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: _____