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