STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
CBAS TEMPORARY ALTERNATIVE SERVICES (TAS) PLAN OF OPERATION
CDA 7012 (NEW 04/2020)

Section I – Provider Information	
NPI:	Date:
Center Name:	
Center Address:	
Provider Name (Licensee):	
Responsible Party (Primary Contact) Name/Title: Contact Phone (must be reachable outside center service hours): Contact Email:	
Responsible Party (Secondary Contact) Name/Title: Contact Phone (must be reachable outside center service hours): Contact Email:	
Section II – Participant Information	
a. Number of enrolled participants on March 1, 2020:	
b. Number of participants to be served by CBAS TAS as of date of form completion:	
c. Number of participants discharged since March 1, 2020:	
Section III – Staffing Information	
Attach updated Staffing Services Arrangement (ADH 0006) (Rev 04/20) form indicating planned staff levels for CBAS TAS. *Providers must staff CBAS TAS with a 1) Program Director; 2) Registered Nurse(s); and 3) Social Worker(s) to carry out CBAS TAS tasks.* *Providers must have additional staff as needed to address the number of participants served and their identified needs and to assist in the delivery of services required for CBAS TAS participation, and as described in the provider's CDA approved CBAS TAS Plan of Operation. All staff must function within their scope of practice, qualifications, and abilities.*	

Section IV – Temporary Alternative Services to be Provided

Services provided under CBAS TAS should be person-centered; based on the assessed health needs and conditions identified in the participants' current Individual Plans of Care (IPC); identified through subsequent assessments; and noted in the health record.

*In addition to the in-person, telephonic, and telehealth services that may be provided as outlined in ACL 20-06, **all CBAS TAS providers are required to do the following**:*

1. *Maintain phone and email access for participant and family support, to be staffed a minimum of 6 hours daily, during provider-defined hours of services, Monday through Friday. The provider-defined hours are to be specified in the CBAS Center's plan of operation.*
2. *Provide a minimum of one service to the participant or their caregiver for each authorized day billed. This service could include a telehealth (e.g., telephone, live video conferencing, written communication via text or email) contact, a service provided on behalf of the participant (Services provided on behalf of the participant include care coordination such as those listed under Items 4, 5, 6, and 7), or an in-person "door-step" brief well check conducted when the provider is delivering food, medicine, activity packets, etc.*
3. *Conduct a COVID-19 wellness check and risk assessment for COVID-19 at least once a week, with greater frequency as needed.*
4. *Assess participants' and caregivers' current needs related to known health status and conditions, as well as emerging needs that the participant or caregiver is reporting.*
5. *Respond to needs and outcomes through targeted interventions and evaluate outcomes.*
6. *Communicate and coordinate with participants' networks of care supports based on identified and assessed need.*
7. *Arrange for delivery or deliver supplies based on assessed need, including, but not limited to, food items, hygiene products, and medical supplies. If needs cannot be addressed, staff will document efforts and reasons why needs could not be addressed.*

a. **Narrative Description:** Please provide a brief narrative description of your proposed plan for operating CBAS TAS, including which staff will provide the array of services to be offered:

b. **Telephonic and Email Access (Hours of Service) & Center Contact Information:**

Hours of Telephonic Access (Hours of Service):

Center Phone:

Center Email:

c. **Date when Center Suspended In-Center Operations:**

d. **Date when Center Began/Or Plans to Begin Alternative Services:**

e. **Do you plan to provide doorstep services?**

☐ Yes ☐ No ☐ Undetermined at this time If yes, or undetermined, describe briefly.

f. **Do you plan to provide individual services in the center?**

☐ Yes ☐ No ☐ Undetermined at this time If yes, or undetermined, describe briefly.

g. **Do you plan to provide individual services in the home?**

☐ Yes ☐ No ☐ Undetermined at this time If yes, or undetermined, describe briefly.

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Approved: ☐ Yes ☐ No

Signature/Title of CDA Representative	Date