# Back-Up Care Plan

**What is it?** *A back-up care plan is a document that caregivers, care recipients and others who care can write down important information about the recipient's plan of care. You can use this document to help the primary caregiver remember every medication, keep smooth transitions between multiple caregivers or give the primary caregiver a break. The document can be used in those unforeseen moments when the caregiver cannot always be there –whether they are taking time for themselves or, whether there is a car accident or the caregiver is sick. Using this outline can help you to have a conversation and documentation for a back-up care plan, which can help reduce anxiety for everyone about what might happen if the caregiver can't be there.*

**Emergency Information:**

**Name: _____ Vision impairment Yes□ No□**
**Address:_____ Hearing Impairment Yes□ No□**
**Phone: _____ Blood Type: _____**
**Date of Birth:_____ Social Security #:_____**
**Primary Language: _____ Allergies:_____**
**Medical Insurance Carrier: _____**
**Policy #:_____**
**Medicaid #: _____Medicare #:_____**
**Health Care Proxy (HCP) Yes□ No□ Name:_____**
**Phone:_____ Location of HCP:_____**
**Power of Attorney (POA) Yes□ No□ Name:_____**
**Phone:_____ Location of POA:_____**
**Location of Do - Not - Resuscitate (DNR) order:_____**
**Emergency Numbers:**
**Fire: _____Police:_____**
**Ambulance: _____Poison Control:_____**
**Hospital: _____Phone:_____**
**Doctor: _____Phone:_____**
**Pharmacy: _____Phone:_____**
**Primary Emergency Contact: _____**
**Home Number: _____**
**Work Number: _____**
**Cell Phone/Beeper Number: _____**
**Secondary Emergency Contact: _____**
**Home Number: _____**
**Work Number: _____**
**Cell Phone/Beeper Number: _____**
**Home Health Care Agency: _____Phone:_____**
**Medicare Toll Free Number: _____**
**Insurance Company_____ Phone: _____**
**Medical Equipment Company: _____ Phone: _____**
**Transportation:_____ Phone: _____**
**Can this care recipient be left alone? Yes□ No□**

**Medication Information**

**Here you can list the medications, instructions, refill dates and any other important information about medication management.**

| Medication List | | | |
|---|---|---|---|
| **Medication Name** | **Instructions** | **Refill Dates** | **Notes** |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Who is the primary medication administrator?** _____

**Who is the secondary medication administrator?** _____

**Comments or other instructions:**

# Caregiving Back-Up Plan

**Primary Caregiver** Name:_____
Phone:_____

**Primary Back-Up Caregiver** Name: _____
Phone:_____

**Can the primary back-up caregiver stay with care recipient indefinitely to provide necessary care in primary caregivers absence? Yes☐ No☐**
**If NO, what is plan of care while the primary caregiver is not available?**
_____
_____
_____
_____

**Secondary Back-Up Caregiver?** Name: _____
Phone:_____

**Will this back up caregiver initiate the same plan of care listed above? Yes☐ No☐**
**Comments:**_____
_____
_____

## Make your care plan personal to how you and your loved one spend your day:

**What is the care recipient's daily routine?**

**What are the care recipients' favorite foods?**

**Special activities:** *(For example: If you do range of motion before getting out of bed or if you have a special way to transfer to assure weight bearing on the affected foot, note that here)*

**Other important things to note:**

**By signing this form, I indicate that I have collaborated in developing this back-up care plan and the directions here reflect my wishes for back-up care.**

**Signatures of Care Plan Team:**
**Signature: _____ Date: _____**
**Signature: _____ Date: _____**
**Signature: _____ Date: _____**
**Signature: _____ Date: _____**

**Copies provided to (circle): Primary Caregiver Posted in Care Recipient's Home**
**First Back-Up Caregiver Second Back-Up Caregiver Case Manager**
**Other_____**