GOVERNMENT OF THE
DISTRICT OF COLUMBIA
DEPT OF HEALTH CARE FINANCE
LONG-TERM CARE ADMINISTRATION

Services My Way

JUSTIFICATION FOR PDS BUDGET MODIFICATION REQUEST

Participant Name: ______________________________________

Participant Medicaid ID Number: ________________________

Participant Phone Number: ______________________________

Authorized Representative Name (*if applicable*)**:** _____________________________________

Authorized Representative Phone Number (*if applicable*)**:** ____________________________

Support Broker Name: __________________________________

Support Broker Phone Number: ___________________________

Date of Request for PDS Modification ________/_________/_________

Proposed Effective Date for PDS Modification(s) ________/_________/_________

I. Reason(s) for Request for PDS Budget Modification (*Check one*)

☐ Reassessment ☐ Reallocation of PDS Budget Funds

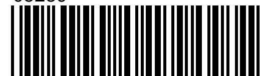
II. Description of Proposed PDS Budget Modification(s) (*Please complete and attach the revised PDS Budget Form to this document.*)

III. If the Request for PDS Budget Modification is for a Reallocation of the Participant's Current PDS Budget Funds, Please Complete the Following Assurance Statement.

I, _________________________________ (*Participant*), request a modification to my current PDS Budget effective _____________________ (*Effective Date of Current PDS Budget*).

This modification reallocates Medicaid PDS funds from __________________________ *(PDS Budget Component)* to __________________________ (*PDS Budget Component*)

I assure that this reallocation of my PDS budget funds does not result in an increase in the amount of total Medicaid funds included in my PDS current budget.



IV. Signatures

______________________________________ ________________
Signature of Participant *Date*

______________________________________ ________________
Signature of Authorized Representative (if applicable) *Date*

______________________________________ ________________
Signature of Support Broker *Date*