

## **COVID - 19 HCBS WAIVER CHECKLIST PRIOR TO FACE- TO -FACE VISIT**

NAME:				DSP:			
Medicaid ID:		DSP					
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2. Has a person in the home traveled to a country for which the CDC has issued warning in the past 14 days?							
3.	3. Have you had contact with anyone with known COVID-19 in the past 14 days?						
4. Do you have any symptoms of a respiratory infection (cough, sore throat, fever or shortness of breath)?							
DATE		QUESTION 1	QUESTION 2	QUESTION 3	QUESTION 4	DSP INITIALS	

Please answer <u>YES</u> or <u>NO</u> to each question **before** each face-to-face visit and sign your Initial. If a <u>yes</u> is answered to any of the above questions DSP should <u>not</u> perform a face-to-face visit.

DSP Signature DSP Initials:	Date:
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