Spending Plan Adjustment Form

Date: _____

Person: _____ **MHWIN#** _____

FMS: _____

The expense report on _____currently has _____(list surplus) in the individual budget. By using the Person-Centered Planning process, I would like to add: (list the items and estimated costs).

_____

_____

_____

_____

This information is in the Periodic Review or Addendum dated and signed:

Goal #: _____ Objective: _____

I understand any use of my individual budget must meet Medicaid requirements of being the most cost effective manner to reasonably meet the intended outcome (goal) identified in the Individual Plan of Service (IPOS). To ensure contractual requirements, DWIHN and the person must agree the item meets Medicaid requirements of medical necessity, is equitable, fiscally responsible, and is a wise use of public funds. Medicaid is the payor of last resort and all other sources must be exhausted first. All Medicaid regulations regarding documentation apply for purchases and will be reviewed by the Support Coordinator. If DWIHN does not view the change as meeting Medicaid guidelines, Grievance rights will be provided within 14 days of the receipt of the request.

Member/Legal Representative Signature: _____ Date: _____

Please email to selfdetermination@dwihn.org.

☐ Medicaid requirements for medical necessity met, approved (budget adjusted)

☐ Does not meet the Medicaid Manual's requirements for medical necessity

☐ Need more information: _____

DWIHN Signature: _____ Date: _____