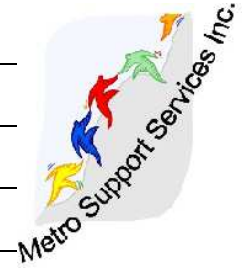


BACK-UP PROVIDER CHECKLIST



Name of Consumer: _____

Name of Back-up Provider: _____

Dates of Back-up Provider Services: _____

Address where Back-up Services are to occur: _____

- **Provider:** Date and list the Plans, Procedures or Protocols, which you have reviewed with the Back-up Provider. Be sure to include client-specific protocols such as OT/PT, use of CPAP, AFOS, special diets, adaptive equipment, etc. By signing, you affirm that you have reviewed the Plans, Procedures and Protocols with the Back-up Provider, and feel that they are competent to implement them as written. Plans, Procedures and Protocols must be reviewed annually, or as updated/changed.
- **Back-Up Provider:** By signing, you affirm that you have been trained to implement the Plans, Procedures, and Protocols, having had all of your questions answered, and that you feel competent to implement these, as written.

Date	Plan/Procedure/Protocol	Signature of Back-up Provider	Signature of Provider
	Nursing Protocol		
	Emergency Notifications Protocol and Emergency Phone Numbers		
	Safety Plan		
	Review of Medications		
	Adaptive Equipment		
	Medical Protocols		
	Therap: (please specify applicable HT & ISP's)		
	T-Logs		
	Health Tracking-		
	ISP Data Entry-		

- Metro Support expects that all Back-up Providers meet the same requirements as our host home providers. Please complete the following with applicable dates and ensure proof of current training/insurance, etc. is attached.

Medication Certification _____	GER/Incident Reporting _____
CPR _____	Auto Insurance _____
First Aid _____	Driver's License _____
MANE _____	Background Check/MVR _____
OSHA _____	HUD Inspection _____
Epilepsy _____	Professional Liability _____
Behavior Intervention _____	Homeowners Insurance _____
Med Minder Boxes _____	Personal Needs _____
Other _____	Other _____