Westbay Community Action
Quarantine & Isolation Facility
Information Needed Before Transportation

Email Referrals can be scanned to Qi-intake@westbaycap.org
Intake Phone Number: 401-262-9009 *Only accepts voicemails*

Some helpful information to share with potential guests regarding the Quarantine and Isolation Facility:

1. All guests must be able to isolate without intensive medical or psychiatric supervision.
2. Individuals and families will be placed on separate floors. Elevator access is available.
3. Families will not share bedrooms with other families. Depending on the availability, the family may be in one bedroom together or in multiple bedrooms within close proximity.
4. All meals are provided to us through Amos House, and we have no control over the types of meals provided. Guests are allowed to bring food and toiletries with them upon arrival.
5. Guests are encouraged to bring their cellphones, chargers, change of clothes, and medications.
6. Individuals must be able to administer all prescribed medications independently.
7. We ask guests to ensure social distancing and to wipe surfaces after each use.
8. Smoking is allowed in designated OUTDOOR area only. Smoking in the building is NOT permitted. *Please refer to smoking policy.*
9. Intake referrals will be accepted and assessed between 10am-6pm, seven days per week. (Referrals will be reviewed and responded to in the order that they were received).

The QI Facility is NOT available to individuals who:
- Have been convicted of a sex crime
- Have homicidal or suicidal ideations
- Have active psychosis and/or active, aggressive behaviors
- Require active detox from alcohol or other substances
- Require assistance with Activities of Daily Living from on-site staff
- Require medication assistance
- Require the level of care provided by a Skilled Nursing Facility

If a COVID-19 Positive parent can have other family members or friends care for their children so that the positive parent can stay on the Isolation floor designed for individuals, that is probably a better option for everyone. We ask that you have these conversations with families before selecting the Family Quarantine and Isolation as the option for them. We want to avoid as much as possible, situations where a family arrives and then identifies someone to care for their children and the entire family needs to quickly move out.

If the children are school-age, please let the parents know that we have wi-fi for distance learning purposes and to bring appropriate materials with them.
Westbay Community Action
COVID-19 Quarantine & Isolation Facility
Family Pre-Intake Information

Individual □
Name: ___________________________ DOB _____________ Gender: M/F/O

Vaccinated: Y / N  Pfizer  Moderna  J&J  1st / 2nd dose

Family □ If family, what is the family size? __________

Parent/Guardian Name: __________________________ DOB: ________________

Vaccinated: Y / N  Pfizer  Moderna  J&J  1st / 2nd dose

Parent/Guardian Name: __________________________ DOB: ________________

Vaccinated: Y / N  Pfizer  Moderna  J&J  1st / 2nd dose

Names of Children:

_________________________________ DOB: ___________________ Gender: M/F/O

_________________________________ DOB: ___________________ Gender: M/F/O

_________________________________ DOB: ___________________ Gender: M/F/O

_________________________________ DOB: ___________________ Gender: M/F/O

_________________________________ DOB: ___________________ Gender: M/F/O

Emergency Contact: __________________________________________________________

Phone Number: ________________________________ Relationship: __________________
Please answer each of the following questions fully.

Who is/are the COVID-19 Positive Guest(s); are they symptomatic or asymptomatic today?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Date of Onset: ________________________________________________________________

Date of Positive COVID Test: ________________________________________________

Symptoms:_______________________________________________________________

______________________________________________________________________________

Past Medical Hx:___________________________________________________________

______________________________________________________________________________

Medications:_______________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

If anyone requires medication, are they coming with a sufficient amount that can be self-administered? All guests must be sent with enough medications to cover their length of stay, plus an additional two days’ worth.

______________________________________________________________________________
Is anyone currently on Methadone, Suboxone, or Naltrexone? __________________________

Does anyone have any food allergies? If yes, please describe as we want to start their meals as immediately as possible.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Is any family member pregnant – if so, how many weeks and are there any pregnancy related medical concerns?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Are there any significant, immediate medical concerns we need to be aware of for intake purposes? Please include challenges that may affect our ability to immediately house them or determine where to house them in the facility (ex. BMI, requiring a walking assistance device or oxygen)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

If this referral is coming from a hospital setting, please attach a copy of the positive test results. A discharge summary must be sent prior to the patient’s arrival. Hospitals are responsible for arranging transportation once accepted to our facility.