



Essential Support Person (ESP) Request Form

COVID Phase 2 Form

Name: _____ Date: _____

Community: _____ (Wyatt, Madison, Madrona)

I am petitioning to be the ESP for: _____ (resident's name)

Please voluntarily check below as to which applies to you. Please note that we do not require vaccination to function as an ESP, but would like to know for risk management purposes. Additionally, we would like to serve as a resource for you if you would like to get vaccinated but have not had the opportunity.

_____ I have been fully vaccinated (2 weeks past second shot for Moderna/Pfizer)

_____ I have been partially vaccinated and will be fully vaccinated on: _____

_____ I have not been vaccinated, but would like guidance on how/where to get vaccinated

_____ I have not been vaccinated yet, but have a date set: _____

_____ I am not interested in getting vaccinated at this time

Please initial next to each of the following statements:

_____ I understand that current visiting hours for the designated ESP are from 9am-5pm unless otherwise arranged with the Executive Director.

_____ I understand that all visitations will occur in the resident's apartment and I will do my best to stay 6' apart from all other residents and staff.

ESP Form BSL

March 2, 2021



_____ I understand that the resident (or their Medical Power of Attorney if in Memory Care) has the final say on who their designated ESP is. Each resident, during Phase 2 is allowed one ESP only.

_____ I understand that I can visit once/day for up to two hours in the memory care unit and up to four hours in a private assisted living apartment.

_____ I understand that as an ESP I will not be able to visit if a resident is COVID positive or is symptomatic or if the resident has had a potential exposure and is in quarantine.

_____ I understand that I must wear proper PPE at all times. I will also perform frequent hand hygiene before and during community visits.

_____ I will check in at the front desk and undergo screening protocols prior to each visit.

_____ I will not visit if I have any COVID symptoms including “allergies”, slight headache, congestion.

_____ I will not visit in the 7 days after travelling to any high-risk community or engaging in any high-risk activities as designated by the Department of Health.

_____ If I have any concern about my health, possible exposure to COVID or reason to be worried that I have COVID, I will obtain a negative COVID test result prior to visiting as an ESP.

Signature of ESP Applicant:

Name: _____ Date: _____

Signature of Resident (or DPOA) Approving ESP Selection:

Name: _____ Date: _____