**Individual COVID-19 Response Plan  
Restarting Non-Residential Services**

**Participant Name:** Click or tap here to enter text. **UCI #:** Click or tap here to enter text.

**Non-Residential Service Provider:** Click or tap here to enter text.

**GGRC Social Worker**: Click or tap here to enter text.

**The following individuals contributed to and helped me fill out my plan**: Click or tap here to enter text.

**I currently live at**:Choose an item. **Other:** Click or tap here to enter text.

**I want to get support in the following ways:**

* Click or tap here to enter text.
* Click or tap here to enter text.
* Click or tap here to enter text.

**I worry about the following when my services restart in person**:

* Click or tap here to enter text.
* Click or tap here to enter text.
* Click or tap here to enter text.

**I would like to get around my community (including to my program) by:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Access Option** | **Yes** | **Unsure** | **No** | **Questions** |
| Walking/rolling in my neighborhood |  |  |  | Click or tap here to enter text. |
| Riding public transit (wearing face coverings, and following physical distancing rules) |  |  |  | Click or tap here to enter text. |
| Riding paratransit |  |  |  | Click or tap here to enter text. |
| Drive myself |  |  |  | Click or tap here to enter text. |
| Driven by my residential provider |  |  |  | Click or tap here to enter text. |
| Driven by my family |  |  |  | Click or tap here to enter text. |
| Driven by my staff alone |  |  |  | Click or tap here to enter text. |
| Driven by my staff with others |  |  |  | Click or tap here to enter text. |
| Taking Curb to Curb service |  |  |  | Click or tap here to enter text. |

**Family/key supporter comments for planning consideration (optional):** Click or tap here to enter text.

**When shelter in place ends, I am hoping to receive supports (check all that apply):**

At my original program site

In the community

At my job/volunteer situation

By remote technology

Where I live (in my home)

Other (add comments): Click or tap here to enter text.

**I understand that my supports will most likely not look the same as they did before the Shelter-in-Place orders went into effect and I will work with my provider to get my needs and desires met in a safe way.**

**I understand that to receive supports in the community, I may need to allow:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Health and Safety Area** | **Yes** | **Unsure** | **No** | **Concerns or Questions** |
| Getting my temperature taken |  |  |  | Click or tap here to enter text. |
| Getting tested for COVID-19 |  |  |  | Click or tap here to enter text. |
| Answering questions about my health |  |  |  | Click or tap here to enter text. |
| Wearing a face covering |  |  |  | Click or tap here to enter text. |
| Using hand sanitizer |  |  |  | Click or tap here to enter text. |
| Washing my hands for 20 seconds |  |  |  | Click or tap here to enter text. |
| Maintaining physical distance from others |  |  |  | Click or tap here to enter text. |
| Receiving services in a group setting |  |  |  | Click or tap here to enter text. |

**I have heard that folks are receiving services at home, on their TV, Computer, phone or by having staff come and support them at home. These are called remote services and supports.**

* I would consider participating in remote classes/activities: Choose an item.
* I would need help with the following to access remote supports:

Internet access

Tablet or computer support

Phone support

Training to use technology

Access to technology

* I would need support from staff or a family member to use technology.Choose an item.

**Health Status Today: check all that apply**

A very important concern to ensure everyone’s health and safety is the need to let us know if you have any COVID-19 symptoms. Have you had any of the following symptoms? Fever, cough, shortness of breath, diarrhea, chills, muscle pain, headache, sore throat or new loss of taste or smell?

I do have one of the health risk factors (diabetes, lung disease, high blood pressure, over the age of 65+, or other risks identified by my doctor), which increases my risk. You can always check with your primary care physician, if you have any questions or concerns.

If I catch COVID-19, I understand that it may change where and how I receive services and supports.

I am not living with or receiving supports from anyone who has been exposed or tested positive for COVID-19.

I have a plan if I start to feel sick or need to leave the services I am receiving to go home.

* Since I have been sheltering in place, I have continued to use or found some new ways to help me minimize my stress and anxiety:

I listen to my favorite music

I meditate or practice mindfulness

I create lists that I or staff can use to help me feel engaged

I relax in a cool, dark space

I play on my phone or tablet

I eat balanced meals

I talk with my friends or family

I go for a walk or other exercise every day

Other ways: Click or tap here to enter text.

**Provider and participant have agreed to these services in the noted location(s):**

**Certifications:**

I have completed this questionnaire to the best of my abilities and have clearly expressed my wants, desires and current health status.

* I am willing and able to receive some supports and services remotely, either by phone or video, such as:

Service coordination support (organizing services between providers and supports)

Individual Program Planning meetings and discussions

Remote learning and activity support

Other: Click or tap here to enter text.

I will report any change in my health to my social worker and program support staff immediately, to help protect my health and the health of those around me.

Participant Name:Click or tap here to enter text. Date:Click or tap here to enter text.

GGRC Social Worker: Click or tap here to enter text. Date: Click or tap here to enter text.

Program Support Staff: Click or tap here to enter text. Date: Click or tap here to enter text.