ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

DDD-EVV MEMBER CONTINGENCY/BACK-UP PLAN FOR THE INDEPENDENT PROVIDER PROGRAM

Member Name _____ AHCCCS ID # _____ Date of Plan _____

	EVV SERVICES PROVIDED	FREQUENCY	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 must be informed that they have the right to a back-up caregiver within two hours if they choose. Place an X next to members preference:*

☐ Needs services within two hours.

☐ Needs services today.

☐ Needs services within 48 hours.

☐ Can wait until next scheduled visit by provider.

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*

_____ Support Coordinator Initial Date: _____

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 back-up provider agency.		
☐	I will contact my Support Coordinator		
☐	I will contact DDD.	DDD	1-844-770-9500
☐	I prefer to have family or friends provide my care instead of another ALTCS provider/caregiver. (name and phone number)	1.	
		2.	
		3.	
		4.	
☐	I can wait until the next scheduled visit from my ALTCS caregiver to receive authorized care.		
☐	Other:		

See page 2 for EOE/ADA disclosures

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*** A gap in EVV 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.

CONTINGENCY/BACK-UP PLAN FOR THE INDEPENDENT PROVIDER PROGRAM

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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, Habilitation, Homemaker and Respite) are called EVV I understand that my health plan must make sure that I receive these DDD services without delays. I understand that if I do not receive my EVV services on time I can call DDD to report the problem so they can assist in replacing my caregiver as soon as possible. I may also call my Support Coordinator 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 Support Coordinator. This plan has been reviewed with me and I agree with it. I will keep a copy of this plan.

HAVE MEMBER/RESPONSIBLE PERSON SIGN HERE AT TIME OF INITIAL PLAN DEVELOPMENT:

Member/Responsible Person _____ Date _____

Relationship to Member _____ Date _____

QUARTERLY VISIT

This plan was reviewed with me by the Support Coordinator 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 Support Coordinator 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/representative sign here to indicate continued agreement with plan at the time of each 90 day service assessment. If the member/Responsible Person 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/Responsible Person Signature: _____

Date of Review: _____ Member/Responsible Person Signature: _____

Date of Review: _____ Member/Responsible Person Signature: _____

cc: Member/Responsible Person
Case File

CONTINGENCY/BACK-UP PLAN FOR THE INDEPENDENT PROVIDER PROGRAM

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DDD INDEPENDENT PROVIDER CONTINGENCY PLAN INSTRUCTIONS

- This form must be completed by the Support Coordinator for all Home and Community Based Service (HCBS) members who receive one or more of the following ALTCS services:

  1. Attendant Care
  2. Habilitation Hourly
  3. Habilitation Independent
  4. Homemaker
  5. 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 DDD toll-free phone line must be listed. The Support Coordinator's name and phone number(s) should also be included.
- The member or Responsible Person 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/Responsible Person. **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/Responsible Person. **A new plan must be written at least once a year.**