Service Provider:

Assessment of Alternative Non- Residential Service Delivery- COVID-19

Participant Name: **UCI Number:**

Date of Agreement: **Vendor Number:**

Person(s) Completing this Assessment:

List of Participants/ Circle of Support Members Involved:

1. **Which of these Alternative Services do you want during COVID-19? (√- the option(s) below)**

	Type of Alternative Service	**How often?**	**Participant Initials**
☐	Supports to Reduce Impact of COVID-19	As Needed/ Upon Request	
☐	Complete Assessments- Skills, Needs, Likes/Dislikes	As Needed	
☐	Complete or Update an ISP	Update in October/November 2020 and at the Annual Date of Renewal.	
☐	Alternative Services	- ☐ Daily	
☐	- Telephone	- Days a Week:	
☐	- Electronic (Email/ Text)	☐M ☐T ☐W ☐Th ☐F	
☐	- Distance/Remote (Zoom)	Health/Wellness Check-In? times a month	
☐	Supplies Drop-Off	times a month: Preferred Supplies?	
☐	Self- Guided Material Drop-Off	times a month: Participant agrees to supply evidence of completion/ collection of materials	
☐	Skills Training for People in the Participant Household	times a month: Identify Topics of Interest	
☐	In- Person Services*		
☐	- Home	Home: times a month	
☐	- Community	Community: times a month	
☐	- Provider Site	Provider Site: times a month	
☐	Supports to Transition to Self-Determination	Upon Request	

Other: An option for Alternative Services NOT listed above. Describe those below and provide consent/agreement by participant/student initials: _____

*** NOTE: In-Person Services will only be provided if in compliance with the most restrictive state or local public health guidelines related to COVID-19 in effect when the service is being given.**

2. **What do you want to achieve from accessing the Alternative Services that you chose?**

3. **What is important to you in your life?**

SERVICE PROVIDER agrees to be available during the hours of service via phone or email, to maintain staffing, and document programming per usual. SERVICE PROVIDER also agrees to train staff on COVID-19 safety precautions and maintain compliance with the most restrictive local and state public health guidelines before in-person services can be delivered.

Additional Comments

_____ I was informed about the options of Alternative Services during COVID-19, and know what I can do if I disagree with these services offered to me. I also am aware that SERVICE PROVIDER will change my current ISP to the choices I made to my programming. (Initial)

Participant Signature: _____

Parent or Conservator Signature (if appropriate): _____