Metro Support Service, Inc.

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	________