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:

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:

The completed form shall be sent via email to CFISpecialRate@dhhs.nh.gov

CM Signature:

Printed Name:

Provider Signature:

Provider Agency & Provider Printed Name:

FMS Signature:

FMS Agency & Printed Name:

Participant Signature: