STATE OF RHODE ISLAND
Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

DIVISION OF DEVELOPMENTAL DISABILITIES
6 Harrington Road
Cranston, RI 02920-3080

TEL: (401) 462-3421
FAX: (401) 462-2775

Individual Goods & Services Request Form

Please use this form to submit requests for goods and services. You can spend up to $5000 of your flexible budget on Goods & Services.

Requests to add goods and services during the plan year will require a new and documented need related to a change in situation. Requests are subject to a $325.00 fee to adjust the plan and purchase order. This fee will be paid using your DD service funds.

Please note, requests for Goods & Services will not be accepted 90 days prior to the expiration of your current budget year. Emergency situations within the last 90 days will be evaluated on a case-by-case basis. Only completed applications will be reviewed.

For more information about allowable and non-allowable goods and services, please visit the DDD Self-Directed Services webpage (https://bhddh.ri.gov/developmental-disabilities/services-adults/self-directed-services).

General Information

Name of Individual: **MID #:**

Date of Birth: **Tier Level:** **Plan Year:**

Fiscal Intermediary:

Support Broker:

BHDDH Social Caseworker:

Relationship to individual receiving services:

- ☐ Self
- ☐ Parent or family member
- ☐ Plan Writer
- ☐ Support Broker
- ☐ Direct Support Professional-Employee
- ☐ Designated Representative
- ☐ Other (*Please include your relationship to Individual):*

Goods & Services Request

Please list all requested goods and services individually. If you need more space, please use the last page.

Please use this answer key for the "Purpose of Request" section below:

A. Helps meet an ISP need or goal	**B.** Decreases the need for Medicaid funds	**C.** Supports independence	**D.** Promotes community inclusion
E. No other funds are available	**F.** CMS considers it cost effective	**G.** Is only for the person's benefit	**H.** Helps ensure health and safety

Good & Service	**Cost**	**Type of request** (Annual or amendment)	**Purpose of Request** (Enter letter from above table; List all that apply)	**Explanation of Need** (Anticipated outcomes and benefits)
1.		☐ New Request ☐ Budget Amendment		
2.		☐ New Request ☐ Budget Amendment		
3.		☐ New Request ☐ Budget Amendment		
4.		☐ New Request ☐ Budget Amendment		
5.		☐ New Request ☐ Budget Amendment		

Request Submission

Please submit this completed application and all other supporting documentation to your Fiscal Intermediary.

Supporting documentation may include:

- A note from a physician, therapist or other healthcare professional explaining the need for the request.
- An article, on-line service description, or picture
- Medicaid and/or private insurance denial letters
- Other information about the item(s)/service(s) that could be used during the approval process.

Signature of Person Completing Form **Date**

By signing my name above, I attest that the Participant/legal guardian/designated representative has made an informed decision. Note: Completing this form before the participant/legal guardian/designated representative has made an informed choice is considered falsification of the document.

Signature of Self Direction Participant **Date**

By signing my name above, I certify that the information on this form and any attached documentation that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge.

Right to an Administrative Review

If you do not agree with the decision of your request, you have the right to an administrative review. Requests for administrative review's must be made within 30 days of receiving the decision of your Goods & Service Request. Please email your request to Natalie.Munoz@bhddh.ri.gov or send written request to: Natalie Munoz, BHDDH – Simpson Hall, 6 Harrington Road, Cranston, RI 02920.

If you do not wish to have an administrative review, you may request a formal hearing with the Executive Office of Health and Human Services (EOHHS). Requests for a formal hearing must be made within 90 days from the date of receiving the decision of your Goods & Services Request. Please email your request to OHHS.AppealsOffice@ohhs.ri.gov or send written request to: ATTN: Appeals State of Rhode Island, P.O. Box 8709, Cranston, 02920-8787.

BHDDH Personnel Only

Request Review

Approved Request(s)	Denied Request(s)	More Information Needed

Reviewer Name and Signature **Date**

Additional Goods & Services Request

Please use this answer key for the "Purpose of Request" section below:

A. Helps meet an ISP need or goal	**B.** Decreases need for Medicaid funds	**C.** Supports independence	**D.** Promotes community inclusion
E. No other funds are available	**F.** CMS considers it cost effective	**G.** Is only for the person's benefit	**H.** Helps ensure health and safety

Good & Service	**Cost**	**Type of request** (Annual or amendment)	**Purpose of Request** (Enter letter from above table; List all that apply)	**Explanation of Need** (Anticipated outcomes and benefits)
6.		☐ New Request ☐ Budget Amendment		
7.		☐ New Request ☐ Budget Amendment		
8.		☐ New Request ☐ Budget Amendment		
9.		☐ New Request ☐ Budget Amendment		
10.		☐ New Request ☐ Budget Amendment		