**Goods and Services Request Form**Only for use with Procedure Code **T1999HI22**  
Must be completed for all requests

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| --- | --- | --- | --- |
| Name of Individual: Click or tap here to enter text. | | Date Completed: June 2024 | |
| DDDiD: Click or tap here to enter text. | Plan #/Version: | Outcome #: Click or tap here to enter text. | Service #: Click or tap here to enter text. |

**Section A: Request Details**

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| Name of Vendor: Click or tap here to enter text. | |
| Address: Click or tap here to enter text. | |
| Website: | Phone: Click or tap here to enter text. |

**This Request is for GOODS:  YES  NO  
If** **YES**, complete the following:

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| 1. Goods Requested: Click or tap here to enter text. |
| 1. Purpose/Goal: Click or tap here to enter text. |
| 1. Total Cost: Click or tap here to enter text. |
| 1. Upload invoice/statement/proposal along with Goods and Services Request Form. |

**This Request is for SERVICES:  YES NO  
If** **YES**, complete the following:

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| Address where services will occur, if different from *Section A* vendor address: Click or tap here to enter text. | |
| 1. Services Requested: Click or tap here to enter text. | |
| 1. Purpose/Goal: Click or tap here to enter text. | |
| 1. Service Start Date: Click or tap here to enter text. | Service End Date: Click or tap here to enter text. |
| 1. Services will be delivered in (check one): | Home Community Other |
| **If Other** is selected, please explain: Click or tap here to enter text. | |
| 1. One unit of service represents (check one): | One Hour One Week One Month |
| One Session One Year One Occurrence (one-time fee) Other | |
| **If** **Session**, provide details: One session is 60 minutes of yoga | If **Other**, provide details: Click or tap here to enter text. |
| 1. Unit Rate (cost per one unit of service): Click or tap here to enter text. | |
| 1. Total cost from service start date to service end date: | |
| 1. Upload invoice/statement/proposal along with Goods and Services Request Form. | |

**Section B: Completed only when request is for a CLASS**

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| Name of Vendor: Click or tap here to enter text. | | | |
| Address: Click or tap here to enter text. | | | |
| Website: Click or tap here to enter text. | Phone: Click or tap here to enter text. | | |
| Address where services will occur, if different from above: Click or tap here to enter text. | | | |
| 1. The requested class is a college class: | | | **YES NO** |
| **If YES**, was a FAFSA (Free Application for Federal Student Aid) completed: | | | **YES NO** |
| **If YES,** upload FAFSA results with this request form. | | | |
| **If NO,** please explain**:** Click or tap here to enter text. | | | |
| 1. Class Title/Subject: Click or tap here to enter text. | | | |
| 1. This vendor/school primarily serves the general public | | **YES NO** | |
| 1. This requested class is attended by the general public | | **YES NO** | |
| 1. This requested class is attended only by people with disabilities: | | **YES NO** | |
| **If YES**, please answer the following: | |  | |
| Number of people who attend this class (cannot exceed 12): | | Click or tap here to enter text. | |
| Number of hours per day class is in session (cannot exceed 3): | | Click or tap here to enter text. | |
| Number of hours per week class is in session (cannot exceed 10): | | Click or tap here to enter text. | |
| Upload invoice/statement with Goods and Services Request Form. Must include class start date. | | | |

**Section C: Funding and PCPT Reference**

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| 1. Requested goods/services were approved for this individual in a previous plan | **YES NO** |
| 1. Section of the PCPT where the requested goods/services are referenced: To do List | |
| 1. Funding for the requested goods/services is available through another source: | **YES NO** |
| **If YES,** please explain**:** Click or tap here to enter text. | |
| 1. Requested goods/services are related to a medical need: | **YES NO** |
| **If YES,** *all supporting documentation must be uploaded with this form, including a* ***current medical prescription, primary/Medicaid MCO denial, and official outcome of appeal.*** | |
| 1. Natural/generic support resources have been researched/explored: | **YES NO** |
| **If NO**, please explain: There are no free culinary classes. | |
| **If YES**, provide details of natural/generic support resources research: Click or tap here to enter text. | |
| 1. The requested goods/services will decrease the need for other services: | **YES NO** |
| 1. The requested goods/services will promote community inclusion: | **YES NO** |
| 1. The requested goods/services will increase safety in the home: | **YES NO** |
| 1. The requested goods/services are related to employment: | **YES NO** |
| 1. The requested goods/services will benefit someone other than the individual: | **YES NO** |
| 1. Is the vendor aware they must complete enrollment with the Fiscal Intermediary to receive payment for services? | **YES NO** |
| Any additional information: Click or tap here to enter text. | |

**Section D: Completed only when the request is for an ACTIVITY FEE**

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| 1. Please provide details of activity/activities to be funded: Click or tap here to enter text. | |
| 1. The activity/activities are strictly for entertainment or recreational purposes: | **YES NO** |

***Important Note to the Support Coordinator***

The New Jersey Department of Human Services, Division of Developmental Disabilities **Guidance to Complete the Goods & Services Request Form** <https://nj.gov/humanservices/ddd/documents/goods-and-services-request-instruction.pdf> must be provided by the Support Coordinator to the Individual, Legal Guardian or Representative signing this form.

***To be completed by the Support Coordination Agency***

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| Full Name: Click or tap here to enter text. |
| Title: Support Coordinator |
| Support Coordination Agency: Spectrum CMC |
| ***List the names of those who provided information for the completion of this form and the organization/vendor/business they are associated with:*** |
| *Full Name:* Click or tap here to enter text. |
| *Name of Organization:* Click or tap here to enter text. |
| *Date:* Click or tap here to enter text. |
| *Full Name:* Click or tap here to enter text. |
| *Name of Organization:* Click or tap here to enter text. |
| *Date:* Click or tap here to enter text. |

***To be completed and signed by the Individual, Legal Guardian, or Representative***

***I acknowledge that the Support Coordinator named above has provided me with a copy pf the instructions/guidance on how to complete the Goods & Services Request Form –and- understand that:***

***Federal Medicaid funding is used as payment for the services requested on this form. As such, I acknowledge that false statements or deliberate omissions on this document may constitute a fraudulent submission and require investigation by the State of New Jersey or its partners, as well as affect future Goods & Services requests.***

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| Print Full Name: |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Relationship to Individual: |
| Date: |