

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT

SECTION 1 – RECIPIENT’S INFORMATION

RECIPIENT’S NAME:

CASE NUMBER:

INDIVIDUALIZED BACK-UP PLAN

SECTION 2 – SUPPORT CONTACTS

If you need non-emergency assistance, and/or your IHSS care provider has not arrived as scheduled, 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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RECIPIENT'S NAME:

CASE NUMBER:

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):

	Comments
<p>B1. Living Arrangements</p> <p>Lives with others who may assist Lives alone, relatives/friends nearby who may assist Lives alone, no relatives/friends nearby</p>	
<p>B2. Evacuation/Environmental Factors</p> <p>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</p>	
<p>B3. Communication</p> <p>Communicates without difficulty Hearing impairment, communication limited Speech impairment, communication limited Can speak or hear with the use of assistive device(s) Assistive device(s): Able to place and receive calls independently Can use telephone only with assistive device(s) Assistive device(s):</p>	

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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RECIPIENT'S NAME:

CASE NUMBER:

AGREEMENT AND SIGNATURES

SECTION 5 – AGREEMENT AND SIGNATURES

By signing below, you, your social worker, and any other individual(s) you have chosen to be involved in this process, are confirming you discussed and 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 Representative

Signature:

Date:

Print Name and Relationship:

Other

Signature:

Date:

Print Name and Relationship: _____

In the event there have been no changes in the Individualized Back-Up Plan and Risk Assessment from the prior year, the Recipient/Social Worker can sign below confirming no change.

Recipient /Authorized Representative

Signature

Date:

County Staff

Signature:

Date: _____

Print Name and Title:

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RECIPIENT'S NAME:

CASE NUMBER:

INSTRUCTIONS

Use this form 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 process. **After completion, a copy 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, and case number. This information will need to be added to each page until CMIPS II can auto-fill.

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, 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 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 recipient refuses any service, clearly document the service refused and the identified risks, and that the recipient 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 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:

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