

In-Home Supportive Services (IHSS) Program
INDIVIDUAL EMERGENCY BACK-UP PLAN

Participant Name: _____ Date: _____

Case #: _____ Declined to participate:

If your Care Provider does not arrive and you need assistance, call:

Family Member: _____

Friend: _____

Neighbor: _____

County Social Services Worker: _____

County IHSS Social Services Office: _____

Public Authority: _____

If you need to report abuse and/or neglect of elderly or disabled individuals, call:

Adult Protective Services: _____

Other important numbers:

Doctor's Office: _____

Medi-Cal Office: _____

Advocacy Group(s): _____

Police Department: _____

Fire Department: _____

Other: _____

If you have an emergency, call 911

Social services staff discussed the above information with the recipient and/or his/her Authorized Representative and all parties are aware of what to do in case of an emergency.

Signature of Participant: _____ Date: _____

Signature of: _____ Date: _____

Authorized Representative, if applicable

Signature of: _____ Date: _____

County Social Services Staff