|  |
| --- |
| **Direct Service Provider: Phone:** |
| **Waiver Type:  Children’s Choice  Supports Waiver  Residential Options Waiver  New Opportunities Waiver** |
| ***Any time a Direct Service Worker (DSW) is unable to provide in-home services according to the plan of care (POC), the DSW is required to contact both the participant/family and the Direct Service Provider as soon as possible. When this happens, the plan below will be followed:***  **Primary responsibility for immediate coverage of a DSW unplanned absence:**   |  | | --- | | **Direct Support Provider is responsible for providing a back-up DSW. Name of a person is required in this section.**  **Contact Direct Support Provider at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (on call phone number).**  **If no response, contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for backup.**  **Provider agency is responsible for ensuring backup staff are trained on the individual’s plan of care prior to being solely responsible for the individual.** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Family/natural support chooses to provide support and does not wish to have a back-up staff. Call the primary contact listed below:**  **Person(s) responsible for back-up coverage if family/natural supports are selected. (List all family/natural supports who have agreed with this Back-Up Staffing Plan and their contact numbers). If provider is secondary backup to family/natural support, then include in boxes below. Must have at least two (2) backups for family/natural support (primary and a second backup). Signature/Verbal agreement indicate they have agreed to provide support.**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Name** | **Relationship** | **Main Contact #** | **Other Contact #** | **Signature** | **Verbal Agreement (indicate name and date of person who obtained verbal agreement)** | **Date** | | **Primary:** |  |  |  |  | **Obtained Verbal Agreement** |  | |  |  |  |  |  | **Obtained Verbal Agreement** |  | |  |  |  |  |  | **Obtained Verbal Agreement** |  | |   **I agree with this back up plan. I understand that the Direct Service Provider cannot require family/natural supports to be the backup for an unplanned DSW absence during the DSP support hours in the plan of care (POC). If I am not happy with the plan, I can choose another Direct Service Provider.**  **Participant/Responsible Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Direct Service Provider Representative Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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**Replaces April 12, 2018 issuance OCDD-P-19-011**

**Universal CPOC Attachment I Page | 1**