

# Take Me Home, West Virginia 24 Hour Emergency Backup Plan - Version 5.2

## PARTICIPANT INFORMATION

Last Name	First Name	Medicaid No.	Date of Birth	Transition Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Street	City	State	Zip	County

## REQUIRED DOMAINS

List Specific Risks	Level 1 Formal Support	Level 2 Informal Support	Level 3 24 Hour Support	Level 4 Extreme Emergency
Direct Care Assistance	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Critical Health - Supportive Services	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**REQUIRED DOMAINS**

List Specific Risks	Level 1	Level 2	Level 3	Level 4
	Formal Support	Informal Support	24 Hour Support	Extreme Emergency
Equipment - Maintenance				
Transportation				

**REQUIRED DOMAINS**

List Specific Risks	Level 1 Formal Support	Level 2 Informal Support	Level 3 24 Hour Support	Level 4 Extreme Emergency
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**Participant agrees with 24 Hour Backup Plan**     Yes     No

**Name of Participant or Legal Representative**

**Signature of Participant or Legal Representative\***

**Date**

\*(if Participant signs with a mark, two witnesses are required.)

**Name of Witness One**

**Signature of Witness One**

**Date**

**Name of Witness Two**

**Signature of Witness Two**

**Date**

Transition Navigator Name:

Transition Navigator Signature:

Date:

Agency: