

Interview Completed by: _____ Date: _____ Entered in MEDSS

COVID-19 Case Day Zero & Case Report Form

First Name: _____ Last Name: _____ MN _____

INTRODUCTION

*Please refer to the Amazon Connect Script in SharePoint for guidance on how on the introduction.

Tennessee Warning- COVID-19

Read to parent/guardian if individual is <18

Before asking for any private information, we are required by Minnesota state law to give you the following information about this interview and your right to privacy. We need to ask questions to help provide information on ways you can take care of yourself, protect others from getting sick, and to learn more about COVID-19. The only people who will have access to your private information such as your name and medical information will be:

- Public health staff from the Minnesota Department of Health and local public health agencies
- Contracted staff who are helping the Minnesota Department of Health with its response to COVID-19
- And, others who are required to have access by law or court order.
- If you need additional medical care, we may also need to share your information with doctors to help you get care.

You do not have to agree to be interviewed and do not have to answer some or all of the questions that we ask. However, we may not be able to explain how to care for yourself and prevent COVID-19 in others if you do not provide enough information.

Was the Tennessee read? Yes No Not Applicable

Amazon Connect Recording Statement

The following statement only applies if using Amazon Connect:

Before we continue, I also want to let you know that this call will be recorded for quality and training purposes. Please let me know if you do not want the call recorded and I will turn it off.

Did the case agree to having interview recorded? Yes No Not Applicable

INTERVIEW LANGUAGE AND PROXY INFORMATION:

Interview Language: _____

Interviewed by proxy? Yes No Unknown

If yes, proxy name and number: _____ **ADDRESS/LIVING SETTING TYPE**

I'd like to verify the demographic information we received from where you were tested.

This is the address we had on file for you at the time your COVID-19 test was done. Is this correct? (Please read and correct address if necessary.)

Living setting type:

- Private residence
- Hotel/motel
- Long-term Care Facility/Assisted living
Facility name: _____ (do not interview)
- Group Home/Residential behavioral health (e.g., mental health facilities, substance abuse treatment centers)
Facility name: _____ (do not interview)
- Homeless- sheltered (includes shelters for people experiencing homelessness or domestic violence)
Facility name: _____
- Homeless- unsheltered (outside, in a car, or other location not meant for human habitation)
- Supportive housing
Facility Name: _____ (do not interview)
- Jail
Facility Name: _____ (do not interview)
- Prison
Facility Name: _____ (do not interview)
- Other Correctional Setting
Facility Name: _____ (do not interview)
- College/university/camp dormitory
- Work dormitory
- Other, specify: _____

Living Setting Type Descriptions

Please select the appropriate type of living situation for the case at the time of their illness onset/specimen collection.

1. **Private residence** includes houses, condos, apartments, duplexes, etc.
2. **Hotel/Motel**
3. **Long-term care or assisted living** includes facilities where there are nursing staff or personal care attendants who provide some level of care for the residents. This includes nursing homes, memory care, transitional care, campuses with multiple types of care, and other similar facilities.
4. **Group Home/Residential behavioral health** includes substance use disorder treatment facilities, facilities for adults with disabilities, detox facilities, withdrawal management facilities, community based behavioral health hospitals, institutions for mental disease, etc.
5. **Homeless/sheltered** includes people experiencing homelessness, housing instability, or domestic violence displacement. Shelters and couch surfing are included in this category.
6. **Homeless/unsheltered** includes people experiencing homelessness, staying outside, in a car, or other location not meant for human habitation.
7. **Supportive housing** includes people who were previously homeless and are now receiving housing with supportive services offered onsite.
8. **Jail** is for county jail (adult or juvenile).
9. **Prison** is for state or federal prison.
10. **Other Correctional Setting** includes workhouses, work release programs, and DOC-licensed juvenile facilities.
11. **College/University/Camp Dormitory** includes college, university, and summer camps communal housing.
12. **Work dormitory** includes communal housing for seasonal workers.

13. **Other** should be used sparingly for situations that do not fit into the above categories. Examples include someone who lives in an RV-type home and has no permanent physical address, or a situation not described above.

Please consult with a senior case investigator if you are unsure what to enter for this field.

ILLNESS HISTORY

Have you had any symptoms related to your COVID-19 infection? (*symptoms can include: fever, cough, shortness of breath, headache, sore throat, nausea/vomiting, diarrhea, loss of taste/smell, loss of appetite, or fatigue*)

Symptomatic Asymptomatic Unknown

What date did you first notice symptoms?

Onset date: ____/____/____

(Enter test date for asymptomatic cases)

Onset date completely unknown?

Yes

Specimen collection date

Specimen date: ____/____/____

Specimen date completely unknown?

Yes

Is the person dead?

Yes No Unk

UNDERLYING HEALTH CONDITIONS

Do you have any underlying health conditions such as: asthma, diabetes, chronic kidney, liver, or heart disease, or an immunocompromising condition?

Yes No Unk

Pregnant at time of report?

N/A

Yes No Unk

OB/GYN Provider name: _____ OB/GYN Clinic & Phone Number: _____

Weeks pregnant at time of symptom onset: _____

What hospital do you plan to deliver at: _____

Do we have your permission to use your name if we contact your healthcare provider? Yes No Unk

EXPOSURE HISTORY

I am now going to ask you about the 14 days BEFORE you got sick (or were tested is asymptomatic) (check all that apply):

Any travel outside of Minnesota? Yes No Unk

Travel to another state?

For any selection:

International travel?

Specify location: _____

In the 14 days before you became sick (or were tested if asymptomatic), did you go to any of the following places? Have Google open to verify addresses of places that were visited. Separate multiple entries with a semicolon ;

Restaurant or bar (excludes take-out only)

If yes, name/address/date(s)/time(s): _____

Yes No Unk

Salon, spa, or barber

If yes, name/address/date(s): _____

Yes No Unk

Did you play any sports or attend any sporting event(s)?

If yes, list sport played/attended, date(s), and location(s): _____

Yes No Unk

Did you go to any gyms, fitness centers, or studios?

If yes, name(s)/address/date(s): _____

Yes No Unk

Community event, mass gatherings, or social gathering (select all that apply)

Yes No Unk

Church service

Wedding

Festival or fair

Funeral/wake

Sporting event

Block party

Family/Social gathering or party

Other: _____

Concert

If yes to any community event/gatherings specify details:

Type of event(s)/describe: _____

Date: _____ Location: _____

In the 14 days before you became sick, were you exposed to a PERSON with a confirmed COVID-19 infection? Yes No Unk

If yes, where did the contact occur? (check all that apply)

- Household
- Community (includes workplaces, childcare, and congregate living)
- Healthcare setting (case was a: patient, visitor, or healthcare worker)

Was this person a US case Yes No Unk

MN ID of source case(s):

MN source case name(s):

RELEASE FROM ISOLATION

To protect others, you need to stay home in isolation and stay from other people until you are not contagious anymore. When you meet the release criteria, you can be released from isolation. This means you can see your family/household members again, go to work or the grocery store, etc. If you work in health care, please talk to your occupational health before returning to work.

[Interviewer- Use criteria to determine the earliest date possible for end of isolation. Note: Case is released on the day following when criteria are met.]

Reported Symptoms	Release Criteria
Any symptoms since start of illness	10 days after onset AND 24 hours fever-free and no fever-reducing medications AND Improvement of symptoms <i>All three points must be met in order to be released from isolation</i>
No symptoms ever	10 days after specimen collection

<p>Isolation status at time of interview: <input type="checkbox"/> Still in isolation at time of interview <input type="checkbox"/> Isolation complete</p>

DETERMINE INFECTIOUS PERIOD

Now I have some questions about your activities and contacts during the time that you were infectious and able to spread the virus to others, which started 2 days before you got sick.

INFECTIOUS PERIOD

Calculate to determine exposed contacts

2 days before onset date	OR	Date released from isolation
2 days before specimen collection date (if no symptoms)	OR	*Leave blank if still in isolation (case is still infectious)
____/____/____	TO	____/____/____

HEALTHCARE VISITS DURING INFECTIOUS PERIOD

Not including when you were tested for COVID-19, did you have any health care visits such as clinic or hospital visits, long-term care visits or dialysis appointment ill or while isolation should have occurred?

Yes No if yes, specify locations and dates: _____

CONGREGATE LIVING DURING INFECTIOUS PERIOD

Since becoming ill, have you been in jail, prison, or any other correctional setting?

Yes No If yes, specify name and location of facility: _____
 Date(s) arrived at facility: _____
 Date(s) left facility: _____

Since becoming ill, have you been in a homeless shelter or encampment?

Yes No If yes, specify name and location of shelter/encampment: _____
 Date(s) arrived at facility/encampment: _____
 Date(s) left facility/encampment: _____

(if yes to above) Do we have your permission to share your name with the above listed facilities? Yes No

TRAVEL DURING INFECTIOUS PERIOD

Did you travel during you infectious period on a commercial flight, train, or bus? (this excludes travel on metro buses/light rail or similar public transportation)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
If yes, flight, bus, or train route number: (if unknown, put the company (e.g., Delta, Greyhound, Amtrak))			
If yes, what date(s) did you travel on this flight, bus, or train?			
What location(s) did you depart from and what place did you arrive? (e.g., MSP airport to SEA airport, or St. Paul Union Station to Duluth)			
What seat(s) did you sit in?			

ASSESS CONTACTS- OCCUPATION

Enter all jobs/worksites below. We will be contacting workplaces to ensure any contacts are identified.

Are you employed or volunteer outside the home (even if you are not currently working or currently work from home)?	<input type="checkbox"/> Yes <input type="checkbox"/> No - if no, skip to next section
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<p>How would you describe your work setting? (check all that apply)</p> <p><input type="checkbox"/> Health care setting</p> <p><input type="checkbox"/> Long-term care or assisted living</p> <p><input type="checkbox"/> Residential treatment facility</p> <p><input type="checkbox"/> Shelter</p> <p><input type="checkbox"/> Group home</p> <p><input type="checkbox"/> Corrections setting</p> <p><input type="checkbox"/> College or University</p> <p><input type="checkbox"/> School (K-12)</p> <p><input type="checkbox"/> Child care center</p> <p><input type="checkbox"/> Organized sports</p> <p><input type="checkbox"/> Other _____</p>	<p>Work Setting Type Descriptions</p> <p>Healthcare setting includes hospital, clinic, and other healthcare setting.</p> <p>Long-term care or assisted living includes nursing homes, memory care.</p> <p>Residential treatment facilities includes substance abuse or treatment facilities</p> <p>Shelter includes homeless or domestic violence centers</p> <p>Group home includes staffing and programming; e.g., housing for adults with disabilities.</p> <p>Corrections setting includes jail, prison, detention center, re-entry into work.</p> <p>College or University includes technical schools, trade programs, state institutions, and private colleges/universities.</p> <p>School K-12 includes private, public, charter, and other K-12 institutions.</p> <p>Child care center includes places where children are cared for, outside of School K-12, can be in home or at another location.</p> <p>Organized sports includes any professional, amateur, or recreational activities where one works – either player or staff.</p> <p>Other, please specify</p>
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Health care setting

What is your role?	
<input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> CNA (Certified Nursing Assistant) <input type="checkbox"/> PCA (Personal Care Assistant)	<input type="checkbox"/> Respiratory Therapist <input type="checkbox"/> Environmental Services (housekeeping, laundry) <input type="checkbox"/> Other, specify: _____

What is the name of the healthcare facility where you work?	
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Did you work while infectious? <i>Look back to the calculated infectious period</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
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Dates you worked while infectious (please list all)	
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Who is your supervisor (who is the person who would best know who you worked with or interacted with and would have their phone numbers)?	
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What is your supervisor's phone number?	
--	--

Do you give permission to share your name and COVID-19 result with this employer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
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Do you give your permission to share your name and COVID-19 result with your coworkers at this workplace?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
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Long-term care/assisted living or Residential treatment facility

What is your role?	
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<input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> CNA (Certified Nursing Assistant) <input type="checkbox"/> PCA (Personal Care Assistant)		<input type="checkbox"/> Respiratory Therapist <input type="checkbox"/> Environmental Services (housekeeping, laundry) <input type="checkbox"/> Other, specify: _____	
What is the name of your workplace? (e.g., Steph's Supermarket, Jane's Hair Salon, Whispering Willows Care Center, etc.)			
What is the address? (street, city, crossroads, etc.)			
Did you work while infectious? <i>Look back to the calculated infectious period</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Dates you worked while infectious (please list all)			
Who is your supervisor (who is the person who would best know who you worked with or interacted with and would have their phone numbers)?			
What is your supervisor's phone number?			
Do you give permission to share your name and COVID-19 result with this employer?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Do you give your permission to share your name and COVID-19 result with your coworkers at this workplace?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Residential treatment facility, Shelter, Group Home, Corrections setting, College University, School (K-12), Child care center, or Organized Sports			
What is your role?			
<input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> CNA (Certified Nursing Assistant) <input type="checkbox"/> PCA (Personal Care Assistant)		<input type="checkbox"/> Respiratory Therapist <input type="checkbox"/> Environmental Services (housekeeping, laundry) <input type="checkbox"/> Other, specify: _____	
What is the name of your workplace? (e.g., Steph's Supermarket, Jane's Hair Salon, Whispering Willows Care Center, etc.)			
What is the address? (street, city, crossroads, etc.)			
Did you work while infectious? <i>Look back to the calculated infectious period</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Dates you worked while infectious (please list all)			
Who is your supervisor (who is the person who would best know who you worked with or interacted with and would have their phone numbers)?			
What is your supervisor's phone number?			

Do you give permission to share your name and COVID-19 result with this employer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Do you give your permission to share your name and COVID-19 result with your coworkers at this workplace?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Shelter			
What is your role/occupation?			
What is the name of your workplace? (e.g., Steph's Supermarket, Jane's Hair Salon, Whispering Willows Care Center, etc.)			
What is the address? (street, city, crossroads, etc.)			
Did you work while infectious? <i>Look back to the calculated infectious period</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Dates you worked while infectious (please list all)			
Who is your supervisor (who is the person who would best know who you worked with or interacted with and would have their phone numbers)?			
What is your supervisor's phone number?			
Do you give permission to share your name and COVID-19 result with this employer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Do you give your permission to share your name and COVID-19 result with your coworkers at this workplace?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Group Home			
What is your role/occupation?			
What is the name of your workplace? (e.g., Steph's Supermarket, Jane's Hair Salon, Whispering Willows Care Center, etc.)			
What is the address? (street, city, crossroads, etc.)			
Did you work while infectious? <i>Look back to the calculated infectious period</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Dates you worked while infectious (please list all)			
Who is your supervisor (who is the person who would best know who you worked with or interacted with and would have their phone numbers)?			
What is your supervisor's phone number?			
Do you give permission to share your name and COVID-19 result with this employer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Do you give your permission to share your name and COVID-19 result with your coworkers at this workplace?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk

Corrections Setting	
What is your role/occupation?	
What is the name of your workplace? (e.g., Steph's Supermarket, Jane's Hair Salon, Whispering Willows Care Center, etc.)	
What is the address? (street, city, crossroads, etc.)	
Did you work while infectious? <i>Look back to the calculated infectious period</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Dates you worked while infectious (please list all)	
Who is your supervisor (who is the person who would best know who you worked with or interacted with and would have their phone numbers)?	
What is your supervisor's phone number?	
Do you give permission to share your name and COVID-19 result with this employer?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Do you give your permission to share your name and COVID-19 result with your coworkers at this workplace?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
College/University	
What is your role/occupation?	
What is the name of the educational facility where you work?	
Did you work while infectious? <i>Look back to the calculated infectious period</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Dates you worked while infectious (please list all)	
Who is your supervisor (who is the person who would best know who you worked with or interacted with and would have their phone numbers)?	
What is your supervisor's phone number?	
Do you give permission to share your name and COVID-19 result with this employer?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Do you give your permission to share your name and COVID-19 result with your coworkers at this workplace?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
School (K-12)	
What is your role/occupation?	
What is the name of the educational facility where you work?	
Did you work while infectious? <i>Look back to the calculated infectious period</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

Dates you worked while infectious (please list all)	
Who is your supervisor (who is the person who would best know who you worked with or interacted with and would have their phone numbers)?	
What is your supervisor's phone number?	
Do you give permission to share your name and COVID-19 result with this employer?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Do you give your permission to share your name and COVID-19 result with your coworkers at this workplace?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Child care center	
What is your role/occupation?	
What is the name of your workplace? (e.g., Steph's Supermarket, Jane's Hair Salon, Whispering Willows Care Center, etc.)	
What is the address? (street, city, crossroads, etc.)	
Did you work while infectious? <i>Look back to the calculated infectious period</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Dates you worked while infectious (please list all)	
Who is your supervisor (who is the person who would best know who you worked with or interacted with and would have their phone numbers)?	
What is your supervisor's phone number?	
Do you give permission to share your name and COVID-19 result with this employer?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Do you give your permission to share your name and COVID-19 result with your coworkers at this workplace?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Organized sports	
What is your role/occupation?	
What is the name of your workplace? (e.g., Steph's Supermarket, Jane's Hair Salon, Whispering Willows Care Center, etc.)	
What is the address? (street, city, crossroads, etc.)	
Did you work while infectious? <i>Look back to the calculated infectious period</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Dates you worked while infectious (please list all)	

Who is your supervisor (who is the person who would best know who you worked with or interacted with and would have their phone numbers)?	
What is your supervisor's phone number?	
Do you give permission to share your name and COVID-19 result with this employer?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Do you give your permission to share your name and COVID-19 result with your coworkers at this workplace?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Other	
Specify your type of work setting:	
What is your role/occupation?	
What is the name of your workplace? (e.g., Steph's Supermarket, Jane's Hair Salon, Whispering Willows Care Center, etc.)	
What is the address? (street, city, crossroads, etc.)	
Did you work while infectious? <i>Look back to the calculated infectious period</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Dates you worked while infectious (please list all)	
Who have you come into close contact with at work and what are their phone numbers? <i>(please specify dates of contact, names, and any phone numbers of people)</i> <i>This helps our contact tracers when calling workplaces/supervisors who may not know all of the close contacts if there isn't enough information for individual Case Contact Surveys.</i>	
Who is your supervisor (who is the person who would best know who you worked with or interacted with and would have their phone numbers)?	
What is your supervisor's phone number?	
Do you give permission to share your name and COVID-19 result with this employer?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Do you give your permission to share your name and COVID-19 result with your coworkers at this workplace?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

ASSESS SPORTS, SCHOOL, CHILDCARE, UNIVERSITY ATTENDANCE DURING INFECTIOUS PERIOD

I'll ask you a few questions about your activities during your infectious period (remind case of their infectious period dates to help them set appropriate context):

Did you attend/play any sports?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
What Sport(s):			
Please describe when/where:			
Please list coach/contact information/phone numbers for each sport:			
Was the sport played/attended with a school or university organization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Did you attend camp, childcare, adult day center, or K-12 school?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
If yes, which educational setting did you attend?			
<input type="checkbox"/> Childcare/Daycare <input type="checkbox"/> Adult day center/program <input type="checkbox"/> School (K-12) <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Youth day camp <input type="checkbox"/> Youth overnight camp			
Childcare/Daycare			
What is the name of the facility?			
What is the address? (street, city, crossroads, etc)			
Did you attend while infectious (between their infectious start date and now)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Dates you attended while infectious (please list all)			
Who is the school nurse/child care or program director/health services?			
What is your school nurse/child care or program director/health services phone number?			
Do we have your permission to share your name and COVID-19 result with your school/program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
School (K-12)			
What is the name of the School? (include address or city)			
Did you attend while infectious (between their infectious start date and now)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Dates you attended while infectious (please list all)			

Who is the school nurse/child care or program director/health services?	
What is your school nurse/child care or program director/health services phone number?	
Do we have your permission to share your name and COVID-19 result with your school/program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Youth Day Camp	
What is the name of the facility?	
What is the address? (street, city, crossroads, etc)	
Did you attend while infectious (between their infectious start date and now)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Dates you attended while infectious (please list all)	
Who is the school nurse/child care or program director/health services?	
What is your school nurse/child care or program director/health services phone number?	
Do we have your permission to share your name and COVID-19 result with your school/program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Youth Overnight Camp	
What is the name of the facility?	
What is the address? (street, city, crossroads, etc)	
Did you attend while infectious (between their infectious start date and now)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Dates you attended while infectious (please list all)	
Who is the school nurse/child care or program director/health services?	
What is your school nurse/child care or program director/health services phone number?	
Do we have your permission to share your name and COVID-19 result with your school/program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Adult Day Center/Program	
Did you attend while infectious (between their infectious start date and now)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Dates you attended while infectious (please list all)	

Adult day center/program name, contact person, and number	
Do we have your permission to share your name and COVID-19 result with your school/program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other	
What is the name of the facility?	
What is the address? (street, city, crossroads, etc)	
Did you attend while infectious (between their infectious start date and now)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Dates you attended while infectious (please list all)	
Who is the school nurse/child care or program director/health services?	
What is your nurse/child care or program director/health services phone number?	
Do we have your permission to share your name and COVID-19 result with your school/program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a student, staff, or otherwise associated with a college or university	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
What is the name of the College/University	
Did you attend classes while infectious?	<input type="checkbox"/> No <input type="checkbox"/> Online <input type="checkbox"/> In Person <input type="checkbox"/> Both
What classes were attended in person while infectious? Include class name, dates, and times	
Were you living on campus while infectious?	<input type="checkbox"/> No <input type="checkbox"/> Dorm <input type="checkbox"/> Campus apartments <input type="checkbox"/> Fraternity/Sorority <input type="checkbox"/> Other campus housing
Describe name of building, dorm/apartment number, and dates and times in building while infectious	
Describe name of fraternity/sorority, and dates and times spent there while infectious	
Describe housing, apt number, and dates and times spent there while infectious	
Describe where you were on campus while infectious – include dates and times	<input type="checkbox"/> Did not spend time on campus while infectious <input type="checkbox"/> Worked on campus <input type="checkbox"/> Used any on campus facilities (i.e. library,

	<p>gym, cafeteria, etc.)</p> <p><input type="checkbox"/> Attended any university sponsored events, clubs, meetings, or activities</p> <p><input type="checkbox"/> Spent time in campus dorms/fraternities/in campus housing (including visiting friends at your or other campuses)</p>
Do we have your permission to share your name and COVID-19 result with your school/college/university?	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

EXCLUSION LETTER

Minnesota state law provides employment protections for a person who is staying away from work due to a health department recommendation for themselves, a minor, or a disabled/vulnerable adult. Do you need a work or school exclusion letter mailed or emailed to you?

Yes No

ASSESS CONTACTS- HOUSEHOLD AND SOCIAL CONTACTS

Have you had any close contact with people in your household while infectious? Close contacts are defined as within 6 feet for at least 15 minutes, even if everyone was wearing masks.

Yes No Ukn **If yes, how many?** _____

Do you have any other people who you would consider close contact outside of your household?

Yes No Ukn NA **If yes, how many?** _____

Fill out contact information for all WORKPLACE, SCHOOL/CHILD CARE, HOUSEHOLD, and SOCIAL CONTACTS.

Please tell you HOUSEHOLD CONTACTS to STAY HOME FOR 14 DAYS after their last contact with you while you were infectious. We recommend close contacts get tested for COVID-19. Even if the result is negative, close contacts still need to quarantine for a full 14 days after their last exposure and monitor themselves for symptoms; they could get sick at any time during the quarantine period. If you are not able to separate yourself from your household members, they must stay home during your isolation, and also for an additional 14 days after your isolation ends.

Close contacts who not live with you may have a short quarantine period depending on their job and whether they get tested. However, we still recommend people quarantine for a full 14 days if possible. Guidance on the shorter quarantine period is on the MDH web page.

Do you understand and agree to share this information with your contacts?

Yes No

CLOSE CONTACT INFORMATION

CONTACT #1

Type of contact: Household Workplace Social/Other

If social/other, explain type of contact:

DATE OF LAST CONTACT: _____

First Name: _____ Last Name: _____ DOB: _____ Age: _____ Gender: _____

Phone number (extension): _____ Email address: _____ *(required for letter)*

Address: _____ *(if no email, required for letter)*

Contact #1's workplace

Does this contact work or live in:

- Health care or enters health care facilities (name, address/location) _____
- Congregate setting: LTC, assisted living, behavioral health (name, address/location) _____

Does this contact need follow-up from the contact tracing team? Yes No

If we contact this person, do we have permission to use your name? Yes No

Notes:

CONTACT #2

Type of contact: Household Workplace Social/Other

If social/other, explain type of contact:

DATE OF LAST CONTACT: _____

First Name: _____ Last Name: _____ DOB: _____ Age: _____ Gender: _____

Phone number (extension): _____ Email address: _____ *(required for letter)*

Address: _____ *(if no email, required for letter)*

Contact #2's workplace

Does this contact work or live in:

- Health care or enters health care facilities (name, address/location) _____
- Congregate setting: LTC, assisted living, behavioral health (name, address/location) _____

Does this contact need follow-up from the contact tracing team? Yes No

If we contact this person, do we have permission to use your name? Yes No

Notes:

CONTACT #3

Type of contact: Household Workplace Social/Other

If social/other, explain type of contact:

DATE OF LAST CONTACT: _____

First Name: _____ Last Name: _____ DOB: _____ Age: _____ Gender: _____

Phone number (extension): _____ Email address: _____ *(required for letter)*

Address: _____ *(if no email, required for letter)*

Contact #3's workplace

Does this contact work or live in:

- Health care or enters health care facilities (name, address/location) _____
- Congregate setting: LTC, assisted living, behavioral health (name, address/location) _____

Does this contact need follow-up from the contact tracing team? Yes No

If we contact this person, do we have permission to use your name? Yes No

Notes:

CONTACT #4

Type of contact: Household Workplace Social/Other

If social/other, explain type of contact:

DATE OF LAST CONTACT: _____

First Name: _____ Last Name: _____ DOB: _____ Age: _____ Gender: _____

Phone number (extension): _____ Email address: _____ *(required for letter)*

Address: _____ *(if no email, required for letter)*

Contact #4's workplace

Does this contact work or live in:

- Health care or enters health care facilities (name, address/location) _____
- Congregate setting: LTC, assisted living, behavioral health (name, address/location) _____

Does this contact need follow-up from the contact tracing team? Yes No

If we contact this person, do we have permission to use your name? Yes No

Notes:

Exposure Notification Application

Do you have a smartphone like an	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, there is an app that can anonymously inform people you were close to while you were able to spread COVID. If you have an iPhone, you may also have opted in when you updated your operating system. Do you have the app COVID Aware?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>If yes, “Great it sounds like you are all set up to help us prevent the spread of COVID-19 by notifying those you may have been near in the past 14 days.</p> <ul style="list-style-type: none"> • We’ll send you a code via text that you should enter in COVIDaware MN. This code is not tied to your identity, but it is a number that only you can use. • You’ll receive a text around 10 minutes after this call ends with your code. You must enter the code within 24 hours of receiving it. If you need to get a new code you can call us back. • When you enter the code in COVIDaware MN, the app will send out an anonymous notification to people who were around you while infectious. At no point will that notification identify you, the location they may have been in contact with you, or the time of the potential exposure. • When you get the code, click on the link to enter the code in your app. • Entering the code is voluntary, but it could help stop the spread of COVID-19 and help keep others in our community safe. 	
Do you want us to send you a code?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not have the app
Notification App Phone Number:	

ESSENTIAL SERVICES

Do you need groceries, medicines, and other necessary (or important) things while you are staying at home (isolating) during the time period we discussed that you are not able to get through online ordering or with help from friends or family? If yes, we may be able to help.

Is this person unable to obtain essential services (either alone or with the help of family and friends) and needs assistance from LPH?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Ukn <input type="checkbox"/> NA
A general description of the essential services needed must be entered here. Essential Services include necessary items (such as food, medications, or a safe place to isolate) that a person who is still in isolation needs but is not able to obtain independently or with the help of family or friends.	
<p>Regular business hours are 8:00-4:30 daily, including weekends and holidays. For urgent essential service requests during this time, please enter the information in the text box above and note that it is urgent. For</p>	

any urgent requests after 4:30 that cannot wait until the next morning, please call 651-201-5414 and relay the need to the answering service.

If you are sending an email to the essential services team as an update, please send it to the health.i.q.essentialservices@state.mn.us

Confirm isolation address IF essential services are requested:

Isolation Street 1: _____

Isolation Street 2: _____

Isolation City: _____

Isolation Zip: _____

Isolation County: _____

PREVENTION STEPS FOR CASES STILL IN ISOLATION

(skip to Demographics and Living Setting if not in isolation at time of interview)

STAY HOME AND SEPARATE FROM OTHER PEOPLE

- You should not leave your home at all until you meet the criteria to be released from isolation that we discussed. The only exception would be if you need medical care.
- As much as possible, you should stay in a specific room away from other people in your home. You should use a separate bathroom, if available. Do you have a room in your home where you can stay separated from other family members? Do you feel this is a safe and appropriate place for you to stay while you are recovering?

[Interviewer: Assess the level of crowding in home. In highly dense households with many people per bedroom (e.g., 4 people/bedroom) use your judgement to request relocation of cases or other household members through local public health. Relocation may not always be available.]

MONITOR YOUR SYMPTOMS

- If your illness is getting worse (such as shortness of breath and difficulty breathing), and you feel you need to seek medical care, you should call your clinic ahead of time to let them know about the situation. This will allow you to get needed care, while minimizing the potential of exposing others.
- If you are experiencing a medical emergency, please call 911 and tell the dispatcher and first responders when they arrive that you have been diagnosed with COVID-19. This is so the dispatcher can tell the emergency responders to take precautions. If possible, put on a facemask before emergency medical services arrive.
- You cannot use public transportation, taxis, or rideshares like Uber and Lyft, **EVEN WHEN SEEKING MEDICAL CARE.**

HOW WE WILL CONTACT YOU, AND HOW YOU CAN CONTACT US

- When you have determined that your isolation period is over (i.e., when you meet the criteria we discussed), you can return to your regular activities.

- You can call us as needed if you have concerns about symptoms, questions, or are not able to get essential items you need.
- Contact us at **651-201-5414, PRESS OPTION 4** during usual work hours (Monday – Friday, 8:00am – 4:30 pm). When you call, please say you are currently in isolation for COVID-19.
- If you are experiencing an urgent matter after hours or on a weekend or holiday, contact us at **651-334-8102**. You can leave a message and your call will be returned.

DEMOGRAPHICS

Finally, we would like to ask you some demographic questions.

Which of the following best describes your race (choose all that apply):	
<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian/Pacific Islander
<input type="checkbox"/> Black / African American	<input type="checkbox"/> Other
<input type="checkbox"/> Asian	<input type="checkbox"/> Unk
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Refused to answer
If enrolled in a Tribe, specify: _____	
Specify race (e.g., African American, Somali, Hmong, etc): _____	
Tribe enrolled in:	
<input type="checkbox"/> Bois Forte Band of Chippewa <input type="checkbox"/> Fond Du Lac Reservation <input type="checkbox"/> Grand Portage Band of Chippewa Indians <input type="checkbox"/> Leech Lake Band of Ojibwe <input type="checkbox"/> Mille Lacs Band of Ojibe <input type="checkbox"/> Prairie Island Indian Community <input type="checkbox"/> Red Lake Band of Chippewa Indians <input type="checkbox"/> Shakopee Mdewakanton Sioux (Dakota) Community <input type="checkbox"/> Upper Sioux Community <input type="checkbox"/> White Earth Reservation <input type="checkbox"/> Multiple Tribes <input type="checkbox"/> Other/Out of state Tribe Specify: _____ <input type="checkbox"/> Not enrolled	
Is your residence on tribal/reservation land	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

Reservation or Tribal Land Name:	
<input type="checkbox"/> Bois Forte Band of Chippewa <input type="checkbox"/> Fond Du Lac Reservation <input type="checkbox"/> Grand Portage Band of Chippewa Indians <input type="checkbox"/> Leech Lake Band of Ojibwe <input type="checkbox"/> Mille Lacs Band of Ojibe <input type="checkbox"/> Prairie Island Indian Community <input type="checkbox"/> Red Lake Band of Chippewa Indians <input type="checkbox"/> Shakopee Mdewakanton Sioux (Dakota) Community <input type="checkbox"/> Upper Sioux Community <input type="checkbox"/> White Earth Reservation	
Do you consider yourself Hispanic or Latino?	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown
How would you describe your sexual orientation?	
<input type="checkbox"/> Straight <input type="checkbox"/> Gay or Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> I don't know <input type="checkbox"/> Something else <input type="checkbox"/> Prefer not to say	
We will have some information to share, preferably via email, after this call. Do you have an email address?	Email: _____

Case Notes: