**Individual Name:**  **ID #:**  **Date/Time:** 

**Contact Method:**  **Individual/Caregiver Interviewed (Name(s)):** 

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| --- | --- | --- |
|  | **YES** | **NO** |
| **In response to the current COVID-19 Public Health Emergency, the following information may be utilized to support discussion with the individual and their caregiver to assist with the identification of service needs.**  **The information obtained supports the intent to ensure that the individuals support plan addresses all assessed needs (including health and safety risk factors) and is updated/revised when warranted by changes in the waiver participant’s needs.**  **In the event of direct contact with someone who is COVID-19 positive or as a result of testing COVID-19 positive themselves, individualized emergency back-up planning can serve as a vital component of risk mitigation and support to promote individual health and welfare.**  [**https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/shared-housing/index.html**](https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/shared-housing/index.html)  [**https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/get-your-household-ready-for-COVID-19.html**](https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/get-your-household-ready-for-COVID-19.html)  [**https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/what-you-can-do.html**](https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/what-you-can-do.html) |  |  |
| ***Does the individual currently have a written emergency back-up plan to support them in the event that they, their room-mate and /or caregiver is COVID-19 positive?*** |  |  |
| **If no, please work with the individual and their caregiver to develop their plan.**  **If yes, please answer the following questions:** |  |  |
| 1. Does the plan address specific support needs for the individual (*noting what is important to and important for the individual*) in the event they would need to self-quarantine? |  |  |
| *For example: behavioral supports, level of supervision (1:1), tolerance to PPE including the type of PPE that they would be agreeable to utilize, other CDC recommendations to mitigate risk to the individual, specific supplies to support the individual and their activity needs. Does the individual’s current home environment support their ability to self-quarantine?* Per CDC: Quarantine Quarantine is used to **keep someone who *might* have been exposed to COVID-19 away from others**. Someone in self-quarantine stays separated from others, and they limit movement outside of their home or current place. A person may have been exposed to the virus without knowing it (for example, when traveling or out in the community), or they could have the virus without feeling symptoms. Quarantine helps limit further spread of COVID-19.  <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html> |  |  |
| **If yes**, please specify: Click or tap here to enter text.  **If no, please work with the individual and their caregiver to amend their plan.** |  |  |

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| 1. Does the plan address specific support needs for the individual (*noting what is important to and important for the individual*) in the event they would need to self-isolate? |  |  |
| *For example: behavioral supports, level of supervision (1:1), tolerance to PPE including the type of PPE that they would be agreeable to utilize, other CDC recommendations to mitigate risk to the individual, specific supplies to support the individual and their activity needs. Does the individual’s current home environment support their ability to self-isolate?*  *Is an alternative residence needed while self-isolating?*  **Per CDC: Isolation**  Isolation is used to **separate sick people from healthy people**. People who are in isolation should stay home. In the home, anyone sick should separate themselves from others by staying in a specific “sick” bedroom or space and using a different bathroom (if possible).  <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html>  <https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/living-in-close-quarters.html> |  |  |
| **If yes**, please specify: Click or tap here to enter text.  **If no, please work with the individual and their caregiver to amend their plan.** |  |  |
| 1. Does the plan address specific support needs for the individual (*noting what is important to and important for the individual*) in the event that their caregiver is unable to provider daily supports and/or services? |  |  |
| For example, identification of additional caregiver options and identification of alternative residence, if needed. Helpful to have at least two alternative caregivers identified and alternative residences in the event that the first option is not available. |  |  |
| **If yes**, please specify: Click or tap here to enter text.  **If no, please work with the individual and their caregiver to amend their plan.** |  |  |
| 1. Individual/caregiver has the **DHSS COVID-19 hotline number if needed: 877-435-8411**. |  |  |
| 1. Individual has adequate over the counter supplies to treat fever and other symptoms. |  |  |
| *For example*, Communication with the individual’s healthcare provider and documentation defining: what an elevated body temperature (fever) is for the individual and what specific actions to take. Including medication type, amount and frequency medications to manage elevated body temperature (fever). |  |  |
| **If yes**, please specify: Click or tap here to enter text.  **If NO**, what is needed?  Identify plan to address: Click or tap here to enter text. |  |  |
| 1. Individual has adequate equipment to monitor changes in health status. |  |  |
| *For example*, Communication with the individual’s healthcare provider and documentation defining: what specific equipment to utilize to monitor body temperature for the individual (type of thermometer best suited for the individual); type of monitoring related to respiratory needs for example pulse oximeter etc…or other devises based on underlying health conditions and what specific actions to take if defined signs and/or symptoms are noted. |  |  |
| **If yes**, please specify: Click or tap here to enter text.  **If NO**, what is needed?  Identify plan to address: Click or tap here to enter text. |  |  |

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| 1. Individual/caregiver has proper and adequate Personal Protective Equipment (PPE). |  |  |
| For example, Communication with the individual’s healthcare provider and documentation defining: the type of PPE best suited for the individual to support their tolerance and protection. |  |  |
| **If yes**, please specify: Click or tap here to enter text.  **If NO**, what is needed?  Identify plan to address: Click or tap here to enter text. |  |  |
| 1. Individual has meals to eat/groceries/nutritional supplements on hand for several days. Supporting their likes and dislikes and any specialized prescribed dietary needs. |  |  |
| For example, diet modifications, textures, fluids etc… |  |  |
| **If yes**, please specify: Click or tap here to enter text.  **If NO**, what is needed?  Identify plan to address: Click or tap here to enter text. |  |  |
| 1. Individual has access to phone and other electronic devises to keep in contact with family and friends. |  |  |
| For example, internet access in the home, equipment to promote independent communication with family and friend for example tablet or personal cell phone and applications for device. |  |  |
| **If yes**, please specify: Click or tap here to enter text.  **If NO**, what is needed?  Identify plan to address: Click or tap here to enter text. |  |  |
| 1. Individual and their caregiver(s) have information and resources to support their understanding of preventative measures to implement regarding COVID-19 |  |  |
| For example, Good handwashing, social distancing, environmental hygiene what self-quarantine vs. self-isolation means |  |  |
| **If yes**, please specify: Click or tap here to enter text.  **If NO**, what is needed?  Identify plan to address: Click or tap here to enter text. |  |  |

If any of the above statements are marked **NO**, please provide any necessary additional documentation to indicate follow-up action to address. For example, who you contacted for follow-up (agency, SC supervisor, other).

Click or tap here to enter text.

**COMMENTS** (Please include any training/educational resources provided to individual and/or caregiver(s) i.e. Infection control measures, environmental hygiene, good handwashing, proper utilization of PPE, agency policy for communication when potential COVID-19 symptoms are identified):

Click or tap here to enter text.

\*Additional documentation can be recorded in the service monitoring note.

SC Signature: Click or tap here to enter text.