Staff & Participant COVID-19 Wellness Check Screening Tool

Participant:

Staff:

Mode of contact: ☐ **Telephone** ☐ **In-person**

Contact with: ☐ **Staff**
☐ **Participant**
☐ **Family/Caregiver/Designee**
☐ **Responsible party**
☐ **Other:**

SOCIAL DISTANCING AREAS OF CONCERN (Check all that apply)

☐ **Individuals identified as high-risk using current DOH & CDC guidelines**
☐ **Limited or no formal or informal supports**
☐ **Caregiver stress/deficits in ability to care for self and consumer/caregiver unavailable**
☐ **Ability of participant to adhere to social distancing issues**
☐ **Need for caregiver to work outside of home**
☐ **Mental health concerns and/or emotional distress**
☐ **Social isolation/loneliness**
☐ **Food insecurity/nutritional risks**
☐ **Other:**

COVID-19 SCREENING	**Staff & Participant Screening** Date: Yes	No
1. Are you, or any one you are living with, experiencing any of the following symptoms? (Consider the ability of your participant to answer these questions, and involve the contacts listed above, as needed) • Fever (100+), cough, shortness of breath or difficulty breathing, diarrhea, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell If yes, when, what, and steps taken to receive medical attention:	☐	☐
2. Are you, someone with whom you have had contact, or any one you are living with been suspected of having or been diagnosed with COVID-19?	☐	☐
3. Have you or someone with whom you have had contact been asked to self-quarantine?	☐	☐
4. Have you, 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?	☐	☐

Staff Signature: Title: Date: