**Insert organization Logo**

**Resident Acknowledgment of risks and procedures  
relating to essential caregiver visits (covid-19)**

[Name of facility] recognizes that residents in our setting are particularly vulnerable to serious consequences of COVID-19. In our COVID-19 response efforts we have and will continue to follow guidance from the Centers for Disease Control & Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), and the Minnesota Department of Health (MDH) in an effort to prevent the spread of the disease to you and others in our care.

There are inherent risks associated with visits to an older adult or person with underlying chronic medical condition. The CDC indicates that ill visitors and healthcare personnel are the most likely sources of introduction of COVID-19 into a congregate living facility such as ours. Furthermore, infected persons can pass along the virus without exhibiting symptoms of the virus themselves.

Although current MDH guidelines do not allow us to re-open our [building/facility/setting/community] to general visitation, it does allow designation of essential caregivers, in appropriate cases per our Essential Caregiver policy.

At this time, we continue to limit visitors inside our [building/facility/setting/community] to all but essential healthcare personnel, compassionate care visitors, and designated essential caregivers. This policy is based on the current guidance from the CDC, CMS and MDH. We will refine and update our policy as more information becomes available and as guidelines change. If you have questions regarding our visitation policy, please contact \_\_\_\_\_\_\_\_\_ [insert an internal staff contact], or you may call the Ombudsman for Long-Term Care at 651-431-2555 or 1-800-657-3591.

I acknowledge that I have read this document and understand the risks of my decision to receive visits from my designated essential caregiver(s). I also agree to follow the procedures and instructions set forth in the acknowledgment form that my Essential Caregiver will sign (copy attached).

Resident name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Representative Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(if signing on behalf of the resident)

*Staff Instructions:*

1. *Provide the form below to the Essential Caregiver(s) for review and signature. Provide the Essential Caregiver(s) with a copy to keep for their use and reference, and provide a copy to the resident.*
2. *Provide the Essential Caregiver with a copy of the MDH Guidance for Essential Caregivers.*

**Insert organization Logo**

**essential caregiver Acknowledgment of risks  
and procedures relating to caregiver visits (covid-19)**

Essential Caregivers (EC) visiting [Insert Organization Name] must abide by the following procedures and instructions:

1. **Screening and Check-In Prior to Entry:**

* You must enter the building through XXX door, and immediately check in XXX for your screening prior to each visit.
* You must perform hand hygiene at XXX before proceeding to visitation.
* You will be screened by staff for temperature and other signs and symptoms of COVID-19. If you do not pass the screening check you will not be allowed entry into the [building/facility/setting/community].
* At each visit you will need to sign and date a visit form indicating you understand the EC requirements and rules.
* You will be required to provide [Insert Organization Name] with your contact information which may be used for contract tracing if needed.

1. **Scheduling Visits.**

* All visits by Essential Caregivers must be scheduled in advance.
* To schedule a visit: XXX *(This is where you identify the scheduling process for your visits)*
* Visits will not be scheduled when a resident is positive for COVID-19 or symptomatic or during a 14-day quarantine, including the first 14 days after admission, unless the visit falls into [Insert Organization Name’s] compassionate care visitation policy. [Insert other appropriate information specific to your policies about scheduling visits, such as length or frequency of visits.]

1. **Conducting Visits.**

* After screening, you must put on the appropriate personal protective equipment and go directly to XXXX (either resident room or other designated visitation area).
* Visits can only be between you and the resident requesting the Essential Caregiver visit. Visits cannot include other residents or staff in the facility. Limit your movement within the [building/facility/setting/community] to traveling to and from the resident’s room or other designated visit location.
* Visits shall be limited to no more than: XXXX(time) in duration.
* Only one Essential Caregiver visit is allowed at any one time.
  + You must perform frequent hand hygiene with alcohol-based hand rub or hand washing.
  + You must wear a face mask and eye protection during the entire visit, and any additional personal protective equipment as required by [Insert Organization Name]. [Insert Organization Name] will educate you on how to don/doff (safely put on and take off) necessary personal protective equipment.
  + You must practice social distancing by remaining at least 6 feet apart from staff and other residents in the [building/facility/setting/ community].
  + [Insert other appropriate items specific to your policies your organization’s policies and procedures.]

1. **Notification of Symptoms or Exposure.** After visiting, you should monitor for signs and symptoms of respiratory infection for at least 14 days. You must inform [Insert Organization Name] immediately if you develop a fever or symptoms consistent with COVID-19 within 14 days of a visit to the resident, or if you become aware that you have been exposed to COVID-19, or if you test positive for COVID-19.

I acknowledge that I have read this document and understand the risks of my decision to visit the resident for whom I am a designated essential caregiver. I agree to follow the procedures,instructions listed above and any other training/education provided and I understand that [Insert Organization Name] may restrict or revoke my Essential Caregiver designation and ability to visit if I do not abide by these procedures. I also understand that [Insert Organization Name] has voluntarily chosen to allow essential caregivers and can suspend or revoke this type of visitation should it become necessary for the safety of our residents.

Essential Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Essential Caregiver Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_