

<i>MEMBER NAME</i>	<i>AHCCCS ID #</i>	<i>DATE OF PLAN</i>
IN-HOME SERVICES PROVIDED BY ALTCS		FREQUENCY
1.		
2.		
3.		
<p>MEMBER SERVICE PREFERENCE LEVEL – <i>Based on member’s choice for how quickly a replacement caregiver will be needed if the scheduled caregiver becomes unavailable. Members must be informed that they have the right to a back-up caregiver within two hours if they choose. Circle member’s choice:</i></p>		
	Needs services within two hours.	
	Needs services today.	
	Needs services within 48 hours.	
	Can wait until next scheduled visit by provider.	
<p>MEMBER HAS BEEN ADVISED THAT S/HE MAY CHANGE THE MEMBER SERVICE PREFERENCE LEVEL AND ALSO HIS/HER BACK-UP PLAN, AS INDICATED BELOW, AT ANY TIME, INCLUDING AT THE TIME OF A GAP*</p>		
<i>Case Manager Initial</i>		<i>Date</i>

If my ALTCS caregiver does not show up to provide services as scheduled, my back-up plan is as follows (check all that apply):

BACK-UP PLAN	NAME	PHONE NUMBER
I will contact my provider agency.		
I will contact my case manager.		
I will contact AHCCCS.	AHCCCS	1-800-218-7509
I prefer to have family or friends provide my care instead of another ALTCS provider/caregiver.	1.	
	2.	
	3.	
	4.	
I can wait until the next scheduled visit from my provider agency to receive authorized care.		
Other:		

- * **A gap in critical services is defined as the difference between the number of hours of critical service scheduled in each individual’s care plan and the hours of the scheduled type of critical service that are actually delivered to the individual.** The following situations are not considered gaps:
- The member is not available to receive the service when the caregiver arrives at the member’s home as scheduled.
 - The member refuses the caregiver when s/he arrives, unless the caregiver is not able to do the assigned duties.
 - The member refuses services.
 - The member’s home is seen as unsafe by the agency/caregiver, so the caregiver refuses to go there.



AHCCCS MEDICAL POLICY MANUAL
ALTCS MEMBER CONTINGENCY/BACK-UP PLAN

MEMBER NAME

AHCCCS ID #

DATE OF PLAN

I understand that I have the right to receive all the services in my care plan to help me with bathing, toileting, dressing, feeding, transferring to or from my bed and wheelchair, and other similar daily activities as needed. These services (Attendant Care, Personal Care, Homemaker and Respite) are called "critical services." I understand that my health plan must make sure that I receive these critical services without delays. I understand that if I do not receive my critical services on time I can call AHCCCS to report the problem so they can assist in replacing my caregiver as soon as possible. I may also call my provider agency or case manager for help. If there is a delay and I do not receive these services on time, my health plan must provide a back-up caregiver within 2 hours of the time they are notified of the gap, unless I specify otherwise at the time of the gap. I understand I also have the right to file a written complaint about the failure to provide such services as scheduled.

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 this. This plan has been reviewed with me and I agree with it. I will keep a copy of this plan.

PLEASE HAVE MEMBER/GUARDIAN/DESIGNATED REPRESENTATIVE SIGN HERE AT TIME OF INITIAL PLAN DEVELOPMENT:

MEMBER/GUARDIAN/DESIGNATED REPRESENTATIVE SIGNATURE

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 a gap may occur. 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.

Please have member/representative sign here to indicate continued agreement with plan at the time of each 90 day service assessment. If the member/representative wishes to make changes to the information in this plan, a new plan must be written. A new plan is required at least once a year.

Date of Review: _____ Member/Guardian/Designated Representative Signature: _____

Date of Review: _____ Member/Guardian/Designated Representative Signature: _____

Date of Review: _____ Member/Guardian/Designated Representative Signature: _____

cc: Member/Guardian/Designated Representative Case File

MEMBER NAME

AHCCCS ID #

DATE OF PLAN

AHCCCS/ALTCS CONTINGENCY PLAN
INSTRUCTIONS

- All ALTCS Contractors must use this standardized form. It may be altered in the ways listed below without AHCCCS approval. All other changes to the form must 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 must be completed by the case manager for all Home and Community Based Service (HCBS) members who receive one or more of the following ALTCS services:
 1. Attendant Care
 2. Personal Care
 3. Homemaker
 4. In-home Respite
- The member must be advised of his/her right to have a back-up on-call caregiver provided in the event an unforeseeable gap occurs.
- The member must be advised of his/her right to change a previously designated Member Service Preference Level at any time, including at the time a gap occurs. The case manager must 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 back-up plan for how the **member chooses** to have his/her needs met in the event the regular caregiver is not available as scheduled. More than one option can be chosen.
- The member/representative should not indicate “I can wait until the next scheduled visit from my provider agency to receive authorized care” in the back-up plan unless the designated Member Service Preference Level is 4 (can wait until next scheduled visit by provider).
- If the member indicates s/he wants 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 must 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 AHCCCS toll-free phone line must be listed. The name and phone number(s) of the member’s provider agency must be listed, including the after-hours number. The case manager’s name and phone number(s) should also be included. The Contractor’s after-hours phone number should be included on this form or made available to members when they call the case manager’s phone number.

MEMBER NAME

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- The member or representative must sign the completed form indicating it has been reviewed with him/her and that s/he is in agreement with it. A copy of the signed plan must be given to the member/representative. **This form must be signed upon initial completion as well as at each 90-day service review if there are no changes to the plan.** If there are changes to any part of the plan, a new plan must be written, signed and a copy left with the member/representative. **A new plan must be written at least once a year.**