**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****. Salinas:** **sirsalinas@sarc.org****. Watsonville:** **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:**  |

Rev 6.05.20