NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Attestation for COVID-19 Isolation/Quarantine Support

If you have been directed by a medical professional, contact tracer, or state/local public health official to quarantine or isolate due to COVID-19 but need financial or social supports to do so, you may be eligible for assistance covered by the NC Department of Health and Human Services at no cost to you.

PLEASE COMPLETE THIS FORM WITH YOUR COMMUNITY HEALTH WORKER. YOUR COMMUNITY HEALTH WORKER MAY COMPLETE THE FORM FOR YOU AND SIGN ON YOUR BEHALF.

PLEASE NOTE: Due to limited availability, there may be delays in receiving support services and the State cannot guarantee the availability or delivery of support services.

I. Your Information (* = required)

Full Name (First, Last) or Anonymous Identifier*
This is needed so that supports may be mailed/delivered to you.

County Where you Currently Live* Check this box if you are currently homeless: ☐

Street Address of Where You Will Isolate/Quarantine* Apt/Suite #
This is needed so that supports may be delivered to your door.

City* State* ZIP Code*

Mailing Address of Where You Will Isolate/Quarantine* (Leave blank if the same as Street Address.) This is needed so that supports may be mailed to you. Apt/Suite #

City* State* ZIP Code*

Phone Number Email

Select Here / / Select Here Select Here Select Here
Primary Language Date of Birth Gender Race Ethnicity

II. What supports do you need to quarantine or isolate? CHECK ANY THAT APPLY TO YOU

☐ COVID Relief Payment ☐ Food Box/Groceries ☐ Healthy Meal ☐ Medically-Tailored Meal

☐ Transportation ☐ Medication delivery ☐ COVID-19 supplies (e.g., face mask, hand sanitizer)

III. Do you need individual-sized or family-sized services? CHECK ONE ☐ Individual ☐ Family

Number of household family members that need support (including you): ☐

IV. Do you have a bank account? ☐ Yes ☐ No If yes, name of account holder:

V. Attestations CHECK ALL BOXES BELOW IF THEY APPLY TO YOU

I declare that…

- ☐ I have been directed by a medical professional, contact tracer, or state/local public health official to quarantine or isolate due to COVID-19.
- ☐ I currently live in one of the following counties: Bladen, Chatham, Columbus, Craven, Duplin, Durham, Franklin, Gaston, Granville, Greene, Hoke, Johnston, Lee, Lenoir, Mecklenburg, Montgomery, Nash, Pitt, Randolph, Robeson, Rowan, Sampson, Scotland, Stanly, Vance, Wake, Warren, Wayne, or Wilson.
- ☐ If I receive the supports identified on this form, I will quarantine or isolate for the full length of time directed. I need the supports identified on this form to safely or effectively quarantine or isolate.
- ☐ The other members of my household also need the support services identified on this form while I am in quarantine or isolation.
- ☐ I understand that I may receive no-cost support services for up to 14 days from the date of this assessment. If I need support services to quarantine or isolate for more than 14 days, a medical professional or state/local public health official must be able to confirm that I need additional time.
- ☐ I understand that I can request support services at any time while I am in quarantine or isolation by contacting my Community Health Worker. I may receive only one COVID relief payment, but I may receive any other support services more than once during my quarantine or isolation.

Additional attestations required only for COVID relief payment:

I declare that…

- ☐ I will only use these funds for living expenses such as housing, food, utilities, medical care, child care and household bills to help me to quarantine or isolate; I will save the receipts from purchases made using this assistance, which I may be required to produce.
- ☐ I acknowledge that I could be required to pay back the COVID relief payment if I do not comply with the directive to quarantine or isolate for the full length of time directed or if I spend the COVID relief payment on anything other than basic living expenses to support isolation or quarantine.

Additional attestation required only for medication delivery:

I declare that…

- ☐ Any prescription medication that I ask to have delivered has been prescribed by a medical professional.

Sign Here

The information provided is true and accurate, and I have not knowingly made a false statement or misrepresented a material fact, omitted or failed to disclose a material fact, or submitted inaccurate records. I understand that an intentional false statement or representation, omission, or submission of inaccurate records may lead to sanctions or other legal action.

Signature of Applicant	Date