



agency for persons with disabilities
State of Florida

Agency for Persons with Disabilities Request for Annual Support Plan Extension

TO:						
FROM:						
DATE:						
Area/ Region:						
Customer Name:						
Current annual Support Plan Date:						
Extension Requested for:		30 days		60 days		90 days, or
Other (Specify):						
Justification for Extension:						
APD Authorizing Signature:					Date:	