TEXAS
Health and Human Services

Form 1742
May 2015-E

Service Backup Plan for HCS, TxHmL and CFC Services

Name of Individual	**Client Assignment and Registration (CARE) ID**	**Effective Date of Service Backup Plan**
Name of Program Provider	**Component Code**	**Contract Number**
Service Type ☐ Home and Community-based Services (HCS) ☐ Texas Home Living (TxHmL) ☐ Community First Choice (CFC)	**Type of Service Backup Plan** ☐ Enrollment/Renewal Backup Plan ☐ Revision to Backup Plan	**Program Service*** _____ * A service backup plan is required for each waiver program or CFC service identified on the Person Directed Plan (PDP) as critical to the health and welfare of the individual. The service backup plan must be reviewed at least annually.

Backup Plan Strategies	**Period of Time Before Health and Safety Begins to Be Effected**	**Specific Action(s) to be Taken in Absence of Service Delivery**	**Resource Person**
1.			Name: _____ Phone Number: _____ Alternate Number: _____ Indicate if resource person will be: ☐ Service Provider (paid) or ☐ Natural support (unpaid)
2.			Name: _____ Phone Number: _____ Alternate Number: _____ Indicate if resource person will be: ☐ Service Provider (paid) or ☐ Natural support (unpaid)
3.			Name: _____ Phone Number: _____ Alternate Number: _____ Indicate if resource person will be: ☐ Service Provider (paid) or ☐ Natural support (unpaid)
4.			Name: _____ Phone Number: _____ Alternate Number: _____ Indicate if resource person will be: ☐ Service Provider (paid) or ☐ Natural support (unpaid)
5.			Name: _____ Phone Number: _____ Alternate Number: _____ Indicate if resource person will be: ☐ Service Provider (paid) or ☐ Natural support (unpaid)

Acknowledgement

The following have received copies of this plan:		
☐ The individual receiving services,	☐ Legally Authorized Representative (LAR), if applicable, and	☐ resource person(s).
☐ All service providers indicated in this plan: Have received a copy of pertinent information, is/are able to meet the needs of the individual; is/are able to protect the individual's health and safety; meet(s) provider qualifications; are not listed on the Employee Misconduct Registry or the Nurses Aid Registry; and do not have any bars to employment as indicated by current criminal history background check.		
☐ All natural supports indicated in this plan: Have received a copy of pertinent information and is/are able to meet the needs of the individual, and is/are able to protect the individual's health and safety.		
Program Provider Representative Signature _____		Date _____
Individual/LAR Signature _____		Date _____