

Back-Up Staffing Plan for OAAS Waiver Participants

This form is completed for all Community Choices Waiver (CCW) participants receiving Personal Assistances Services (PAS) and Adult Day Health Care (ADHC) Waiver participants receiving Long-Term Personal Care Services (LT-PCS) by the Direct Service Provider (DSP).

Participant's Name: _____ DOB: _____ Region: _____

Waiver: CCW ADHC (with LT-PCS) Direct Service Provider: _____ Phone: _____

If a Direct Service Worker (DSW) is unable to provide services according to the Plan of Care (POC), the DSW is required to contact the DSP and participant/family as soon as possible. When this happens, the plan below will be followed.

Primary responsibility for immediate coverage of a DSW unplanned absence:

1. DSP accepts primary responsibility by providing a back-up DSW. Call Direct Service Provider (DSP) at _____.
2. Family/natural support accepts responsibility. Call the contact person(s) listed below, beginning with the Primary contact.

Person(s) responsible for Back-Up coverage: List all family/natural supports who have accepted responsibility with this Back-Up Staffing Plan and their contact numbers. Signatures/verbal agreement indicate acceptance of the responsibility.

Back-Up Name	Relationship	Main Contact Phone #	Other Contact Phone #	Signature	OR	Verbal Agreement <small>(list person who obtained verbal agreement and date)</small>	Date
Primary:						Obtained verbal agreement	
						Obtained verbal agreement	
						Obtained verbal agreement	

DSP Representative Signature: _____ Date: _____

If I am not happy with the plan, I can choose another DSP. I agree with this Back-Up Staffing Plan.

Participant/Responsible Representative: _____ Date: _____