



**Office for People With
Developmental Disabilities**

Updated COVID-19 Reporting and Entry into the Incident Report and Management Application (IRMA) for All Certified Residential Sites

August 31, 2021

IRMA Changes: COVID-19 Event Situations

- Effective September 3, 2021 OPWDD's Incident Report and Management Application (IRMA) will display additional fields to be completed to assist OPWDD's tracking of the type of COVID-19 positive cases occurring in OPWDD certified residential sites.
- The criteria for reporting of COVID-19 positive or presumed positive cases remains the same. However, for cases reported as of **August 01, 2021**, IRMA has been modified with additional fields so that providers of certified residential sites will enter vaccination information on the COVID-19 Individual and Staff Forms in IRMA.
- Providers of certified residential sites are required to enter additional fields of data on the COVID-19 Individual and Staff Forms when there is a new presumed positive or positive test for COVID-19 infection for an individual or staff in a certified residential site.



New Vaccination Fields in COVID-19 Individual and Staff Forms

- All certified residential sites are required to complete data fields on the COVID-19 Individual and Staff Forms when there is a new positive or presumed positive COVID-19 infection for an individual or staff in a certified or OPWDD operated residential setting (including Family Care).
- These data fields will gather information to determine:
 - If the person was vaccinated
 - The type of vaccination they received
 - The date of vaccination
 - If the person received a booster and the date that booster shot was received




Certified Residential Sites


- IRMA will only display these new fields in the appropriate programs.
- The programs that will display these fields are:
 - All ICFs
 - All IRAs
 - All Community Residences
 - All Developmental Centers
 - All Residential Schools
 - All Specialty Hospitals
 - All Family Care



COVID-19 Individual Form:

Individual Header Information


[Program Form](#)


[Individual Form](#)

DOE, JOHN

Individual Information					
TABS ID	Name	DOB	Age	Gender	WillowBrook
123456	DOE, JOHN	May 30, 1969	50 Years	MALE	No

Program Involved in the Incident		
Agency Legal Name	Program Type	Program ID
TEST AGENCY	24 - FAMILY CARE	0110110
Program Address	Program County	Program DDSO
8267 HONEYSUCKLE DRIVE, LIVERPOOL NY 13090	Onondaga	0261-Central New York DDSO



COVID-19 Individual Form:

* Required fields to complete the form




Start Date	April 28, 2020
* The Individual currently under	<input type="radio"/> Precautionary Quarantine (Isolation of individuals with proximate exposure) <input type="radio"/> Required Mandatory Quarantine (Isolation of individuals with close exposure) <input type="radio"/> Required Mandatory Isolation (Individuals with Confirmed COVID-19 Diagnosis) <input type="radio"/> Other Exposure
* Considered Vulnerable individual?	<input type="radio"/> Yes <input type="radio"/> No

COVID-19 Health Questionnaire

Exposure Date (If known)	<input type="text"/>
* Has Individual been evaluated by Medical Practitioner?	<input type="radio"/> Yes <input type="radio"/> No
* Has the Health Department been notified?	<input type="radio"/> Yes <input type="radio"/> No
County (only if different from above)	-----Select County----- ▼
Number of Isolation/Quarantine days required if known	<input type="text"/> number only days
* Start Date of Isolation/Quarantine	<input type="text"/>
* Actual End Date of Isolation/Quarantine	<input type="text"/>



COVID-19 Individual Form:

* Has the Individual been Hospitalized?	<input checked="" type="radio"/> Yes <input type="radio"/> No									
Hospital Name (If known)	<input type="text"/>									
* Hospitalization Start Date	<input type="text"/>									
* Hospitalization End Date	<input type="text"/>									
* Will the Individual be discharged to this program?	<input checked="" type="radio"/> Yes <input type="radio"/> No									
* Is the individual presumed positive?	<input checked="" type="radio"/> Yes <input type="radio"/> No									
* Was the Individual Tested?	<input checked="" type="radio"/> Yes <input type="radio"/> No	<div>Test Results</div> <table border="1"> <thead> <tr> <th>#</th> <th>Date of the Test</th> <th>Test Result</th> <th> Add Test</th> </tr> </thead> <tbody> <tr> <td colspan="4">Please submit the form to save test results.</td> </tr> </tbody> </table>	#	Date of the Test	Test Result	 Add Test	Please submit the form to save test results.			
#	Date of the Test	Test Result	 Add Test							
Please submit the form to save test results.										

COVID-19 Individual Form:

* Is the individual presumed positive?	<input checked="" type="radio"/> Yes <input type="radio"/> No
* Was the Individual Tested?	<input type="radio"/> Yes <input type="radio"/> No
* Was the individual vaccinated?	<input checked="" type="radio"/> Yes <input type="radio"/> No
* Vaccine type	Pfizer <input type="button" value="v"/>
* Did the individual receive two doses?	<input checked="" type="radio"/> Yes <input type="radio"/> No
* Date of last vaccination	<input type="text"/>
* Did the individual receive a booster?	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="text"/>
* Date of last booster vaccination	<input type="text"/>


COVID-19 Individual Form:

Activity Restriction Start Date	<input type="text"/>
Activity Restriction End Date	<input type="text"/>
* Has notification been made to family?	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NA
* Has notification been made to the advocate?	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NA
* Has the individual passed away?	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
* Please enter approx. date if exact date is unknown.	<input type="text"/>
*Location of Death	<div> <div> <div>---Select Location---</div> <div> Hospital Residential Program Family Home Nursing/Rehab/Recovery Center Other </div> </div> <div> <div>comments.</div> <div> <div></div> <div></div> </div> </div> </div>
Additional Comments	
*Form Completed by	KCSX

☐ Form Completed

COVID-19 Staff Form:

Staff Header Information

 **Staff Form**

MARY SMITH

Staff Information		
Person Type	Person Sub-Type	Person Name
Person Present	Staff - agency employee	Mary Smith

Program Involved in the Incident		
Agency Legal Name	Program Type	Program ID
TEST AGENCY	24 - FAMILY CARE	0110110
Program Address	Program County	Program DDSO
123 Main Street, Norwich, NY 12206	Onondaga	0261-Central New York DDSO



COVID-19 Staff Form

* Required fields to complete the form

Start Date	April 28, 2020	
* The person currently under	<input type="radio"/> Precautionary Quarantine (Isolation of individuals with proximate exposure) <input type="radio"/> Required Mandatory Quarantine (Isolation of individuals with close exposure) <input type="radio"/> Required Mandatory Isolation (Individuals with Confirmed COVID-19 Diagnosis) <input type="radio"/> Other Exposure	
*Primary Phone Number	<input type="text" value="xxx-xxx-xxxx"/>	
Secondary Phone Number	<input type="text" value="xxx-xxx-xxxx"/>	
*Email	<input type="text" value="Email Address"/>	Note : Please enter a valid email or enter "No email"
*Date of Birth	<input type="text"/>	
*Address of primary work site	<input type="text" value="Address of primary work site"/>	
*County of primary work site	<input type="text" value="-----Select County-----"/> ▼	
*Was the person symptomatic at work?	<input type="radio"/> Yes <input type="radio"/> No	

COVID-19 Staff Form

* Did this exposure occur at work?	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Location of the exposure	<div> Please enter Location of the exposure. <div> Maximum 250 characters. </div> </div>
Exposure Date (If known)	<input type="text"/>
*Has person been evaluated by Health Department or Medical Provider?	<input checked="" type="radio"/> Yes <input type="radio"/> No
County (only if different from above)	<input type="text" value="-----Select County-----"/> ▼
Has notification been made to Bargaining Unit? (State Operations Only)	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NA
* Start Date of Isolation/Quarantine	<input type="text"/>
* Actual End Date of Isolation/Quarantine	<input type="text"/>
* Has the person been hospitalized?	<input checked="" type="radio"/> Yes <input type="radio"/> No
Hospital Name (If known)	<input type="text"/>
* Hospitalization Start Date	<input type="text"/>



COVID-19 Staff Form

* Was the person discharged?	<input checked="" type="radio"/> Yes <input type="radio"/> No
* Hospitalization End Date	<input type="text"/>
Discharge Description	<div> Please enter Discharge Description. <div> ^ v </div> </div> Maximum 250 characters.
* Is the person presumed positive?	<input checked="" type="radio"/> Yes <input type="radio"/> No
* Was the person Tested?	<input type="radio"/> Yes <input type="radio"/> No <div></div>
* Was the person vaccinated?	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
* Vaccine type	Pfizer <input type="button" value="v"/>
* Did the person receive two doses?	<input checked="" type="radio"/> Yes <input type="radio"/> No
* Date of last vaccination	<input type="text"/>
* Did the person receive a booster?	<input checked="" type="radio"/> Yes <input type="radio"/> No <div></div>
* Date of last booster vaccination	<input type="text"/>
* Has the person passed away?	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unknown
Additional Comments	<div> Please enter any additional comments. <div> ^ v </div> </div>
*Form Completed by	Full Name <input type="text"/>
<input type="checkbox"/> Form Completed	
<div> <div>Submit</div> <div>Clear Form</div> </div>	



OPWDD COVID-19 Guidance

- Can be found at:

<https://opwdd.ny.gov/coronavirus-guidance/covid-19-guidance-documents>



IRMA Entry Resource Issues

If your agency needs assistance with the following, please contact incident.management@opwdd.ny.gov and copy your IMU Incident Compliance Officer:

- If the agency requires additional IRMA users, please complete a User Access Request (UAR) and email with the subject line: COVID-19 IRMA Access UAR.
- If the agency needs assistance in entering COVID-19 related updates, please email with the subject line: COVID-19, the Master Incident Number (MIN) and Agency Name.
- If your agency has specific questions related to linking COVID-19 Events, please email with the subject line: Master Incident Number (MIN) “Linking Question.”
- If the agency needs assistance with contact tracing, please email with the subject line: COVID-19 Contact Tracing Assistance.



Thank you for participating in this training!

If you need assistance with IRMA entry or
have any questions about this process,
please email
incident.management@opwdd.ny.gov
and copy your IMU Compliance Officer.

