Texas Department of Aging
and Disability Services

Form 2306
June 2012-E

In-Home and Family Support Program

Service Plan

Date of Contact:

Certification/Recertification	Six-Month Review	Service Plan Change

I. Individual Information

Individual Name (Last, First, MI)

Type of Service Plan

☐ Certification/Recertification ☐ Six-Month Review ☐ Service Plan Change

Case Manager Name

Residency Verification

II. Service Plan

Will a grant be issued? ☐ Yes ☐ No

	Initial/Annual	Six-Month	Plan Change		Initial/Annual	Six-Month	Plan Change
Subsidy				Amount in spend down			
Capital				Amount of repayment			
Total				☐ No additional funds needed for the last six months of certification period.			

III. Approved Items and Services *(See Page 2 to document additional items/services.)*

Subsidy Item/Capital Expenditure	Estimate	Source of Estimate

If on spend down: Spend-down begin date _____ Spend-down end date _____

☐ No changes to the service plan. Approved items listed in Section III will continue for the last six months of the certification period.

IV. Certification/Recertification Dates

Select one of the following:

☐ Individual is certified/recertified as financially and functionally eligible effective: _____ Receipts due: _____

☐ Spend Down/Repayment Begin Date: _____ Receipts/repayment due: _____

Approved Items and Services *(continued from Section III on Page 1)*

Subsidy Item/Capital Expenditure	Estimate	Source of Estimate

V. Signatures

Certification/Recertification		Six-Month Review		Plan Change	
Signature - Case Manager	Date	Signature - Case Manager	Date	Signature - Case Manager	Date