**WRC COVID-19 FORM FOR CONSUMER**

***TO BE COMPLETED IN WORD FORMAT AND E-MAILED TO THE WESTSIDE REGIONAL CENTER DESIGNATED SIR EMAIL ADDRESS***

**Send the SIR and COVID 19 Form to Westside Regional Center SIR email:** [**SIR@westsiderc.org**](mailto:SIR@westsiderc.org)

**Your assistance is needed and appreciated. The Department of Developmental Services (DDS) has requested that vendors and Long term Care Providers (ICF DD- H/N/ CN) report any Consumer who is symptomatic (fever, cough, shortness of breath) or have been tested for COVID-19.**

**Written by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Report: \_\_\_\_\_\_\_\_\_ Updated On: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reporting Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reporting Agency Vendor #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Consumer Name:** | | 1. **2. UCI:** | |
| 1. **DOB:** | | 1. **AGE:** | |
| **5. Where Consumer was Exposed:**  🞏 **Family Home**  🞏 **Consumer Residence**  **🞏 Unknown** | 🞏 **Residence** (name of provider/type)**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  🞏 **Day Program** (name of provider):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  🞏 **Job Site** (name of provider):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  🞏 **Other** (location, if known):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **6. What is the individual’s’ living arrangement,** e.g. Family home, RCF, ICF, ARFPSHN, CCH, EBSH, supported living, independent living)? | | | |
| **7. Where does the individual live? Please provide residential provider or other home support (ILS/SLS) vendor name and vendor number:** | | **8. Number of consumers/employees at Home:**  **#C \_\_\_\_\_ / #E \_\_\_\_\_** | |
| **9. What is the individual’s day program or employment program? Please provide day program’s vendor name and vendor number.** | | **10. Number of consumers/employees at Worksite/Day Program:**  **#C \_\_\_\_\_ / #E \_\_\_\_\_** | |
| **11. Date Reported To County Public Health:** |  | **12. Which County Reported To:** |  |
| **13. Date Symptoms Noted:** |  | **14. Isolation: 🞏 Y/ 🞏 N** | **If Yes, Date:** |
| **15. Tested: 🞏 Y / 🞏 N** | **16. If Yes, Date Conducted:** | **17. Test Results:** | **🞏 Positive**  **🞏 Negative** |
| **8. Management Plan – Document how you are addressing the concern (e.g., isolation room, home isolation, hospitalized, etc.) – Additional detail should be added in the SIR:** | | | |

**All FIELDS ARE REQUIRED UNLESS OTHERWISE INDICATED.**

3.23.20