



Louisiana Department of Health and Hospitals (DHH)
Office of Aging and Adult Services (OAAS)
Individualized Back-Up Staffing Plan and Agreement Form

Participant's Name: _____ DOB: _____ Waiver: _____

Name of Direct Service Provider: _____ Phone: _____

Any time a Direct Support Worker (DSW) is unable to provide support due to unplanned circumstances, including emergencies which arise during a shift, the DSW is required to contact the supervisor and family/participant immediately upon discovery. Action will be then taken according to this plan.

Primary responsibility for immediate coverage of a DSW unplanned absence:

- Direct Service Provider (DSP) assumes responsibility for immediate action to cover a worker's unplanned absence and subsequent coverage until the DSW resumes their normal schedule.
- Family or other natural support assumes responsibility for immediate action to cover a worker's unplanned absence and DSP assumes responsibility for coverage of regularly scheduled shifts after a period of time designated in the staffing plan.
- Period of time after which the DSP assumes responsibility for coverage of regularly scheduled shifts: _____
- Family or other natural support assumes responsibility for immediate action to cover a worker's unplanned absence and subsequent coverage until the DSW resumes their normal schedule but not to exceed _____.



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Persons responsible for emergency coverage: (All parties who have accepted full or partial responsibility within this back-up staffing plan must be listed with their contact numbers.) Signatures indicate acceptance of the responsibilities indicated above.

Name	Relationship	Contact Number 1	Contact Number 2	Signature

Is there an attachment to this back-up staffing plan? Yes No If Yes, Describe (i.e. List of approved workers, etc.)

DSP Director or Authorized Designee*: _____ Date: _____

I understand that I have Freedom of Choice to choose a Direct Service Provide who best meets my needs and that my Support Coordinator can assist me with that process. My signature below indicates my agreement with the above back up staffing plan.

Participant/Authorized Representative: _____ Date: _____

*DSP Director or Authorized Designee must sign.