<DATE>

<Member Name>

<Member Address>

<City, State, Zip Code>

Dear <Member Name>,

During our recent conversation, you said you would like a . Your documents have been updated to reflect this change. Along with this letter please find a copy of your updated support plan that reflects the change(s).

We discussed the requirement and purpose of sharing your support plan information and support instructions with the provider(s). Per our discussion you have chosen to .

Please sign and return the last page (My Signature) of the attached support plan to indicate you agree with the change(s). If you have any questions, you can contact me at the number listed below.

Sincerely,

<Care Coordinator Name, Title>

Blue Plus Care Coordinator

<Name of County/Clinic/Organization>

<CC phone number>

DHS\_111324\_O02 DHS Approved 11/13/2024