SASH® a caring partnership
SUPPORT AND SERVICES AT HOME

COVID-19 Individual Plan for SASH Participants

Participant's Name:_____ Date of Birth: _____

Phone Number: _____ Email: _____

Address: _____

PCP:_____ PCP Phone:_____

Local Pharmacy: _____ Pharmacy Phone: _____

Other Health or Service Providers *(home health, mental health, AAA, Adult Day, Choices for Care case manager, etc.)*:

_____

_____

_____

Use & Disclosure Expiration Date: _____

Risk Assessment: *(Refer to Participant Health Risk Criteria on STAR)*

- ☐ **High** *(experiencing COVID-19 symptoms, cancer, dialysis, group home, age > 90, COPD/asthma, homebound, no PCP, complex medical, regular @ adult day)*
- ☐ **Moderate** *(food insecure, mental illness, age > 80, diabetes, heart disease, low health literacy, isolated; consider VA patients, children in home)*
- ☐ **Low**

Needs Assessment:

- ☐ COVID-19 symptoms? Answer the questions about their COVID-19 status (located at the end of this document)
- ☐ Food (day to day, plan for isolation, 2-week supply)
- ☐ Toiletries — incontinence supplies, etc.?
- ☐ Emotional Support (how is their mental health?)
- ☐ Social Network (Whom can they talk to?)
- ☐ Medication Supply
- ☐ Housing Secure?
- ☐ Would like help reviewing advanced directives
- ☐ Transportation Plan (if they need testing, food, medications, etc.)
- ☐ Pets? Plan in place if participant becomes ill
- ☐ COVID-19 understanding (Whom to call? When to be tested? Social distance? Scams?)
- ☐ SmartPhone/Internet? ❑Yes ❑No
  Active user of this technology? ❑Yes ❑No

Whom can Participant contact for help? *(Neighbor, family member, friend)* _____

Participant's biggest concern/challenge? _____

How can SASH help? _____

How can Participant help others? *(volunteer opportunities, phone buddy, write letters, etc.)* _____

Action Plan: **HIGH RISK** = Weekly or more phone check-in by WN
MODERATE RISK = Weekly WN or SC check-in or as requested
LOW RISK = Every other week or as needed/requested; open office hours by SC

Date Concern/Issue Addressed & By Whom: _____

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Notes: _____

_____

_____

_____

_____

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_____

COVID-19 Status (PHL Entry): This section only needs to be completed if participant is reporting symptoms. Answer the questions that are relevant in this moment. As the answers to the questions change, update that information in PHL under a new visit entry.

1. Participant reports showing the following symptoms: ☐Fever ☐Cough ☐Shortness of Breath ☐Chills ☐Repeated Shaking with Chills ☐Muscle Pain ☐Headache ☐Sore Throat ☐New Loss of Taste or Smell
2. Date COVID-19 like symptoms started: _____
3. Has participant contacted PCP about the above symptoms? ☐Yes ☐No ☐Unknown
4. Status of COVID-19 test: ☐In Progress ☐Participant Refused Testing ☐COVID-19 Test Not Currently Available ☐Not Recommended/Ordered
5. COVID-19 test results: ☐Positive for COVID-19 ☐Negative
6. Date COVID-19 test was administered: _____
7. Status of participant's COVID treatment: ☐Self-Isolation ☐Hospitalized ☐Recovered ☐Deceased

Follow-up using the risk assessment criteria on page 1.