

MEMBER NAME

AHCCCS ID #

DATE OF PLAN

IN-HOME SERVICES PROVIDED BY ALTCS		FREQUENCY	PREFERENCE LEVEL	PROVIDER
1.				
2.				
3.				

MEMBER SERVICE PREFERENCE LEVEL – Based on member’s choice for how quickly a replacement caregiver will be needed if the scheduled caregiver becomes unavailable. Members shall be informed that they have the right to a back-up caregiver within two hours if they choose. Place Preference Level letter (A,B,C,D) on the corresponding service Preference Level line:

A	Needs services within two hours.
B	Needs services today.
C	Needs services within 48 hours.
D	Can wait until next scheduled visit by provider.

MEMBER HAS BEEN ADVISED THAT THEY MAY CHANGE THE MEMBER SERVICE PREFERENCE LEVEL AND ALSO THEIR CONTINGENCY PLAN, AS INDICATED BELOW, AT ANY TIME, INCLUDING AT THE TIME OF REPORT A MISSED, LATE OR SHORT VISIT.

Case Manager Initial

Date

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If my ALTCS caregiver is late, does not show up or leaves early and is unable to provide services as scheduled, my Contingency Plan is as follows (check all that apply):

BACK-UP PLAN	NAME	PHONE NUMBER
<input type="checkbox"/> I will contact my back-up provider agency.		
<input type="checkbox"/> I will contact my case manager.		
<input type="checkbox"/> I will contact [Health Plan].		
<input type="checkbox"/> I prefer to have family or friends provide my care instead of another ALTCS provider/caregiver.		1.
		2.
		3.
		4.
<input type="checkbox"/> I can wait until the next scheduled visit from my ALTCS caregiver to receive authorized care.		
<input type="checkbox"/> Other:		

The member may experience adverse if health outcomes if one of the following incidences occurs:

Missed Visit - The Direct Care Worker (DCW) does not show up at all for the visit

Late Visit - The DCW shows up more than 60 minutes after the scheduled start time.

Short Visit - The DCW provides services for less than the scheduled length of time

The Case Managers use this form to facilitate a discussion with the member and document the member's preferences on what to do should a visit be late, missed or short to mitigate negative impacts to the members health.

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I understand that my health plan must make sure that I receive these SDAC services without delays. I understand that if I do not receive SDAC services as scheduled I must call my case manager to report the problem so they can assist in replacing my caregiver as stated in the Contingency Plan. My case manager must provide a back-up caregiver as stated in the Contingency Plan, unless I say otherwise when I report a missed, late or short visit. I understand I also have the right to file a written complaint with my health plan about not receiving services as stated in my Contingency Plan.

I understand that in order to receive services I must be available and willing to accept the scheduled services. If I choose not to accept the services I understand I must tell my case manager and let my caregiver know. If I do want the services and the visit is missed, short or late I must report these incidents to my case manager so the Contingency Plan can be used. This plan has been reviewed with me and I agree with it. I will keep a copy of this plan.

HAVE MEMBER/LEGAL GUARDIAN SIGN HERE AT TIME OF INITIAL PLAN DEVELOPMENT:

MEMBER/LEGAL GUARDIAN

DATE

RELATIONSHIP TO MEMBER

DATE

QUARTERLY VISIT

This plan was reviewed with me by the case manager during my quarterly service review. My signature below indicates I still agree with this plan and no changes are needed. I understand that I may change my Member Service Preference Level at any time, including at the time when I report a missed, short or late visit. My case manager and I will fill out a new Contingency Plan form if I have changes to my plan, but at least once a year.

Have member sign here to indicate continued agreement with plan at the time of each 90 day Person Centered Service Plan (PCSP) meeting. If the member wishes to make changes to the information in this Contingency plan, a new plan shall be written. A new Contingency plan is required at least once a year.

Date of Review: _____ Member/Legal Guardian Signature: _____

Date of Review: _____ Member/Legal Guardian Signature: _____

Date of Review: _____ Member/Legal Guardian Signature: _____

cc: Member
Case File

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**AHCCCS/ALTCS CONTINGENCY PLAN
INSTRUCTIONS**

- All ALTCS Contractors shall use this standardized form. It may be altered in the ways listed below without AHCCCS approval. All other changes to the form shall be prior approved by AHCCCS.
 1. Contractor letterhead may be added.
 2. Terms such as “case manager” and “health plan” may be changed to terms more commonly used by the Contractor.
 3. Contractor-specific member ID numbers may be added.
- This form shall be completed by the case manager for all members who receive one or more of the following SDAC services:
 1. Attendant Care.
 2. Personal Care.
 3. Homemaker.
- The member shall be advised of their right to have a back-up on-call caregiver provided in the event an unforeseeable missed, short or late visit occurs.
- The member shall be advised of their right to change a previously designated Member Service Preference Level at any time, including at the time an incident occurs. The case manager shall initial and date the statement on the first page indicating this was done at the time the plan was developed.
- The member should designate the Contingency Plan for how the member chooses to have their needs met in the event the regular caregiver is not available as scheduled. More than one option can be chosen.
- If the member indicates they want family or friends to provide unpaid back-up care for some or all of the time that the ALTCS provider was scheduled to be there, the names of those individuals should be listed. **The selection of this informal support system as the back-up plan shall be the member's choice and not assumed simply because those individuals live in the home and/or appear to be available.**

The phone number for the [Health Plan] toll-free phone line shall be listed. The name and phone number(s) of the member's back-up provider agency shall be listed, including the after-hours number. The case manager's name and phone number(s) should also be included.

- The member shall sign the completed form indicating it has been reviewed with them and that they are in agreement with it. A copy of the signed plan shall be given to the member. **This form shall be signed upon initial completion as well as at each 90-day service Person Centered Service Plan (PCSP) review if there are no changes to the Contingency Plan.** If there are changes to any part of the Contingency Plan, a new plan shall be written, signed and a copy left with the member. **A new Contingency Plan shall be written at least once a year.**
- The Case Manager shall document the contingency planning in the case file and shall clearly indicate the members involvement in the planning exercise.