

In-Home Supportive Services (IHSS) Program
INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT

SECTION 1 – RECIPIENT’S INFORMATION

Recipient Name: _____
 Case #: _____ Face-to-Face Date: _____

INDIVIDUALIZED BACK-UP PLAN

SECTION 2 – SUPPORT CONTACTS

If your IHSS care provider does not arrive and/or you need non-emergency assistance, call:

	Name	Phone
Family Member:		
Friend/Neighbor:		
County Social Services Worker:		
County IHSS Social Services Office:		
Public Authority:		
Other:		

Other important numbers available to you, if needed:

Doctor’s Office:	
Advocacy Group(s):	
Police Department:	
Fire Department:	
Other:	

If you need to report abuse, fraud and/or neglect, call:

Adult Protective Services:	
Child Protective Services:	
Deaf or Hard of Hearing Resource Hotline:	(916) 558-5670
Fraud & Elder Abuse Hotline:	(800) 722-0432
Medi-Cal Fraud Hotline:	(800) 822-6222
Social Security Administration Fraud Hotline:	(800) 269-0271

If you have an emergency, call: 911

An emergency is an immediate threat to your health, welfare and/or safety.

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RISK ASSESSMENT**SECTION 3 – GENERAL RISK ASSESSMENT****A. IHSS Assessment**

During this IHSS assessment process, you and your social worker identified risks based on those personal care and domestic and related services for which you may need assistance. Assistance may be met through IHSS or with other formal or informal services.

B. Additional Risk Areas

The following are additional risk areas that you and your social worker discussed that may be outside the scope of the IHSS program (check all that apply):

B1. Living Arrangements

- Lives with others
 Lives alone, relatives/friends nearby
 Lives alone, no relatives/friends nearby

Comments:**B2. Evacuation/Environmental Factors**

- Can evacuate independently
 Can evacuate, but only with supervision/verbal direction
 Needs physical assistance to evacuate home in an emergency
 Able to access food/water independently
 Aware of emergency or crisis numbers/contacts
 Able to control lights, heat, cooling or other utilities

Comments:**B3. Communication**

- Communicates without difficulty
 Hearing impairment, communication limited
 Speech impairment, communication limited
 Can speak or hear with the use of assistive devices
 Assistive device(s): _____
 Able to place and receive calls independently
 Can use telephone only with assistive devices
 Assistive device(s): _____

Comments:**SECTION 4 – DISASTER PREPAREDNESS**

In preparation for a disaster, such as hot and cold weather emergencies, fires, floods, and earthquakes, you and your social worker discussed the following:

- Your individual health needs that will be listed in the County's Disaster Preparedness Assessment Plan (if utilized by your county).

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AGREEMENT AND SIGNATURES

SECTION 5 – AGREEMENT AND SIGNATURES

You and your social worker have discussed the following information (check all that apply):

- Your Individualized Back-Up Plan, and
- Your Risk Assessment.

By signing below, you, your social worker, and any other individual(s) you have chosen to be involved in this process, are confirming you agree with the information contained in this Individualized Back-Up Plan and Risk Assessment.

Recipient

Signature: _____ Date: _____

County Staff

Signature: _____ Date: _____

Print Name and Title: _____

Authorized Rep

Signature: _____ Date: _____

Print Name and Relationship: _____

Other

Signature: _____ Date: _____

Print Name and Relationship: _____

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INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT

Case Number: _____

INSTRUCTIONS

PLAN PURPOSE: To work with the recipient to allow him/her independence and choice in decisions related to his/her Individualized Back-Up Plan and Risk Assessment.

Ensure that discussion and negotiation occurs between the social worker, the recipient, and any others whom the recipient wants involved while working through this Plan. **After completion, a copy of pages 1-3 (excluding Instructions) of the Individualized Back-Up Plan and Risk Assessment shall be provided to the recipient. The original form shall be filed in the recipient's case file. Social worker shall encourage the recipient to post page 1 in an easily accessible area.**

SECTION 1: Fill-in the recipient's name, case number and date of face-to-face visit. To add the recipient's name and case number to pages 2-4, double-click in the header section of the page and type in the information. If the spaces move, and the information is not underlined, highlight the information and click on underline, and delete the additional spaces.

SECTION 2: Through discussion with the recipient/others involved in the development of this plan, fill in the recipient's choices and preferences of back-up contacts, as well as other important numbers identified, if needed. Discuss abuse, fraud and neglect with the recipient, the process to report abuse, fraud and neglect issues, and include the local APS/CPS numbers in their area. Reinforce with the recipient to call 911 if he/she has an emergency.

SECTION 3A: If assistance will be met through IHSS or with other formal or informal services, complete the SOC 450, Voluntary Services Certification, as needed. Identified risks may be mitigated through the authorization of hours in the service plan. If the client refuses any service, clearly document the service refused and the identified risks, and that the client elects to assume the risks associated with not receiving the service.

SECTION 3B: Also, discuss with the recipient additional risk areas that could be mitigated or improved through discussion and planning (Back-Up Plan).

SECTION 4: Discuss disaster preparedness with the recipient/others involved in the development of the plan. Include a discussion of how individual health needs may be addressed in the event of a disaster.

Section 5: With the recipient's/others' participation, review all sections, and check the boxes verifying that each area was discussed during the process. Ensure that all appropriate individuals sign the form to confirm agreement with the information on the form.

Comments/Notes: