Participant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Informant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assessment Date(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mode of contact: **🞏** Phone **🞏** Email **🞏** At Door **🞏** In-Home **🞏** Video

Contact with: **🞏** Participant **🞏** Caregiver \_\_\_\_\_\_\_\_ **🞏** IHSS Worker \_\_\_\_\_\_ **🞏** Other\_\_\_\_\_\_\_

**COVID-19 Screening (use extended COVID-19 Screening Tool if any concerns are identified here and for assessing individual’s level of understanding and to provide education)**

|  |  |  |
| --- | --- | --- |
| 1. Are you or any one you are living with, having flu-like symptoms, such as fever (100+), cough, or shortness of breath? GI symptoms? Loss of taste and smell? If yes, when and what:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Yes** | **No** |
| 1. Have you, someone with whom you have had contact, or any one you are living with been suspected of having or been diagnosed with coronavirus? |  |  |
| 1. Have you or someone with whom you have had contact been asked to self-quarantine by the health department? |  |  |
| 1. Have you, or someone with whom you have had contact or anyone you are living with traveled out of the state or country in the last 14 days? |  |  |

**🞏 Determination of Urgent Situation** **FOR ANY REASON (Move into emergency response)**

**ASSESS FOR AREAS OF RISK (Check all that apply to assess risk level)**

**🞏** Limited or No Social Supports/Family while “staying at home” – ADL needs being met?

**🞏** Caregiver Stress/Inconsistency/Possible abuse/deficits in ability to care for self and pt.

**🞏** IHSS Inconsistency - Problems with IHSS Provider? Are ADL/IADL needs being met?

**🞏** Mental Health Concerns and/or Emotional Distress

**🞏** Social Isolation/Loneliness and/or failure to heed sheltering in place (pt. or caregivers)

**🞏** Lack of activity

**🞏** Unstable or Unsafe Housing or associated threats

**🞏** Financial Insecurity/Lack of Resources while “Staying at Home”

**🞏** Food Insecurity – Lacks supplies/unable to prepare/unable to safely reheat/dependent

**🞏** Lack of Transportation to medical visits and other essential errands (Ex: Shopping)

**🞏** Medication Management (Administration & Availability)/

**🞏** Fall Risk – Fell or tripped/home presents risks/lacks support

**🞏** Diabetic Management: Potential challenges with Diet/Monitoring/Medications **🞏 N/A**

**🞏** Hypertension Management: Potential Challenges with Diet/Monitoring **🞏 N/A**

**🞏** Multiple chronic conditions and/or ADL/IADL challenges

**SUMMARY OF IDENTIFIED PROBLEMS AND ACTION PLAN TO ADDRESS AS NEEDED (Use Progress Notes or related formats to provide detail of assessed needs and document provider’s response over time)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Signature/Title/Date