



# Community Choices Waiver (CCW) Participant Directed Services Back-up Plan Template

**In the event services cannot be provided by the Primary Direct Service Worker (DSW), the following back-up plan will be put in place.**

**Participant Information:**

**Participant's Name:** \_\_\_\_\_

**Authorized Representative\* Name:** \_\_\_\_\_  
*(if applicable)*

*\*An Authorized Representative (aka Employer of Record) is an individual who has been approved by the Community Choices Waiver program to direct the plan of care on behalf of the Participant.*

**Back-up Coverage Provider Information:**

Please, check **one box** and fill in the Back-up's information.

- Enrolled DSW                       Natural Support Person (i.e. family/friend/neighbor - *unpaid* provider)

|                                   |               |                      |  |
|-----------------------------------|---------------|----------------------|--|
| <b>Back-up's Name:</b>            |               | <b>Relationship:</b> |  |
| <b>Address:</b>                   |               |                      |  |
| <b>City:</b>                      | <b>State:</b> | <b>Zip Code:</b>     |  |
| <b>Phone Number:</b>              |               |                      |  |
| <b>ACES\$ Start Date (if DSW)</b> |               |                      |  |

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| <b>Phone Number:</b>              |               |                      |  |
| <b>ACES\$ Start Date (if DSW)</b> |               |                      |  |

**Attestation of Participant and Case Manager Responsibilities:**

I understand and agree with the Back-up Coverage Plan listed above in the event services cannot be provided by the Primary Direct Service Worker for the above-named Participant, of the CCW Participant Directed Services option. Services to the Participant, as identified on the Participant Profile (PDO-3), will be provided by the designated Back-Up Coverage Provider as indicated on this plan. I understand that a copy of the Participant Profile must be provided in accordance with the Participant's approved and authorized waiver Plan of Care (POC). If at any time, a change is required to the Back-up plan the Participant or their Authorized Representative (aka Employer of Record), will notify the Case Manager within \_\_\_\_\_ days.

I understand I have the choice to have my plan of care switched to agency option or elect to no longer receive waiver services in the event neither my primary DSW nor designated back-up can provide services. If I choose to no longer receive waiver services, please provide a written and signed statement to your case manager indicating you are choosing to close your waiver case and end services. I also agree and understand that my Case Manager and I will review this plan at each monthly visit to ensure that it is still acceptable.

**Case Manager Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Participant's Signature\*:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*Authorized Representative's signature (if applicable)