COVID-19 INDIVIDUAL RISK ASSESSMENT FOR REVISED PERSON-CENTERED PLANNING

Name:	Date:

SECTION 1

N/A	NO	YES	MEDICAL
☐	☐	☐	1. Does the person have any risk factors identified by the CDC that places the person at a higher risk level?
☐	☐	☐	2. If so, does the benefit of returning to facility-based services outweigh health risk?
☐	☐	☐	3. Is anyone in the home vulnerable or at a higher risk (elderly caregivers, roommates, etc.)?
☐	☐	☐	4. Can and will the person protect themselves and others by washing their hands often; avoid touching their eyes, nose and mouth; cover their coughs and sneezes and wear protective mask or cloth face covering?

SECTION 2

N/A	NO	YES	PREVENTATIVE MEASURES
☐	☐	☐	5. Does the person have access to PPE (facemasks or cloth face covering)? Indicate who is responsible for providing the PPE:_____
☐	☐	☐	6. Can the person tolerate wearing a facemask/covering?
☐	☐	☐	7. Is there a plan for cleaning the mask or face covering regularly?
☐	☐	☐	8. Has the person received training on proper hand washing and will practice frequent hand washing?
☐	☐	☐	9. Can the person practice social distancing - keep away from others in the public and limit close contact with support staff & peers?
☐	☐	☐	10. Are measures in place for when the person returns home from day services to minimize any further risk of exposure (wash hands upon return, change clothes, etc.)?

SECTION 3

N/A	NO	YES	TRANSPORTATION
☐	☐	☐	11. Does the person use public bus, Uber, or Lyft to get to day services? If yes, can they maintain 6 feet distance from other passengers, avoid touching high-touch surfaces (grab bars and handrails), and wash hands or use hand sanitizers as soon as possible after leaving?
☐	☐	☐	12. Can the family or residential support staff transport the individual directly to the day service site?
☐	☐	☐	13. Is the person transported to day service site by agency vehicle? If yes, must limit close contact, create space between others in the vehicle, and improve air flow in the van by opening the windows.
☐	☐	☐	14. Are there any additional concerns or considerations related to transportation? Explain: _____

Prior to COVID-19 Stay-at-Home orders what services did you receive? (Check ALL that apply)

☐ **Facility Day Hab** ☐ **Community Day Hab** ☐ **Community Experience**

☐ **Personal Care** ☐ **Companion Services** ☐ **Skilled Nursing**

☐ **24 hr. Res Hab** ☐ **Supported Employment** ☐ **Pre-Voc** ☐ **Other:_____**

At this time what Waiver services would you LIKE to receive? (Check ALL that apply)

☐ **Facility Day Hab** ☐ **Community Day Hab** ☐ **Community Experience**

☐ **Personal Care** ☐ **Companion Services** ☐ **Skilled Nursing**

☐ **24 hr. Res Hab** ☐ **Supported Employment** ☐ **Pre-Voc** ☐ **Other:_____**

NOTE: Please complete the COVID-19 RETURN TO WORK ASSESSMENT if the individual chooses work

Individual desires or would benefit from these NEW Learning Opportunities as a result of this assessment:

NEED/FOCUS AREA	ACTION STEP	TARGET DATE	PERSON(S) RESPONSIBLE

OTHER TEAM RECOMMENDATIONS:

The following individuals participated in the POST-COVID-19 Person-Centered Planning Discussion and the Return to Services Assessment:

Name	Relationship

Form Completed By: