\*\*\* Change forms need to be submitted 30 days prior to the end of the approved CDCS CSP.

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| **Name:**  |  | **PMI:** |  |
| **County:**  |  | **CDCS date span:** |  |
| **Case manager:** |  | **FMS email:** |  |

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| **Summary of request:** |
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| **Goals related to each item/ service:** |
| **Need:** | **Intervention:** | **Measurable outcome:** |
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| **Expense category: Training & Treatment, Environmental, self-directed services** | **Item/ service being requested** | **Cost of item/ service:** | **Transferring from expense & amount:** |
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| **Additional staffing request** |
| **Staffing:** | **Current approved hours:** | **Proposed hours:** |  **Transferring from expense & amount:** |
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| **Client/ managing party signature** | **Date** | **Case manager signature** | **Date** |

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| **County decision & justification:** |
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