Department of
Developmental Disabilities

Team Acknowledgment Form

Instructions

At the time the service and support administrator (SSA) or qualified intellectual disabilities professional (QIDP) receives a request from the person, parent, guardian, or provider that someone would like to begin Adult Day Support (ADS), Vocational Habilitation (VH), or Intermediate Care Facility (ICF) Day Program, the SSA or QIDP has seven business days to complete the Adult Day Support, Vocational Habilitation, ICF Day Programs, and Transportation Risk/Benefit Discussion Guide and outline the plan for resuming services, if the person is a good candidate to attend.

Once completed and signed, the SSA or QIDP should send this form to the ADS, VH, ICF Day Program, or Transportation provider.

Acknowledgment

Using a team process and the results of the Risk/Benefit Discussion Guide, it has been determined that ___________________________________ (person's name):

- has been provided information related to coronavirus (COVID-19), including what to expect, potential risks, what's expected of him/her, and other applicable information that allows him/her to make an informed decision to resume ICF Day services, Adult Day Support, or Vocational Habilitation services;
- has discussed with the team regarding his/her important to/important for information and how these may look different in the current service environment;
- has a desire to attend scheduled services;
- is willing and able to comply with health screening before all transportation, upon arrival, before leaving, and otherwise as needed;
- has discussed with the team regarding face coverings and whether one will be required for him/her;
  - is willing and able to comply with masking, handwashing, and social distancing (and gloves if needed for activities);
  - or, if not willing, was provided documentation of medical, functional, or practical reason for the exception;
- is willing and able to comply with decontamination practices when returning home by washing hands and changing clothing at a minimum.

OR

- has tested positive for COVID-19 and has met the criteria for Discontinuing Transmission Based Precautions.

ADS, VH, or ICF Day Program Provider

Name: ____

Setting this form is relevant to: ____

Transportation Provider: ____

County or counties this form is relevant to: ____

Contact Information for the SSA/QIDP (Name/phone number/email address): _______________

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Acknowledgment of and attestation to the above statements (written, verbal, or electronic):

___________________________________	___________________________________
Person and/or Guardian Printed Name	Person and/or Guardian Signature/Date
___________________________________	___________________________________
SSA/QIDP Printed Name	SSA/QIDP Signature/Date