AGED AND DISABLED WAIVER

SERVICE PLAN ADDENDUM

Last Name	**First Name**	**Service Level_____** **Range of HRs_____** **Medicaid #**
☐ **CHANGE IN NEED for Service Plan period of _____ DATE: _____**		
Complete this section for change in need only. Initial, six month and annual plan requires completion of entire Service Plan.		
Describe how the members needs have changed.		
Describe any changes in services.		
Other		

_____ _____

Case Manager Signature Date

_____ _____

Member/ Legal Representative Signature Date

Copy sent to Personal Assistance/Homemaker Agency on _____

Copy sent to Member/Legal Representative on _____