Support and Spending Plan Change #________ Authorization
Date of Plan Change: _____________
Support and Spending Plan Change Authorization

Individual's Name: __________

Medicaid ID # ________________

"ADD" Total:--------------------------$ ____

"DELETE" Total + "REDUCE" Total - $

Budget dollars requested---------- = $

Plan Start Date:
From _______to _________DOB: _________

Plan Approved By:

____
Regional Medicaid Services Signature

Total Annual Medicaid Budget:
$________________________
Prior Approved Budget Amount as of: _______
$______________________________
Additional Budget Dollars Approved: $_______

ADD:

Service, task or good	**Type of Support** ☑ only one box	**Cost**
	☐ Personal ☐ Emotional Job ☐ Skilled Nursing ☐ Transportation ☐ Relationship ☐ Learning ☐ Adaptive Equipment	$

TOTAL: $

DELETE:

Service, task or good	Type of Support ☑ only one box	Cost
	☐ Personal ☐ Job ☐ Transportation ☐ Learning Emotional ☐ Skilled Nursing ☐ Relationship ☐ Adaptive Equipment	$

TOTAL: $

REDUCE:

Service, task or good	Type of Support ☑ only one box	Cost
	Personal ☐ Job ☐ Transportation ☐ Learning ☐ Emotional ☐ Skilled Nursing ☐ Relationship ☐ Adaptive Equipment	$

TOTAL: $

Participant Signature ______________________ Date: ______________

Legal Guardian (if applicable) ______________________ Date: ______________