

### Provider Agency Model Service Backup Plan

Name of Individual	Program <input type="checkbox"/> Community Living Assistance and Support Services (CLASS) <input type="checkbox"/> Deaf Blind with Multiple Disabilities (DBMD) <input type="checkbox"/> Community First Choice (CFC)	Service
Case Management Agency	Direct Services Agency	DBMD Provider Agency

Type of Service Backup Plan	Date of Service Planning Team Meeting	Effective Date of Service Backup Plan
<input type="checkbox"/> Enrollment/Renewal Backup Plan <input type="checkbox"/> Revision to Backup Plan		

Backup Plan Strategies and Sequence	Specific Action(s) to be Taken in Absence of Service Delivery	Resource Person, Area Code and Telephone No.
1.		Signature of Backup Service Provider
2.		Signature of Backup Service Provider
3.		Signature of Backup Service Provider
4.		Signature of Backup Service Provider
5.		Signature of Backup Service Provider
6.		Signature of Backup Service Provider

#### Plan Approval Signatures:

Individual/Legally Authorized Representative	Date	Service Planning Team Member/Title	Date
Provider Agency Representative	Date	Service Planning Team Member/Title	Date
Case Manager	Date	Service Planning Team Member/Title	Date