



STATE OF NEW HAMPSHIRE  
 DEPARTMENT OF HEALTH & HUMAN SERVICES  
 DIVISION OF LONG TERM SUPPORTS AND SERVICES  
 BUREAU OF ELDERLY & ADULT SERVICES

BEAS 3790  
 08/23

## CFI Specialized Rate Request

**Date:**

**Participant Name & MID**

**Case Management Agency:**

**Case Manager Name & Contact  
 Number:**

**Provider Name & Contact Number:**

**Type of Service:**

**Instructions:**

- Section 1- must always be completed by the Case Manager
- Section 2- completed by Provider for both Agency Directed and PDMS CFI Services
- Section 3- worksheet for Provider- use for Agency Directed CFI only
- Section 4- completed by the Financial Management Service (FMS) for PDMS Participants only

**Section 1- To be completed by the Case Manager**

1) Please describe the participant need(s) or special provider requirement(s) that lead you to request a specialized rate.

2) I certify that this request and the need for this specialized rate is based on the needs of the participant or special provider need. YES      NO

3) Have you conducted a thorough provider search and exhausted all standard rate options within the network? YES      NO      \*\* Please be prepared to provide documentation to verify this search if requested by the department. You may request a current list of all network providers at any time from the department to assist with your search.



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**Section 2- To be completed by the Provider**

1) Please document the specialized need and your explanation/justification for requesting a specialized rate for this need.

**Section 3- Provider Worksheet (for Agency Directed only)**

1) Document the rate needed to achieve the specialized service or provider:

Service:

Current Rate:

Additional needs outside of the current rate:

- |         |                       |
|---------|-----------------------|
| • Need: | Rate increase amount: |
| • Need: | Rate increase amount: |
| • Need: | Rate increase amount: |

Total of rate increase amounts:                    + Standard Rate =                    (total specialized rate)

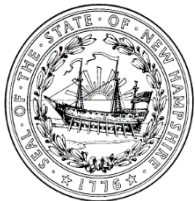
Total of rate increase amounts                    x 80% =                    (minimum amount that must be paid to the individual providing the care)

2) What time frame will be required to meet the participant need?

- 60 days            90 days            120 days            365 days            Other

\* Explanation for "other" choice:

3) Additional Information:



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**Section 4- To be completed by the FMS for PDMS only**

- 1) Amount of specialized rate requested by participant to be paid to provider:
  
  
- 2) FMS calculated rate/ specialized rate needed from department to achieve provider payment amount:

FMS representative name:

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**The completed form shall be sent via email to [CFISpecialRate@dhhs.nh.gov](mailto:CFISpecialRate@dhhs.nh.gov)**

CM Signature:

Printed Name:

Provider Signature:

Provider Agency & Provider Printed Name:

FMS Signature:

FMS Agency & Printed Name:

Participant Signature:

