|  |  |
| --- | --- |
| Consumer Name and Address: | Counselor Name: |
|  |  |
|  |  |
| Counselor Phone: Check if TDD |
| Counselor Email: |
|  |  |

# Plan Number Amendment Number

As we agreed the following changes have been made to the services in my Individualized Plan for Employment:

|  |  |  |
| --- | --- | --- |
| **Addition** | **Change** | **Deletion** |
| **Service Provided Date** | **Service Provider** | **Funded By Start** |
|  |  |  |

# Amendment Reason:

|  |  |  |  |
| --- | --- | --- | --- |
| **Addition** | **Change** | **Deletion** |  |
| **Service Provided** | **Service Provider** | **Funded By** | **Start** |
| **Date** |  |  |  |
|  |  |  |  |

# Amendment Reason:

These changes to your Individualized Plan for Employment are consistent with your informed choice.

By signing below, I understand that this Plan Amendment is effective on the date upon which both the Rehabilitation Counselor and I sign the document. If the two signatures bear different dates, the later date will be the effective date of the Plan Amendment.

*For more information, see CCR, title 9, section 7131(a)(6) at* [*http://oal.ca.gov.*](http://oal.ca.gov/)

|  |  |
| --- | --- |
| Consumer Signature:   | Date Signed: |
| Parent/Guardian/Representative Signature (if needed):   | Date Signed: |
| Rehabilitation Counselor Signature:   | Date Signed: |

Attachment – DR 1000 RIGHTS AND REMEDIES