

Community Based Alternatives
Service Backup Plan

1. Applicant/Individual Name	2. Medicaid/Social Security No.	3. Date Completed	4. For DADS Use Only ISP Date
5. DADS Case Manager	6. Contract No.	7. Update 1 – Date Completed	8. For DADS Use Only Update 1 – ISP Date

A service backup plan is required for program service, as needed, when normal services delivery is interrupted in the absence of the service provider or in an emergency. The service backup plan must be maintained in the individual case record. The service backup plan must be reviewed by the HCSSA RN and individual receiving services at least annually.

9. Type of Service Backup Plan: Initial Revision Reassessment

10. Service Backup Plan:

	Program Service	Specify the Person the Individual Contacts when there is an Absence of Service Delivery	Designated Resource	Notes:
a.	<input type="checkbox"/> Nursing Services <input type="checkbox"/> Personal Attendant Services <input type="checkbox"/> Other:	<input type="checkbox"/> HCSSA Telephone No. _____ <input type="checkbox"/> Responsible Party Name _____ Telephone No. _____ <input type="checkbox"/> Other Name _____ Telephone No. _____	<input type="checkbox"/> HCSSA <input type="checkbox"/> Responsible Party <input type="checkbox"/> Other <input type="checkbox"/> Other	
b.	<input type="checkbox"/> Nursing Services <input type="checkbox"/> Personal Attendant Services <input type="checkbox"/> Other:	<input type="checkbox"/> HCSSA Telephone No. _____ <input type="checkbox"/> Responsible Party Name _____ Telephone No. _____ <input type="checkbox"/> Other Name _____ Telephone No. _____	<input type="checkbox"/> HCSSA <input type="checkbox"/> Responsible Party <input type="checkbox"/> Other <input type="checkbox"/> Other	
c.	<input type="checkbox"/> Nursing Services <input type="checkbox"/> Personal Attendant Services <input type="checkbox"/> Other:	<input type="checkbox"/> HCSSA Telephone No. _____ <input type="checkbox"/> Responsible Party Name _____ Telephone No. _____ <input type="checkbox"/> Other Name _____ Telephone No. _____	<input type="checkbox"/> HCSSA <input type="checkbox"/> Responsible Party <input type="checkbox"/> Other <input type="checkbox"/> Other	

11. Comments:

12. Certification by Interdisciplinary Team Members and Individual Responsible Person, if applicable. The waiver services backup plan identified above for this applicant/individual is necessary to prevent nursing facility placement, assure health and safety, and is appropriate to meet the needs of the applicant/individual in the community.

_____	_____	_____	_____
Signature – HCSSA Nurse Assessor	Date	Signature –HCSSA – Representative (if required)	Date
_____	_____	_____	_____
Signature-Applicant/Individual/Responsible Party	Date	Signature – Designated Resource (has agreed to provide backup services as outlined above)	Date
_____	_____		
Signature – DADS Case Manager	Date		

Update 1 Individual/responsible party and HCSSA representative signatures on Form 3671-2, Individual Service Plan, at annual reassessment and changes to the service backup plan.

_____ Signature – HCSSA Nurse Assessor	_____ Date	_____ Signature –HCSSA – Representative (if required)	_____ Date
_____ Signature-Applicant/Individual/Responsible Party	_____ Date	_____ Signature – Designated Resource (has agreed to provide backup services as outlined above)	_____ Date
_____ Signature – DADS Case Manager	_____ Date		