Arc Jefferson-St. Lawrence
New York

EXTENDED HOME VISIT RETURN QUESTIONNAIRE

PWS Name:_____ Date of Return:_____

1. Is anyone in the household to include the person supported, currently under isolation or quarantine for COVID-19? YES NO

2. Has anyone in the household to include the person supported, had any known exposure to COVID-19 in the last 14 days? YES NO

3. Has anyone in the household to include the person supported, had any of the following symptoms in the last 14 days? YES NO
    a. Cough
    b. Fever of 100.0 degrees or greater
    c. Sore Throat
    d. Shortness of breath
    e. Headache
    f. Chills
    g. Muscle Pain
    h. New loss of taste or smell

**Any YES to any of the above, a COVID-19 test must be completed with negative results before returning to the site.

Arrival back to site from home visit:

PWS Health Screening:

Symptom Check Negative? YES NO Temp Below 100.0 Degrees? YES NO

_____ _____
Staff Signature/Title Date

_____ _____
Signature of Person Dropping Off Date