State of Vermont

Department of Disabilities, Aging & Independent Living

**Agency Accessibility Modification Plan**

**And**

**Request for Modification Reimbursement**

**Attachment**

This is a supplement form for Agency Accessibility Modification Plan and Request for Modification Reimbursement, when additional space for listing Assessment items is needed.

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| PARTICIPANTS NAME: | Click or tap here to enter text. |
| ADDRESS: | Click or tap here to enter text. |
| AGENCY NAME: | Click or tap here to enter text. |
| ASSESSMENT IDENTIFICATION NUMBER (AID): | Click or tap here to enter text. |

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| Assessment Item Number (AI) | Click or tap here to enter text. |
| Description of Modification | Click or tap here to enter text. |
| Planned Date of Completion | Click or tap to enter a date. |
| Plan of action | Click or tap here to enter text. |
| Actions Taken or Comments  | Click or tap here to enter text. |
| Modification Cost | Click or tap here to enter text. |
| Requesting Cost Reimbursement |  [ ]  Yes [ ]  No |

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| PARTICPANTS NAME: | Click or tap here to enter text. |
| ASSESSMENT IDENTIFICATION NUMBER (AID): | Click or tap here to enter text. |

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| Modification Cost | Click or tap here to enter text. |
| Requesting Cost Reimbursement |  [ ]  Yes [ ]  No |

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| Modification Cost | Click or tap here to enter text. |
| Requesting Cost Reimbursement |  [ ]  Yes [ ]  No |

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| Actions Taken or Comments  | Click or tap here to enter text. |
| Modification Cost | Click or tap here to enter text. |
| Requesting Cost Reimbursement |  [ ]  Yes [ ]  No |
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| Requesting Cost Reimbursement |  [ ]  Yes [ ]  No |