Coronavirus Relief Fund
Frequently Asked Questions
Updated as of May 4, 2020

The following answers to frequently asked questions supplement Treasury's Coronavirus Relief Fund ("Fund") Guidance for State, Territorial, Local, and Tribal Governments, dated April 22, 2020, ("Guidance").[1] Amounts paid from the Fund are subject to the restrictions outlined in the Guidance and set forth in section 601(d) of the Social Security Act, as added by section 5001 of the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act").

Eligible Expenditures

Are governments required to submit proposed expenditures to Treasury for approval?

No. Governments are responsible for making determinations as to what expenditures are necessary due to the public health emergency with respect to COVID-19 and do not need to submit any proposed expenditures to Treasury.

The Guidance says that funding can be used to meet payroll expenses for public safety, public health, health care, human services, and similar employees whose services are substantially dedicated to mitigating or responding to the COVID-19 public health emergency. How does a government determine whether payroll expenses for a given employee satisfy the "substantially dedicated" condition?

The Fund is designed to provide ready funding to address unforeseen financial needs and risks created by the COVID-19 public health emergency. For this reason, and as a matter of administrative convenience in light of the emergency nature of this program, a State, territorial, local, or Tribal government may presume that payroll costs for public health and public safety employees are payments for services substantially dedicated to mitigating or responding to the COVID-19 public health emergency, unless the chief executive (or equivalent) of the relevant government determines that specific circumstances indicate otherwise.

The Guidance says that a cost was not accounted for in the most recently approved budget if the cost is for a substantially different use from any expected use of funds in such a line item, allotment, or allocation. What would qualify as a "substantially different use" for purposes of the Fund eligibility?

Costs incurred for a "substantially different use" include, but are not necessarily limited to, costs of personnel and services that were budgeted for in the most recently approved budget but which, due entirely to the COVID-19 public health emergency, have been diverted to substantially different functions. This would include, for example, the costs of redeploying corrections facility staff to enable compliance with COVID-19 public health precautions through work such as enhanced sanitation or enforcing social distancing measures; the costs of redeploying police to support management and enforcement of stay-at-home orders; or the costs of diverting educational support staff or faculty to develop online learning capabilities, such as through providing information technology support that is not part of the staff or faculty's ordinary responsibilities.

Note that a public function does not become a "substantially different use" merely because it is provided from a different location or through a different manner. For example, although developing online instruction capabilities may be a substantially different use of funds, online instruction itself is not a substantially different use of public funds than classroom instruction.

1 The Guidance is available at https://home.treasury.gov/system/files/136/Coronavirus-Relief-Fund-Guidance-for-State-Territorial-Local-and-Tribal-Governments.pdf.

May a State receiving a payment transfer funds to a local government?

Yes, provided that the transfer qualifies as a necessary expenditure incurred due to the public health emergency and meets the other criteria of section 601(d) of the Social Security Act. Such funds would be subject to recoupment by the Treasury Department if they have not been used in a manner consistent with section 601(d) of the Social Security Act.

May a unit of local government receiving a Fund payment transfer funds to another unit of government?

Yes. For example, a county may transfer funds to a city, town, or school district within the county and a county or city may transfer funds to its State, provided that the transfer qualifies as a necessary expenditure incurred due to the public health emergency and meets the other criteria of section 601(d) of the Social Security Act outlined in the Guidance. For example, a transfer from a county to a constituent city would not be permissible if the funds were intended to be used simply to fill shortfalls in government revenue to cover expenditures that would not otherwise qualify as an eligible expenditure.

Is a Fund payment recipient required to transfer funds to a smaller, constituent unit of government within its borders?

No. For example, a county recipient is not required to transfer funds to smaller cities within the county's borders.

Are recipients required to use other federal funds or seek reimbursement under other federal programs before using Fund payments to satisfy eligible expenses?

No. Recipients may use Fund payments for any expenses eligible under section 601(d) of the Social Security Act outlined in the Guidance. Fund payments are not required to be used as the source of funding of last resort. However, as noted below, recipients may not use payments from the Fund to cover expenditures for which they will receive reimbursement.

Are there prohibitions on combining a transaction supported with Fund payments with other CARES Act funding or COVID-19 relief Federal funding?

Recipients will need to consider the applicable restrictions and limitations of such other sources of funding. In addition, expenses that have been or will be reimbursed under any federal program, such as the reimbursement by the federal government pursuant to the CARES Act of contributions by States to State unemployment funds, are not eligible uses of Fund payments.

Are States permitted to use Fund payments to support state unemployment insurance funds generally?

To the extent that the costs incurred by a state unemployment insurance fund are incurred due to the COVID-19 public health emergency, a State may use Fund payments to make payments to its respective state unemployment insurance fund, separate and apart from such State's obligation to the unemployment insurance fund as an employer. This will permit States to use Fund payments to prevent expenses related to the public health emergency from causing their state unemployment insurance funds to become insolvent.

Are recipients permitted to use Fund payments to pay for unemployment insurance costs incurred by the recipient as an employer?

Yes, Fund payments may be used for unemployment insurance costs incurred by the recipient as an employer (for example, as a reimbursing employer) related to the COVID-19 public health emergency if such costs will not be reimbursed by the federal government pursuant to the CARES Act or otherwise.

The Guidance states that the Fund may support a "broad range of uses" including payroll expenses for several classes of employees whose services are "substantially dedicated to mitigating or responding to the COVID-19 public health emergency." What are some examples of types of covered employees?

The Guidance provides examples of broad classes of employees whose payroll expenses would be eligible expenses under the Fund. These classes of employees include public safety, public health, health care, human services, and similar employees whose services are substantially dedicated to mitigating or responding to the COVID-19 public health emergency. Payroll and benefit costs associated with public employees who could have been furloughed or otherwise laid off but who were instead repurposed to perform previously unbudgeted functions substantially dedicated to mitigating or responding to the COVID-19 public health emergency are also covered. Other eligible expenditures include payroll and benefit costs of educational support staff or faculty responsible for developing online learning capabilities necessary to continue educational instruction in response to COVID-19-related school closures. Please see the Guidance for a discussion of what is meant by an expense that was not accounted for in the budget most recently approved as of March 27, 2020.

In some cases, first responders and critical health care workers that contract COVID-19 are eligible for workers' compensation coverage. Is the cost of this expanded workers compensation coverage eligible?

Increased workers compensation cost to the government due to the COVID-19 public health emergency incurred during the period beginning March 1, 2020, and ending December 30, 2020, is an eligible expense.

If a recipient would have decommissioned equipment or not renewed a lease on particular office space or equipment but decides to continue to use the equipment or to renew the lease in order to respond to the public health emergency, are the costs associated with continuing to operate the equipment or the ongoing lease payments eligible expenses?

Yes. To the extent the expenses were previously unbudgeted and are otherwise consistent with section 601(d) of the Social Security Act outlined in the Guidance, such expenses would be eligible.

May recipients provide stipends to employees for eligible expenses (for example, a stipend to employees to improve telework capabilities) rather than require employees to incur the eligible cost and submit for reimbursement?

Expenditures paid for with payments from the Fund must be limited to those that are necessary due to the public health emergency. As such, unless the government were to determine that providing assistance in the form of a stipend is an administrative necessity, the government should provide such assistance on a reimbursement basis to ensure as much as possible that funds are used to cover only eligible expenses.

May Fund payments be used for COVID-19 public health emergency recovery planning?

Yes. Expenses associated with conducting a recovery planning project or operating a recovery coordination office would be eligible, if the expenses otherwise meet the criteria set forth in section 601(d) of the Social Security Act outlined in the Guidance.

Are expenses associated with contact tracing eligible?

Yes, expenses associated with contract tracing are eligible.

To what extent may a government use Fund payments to support the operations of private hospitals?

Governments may use Fund payments to support public or private hospitals to the extent that the costs are necessary expenditures incurred due to the COVID-19 public health emergency, but the form such assistance would take may differ. In particular, financial assistance to private hospitals could take the form of a grant or a short-term loan.

May payments from the Fund be used to assist individuals with enrolling in a government benefit program for those who have been laid off due to COVID-19 and thereby lost health insurance?

Yes. To the extent that the relevant government official determines that these expenses are necessary and they meet the other requirements set forth in section 601(d) of the Social Security Act outlined in the Guidance, these expenses are eligible.

May recipients use Fund payments to facilitate livestock depopulation incurred by producers due to supply chain disruptions?

Yes, to the extent these efforts are deemed necessary for public health reasons or as a form of economic support as a result of the COVID-19 health emergency.

Would providing a consumer grant program to prevent eviction and assist in preventing homelessness be considered an eligible expense?

Yes, assuming that the recipient considers the grants to be a necessary expense incurred due to the COVID-19 public health emergency and the grants meet the other requirements for the use of Fund payments under section 601(d) of the Social Security Act outlined in the Guidance. As a general matter, providing assistance to recipients to enable them to meet property tax requirements would not be an eligible use of funds, but exceptions may be made in the case of assistance designed to prevent foreclosures.

May recipients create a "payroll support program" for public employees?

Use of payments from the Fund to cover payroll or benefits expenses of public employees are limited to those employees whose work duties are substantially dedicated to mitigating or responding to the COVID-19 public health emergency.

May recipients use Fund payments to cover employment and training programs for employees that have been furloughed due to the public health emergency?

Yes, this would be an eligible expense if the government determined that the costs of such employment and training programs would be necessary due to the public health emergency.

May recipients use Fund payments to provide emergency financial assistance to individuals and families directly impacted by a loss of income due to the COVID-19 public health emergency?

Yes, if a government determines such assistance to be a necessary expenditure. Such assistance could include, for example, a program to assist individuals with payment of overdue rent or mortgage payments to avoid eviction or foreclosure or unforeseen financial costs for funerals and other emergency individual needs. Such assistance should be structured in a manner to ensure as much as possible, within the realm of what is administratively feasible, that such assistance is necessary.

The Guidance provides that eligible expenditures may include expenditures related to the provision of grants to small businesses to reimburse the costs of business interruption caused by required closures. What is meant by a "small business," and is the Guidance intended to refer only to expenditures to cover administrative expenses of such a grant program?

Governments have discretion to determine what payments are necessary. A program that is aimed at assisting small businesses with the costs of business interruption caused by required closures should be tailored to assist those businesses in need of such assistance. The amount of a grant to a small business to reimburse the costs of business interruption caused by required closures would also be an eligible expenditure under section 601(d) of the Social Security Act, as outlined in the Guidance.

The Guidance provides that expenses associated with the provision of economic support in connection with the public health emergency, such as expenditures related to the provision of grants to small businesses to reimburse the costs of business interruption caused by required closures, would constitute eligible expenditures of Fund payments. Would such expenditures be eligible in the absence of a stay-at-home order?

Fund payments may be used for economic support in the absence of a stay-at-home order if such expenditures are determined by the government to be necessary. This may include, for example, a grant program to benefit small businesses that close voluntarily to promote social distancing measures or that are affected by decreased customer demand as a result of the COVID-19 public health emergency.

May Fund payments be used to assist impacted property owners with the payment of their property taxes?

Fund payments may not be used for government revenue replacement, including the provision of assistance to meet tax obligations.

May Fund payments be used to replace foregone utility fees? If not, can Fund payments be used as a direct subsidy payment to all utility account holders?

Fund payments may not be used for government revenue replacement, including the replacement of unpaid utility fees. Fund payments may be used for subsidy payments to electricity account holders to the extent that the subsidy payments are deemed by the recipient to be necessary expenditures incurred due to the COVID-19 public health emergency and meet the other criteria of section 601(d) of the Social Security Act outlined in the Guidance. For example, if determined to be a necessary expenditure, a government could provide grants to individuals facing economic hardship to allow them to pay their utility fees and thereby continue to receive essential services.

Could Fund payments be used for capital improvement projects that broadly provide potential economic development in a community?

In general, no. If capital improvement projects are not necessary expenditures incurred due to the COVID-19 public health emergency, then Fund payments may not be used for such projects. However, Fund payments may be used for the expenses of, for example, establishing temporary public medical facilities and other measures to increase COVID-19 treatment capacity or improve mitigation measures, including related construction costs.

The Guidance includes workforce bonuses as an example of ineligible expenses but provides that hazard pay would be eligible if otherwise determined to be a necessary expense. Is there a specific definition of "hazard pay"?

Hazard pay means additional pay for performing hazardous duty or work involving physical hardship, in each case that is related to COVID-19.

The Guidance provides that ineligible expenditures include "[p]ayroll or benefits expenses for employees whose work duties are not substantially dedicated to mitigating or responding to the COVID-19 public health emergency." Is this intended to relate only to public employees?

Yes. This particular nonexclusive example of an ineligible expenditure relates to public employees. A recipient would not be permitted to pay for payroll or benefit expenses of private employees and any financial assistance (such as grants or short-term loans) to private employers are not subject to the restriction that the private employers' employees must be substantially dedicated to mitigating or responding to the COVID-19 public health emergency.

May counties pre-pay with CARES Act funds for expenses such as a one or two-year facility lease, such as to house staff hired in response to COVID-19?

A government should not make prepayments on contracts using payments from the Fund to the extent that doing so would not be consistent with its ordinary course policies and procedures.

Questions Related to Administration of Fund Payments

Do governments have to return unspent funds to Treasury?

Yes. Section 601(f)(2) of the Social Security Act, as added by section 5001(a) of the CARES Act, provides for recoupment by the Department of the Treasury of amounts received from the Fund that have not been used in a manner consistent with section 601(d) of the Social Security Act. If a government has not used funds it has received to cover costs that were incurred by December 30, 2020, as required by the statute, those funds must be returned to the Department of the Treasury.

What records must be kept by governments receiving payment?

A government should keep records sufficient to demonstrate that the amount of Fund payments to the government has been used in accordance with section 601(d) of the Social Security Act

May recipients deposit Fund payments into interest bearing accounts?

Yes, provided that if recipients separately invest amounts received from the Fund, they must use the interest earned or other proceeds of these investments only to cover expenditures incurred in accordance

with section 601(d) of the Social Security Act and the Guidance on eligible expenses. If a government deposits Fund payments in a government's general account, it may use those funds to meet immediate cash management needs provided that the full amount of the payment is used to cover necessary

CDC Centers for Disease Control and Prevention

Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities

Updated Feb. 19, 2021 Print

This interim guidance is based on what is currently known about the transmission and severity of coronavirus disease 2019 (COVID-19) as of the date of posting.

The US Centers for Disease Control and Prevention (CDC) will update this guidance as needed and as additional information becomes available. Please check the CDC website periodically for updated interim guidance.

This document provides interim guidance specific for correctional facilities and detention centers during the outbreak of COVID-19, to ensure continuation of essential public services and protection of the health and safety of incarcerated and detained persons, staff, and visitors. Recommendations may need to be revised as more information becomes available.

A revision was made on 1/19/2021 to reflect the following:

- Clarification that correctional and detention facilities should continue to use a 14-day quarantine period. Recommendations for quarantine duration in correctional and detention facilities

A revision was made 12/3/2020 to reflect the following:

- Updated language on quarantine recommendations

A revision was made 12/3/2020 to reflect the following:

- Updated language on quarantine recommendations

A revision was made 10/21/2020 to reflect the following:

- Updated language for the close contact definition.

A revision was made 10/7/2020 to reflect the following:

- Updated criteria for releasing individuals with confirmed COVID-19 from medical isolation (symptom-based approach).
- Added link to CDC Guidance for Performing Broad-Based Testing for SARS-CoV-2 in Congregate Settings
- Reorganized information on Quarantine into 4 sections: Contact Tracing, Testing Close Contacts, Quarantine Practices, and Cohorted Quarantine for Multiple Close Contacts

A revision was made 7/14/20 to reflect the following:

- Added testing and contact tracing considerations for incarcerated/detained persons (including testing newly incarcerated or detained persons at intake; testing close contacts of cases; repeated testing of persons in cohorts of quarantined close contacts; testing before release). Linked to more detailed Interim Considerations for SARS-CoV-2 Testing in Correctional and Detention Facilities.
- Added recommendation to consider testing and a 14-day quarantine for individuals preparing for release or transfer to another facility.

- Added recommendation that confirmed COVID-19 cases may be medically isolated as a cohort. (Suspected cases should be isolated individually.)
- Reduced recommended frequency of symptom screening for quarantined individuals to once per day (from twice per day).
- Added recommendation to ensure that PPE donning/doffing stations are set up directly outside spaces requiring PPE. Train staff to move from areas of lower to higher risk of exposure if they must re-use PPE due to shortages.
- Added recommendation to organize staff assignments so that the same staff are assigned to the same areas of the facility over time, to reduce the risk of transmission through staff movements.
- Added recommendation to suspend work release programs, especially those within other congregate settings, when there is a COVID-19 case in the correctional or detention facility.
- Added recommendation to modify work details so that they only include incarcerated/detained persons from a single housing unit.
- Added considerations for safely transporting individuals with COVID-19 or their close contacts.
- Added considerations for release and re-entry planning in the context of COVID-19.

Intended Audience

This document is intended to provide guiding principles for healthcare and non-healthcare administrators of correctional and detention facilities (including but not limited to federal and state prisons, local jails, and detention centers), law enforcement agencies that have custodial authority for detained populations (i.e., U.S. Immigration and Customs Enforcement and U.S. Marshals Service), and their respective health departments, to assist in preparing for potential introduction, spread, and mitigation of SARS-CoV-2 (the virus that causes Coronavirus Disease 2019, or COVID-19) in their facilities. In general, the document uses terminology referring to correctional environments but can also be applied to civil and pre-trial detention settings.

This guidance will not necessarily address every possible custodial setting and may not use legal terminology specific to individual agencies' authorities or processes.

The guidance may need to be adapted based on individual facilities' physical space, staffing, population, operations, and other resources and conditions. Facilities should contact CDC or their state, local, territorial, and/or tribal public health department if they need assistance in applying these principles or addressing topics that are not specifically covered in this guidance.

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Guidance Overview

The guidance below includes detailed recommendations on the following topics related to COVID-19 in correctional and detention settings:

- ✓ Operational and communications preparations for COVID-19
- ✓ Enhanced cleaning/disinfecting and hygiene practices
- ✓ Social distancing strategies to increase space between individuals in the facility
- ✓ Strategies to limit transmission from visitors
- ✓ Infection control, including recommended personal protective equipment (PPE) and potential alternatives during PPE shortages

✓ Verbal screening and temperature check protocols for incoming incarcerated/detained individuals, staff, and visitors

✓ Testing considerations for SARS-CoV-2

✓ Medical isolation of individuals with confirmed and suspected COVID-19 and quarantine of close contacts, including considerations for cohorting when individual spaces are limited

✓ Healthcare evaluation for individuals with suspected COVID-19

✓ Clinical care for individuals with confirmed and suspected COVID-19

✓ Considerations for people who are at increased risk for severe illness from COVID-19

Definitions of Commonly Used Terms

Close contact of someone with COVID-19 – Someone who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period* starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the patient is isolated.

** Individual exposures added together over a 24-hour period (e.g., three 5-minute exposures for a total of 15 minutes). Data are limited, making it difficult to precisely define "close contact;" however, 15 cumulative minutes of exposure at a distance of 6 feet or less can be used as an operational definition for contact investigation. Factors to consider when defining close contact include proximity (closer distance likely increases exposure risk), the duration of exposure (longer exposure time likely increases exposure risk), whether the infected individual has symptoms (the period around onset of symptoms is associated with the highest levels of viral shedding), if the infected person was likely to generate respiratory aerosols (e.g., was coughing, singing, shouting), and other environmental factors (crowding, adequacy of ventilation, whether exposure was indoors or outdoors). Because the general public has not received training on proper selection and use of respiratory PPE, such as an N95, the determination of close contact should generally be made irrespective of whether the contact was wearing respiratory PPE. At this time, differential determination of close contact for those using fabric face coverings is not recommended.*

Cohorting – In this guidance, cohorting refers to the practice of isolating multiple individuals with laboratory-confirmed COVID-19 together or quarantining close contacts of an infected person together as a group due to a limited number of individual cells. While cohorting those with confirmed COVID-19 is acceptable, cohorting individuals with suspected COVID-19 is not recommended due to high risk of transmission from infected to uninfected individuals. See Quarantine and Medical Isolation sections below for specific details about ways to implement cohorting as a harm reduction strategy to minimize the risk of disease spread and adverse health outcomes.

Community transmission of SARS-CoV-2 – Community transmission of SARS-CoV-2 occurs when individuals are exposed to the virus through contact with someone in their local community, rather than through travel to an affected location. When community transmission is occurring in a particular area, correctional facilities and detention centers are more likely to start seeing infections inside their walls. Facilities should consult with local public health departments if assistance is needed to determine how to define "local community" in the context of SARS-CoV-2 spread. However, because all states have reported cases, all facilities should be vigilant for introduction of the virus into their populations.

Confirmed vs. suspected COVID-19 – A person has **confirmed COVID-19** when they have received a positive result from a COVID-19 viral test (antigen or PCR test) but they may or may not have symptoms. A person has **suspected COVID-19** if they show symptoms of COVID-19 but either have not been tested via a viral test or are awaiting test results. If their test result is positive, suspected COVID-19 is reclassified as confirmed COVID-19.

Incarcerated/detained persons – For the purpose of this document, "incarcerated/detained persons" refers to persons held in a prison, jail, detention center, or other custodial setting. The term includes those who have been sentenced (i.e., in prisons) as well as those held for pre-trial (i.e., jails) or civil purposes (i.e., detention centers). Although this guidance does not specifically reference individuals in every type of custodial setting (e.g., juvenile facilities, community confinement facilities), facility administrators can adapt this guidance to apply to their specific circumstances as needed.

Masks – Masks cover the nose and mouth and are intended to help prevent people who have the virus from transmitting it to others, even if they do not have symptoms. CDC recommends wearing cloth masks in public settings where social distancing measures are difficult to maintain. Masks are recommended as a simple barrier to help prevent respiratory droplets from traveling into the air and onto other people when the person wearing the mask coughs, sneezes, talks, or raises their voice. This is called source control. If everyone wears a mask in congregate settings, the risk of exposure to SARS-CoV-2 can be reduced. Anyone who has trouble breathing or is unconscious, incapacitated, younger than 2 years of age or otherwise unable to remove the mask without assistance should not wear a mask (for more details see How to Wear Masks). **CDC does not recommend use of masks for source control if they have an exhalation valve or vent).** Individuals working under conditions that require PPE should not use a cloth mask when a surgical mask or N95 respirator is indicated (see Table 1). Surgical masks and N95 respirators should be reserved for situations where the wearer needs PPE. Detailed recommendations for wearing a mask can be found here.

Medical isolation – Medical isolation refers to separating someone with confirmed or suspected COVID-19 infection to prevent their contact with others to reduce the risk of transmission. Medical isolation ends when the individual meets pre-established criteria for release from isolation, in consultation with clinical providers and public health officials. In this context, isolation does NOT refer to punitive isolation for behavioral infractions within the custodial setting. Staff are encouraged to use the term "medical isolation" to avoid confusion, and should ensure that the conditions in medical isolation spaces are distinct from those in punitive isolation.

Quarantine – Quarantine refers to the practice of separating individuals who have had close contact with someone with COVID-19 to determine whether they develop symptoms or test positive for the disease. Quarantine reduces the risk of transmission if an individual is later found to have COVID-19. Quarantine for COVID-19 should last for 14 days after the exposure has ended. Ideally, each quarantined individual should be housed in a single cell with solid walls and a solid door that closes. If symptoms develop during the 14-day period, and/or a quarantined individual receives a positive viral test result for SARS-CoV-2, the individual should be placed under medical isolation and evaluated by a healthcare professional. If symptoms do not develop during the 14-day period and the individual does not receive a positive viral test result for SARS-CoV-2, quarantine restrictions can be lifted. (NOTE: Some facilities may also choose to implement a "routine intake quarantine," in which individuals newly incarcerated/detained are housed separately or as a group for 14 days before being integrated into general housing. This type of quarantine is conducted to prevent introduction of SARS-CoV-2 from incoming individuals whose exposure status is unknown, rather than in response to a known exposure to someone infected with SARS-CoV-2.)

- The best way to protect incarcerated/detained persons, staff, and visitors is to have the individual quarantine for 14 days. For more information, please see Recommendations for quarantine duration in correctional and detention facilities.

Social distancing – Social distancing is the practice of increasing the space between individuals and decreasing their frequency of contact to reduce the risk of spreading a disease (ideally to maintain at least 6 feet between all individuals, even those who are asymptomatic). Social distancing strategies can be applied on an individual level (e.g., avoiding physical contact), a group level (e.g., canceling group activities where individuals would be in close contact), and an operational level (e.g., rearranging chairs in the dining hall to increase distance between them). Social distancing can be challenging to practice in correctional and detention environments; examples of potential social distancing strategies for correctional and detention facilities are detailed in the guidance below. Social distancing is vital for the prevention of respiratory diseases such as COVID-19, especially because people who have been infected with SARS-CoV-2 but do not have symptoms can still spread the infection. Additional information about social distancing, including information on its use to reduce the spread of other viral illnesses, is available in this CDC publication [900 KB, 36 pages].

Staff – In this document, "staff" refers to all public or private-sector employees (e.g., contracted healthcare or food service workers) working within a correctional facility. Except where noted, "staff" does not distinguish between healthcare, custody, and other types of staff, including private facility operators.

Symptoms – Symptoms of COVID-19 include cough, shortness of breath or difficulty breathing, fever, chills, muscle pain, sore throat, and new loss of taste or smell. This list is not exhaustive. Other less common symptoms have been reported, including nausea and vomiting. Like other respiratory infections, COVID-19 can vary in severity from mild to severe, and pneumonia, respiratory failure, and death are possible. COVID-19 is a novel disease, therefore the full range of signs and symptoms, the clinical course of the disease, and the individuals and populations at increased risk for severe illness are not yet fully understood. Monitor the CDC website for updates on symptoms.

Facilities with Limited Onsite Healthcare Services

Although many large facilities such as prisons and some jails employ onsite healthcare staff and have the capacity to evaluate incarcerated/detained persons for potential illness within a dedicated healthcare space, many smaller facilities do not. Some of these facilities have access to on-call healthcare staff or providers who visit the facility every few days. Others have neither onsite healthcare capacity nor onsite medical isolation/quarantine space and must transfer ill patients to other correctional or detention facilities or local hospitals for evaluation and care.

The majority of the guidance below is designed to be applied to any correctional or detention facility, either as written or with modifications based on a facility's individual structure and resources. However, topics related to healthcare evaluation and clinical care of persons with confirmed and suspected COVID-19 infection and their close contacts may not apply directly to facilities with limited or no onsite healthcare services. It will be especially important for these types of facilities to coordinate closely with their state, local, tribal, and/or territorial health department when they identify incarcerated/detained persons or staff with confirmed or suspected COVID-19, in order to ensure effective medical isolation and quarantine, necessary medical evaluation and care, and medical transfer if needed. The guidance makes note of strategies tailored to facilities without onsite healthcare where possible.

Note that all staff in any sized facility, regardless of the presence of onsite healthcare services, should observe guidance on recommended PPE in order to ensure their own safety when interacting with persons with confirmed or suspected COVID-19 infection.

COVID-19 Guidance for Correctional Facilities

Guidance for correctional and detention facilities is organized into 3 sections: Operational Preparedness, Prevention, and Management of COVID-19. Recommendations across these sections should be applied simultaneously based on the progress of the outbreak in a particular facility and the surrounding community.

- **Operational Preparedness.** This guidance is intended to help facilities prepare for potential SARS-CoV-2 transmission in the facility. Strategies focus on operational and communications planning, training, and personnel practices.
- **Prevention.** This guidance is intended to help facilities prevent spread of SARS-CoV-2 within the facility and between the community and the facility. Strategies focus on reinforcing hygiene practices; intensifying cleaning and disinfection of the facility; regular symptom screening for new intakes, visitors, and staff; continued communication with incarcerated/detained persons and staff; social distancing measures; as well as testing symptomatic and asymptomatic individuals in correctional and detention facilities. Refer to the Interim Guidance on Testing for SARS-CoV-2 in Correctional and Detention Facilities for additional considerations regarding testing in correctional and detention settings.
- **Management.** This guidance is intended to help facilities clinically manage persons with confirmed or suspected COVID-19 inside the facility and prevent further transmission of SARS-CoV-2. Strategies include medical isolation and care of incarcerated/detained persons with COVID-19 (including considerations for cohorting), quarantine and testing of close contacts, restricting movement in and out of the facility, infection control practices for interactions with persons with COVID-19 and their quarantined close contacts or contaminated items, intensified social distancing, and cleaning and disinfecting areas where infected persons spend time.

Operational Preparedness

Administrators can plan and prepare for COVID-19 by ensuring that all persons in the facility know the symptoms of COVID-19 and the importance of reporting those symptoms if they develop. Other essential actions include developing contingency plans for reduced workforces due to absences, coordinating with public health and correctional partners, training staff on proper use of personal protective equipment (PPE) that may be needed in the course of their duties, and communicating clearly with staff and incarcerated/detained persons about these preparations and how they may temporarily alter daily life.

Communication and Coordination

✓ **Develop information-sharing systems with partners.**

- Identify points of contact in relevant state, local, tribal, and/or territorial public health departments before SARS-CoV-2 infections develop. Actively engage with the health department to understand in advance which entity has jurisdiction to

implement public health control measures for COVID-19 in a particular correctional or detention facility.

- Create and test communications plans to disseminate critical information to incarcerated/detained persons, staff, contractors, vendors, and visitors as the pandemic progresses.
- Communicate with other correctional facilities in the same geographic area to share information including disease surveillance and absenteeism patterns among staff.
- Where possible, put plans in place with other jurisdictions to prevent individuals with confirmed or suspected COVID-19 and their close contacts from being transferred between jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, release, or to prevent overcrowding.
- Stay informed about updates to CDC guidance via the CDC COVID-19 website as more information becomes known.

✓ **Review existing influenza, all-hazards, and disaster plans, and revise for COVID-19.**

- Train staff on the facility's COVID-19 plan. All personnel should have a basic understanding of COVID-19, how the disease is thought to spread, what the symptoms of the disease are, and what measures are being implemented and can be taken by individuals to prevent or minimize the transmission of SARS-CoV-2.
- Ensure that **separate** physical locations (dedicated housing areas and bathrooms) have been identified to 1) isolate individuals with confirmed COVID-19 (individually or cohorted), 2) isolate individuals with suspected COVID-19 (individually - do not cohort), and 3) quarantine close contacts of those with confirmed or suspected COVID-19 (ideally individually; cohorted if necessary). The plan should include contingencies for multiple locations if numerous infected individuals and/or close contacts are identified and require medical isolation or quarantine simultaneously. See Medical Isolation and Quarantine sections below for more detailed cohorting considerations.
- Facilities without onsite healthcare capacity should make a plan for how they will ensure that individuals with suspected COVID-19 will be isolated, evaluated, tested, and provided necessary medical care.
- Make a list of possible social distancing strategies that could be implemented as needed at different stages of transmission intensity.
- Designate officials who will be authorized to make decisions about escalating or de-escalating response efforts as the disease transmission patterns change.

✓ **Coordinate with local law enforcement and court officials.**

- Identify legally acceptable alternatives to in-person court appearances, such as virtual court, as a social distancing measure to reduce the risk of SARS-CoV-2
- Consider options to prevent overcrowding (e.g., diverting new intakes to other facilities with available capacity, and encouraging alternatives to incarceration and other decompression strategies where allowable).

✓ **Encourage all persons in the facility to take the following actions to protect themselves and others from COVID-19. Post signs throughout the facility and communicate this information verbally on a regular basis. Sample signage and other communications materials are available on the CDC website.** Ensure that materials can be understood by non-English speakers and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or have low-vision.

For all:

- Practice good cough and sneeze etiquette: Cover your mouth and nose with your elbow (or ideally with a tissue) rather than with your hand when you cough or sneeze, and throw all tissues in the trash immediately after use.
- Practice good hand hygiene: Regularly wash your hands with soap and water for at least 20 seconds, especially after coughing, sneezing, or blowing your nose; after using the bathroom; before eating; before and after preparing food; before taking medication; and after touching garbage.
- Wear masks, unless PPE is indicated.
- Avoid touching your eyes, nose, or mouth without cleaning your hands first.
- Avoid sharing eating utensils, dishes, and cups.
- Avoid non-essential physical contact.

For incarcerated/detained persons:

- the importance of reporting symptoms to staff
- Social distancing and its importance for preventing COVID-19
- Purpose of quarantine and medical isolation

For staff:

- Stay at home when sick
- If symptoms develop while on duty, leave the facility as soon as possible and follow CDC-recommended steps for persons who are ill with COVID-19 symptoms including self-isolating at home, contacting a healthcare provider as soon as possible to determine whether evaluation or testing is needed, and contacting a supervisor.

Personnel Practices

✓ **Review the sick leave policies of each employer that operates within the facility.**

- Review policies to ensure that they are flexible, non-punitive, and actively encourage staff not to report to work when sick.
- Determine which officials will have the authority to send symptomatic staff home.

✓ **Identify duties that can be performed remotely.** Where possible, allowing staff to work from home can be an effective social distancing strategy to reduce the risk of SARS-CoV-2

✓ **Plan for staff absences.** Staff should stay home when they are sick, or they may need to stay home to care for a sick household member or care for children in the event of school and childcare dismissals.

- Identify critical job functions and plan for alternative coverage.
- Determine minimum levels of staff in all categories required for the facility to function safely. If possible, develop a plan to secure additional staff if absenteeism due to COVID-19 threatens to bring staffing to minimum levels.
- Review CDC guidance on safety practices for critical infrastructure workers (including correctional officers, law enforcement officers, and healthcare workers) who continue to work after a potential exposure to SARS-CoV-2.
- Consider increasing keep on person (KOP) medication orders to cover 30 days in case of healthcare staff shortages.

✓ **Consider offering revised duties to staff who are at increased risk for severe illness from COVID-19.** Persons at increased risk may include older adults and persons of any age with serious underlying medical conditions including lung disease, moderate to severe asthma, heart disease, chronic kidney disease, severe obesity, and diabetes. See CDC's website for a complete list and check regularly for updates as more data become available.

- Consult with occupational health providers to determine whether it would be allowable to reassign duties for specific staff members to reduce their likelihood of exposure to SARS-CoV-2.

✓ **Make plans in advance for how to change staff duty assignments to prevent unnecessary movement between housing units during a COVID-19**

- If there are people with COVID-19 inside the facility, it is **essential** for staff members to maintain a consistent duty assignment in the same area of the facility across shifts to prevent transmission across different facility areas.
- Where feasible, consider the use of telemedicine to evaluate persons with COVID-19 symptoms and other health conditions to limit the movement of healthcare staff across housing units.

✓ **Offer the seasonal influenza vaccine to all incarcerated/detained persons (existing population and new intakes) and staff throughout the influenza season.** Symptoms of COVID-19 are similar to those of influenza. Preventing influenza in a facility can speed the detection of COVID-19 and reduce pressure on healthcare resources.

✓ **Reference the Occupational Safety and Health Administration website for recommendations regarding worker health.**

✓ **Review CDC's guidance for businesses and employers** to identify any additional strategies the facility can use within its role as an employer, or share with others.

Operations, Supplies, and PPE Preparations

✓ **Ensure that sufficient stocks of hygiene supplies, cleaning supplies, PPE, and medical supplies (consistent with the healthcare capabilities of the facility) are on hand and available and have a plan in place to restock as needed.**

- Standard medical supplies for daily clinic needs
- Tissues
- Liquid or foam soap when possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing. Ensure a sufficient supply of soap for each individual.
- Hand drying supplies, such as paper towels or hand dryers
- Alcohol-based hand sanitizer containing at least 60% alcohol (where permissible based on security restrictions)
- Cleaning supplies, including EPA-registered disinfectants effective against SARS-CoV-2 , the virus that causes COVID-19
- Recommended PPE (surgical masks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls). See PPE section and Table 1 for more detailed information, including recommendations for extending the life of all PPE categories in the event of shortages, and when surgical masks are acceptable alternatives to N95s. Visit CDC's website for a calculator to help determine rate of PPE usage.
- Cloth face masks for source control
- SARS-CoV-2 specimen collection and testing supplies

✓ **Make contingency plans for possible PPE shortages during the COVID-19 pandemic, particularly for non-healthcare workers.**

- See CDC guidance optimizing PPE supplies.

✓ **Consider relaxing restrictions on allowing alcohol-based hand sanitizer in the secure setting, where security concerns allow.** If soap and water are not available, CDC recommends cleaning hands with an alcohol-based hand sanitizer that contains at least 60% alcohol. Consider allowing staff to carry individual-sized bottles for their personal hand hygiene while on duty, and place dispensers at facility entrances/exits and in PPE donning/doffing stations.

✓ **Provide a no-cost supply of soap to incarcerated/detained persons, sufficient to allow frequent hand washing.** (See Hygiene section below for additional detail regarding recommended frequency and protocol for hand washing.)

- Provide liquid or foam soap where possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing, and ensure that individuals do not share bars of soap.

✓ **If not already in place, employers operating within the facility should establish a respiratory protection program as appropriate, to ensure that staff and incarcerated/detained persons are fit-tested for any respiratory protection they will need within the scope of their responsibilities.**

✓ **Ensure that staff and incarcerated/detained persons are trained to correctly don, doff, and dispose of PPE that they will need to use within the scope of their responsibilities.**

- See Table 1 for recommended PPE for incarcerated/detained persons and staff with varying levels of contact with persons with COVID-19 or their close contacts.
- Visit CDC's website for PPE donning and doffing training videos and job aids [2.9 MB, 3 pages].

✓ **Prepare to set up designated PPE donning and doffing areas outside all spaces where PPE will be used. These spaces should include:**

- A dedicated trash can for disposal of used PPE
- A hand washing station or access to alcohol-based hand sanitizer
- A poster demonstrating correct PPE donning and doffing procedures

✓ Review CDC and EPA guidance for cleaning and disinfecting of the facility.

Prevention

Cases of COVID-19 have been documented in all 50 US states. Correctional and detention facilities can prevent introduction of SARS-CoV-2 and reduce transmission if it is already inside by reinforcing good hygiene practices among incarcerated/detained persons, staff, and visitors (including increasing access to soap and paper towels), intensifying cleaning/disinfection practices, and implementing social distancing strategies.

Because many individuals infected with SARS-CoV-2 do not display symptoms, the virus could be present in facilities before infections are identified. Good hygiene practices, vigilant symptom screening, wearing cloth face masks (if not contraindicated), and social distancing are critical in preventing further transmission.

Testing symptomatic and asymptomatic individuals and initiating medical isolation for suspected and confirmed cases and quarantine for close contacts, can help prevent spread of SARS-CoV-2.

Operations

✓ **Stay in communication with partners about your facility's current situation.**

- State, local, territorial, and/or tribal health departments
- Other correctional facilities

✓ **Communicate with the public about any changes to facility operations, including visitation programs.**

✓ **Limit transfers of incarcerated/detained persons to and from other jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, release, or to prevent overcrowding.**

If a transfer is absolutely necessary:

- Perform verbal screening and a temperature check as outlined in the Screening section below, before the individual leaves the facility. If an individual does not clear the screening process, delay the transfer and follow the protocol for suspected COVID-19 infection – including giving the individual a cloth face mask (unless contraindicated), if not already wearing one, immediately placing them under medical isolation, and evaluating them for SARS-CoV-2
- Ensure that the receiving facility has capacity to properly quarantine or isolate the individual upon arrival.
- See Transportation section below on precautions to use when transporting an individual with confirmed or suspected COVID-19.

✓ **Make every possible effort to modify staff assignments to minimize movement across housing units and other areas of the facility.** For example, ensure that the same staff are assigned to the same housing unit across shifts to prevent cross-contamination from units where infected individuals have been identified to units with no infections.

✓ **Consider suspending work release and other programs that involve movement of incarcerated/detained individuals in and out of the facility, especially if the work release assignment is in another congregate setting, such as a food processing plant.**

✓ **Implement lawful alternatives to in-person court appearances where permissible.**

✓ **Where relevant, consider suspending co-pays for incarcerated/detained persons seeking medical evaluation for possible COVID-19 symptoms, to remove possible barriers to symptom reporting.**

✓ **Limit the number of operational entrances and exits to the facility**

✓ **Where feasible, consider establishing an on-site laundry option for staff so that they can change out of their uniforms, launder them at the facility, and wear street clothes and shoes home.** If on-site laundry for staff is not feasible, encourage them to change clothes before they leave the work site, and provide a location for them to do so. This practice may help minimize the risk of transmitting SARS-CoV-2 between the facility and the community.

Cleaning and Disinfecting Practices

✓ **Even if COVID-19 has not yet been identified inside the facility or in the surrounding community, implement intensified cleaning and disinfecting procedures according to the recommendations below. These measures can help prevent spread of SARS-CoV-2 if introduced, and if already present through asymptomatic infections.**

✓ **Adhere to CDC recommendations for cleaning and disinfection during the COVID-19 response.** Monitor these recommendations for updates.

- Visit the CDC website for a tool to help implement cleaning and disinfection.
- Several times per day, clean and disinfect surfaces and objects that are frequently touched, especially in common areas. Such surfaces may include objects/surfaces not ordinarily cleaned daily (e.g., doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment, kiosks, telephones, and computer equipment).
- Staff should clean shared equipment (e.g., radios, service weapons, keys, handcuffs) several times per day and when the use of the equipment has concluded.
- Use household cleaners and EPA-registered disinfectants effective against SARS-CoV-2, the virus that causes COVID-19 as appropriate for the surface.
- Follow label instructions for safe and effective use of the cleaning product, including precautions that should be taken when applying the product, such as wearing gloves and making sure there is good ventilation during use, and around people. Clean according to label instructions to ensure safe and effective use, appropriate product dilution, and contact time. Facilities may consider lifting restrictions on undiluted disinfectants (i.e., requiring the use of undiluted product), if applicable.

✓ **Consider increasing the number of staff and/or incarcerated/detained persons trained and responsible for cleaning common areas to ensure continual cleaning of these areas throughout the day.**

✓ **Ensure adequate supplies to support intensified cleaning and disinfection practices, and have a plan in place to restock rapidly if needed.**

Hygiene

✓ **Encourage all staff and incarcerated/detained persons to wear a cloth face mask as much as safely possible, to prevent transmission of SARS-CoV-2 through respiratory droplets that are created when a person talks, coughs, or sneezes ("source control").**

- Provide masks at no cost to incarcerated/detained individuals and launder them routinely.
- Clearly explain the purpose of masks and when their use may be contraindicated. Because many individuals with COVID-19 do not have symptoms, it is important for everyone to wear masks in order to protect each other: "My mask protects you, your mask protects me."
- Ensure staff know that cloth masks should not be used as a substitute for surgical masks or N95 respirators that may be required based on an individual's scope of duties. Cloth masks are not PPE but are worn to protect others in the surrounding area from respiratory droplets generated by the wearer.
- Surgical masks may also be used as source control but should be conserved for situations requiring PPE.

✓ **Reinforce healthy hygiene practices, and provide and continually restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms and waiting rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).**

✓ **Provide incarcerated/detained persons and staff no-cost access to:**

- **Soap** – Provide liquid or foam soap where possible. If bar soap must be used, ensure that it does not irritate the skin, as this would discourage frequent hand washing, and ensure that individuals are not sharing bars of soap.
- **Running water, and hand drying machines or disposable paper towels** for hand washing
- **Tissues** and (where possible) no-touch trash receptacles for disposal
- Face masks

✓ **Provide alcohol-based hand sanitizer with at least 60% alcohol where permissible based on security restrictions.** Consider allowing staff to carry individual-sized bottles to maintain hand hygiene.

✓ **Communicate that sharing drugs and drug preparation equipment can spread SARS-CoV-2 due to potential contamination of shared items and close contact between individuals.**

Testing for SARS-CoV-2

Correctional and detention facilities are high-density congregate settings that present unique challenges to implementing testing for SARS-CoV-2, the virus that causes COVID-19. Refer to Testing guidance for details regarding testing strategies in correctional and detention settings.

Prevention Practices for Incarcerated/Detained Persons

✓ **Provide cloth face masks (unless contraindicated) and perform pre-intake symptom screening and temperature checks for all new entrants in order to identify and immediately place individuals with symptoms under medical isolation. Screening should take place in an outdoor space prior to entry, in the sally port, or at the point of entry into the facility immediately upon entry, before beginning the intake process.** See Screening section below for the wording of screening questions and a recommended procedure to safely perform a temperature check. Staff performing temperature checks should wear recommended PPE (see PPE section below).

If an individual has symptoms of COVID-19:

- Require the individual to wear a mask (as much as possible, use cloth masks in order to reserve surgical masks for situations requiring PPE). Anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the mask without assistance should not wear a mask.
- Ensure that staff who have direct contact with the symptomatic individual wear recommended PPE.
- Place the individual under medical isolation and refer to healthcare staff for further evaluation. (See Infection Control and Clinical Care sections below.)
- Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective medical isolation and necessary medical care. See Transport section and coordinate with the receiving facility.

If an individual is an asymptomatic close contact of someone with COVID-19:

- Quarantine the individual and monitor for symptoms at least once per day for 14 days. (See Quarantine section below.)
- The best way to protect incarcerated/detained persons, staff, and visitors is to have the individual quarantine for 14 days. For more information, please see Recommendations for quarantine duration in correctional and detention facilities.
- Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective quarantine and necessary medical care. See Transport section and coordinate with the receiving facility.

✓ **Consider strategies for testing asymptomatic incarcerated/detained persons without known SARS-CoV-2 exposure for early identification of SARS-CoV-2 in the facility.**

Implement social distancing strategies to increase the physical space between incarcerated/detained persons (ideally 6 feet between all individuals, regardless of symptoms), and to minimize mixing of individuals from different housing units. Strategies will need to be tailored to the individual space in the facility and the needs of the population and staff. Not all strategies will be feasible in all facilities. Example strategies with varying levels of intensity include:

Common areas:

- Enforce increased space between individuals in holding cells as well as in lines and waiting areas such as intake (e.g., remove every other chair in a waiting area).

Recreation:

- Choose recreation spaces where individuals can spread out
- Stagger time in recreation spaces (clean and disinfect between groups).
- Restrict recreation space usage to a single housing unit per space (where feasible).

Meals:

- Stagger meals in the dining hall (one housing unit at a time; clean and disinfect between groups).
- Rearrange seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table).
- Provide meals inside housing units or cells.

Group activities:

- Limit the size of group activities.
- Increase space between individuals during group activities.
- Suspend group programs where participants are likely to be in closer contact than they are in their housing environment.
- Consider alternatives to existing group activities, in outdoor areas or other areas where individuals can spread out.

Housing:

- If space allows, reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions. (Ensure that bunks are cleaned thoroughly if assigned to a new occupant.)
- Arrange bunks so that individuals sleep head to foot to increase the distance between their faces.
- Minimize the number of individuals housed in the same room as much as possible.
- Rearrange scheduled movements to minimize mixing of individuals from different housing areas.

Work details:

- Modify work detail assignments so that each detail includes only individuals from a single housing unit.

Medical:

- If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit. If this is not feasible, consider staggering individuals' sick call visits.

- Stagger pill line, or stage pill line within individual housing units.
- Identify opportunities to implement telemedicine to minimize the movement of healthcare staff across multiple housing units and to minimize the movement of ill individuals through the facility.
- Designate a room near the intake area to evaluate new entrants who are flagged by the intake symptom screening process before they move to other parts of the facility.

✓ **Note that if group activities are discontinued, it will be important to identify alternative forms of activity to support the mental health of incarcerated/detained persons.**

✓ **Provide up-to-date information about COVID-19 to incarcerated/detained persons on a regular basis.** As much as possible, provide this information in person and allow opportunities for incarcerated/detained individuals to ask questions (e.g., town hall format if social distancing is feasible, or informal peer-to-peer education). Updates should address:

- Symptoms of COVID-19 and its health risks
- Reminders to report COVID-19 symptoms to staff at the first sign of illness
  - Address concerns related to reporting symptoms (e.g., being sent to medical isolation), explain the need to report symptoms immediately to protect everyone, and explain the differences between medical isolation and solitary confinement.
- Reminders to use masks as much as possible
- Changes to the daily routine and how they can contribute to risk reduction

Prevention Practices for Staff

✓ **When feasible and consistent with security priorities, encourage staff to maintain a distance of 6 feet or more from an individual with COVID-19 symptoms while interviewing, escorting, or interacting in other ways, and to wear recommended PPE if closer contact is necessary.**

✓ **Ask staff to keep interactions with individuals with COVID-19 symptoms as brief as possible.**

✓ **Remind staff to stay at home if they are sick.** Ensure staff are aware that they will not be able to enter the facility if they have symptoms of COVID-19, and that they will be expected to leave the facility as soon as possible if they develop symptoms while on duty.

✓ **Consider strategies for testing asymptomatic staff without known SARS-CoV-2 exposure** for early identification of SARS-CoV-2 in the facility.

Follow guidance from the Equal Employment Opportunity Commission when offering testing to staff. **Any time a positive test result is identified, relevant employers should:**

- Ensure that the individual is rapidly notified, connected to appropriate medical care, and advised how to self-isolate.
- Inform other staff about their possible exposure in the workplace but should maintain the infected employee's confidentiality as required by the Americans with Disabilities Act .

✓ **Perform verbal screening and temperature checks for all staff daily on entry.** See Screening section below for wording of screening questions and a recommended procedure to safely perform temperature checks.

- In very small facilities with only a few staff, consider self-monitoring or virtual monitoring (e.g., reporting to a central authority via phone).
- Send staff home who do not clear the screening process, and advise them to follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.

✓ **Provide staff with up-to-date information about COVID-19 and about facility policies on a regular basis, including:**

- Symptoms of COVID-19 and its health risks

- Employers' sick leave policy

✓ **If staff develop a fever or other symptoms of COVID-19 while at work,** they should immediately put on a mask (if not already wearing one), inform their supervisor, leave the facility, and follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.

✓ **Staff identified as close contacts of someone with COVID-19 should self-quarantine at home for 14 days, unless a shortage of critical staff precludes quarantine.**

- Staff identified as close contacts should self-monitor for symptoms and seek testing.
- Refer to CDC guidelines for further recommendations regarding home quarantine.
- The best way to protect incarcerated/detained persons, staff, and visitors is to have the individual quarantine for 14 days. For more information, please see Recommendations for quarantine duration in correctional and detention facilities.
- **To ensure continuity of operations, critical infrastructure workers (including corrections officers, law enforcement officers, and healthcare staff) may be permitted to continue work following potential exposure to SARS-CoV-2 , provided that they remain *asymptomatic* and additional precautions are implemented to protect them and others.**
  - **Screening:** The facility should ensure that temperature and symptom screening takes place daily before the staff member enters the facility.
  - **Regular Monitoring:** The staff member should self-monitor under the supervision of their employer's occupational health program. If symptoms develop, they should follow CDC guidance on isolation with COVID-19 symptoms.
  - **Wear a Mask:** The staff member should wear a mask (unless contraindicated) at all times while in the workplace for 14 days after the last exposure (if not already wearing one due to universal use of masks).
  - **Social Distance:** The staff member should maintain 6 feet between themselves and others and practice social distancing as work duties permit.
  - **Disinfect and Clean Workspaces:** The facility should continue enhanced cleaning and disinfecting practices in all areas including offices, bathrooms, common areas, and shared equipment.

✓ **Staff with confirmed or suspected COVID-19 should inform workplace and personal contacts immediately. These staff should be required to meet CDC criteria for ending home isolation before returning to work.** Monitor CDC guidance on discontinuing home isolation regularly, as circumstances evolve rapidly.

Prevention Practices for Visitors

✓ **Restrict non-essential vendors, volunteers, and tours from entering the facility.**

✓ **If possible, communicate with potential visitors to discourage contact visits in the interest of their own health and the health of their family members and friends inside the facility.**

✓ **Require visitors to wear masks (unless contraindicated), and perform verbal screening and temperature checks for all visitors and volunteers on entry.** See Screening section below for wording of screening questions and a recommended procedure to safely perform temperature checks.

- Staff performing temperature checks should wear recommended PPE.
- Exclude visitors and volunteers who do not clear the screening process or who decline screening.

✓ **Provide alcohol-based hand sanitizer with at least 60% alcohol in visitor entrances, exits, and waiting areas.**

✓ **Provide visitors and volunteers with information to prepare them for screening.**

- Instruct visitors to postpone their visit if they have COVID-19 symptoms.
- If possible, inform potential visitors and volunteers before they travel to the facility that they should expect to be screened for COVID-19 (including a temperature check), and will be unable to enter the facility if they do not clear the screening process or if they decline screening.

- Display signage outside visiting areas explaining the COVID-19 symptom screening and temperature check process. Ensure that materials are understandable for non-English speakers and those with low literacy.

✓ **Promote non-contact visits:**

- Encourage incarcerated/detained persons to limit in-person visits in the interest of their own health and the health of their visitors.
- Consider reducing or temporarily eliminating the cost of phone calls for incarcerated/detained persons.
- Consider increasing incarcerated/detained persons' telephone privileges to promote mental health and reduce exposure from direct contact with community visitors.

✓ **Consider suspending or modifying visitation programs, if legally permissible. For example, provide access to virtual visitation options where available.**

- If moving to virtual visitation, clean electronic surfaces regularly after each use. (See Cleaning guidance below for instructions on cleaning electronic surfaces.)
- Inform potential visitors of changes to, or suspension of, visitation programs.
- Clearly communicate any visitation program changes to incarcerated/detained persons, along with the reasons for them (including protecting their health and their family and community members' health).
- If suspending contact visits, provide alternate means (e.g., phone or video visitation) for incarcerated/detained individuals to engage with legal representatives, clergy, and other individuals with whom they have legal right to consult.

NOTE: Suspending visitation should only be done in the interest of incarcerated/detained persons' physical health and the health of the general public. Visitation is important to maintain mental health. If visitation is suspended, facilities should explore alternative ways for incarcerated/detained persons to communicate with their families, friends, and other visitors in a way that is not financially burdensome for them.

Management

If there is an individual with suspected COVID-19 inside the facility (among incarcerated/detained persons, staff, or visitors who have recently been inside), begin implementing Management strategies while test results are pending. Essential Management strategies include placing individuals with suspected or confirmed COVID-19 under medical isolation, quarantining their close contacts, and facilitating necessary medical care, while observing relevant infection control and environmental disinfection protocols and wearing recommended PPE.

Testing symptomatic and asymptomatic individuals (incarcerated or detained individuals and staff) and initiating medical isolation for suspected and confirmed cases and quarantine for close contacts, can help prevent spread of SARS-CoV-2 in correctional and detention facilities. Continue following recommendations outlined in the Preparedness and Prevention sections above.

Operations

✓ **Coordinate with state, local, tribal, and/or territorial health departments.** When an individual has suspected or confirmed COVID-19, notify public health authorities and request any necessary assistance with medical isolation, evaluation, and clinical care, and contact tracing and quarantine of close contacts. See Medical Isolation, Quarantine and Clinical Care sections below.

✓ **Implement alternate work arrangements deemed feasible in the Operational Preparedness section.**

✓ **Suspend all transfers of incarcerated/detained persons to and from other jurisdictions and facilities (including work release), unless necessary for medical evaluation, medical isolation/quarantine, health care, extenuating security concerns, release, or to prevent overcrowding.**

✓ **Set up PPE donning/doffing stations as described in the Preparation section.**

✓ **If possible, consider quarantining all new intakes for 14 days before they enter the facility's general population (separately from other individuals who are quarantined due to contact with someone who has COVID-19).** This practice is referred to as **routine intake quarantine**.

✓ **Consider testing all newly incarcerated/detained persons before they join the rest of the population in the correctional or detention facility.**

✓ **Minimize interactions between incarcerated/detained persons living in different housing units, to prevent transmission from one unit to another.** For example, stagger mealtimes and recreation times, and consider implementing broad movement restrictions.

✓ **Ensure that work details include only incarcerated/detained persons from a single housing unit, supervised by staff who are normally assigned to the same housing unit.**

- If a work detail provides goods or services for other housing units (e.g., food service or laundry), ensure that deliveries are made with extreme caution. For example, have a staff member from the work detail deliver prepared food to a set location, leave, and have a staff member from the delivery location pick it up. Clean and disinfect all coolers, carts, and other objects involved in the delivery.

✓ **Incorporate COVID-19 prevention practices into release planning.**

- Consider implementing a release quarantine (ideally in single cells) for 14 days prior to individuals' projected release date.
- The best way to protect incarcerated/detained persons, staff, and visitors is to have the individual quarantine for 14 days. For more information, please see Recommendations for quarantine duration in correctional and detention facilities.
- Screen all releasing individuals for COVID-19 symptoms and perform a temperature check (see Screening section below.)
  - If an individual does not clear the screening process, follow the protocol for suspected COVID-19 – including giving the individual a mask, if not already wearing one, immediately placing them under medical isolation, and evaluating them for SARS-CoV-2 testing.
  - If the individual is released from the facility before the recommended medical isolation period is complete, discuss release of the individual with state, local, tribal, and/or territorial health departments to ensure safe medical transport and continued shelter and medical care, as part of release planning. Make direct linkages to community resources to ensure proper medical isolation and access to medical care.
  - Before releasing an incarcerated/detained individual who has confirmed or suspected COVID-19, or who is a close contact of someone with COVID-19, contact local public health officials to ensure they are aware of the individual's release and anticipated location. If the individual will be released to a community-based facility, such as a homeless shelter, contact the facility's staff to ensure adequate time for them to prepare to continue medical isolation or quarantine as needed.

✓ **Incorporate COVID-19 prevention practices into re-entry programming.**

- Ensure that facility re-entry programs include information on accessing housing, social services, mental health services, and medical care within the context of social distancing restrictions and limited community business operations related to COVID-19.
- Provide individuals about to be released with COVID-19 prevention information, hand hygiene supplies, and masks.
- Link individuals who need medication-assisted treatment for opioid use disorder to substance use, harm reduction, and/or recovery support systems . If the surrounding community is under movement restrictions due to COVID-19, ensure that referrals direct releasing individuals to programs that are continuing operations.
- Link releasing individuals to Medicaid enrollment and healthcare resources , including continuity of care for chronic conditions that may place an individual at increased risk for severe illness from COVID-19.
- When possible, encourage releasing individuals to seek housing options among their family or friends in the community, to prevent crowding in other congregate settings such as homeless shelters. When linking individuals to shared housing, link preferentially to accommodations with the greatest capacity for social distancing.

Hygiene

✓ **Continue to ensure that hand hygiene supplies are well-stocked in all areas of the facility** (see above).

✓ **Continue to emphasize practicing good hand hygiene and cough etiquette** (see above).

Cleaning and Disinfecting Practices

✓ **Continue adhering to recommended cleaning and disinfection procedures for the facility at large** (see above).

✓ **Reference specific cleaning and disinfection procedures for areas where individuals with COVID-19 spend time** (see below).

Management of Incarcerated/Detained Persons with COVID-19 Symptoms

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. Facilities without onsite healthcare capacity or without sufficient space for medical isolation should coordinate with local public health officials to ensure that individuals with suspected COVID-19 will be effectively isolated, evaluated, tested (if indicated), and given care.

✓ **Staff interacting with incarcerated/detained individuals with COVID-19 symptoms should wear recommended PPE** (see Table 1).

✓ **If possible, designate a room near each housing unit for healthcare staff to evaluate individuals with COVID-19 symptoms, rather than having symptomatic individuals walk through the facility to be evaluated in the medical unit.**

✓ **Incarcerated/detained individuals with COVID-19 symptoms should wear a mask (if not already wearing one, and unless contraindicated) and should be placed under medical isolation immediately. See Medical Isolation section below.**

✓ **Medical staff should evaluate symptomatic individuals to determine whether SARS-CoV-2 testing is indicated.** Refer to CDC guidelines for information on evaluation and testing. See Infection Control and Clinical Care sections below as well. Incarcerated/detained persons with symptoms are included in the high-priority group for testing in CDC's recommendations due to the high risk of transmission within congregate settings.

- If the individual's SARS-CoV-2 test is positive, continue medical isolation. (See Medical Isolation section below.)
- If the SARS-CoV-2 test is negative, the individual can be returned to their prior housing assignment unless they require further medical assessment or care or if they need to be quarantined as a close contact of someone with COVID-19.

✓ **Work with public health or private labs, as available, to access testing supplies or services.**

Medical Isolation of Individuals with Confirmed or Suspected COVID-19

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. Facilities without onsite healthcare capacity, or without sufficient space to implement effective medical isolation, should coordinate with local public health officials to ensure that individuals with confirmed or suspected COVID-19 will be appropriately isolated, evaluated, tested, and given care.

✓ **As soon as an individual develops symptoms of COVID-19 or tests positive for SARS-CoV-2 they should be given a mask (if not already wearing one and if it can be worn safely), immediately placed under medical isolation in a separate environment from other individuals, and medically evaluated.**

✓ **Ensure that medical isolation for COVID-19 is distinct from punitive solitary confinement of incarcerated/detained individuals, both in name and in practice.**

Because of limited individual housing spaces within many correctional and detention facilities, infected individuals are often placed in the same housing spaces that are used for solitary confinement. To avoid being placed in these conditions, incarcerated/detained individuals may be hesitant to report COVID-19 symptoms, leading to continued transmission within

shared housing spaces and, potentially, lack of health care and adverse health outcomes for infected individuals who delay reporting symptoms. Ensure that medical isolation is *operationally* distinct from solitary confinement, even if the same housing spaces are used for both. For example:

- Ensure that individuals under medical isolation receive regular visits from medical staff and have access to mental health services.
- Make efforts to provide similar access to radio, TV, reading materials, personal property, and commissary as would be available in individuals' regular housing units.
- Consider allowing increased telephone privileges without a cost barrier to maintain mental health and connection with others while isolated.
- Communicate regularly with isolated individuals about the duration and purpose of their medical isolation period.

✓ **Keep the individual's movement outside the medical isolation space to an absolute minimum.**

- Provide medical care to isolated individuals inside the medical isolation space, unless they need to be transferred to a healthcare facility. See Infection Control and Clinical Care sections for additional details.
- Serve meals inside the medical isolation space.
- Exclude the individual from all group activities.
- Assign the isolated individual(s) a dedicated bathroom when possible. When a dedicated bathroom is not feasible, do not reduce access to restrooms or showers as a result. Clean and disinfect areas used by infected individuals frequently on an ongoing basis during medical isolation.

✓ **Ensure that the individual is wearing a mask if they must leave the medical isolation space for any reason, and whenever another individual enters.** Provide clean masks as needed. Masks should be washed routinely and changed when visibly soiled or wet.

✓ **If the facility is housing individuals with confirmed COVID-19 as a cohort:**

- **Only individuals with laboratory-confirmed COVID-19 should be placed under medical isolation as a cohort. Do not cohort those with confirmed COVID-19 with those with suspected COVID-19, with close contacts of individuals with confirmed or suspected COVID-19, or with those with undiagnosed respiratory infection who do not meet the criteria for suspected COVID-19.**
- Ensure that cohorted groups of people with confirmed COVID-19 wear masks whenever anyone else (including staff) enters the isolation space. (Anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the mask without assistance should not wear a mask.)
- When choosing a space to cohort groups of people with confirmed COVID-19, use a well-ventilated room with solid walls and a solid door that closes fully.
- Use one large space for cohorted medical isolation rather than several smaller spaces. This practice will conserve PPE and reduce the chance of cross-contamination across different parts of the facility.

✓ **If possible, avoid transferring infected individual(s) to another facility unless necessary for medical care. If transfer is necessary, see Transport section for safe transport guidance.**

✓ **Staff assignments to isolation spaces should remain as consistent as possible, and these staff should limit their movements to other parts of the facility as much as possible.** These staff should wear recommended PPE as appropriate for their level of contact with the individual under medical isolation (see PPE section below) and should limit their own movement between different parts of the facility.

- If staff must serve multiple areas of the facility, ensure that they change PPE when leaving the isolation space. If a shortage of PPE supplies necessitates reuse, ensure that staff move only from areas of low to high exposure risk while wearing the same PPE, to prevent cross-contamination. For example, start in a housing unit where no one is known to be infected, then move to a space used as quarantine for close contacts, and end in an isolation unit. Ensure that staff are highly trained in infection control practices, including use of recommended PPE.

✓ **Provide individuals under medical isolation with tissues and, if permissible, a lined no-touch trash receptacle.** Instruct them to:

them to:

- **Cover** their mouth and nose with a tissue when they cough or sneeze
- **Dispose** of used tissues immediately in the lined trash receptacle
- **Wash hands** immediately with soap and water for at least 20 seconds. If soap and water are not available, clean hands with an alcohol-based hand sanitizer that contains at least 60% alcohol (where security concerns permit). Ensure that hand washing supplies are continually restocked.

✓ **Maintain medical isolation at least until CDC criteria for discontinuing home-based isolation have been met. These criteria have changed since CDC corrections guidance was originally issued and may continue to change as new data become available. Monitor the sites linked below regularly for updates.** This content will not be outlined explicitly in this document due to the rapid pace of change.

- CDC's recommended strategy for release from home-based isolation can be found in the *Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings Interim Guidance*.
- Detailed information about the data informing the symptom-based strategy, and considerations for extended isolation periods for persons in congregate settings including corrections, can be found here.
- If persons will require ongoing care by medical providers, discontinuation of transmission-based precautions (PPE) should be based on similar criteria found here.

Cleaning Spaces where Individuals with COVID-19 Spend Time

✓ **Ensure that staff and incarcerated/detained persons performing cleaning wear recommended PPE.** (See PPE section below.)

✓ **Thoroughly and frequently clean and disinfect all areas where individuals with confirmed or suspected COVID-19 spend time.**

- After an individual has been medically isolated for COVID-19, close off areas that they have used prior to isolation. If possible, open outside doors and windows to increase air circulation in the area. Wait as long as practical, up to 24 hours under the poorest air exchange conditions (consult CDC Guidelines for Environmental Infection Control in Health-Care Facilities for wait time based on different ventilation conditions) before beginning to clean and disinfect, to minimize potential for exposure to respiratory droplets.
- Clean and disinfect all areas (e.g., cells, bathrooms, and common areas) used by the infected individual, focusing especially on frequently touched surfaces (see list above in Prevention section).
- Clean and disinfect areas used by infected individuals on an ongoing basis during medical isolation.

✓ **Hard (non-porous) surface cleaning and disinfection**

- If surfaces are soiled, they should be cleaned using a detergent or soap and water prior to disinfection.
- Consult the list of products that are EPA-approved for use against the virus that causes COVID-19external icon . Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, etc.).
- If EPA-approved disinfectants are not available, diluted household bleach solutions can be used if appropriate for the surface. Unexpired household bleach will be effective against coronaviruses when properly diluted.
  - Use bleach containing 5.25%–8.25% sodium hypochlorite. Do not use a bleach product if the percentage is not in this range or is not specified.
  - Follow the manufacturer's application instructions for the surface, ensuring a contact time of at least 1 minute.
  - Ensure proper ventilation during and after application.
  - Check to ensure the product is not past its expiration date.
  - Never mix household bleach with ammonia or any other cleanser. This can cause fumes that may be very dangerous to breathe in.
- Prepare a bleach solution by mixing:
  - 5 tablespoons (1/3rd cup) of 5.25%–8.25% bleach per gallon of room temperature water

OR

4 teaspoons of 5.25%–8.25% bleach per quart of room temperature water

- Bleach solutions will be effective for disinfection up to 24 hours.
- Alcohol solutions with at least 70% alcohol may also be used.

✓ **Soft (porous) surface cleaning and disinfection**

- For soft (porous) surfaces such as carpeted floors and rugs, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:
  - If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.
  - Otherwise, use products that are EPA-approved for use against the virus that causes COVID-19external icon and are suitable for porous surfaces.

✓ **Electronics cleaning and disinfection**

- For electronics such as tablets, touch screens, keyboards, and remote controls, remove visible contamination if present.
  - Follow the manufacturer's instructions for all cleaning and disinfection products.
  - Consider use of wipeable covers for electronics.
  - If no manufacturer guidance is available, consider the use of alcohol-based wipes or spray containing at least 70% alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

Additional information on cleaning and disinfection of communal facilities such can be found on CDC's website.

✓ **Check light icon Food service items.** Individuals under medical isolation should throw disposable food service items in the trash in their medical isolation room. Non-disposable food service items should be handled with gloves and washed following food safety requirements. Individuals handling used food service items should clean their hands immediately after removing gloves.

✓ **Laundry from individuals with COVID-19 can be washed with other's laundry.**

- Individuals handling laundry from those with COVID-19 should wear a mask, disposable gloves, and a gown, discard after each use, and clean their hands immediately after.
- Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air. Ensure that individuals performing cleaning wear recommended PPE (see PPE section below).
- Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
- Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

Transporting Individuals with Confirmed and Suspected COVID-19 and Quarantined Close Contacts

✓ **Refer to CDC guidance for Emergency Medical Services (EMS) on safely transporting individuals with confirmed or suspected COVID-19.** This guidance includes considerations for vehicle type, air circulation, communication with the receiving facility, and cleaning the vehicle after transport.

- If the transport vehicle is not equipped with the features described in the EMS guidance, at minimum drive with the windows down and ensure that the fan is set to high, in non-recirculating mode. If the vehicle has a ceiling hatch, keep it open.

✓ **Use the same precautions when transporting individuals under quarantine as close contacts of someone with COVID-19.**

✓ **See Table 1 for the recommended PPE for staff transporting someone with COVID-19.**

Managing Close Contacts of Individuals with COVID-19

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. Facilities without onsite healthcare capacity or without sufficient space to implement effective quarantine should coordinate with local public health officials to ensure that close contacts of individuals with COVID-19 will be effectively quarantined and medically monitored

Contact Tracing

✓ **To determine who is considered a close contact of an individual with COVID-19, see definition of close contact and the Interim Guidance on Developing a COVID-19 Case Investigation and Contact Tracing Plan [12 Kb, 1 page] for more information.**

✓ **Contact tracing can be a useful tool to help contain disease outbreaks. When deciding whether to perform contact tracing, consider the following:**

Have a plan in place for how close contacts of individuals with COVID-19 will be managed, including quarantine logistics.

- Contact tracing can be especially impactful when:
  - There is a small number of infected individuals in the facility or in a particular housing unit. Aggressively tracing close contacts can help curb transmission before many other individuals are exposed.
  - The infected individual is a staff member or an incarcerated/detained individual who has had close contact with individuals from other housing units or with other staff. Identifying those close contacts can help prevent spread to other parts of the facility.
  - The infected individual is a staff member or an incarcerated/detained individual who has recently visited a community setting. In this situation, identifying close contacts can help reduce transmission from the facility into the community.
- Contact tracing may be more feasible and effective in settings where incarcerated/detained individuals have limited contact with others (e.g., celled housing units), compared to settings where close contact is frequent and relatively uncontrolled (e.g., open dormitory housing units).
- If there is a large number of individuals with COVID-19 in the facility, contact tracing may become difficult to manage. Under such conditions, consider broad-based testing in order to identify infections and prevent further transmission.
- Consult CDC recommendations for Performing Broad-Based Testing for SARS-CoV-2 in Congregate Settings for further information regarding selecting a testing location, ensuring proper ventilation and PPE usage, setting up testing stations and supplies, and planning test-day operations.

Testing Close Contacts

✓ **Testing is recommended for all close contacts [12 KB, 1 page] of persons with SARS-CoV-2 infection, regardless of whether the close contacts have symptoms.**

- Medically isolate those who test positive to prevent further transmission (see Medical Isolation section above).
- Asymptomatic close contacts testing negative should be placed under quarantine precautions for 14 days from their last exposure.

Quarantine for Close Contacts (who test negative)

✓ **Incarcerated/detained persons who are close contacts of someone with confirmed or suspected COVID-19 (whether the infected individual is another incarcerated/detained person, staff member, or visitor) should be placed under quarantine for 14 days. (Refer to the Interim Guidance on Developing a COVID-19 Case Investigation and Contact Tracing Plan [12 KB, 1 page] for more information):**

- If a quarantined individual is tested again during quarantine and they remain negative, they should continue to quarantine for the full 14 days after last exposure and follow all recommendations of local public health authorities.
- If an individual is quarantined due to contact with someone with suspected COVID-19 who is subsequently tested and receives a negative result, they can be released from quarantine. See Interim Guidance on Testing for SARS-CoV-2 in

Correctional and Detention Facilities for more information about testing strategies in correctional and detention settings.

- The best way to protect incarcerated/detained persons, staff, and visitors is to have the individual quarantine for 14 days. For more information, please see Recommendations for quarantine duration in correctional and detention facilities.

✓ **Quarantined individuals should be monitored for COVID-19 symptoms at least once per day including temperature checks.**

- See Screening section for a procedure to perform temperature checks safely on asymptomatic close contacts of someone with COVID-19.
- If an individual develops symptoms for SARS-CoV-2, they should be considered a suspected COVID-19 case, given a mask (if not already wearing one), and moved to medical isolation immediately (individually, and separately from those with confirmed COVID-19 and others with suspected COVID-19) and further evaluated. (See Medical Isolation section above.) If the individual is tested and receives a positive result, they can then be cohorted with other individuals with confirmed COVID-19.

✓ **Quarantined individuals can be released from quarantine restrictions if they have not developed COVID-19 symptoms and have not tested positive for SARS-CoV-2 for 14 days since their last exposure to someone who tested positive.**

✓ **Keep a quarantined individual's movement outside the quarantine space to an absolute minimum.**

- Provide medical evaluation and care inside or near the quarantine space when possible.
- Serve meals inside the quarantine space.
- Exclude the quarantined individual from all group activities.
- Assign the quarantined individual a dedicated bathroom when possible. When providing a dedicated bathroom is not feasible, do not reduce access to restrooms or showers as a result.

✓ **Restrict quarantined individuals from leaving the facility (including transfers to other facilities) during the 14-day quarantine period, unless released from custody or a transfer is necessary for medical care, infection control, lack of quarantine space, or extenuating security concerns.**

✓ **If a quarantined individual leaves the quarantine space for any reason, they should wear a mask (unless contraindicated) as source control, if not already wearing one.**

- Quarantined individuals housed as a cohort should wear masks at all times (see cohorted quarantine section below).
- Quarantined individuals housed alone should wear a mask whenever another individual enters the quarantine space.
- Anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the mask without assistance should not wear a mask.

✓ **Meals should be provided to quarantined individuals in their quarantine spaces.** Individuals under quarantine should throw disposable food service items in the trash. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands immediately after removing gloves.

✓ **Laundry from quarantined individuals can be washed with others' laundry.**

- Individuals handling laundry from quarantined persons should wear a mask, disposable gloves, and a gown, discard after each use, and clean their hands immediately after.
- Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
- Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
- Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

✓ **Staff assignments to quarantine spaces should remain as consistent as possible, and these staff should limit their movements to other parts of the facility.** These staff should wear recommended PPE based on their level of contact with the individuals under quarantine (see PPE section below).

- If staff must serve multiple areas of the facility, ensure that they change PPE when leaving the quarantine space. If a shortage of PPE supplies necessitates reuse, ensure that staff move only from areas of low to high exposure risk while wearing the same PPE, to prevent cross-contamination.
- Staff supervising asymptomatic incarcerated/detained persons under routine intake quarantine (with no known exposure to someone with COVID-19) do not need to wear PPE but should still wear a mask as source control.

Cohorted Quarantine for Multiple Close Contacts (who test negative)

✓ **Facilities should make every possible effort to individually quarantine close contacts of individuals with confirmed or suspected COVID-19.** Cohorting multiple quarantined close contacts could transmit SARS-CoV-2 from those who are infected to those who are uninfected. Cohorting should only be practiced if there are no other available options.

✓ **In order of preference, multiple quarantined individuals should be housed:**

- **IDEAL:** Separately, in single cells with solid walls (i.e., not bars) and solid doors that close fully
- Separately, in single cells with solid walls but without solid doors
- As a cohort, in a large, well-ventilated cell with solid walls, a solid door that closes fully, and at least 6 feet of personal space assigned to each individual in all directions
- As a cohort, in a large, well-ventilated cell with solid walls and at least 6 feet of personal space assigned to each individual in all directions, but without a solid door
- As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells creating at least 6 feet of space between individuals. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
- As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section to maintain at least 6 feet of space between individuals housed in the same cell.
- As a cohort, in individuals' regularly assigned housing unit but with no movement outside the unit (if an entire housing unit has been exposed – referred to as "quarantine in place"). Employ social distancing strategies related to housing in the Prevention section above to maintain at least 6 feet of space between individuals.
- Safely transfer to another facility with capacity to quarantine in one of the above arrangements. (See Transport) (NOTE – Transfer should be avoided due to the potential to introduce infection to another facility; proceed only if no other options are available.)

If the ideal choice does not exist in a facility, use the next best alternative as a harm reduction approach.

✓ **If cohorting close contacts is absolutely necessary, be especially mindful of those who are at increased risk for severe illness from COVID-19.** Ideally, they should not be cohorted with other quarantined individuals. If cohorting is unavoidable, make all possible accommodations to reduce exposure for the individuals with increased risk of severe illness. (For example, intensify social distancing strategies for individuals with increased risk.)

✓ **If single cells for isolation (of those with suspected COVID-19) and quarantine (of close contacts) are limited, prioritize them in rank order as follows to reduce the risk of further SARS-CoV-2 transmission and adverse health outcomes:**

- Individuals with suspected COVID-19 who are at increased risk for severe illness from COVID-19
- Others with suspected COVID-19
- Quarantined close contacts of someone with COVID-19 who are themselves at increased risk for severe illness from COVID-19

✓ **If a facility must cohort quarantined close contacts, all cohorted individuals should be monitored closely for symptoms of COVID-19, and those with symptoms should be placed under medical isolation immediately.**

✓ **If an individual who is part of a quarantined cohort becomes symptomatic:**

- **If the individual is tested for SARS-CoV-2 and receives a positive result:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
- **If the individual is tested for SARS-CoV-2 and receives a negative result:** the 14-day quarantine clock for this individual and the remainder of the cohort does not need to be reset. This individual can return from medical isolation to the quarantine cohort for the remainder of the quarantine period as their symptoms and diagnosis allow.
- **If the individual is not tested for SARS-CoV-2:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.

✓ **Consider re-testing all individuals in a quarantine cohort every 3-7 days, and immediately place those who test positive under medical isolation.** This strategy can help identify and isolate infected individuals early and minimize continued transmission within the cohort.

✓ **Consider testing all individuals quarantined as close contacts of someone with suspected or confirmed COVID-19 at the end of the 14-day quarantine period, before releasing them from quarantine precautions.**

✓ **Do not add more individuals to an existing quarantine cohort after the 14-day quarantine clock has started.** Doing so would complicate the calculation of the cohort's quarantine period, and potentially introduce new sources of infection.

✓ Some facilities may choose to quarantine all new intakes for 14 days before moving them to the facility's general population as a general rule (not because they were exposed to someone with COVID-19). **Under this scenario, do not mix individuals undergoing routine intake quarantine with those who are quarantined due to COVID-19 exposure.**

Management Strategies for Incarcerated/Detained Persons without COVID-19 Symptoms

✓ **Provide clear information to incarcerated/detained persons about the presence of COVID-19 within the facility, and the need to increase social distancing and maintain hygiene precautions.**

- As much as possible, provide this information in person and allow opportunities for incarcerated/detained individuals to ask questions (e.g., town hall format if social distancing is feasible, or informal peer-to-peer education).
- Ensure that information is provided in a manner that can be understood by non-English speaking individuals and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf or hard-of-hearing, blind, or have low-vision.

✓ **If individuals with COVID-19 have been identified among staff or incarcerated/detained persons anywhere in a facility, consider implementing regular symptom screening and temperature checks in housing units that have *not* yet identified infections, until no additional infections have been identified in the facility for 14 days.** Because some incarcerated/detained persons are hesitant to report symptoms, it is very important to monitor for symptoms closely even though doing so is resource intensive. See Screening section for a procedure to safely perform a temperature check.

✓ **Consider additional options to intensify social distancing** within the facility.

Management Strategies for Staff

✓ **Provide clear information to staff about the presence of COVID-19 within the facility, and the need to enforce universal use of masks (unless contraindicated) and social distancing and to encourage hygiene precautions.**

- As much as possible, provide this information in person (if social distancing is feasible) and allow opportunities for staff to ask questions.

✓ **Staff identified as close contacts of someone with COVID-19 should be tested for SARS-CoV-2 and self-quarantine at home for 14 days, unless a shortage of critical staff precludes quarantine of those who are asymptomatic** (see considerations for critical infrastructure workers). Refer to the Interim Guidance on Developing a COVID-19 Case Investigation and Contact Tracing Plan [12 KB, 1 page] for more information about contact tracing.

- The best way to protect incarcerated/detained persons, staff, and visitors is to have the individual quarantine for 14 days. For more information, please see Recommendations for quarantine duration in correctional and detention facilities.
- Close contacts should self-monitor for symptoms and seek testing.
- Refer to CDC guidelines for further recommendations regarding home quarantine.

✓ **Staff who have confirmed or suspected COVID-19 should meet CDC criteria for ending home isolation before returning to work.** Monitor CDC guidance on discontinuing home isolation regularly, as circumstances evolve rapidly.

Infection Control

Infection control guidance below is applicable to all types of correctional and detention facilities. Individual facilities should assess their unique needs based on the types of exposure staff and incarcerated/detained persons may have with someone with confirmed or suspected COVID-19.

✓ **All individuals who have the potential for direct or indirect exposure to someone with COVID-19 or infectious materials (including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air) should follow infection control practices outlined in the CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. Monitor these guidelines regularly for updates.**

- Implement the above guidance as fully as possible within the correctional/detention context. Some of the specific language may not apply directly to healthcare settings within correctional facilities and detention centers, or to facilities without onsite healthcare capacity, and may need to be adapted to reflect facility operations and custody needs.
- Note that these recommendations apply to staff as well as to incarcerated/detained individuals who may come in contact with contaminated materials during the course of their work placement in the facility (e.g., cleaning).

✓ **Staff should exercise caution and wear recommended PPE when in contact with individuals showing COVID-19 symptoms.** Contact should be minimized to the extent possible until the infected individual is wearing a mask (if not already wearing one and if not contraindicated) and staff are wearing PPE.

✓ **Refer to PPE section to determine recommended PPE for individuals in contact with individuals with COVID-19, their close contacts, and potentially contaminated items.**

✓ **Remind staff about the importance of limiting unnecessary movements between housing units and through multiple areas of the facility, to prevent cross-contamination.**

✓ **Ensure that staff and incarcerated/detained persons are trained to doff PPE after they leave a space where PPE is required, as needed within the scope of their duties and work details. Ideally, staff should don clean PPE before entering a different space within the facility that also requires PPE.**

- If PPE shortages make it impossible for staff to change PPE when they move between different spaces within the facility, ensure that they are trained to move from areas of low exposure risk ("clean") to areas of higher exposure risk ("dirty") while wearing the same PPE, to minimize the risk of contamination across different parts of the facility.

Clinical Care for Individuals with COVID-19

✓ **Facilities should ensure that incarcerated/detained individuals receive medical evaluation and treatment at the first signs of COVID-19 symptoms.**

- If a facility is not able to provide such evaluation and treatment, a plan should be in place to safely transfer the individual to another facility or local hospital (including notifying the facility/hospital in advance). See Transport section. The initial medical evaluation should determine whether a symptomatic individual is at increased risk for severe illness from COVID-19. Persons at increased risk may include older adults and persons of any age with serious underlying medical conditions, including chronic kidney disease, serious heart conditions, and Type-2 diabetes. See CDC's website for a complete list and check regularly for updates as more data become available to inform this issue.

- Based on available information, pregnant people seem to have the same risk of COVID-19 as adults who are not pregnant. However, much remains unknown about the risks of COVID-19 to the pregnant person, the pregnancy, and the unborn child. Prenatal and postnatal care is important for all pregnant people, including those who are incarcerated/detained. Visit the CDC website for more information on pregnancy and breastfeeding in the context of COVID-19.

✓ **Staff evaluating and providing care for individuals with confirmed or suspected COVID-19 should follow the CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) and monitor the guidance website regularly for updates to these recommendations.**

✓ **Healthcare staff should evaluate persons with COVID-19 symptoms and those who are close contacts of someone with COVID-19 in a separate room, with the door closed if possible, while wearing recommended PPE and ensuring that the individual being evaluated is wearing a mask.**

- If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having symptomatic individuals walk through the facility to be evaluated in the medical unit.

✓ **Clinicians are strongly encouraged to test for other causes of respiratory illness (e.g., influenza).** However, presence of another illness such as influenza does not rule out COVID-19.

✓ **When evaluating and treating persons with symptoms of COVID-19 who do not speak English, use a language line or provide a trained interpreter when possible.**

Recommended PPE and PPE Training for Staff and Incarcerated/Detained Persons

✓ **Ensure that all staff (healthcare and non-healthcare) and incarcerated/detained persons who will have contact with infectious materials in their work placements have been trained to correctly don, doff, and dispose of PPE relevant to the level of contact they will have with individuals with confirmed and suspected COVID-19. Ensure strict adherence to OSHA PPE requirements.**

- Ensure that staff and incarcerated/detained persons who require respiratory protection (e.g., N95 respirator) for their work responsibilities have been medically cleared, trained, and fit-tested in the context of an employer's respiratory protection program. If individuals wearing N95 respirators have facial hair, it should not protrude under the respirator seal, or extend far enough to interfere with the device's valve function (see OSHA regulations).
- For PPE training materials and posters, visit the CDC website on Protecting Healthcare Personnel.

✓ **Ensure that all staff are trained to perform hand hygiene after removing PPE.**

✓ **Ensure that PPE is readily available where and when needed, and that PPE donning/doffing/disposal stations have been set up as described in the Preparation section.**

✓ **Recommended PPE for incarcerated/detained individuals and staff in a correctional facility** will vary based on the type of contact they have with someone with COVID-19 and their close contacts (see Table 1). Each type of recommended PPE is defined below. **As above, note that PPE shortages are anticipated in every category during the COVID-19 response.**

- **N95 respirator**
  N95 respirators should be prioritized when staff anticipate contact with infectious aerosols or droplets from someone with COVID-19. See below for guidance on when surgical masks are acceptable alternatives for N95s. Individuals working under conditions that require an N95 respirator should not use a cloth mask when an N95 is indicated.
- **Surgical mask**
  Worn to protect the wearer from splashes, sprays, and respiratory droplets generated by others. (NOTE: Surgical masks are distinct from cloth masks, which are not PPE but are worn to protect others in the surrounding area from respiratory droplets generated by the wearer. Individuals working under conditions that require a surgical mask should not use a cloth mask when a surgical mask is indicated.)

- **Eye protection**
  Goggles or disposable face shield that fully covers the front and sides of the face.
- **A single pair of disposable patient examination gloves**
  Gloves should be changed if they become torn or heavily contaminated.
- **Disposable medical isolation gown or single-use/disposable coveralls, when feasible**
  - If custody staff are unable to wear a disposable gown or coveralls because it limits access to their duty belt and gear, ensure that duty belt and gear are disinfected after close contact with an individual with confirmed or suspected COVID-19, and that clothing is changed as soon as possible and laundered. Clean and disinfect duty belt and gear prior to reuse using a household cleaning spray or wipe, according to the product label.
  - If there are shortages of gowns, they should be prioritized for aerosol-generating procedures, activities where splashes and sprays are anticipated, and high-contact activities that provide opportunities for transfer of pathogens to the hands and clothing of the wearer.

✓ **Note that shortages of all PPE categories have been seen during the COVID-19 response, particularly for non-healthcare workers. Guidance for optimizing the supply of each category (including strategies to reuse PPE safely) can be found on CDC's website:**

- Strategies for optimizing the supply of N95 respirators
  - Based on local and regional situational analysis of PPE supplies, **surgical masks are an acceptable alternative when the supply chain of respirators cannot meet the demand**. During this time, available respirators should be prioritized for staff engaging in activities that would expose them to respiratory aerosols, which pose the highest exposure risk.

- Strategies for optimizing the supply of surgical masks
  - Reserve surgical masks for individuals who need PPE. Issue cloth masks to incarcerated/detained persons and staff as source control, in order to preserve surgical mask supply (see recommended PPE).

- Strategies for optimizing the supply of eye protection
- Strategies for optimizing the supply of gowns/coveralls
- Strategies for optimizing the supply of disposable medical gloves

Table 1. Recommended Personal Protective Equipment (PPE) for Incarcerated/Detained Persons and Staff in a Correctional or Detention Facility during the COVID-19 Response

Classification of Individual Wearing PPE	N95 respirator	Surgical mask	Eye Protection	Gloves	Gown/ Coveralls
Incarcerated/Detained Persons					
Asymptomatic incarcerated/detained persons (under quarantine as close contacts of someone with COVID-19)	Use cloth masks as source control (NOTE: cloth face coverings are NOT PPE and may not protect the wearer. Prioritize cloth masks for source control among all persons who do not meet criteria for N95 or surgical masks, and to conserve surgical masks for situations that require PPE.)				
Incarcerated/detained persons who have confirmed or suspected COVID-19, or showing symptoms of COVID-19					
Incarcerated/detained persons handling laundry or used food service items from someone with COVID-19 or their close contacts				X	X

Classification of Individual Wearing PPE	N95 respirator	Surgical mask	Eye Protection	Gloves	Gown/ Coveralls
Incarcerated/detained persons cleaning an area where someone with COVID-19 spends time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			X	X
Staff					
Staff having direct contact with asymptomatic incarcerated/detained persons under quarantine as close contacts of someone with COVID-19* (but not performing temperature checks or providing medical care)		Surgical mask, eye protection, and gloves as local supply and scope of duties allow.			
Staff performing temperature checks on any group of people (staff, visitors, or incarcerated/detained persons), or providing medical care to asymptomatic quarantined persons		X	X	X	
Staff having direct contact with (including transport) or offering medical care to individuals with confirmed or suspected COVID-19 (See CDC infection control guidelines). For recommended PPE for staff performing collection of specimens for SARS-CoV-2 testing see the Standardized procedure for SARS-CoV-2 testing in congregate settings.	X**		X	X	X
Staff present during a procedure on someone with confirmed or suspected COVID-19 that may generate infectious aerosols (See CDC infection control guidelines)	X		X	X	X
Staff handling laundry or used food service items from someone with COVID-19 or their close contacts				X	X
Staff cleaning an area where someone with COVID-19 spends time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			X	X

Classification of Individual Wearing PPE

* A NIOSH-approved N95 respirator is preferred. However, based on local and regional situational analysis of PPE supplies, surgical masks are an acceptable alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to staff.

Verbal Screening and Temperature Check Protocols for Incarcerated/Detained Persons, Staff, and Visitors

The guidance above recommends verbal screening and temperature checks for incarcerated/detained persons, staff,

COVID-19

✓ **Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions:**

- *Today or in the past 24 hours, have you had any of the following symptoms?*
  - *Fever, felt feverish, or had chills?*
  - *Cough?*
  - *Difficulty breathing?*
- *In the past 14 days, have you had close contact with a person known to be infected with the novel coronavirus (COVID-19)?*

✓ **The following is a protocol to safely check an individual's temperature:**

- Wash hands with soap and water for at least 20 seconds. If soap and water are not available, use hand sanitizer with at least 60% alcohol.
- Put on a surgical mask, eye protection (goggles or disposable face shield that fully covers the front and sides of the face), and a single pair of disposable gloves
- Check individual's temperature
- **If performing a temperature check on multiple individuals, ensure that a clean pair of gloves is used for each individual and that the thermometer has been thoroughly cleaned in between each check.** If disposable or non-contact thermometers are used and the screener did not have physical contact with an individual, gloves do not need to be changed before the next check. If non-contact thermometers are used, they should be cleaned with an alcohol wipe (or isopropyl alcohol on a cotton swab) between each individual.
- Remove and discard PPE
- Wash hands with soap and water for at least 20 seconds. If soap and water are not available, use hand sanitizer with at least 60% alcohol

✓ **If a physical barrier or partition is used to protect the screener rather than a PPE-based approach, the following protocol can be used.** (During screening, the screener stands behind a physical barrier, such as a glass or plastic window or partition, that can protect the screener's face and mucous membranes from respiratory droplets that may be produced when the person being screened sneezes, coughs, or talks.)

- Wash hands with soap and water for at least 20 seconds. If soap and water are not available, use hand sanitizer with at least 60% alcohol.
- Put on a single pair of disposable gloves.
- Check the individual's temperature, reaching around the partition or through the window. Make sure the screener's face stays behind the barrier at all times during the screening.
- **If performing a temperature check on multiple individuals, ensure that a clean pair of gloves is used for each individual and that the thermometer has been thoroughly cleaned in between each check.** If disposable or non-contact thermometers are used and the screener did not have physical contact with an individual, gloves do not need to be changed before the next check. If non-contact thermometers are used, they should be cleaned with an alcohol wipe (or isopropyl alcohol on a cotton swab) between each individual.
- Remove and discard gloves.

Last Updated Feb. 19, 2021

Coronavirus Relief Fund
Guidance for State, Territorial, Local, and Tribal Governments
Updated September 2, 2020[1]

The purpose of this document is to provide guidance to recipients of the funding available under section 601(a) of the Social Security Act, as added by section 5001 of the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"). The CARES Act established the Coronavirus Relief Fund (the "Fund") and appropriated $150 billion to the Fund. Under the CARES Act, the Fund is to be used to make payments for specified uses to States and certain local governments; the District of Columbia and U.S. Territories (consisting of the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands); and Tribal governments.

The CARES Act provides that payments from the Fund may only be used to cover costs that—

1. are necessary expenditures incurred due to the public health emergency with respect to the Coronavirus Disease 2019 (COVID–19);

2. were not accounted for in the budget most recently approved as of March 27, 2020 (the date of enactment of the CARES Act) for the State or government; and

3. were incurred during the period that begins on March 1, 2020, and ends on December 30, 2020.[2]

The guidance that follows sets forth the Department of the Treasury's interpretation of these limitations on the permissible use of Fund payments.

Necessary expenditures incurred due to the public health emergency

The requirement that expenditures be incurred "due to" the public health emergency means that expenditures must be used for actions taken to respond to the public health emergency. These may include expenditures incurred to allow the State, territorial, local, or Tribal government to respond directly to the emergency, such as by addressing medical or public health needs, as well as expenditures incurred to respond to second-order effects of the emergency, such as by providing economic support to those suffering from employment or business interruptions due to COVID-19-related business closures.

Funds may not be used to fill shortfalls in government revenue to cover expenditures that would not otherwise qualify under the statute. Although a broad range of uses is allowed, revenue replacement is not a permissible use of Fund payments.

The statute also specifies that expenditures using Fund payments must be "necessary." The Department of the Treasury understands this term broadly to mean that the expenditure is reasonably necessary for its intended use in the reasonable judgment of the government officials responsible for spending Fund payments.

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[1] On June 30, 2020, the guidance provided under "Costs incurred during the period that begins on March 1, 2020, and ends on December 30, 2020" was updated. On September 2, 2020, the "Supplemental Guidance on Use of Funds to Cover Payroll and Benefits of Public Employees" and "Supplemental Guidance on Use of Funds to Cover Administrative Costs" sections were added.

[2] *See* Section 601(d) of the Social Security Act, as added by section 5001 of the CARES Act.

Costs not accounted for in the budget most recently approved as of March 27, 2020

The CARES Act also requires that payments be used only to cover costs that were not accounted for in the budget most recently approved as of March 27, 2020. A cost meets this requirement if either (a) the cost cannot lawfully be funded using a line item, allotment, or allocation within that budget *or* (b) the cost is for a substantially different use from any expected use of funds in such a line item, allotment, or allocation.

The "most recently approved" budget refers to the enacted budget for the relevant fiscal period for the particular government, without taking into account subsequent supplemental appropriations enacted or other budgetary adjustments made by that government in response to the COVID-19 public health emergency. A cost is not considered to have been accounted for in a budget merely because it could be met using a budgetary stabilization fund, rainy day fund, or similar reserve account.

Costs incurred during the period that begins on March 1, 2020, and ends on December 30, 2020

Finally, the CARES Act provides that payments from the Fund may only be used to cover costs that were incurred during the period that begins on March 1, 2020, and ends on December 30, 2020 (the "covered period"). Putting this requirement together with the other provisions discussed above, section 601(d) may be summarized as providing that a State, local, or tribal government may use payments from the Fund only to cover previously unbudgeted costs of necessary expenditures incurred due to the COVID–19 public health emergency during the covered period.

Initial guidance released on April 22, 2020, provided that the cost of an expenditure is incurred when the recipient has expended funds to cover the cost. Upon further consideration and informed by an understanding of State, local, and tribal government practices, Treasury is clarifying that for a cost to be considered to have been incurred, performance or delivery must occur during the covered period but payment of funds need not be made during that time (though it is generally expected that this will take place within 90 days of a cost being incurred). For instance, in the case of a lease of equipment or other property, irrespective of when payment occurs, the cost of a lease payment shall be considered to have been incurred for the period of the lease that is within the covered period but not otherwise. Furthermore, in all cases it must be necessary that performance or delivery take place during the covered period. Thus the cost of a good or service received during the covered period will not be considered eligible under section 601(d) if there is no need for receipt until after the covered period has expired.

Goods delivered in the covered period need not be used during the covered period in all cases. For example, the cost of a good that must be delivered in December in order to be available for use in January could be covered using payments from the Fund. Additionally, the cost of goods purchased in bulk and delivered during the covered period may be covered using payments from the Fund if a portion of the goods is ordered for use in the covered period, the bulk purchase is consistent with the recipient's usual procurement policies and practices, and it is impractical to track and record when the items were used. A recipient may use payments from the Fund to purchase a durable good that is to be used during the current period and in subsequent periods if the acquisition in the covered period was necessary due to the public health emergency.

Given that it is not always possible to estimate with precision when a good or service will be needed, the touchstone in assessing the determination of need for a good or service during the covered period will be reasonableness at the time delivery or performance was sought, *e.g.*, the time of entry into a procurement contract specifying a time for delivery. Similarly, in recognition of the likelihood of supply chain disruptions and increased demand for certain goods and services during the COVID-19 public health emergency, if a recipient enters into a contract requiring the delivery of goods or performance of services by December 30, 2020, the failure of a vendor to complete delivery or services by December 30, 2020, will not affect the ability of the recipient to use payments from the Fund to cover the cost of such goods or services if the delay is due to circumstances beyond the recipient's control.

This guidance applies in a like manner to costs of subrecipients. Thus, a grant or loan, for example, provided by a recipient using payments from the Fund must be used by the subrecipient only to purchase (or reimburse a purchase of) goods or services for which receipt both is needed within the covered period and occurs within the covered period. The direct recipient of payments from the Fund is ultimately responsible for compliance with this limitation on use of payments from the Fund.

Nonexclusive examples of eligible expenditures

Eligible expenditures include, but are not limited to, payment for:

1. Medical expenses such as:

    - COVID-19-related expenses of public hospitals, clinics, and similar facilities.
    - Expenses of establishing temporary public medical facilities and other measures to increase COVID-19 treatment capacity, including related construction costs.
    - Costs of providing COVID-19 testing, including serological testing.
    - Emergency medical response expenses, including emergency medical transportation, related to COVID-19.
    - Expenses for establishing and operating public telemedicine capabilities for COVID-19-related treatment.

2. Public health expenses such as:

    - Expenses for communication and enforcement by State, territorial, local, and Tribal governments of public health orders related to COVID-19.
    - Expenses for acquisition and distribution of medical and protective supplies, including sanitizing products and personal protective equipment, for medical personnel, police officers, social workers, child protection services, and child welfare officers, direct service providers for older adults and individuals with disabilities in community settings, and other public health or safety workers in connection with the COVID-19 public health emergency.
    - Expenses for disinfection of public areas and other facilities, *e.g.*, nursing homes, in response to the COVID-19 public health emergency.
    - Expenses for technical assistance to local authorities or other entities on mitigation of COVID-19-related threats to public health and safety.
    - Expenses for public safety measures undertaken in response to COVID-19.
    - Expenses for quarantining individuals.

3. Payroll expenses for public safety, public health, health care, human services, and similar employees whose services are substantially dedicated to mitigating or responding to the COVID-19 public health emergency.

4. Expenses of actions to facilitate compliance with COVID-19-related public health measures, such as:

- Expenses for food delivery to residents, including, for example, senior citizens and other vulnerable populations, to enable compliance with COVID-19 public health precautions.
- Expenses to facilitate distance learning, including technological improvements, in connection with school closings to enable compliance with COVID-19 precautions.
- Expenses to improve telework capabilities for public employees to enable compliance with COVID-19 public health precautions.
- Expenses of providing paid sick and paid family and medical leave to public employees to enable compliance with COVID-19 public health precautions.
- COVID-19-related expenses of maintaining state prisons and county jails, including as relates to sanitation and improvement of social distancing measures, to enable compliance with COVID-19 public health precautions.
- Expenses for care for homeless populations provided to mitigate COVID-19 effects and enable compliance with COVID-19 public health precautions.

5. Expenses associated with the provision of economic support in connection with the COVID-19 public health emergency, such as:

- Expenditures related to the provision of grants to small businesses to reimburse the costs of business interruption caused by required closures.
- Expenditures related to a State, territorial, local, or Tribal government payroll support program.
- Unemployment insurance costs related to the COVID-19 public health emergency if such costs will not be reimbursed by the federal government pursuant to the CARES Act or otherwise.

6. Any other COVID-19-related expenses reasonably necessary to the function of government that satisfy the Fund's eligibility criteria.

Nonexclusive examples of ineligible expenditures[3]

The following is a list of examples of costs that would not be eligible expenditures of payments from the Fund.

1. Expenses for the State share of Medicaid.[4]
2. Damages covered by insurance.

[3] In addition, pursuant to section 5001(b) of the CARES Act, payments from the Fund may not be expended for an elective abortion or on research in which a human embryo is destroyed, discarded, or knowingly subjected to risk of injury or death. The prohibition on payment for abortions does not apply to an abortion if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. Furthermore, no government which receives payments from the Fund may discriminate against a health care entity on the basis that the entity does not provide, pay for, provide coverage of, or refer for abortions.

[4] *See* 42 C.F.R. § 433.51 and 45 C.F.R. § 75.306.

3. Payroll or benefits expenses for employees whose work duties are not substantially dedicated to mitigating or responding to the COVID-19 public health emergency.

4. Expenses that have been or will be reimbursed under any federal program, such as the reimbursement by the federal government pursuant to the CARES Act of contributions by States to State unemployment funds.

5. Reimbursement to donors for donated items or services.

6. Workforce bonuses other than hazard pay or overtime.

7. Severance pay.

8. Legal settlements.

Supplemental Guidance on Use of Funds to Cover Payroll and Benefits of Public Employees

As discussed in the Guidance above, the CARES Act provides that payments from the Fund must be used only to cover costs that were not accounted for in the budget most recently approved as of March 27, 2020. As reflected in the Guidance and FAQs, Treasury has not interpreted this provision to limit eligible costs to those that are incremental increases above amounts previously budgeted. Rather, Treasury has interpreted this provision to exclude items that were already covered for their original use (or a substantially similar use). This guidance reflects the intent behind the Fund, which was not to provide general fiscal assistance to state governments but rather to assist them with COVID-19-related necessary expenditures. With respect to personnel expenses, though the Fund was not intended to be used to cover government payroll expenses generally, the Fund was intended to provide assistance to address increased expenses, such as the expense of hiring new personnel as needed to assist with the government's response to the public health emergency and to allow recipients facing budget pressures not to have to lay off or furlough employees who would be needed to assist with that purpose.

Substantially different use

As stated in the Guidance above, Treasury considers the requirement that payments from the Fund be used only to cover costs that were not accounted for in the budget most recently approved as of March 27, 2020, to be met if either (a) the cost cannot lawfully be funded using a line item, allotment, or allocation within that budget *or* (b) the cost is for a ***substantially different use*** from any expected use of funds in such a line item, allotment, or allocation.

Treasury has provided examples as to what would constitute a substantially different use. Treasury provided (in FAQ A.3) that costs incurred for a substantially different use would include, for example, the costs of redeploying educational support staff or faculty to develop online learning capabilities, such as through providing information technology support that is not part of the staff or faculty's ordinary responsibilities.

Substantially dedicated

Within this category of substantially different uses, as stated in the Guidance above, Treasury has included payroll and benefits expenses for public safety, public health, health care, human services, and similar employees whose services are *substantially dedicated* to mitigating or responding to the COVID-19 public health emergency. The *full amount* of payroll and benefits expenses of substantially dedicated employees may be covered using payments from the Fund. Treasury has not developed a precise definition of what "substantially dedicated" means given that there is not a precise way to define this term across different employment types. The relevant unit of government should maintain documentation of the "substantially dedicated" conclusion with respect to its employees.

If an employee is not substantially dedicated to mitigating or responding to the COVID-19 public health emergency, his or her payroll and benefits expenses may not be covered *in full* with payments from the Fund. A *portion* of such expenses may be able to be covered, however, as discussed below.

Public health and public safety

In recognition of the particular importance of public health and public safety workers to State, local, and tribal government responses to the public health emergency, Treasury has provided, as an administrative accommodation, that a State, local, or tribal government may presume that public health and public safety employees meet the substantially dedicated test, unless the chief executive (or equivalent) of the relevant government determines that specific circumstances indicate otherwise. This means that, if this presumption applies, work performed by such employees is considered to be a substantially different use than accounted for in the most recently approved budget as of March 27, 2020. All costs of such employees may be covered using payments from the Fund for services provided during the period that begins on March 1, 2020, and ends on December 30, 2020.

In response to questions regarding which employees are within the scope of this accommodation, Treasury is supplementing this guidance to clarify that public safety employees would include police officers (including state police officers), sheriffs and deputy sheriffs, firefighters, emergency medical responders, correctional and detention officers, and those who directly support such employees such as dispatchers and supervisory personnel. Public health employees would include employees involved in providing medical and other health services to patients and supervisory personnel, including medical staff assigned to schools, prisons, and other such institutions, and other support services essential for patient care (*e.g.*, laboratory technicians) as well as employees of public health departments directly engaged in matters related to public health and related supervisory personnel.

Not substantially dedicated

As provided in FAQ A.47, a State, local, or tribal government may also track time spent by employees related to COVID-19 and apply Fund payments on that basis but would need to do so consistently within the relevant agency or department. This means, for example, that a government could cover payroll expenses allocated on an hourly basis to employees' time dedicated to mitigating or responding to the COVID-19 public health emergency. This result provides equitable treatment to governments that, for example, instead of having a few employees who are substantially dedicated to the public health emergency, have many employees who have a minority of their time dedicated to the public health emergency.

Covered benefits

Payroll and benefits of a substantially dedicated employee may be covered using payments from the Fund to the extent incurred between March 1 and December 30, 2020.

Payroll includes certain hazard pay and overtime, but not workforce bonuses. As discussed in FAQ A.29, hazard pay may be covered using payments from the Fund if it is provided for performing hazardous duty or work involving physical hardship that in each case is related to COVID-19. This means that, whereas payroll and benefits of an employee who is substantially dedicated to mitigating or responding to the COVID-19 public health emergency may generally be covered in full using payments from the Fund, hazard pay specifically may only be covered to the extent it is related to COVID-19. For example, a recipient may use payments from the Fund to cover hazard pay for a police officer coming in close contact with members of the public to enforce public health or public safety orders, but across-the-board hazard pay for all members of a police department regardless of their duties would not be able to be

covered with payments from the Fund. This position reflects the statutory intent discussed above: the Fund was intended to be used to help governments address the public health emergency both by providing funds for incremental expenses (such as hazard pay related to COVID-19) and to allow governments not to have to furlough or lay off employees needed to address the public health emergency but was not intended to provide across-the-board budget support (as would be the case if hazard pay regardless of its relation to COVID-19 or workforce bonuses were permitted to be covered using payments from the Fund).

Relatedly, both hazard pay and overtime pay for employees that are not substantially dedicated may only be covered using the Fund if the hazard pay and overtime pay is for COVID-19-related duties. As discussed above, governments may allocate payroll and benefits of such employees with respect to time worked on COVID-19-related matters.

Covered benefits include, but are not limited to, the costs of all types of leave (vacation, family-related, sick, military, bereavement, sabbatical, jury duty), employee insurance (health, life, dental, vision), retirement (pensions, 401(k)), unemployment benefit plans (federal and state), workers compensation insurance, and Federal Insurance Contributions Act (FICA) taxes (which includes Social Security and Medicare taxes).

Supplemental Guidance on Use of Funds to Cover Administrative Costs

General

Payments from the Fund are not administered as part of a traditional grant program and the provisions of the Uniform Guidance, 2 C.F.R. Part 200, that are applicable to indirect costs do not apply. Recipients may not apply their indirect costs rates to payments received from the Fund.

Recipients may, if they meet the conditions specified in the guidance for tracking time consistently across a department, use payments from the Fund to cover the portion of payroll and benefits of employees corresponding to time spent on administrative work necessary due to the COVID-19 public health emergency. (In other words, such costs would be eligible direct costs of the recipient). This includes, but is not limited to, costs related to disbursing payments from the Fund and managing new grant programs established using payments from the Fund.

As with any other costs to be covered using payments from the Fund, any such administrative costs must be incurred by December 30, 2020, with an exception for certain compliance costs as discussed below. Furthermore, as discussed in the Guidance above, as with any other cost, an administrative cost that has been or will be reimbursed under any federal program may not be covered with the Fund. For example, if an administrative cost is already being covered as a direct or indirect cost pursuant to another federal grant, the Fund may not be used to cover that cost.

Compliance costs related to the Fund

As previously stated in FAQ B.11, recipients are permitted to use payments from the Fund to cover the expenses of an audit conducted under the Single Audit Act, subject to the limitations set forth in 2 C.F.R. § 200.425. Pursuant to that provision of the Uniform Guidance, recipients and subrecipients subject to the Single Audit Act may use payments from the Fund to cover a reasonably proportionate share of the costs of audits attributable to the Fund.

To the extent a cost is incurred by December 30, 2020, for an eligible use consistent with section 601 of the Social Security Act and Treasury's guidance, a necessary administrative compliance expense that relates to such underlying cost may be incurred after December 30, 2020. Such an expense would include, for example, expenses incurred to comply with the Single Audit Act and reporting and recordkeeping requirements imposed by the Office of Inspector General. A recipient with such necessary administrative expenses, such as an ongoing audit continuing past December 30, 2020, that relates to Fund expenditures incurred during the covered period, must report to the Treasury Office of Inspector General by the quarter ending September 2021 an estimate of the amount of such necessary administrative expenses.