

COMMUNITY SUPPORT PLAN ADDITION/CHANGE

Plan Year: \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_

Consumer Name: \_\_\_\_\_ DOB: \_\_\_-\_\_\_-\_\_\_

PMI# \_\_\_\_\_ Case Manager: \_\_\_\_\_

- 1. What is the requested item/service, and how will this help achieve the outcome (CCT Waiver only) or habilitation (DD Waiver only) listed in the Consumer’s Support Plan (CSP or ISP)? Please attach description or picture of items or services, if unclear. Provide recommendation from medical professional, when required. Please describe how it/they relate to a person’s disability/condition.

---



---



---



---



---

- 2. What expenditure category is it in:
  - \_\_\_\_\_ Personal Supports
  - \_\_\_\_\_ Treatment and Training
  - \_\_\_\_\_ Environmental Modifications and Provisions
  - \_\_\_\_\_ Self-Direction Support Activities

- 3. What is the cost of the item/service and from what category is the funding being moved?

---

I am requesting the above change(s) to my Community Support Plan.

\_\_\_\_\_  
 Consumer/Parent/Legal Representative Date  
*A signature on a faxed or scanned document constitutes an original signature for the purposes of this program.*

-----  
 Date Reviewed by Waiver Advisory Committee or Case Manager: \_\_\_\_\_ Initials \_\_\_\_\_

- \_\_\_ Approved
- \_\_\_ Approved with changes: \_\_\_\_\_
- \_\_\_ Pending. Need additional information, before decision can be made
  - \_\_\_ Need specific information on requested item
  - \_\_\_ Need specific information on relationship to his/her disability and/or condition
  - \_\_\_ Other: \_\_\_\_\_
- \_\_\_ Denied. Reason: \_\_\_\_\_