ATTACHMENT A

ADULT DAILY LIVING REMOTE WELLNESS CHECKLIST

Provider:			
Participant's Name:		Date of Birth:	
Who did you speak with?		Date and Time of Contact:	
QUESTIONS		**YES**	**NO**
Do you have enough food and fluids?			
Are you taking all of the medicines your doctor told you to take?			
Are there any essential supplies that you need?			
Is your worker/caregiver available to help you?			
Remind the participant to contact their doctor if they don't feel well. If the participant has any significant change in their health or reports new medical complaints, then the caller shall notify the center's nurse.			
Comments:			
Signature of Employee:	Print Name:		
By signing above, I hereby certify, under penalty of perjury, that the foregoing information is true and correct. This record will be maintained for at least 5 years from the date of creation and shall immediately be made available to the Pennsylvania Department of Human Services upon request.			