

Office of Developmental Programs Agreement to Change(s) in Waiver Services

Waiver Participant Name: _____ Telephone: _____

Address: _____

I hereby agree to the following change(s) to my individual support plan of care for the Person/Family Directed Support Waiver or Consolidated Waiver.

Effective Date
of Change(s)

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of Change(s)

- Assistive Technology**
- Behavioral Support**
- Companion**
- Day Services**
 - Licensed Day Habilitation – ATF
 - Licensed Day Habilitation – OADLC
 - Prevocational Service
- Employment Services**
 - Supported Employment
 - Transitional Work
- Education Support Services**
- Home Accessibility Adaptations**
- Home and Community Habilitation (Unlicensed)**
- Homemaker/Chore Services**
- Nursing Services**
- Respite Services (Waiver Funded only)**
 - In-Home Respite
 - Licensed Out-of-Home Respite
 - Respite Camp
 - Unlicensed Out-of-Home Respite

- Residential Habilitation Services**
 - Child Residential Svcs (licensed)
 - Community Residential Rehabilitation Svcs for the Mentally Ill (licensed)
 - Family Living Home Svcs (licensed)
 - Community Home Svcs (licensed)
 - Community Home Svcs (unlicensed)
 - Family Living Home Svcs (unlicensed)
 - Supplemental Habilitation (SH)[†]
 - Additional Individualized Staffing (AIS)[†]
- Specialized Supplies**
- Supports Broker Service**
- Supports Coordination (Waiver Funded)**
- Therapy Services**
 - Behavioral Therapy
 - Occupational Therapy
 - Physical Therapy
 - Speech & Language Therapy
 - Visual/Mobility Therapy
- Transportation Services**
 - Public Transportation
 - Transportation – Mile
 - Transportation – Per Diem
 - Transportation – Trip
- Vehicle Accessibility Adaptations**

[†] Available in licensed Residential Habilitation settings with Consolidated Waiver Funding only. Prior authorization from ODP applies.

Specific Change(s):

- I was offered a choice of providers. I was not offered a choice of providers.
- I hereby agree to the following change(s) to my individual support plan of care for the Person/Family Directed Support Waiver or Consolidated Waiver.
- I have received my rights to a Fair Hearing.

This agreement is made with the understanding that I have the right to request a change in these services at any time. I have the right to a meeting with the Administrative Entity, or ODP (SH/AIS only), or to request a fair hearing and appeal if services are reduced, terminated or suspended.

Signed: _____
Signature of Waiver Participant or Surrogate Date Signature of Supports Coordinator Date



BACKGROUND: This form replaces the **Consent to Reduction, Suspension or Termination of Services Under the 2176 Waiver Program** form, which was distributed as Attachment 4 with Bulletin No. 99-87-08, **Revised Fair Hearing Procedures Related to Services Under 2176 Waiver Program**.

PURPOSE: This Office of Developmental Programs form is intended to be used, completed, and signed by the individual or surrogate during the Individual Support Plan, or ISP, meetings. By signing the DP 1027, the individual or surrogate agrees to the change(s) to waiver services that are made to the ISP and documented on the DP 1027 form. The individual or surrogate signature does not limit the right of the individual to request a change in these services at any time. The individual or surrogate is afforded due process rights each time services are discussed.

INSTRUCTIONS TO COMPLETE THE “AGREEMENT TO CHANGE(S) IN WAIVER SERVICES” FORM, DP 1027

- STEP 1: Enter the “Waiver Participant Name,” “Telephone,” and “Address” in the spaces provided.
- STEP 2: Check the box or boxes next to all of the service(s) to be changed. The boxes are located before the service name of each service listed. Enter the “Effective Date(s) of Changes” for each of the service change(s) in the space(s) provided.
- STEP 3: In the space directly under the section titled “Specific Changes,” the Supports Coordinator, or SC, should enter the detailed changes that the individual agrees to have made to their waiver services.
- STEP 4: The individual or surrogate should check the box next to one of the two phrases, “I was offered a choice of providers,” or “I was not offered a choice of providers.” By checking one of the boxes, the individual or surrogate affirms that a choice of providers was or was not offered.
- STEP 5: The individual or surrogate should check the box next to the phrase, “I have received my rights to a Fair Hearing,” once the individual or surrogate has received this information. Also by checking this box:
- The individual or surrogate understands that they may request a change in services at any time.
 - The individual or surrogate acknowledges their understanding of the right to meet with the Administrative Entity, or with ODP, and to request a fair hearing and appeal if services are reduced, terminated or suspended.
- STEP 6: The individual or surrogate should sign the form in the area located at the bottom titled, “Signature of Waiver Participant or Surrogate,” and also enter a date in the space provided. By signing and dating the DP 1027, the individual or surrogate attests that they agree to the Waiver service changes made to the ISP.
- STEP 7: The SC should also sign and date the DP 1027 in the space provided. The SC’s signature and date attests that the SC witnessed the individual or surrogate sign and date the DP 1027.

PLEASE NOTE:

Each service name listed on the DP 1027 corresponds to the waiver services found in the **Service Definitions Narrative for the Consolidated Waiver, Person/Family Directed Support Waiver, Administrative Services, and Base-Funded Services**, which is Attachment 1 to Bulletin No. 00-10-07, entitled **Service Definitions for the Pennsylvania Mental Retardation Program**.