IDAHO DEPARTMENT OF HEALTH & WELFARE

Bureau of Developmental Disability Services
Individual Support Plan

Authorized by:_____
Date:_____

EXAMPLE

Supports and Services Addendum Worksheet

Participant Name/Address/Phone:	Sally Jones 001 Main St. Anytown, ID 80000 (208) 123-4567	**Medicaid ID #**	XXXXXXX
Guardian Name/Address/Phone/Email:	Nancy Jones 002 West St. Anytown ID 80000 (208) 000-5555	**ISP Start Date:**	8/1/2014
If this addendum is for a change of participant/guardian demographic information ONLY, add new information above.			
Plan Developer Agency/Name/Phone/Email:	Susie Planwriter XYZ Service Coordination (208) 901-2345 sp@tsc.com		
Provider Requesting Addendum:	Nancy Jones	**Date requested:**	8/16/2014
Reason for Addendum Request:	Sally would like to increase her comm DT hours, stop her center DT hours , and add CFH services		
DD Waiver: ☑	**A&D/DD State Plan:** ☐	**DD State Plan:** ☐	**MMCP:** ☐

Provider Name	*Procedure Code*	*Start Date*	*Stop Date*	*Units*	*Unit Cost*	*Frequency (x365, x52, x12, etc.)*	*Annual Cost*	*Annual Units*	*IPA #- fpr Dept. use only*
EFG Developmental (DT)	97537	09/01/14	07/31/14	10	$3.34	48	$1,603.20	480	
EFG Developmental (DT)	H2032		08/31/14	-20	$3.02	48	-$2,899.20	-960	
Mary Smith (CFH)	S5140	09/01/14	07/31/14	1	$53.39	334	$17,832.26	334	
							$0.00	0	
							$0.00	0	
							$0.00	0	
							$0.00	0	

Authorized by:_____
Date:_____

EXAMPLE

							$0.00	0	
							$0.00	0	

Addendum Sub-Total	$16,536.26
Previous Annual Plan Total	$32,000.00
Calculated Budget Amount	$50,000.00
New Medicaid Annual Total	**$48,536.26**

Participant Signature/Date

Guardian Signature (if applicable)/Date

Plan Developer Signature Acknowledgment/Date

For Participants enrolled in Medicare-Medicaid Coordinated Plan (MMCP), this signature is required to ensure no duplication or contraindicated services.

ICT Care Coordinator Signature Date