LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

Back-Up Staffing Plan for OAAS MIHC Participants

This form is completed for all Community Choices Waiver (CCW) participants receiving Monitored in-Home Caregiver (MIHC) services by the MIHC provider.

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

MIHC Provider: _____ Phone: _____

If the principal MIHC caregiver is unable to provide services according to the Plan of Care (POC), the MIHC caregiver is required to notify the participant/family and the MIHC provider and follow the plan below. There must be either an alternate caregiver or two identified back-up persons **other than the principal MIHC caregiver.**

Primary responsibility for immediate coverage during the Principal MIHC Caregiver's unplanned absence, choose one:

1. ☐ **Alternate Caregiver** (credentialed, other than the principal MIHC Caregiver) Contact the Alternate Caregiver _____ (on call phone number). If no response, contact _____ at _____.
   The MIHC provider is responsible for ensuring the alternate caregiver is fully trained prior to being designated as the back-up caregiver.
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 (other than the principal MIHC Caregiver)	**Relationship**	**Main Contact Phone #**	**Other Contact Phone #**	**Signature** **OR**	**Verbal Agreement** (list person who obtained verbal agreement and date)	**Date**
Primary Back-Up:					☐ Obtained verbal agreement	
Emergency Back-Up:					☐ Obtained verbal agreement	

I agree with this back up plan. I understand that the MIHC provider does not provide Direct Support Workers (DSWs). If I am not happy with the plan, I can choose another Provider or Provider type.

MIHC Provider Representative Signature: _____ **Date:** _____

Participant/Responsible Representative (RR): _____ **Date:** _____

Principal Caregiver (if not the RR):_____ **Date:** _____