DD-224-PF (2-08)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities
INDIVIDUAL SUPPORT PLAN (ISP)

CHANGES IN THE ISP

INDIVIDUAL'S NAME *(Last, First, M.I.)*	DATE

Use this form to describe and document changes in the annual ISP.

TYPE OF CHANGE(S)

- ☐ New objective/Outcome
- ☐ Discontinue objective/outcome
- ☐ Revised objective/outcome
- ☐ Change Team Agreement/Assignment
- ☐ Other *(Specify):* _____

Service Plan Change: The responsible person must initial one of the Service Plan Acknowledgement Statements.

- ☐ Add new service *(include frequency and duration)*
- ☐ Reduce frequency of current service
- ☐ Terminate a service
- ☐ Assessment needed

DESCRIPTION OF CHANGE(S)

Use the space below to describe the specific change(s) being made, e.g., list new objective or the service and units to be provided.

REASON FOR CHANGE(S)

PRINT NAME OF PERSON SUBMITTING CHANGE	SIGNATURE OF PERSON SUBMITTING CHANGE	DATE

PRINT NAME OF SUPPORT COORDINATOR	SUPPORT COORDINATOR'S SIGNATURE	PHONE NO.	DATE

Service Plan Acknowledgement: The Service Plan has been reviewed with me by my Support Coordinator. I understand what services will be provided to me and at what frequency. I understand that service decisions may require further approval, subject to ALTCS requirements or state funding.

*Please initial **ONE** of the following statements:*

_____I am in agreement with the Service Plan and service(s) that have been authorized in this plan. If I need more of the service(s) or other services, I will contact my Support Coordinator at _____, to discuss those changes.

_____I understand that my Support Coordinator will contact me within 14 calendar days of my request to discuss those changes.

_____I do not agree with the Service Plan and service(s) that have been authorized in this plan. I understand that my Support Coordinator will send me a letter to explain why the service(s) I requested was denied, reduced, suspended or terminated. That letter will tell me how to appeal the decision that has been made about my service(s).

PRINT NAME OF CONSUMER/RESPONSIBLE PERSON	SIGNATURE OF CONSUMER/RESPONSIBLE PERSON	DATE

Routing: **Copy** - Support Coordinator File, **Copy** – Consumer/Responsible Person, Copy - Provider

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