**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 March 14, 2021):**

**1) A consumer who tests positive for a new case of COVID-19 (“New Case” means the first time someone becomes ill from COVID-19, or a subsequent illness after recovery from a prior COVID-19 illness. Please do not report every positive test result for the same instance of illness).**

**2) A consumer whose death is attributed to COVID-19, either by confirmed COVID-19 positive testing or by medical diagnosis (Means a death described in the SIR as attributed to COVID-19).**

COVID-19 signs/symptoms: fever, chills, new persistent cough, runny nose or nasal congestion, sore throat, gastrointestinal upset, headache, muscle aches, unusual shortness of breath appearing as related to COVID-19. Find more information here: [CDC Clinical Care Quick Reference for COVID-19](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwi8rbmwpNr1AhVXDkQIHQI2DA8QFnoECAsQAw&url=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Fclinical-care-quick-reference.html%23%3A~%3Atext%3D%25E2%2580%25A2%2520Signs%2520and%2520symptoms%2520of%2C%252C%2520and%2520skin%2520rashes.&usg=AOvVaw0oqaPOdKcuoWDmGtEF9KnW)

**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")**

 |
| **6. Vendor/Provider Address:** |
| 1. **Vendor/Provider Primary Contact Phone number: ( )**

 |
| **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. Reporting COVID-19 Criteria:** [ ]  **1) New COVID-19 Case OR** [ ]  **2) Death attributed to COVID-19**  |
| **11. Tested:** [ ]  **Yes** [ ]  **No** [ ]  **Unknown**  | **12. If Yes, Date?** |
| **13. Test Results:** [ ]  **Negative** [ ]  **Positive** |
| **14. Consumer fully vaccinated when tested positive?** [ ]  **No** [ ]  **Yes If yes, date of second dose:** |
| **15. 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)** |
| **16. Management Plan /Comments – Document how you are addressing the concern:**  |

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