New Jersey Department of Human Services
Division of Aging Services

SPECIAL REQUEST

1. Name of Participant	2. Date	3. JACC No.

4. Name of Care Manager	5. Care Manager Telephone Number

6. Name of Care Management Agency	7. County

8. Current Authorized Services

- ☐ Adult Day Health Services (ADHS)
- ☐ Attendant Care
- ☐ Caregiver/Recipient Training
- ☐ Care Management
- ☐ Chore Service
- ☐ Environmental Accessibility Adaptations (EAA)
- ☐ Home-Based Supportive Care (HBSC)
- ☐ Home-Delivered Meal
- ☐ PERS
- ☐ Respite
- ☐ Social Adult Day Care (SADC)
- ☐ Special Medical Equipment and Supplies (SME)
- ☐ Transportation

9. Special Request Type (check as applicable)

JACC

Prior Approval	Exception
☐ Chore Service ☐ Environmental Accessibility Adaptations (EAA) ☐ Special Medical Equipment and Supplies (SME)	☐ ADHS ☐ Home-Based Supportive Care (HBSC) ☐ Respite ☐ Transportation ☐ Total Monthly service budget exceed $600 per month.

10. Is the Home Care agency for the exceptions request in #9 accredited ☐ yes ☐ no

11. Special Request Justification - The narrative to support the reasons for this request are to address the following areas:

A. What are the reasons for making this request? Be specific and thorough. **Include the item or service being requested and the name of the provider. For Respite Requests, indicate whether it will be in-home or in-facility. For in-home respite, a back-up plan must be included.**

B. How does the item/service requested meet the particular needs of the participant involved? Include any relevant factors about the client's age, diagnosis, activities of daily living functioning, and informal support systems.

C. What is the expected duration of the conditions prompting this request? **For Respite Requests, include the date range and number of days being requested.**

D. What other alternatives have been explored, and with what result?

E. If not granted, what will be the result for the participant?

12. Has this participant had any previous JACC Special Requests approved within this State fiscal year? ☐ No ☐ Yes, Specify:	13. Cost of this Request **(For Respite Requests, indicate the per diem, along with the total.)** **$**

14. Will the costs be maintained/amortized within the participant's annual service cap? ☐ No ☐ Yes	15. Current Monthly Authorized Cost **$**	16. Monthly Authorized Cost, if Request Granted **$**

Name of Care Manager (CM)	Signature	Date

Name of Care Coordinator/CM Supervisor	Signature	Date

Use additional sheets as necessary and attach estimates, literature, or any other supporting documentation.