

Name:	Date:			
Names of all involved in the planning discussion:				
Date of planning meeting to discuss the change:				
Effective date of change: Agenc	y:			
Due date: This form must be filled out and sent to each individual and their guardian by June 15, 2020.				

Part 1 – ISA, COVID-19 Change Form

1. Please describe the change, specifically:

What are the changes in funded service areas? Please describe the changes made by service type and expected frequency (i.e. daily, weekly, monthly, range of expected hours). Common examples include reduction, temporary suspension and/or conversion of respite, community supports, and employment supports into service coordination and home supports. Example of expected documentation-

"John's respite was suspended, and community support hours are being reduced due to the COVID emergency. Rather than 15 hours of in person supports, John will be receiving 4-6 hours of remote support via telehealth. His case manager will increase contact with John, the home provider and team during the emergency."

	-	ges to the individual's C w Outcomes developed,	Dutcomes? (e.g. which Outcomes are , etc.)	
	Reminder that no work changes.	vaiver rate adjustment fo	orm needs to be submitted for these	
		•	provide COVID Emergency Flexibility Relief Options to parents.	
2.	Indications of approval for the change: (Describe specifically in what form approval was obtained, verbally, head nod, thumbs up, etc.) When period of quarantine ends, approval in the form that is typical for the individual and other approvers needs to be obtained.			
	Individual	Date	Agency providing services	
	Guardian (If the individual has one)			
	QDDP	Date	Physician (Required only for clinic rehabilitation, transportation, & ICF/DD)	

Reminder- individuals retain their right to appeal decisions impacting benefit levels.

Part 2 – ISA, COVID-19 Change Form

1.	Describe the Pe	erson-Centered	Process to r	return to pre	vious ISA	&
	Outcomes.					

Names of all involved in the planning discussion:			
Date of planning meeting to discuss the change:			
Effective date of c	hange:		
approval was ob	tained, verbally, head not approval in the form that	: (Describe specifically in what form d, thumbs up, etc.) When period of is typical for the individual and other	
Individual	Date	Agency providing services	
Guardian (If the in	dividual has one)		
QDDP	Date	Physician (Required only for clinic rehabilitation, transportation, & ICF/DD)	

Reminder- individuals retain their right to appeal decisions impacting benefit levels.