NORTH CAROLINA
HOME CARE INDEPENDENCE

BACK UP PLAN FOR CONSUMER DIRECTED SERVICES
Initial_____ or Revised_____

Participant______________________________
Address________________________________
________________________________ Tele:_______________

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In the event that care giving as determined on the Plan of Care for on-going service is not able to be fulfilled on any given day, the following is my plan for obtaining service:

I have a relative_____ (specify)__________________whom I can call upon.
Address and Telephone number of relative:
____
______________________________________ Tele:_____________

I have neighbor/friend____ (specify)______________whom I can call upon.
Address and Telephone number of neighbor/friend:
____
______________________________________ Tele:_____________

As a last resort, I will contact a licensed Home Care Agency_____.

I know that if I use an agency that my budget for service will need to be adjusted_____

I will contact my Care Advisor if I need to use an agency for service so that my service budget can be adjusted as needed______

I will also let the FMS know that service on a given day was based upon my backup plan_____

Signature of Participant________________________________ Date_______

Signature of Care Advisor______________________________ Date_______

Eff.7/1/11