MEMBER NAME	*AHCCCS ID #*	*DATE OF PLAN*

SERVICES PROVIDED		FREQUENCY	PREFERENCE LEVEL
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 Preference Level letter (A, B, C, etc.) on the corresponding service Preference Level line:*

A	Must be rescheduled within two hours of originally scheduled start time.		
B	Must be rescheduled within 24 hours of originally scheduled start time.		
C	Must be rescheduled within 48 hours of originally scheduled start time.		
D	Will be performed at the next scheduled visit.		
E	Will be performed by a non-paid caregiver.	Name:	Phone Number:
		Name:	Phone Number:
		Name:	Phone Number:

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 THE CAREGIVER IS LATE OR DOES NOT SHOW UP*

Provider Initial	*Date*

If my 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. My provider agency will answer my call or get back to me in 15 minutes.		
☐	If my provider agency doesn't respond in 15 minutes, I will contact Sandata EVV.		
☐	In the case of a life-threatening emergency, I will contact 9-1-1.		

OPEN UNTIL 01/01/21

Effective Date: 01/01/21
Approval Date: 11/19/20

______________________	______________________	______________________
MEMBER NAME	*AHCCCS ID #*	*DATE OF PLAN*

I understand that if I do not receive my critical services on time I can call the Agency or Sandata to report the problem so they can assist in replacing my caregiver as soon as possible. I understand I also have the right to file a written complaint about the failure to provide 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 or provider this. This plan has been reviewed with me and I agree with it. I will keep a copy of this plan. I understand I will talk with my provider at least once a year about my plan but I can change it at any time.

PLEASE HAVE MEMBER/HEALTH CARE DECISION MAKER SIGN HERE AT TIME OF INITIAL PLAN DEVELOPMENT:

____ ______________________

MEMBER/HEALTH CARE DECISION MAKER SIGNATURE *DATE*

____ ______________________

MEMBER/HEALTH CARE DECISION MAKER PRINTED NAME *DATE*

____

RELATIONSHIP TO MEMBER

OPEN UNTIL 01/04/21