ATTACHMENT 1

DO NOT SUBMIT THIS FORM TO THE STATE SEOC

Initial Intake and Assessment Tool

(If multiple family members, all must be screened)

AFTER ASSESSMENT: Referred to Alternate Housing Facility? Yes / No

Interviewer Information

Date/Time:___________ Local Health Department:__________________________ City/County:___________________

Interviewer Name:__________________________________ Health Dept. Phone:________________________________

Client Information

Family Last Name:_________________________________ Family Contact Number: _________________________

Does the family need language assistance / interpreter? Yes / No (If yes, identify interpreter)

Primary language spoken in home: ______________________

Home Address: ____

Names/ages/genders of all family members present: ____

Emergency Contact Name:______________________________Relationship to Client:______________________________

Emergency Contact Primary Phone:________________________Emergency Contact Secondary Phone:_________________

INITIAL SCREENING	Circle	Actions to be taken	Include ONLY name of affected family member
If individual is a limited English speaker, is there an adult with you who speaks English?	YES / NO	If yes, name(s) of family member(s) who speak English.	
1. Do you need assistance hearing me?	YES / NO	If Yes, answer following questions	
Will you need assistance with understanding or answering these questions?	YES / NO	If yes ask the next two questions. If No, skip next two questions.	
Do you use a hearing aid and do you have it with you? Is the hearing aid working? Ensure you bring batteries with you.	YES / NO	If no, identify potential resources for replacement.	
Do you need a sign language interpreter?	YES / NO	If yes, identify potential resources in conjunction with shelter manager.	
How do you best communicate with others?		Sign language? Lip read? Use a TTY? Other (explain).	
2. Are you a Veteran, homeless, first responder or healthcare worker?	YES / NO	If yes, please list which one.	
3. ***Observation by the Screener:*** Do you observe a bruise or patterned mark anywhere on the child, specifically on the trunk, ears, and/or neck? Question for the Caregiver with the child: Has your child ever been harmed by someone caring for him/her? Have you ever seen a bruise or patterned mark anywhere on your child's body and more specifically on the trunk, ears and neck?	YES / NO	If yes, any of these questions should require clarifying questions and/or report to the DCFS hotline (1-800-25-ABUSE)	

4. Is minor in foster care/DCFS custody and being treated medically?	YES / NO	If yes the DCFS Guardian will need to be contacted. That hotline is 800-828-2179 Monday through Friday from 8:30 a.m. to 4:30 p.m. and after hours at 866-503-0184.	
5. Do you have a medical or mental health concern or need **right now**?	YES / NO	If Yes, refer to PCM or in house social worker immediately. **If life threatening, call 911.**	
6. *Observation by the Screener*: *Does the client appear to be overwhelmed, disoriented, agitated, or a threat to self or others?*	YES/ NO	If yes, conduct abbreviated Columbia Suicide questions or PHQ9 (for children). **If life threatening, call 911.**	PHQ9 Link: https://www.mdcalc.com/phq-9-patient-health-questionnaire-9 Columbia:http://cssrs.columbia.edu/ec-ssrs/
7. Do you have a history of seeing people/things or hearing voices?	YES/ NO	If Yes, refer to in house social worker, consider completing the diamond schizophrenia screening	
8. Are you having any thoughts of harming self (i.e. suicide) or others (homicide)?	YES/ NO	**If Yes,** conduct abbreviated Columbia Suicide questions. Refer to in house social worker. If have plan and intent call 911.	
9. Do you have an alcohol or substance dependency?	YES/ NO		
10. Do you take medications on a daily basis or use special medical equipment or supplies? If yes, do your medications require refrigeration? Ensure they have 14 day supply to bring. Bring equipment and supplies with them.	YES / NO	If yes, ensure mini fridge is located in hotel room.	
11. Do you normally need a caregiver, personal assistant, or service animal? If yes, what care do they provide for you?	YES / NO	If yes, go to Section F "Activities of Daily Living". Will your service animal be coming with you? If yes, go to page 4. If No, skip next question.	
Is your caregiver, personal assistant, or service animal inaccessible?	YES / NO	If yes, circle which one.	
12. Do you have any severe environmental, food, or medication allergies?	YES / NO		
13. Do you have any dietary restrictions?	YES / NO	If yes, list	
***Question to Interviewer*: Would this person benefit from a more detailed health or mental health assessment?**	YES / NO	If yes, refer to PCM for health related issues. For Mental Health issues conduct in-depth screening.	
STOP HERE!	**REFER to: PCM Yes □ No □ DMH Yes □ No □ Interviewer Initial ____________**		
A. MEDICAL	**Circle**	**Actions to be taken**	**Comments**
Have you been hospitalized or under the care of a physician in the past month?	YES / NO	If yes, list reason.	
Are you currently having symptoms related to COVID-19 (fever, chills, cough, shortness of breath, muscle aches, etc)?	YES / NO	If yes list symptoms.	
Have you been tested for COVID-19? When?	YES / NO	If yes, have they gotten results yet?	
Do you have a high risk pre-existing medical condition (i.e. COPD, diabetes, cardiovascular disease, chronic renal disease, liver disease, etc)?	YES / NO	If Yes, list medical condition.	
If female, are you currently pregnant?	YES / NO	If yes, please specify delivery location / due date	

Are you a smoker? Advise that they will not be allowed to smoke in rooms.	YES / NO		
B. LEGAL HISTORY	**Circle**	**Actions to be taken**	**Comments**
Do you have a past record of arrests, misdemeanors, felony, prison/jail, probation, sex offender?	YES / NO		
Are you currently on probation, parole, or on the lifetime sex offender registry?	YES / NO		
B. VISION/SIGHT	**Circle**	**Actions to be taken**	**Comments**
Do you wear prescription glasses and do you have them with you?	YES / NO	If yes to either, ask next question. If No, skip the next question.	
Do you have difficulty seeing, even with glasses?	YES / NO	If no, skip the remaining Vision/Sight questions and go to Activities of Daily Living section.	
Do you use a white cane?	YES / NO	If yes, ask next question. If no, skip the next question.	
Do you have your white cane with you?	YES / NO	If no, identify potential resources for replacement.	
Do you need assistance getting around, even with your white cane?	YES / NO	If yes, collaborate with hotel manager.	
C. ACTIVITIES OF DAILY LIVING	**Circle**	**Actions to be taken**	**Comments**
Do you utilize equipment such as a C-pap or Bi-pap machine, or something similar, necessitating distilled water?		If yes, notify facility manager to ensure distilled water on-site.	
Do you need help getting dressed, bathing, eating, toileting?	YES / NO	If yes, specify and explain.	
Do you have a family member, friend or caregiver with you to help with these activities?	YES / NO	If no, consult hotel manager to determine if general population hotel is appropriate.	
Do you need help moving around or getting in and out of bed?	YES / NO	If yes, explain.	
Do you rely on a mobility device such as a cane, walker, wheelchair or transfer board?	YES / NO	If no, skip the next question. If yes, list.	
Do you have the mobility device/equipment with you?	YES / NO	Must bring with them.	
D. NUTRITION	**Circle**	**Actions to be taken**	**Comments**
Do you wear dentures? Ensure you bring with you.	YES / NO		
Are you on any special diet?	YES / NO	If yes, list special diet and notify feeding staff.	
IMPORTANT! INTERVIEWER EVALUATION			
Do you have any other needs that we haven't addressed?	List:		
NAME OF LOCAL PUBLIC HEALTH REP	Signature:		Date:
NAME OF PERSON COLLECTING INFORMATION:	Signature:		Date:

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Instructions: Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***How long ago did you do any of these?*** Over a year ago? Between three months and a year ago? Within the last three months?		

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Service Animal Intake		
Owner Information	**Answer**	**Comments**
Name		
Shelter Location		
Phone		
Email		
Pet Information	**Answer**	**Comments**
Name		
Species		
Breed		
Color/Markings		
Gender (circle one)	Male/Female	
Spayed/Neutered? (circle one)	Yes/No	
Identification (circle all that apply & list number in column, may have multiple)	ID Tag Rabies Tag Microchip Tattoo	
Health Issues? (circle one and explain)	Yes/No	
Medications? (circle one and explain)	Yes/No	Medication Type and Frequency:
Special Diet? (circle one and explain)	Yes/No	Diet:
Behavioral Concerns? (circle all that apply one and explain)	Aggressive Fear Biting General Fear/Timid Separation Anxiety Will run if escapes	
Crate Trained? (circle one)	Yes/No	
Veterinarian Information	**Answer**	**Comments**
Clinic Name		
Primary Veterinarian Name		
Phone Number		
Email (if known)		
Date of Last Exam		
Date of last RABIES vaccine		Type: 1-year/3-year (circle one)

Owner to bring these minimum supplies:

- ☐Service Animal Vest
- ☐Crate/Cage
- ☐Collar & Identification tabs
- ☐Leash/halter
- ☐Food (14-day supply)
- ☐Food & Water Bowls
- ☐Small Waste Bags (dogs, yard waste pick-up)
- ☐+/- Absorbent (pee) Pads (if needed)
- ☐Pet Bedding
- ☐Vet medications including flea/tick
- ☐Veterinary records and vet contact information (proof of rabies vaccination)

If pet has veterinary prescriptions (medication or food), how many days of your pet's prescriptions do you have?

Please list any supplies not accessible to you at this time:

EMERGENCY INFORMATION		
If you can no longer care for your pet and you are unavailable to provide this information to us, this information will be used to assist in determining immediate care for him/her.		
Information	**Answer**	**Comments**
Do you have someone to care for your pet if you are unable? (circle one)	Yes/No	IF YES, go to Section A If NO, go to Section B
Section A: Emergency Pet Care Friend/Family	**Answer**	**Comments**
Contact Name		
Contact Address		
Contact Phone		
Contact Email		
Can they Pick Up Pets? (Circle one, if yes circle in second column. If no, consider plan for transportation)	Yes/No	How Quickly? <12 hours >12 hours
Section B: Emergency Pet Care Shelter/Kennel	**Answer**	**Comments**
Shelter/Kennel Name		
Shelter/Kennel Address		
Shelter/Kennel Phone		
Shelter/Kennel Email		

Initial Each Below:

______I, the pet owner, am responsible for the care of their pet for the duration of their stay in this facility. The pet must always be supervised and properly restrained (collar and leash/halter) whenever they are outside of their personal area. Dogs will be walked in designated areas.

_____I, the animal owner, am responsible for requesting veterinary care if needed. I acknowledge that I am responsible for all veterinary care or expenses which may be incurred in the necessary treatment of my animals.

_____ (If applicable) The owner of a dog or cat agrees to 1-yr rabies vaccine plus tag if pet is not currently vaccinated against rabies (approved vaccines in Illinois are a 1-year or 3-year vaccine; currently vaccinated would mean either within 12 months or 36 months of the last administered rabies vaccine, respectively). This is in accordance with the Illinois Animal Control Act 510 ILCS 5, Section 8 (a) and (b).

_____If I, the animal owner, am unable to care for my pet and cannot verbally arrange or consent to transfer, I grant the alternative housing staff permission to contact the emergency pet care friend/family that I have listed for transfer. If there is no emergency pet care friend/family contact or they cannot/decline to care for the pets, then the pet emergency shelter/kennel facility will be contacted for transfer. All paperwork will be copied, and a copy given to the person/facility where the pet(s) is/are transferred to. At the time of transfer, alternative housing is relieved of any responsibility for the care of the animals.

____In the event that the pet owner is deceased and has not given written instructions to alternative housing, animal shelter or kennel, the pets be relinquished to animal control to complete the recommended 14 days isolation

____I have received a copy of “Information for Owners of Companion/Service Animals in Alternative Housing and will comply with all guidance within these two documents.

______________________________ ______________________________ ____________________

Owner Signature Print Date

____

<u>Veterinary Care and Treatment Guidance:</u>
If a pet owners states that they are *concerned their pet is ill or may need to be seen by a veterinarian*, please use this matrix to decide how this can be accomplished in an efficient and safe manner.
PET **<u>HAS</u>** HAD AN EXAM IN THE PAST 12 MONTHS:

- Telehealth; have the owner contact their veterinarian and request a telehealth appointment.
- If the veterinarian determines that the pet needs to be seen, coordination must take place for on-site exam (outside) or transport by third-party to the veterinarian. If veterinarian uses telehealth and prescribes medication, coordination will be needed for third-party pick up
- If veterinarian is not available or cannot see the pet, then move to Option B/C/D below.
- Owner will need to address invoice and payment options with any method of exam utilized.

PET <u>HAS NOT</u> HAD AN EXAM IN THE PAST 12 MONTHS:

- The following options should be used, IN ORDER:

<u>Option A:</u> Owner contacts their veterinarian; coordination must take place for on-site exam (outside) or transport by third-party to the veterinarian.
<u>Option B:</u> Owner can call a veterinary clinic of their choice and coordinate on-site or transportation by third party to veterinarian.
<u>Option C:</u> If owner needs assistance, shelter staff contacts county/local animal control veterinarian; coordination must take place for on-site exam (outside) or transport by third-party to veterinarian.
<u>Option D:</u> If owner needs assistance, shelter staff contacts local contract veterinarian (if one exists) or local veterinarian; coordination must take place for on-site exam (outside) or transport by third-party to veterinarian.

- Telehealth; if the pet has not had an exam within 12 months, this is only an option if the State Veterinarian, State Public Health Veterinarian, and the Illinois Department of Financial and Professional Regulation approve. Contact Sandra Gilmore, DVM prior to moving forward (sandy.gilmore@illinois.gov or 217-299-7223) and she will coordinate a call with all parties.
- Owner will need to address invoice and payment options with any method of exam utilized.

Voluntary Quarantine Form

I ____________________voluntarily agree to quarantine at this alternate housing facility for up to 14 days to prevent the spread of the COVID-19 virus. By signing this form, I agree to the following provisions:

- I will follow all rules explained to me during intake.
- I will stay confined to my room at all times except as otherwise permitted by facility staff.
- I will maintain social distancing while housed at this facility.
- I will self-administer a daily test of my temperature.
- I will monitor my symptoms for changes in my condition (including changes in my temperature) and call my primary care physician or emergency medical services if the symptoms worsen.
- I acknowledge that no standard of care or medical care will be provided by staff at this facility.
- I will clean my assigned room using the supplies provided in order to promote a healthy environment.
- I understand that if I choose to leave or cannot adhere to the rules then I am free to leave this alternate housing facility and return to my residence.
- I understand that if I do choose to leave this alternate housing facility, I cannot return to this facility once I leave.
- I understand that noncompliance with the rules will result in eviction from the alternate housing facility.
- I will be responsible for any damages caused during my stay.
- I understand that visitors are not allowed throughout the duration of the stay.
- I understand that an interpreter will be provided upon request.

___________________________________ ______________________

Signature of the resident Date

___________________________________ ______________________

Signature of the Facility Manager Date

ATTACHMENT 3

First Responder and Healthcare Worker Lodging Guidelines

1. The room is direct-billed to the state, but a credit card is required at check in for any incidental charges imposed during the stay.

2. The room has been acquired for an initial period of 7 days. Any requests to extend the stay beyond the initial 7 days will be submitted to IEMA by the local health department for evaluation.

3. Residents are responsible for their own meals, laundry and any other services required.

4. Daily wellness checks are required as part of the Alternate Housing program. Residents are expected to contact their local health department at a time specified via phone or email, throughout the duration of the stay, to confirm they are safe and well.

5. The guest must comply with CDC guidelines for social distancing. The guest must stay at least six (6) feet from other people at all times.

6. When outside your room or in contact with facility staff or other occupants, a face mask must be worn for the protection of all occupants and staff.

7. Residents should perform daily self-screening and monitor for symptoms of COVID-19. Residents who experience any of the following must notify the local health department:

   A. Feel unwell and have respiratory symptoms.

   B. A temperature of 100.4°F or greater.

   C. The resident has no fever, but has another singular primary COVID-19 symptom (shortness of breath or cough) that is not attributed to a known cause (asthma, COPD, chronic sinusitis, etc.).

   D. The resident has no fever, but has more than one of the less common COVID-19 symptoms (muscle pain, headache, sore throat, diarrhea, new loss of taste or smell, chills, and fatigue).

   E. The resident is tested for COVID-19 and confirmed positive.

______________________________________ _______________________

Signature Date

ATTACHMENT 3

Quarantine/Isolation Lodging Guidelines

1. Occupants must comply with all facility rules and direction of Facility Management staff.
2. Residents are not allowed to leave the premises. If they leave the premises, they will not be allowed to continue their stay at the facility.
3. No weapons or non-prescribed drugs allowed on the premises.
4. Social distancing will be practiced per the governor's order. You must stay at least six (6) feet from other people at all times.
5. If for some reason, the guest must exit their room or interact with facility staff or other occupants, a face mask must be worn for the protection of all occupants and staff.
6. No smoking inside the facility. If you must take an outside break (whether or not you are a smoker), you must ask the front desk.
7. All of your meals will be provided. If you wish to purchase your own food, you must pre-pay with a restaurant that practices no-contact food delivery. Give the restaurant your room number and your food will be dropped off in the hotel lobby for our staff to bring to your room.
8. There will be no lounging in common areas of the facility and no congregating with anyone who is not registered to your room.
9. Children – Parents are responsible for keeping track of and controlling the actions of their children. Do not leave children unattended.
10. Be respectful and courteous to others at all times. Loud, boisterous, and disruptive behavior is not permitted. Quiet hours are enforced between the posted hours at your facility (e.g., 10:00 p.m. to 6:00 a.m.).
11. Immediately report all health or safety concerns to facility staff.
12. No pets/animals allowed, except for service animals which must be pre-approved during the registration process. Call the front desk when you need to take your service animal outside.
13. No shipments or mail items will be accepted if not medically necessary.
14. No visitors allowed.

______________________________________ _______________________

Signature Date

Guidance: Wellness Checks

All persons working or housed in an alternate housing site require a daily wellness check. The nature of a wellness check will be defined by the local health department, but shall consist of the procedure below at a minimum. The daily wellness checks are required for those in quarantine, isolation, as well as first responders or healthcare workers sheltering between shifts. Records of wellness checks shall be maintained by the referring local health department in a format that can be provided to IEMA upon request.

Resident Monitoring Protocol

The referring local health department, or their designee, shall determine the appropriate method of wellness checks. First responders and healthcare workers, due to varying shifts, can relay the information below via email to the county health department. At a minimum, the daily wellness check should include the questions below. The procedure can deviate from this as long as it includes, at a minimum, the following steps:

"How are you feeling today? Any new or changing symptoms?"

"Are you needing to speak to anyone about anything?"

"Is there anything you are needing, that you don't have right now?"

"What is your temperature today?"

The local health department should be notified immediately if residents experience any of the following symptoms (if symptoms persist or are serious, call 911):

A. Feels unwell and has respiratory symptoms,
B. A temperature of 100.4ºF or greater,
C. The resident has no fever, but has another singular primary COVID-19 symptom (shortness of breath or cough) that is not attributed to a known cause (asthma, COPD, chronic sinusitis, etc.),
D. The resident has no fever, but has more than one of the less common COVID-19 symptoms (muscle pain, headache, sore throat, diarrhea, new loss of taste or smell, chills, and fatigue), or
E. The resident is tested for COVID-19 and confirmed positive.

If no one answers the wellness check phone call or fails to self-report a wellness check:

1. Call again in increments of 2 minutes until response.
2. If no response after three attempts, wear PPE and knock on the door.
3. If no audible response to knock, enter the room and attempt to elicit an audible response.
4. If the subject provides an audible, calm response, exit room, and document response.
5. If the subject is found to be non-responsive, call 911, notify superiors per standard protocol, and file an incident report. Secure the room.
6. If the resident indicates that their symptoms are becoming worse, repeat the temperature check.
7. If the temperature is above 100.4 degrees Fahrenheit, or if the resident is in distress, notify the facility manager and/or call 911.