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

PARTICIPANT INFORMATION

Complete this form when the 24 Hour Emergency Backup Plan was utilized.

Last Name	First Name	Social Security No.	Medicaid No.	Date of Birth	Transition Date

Target Population:

- ☐ Elderly
- ☐ Physical Disability
- ☐ Mental Illness (IMD Transitions Only)

Who reported that the 24 Hour Emergency Backup Plan had been utilized? _____

Date Emergency Backup Plan was utilized: _____ (If the exact date is not known, provide the month and year.)

Reason the 24 Hour Emergency Backup Plan was utilized:

- ☐ Transportation: to get to medical appointments
- ☐ Life-support equipment repair/replacement
- ☐ Critical health services
- ☐ Direct care service staff not showing up
- ☐ Other, specify _____

Was 911 contacted? ☐ Yes ☐ No

Did the participant activate their Personal Emergency Response System? ☐ Yes ☐ No

Was the 24 Hour Emergency Backup Plan effective? (i.e., was the participant able to get the assistance that was needed when it was needed?) ☐ Yes ☐ No

Was the participant re-institutionalized as a result of the emergency? ☐ Yes ☐ No (If Yes, please complete the Re-institutionalization Reporting Form)

Did the 24 Hour Emergency Backup Plan work as intended? ☐ Yes ☐ No (If No, please explain, and provide details on what changes were made to the plan to avoid future breakdowns.)

Provide a summary of why the 24 Hour Emergency Backup Plan was utilized, and how the plan utilization was reported to the Transition Navigator.

Transition Navigator Name	Transition Navigator Signature	Agency	Date