days	Yes
110	Masks - N95 Harley L-188 Foldable	20000	5-7 days	
111	Masks - N95 Harley L-288 Cup	20000	5-7 days	
112	Masks - Surgical Level 1	1.5M	5-7 days	
113	Medical Bouffants	200000	5-7 days	
114	Santizing Wipes	38000	5-7 days	
115	Shoe Covers	200000	5-7 days	
116	Face Shields	3000	1 day	Yes
117	Gloves - Nitrile	Production Capable	February 11th-18th	
118	Gloves - Latex	Production Capable	February 11th-18th	
119	Gowns - Level 2 Reusable (175)	150000	1-2 days	Yes
120	Gowns - Level 2 Reusable (50 Wash)	150000	1-2 days	
121	Gowns (Level 1, 2 , 3)	200,000 (production)	14 days	
122	Gowns - CPE	5-10K	8-12 days	Yes
123	Masks - N95	Thousands (MOQ 10,000)	8-12 days	
124	Caps - Nurses (2,000/box)	10,000 boxes (MOQ 10)	3-10 days	
125	Caps - Surgeon (2,000/box)	10,000 boxes (MOQ 10)	3-10 days	
126	Face Shields	1,000,000 units (MOQ 3,000)	3-10 days	
127	Gloves - Nitrile (100 units/box)	15,000,000 boxes (MOQ 100,000)	3-10 days	Yes
128	Gowns	1,000,000 units (MOQ 2,000)	3-10 days	
129	Masks - 3-Ply Disposable (50 units/box)	50,000 boxes (MOQ 10,000)	3-10 days	
130	Shoe covers (2,000/box)	10,000 boxes (MOQ 10)	3-10 days	
131	Disinfectant Wipes	80,000	3-4 days	
132	Gloves - Latex Exam	100,000	3-4 days	
133	Gloves - Nitrile Belnded Exam	100,000	3-4 days	
134	Gloves - Nitrile Exam	25,000	3-4 days	
135	Gloves - Vinyl Exam	200,000	3-4 days	
136	Gowns - Level 1 and Level 2	250,000	3-4 days	
137	Gowns - Level 3 and Level 4	100,000	3-4 days	Yes
138	Infared Thermometer	20,000 pcs	3-4 days	
139	Masks - 3-Ply (All Levels)	1M	3-4 days	
140	Masks - KF94	100,000 pcs	3-4 days	
141	Masks - KN95	500,000	3-4 days	
142	Masks - N95	500,000	3-4 days	
143	Safety Goggles	50,000 pcs	3-4 days	
144	Coveralls	50000 (per month)	30 days (sea freight)	
145	Gowns - Isolation	50000 (per month)	32 days (sea freight)	Yes
146	Scrub suits	50000 (per month)	33 days (sea freight)	
147	Shoe covers	10000 (per day)	31 days (sea freight)	
148	Gloves - Nitrile	150K	7 days	
149	Gloves - Nitrile/Vinyl Blend	500K	7 days	
150	Gowns - Level 3	800K	1-2 days	Yes
151	Masks - KN95	2.5M	7 days	
152	Masks - N95 1870+ 3M	800K	1-2 days	
153	Disenfectant Aerosol	100,000	2 days	
154	Disinfectant Multi-Surface Cleaner	100,000	2 days	Yes
155	Disinfectant Wipes	300,000	2 days	
156	Disninfectant Wipes	500,000 (MOQ 30K)	7 days	
157	Gloves - Nitrile	3M	3-4 days on ground (40-50 days production)	Yes
158	Gowns - Level 2	1M	7 days	
159	Masks - N95	3M (MOQ 11,000)	7 days	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
1	**Vendor**	**POC**	**Phone**	**E-Mail**	**Website**	**Items**	**Quantity**	**Lead Time**	a Marketplace Re	
2	PPE Logistics	Ken Chu	646-200-2626	ken@ppelogistic.c	www.ppelogistic.c	Infared Thermom	20,000 pcs	3-4 days	Yes	
3	Globaltek	Devyn Germia	603-842-5608	devyn@gtcusa.co	www.globaltekcor	Temperature scar	oduction Capable	7 days	Yes	
4	D&W Sourceall	Barry Wood	561-352-5438	bwsource@bellsc	www.dwsourceall	Thermometer - DI	2,980	1-2 days	Yes	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
1	**Vendor**	**POC**	**Phone**	**E-Mail**	**Website**	**Items**	**Quantity**	**Lead Time**	a Marketplace Re	
2	Cartagena Sun DBA Be	Jeff Su, RN	(206) 914-0874	jeff@cartagenasu	http://www.bereac	Boot Covers	200,000	5 days	Yes	
3	Cartagena Sun DBA Be	Jeff Su, RN	(206) 914-0874	jeff@cartagenasu	http://www.bereac	Caps	80,000	5 days	Yes	
4	Plush Apparel	Jennifer Newton	844-384-5592	jennifer@plush-a	www.Plush-Appar	Caps - Nurses (2,	boxes (MOQ 10)	3-10 days	Yes	
5	Plush Apparel	Jennifer Newton	844-384-5592	jennifer@plush-a	www.Plush-Appar	Caps - Surgeon (2	boxes (MOQ 10)	3-10 days	Yes	
6	Guardia Medical	Zach Smith	719-396-9165	zsmith@youarebr	www.guardiamed	Caps - Surgical	20000	5-7 days	Yes	
7	Siyasebenza Manufactu	Sarah Morrison	(+27) 794-03-121	esjaymorrison@g	https://siyasebenz	Coveralls	0000 (per month)	days (sea freight)	Yes	
8	Digital Dolphin	Daniel Fernandez	424-309-7650 x3	dfernandez@digit	www.digitaldolphi	Caps	10K Cases	3-7 days	Yes	
9	Siyasebenza Manufactu	Sarah Morrison	(+27) 794-03-121	esjaymorrison@g	https://siyasebenz	Scrub suits	0000 (per month)	days (sea freight)	Yes	
10	Guardia Medical	Zach Smith	719-396-9165	zsmith@youarebr	www.guardiamed	Medical Bouffants	200000	5-7 days	Yes	
11	Digital Dolphin	Daniel Fernandez	424-309-7650 x3	dfernandez@digit	www.digitaldolphi	Shoe Covers	10-15K Cases	3-7 days	Yes	
12	Guardia Medical	Zach Smith	719-396-9165	zsmith@youarebr	www.guardiamed	Shoe Covers	200000	5-7 days	Yes	
13	Siyasebenza Manufactu	Sarah Morrison	(+27) 794-03-121	esjaymorrison@g	https://siyasebenz	Shoe covers	10000 (per day)	days (sea freight)	Yes	
14	Plush Apparel	Jennifer Newton	844-384-5592	jennifer@plush-a	www.Plush-Appar	Shoe covers (2,0(	boxes (MOQ 10)	3-10 days	Yes	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
1	**Vendor**	**POC**	**Phone**	**E-Mail**	**Website**	**Items**	**Quantity**	**Lead Time**	a Marketplace Re	
2	Plush Apparel	Jennifer Newton	844-384-5592	jennifer@plush-a	www.Plush-Appa	Face Shields	nits (MOQ 3,000)	3-10 days	Yes	
3	Biomax Solutions	Bruce Powell	612-804-9264	mruzich@exhibitr	www.exhibitmax.r	Face Shields	1M	2-4 days	Yes	
4	D&W Sourceall	Barry Wood	561-352-5438	bwsource@bellsc	www.dwsourceall	Face Shields	25,152	1-2 days	Yes	
5	Advanced Shelter Systems	Christian Weber	512-508-1228	govsales@assi.gl	www.advancedsh	Face Shields	12,000	1 day	Yes	
6	ALLSTATES MEDICAL	Ty Akbasli, Josinc	305-929-3088	tyakbasli@gmail.c	www.allstatesmec	Face Shields	Thousands	1-3 days	Yes	
7	FORSUPPLIES INCORPO	Jose lopez	(850) 635-0361	josel@forsupplies	www.forsupplies.c	Face Shields	5000	5-7 days	Yes	
8	Galls	Billy DeVault	904-426-8236	deVault-billy@gal	www.galls.com	Face Shields	200000	10 days	Yes	
9	Globaltek	Devyn Germia	603-842-5608	devyn@gtcusa.co	www.globaltekcor	Face Shields	1,000-5,000	7 days	Yes	
10	Jamestown Plastics, Inc.	Craig Zwilling	320-491-2918	czwilling@jamest	www.jamestownp	Face Shields	3000	1 day	Yes	
11	Exiom Health	Erik Paul	808-651-1562	erik@exiomhealth	www.exiomhealth	Face Shields	Few Thousand	1-2 days	Yes	
12	PPE Logistics	Ken Chu	646-200-2626	ken@ppelogistic.c	www.ppelogistic.c	Safety Goggles	50,000 pcs	3-4 days	Yes	
13	FORSUPPLIES INCORPO	Jose lopez	(850) 635-0361	josel@forsupplies	www.forsupplies.c	Sneeze Guard	300	5-7 days	Yes	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
1	**Vendor**	**POC**	**Phone**	**E-Mail**	**Website**	**Items**	**Quantity**	**Lead Time**	a Marketplace Re	
2	Social6Solutions	Robert William Ku	954-595-4799	RWKuypers@soc	Social6Solutions.(	Glove - Nitrile	150K	7 days	Yes	
3	Merrow Sewing Machine	Kasey Hereth, Sie	(508) 689-4095, 5	k.hereth@merrow	www.merrow.com	Glove - Nitrile	oduction Capable	ebruary 11th-18th	Yes	
4	Exiom Health	Erik Paul	808-651-1562	erik@exiomhealth	www.exiomhealth	Gloves	Few Thousand	1-2 days	Yes	
5	Globaltek	Devyn Germia	603-842-5608	devyn@gtcusa.co	www.globaltekcor	Gloves	20 cases per day)	7+ Days	Yes	
6	Digital Dolphin	Daniel Fernandez	424-309-7650 x31	dfernandez@digit	www.digitaldolphi	Gloves - Chemo	5K Cases	3-7 days	Yes	
7	FORSUPPLIES INCORP	Jose lopez	(850) 635-0361	josel@forsupplies	www.forsupplies.(	Gloves - Latex	700	5-7 days	Yes	
8	Merrow Sewing Machine	Kasey Hereth, Sie	(508) 689-4095, 5	k.hereth@merrow	www.merrow.com	Gloves - Latex	oduction Capable	ebruary 11th-18th	Yes	
9	Galls	Billy DeVault	904-426-8236	deVault-billy@gal	www.galls.com	Gloves - Latex	13,000	12 days	Yes	
10	ALLSTATES MEDICAL	Ty Akbasli, Josinc	305-929-3088	tyakbasli@gmail.(	www.allstatesmec	Gloves - Latex	Thousands	1-3 days	Yes	
11	PPE Logistics	Ken Chu	646-200-2626	ken@ppelogistic.(	www.ppelogistic.c	Gloves - Latex Exam	100,000	3-4 days	Yes	
12	Fersten International	Mitchell Fersten	800-565-7462 x 1	mitchell@fersten.	www.fersten.com/	Gloves - Nitrile	3.3M	45 Days	Yes	
13	FORSUPPLIES INCORP	Jose lopez	(850) 635-0361	josel@forsupplies	www.forsupplies.(	Gloves - Nitrile	600	5-7 days	Yes	
14	Guardia Medical	Zach Smith	719-396-9165	zsmith@youarebr	www.guardiamed	Gloves - Nitrile	3000	5-7 days	Yes	
15	Vital Sourcing Co	Dean Siokas	(516) 965-3748	dean@vitalsourci	www.vitalsourcing	Gloves - Nitrile	3M	days production)	Yes	
16	Galls	Billy DeVault	904-426-8236	deVault-billy@gal	www.galls.com	Gloves - Nitrile	435,000	11 days	Yes	
17	Plush Apparel	Jennifer Newton	844-384-5592	jennifer@plush-a	www.Plush-Appa	Gloves - Nitrile (100 units/	s (MOQ 100,000)	3-10 days	Yes	
18	PPE Logistics	Ken Chu	646-200-2626	ken@ppelogistic.(	www.ppelogistic.c	Gloves - Nitrile Belnded E	100,000	3-4 days	Yes	
19	PPE Logistics	Ken Chu	646-200-2626	ken@ppelogistic.(	www.ppelogistic.c	Gloves - Nitrile Exam	25,000	3-4 days	Yes	
20	Social6Solutions	Robert William Ku	954-595-4799	RWKuypers@soc	Social6Solutions.(	Gloves - Nitrile/Vinyl Blen	500K	7 days	Yes	
21	Advanced Shelter Systen	Christian Weber	512-508-1228	govsales@assi.gl	www.advancedsh	Gloves - OTG Nitrile	500,000	1 day	Yes	
22	Aadvantage Relocation, I	Ricky Abernathy	678-520-3930	abernathy.ricky@	www.N95-US.com	Gloves - TDE	kes (100 pcs box)	2 weeks out 1/27)	Yes	
23	Guardia Medical	Zach Smith	719-396-9165	zsmith@youarebr	www.guardiamed	Gloves - TPE Stretch Hyb	35000	5-7 days	Yes	
24	FORSUPPLIES INCORP	Jose lopez	(850) 635-0361	josel@forsupplies	www.forsupplies.(	Gloves - Vinyl	1,200	5-7 days	Yes	
25	PPE Logistics	Ken Chu	646-200-2626	ken@ppelogistic.(	www.ppelogistic.c	Gloves - Vinyl Exam	200,000	3-4 days	Yes	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
1	Vendor	POC	Phone	E-Mail	Website	Items	Quantity	Lead Time	a Marketplace Re	
2	Aadvantage Relocation,	Ricky Abernathy	678-520-3930	abernathy.ricky@	www.N95-US.cor	Masks - 3ply Level 2	25M	1-2 days	Yes	
3	Biomax Solutions	Bruce Powell	612-804-9264	mruzich@exhibitr	www.exhibitmax.r	Masks - N95 folding style	9.5M	2-4 days	Yes	
4	Advanced Shelter Syster	Christian Weber	512-508-1228	govsales@assi.gl	www.advancedsh	Masks - KN95	10M	1 day	Yes	
5	Digital Dolphin	Daniel Fernandez	424-309-7650 x3	dfernandez@digit	www.digitaldolphi	Masks - KN95	10K Cases	3-7 days	Yes	
6	Aadvantage Relocation,	Ricky Abernathy	678-520-3930	abernathy.ricky@	www.N95-US.cor	Masks - KN95 (3M)	25,000	1-2 days	Yes	
7	Exiom Health	Erik Paul	808-651-1562	erik@exiomhealth	www.exiomhealth	Masks - N95	Few Thousand	1-2 days	Yes	
8	D&W Sourceall	Barry Wood	561-352-5438	bwsource@bellsc	www.dwsourceall	Masks - 3 Ply General	78,400	1-2 days	Yes	
9	Plush Apparel	Jennifer Newton	844-384-5592	jennifer@plush-a	www.Plush-Appa	Masks - 3-Ply Disposable (5	es (MOQ 10,000)	3-10 days	Yes	
10	D&W Sourceall	Barry Wood	561-352-5438	bwsource@bellsc	www.dwsourceall	Masks - KN95	28,000	1-2 days	Yes	
11	Digital Dolphin	Daniel Fernandez	424-309-7650 x3	dfernandez@digit	www.digitaldolphi	Masks - 3 Ply Level 4 Medic	7K Cases	3-7 days	Yes	
12	D&W Sourceall	Barry Wood	561-352-5438	bwsource@bellsc	www.dwsourceall	Masks - 3 Ply Medical	75,800	1-2 days	Yes	
13	PPE Logistics	Ken Chu	646-200-2626	ken@ppelogistic.(	www.ppelogistic.c	Masks - 3-Ply (All Levels)	1M	3-4 days	Yes	
14	ALLSTATES MEDICAL	Ty Akbasli, Josino “Joe”	305-929-3088	tyakbasli@gmail.(	www.allstatesmec	Masks - 3-Ply Level 1	Thousands	1-3 days	Yes	
15	Cartagena Sun DBA Be	Jeff Su, RN	(206) 914-0874	jeff@cartagenasu	http://www.bereac	Masks - 3-Ply Level 1	2.5M	5 days	Yes	
16	AA Mills	Grant Neel	770-312-5794	grant@aamills.co	www.aamills.com	Masks - 3-Ply Level 2	1,107,700	1-2 days	Yes	
17	Galls	Billy DeVault	904-426-8236	deVault-billy@gal	www.galls.com	Masks - 3-Ply Level 2 (2500	2623	9 days	Yes	
18	AA Mills	Grant Neel	770-312-5794	grant@aamills.co	www.aamills.com	Masks - 3-Ply Level 3	15,000	1-2 days	Yes	
19	Cartagena Sun DBA Be	Jeff Su, RN	(206) 914-0874	jeff@cartagenasu	http://www.bereac	Masks - 3-Ply Level 3	1M	5 days	Yes	
20	FORSUPPLIES INCORF	Jose lopez	(850) 635-0361	josel@forsupplies	www.forsupplies.(	Masks - 3-Ply Level 3	3300	5-7 days	Yes	
21	ALLSTATES MEDICAL	Ty Akbasli, Josino “Joe”	305-929-3088	tyakbasli@gmail.(	www.allstatesmec	Masks - 3-Ply Level 3	Thousands	1-3 days	Yes	
22	Ever Win International C	Robert Stern	714-296-3370	robert.stern@eve	www.everwin.com	Masks - 3-Ply Medical	2M (50 pcs box)	5-7 days	Yes	
23	Exiom Health	Erik Paul	808-651-1562	erik@exiomhealth	www.exiomhealth	Masks - 3-Ply Medical	Few Thousand	1-2 days	Yes	
24	PPE Logistics	Ken Chu	646-200-2626	ken@ppelogistic.(	www.ppelogistic.c	Masks - KF94	100,000 pcs	3-4 days	Yes	
25	ALLSTATES MEDICAL	Ty Akbasli, Josino “Joe”	305-929-3088	tyakbasli@gmail.(	www.allstatesmec	Masks - KN95	Thousands	1-3 days	Yes	
26	AA Mills	Grant Neel	770-312-5794	grant@aamills.co	www.aamills.com	Masks - KN95	57,000	1-2 days	Yes	
27	Social6Solutions	Robert William Kuypers	954-595-4799	RWKuypers@soc	Social6Solutions.(	Masks - KN95	2.5M	7 days	Yes	
28	PPE Logistics	Ken Chu	646-200-2626	ken@ppelogistic.(	www.ppelogistic.c	Masks - KN95	500,000	3-4 days	Yes	
29	Galls	Billy DeVault	904-426-8236	deVault-billy@gal	www.galls.com	Masks - KN95 (1000 per cas	140000	7 days	Yes	
30	FORSUPPLIES INCORF	Jose lopez	(850) 635-0361	josel@forsupplies	www.forsupplies.(	Masks - KnN95	38,000	5-7 days	Yes	
31	Fersten International	Mitchell Fersten	800-565-7462 x 1	mitchell@fersten.	www.fersten.com.	Masks - Level 1Disposable A	1.1M	3-5 Dyas	Yes	
32	Biomax Solutions	Bruce Powell	612-804-9264	mruzich@exhibitr	www.exhibitmax.r	Masks - Level 2	1.5M	2-4 days	Yes	
33	Biomax Solutions	Bruce Powell	612-804-9264	mruzich@exhibitr	www.exhibitmax.r	Masks - Level 3	10M	2-4 days	Yes	
34	NJF Worldwide	Alex Donofrio	908-839-3705	alex@njfworldwid	www.55industries	Masks - N95	ds (MOQ 10,000)	8-12 days	Yes	
35	Vital Sourcing Co	Dean Siokas	(516) 965-3748	dean@vitalsourci	www.vitalsourcing	Masks - N95	M (MOQ 11,000)	7 days	Yes	
36	PPE Logistics	Ken Chu	646-200-2626	ken@ppelogistic.(	www.ppelogistic.c	Masks - N95	500,000	3-4 days	Yes	
37	Cartagena Sun DBA Be	Jeff Su, RN	(206) 914-0874	jeff@cartagenasu	http://www.bereac	Masks - N95	12M	5 days	Yes	
38	Digital Dolphin	Daniel Fernandez	424-309-7650 x3	dfernandez@digit	www.digitaldolphi	Masks - N95 1870+ 3M	5-10K Cases	3-7 days	Yes	
39	Galls	Billy DeVault	904-426-8236	deVault-billy@gal	www.galls.com	Masks - N95 (300 per case)	132	8 days	Yes	
40	Digital Dolphin	Daniel Fernandez	424-309-7650 x3	dfernandez@digit	www.digitaldolphi	Masks - N95 1860 3M	16K Cases	3-7 days	Yes	
41	Guardia Medical	Zach Smith	719-396-9165	zsmith@youarebr	www.guardiamed	Masks - N95 1869 3M	1500	5-7 days	Yes	
42	Social6Solutions	Robert William Kuypers	954-595-4799	RWKuypers@soc	Social6Solutions.(	Masks - N95 1870+ 3M	800K	1-2 days	Yes	
43	Digital Dolphin	Daniel Fernandez	424-309-7650 x3	dfernandez@digit	www.digitaldolphi	Masks - N95 3M	3K Cases	3-7 days	Yes	
44	Digital Dolphin	Daniel Fernandez	424-309-7650 x3	dfernandez@digit	www.digitaldolphi	Masks - N95 8210 3M	5-10K Cases	3-7 days	Yes	
45	Digital Dolphin	Daniel Fernandez	424-309-7650 x3	dfernandez@digit	www.digitaldolphi	Masks - N95 8210V 3M	5-10K Cases	3-7 days	Yes	
46	Digital Dolphin	Daniel Fernandez	424-309-7650 x3	dfernandez@digit	www.digitaldolphi	Masks - N95 9205+ 3M	3-5K Cases	3-7 days	Yes	
47	FORSUPPLIES INCORF	Jose lopez	(850) 635-0361	josel@forsupplies	www.forsupplies.(	Masks - N95 Cup	46,000	5-7 days	Yes	
48	Biomax Solutions	Bruce Powell	612-804-9264	mruzich@exhibitr	www.exhibitmax.r	Masks - N95 cup style	100,000	2-4 days	Yes	
49	Globaltek	Devyn Germia	603-842-5608	devyn@gtcusa.co	www.globaltekcor	Masks - N95 cup style	50,000-100,000	14 days	Yes	
50	Fersten International	Mitchell Fersten	800-565-7462 x 1	mitchell@fersten.	www.fersten.com.	Masks - N95 Flat-fold	1.2M	3-5 Days	Yes	
51	Guardia Medical	Zach Smith	719-396-9165	zsmith@youarebr	www.guardiamed	Masks - N95 Harley L-188 F	20000	5-7 days	Yes	
52	Guardia Medical	Zach Smith	719-396-9165	zsmith@youarebr	www.guardiamed	Masks - N95 Harley L-288 C	20000	5-7 days	Yes	
53	Ever Win International C	Robert Stern	714-296-3370	robert.stern@eve	www.everwin.com	Masks - N95 Resp	style (10 pcs box)	5-7 days	Yes	
54	Ever Win International C	Robert Stern	714-296-3370	robert.stern@eve	www.everwin.com	Masks - N95 vfold	.4M (10 pcs box)	5-7 days	Yes	

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	A	B	C	D	E	F	G	H	I	J
55	Globaltek	Devyn Germia	603-842-5608	devyn@gtcusa.cc	www.globaltekcor	Masks - Surgical	100,000	1-7 days	Yes	
56	Guardia Medical	Zach Smith	719-396-9165	zsmith@youarebr	www.guardiamed	Masks - Surgical Level 1	1.5M	5-7 days	Yes	
57	Digital Dolphin	Daniel Fernandez	424-309-7650 x3	dfernandez@digit	www.digitaldolphi	Masks 3 Ply Level 1,2,3	50K Cases	3-7 days	Yes	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
1	**Vendor**	**POC**	**Phone**	**E-Mail**	**Website**	**Items**	**Quantity**	**Lead Time**	a Marketplace Re	
2	Digital Dolphin	Daniel Fernandez	424-309-7650 x332	dfernandez@digit	www.digitaldolphi	Gowns - Chemo Level 2	5-10K Cases	3-7 days	Yes	
3	Biomax Solutions	Bruce Powell	612-804-9264	mruzich@exhibitr	www.exhibitmax.r	Gowns - Level 1	900,000	2-4 days	Yes	
4	Biomax Solutions	Bruce Powell	612-804-9264	mruzich@exhibitr	www.exhibitmax.r	Gowns - Level 2	500,000	2-4 days	Yes	
5	Biomax Solutions	Bruce Powell	612-804-9264	mruzich@exhibitr	www.exhibitmax.r	Gowns - Level 3	200,000	18-27 days	Yes	
6	Guardia Medical	Zach Smith	719-396-9165	zsmith@youarebr	www.guardiamed	Gowns - Surgical	200000	7-10 days	Yes	
7	Exiom Health	Erik Paul	808-651-1562	erik@exiomhealth	www.exiomhealth	Gowns - Isolation	Few Thousand	1-2 days	Yes	
8	FORSUPPLIES INCO	Jose lopez	(850) 635-0361	josel@forsupplies	www.forsupplies.c	Gowns - Isolation	4000	5-7 days	Yes	
9	Plush Apparel	Jennifer Newton	844-384-5592	jennifer@plush-ap	www.Plush-Appar	Gowns - Isolation	nits (MOQ 2,000)	3-10 days	Yes	
10	Galls	Billy DeVault	904-426-8236	deVault-billy@gal	www.galls.com	Gowns - Isolation	150000	13 days	Yes	
11	NJF Worldwide	Alex Donofrio	908-839-3705	alex@njfworldwid	www.55industries	Gowns - CPE	5-10K	8-12 days	Yes	
12	Siyasebenza Manufac	Sarah Morrison	(+27) 794-03-1217	esjaymorrison@g	https://siyasebenz	Gowns - Isolation	0000 (per month)	days (sea freight)	Yes	
13	PPE Logistics	Ken Chu	646-200-2626	ken@ppelogistic.c	www.ppelogistic.c	Gowns - Level 1 and Le	250,000	3-4 days	Yes	
14	Aadvantage Relocatio	Ricky Abernathy	678-520-3930	abernathy.ricky@	www.N95-US.com	Gowns - Level 2	50,000	1-2 days	Yes	
15	Cartagena Sun DBA B	Jeff Su, RN	(206) 914-0874	jeff@cartagenasu	http://www.bereac	Gowns - Level 2	99,000	5 days	Yes	
16	Vital Sourcing Co	Dean Siokas	(516) 965-3748	dean@vitalsourci	www.vitalsourcing	Gowns - Level 2	1M	7 days	Yes	
17	Ever Win International	Robert Stern	714-296-3370	robert.stern@eve	www.everwin.com	Gowns - Level 2 Iso (AA	20,000	5-7 days	Yes	
18	Merrow Sewing Machi	Kasey Hereth, Sierra H	(508) 689-4095, 508-28	k.hereth@merrow	www.merrow.com	Gowns - Level 2 Reusa	150000	1-2 days	Yes	
19	Merrow Sewing Machi	Kasey Hereth, Sierra H	(508) 689-4095, 508-28	k.hereth@merrow	www.merrow.com	Gowns - Level 2 Reusa	150000	1-2 days	Yes	
20	Globaltek	Devyn Germia	603-842-5608	devyn@gtcusa.co	www.globaltekcor	Gowns - Level 2-3	100,000	1-7 days	Yes	
21	Cartagena Sun DBA B	Jeff Su, RN	(206) 914-0874	jeff@cartagenasu	http://www.bereac	Gowns - Level 3	210,000	6 days	Yes	
22	Social6Solutions	Robert William Kuyper	954-595-4799	RWKuypers@soc	Social6Solutions.	Gowns - Level 3	800K	1-2 days	Yes	
23	PPE Logistics	Ken Chu	646-200-2626	ken@ppelogistic.c	www.ppelogistic.c	Gowns - Level 3 and Le	100,000	3-4 days	Yes	
24	Digital Dolphin	Daniel Fernandez	424-309-7650 x332	dfernandez@digit	www.digitaldolphi	Gowns - Surgical Level	5-10K Cases	3-7 days	Yes	
25	AA Mills	Grant Neel	770-312-5794	grant@aamills.co	www.aamills.com	Gowns - 33 GSM	2,000	1-2 days	Yes	
26	AA Mills	Grant Neel	770-312-5794	grant@aamills.co	www.aamills.com	Gowns - 72 GSM	5,000	1-2 days	Yes	
27	Merrow Sewing Machi	Kasey Hereth, Sierra H	(508) 689-4095, 508-28	k.hereth@merrow	www.merrow.com	Gowns - Level 1, 2 , 3	,000 (production)	14 days	Yes	
28	ALLSTATES MEDICA	Ty Akbasli, Josino "Jo	305-929-3088	tyakbasli@gmail.c	www.allstatesmed	Gowns - Level 2	Thousands	1-3 days	Yes	
29	Cartagena Sun DBA B	Jeff Su, RN	(206) 914-0874	jeff@cartagenasu	http://www.bereac	Gowns - Level 3	330,000	5 days	Yes	

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
1	**Vendor**	**POC**	**Phone**	**E-Mail**	**Website**	**Items**	**Quantity**	**Lead Time**	a Marketplace Re	
2	United Medco	Heather DiMauro	954-947-4391	hdimauro@united	www.unitedmedc	Disenfectant Aerosol	100,000	2 days	Yes	
3	United Medco	Heather DiMauro	954-947-4391	hdimauro@united	www.unitedmedc	Disinfectant Multi-Surface Cleaner	100,000	2 days	Yes	
4	United Medco	Heather DiMauro	954-947-4391	hdimauro@united	www.unitedmedc	Disinfectant Wipes	300,000	2 days	Yes	
5	PPE Logistics	Ken Chu	646-200-2626	ken@ppelogistic.(	www.ppelogistic.c	Disinfectant Wipes	80,000	3-4 days	Yes	
6	Exiom Health	Erik Paul	808-651-1562	erik@exiomhealth	www.exiomhealth	Disninfectant Wipes	Few Thousand	1-2 days	Yes	
7	Vital Sourcing Co	Dean Siokas	(516) 965-3748	dean@vitalsourci	www.vitalsourcing	Disninfectant Wipes	),000 (MOQ 30K)	7 days	Yes	
8	AA Mills	Grant Neel	770-312-5794	grant@aamills.co	www.aamills.com	Hand Sanitizer	60,000	1-2 days	Yes	
9	ALLSTATES MEDICA	Ty Akbasli, Josino "	305-929-3088	tyakbasli@gmail.(	www.allstatesmec	Hand Sanitizer	Thousands	1-3 days	Yes	
10	Exiom Health	Erik Paul	808-651-1562	erik@exiomhealth	www.exiomhealth	Hand Sanitizer	Few Thousand	1-2 days	Yes	
11	FORSUPPLIES INCO	Jose lopez	(850) 635-0361	josel@forsupplies	www.forsupplies.(	Hand Sanitizer	2000	5-7 days	Yes	
12	Galls	Billy DeVault	904-426-8236	deVault-billy@gal	www.galls.com	Hand Sanitizer	30,000	15 days	Yes	
13	Globaltek	Devyn Germia	603-842-5608	devyn@gtcusa.co	www.globaltekcor	Hand Sanitizer	100-500	8 days	Yes	
14	Guardia Medical	Zach Smith	719-396-9165	zsmith@youarebr	www.guardiamed	Hand Sanitizer - 16oz	37000	5-7 days	Yes	
15	D&W Sourceall	Barry Wood	561-352-5438	bwsource@bellso	www.dwsourceall	Hand Sanitizer - Free Standing Disper	4,100	1-2 days	Yes	
16	D&W Sourceall	Barry Wood	561-352-5438	bwsource@bellso	www.dwsourceall	Hand Sanitizer - Wall unit dispensers	7,000	1-2 days	Yes	
17	D&W Sourceall	Barry Wood	561-352-5438	bwsource@bellso	www.dwsourceall	Hand Sanitizer (1 Gallon)	1,088	1-2 days	Yes	
18	D&W Sourceall	Barry Wood	561-352-5438	bwsource@bellso	www.dwsourceall	Hand Sanitizer (16.9 oz)	19,840	1-2 days	Yes	
19	Aadvantage Relocatic	Ricky Abernathy	678-520-3930	abernathy.ricky@	www.N95-US.com	Hand Sanitizer (16oz)	100,000	1-2 days	Yes	
20	Globaltek	Devyn Germia	603-842-5608	devyn@gtcusa.co	www.globaltekcor	Sharps hazard containers	500-2000	3-4 days	Yes	
21	Globaltek	Devyn Germia	603-842-5608	devyn@gtcusa.co	www.globaltekcor	Sanitizer stands/dispensers	oduction Capable	7 days	Yes	
22	ALLSTATES MEDICA	Ty Akbasli, Josino "	305-929-3088	tyakbasli@gmail.(	www.allstatesmec	Sanitizing Wipes	Thousands	1-3 days	Yes	
23	Galls	Billy DeVault	904-426-8236	deVault-billy@gal	www.galls.com	Sanitizing Wipes	1M	14 days	Yes	
24	Guardia Medical	Zach Smith	719-396-9165	zsmith@youarebr	www.guardiamed	Santizing Wipes	38000	5-7 days	Yes	

AMERICAN OVERSIGHT

	A	B	C
1	AA Mills	Grant Neel	770-312-5794
7	Aadvantage Relo	Ricky Abernathy	678-520-3930
12	Advanced Shelter	Christian Weber	512-508-1228
15	ALLSTATES MED	Ty Akbasli, Josinc	305-929-3088
23	Biomax Solutions	Bruce Powell	612-804-9264
31	Cartagena Sun D	Jeff Su, RN	(206) 914-0874
39	D&W Sourceall	Barry Wood	561-352-5438
48	Digital Dolphin	Daniel Fernandez	424-309-7650 x3

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62	Ever Win Internat	Robert Stern	714-296-3370
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66	Exiom Health	Erik Paul	808-651-1562
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73	Fersten Internatio	Mitchell Fersten	800-565-7462 x 1
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76	FORSUPPLIES In	Jose lopez	(850) 635-0361
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86	Galls	Billy DeVault	904-426-8236
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95	Globaltek	Devyn Germia	603-842-5608
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115	Jamestown Plasti	Craig Zwilling	320-491-2918
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118	Merrow Sewing M	Kasey Hereth, Sie	(508) 689-4095, 5
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121	NJF Worldwide	Alex Donofrio	908-839-3705
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126	Plush Apparel	Jennifer Newton	844-384-5592
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136	PPE Logistics	Ken Chu	646-200-2626
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144	Siyasebenza Mar	Sarah Morrison	(+27) 794-03-121
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149	Social6Solutions	Robert William Ku	954-595-4799
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153	United Medco	Heather DiMauro	954-947-4391
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156	Vital Sourcing Co	Dean Siokas	(516) 965-3748
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AMERICAN OVERSIGHT

From: McLeary, Allison <Allison.McLeary@em.myflorida.com>
Sent: Tuesday, January 05, 2021 5:32 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Subject: Update on CARES Phase 3 Payments

Good Afternoon and Happy New Year,

This email has been sent to the CARES Act POCs for each of your counties, but wanted to make you aware as well.

We wanted to update you as to the progress of CARES Phase 3 reimbursements. To date, the Florida Department of Financial Services has paid, or is currently reviewing for payment, 126 Phase 3 RFRs. In addition to these, we continue to diligently process remaining RFRs and look forward to getting you all closer to receipt of your full allocation across all Phases. I encourage you all to visit the DFS FLAIR Vendor Payment System and look up your payments because there will be significant cash flow over the coming days and weeks. The DFS site can be accessed here, https://fs.fldfs.com/dispub2/cvnhphst.htm.
To search your county, follow the steps below:

FEID: enter the FEID for your County (excluding the "F" and any spaces)
Beginning Month: December
Desired Year: 2020
Department: Executive Office of the Governor

A short reference guide for the site:

Payment Date: This is the date the payment was made. Sometimes the date may be in the future, this just means that they have indicated they will pay it a day or two later
Payment Type: This is important. "Regular EFT" means that the payment will be made electronically and should be deposited within 2 business days from the "payment date". "Regular Warrant" means this payment will be made with an actual check. Payment will be sent via USPS 1-2 business days after the "payment date"
Click here for Pending Payments (located in top left of screen): These payments that are pending mean that the payment is in the State Accounting System and are awaiting audit from DFS. As soon as the audit is complete (usually within a few business days), they will be moved to "paid"

I know many of you know this site well, but wanted to share so that you can track the status of your RFRs alongside us. As always, contact your assigned liaison, FDEM's representative Wes Sapp or me with additional questions or concerns.

Thank you,

Allison McLeary, Esq.
Recovery Bureau Chief
Florida Division of Emergency Management

Rebuilding Together

(850) 509-8643 (Cell)
Allison.McLeary@em.myflorida.com

Please note that Florida has a broad public records law (Chapter 119, Florida Statutes). Most written communications to or from state employees are public records obtainable by the public upon request. Emails sent to me at this email address may be considered public and will only be withheld from disclosure if deemed confidential pursuant to the laws of the State of Florida.

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

AMERICAN OVERSIGHT

From: EOC-Plans <EOC-Plans@em.myflorida.com>
Sent: Tuesday, January 12, 2021 5:10 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; james.grant@dms.fl.gov <james.grant@dms.fl.gov>; Otis, Aaron <Aaron.Otis@flhealth.gov>
Subject: Vaccination POD Registration System Survey

Good afternoon County EM Directors,

Thank you for those able to join the webinar today on the ShareCare Vaccination Site Registration System. The webinar was recorded and will be shared when available. Likewise, questions in the chat were recorded, and responses will be sent out as soon as possible.

Please fill out this form if you are interested in opting in to use this system: https://www.surveymonkey.com/r/VPODSurvey . Answering this survey is not a firm commitment, and will be used for planning assumptions and to initiate next steps.

If you have any questions for the team, please send them toeoc-plans@em.myflorida.com or include it in the “Comments” section of the survey and we will send to the appropriate person.

Thank you all,

Ryan Lock | Florida Division of Emergency Management
State Emergency Response Team | Planning Section Chief
Preparedness Bureau | All-Hazards Preparedness Manager
Ryan.Lock@em.myflorida.com | 850-841-9484

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AMERICAN OVERSIGHT

From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Friday, January 22, 2021 4:27 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: DEM All Staff <DEM@em.myflorida.com>; DEM ESF Leads and Partners <ECO_ESF@em.myflorida.com>; Grant, James <James.Grant@dms.fl.gov>
Subject: Vaccination registration platform and next steps

Team:

I appreciate your patience and support throughout the roll-out of vaccination registration platform. Below you will find action items for your situational awareness.

Action items:

- Post a WebEOC mission to utilize Sharecare/Tidal Basin.
- Validate information for each of PODs at your County EM/CHDs, please validate information in WebEOC.
- FYI – you may receive additional calls/emails validating information – please be patient with our team.
  - In the meantime, please proceed with your current vaccination registration process.
- FYI – We have eight (8) counties going live within the next week (Lee, Seminole, and Miami-Dade served as a pilot).

SERT Action items:

- Deploy resources to those counties to support registration.
- Those counties that are coming onboard, iPads will be provided to use with registration.
- Develop FAQs.
- Identify additional counties to go live (I do not have that list of counties).
- A representative from our team will contact your POC to set-up trainings.
  - Note – training is provided for one day, the training team will provide support for a second day, and one person will remain onsite for up to 5 days to support as needed.
- A representative from our team will contact you, but it may take several business days as we want to ensure we are managing expectations.
- A representative from our team has TtT webinars which we will provide to you and/or post in WebEOC.
- Clay County EM is recording their training to share lessons learned and best practices.
  - We will share that with you and/or post on WebEOC.
- Continue to identify potential challenges/successes and capture lessons learned to enhance the platform.

Please know that we are taking every precaution and doing everything at our disposal to prepare the state website for what will almost certainly be an extraordinarily high volume of traffic. While the software is currently being accessed through the call center process, we are working very aggressively to provide access to it via the state's forthcoming website.

Once again, I appreciate your time and support throughout this event as we navigate unchartered waters.

V/r,
Ash

Ashley H. Davis, FPEM, CEM | Bureau Chief of Response
Operations Section Chief
Florida Division of Emergency Management
Ashley.Davis@em.myflorida.com

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AMERICAN OVERSIGHT

From: Cintron, Morgan <Morgan.Cintron@em.myflorida.com>
Sent: Friday, January 08, 2021 10:27 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Subject: Vaccine allocation by County
Attachment(s): "Allocations by county to date 01072021 wk1-4.xlsx","Vaccination Report 2021-01-08.pdf"

Please see attached excel document for vaccine allocation by County.

In addition there is the daily vaccine report that shows how many people have been vaccinated by County. Let me know if you have any questions!

Morgan L. Cintron, MECM
External Affairs Director
Office of the Director
Florida Division of Emergency Management
2555 Shumard Oak Boulevard
Tallahassee, FL 32399
C-850-755-2722
O-850-815-4013
Morgan.Cintron@em.myflorida.com
www.floridadisaster.org

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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
1	County	Week 1 Pfizer	Week 1 Total	Week 2 Pfizer	Week 2 Moderna	Week 2 Total	Week 3 Pfizer	Week 3 Moderna	Week 3 Total
2	ALACHUA	-	-	5,850	6,400	12,250	975	4,200	5,175
3	BAKER	-	-	-	-	-	-	600	600
4	BAY	-	-	-	2,000	2,000	-	2,200	2,200
5	BRADFORD	-	-	-	-	-	-	500	500
6	BREVARD	-	-	-	7,500	7,500	-	3,700	3,700
7	BROWARD	30,225	30,225	-	11,200	11,200	75,075	3,700	78,775
8	CALHOUN	-	-	-	-	-	-	500	500
9	CHARLOTTE	-	-	-	500	500	-	3,600	3,600
10	CITRUS	-	-	-	600	600	-	3,000	3,000
11	CLAY	-	-	-	1,600	1,600	-	3,200	3,200
12	COLLIER	-	-	-	5,100	5,100	-	4,200	4,200
13	COLUMBIA	-	-	-	600	600	-	800	800
14	DADE	19,500	19,500	20,475	50,900	71,375	74,100	1,400	75,500
15	DESOTO	-	-	-	-	-	-	800	800
16	DIXIE	-	-	-	-	-	-	400	400
17	DUVAL	19,500	19,500	-	38,800	38,800	32,175	6,000	38,175
18	ESCAMBIA	-	-	-	12,700	12,700	-	-	-
19	FLAGLER	-	-	-	1,100	1,100	-	1,200	1,200
20	FRANKLIN	-	-	-	-	-	-	600	600
21	GADSDEN	-	-	-	-	-	-	1,000	1,000
22	GILCHRIST	-	-	-	-	-	-	400	400
23	GLADES	-	-	-	-	-	-	400	400
24	GULF	-	-	-	100	100	-	400	400
25	HAMILTON	-	-	-	-	-	-	400	400
26	HARDEE	-	-	-	100	100	-	500	500
27	HENDRY	-	-	-	-	-	-	800	800
28	HERNANDO	-	-	-	2,500	2,500	-	3,700	3,700
29	HIGHLANDS	-	-	-	4,200	4,200	-	1,000	1,000
30	HILLSBOROUGH	30,225	30,225	1,950	21,300	23,250	69,225	5,300	74,525
31	HOLMES	-	-	-	200	200	-	500	500
32	INDIAN RIVER	-	-	-	3,300	3,300	-	2,300	2,300
33	JACKSON	-	-	-	800	800	-	800	800
34	JEFFERSON	-	-	-	-	-	-	400	400
35	LAFAYETTE	-	-	-	-	-	-	400	400
36	LAKE	-	-	-	4,500	4,500	-	3,100	3,100
37	LEE	-	-	4,875	12,600	17,475	-	5,800	5,800
38	LEON	-	-	-	11,700	11,700	17,550	-	17,550
39	LEVY	-	-	-	-	-	-	500	500
40	LIBERTY	-	-	-	-	-	-	400	400
41	MADISON	-	-	-	600	600	-	400	400
42	MANATEE	-	-	-	11,800	11,800	-	3,500	3,500
43	MARION	-	-	-	3,000	3,000	13,650	3,400	17,050
44	MARTIN	-	-	-	1,500	1,500	-	2,000	2,000
45	MONROE	-	-	-	1,300	1,300	-	1,500	1,500
46	NASSAU	-	-	-	-	-	-	1,400	1,400

AMERICAN OVERSIGHT

Allocations by county

	J	K	L	M
1	Week 4 Pfizer	Week 4 Moderna	Week 4 Total	Total Allocations
2	-	1,900	1,900	19,325
3	-	1,100	1,100	1,700
4	-	1,400	1,400	5,600
5	-	800	800	1,300
6	-	3,200	3,200	14,400
7	-	1,900	1,900	122,100
8	-	700	700	1,200
9	-	1,100	1,100	5,200
10	-	800	800	4,400
11	-	1,100	1,100	5,900
12	-	4,100	4,100	13,400
13	-	1,100	1,100	2,500
14	-	9,400	9,400	175,775
15	-	1,300	1,300	2,100
16	-	700	700	1,100
17	-	900	900	97,375
18	-	800	800	13,500
19	-	500	500	2,800
20	-	700	700	1,300
21	-	1,900	1,900	2,900
22	-	1,100	1,100	1,500
23	-	700	700	1,100
24	-	700	700	1,200
25	-	400	400	800
26	-	800	800	1,400
27	-	800	800	1,600
28	-	800	800	7,000
29	-	800	800	6,000
30	-	8,100	8,100	136,100
31	-	800	800	1,500
32	4,875	2,100	6,975	12,575
33	-	1,400	1,400	3,000
34	-	400	400	800
35	-	700	700	1,100
36	12,675	1,500	14,175	21,775
37	-	6,600	6,600	29,875
38	4,875	4,300	9,175	38,425
39	-	1,100	1,100	1,600
40	-	700	700	1,100
41	-	800	800	1,800
42	-	1,400	1,400	16,700
43	-	2,100	2,100	22,150
44	-	1,400	1,400	4,900
45	-	500	500	3,300
46	-	500	500	1,900

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
47	OKALOOSA	-	-	-	3,200	3,200	4,875	2,900	7,775
48	OKEECHOBEE	-	-	-	-	-	-	600	600
49	ORANGE	19,500	19,500	-	38,900	38,900	19,500	2,900	22,400
50	OSCEOLA	-	-	-	3,300	3,300	-	3,000	3,000
51	PALM BEACH	-	-	-	37,600	37,600	-	1,000	1,000
52	PASCO	-	-	-	5,000	5,000	-	3,500	3,500
53	PINELLAS	-	-	-	18,800	18,800	-	700	700
54	POLK	-	-	-	9,500	9,500	-	4,000	4,000
55	PUTNAM	-	-	-	600	600	-	800	800
56	SANTA ROSA	-	-	-	700	700	-	2,700	2,700
57	SARASOTA	-	-	-	8,500	8,500	-	6,900	6,900
58	SEMINOLE	-	-	-	10,400	10,400	12,675	2,000	14,675
59	ST. JOHNS	-	-	1,950	-	1,950	-	3,000	3,000
60	ST. LUCIE	-	-	-	3,300	3,300	-	3,000	3,000
61	SUMTER	-	-	-	200	200	-	2,500	2,500
62	SUWANNEE	-	-	-	-	-	-	500	500
63	TAYLOR	-	-	-	-	-	-	500	500
64	UNION	-	-	-	-	-	-	400	400
65	VOLUSIA	-	-	-	9,100	9,100	1,950	3,500	5,450
66	WAKULLA	-	-	-	-	-	-	500	500
67	WALTON	-	-	-	-	-	-	800	800
68	WASHINGTON	-	-	-	300	300	-	500	500
69	Grand Total	118,950	118,950	35,100	367,900	403,000	321,750	127,100	448,850

AMERICAN OVERSIGHT

	J	K	L	M
47	-	300	300	11,275
48	-	800	800	1,400
49	19,500	18,000	37,500	118,300
50	-	2,200	2,200	8,500
51	-	6,900	6,900	45,500
52	-	2,300	2,300	10,800
53	-	3,300	3,300	22,800
54	-	3,800	3,800	17,300
55	-	1,100	1,100	2,500
56	-	800	800	4,200
57	-	1,900	1,900	17,300
58	-	900	900	25,975
59	-	800	800	5,750
60	12,675	900	13,575	19,875
61	-	800	800	3,500
62	-	1,100	1,100	1,600
63	-	800	800	1,300
64	-	500	500	900
65	-	1,400	1,400	15,950
66	-	800	800	1,300
67	-	800	800	1,600
68	-	500	500	1,300
69	54,600	126,600	181,200	1,152,000

AMERICAN OVERSIGHT

COVID-19: vaccine summary

Vaccination data through Jan 7, 2021 as of Jan 8, 2021 at 12:05 AM

Data in this report are provisional and subject to change.

Data in this summary pertain to COVID-19 vaccines approved by the U.S. Food and Drug Administration and have been issued an Emergency Use Authorization. These data summarize the number of people who have received either their first dose or have completed the series for a COVID-19 vaccine. A person can only be counted in one category, first dose or series complete.

Overview of COVID-19 vaccinations in Florida

Total people vaccinated	**443,616**
First dose	419,416
Series completed	24,200

First dose: received their first dose of the COVID-19 vaccine.
Series complete: received all recommended doses of the COVID-19 vaccine to be considered fully immunized.

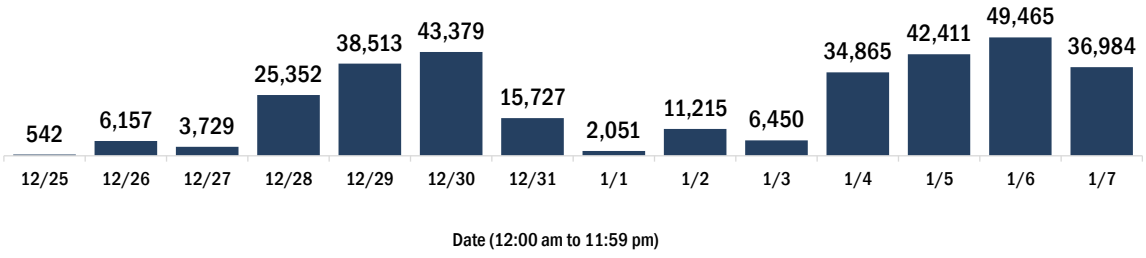
Immunization status	**443,616**
Up-to-date	417,055
Series completed	24,200
Overdue	2,361

Immunization status: status of each person who has received at least one dose of the COVID-19 vaccine.
Up-to-date: describes those who have received their first dose and have not passed the recommended timeframe for their second dose.
Overdue: describes those who have received their first dose and have passed the recommended timeframe to receive their second dose.
Series complete: describes those who have received all recommended doses to be considered fully immunized.

Demographic summary	First dose	Series complete	Total people vaccinated
Age group	419,416	24,200	443,616
16-24 years	10,310	500	10,810
25-34 years	43,728	5,129	48,857
35-44 years	53,017	5,552	58,569
45-54 years	59,552	5,260	64,812
55-64 years	65,295	4,899	70,194
65-74 years	107,220	1,889	109,109
75-84 years	55,589	522	56,111
85+ years	24,705	449	25,154
Race	419,416	24,200	443,616
American Indian/Alaskan	1,359	87	1,446
Black	21,563	1,773	23,336
Other	70,440	5,318	75,758
Unknown	70,120	1,548	71,668
White	255,934	15,474	271,408
Other race includes Asian, native Hawaiian/Pacific Islander, or other.			
Gender	419,416	24,200	443,616
Female	253,388	13,288	266,676
Male	165,233	10,854	176,087
Unknown	795	58	853

COVID-19 vaccinations for the past 2 weeks

Number of persons who received their first dose of the COVID-19 vaccine



Date (12:00 am to 11:59 pm)

AMERICAN OVERSIGHT

COVID-19: vaccine summary

Vaccination data through Jan 7, 2021 as of Jan 8, 2021 at 12:05 AM

Data in this report are provisional and subject to change.

Number of people who received their first dose or completed their COVID-19 vaccine series yesterday and cumulatively

	Yesterday (Jan 7)			Cumulative		
County of residence	First dose	Series complete	Total people vaccinated	First dose	Series complete	Total people vaccinated
Alachua	707	285	992	11,258	1,283	12,541
Baker	109	2	111	489	5	494
Bay	307	1	308	2,362	4	2,366
Bradford	31	2	33	308	5	313
Brevard	822	34	856	10,539	66	10,605
Broward	3,163	1,268	4,431	33,080	4,061	37,141
Calhoun	161	0	161	313	0	313
Charlotte	244	0	244	3,411	4	3,415
Citrus	231	4	235	2,547	8	2,555
Clay	329	30	359	4,104	101	4,205
Collier	473	5	478	7,843	16	7,859
Columbia	284	3	287	1,487	18	1,505
Dade	5,650	2,074	7,724	43,276	6,792	50,068
Desoto	14	1	15	621	1	622
Dixie	10	1	11	161	3	164
Duval	794	365	1,159	19,281	1,128	20,409
Escambia	284	0	284	6,073	2	6,075
Flagler	274	9	283	2,499	13	2,512
Franklin	91	0	91	334	4	338
Gadsden	121	0	121	969	0	969
Gilchrist	91	3	94	423	7	430
Glades	31	0	31	240	0	240
Gulf	74	0	74	408	0	408
Hamilton	124	1	125	456	1	457
Hardee	20	1	21	193	2	195
Hendry	56	1	57	625	1	626
Hernando	284	13	297	3,157	23	3,180
Highlands	302	4	306	1,444	6	1,450
Hillsborough	1,623	1,419	3,042	20,149	2,679	22,828
Holmes	20	0	20	933	0	933
Indian River	322	0	322	3,374	0	3,374
Jackson	194	0	194	1,617	0	1,617
Jefferson	79	0	79	420	0	420
Lafayette	6	0	6	122	1	123
Lake	683	110	793	9,212	192	9,404
Lee	1,411	7	1,418	17,331	36	17,367
Leon	679	8	687	7,787	20	7,807
Levy	94	0	94	594	14	608
Liberty	100	1	101	230	1	231
Madison	168	0	168	600	0	600
Manatee	615	13	628	9,264	40	9,304
Marion	536	22	558	4,613	55	4,668
Martin	300	4	304	3,573	19	3,592
Monroe	93	11	104	1,033	31	1,064
Nassau	131	62	193	1,366	104	1,470
Okaloosa	151	1	152	2,064	1	2,065
Okeechobee	44	2	46	695	2	697
Orange	2,369	1,654	4,023	29,723	2,992	32,715
Osceola	497	192	689	5,144	299	5,443
Out-Of-State	667	40	707	18,039	104	18,143
Palm Beach	3,506	147	3,653	27,661	401	28,062
Pasco	433	206	639	9,000	352	9,352
Pinellas	1,962	237	2,199	20,923	1,854	22,777
Polk	636	127	763	6,976	204	7,180
Putnam	133	1	134	858	8	866
Santa Rosa	1,120	2	1,122	5,107	2	5,109
Sarasota	475	7	482	12,777	51	12,828
Seminole	663	455	1,118	11,068	763	11,831
St. Johns	304	63	367	8,717	201	8,918
St. Lucie	338	1	339	4,108	6	4,114
Sumter	193	5	198	1,474	9	1,483
Suwannee	151	1	152	578	8	586
Taylor	1	0	1	339	0	339
Union	94	0	94	209	4	213
Unknown	35	9	44	409	41	450
Volusia	930	102	1,032	11,449	151	11,600
Wakulla	109	1	110	636	1	637
Walton	26	0	26	545	0	545
Washington	12	0	12	798	0	798
Total	**36,984**	**9,017**	**46,001**	**419,416**	**24,200**	**443,616**

AMERICAN OVERSIGHT

From: Sussman, Andrew <Andrew.Sussman@em.myflorida.com>
Sent: Tuesday, February 02, 2021 9:45 AM EST
To: Alert Florida Group <AlertFloridaGroup@em.myflorida.com>
CC: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Subject: Vaccine Scheduling - Acceptable Uses under AlertFlorida Contract

Good Morning All,
Using Nixle, the text a keyword feature in Everbridge, to encourage eligible citizens to register for receiving a vaccine is an acceptable use case. However, sending a message through the system to individual citizens about their specific appointment is **not** an acceptable use case under the AlertFlorida Contract. Please contact Andrew Sussman for contract questions or Kate Dean for technical questions.

Respectfully,

Andrew Sussman, MPA, FPEM
Hurricane Program Manager/AlertFlorida Contract Manager
Florida Division of Emergency Management
Office Number: 850-815-4110
Smartphone: 850-509-7382

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AMERICAN OVERSIGHT

From: Miller, Carly <carly.miller@em.myflorida.com>
Sent: Tuesday, January 19, 2021 11:30 AM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
Subject: volunteer nurse registration

Live link to volunteer nurse registration on FDEM website here -https://www.floridadisaster.org/covid19/

Carly Miller FPEM, FCCM
Executive Assistant
Florida Division of Emergency Management
2555 Shumard Oak Boulevard
Tallahassee, FL 32399
850-320-3613
Carly.Miller@em.myflorida.com
www.floridadisaster.org

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AMERICAN OVERSIGHT

From: Miller, Carly <carly.miller@em.myflorida.com>
Sent: Tuesday, January 05, 2021 3:13 PM EST
To: County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
CC: Otis, Aaron <Aaron.Otis@flhealth.gov>
Subject: Who is authorized to administer the vaccine?

Carly Miller, FPEM, FCCM
850-320-3613

From: Otis, Aaron <Aaron.Otis@flhealth.gov>
Sent: Tuesday, January 5, 2021 2:58 PM
To: Miller, Carly <carly.miller@em.myflorida.com>
Subject: FW:

Can you send to EM directors

Aaron Otis
aaron.otis@flhealth.gov
850-445-1380

From: Riggen, Amy <Amy.Riggen@flhealth.gov>
Sent: Tuesday, January 5, 2021 2:57 PM
To: Otis, Aaron <Aaron.Otis@flhealth.gov>
Subject:

8.) Who is authorized to administer the vaccine?

Position Title	Administer Immunizations	Supervision Requirements for Administration of Immunizations	Other Requirements
Certified Nursing Assistant- CNA	Yes	Direct supervision by RN	Section 464.201 (5), Florida Statute '…may perform after training beyond that required for initial certification and upon validation of competence in that skill by a registered nurse.'
Licensed Practical Nurse	Yes	*Direct supervision by a RN, APRN, or Physician	
Registered Nurse	Yes		
Advance Practice Registered Nurse	Yes		
Medical Physician and Osteopathic Physician	Yes		Based on guidance from MQA under Chapter 458 and 459
Medical Assistant	Yes	Direct supervision by a physician	Chapter 458.3485, *F.S.*
Physician Assistant	Yes	Direct or indirect supervision by a physician physician	Physician determines ability and supervision type
Pharmacist	Yes		Protocols & training required.
Pharmacy Intern	Yes	Direct supervision by a certified pharmacist	Section 465.189 (6), Florida Statute Any pharmacist or registered intern seeking to administer vaccines to adults under this section must be certified to administer such vaccines pursuant to a certification program approved by the Board of Pharmacy in consultation with the Board of Medicine and the Board of Osteopathic Medicine. The certification program shall, at a minimum, require that the pharmacist attend at least 20 hours of continuing education classes approved by the board and the registered intern complete at least 20 hours of coursework approved by the board.
Paramedic	Yes Non-emergency environment		Under direction of a medical director who must document & verify receipt of sufficient training & experience on department forms. Completed forms must be maintained @ the service location of the licensee and available upon request. There must be a written agreement between the paramedic's medical director & the CHD located in each county in which the paramedic administers immunizations.
Emergency Medical Technicians (EMT)	No		401.272 Emergency medical services community health care

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AMERICAN OVERSIGHT

Dentist	No		No documentation or F.S. supports
Dentist Hygienist	No		No documentation or F.S. supports
Retired Nurses (LPN/RN)	Yes	*LPN requires direct supervision	Chapter 464.0205 F.S. volunteer nurse certificate from the board needed. Volunteer nurses cannot supervise or receive monetary compensation.
Nursing Students	Yes	Direct supervision by a program faculty member or clinical preceptor	Chapter 464.019 F.S. Written policies related to supervision required for faculty and/or preceptor.

AMERICAN OVERSIGHT