SERVICE PLAN ADDENDUM

Last Name	**First Name**	**Service Level**_____ **Range of HRs**_____ **Medicaid #** _____
☐		
Service Plan period of _____ **DATE:** _____		
Reason for Addendum: ___ **Change in Need(s)/Services** ___ **Service Level Change** ___ **Dual Services Request** ___ **Transfer** ___ **Other**		
Complete this section to justify Reason, above. Initial, six month and annual plan requires completion of entire Service Plan.		
Describe how the members' needs have changed.		
Describe any changes in services.		

Dual Services Request	
Transfer	
Other	

Case Manager Signature _____ Date _____

Member/ Legal Representative Signature_____ Date _____

Copy sent to Personal Attendant Agency on _____

Copy sent to Member/Legal Representative on _____