**SARC COVID-19 CONSUMER FORM**

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

**Send the SIR and COVID 19 Form to the office that the consumer’s service coordinator works from: San Jose Office:** [**sirsanjose@sarc.org**](mailto:sirsanjose@sarc.org)**. Salinas:** [**sirsalinas@sarc.org**](mailto:sirsalinas@sarc.org)**. Watsonville:** [**sirwatsonville@sarc.org**](mailto:sirwatsonville@sarc.org)**.**

**Your assistance is needed and appreciated. The Department of Developmental Services (DDS) requests Vendors and Long Term Care Providers (ICF DD- H/N/CN) complete this information for consumer meeting the following criteria (please note new criteria for reporting as of May 22, 2020):**

**1) A consumer who tests positive for COVID-19; or 2) A consumer who receives medical attention at a hospital, ER, or urgent care, due to COVID-19 symptoms\*; or   
3) A consumer whose death is related to COVID-19, either by confirmed COVID-19 positive testing or by medical diagnosis unconfirmed testing.**

\* Symptoms are defined as: fever, new persistent cough, unusual shortness of breath that appears related to COVID-19.

**Written By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Report: \_\_\_\_\_\_\_\_\_\_\_\_ Updated On: \_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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

|  |  |
| --- | --- |
| 1. **Consumer Name:** | 1. **2. DOB:** |
| 1. **Age:** | 1. **UCI:** |
| 1. **Vendor/Provider Agency Name (If living with family please indicate "Family Home")**  **Family Home** | |
| **6. Vendor/Provider Address:** | |
| 1. **Vendor/Provider Primary Contact Phone number: ( )** | |
| 1. **8. Vendor/Provider E-mail Address:** | |
| **9. Residence Type:**  **ARF**  **ARFPSHN**  **CCH**  **EBSH**  **FAMILY HOME**  **FHA**  **GROUP HOME**  **ICF/ DD-H**  **ICF/DD-N**  **SNF**  **INDEPENDENT LIVING**  **SLS**  **OTHER** | |
| **10. Tested:**  **Yes**  **No**  **Unknown** | **11. If Yes, Date?** |
| **12. Test Results:**  **Negative**  **Positive** | |
| **13. Consumer Placement Status:**  **Hospital**  **Discharge from hospital to current living arrangement with isolation protocol**  **Move from current placement to alternative placement**  **Remain in current living arrangement (isolation)** | |
| **14. Management Plan /Comments – Document how you are addressing the concern:** | |

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