New Jersey Department of Human Services
Division of Aging Services
Jersey Assistance for Community Caregiving (JACC)

INSTRUCTIONS FOR COMPLETING THE SPECIAL REQUEST (CP-10) FORM

1. **Enter the** Full Name of the Participant **(first and last name)**
2. **Enter the full** Date **(Month/day/Year) that the Special Request is submitted for approval.**
3. Enter the participant's **JACC Identification Number** (12 digits).
4. Print the full name of the **Care Manager** (first and last name).
5. Enter the Care Manager's **Telephone Number**.
6. Enter the **Name of the Care Management Agency**.
7. Enter the **County** in which the participant currently resides.
8. **Current Authorized Services:**
   Check all applicable services currently identified in the participant's Plan of Care.
9. **Special Request Type:**

   Prior Approval is necessary for:
   - Chore Services that will exceed $50.00.
   - Environmental Accessibility Adaptations (EAA) that will exceed $500.00 (with at least two estimates/ bids)
     Copy of the ISA is to be faxed to Patricia Hezlep at **(609) 588-7153** (this is for billing purposes only)
   - Special Medical Equipment & Supplies (SME) that will exceed $250.00.

   Exception
   - Adult Day Health Services ADHS
   - Home-Based Supportive Care (HBSC) hours,
     (Six (6) months at a time with re-evaluation 2 weeks prior to ending)
   - Respite
   - Transportation
   - An **Exception** can be requested to exceed limitations or exclusions regarding the amount of program services delivered.
10. Check box – **Accredited Agency** yes or no
11. **Special Request Justification:**
    Prepare a narrative to support reasons for the request. Information must be sufficiently thorough and compelling to justify the request. Include any data or additional documentation that supports the request, such as prescriptions, product brochures, information sheets, contracts, permits, landlord approval, building estimates, service cost record, etc.
12. Every justification must address areas identified with letters A through E in Question 11. Use additional sheets as necessary.
    Indicate if this participant has been previously approved for any **other Special Request** during the current fiscal year. If so, briefly explain what was approved.
13. Enter the **Cost of this Special Request**.
14. If approved, indicate if the costs will be maintained/ amortized within the participant's annual service cap.
15. Enter the monthly amount of the current complement of authorized services.
16. Enter the monthly amount of authorized services that would result if the request is granted.

***Care Manager (CM) Name, Signature and Date:**
The Care Manager shall sign the Special Request as indication that 1) he or she has assessed the need for this Special Request and 2) all other possible venues/alternate means to render or fund this service have been exhausted.

***Care Coordinator/CM Supervisor Name, Signature and Date:**
The Care Management Supervisor shall sign the Special Request as indication that he or she 1) has reviewed it in its entirety, 2) is aware of the increased cost of services and it's correlation to any applicable County Allocation can absorb the cost of this request, and 3) agrees that the Request has been identified as an assessed need and justification warranted to submit the request for approval.

Email the Special Request form with any supporting documents to the attention of the assigned County Liaison in the NJ Division of Aging Services to**: DOAS.JACC@dhs.state.nj.us**

A copy of this Request and the corresponding Response are to be kept in the participant's file.