

COVID-19 Participant Wellness Check & Risk Assessment

Participant: _____ Other Informant: _____

Assessment Date(s): _____ Time(s) _____

Mode of contact: ☐ Phone ☐ Email ☐ At Door ☐ In-Home ☐ Video

Contact with: ☐ Participant ☐ Caregiver _____ ☐ IHSS Worker _____ ☐ Other _____

COVID-19 Screening (use extended COVID-19 Screening Tool if any concerns are identified here and for assessing individual's level of understanding and to provide education)

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|---|-----|----|
| 1. Are you or any one you are living with, having flu-like symptoms, such as fever, chills, repeated shaking with chills, cough, shortness of breath? Muscle pain, headache, sore throat, GI symptoms? New loss of taste and smell? | Yes | No |
| 2. If yes, when and what: _____ | | |
| 3. Have you, someone with whom you have had contact, or any one you are living with been suspected of having or been diagnosed with coronavirus? | | |
| 4. Have you or someone with whom you have had contact been asked to self-quarantine by the health department? | | |
| 5. Have you, or 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? | | |

☐ **Determination of Urgent Situation FOR ANY REASON (Move into emergency response)**

ASSESS FOR AREAS OF RISK (Check all that apply to assess risk level)

- ☐ Limited or No Social Supports/Family while "staying at home" – ADL needs being met?
- ☐ Caregiver Stress/Inconsistency/Possible abuse/deficits in ability to care for self and pt.
- ☐ IHSS Inconsistency - Problems with IHSS Provider? Are ADL/IADL needs being met?
- ☐ Mental Health Concerns and/or Emotional Distress
- ☐ Social Isolation/Loneliness and/or failure to heed sheltering in place (pt. or caregivers)
- ☐ Lack of activity
- ☐ Unstable or Unsafe Housing or associated threats
- ☐ Financial Insecurity/Lack of Resources while "Staying at Home"
- ☐ Food Insecurity – Lacks supplies/unable to prepare/unable to safely reheat/dependent
- ☐ Lack of Transportation to medical visits and other essential errands (Ex: Shopping)
- ☐ Medication Management (Administration & Availability)/
- ☐ Fall Risk – Fell or tripped/home presents risks/lacks support
- ☐ Diabetic Management: Potential challenges with Diet/Monitoring/Medications ☐ N/A
- ☐ Hypertension Management: Potential Challenges with Diet/Monitoring ☐ N/A
- ☐ Multiple chronic conditions and/or ADL/IADL challenges

SUMMARY OF IDENTIFIED PROBLEMS AND ACTION PLAN TO ADDRESS AS NEEDED (Use Progress Notes or related formats to provide detail of assessed needs and document provider's response over time)

Staff Signature/Title/Date _____