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

|  |  |
| --- | --- |
| 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**

|  |
| --- |
| 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** [x]  **NO
If** **YES**, complete the following:

|  |
| --- |
| 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:** [x]  **YES** [ ] **NO
If** **YES**, complete the following:

|  |
| --- |
| 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):
 | [x] 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 |
| [x] One Session [ ] One Year [ ] One Occurrence (one-time fee) [x] 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**

|  |
| --- |
| 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.      |
| [x]  **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**

|  |  |
| --- | --- |
| 1. Requested goods/services were approved for this individual in a previous plan
 | [x]  **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** [x] **NO** |
| [ ]  **If YES,** please explain**:** Click or tap here to enter text. |
| 1. Requested goods/services are related to a medical need:
 | [ ]  **YES** [x] **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** [x] **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:
 | [x]  **YES** [ ] **NO** |
| 1. The requested goods/services will promote community inclusion:
 | [ ]  **YES** [x] **NO** |
| 1. The requested goods/services will increase safety in the home:
 | [x]  **YES** [ ] **NO** |
| 1. The requested goods/services are related to employment:
 | [ ]  **YES** [x] **NO** |
| 1. The requested goods/services will benefit someone other than the individual:
 | [ ]  **YES** [x] **NO** |
| 1. Is the vendor aware they must complete enrollment with the Fiscal Intermediary to receive payment for services?
 | [x]  **YES** [ ] **NO** |
| Any additional information: Click or tap here to enter text. |

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

|  |
| --- |
| 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***

|  |
| --- |
| 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.***

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