



**ADvantage Program
SERVICES BACKUP PLAN**

Member last name	First name	Middle initial	Medicaid number
Street address			
City	County	State OK	Zip

NOTE: The case manager uses this form when assisting the member with the development of a backup plan in the event essential services are unavailable from the designated provider. Use this form to describe the essential tasks, expectations, and scheduling requirements as appropriate that correspond to the services addressed in the service plan goals.

List specific tasks related to each section. If more than one designated backup is needed to perform more than one designated task, list individually under "Other."

Direct care assistance:		
Backup	Name of designated backup	Phone number
First		
Second		
Third		

Critical health and supportive services: (Life and health threatening conditions always default to 911 or emergency services.)		
Backup	Name of designated backup	Phone number
First		
Second		
Third		

Member initials	Date
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Member last name	First name	Middle initial	Medicaid number
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Equipment repair or replacement:

Backup	Name of designated backup	Phone number
First		
Second		
Third		

Other: (include plan for essential services not listed above)

Backup	Name of designated backup	Phone number
First		
Second		
Third		

Other: (include plan for essential services not listed above)

Backup	Name of designated backup	Phone number
First		
Second		
Third		

Member agrees to backup plan

Yes

No

 Signature of member or legal agent Date
If member signs with a mark, two witnesses are required

 Witness signature Date _____
 Witness signature Date

 Case manager name (print or type) Case management agency name

 Case manager signature Date