



Interim Policy Guide to Support Coordination



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1 INTRODUCTION

The purpose of the New Jersey Division of Developmental Disabilities (Division) Interim Policy Guide to Support Coordination is to provide clarity on practices governing the delivery of Support Coordination services during the transition period to full implementation of the Supports Program and a fee-for-service system. These policies apply to all Support Coordination Agencies (and its personnel) currently working with “new presenters” and using the Individualized Service Plan (ISP).

Some of these policies will change as ongoing Division-wide reform efforts are implemented in the coming months. The current standards will remain in place in the interim as established in this guide. Updates and revisions will be made as needed.

1.1 Development/Revision of Policies and Procedures

The Division adheres to all State and federal laws, regulations, and rules that relate to the operation of the Division and the programs it administers. The Division is required to develop policies and procedures for program operations that conform with State and federal requirements.

Questions or requests for revisions or clarification should be directed to the Division’s Supports Program Help Desk at DDD.SuppProgHelpDesk@dhs.state.nj.us.

2 OVERVIEW OF INTERIM PHASE OF SYSTEM TRANSFORMATION

The Division is in the process of system transformation. In June 2013, Support Coordination services were expanded beyond the three (3) Division-contracted Support Coordination providers (who served individuals in Self-Directed Services) to Division Approved Support Coordination Agencies funded through a fee-for-service model. These new Support Coordination Agencies have begun providing Support Coordination services to “new presenters” entering the Division as of June 2013 (with the exception of individuals enrolled on the Community Care Waiver).

The “interim phase” refers to the time period between June 1, 2013 and present. It applies to the following individuals receiving Division services:

- Individuals who were not yet eligible for or accessing Division services prior to June 1, 2013, except those slated for the CCW
- Individuals who exhausted their educational entitlement and graduated in 2013
- Individuals who have chosen to switch from Self-Directed Day Services (SDDS) to contracted day programs, since June 1, 2013
- Individuals who have chosen to switch from contracted day programs to Self-Directed Day Programs, since June 1, 2013
- Individuals who, as of June 1, 2013, were not receiving any type of day services but subsequently requested to begin receiving day services (either contracted or Self-Directed Day Services)



The aforementioned individuals will all receive care management services through the Support Coordination Agencies and utilize the Individualized Service Plan (ISP) to identify outcomes and goals and authorize services.

3 DIVISION ELIGIBILITY

The eligibility criteria to receive services from the Division, within available appropriations, are described in [Division Circular #3](#) (N.J.A.C. 10:46), which establishes guidelines and criteria for determination of eligibility for services to individuals with developmental disabilities.

- An individual must be determined eligible for services before the Division can provide services.
- The determination of an applicant's eligibility for Division services shall be completed as expeditiously as possible.
- In order to receive Division services, individuals are responsible to apply, become eligible for, and maintain Medicaid eligibility.
- An individual must establish that New Jersey is his or her primary residence at the time of application.
- At 16 years of age, individuals may participate in Planning for Adult Life information sessions, webinars, projects, etc. from the Division.
- At 18 years of age individuals may apply for eligibility.
- At 21 years of age, eligible individuals may receive Division services.

4 INDIVIDUAL ENROLLMENT

The following steps will be taken by "new presenters" in order to receive Division-funded services:

- The individual will contact the Division Regional Community Services Office to discuss needs;
- The Division will confirm that the individual has completed the Division's intake process, has been deemed eligible for Division services, and is not currently on the Community Care Waiver (CCW);
- The individual will be assigned a budget based on the assessed level of need found through completion of the Developmental Disabilities Resource Tool (DDRT);
- The individual will be assigned a Support Coordination Agency through the process described in section 5.8;
- Once the individual is assigned a Support Coordination Agency, the policies and procedures described in this guide will be followed in order to assist the individual in accessing services.



5 SUPPORT COORDINATION

5.1 Support Coordination Overview

This section defines the role of both the Support Coordination Supervisor and the Support Coordinator and provides a summary of the responsibilities for coordinating service provision during this interim phase.

5.2 Role of the Support Coordination Supervisor (SC Supervisor)

The SC Supervisor does not have a caseload and provides oversight and management of the Support Coordinators.

5.3 Responsibilities of the Support Coordination Supervisor

The SC Supervisor is responsible for:

- Assigning Support Coordinators to individuals who have been assigned to the Support Coordination Agency
- Ensuring that caseloads are at the proper capacity to meet all deliverables
- Reviewing and approving all Individualized Service Plans (ISP), utilizing the ISP Quality Review Checklist, and obtaining approval for the ISP from the Division
- Ensuring that resources other than those funded by the Division have been explored and are either not available or not sufficient to meet the documented need
- Ensuring that services are provided in accordance with the service definitions and parameters outlined in Division policy
- Reviewing and signing, as appropriate, the Support Coordination Monitoring Tool. At a minimum the tool must be reviewed and signed during the following circumstances:
 - First 60 days of any new Support Coordinator
 - When performance issues with a Support Coordinator are identified
 - Involved/difficult cases
- Conducting internal monitoring and oversight of Support Coordination Agency documentation and practices
- Acting as the liaison with designated Division personnel
- Ensuring compliance with all qualifications, standards, and policies related to Support Coordination as explained in this guide
- Remaining up-to-date and in compliance with policy changes and updates posted on the Support Coordination Resource Page referred to in Appendix A.

5.4 Role of the Support Coordinator

The Support Coordinator manages Support Coordination services for each participant. Support Coordination services are services that assist participants in gaining access to needed program and State plan services, as well as needed medical, social, educational and other services. The Support Coordinator is responsible for developing and maintaining the Individualized Service Plan with the



participant, their family (if applicable), and other team members designated by the participant. The Support Coordinator is responsible for the ongoing monitoring of the provision of services included in the Individualized Service Plan.

The Support Coordinator writes the Individual Service Plan based on assessed need and the person-centered planning process with the individual and the planning team. The Support Coordinator links the individual to needed services and supports and assists the individual in identifying service providers as needed. The Support Coordinator also ensures that the services and supports remain within the allotted budget and monitor the delivery of services. The Support Coordinator must make a clear distinction between acting as a resource and providing advocacy on behalf of the individual/family. The Support Coordinator provides information, supports individuals in advocating for themselves, and links individuals to advocacy resources but does not serve as the advocate for the individual/family.

The Support Coordinator's role can be divided into the following 4 general functions: individual discovery, plan development, coordination of services, and monitoring.

5.4.1 Individual Discovery

Individual discovery is the process by which the Support Coordinator, in conjunction with the individual and planning team, gathers and evaluates information in order to assist the individual to determine his/her outcomes, supports, and service needs. This function begins once the individual is assigned a Support Coordinator and occurs concurrently with other functions. This process and the tools used to facilitate it are further described in section 6.4.1 "Assessments/Evaluations."

5.4.2 Plan Development

This function involves the process by which the Support Coordinator facilitates a planning team to develop the Person Centered Planning Tool (PCPT) and Individualized Service Plan (ISP). The PCPT is a person-centered plan which identifies needed outcomes, goals, supports, and services. The ISP directs the provision of those supports and services. Section 6 details the policies and procedures necessary to complete this function.

5.4.3 Coordination of Services

This function includes activities necessary to obtain the supports and services identified in the ISP. Coordination of services requirements are outlined in section 7.

5.4.4 Monitoring

Monitoring is the process by which the Support Coordinator ensures that the individual progresses toward identified outcomes and receives quality supports and services as outlined in the ISP and in accordance with the Division's mission and core principles. Section 8 describes specific responsibilities for accomplishing the monitoring function.



5.5 Responsibilities of the Support Coordinator

The Support Coordinator is responsible for:

- Using and coordinating community resources and other programs/agencies in order to ensure that services funded by the Division will be considered only when the following conditions are met:
 - other resources and supports are insufficient or unavailable,
 - the services do not meet the needs of the individual, and
 - the services are attributable to the person's disability.
- Accessing these community resources and other programs/agencies by
 - utilizing resources and supports available within the individual's family, neighborhood, and community;
 - developing a thorough understanding of programs and services operated by other local, State, and federal agencies;
 - ensuring these resources are used and making referrals as appropriate; and
 - coordinating services between and among the varied agencies so the services provided by the Division complement, but do not duplicate, services provided by the other agencies.
- Developing a thorough understanding of the services funded by the Division and ensuring these services are utilized in accordance with the parameters defined in the Current Division of Developmental Disabilities (DDD) Services Chart found in Appendix B.
- Interviewing the individual and, if appropriate, the family; reviewing/compiling various assessments or evaluations to make sure this information is understandable and useful for the planning team to assist in identifying needed supports; and facilitating completion of discovery tools, if applicable.
- Scheduling and facilitating planning team meetings; writing and distributing the ISP (and PCPT when the individual consents) to the individual, all team members, and the identified service providers; and reviewing the ISP through monitoring conducted at specified intervals.
- Obtaining authorization from the SC Supervisor for Division-funded services.
- Monitoring and following up to ensure delivery of quality services, and ensuring that services are provided in a safe manner, in full consideration of the individual's rights.
- Maintaining a confidential case record that includes but is not limited to the NJ Comprehensive Assessment Tool (NJ CAT), completed Support Coordinator Monitoring Tools, PCPTs, ISPs, notes/reports, annual satisfaction surveys, and other supporting documents uploaded to the iRecord for each individual served.
- Ensuring individuals served are free from abuse and neglect, reporting suspected abuse or neglect in accordance with specified procedures, and providing follow-up as necessary.
- Ensuring that incidents are reported in a timely manner in accordance with policy and follow-up responsibilities are identified and completed.
- Notifying the individual, planning team, and service provider and revising the ISP whenever services are changed, reduced, or services are terminated.
- Reporting any suspected violations of contract, certification or monitoring/licensing requirements to the Division.



- Entering required information into the iRecord in an accurate and timely manner.
- Ensuring that individuals/families are offered informed choice of service provider.
- Notifying the individual regarding any pertinent expenditure issues.
- Conducting monthly contacts, quarterly face-to-face visits, and an annual home visit that includes review of the ISP and is documented on the Support Coordinator Monitoring Tool.

5.6 Support Coordinator Deliverables

- Monthly contact documented on the Support Coordinator Monitoring Tool
- Quarterly face-to-face contact documented on the Support Coordinator Monitoring Tool
- Annual home visit documented on the Support Coordinator Monitoring Tool
- Completed PCPT & ISP by 30 days from date the individual was assigned and annually thereafter
- Notes/reports as needed
- Reporting data to the Division upon request

If meeting the previously mentioned deliverables is delayed due to the individual (or family) failing to comply with attending meetings, participating in mandated contacts, allowing access to the home for visits, etc., the Support Coordinator should notify the individual that non-compliance regarding Division policy will be reported to the Division. If non-compliance continues, the SC Supervisor shall notify the designated Division personnel and he/she will follow-up with the individual. Ongoing non-compliance may result in termination from Division services.

5.7 Support Coordinator Training

Approved Support Coordination Agencies are responsible for ensuring that all SC Supervisors on staff meet the qualifications, including completion of mandatory training, necessary to deliver Support Coordination services.

5.7.1 Classroom Training

A mandatory classroom training covers topics which include but are not limited to the following areas:

- Overview of the Division of Developmental Disabilities
- Entering the Division System
- Overview of Support Coordination
- Support Coordination Agency Policies
- Accessing Services
- Authorizing Services
- Monitoring
- Providing Support Coordination Services
- Writing the Person-Centered Planning Tool (PCPT)
- Development of the Service Plan
- Writing Quality Individualized Service Plan (ISP) Outcomes and Goals



5.7.2 Additional Mandatory Training

The following online training (through the College of Direct Supports - CDS) is also mandatory within the following timeframes:

30 Days of Hire

- Danielle's Law (1 lesson)
- Preventing Abuse & Neglect (16 lessons)

90 Days of Hire

- Medicaid Training for NJ Support Coordinators (3 lessons)
- Support Coordination Modules (5 modules)

Accessing CDS

Each Support Coordination agency needs to designate at least one person at their organization to be the Agency CDS Administrator. The Agency CDS Administrator is the person that enters the Support Coordinators into the CDS, assigns online lessons, and has access to run agency reports and use the various other features of the system. The first step is to register this designated person for the CDS Administrator Training by going to:

<http://rwjms.rutgers.edu/boggscenter/training/CDSAdministratorTraining.html>.

Once Boggs confirms with you that your CDS Administrator is approved, they will set up the agency in CDS. The CDS Administrator attends training and gets access to the system and assigns required online lessons to support coordinators.

5.7.3 iRecord Tutorials

Video tutorials explaining how to perform various tasks on iRecord are available and can be accessed on the Support Coordination website at <http://rwjms.rutgers.edu/boggscenter/projects/njisp.html>.

5.7.4 Optional Training

The Division also offers several optional training courses to Support Coordinators as part of the College of Direct Supports (CDS) and through webinars.

5.8 Assignment of Support Coordinators from Support Coordination Agencies

During this interim phase, each person eligible to receive services must have a Support Coordinator. A Support Coordination Agency is assigned by the Division after submission of the Support Coordination Agency Selection Form available on the Division's website. Only individuals and families can submit Support Coordination Selection Forms. The individual has the opportunity to indicate his/her preferred Support Coordination Agency – from a list of approved agencies – on the Support Coordination Agency Selection Form, and the Division will assign the Support Coordination Agency based on the individual's indicated preference as long as that preferred Support Coordination Agency provides support coordination services in the county in which the individual resides, has the capacity to add the individual



to their services, and meets the conflict free policy. If the individual does not indicate a preference or the preferred Support Coordination Agency does not meet the previously mentioned criteria to serve the individual, the Division will auto assign the Support Coordination Agency based on location and available capacity.

The Support Coordination Agency Selection Form and list of currently approved Support Coordination Agencies can be accessed on the Division's website at <http://www.nj.gov/humanservices/ddd/programs/supportsprgm.html>.

Once assigned, the Support Coordination Agency will identify a Support Coordinator within their agency and have him/her contact the Division's Regional personnel to initiate a case conference using the Support Coordination Case Conference Guide. The individual can inform the Support Coordination Agency of any preference they may have in Support Coordinator, but there is no guarantee that the Support Coordination Agency will be able to assign the preferred Support Coordinator to the individual. The assigned Support Coordinator will contact the individual to introduce him/herself and begin the planning process.

5.8.1 Changing Support Coordinators

The individual must commit to a full month of services from the assigned Support Coordination Agency. In any given month, a deliverable must have been met in order to receive payment for Support Coordination services.

If the individual wishes to change Support Coordinators, he/she must follow the policies/procedures set forth by the Support Coordination Agency to request a change in Support Coordinator. The Support Coordination Agency should make every effort to accommodate the request and assign a new Support Coordinator to the individual but is not obligated to do so.

If the individual wishes to change Support Coordination Agencies, he/she must indicate that request on the Support Coordination Agency Selection Form and submit it to the Division by following the directions indicated on the form. Once the form is received, the reassignment process will follow the assignment process indicated in section 5.8. As soon as the new Support Coordination Agency is assigned, the previous Support Coordination Agency will no longer have access to the individual's information or be able to upload associated documents for that individual on iRecord.

In order to maintain continuity of care upon Support Coordination Agency reassignment, transfer of case records is essential. Thus, it is strongly recommended to use iRecord in order for the newly assigned agency to automatically gain access to the documents associated with the reassigned individual. In the event the Support Coordination Agency has not begun using iRecord, a hard copy of all current documents must be distributed to the newly assigned Support Coordination Agency within 3 business days.



5.9 Conflict Free Care Management

According to the Centers for Medicare & Medicaid Services (CMS), care management services must be “conflict-free,” which has the following characteristics: there is a separation of care management from direct services provision; there is a separation of eligibility determination from direct services provision; care managers do not establish the levels of funding for individuals; and anyone who is conducting evaluations, assessments, and the plan of care cannot be related by blood or by marriage to the individual or any of their paid caregivers.

The full policy is available on the Division’s website at:

<http://www.nj.gov/humanservices/ddd/documents/Documents%20for%20Web/Conflict%20Free%20Policy%20Revised.pdf>.

5.10 Caseloads & Capacity

Currently, there are no mandated caseload ratios, but the Support Coordination Agency must be able to meet the deliverables and fulfill the roles and responsibilities outlined in sections 5.2, 5.3, 5.4, 5.5, and 5.6. In addition, the Division will monitor caseload ratios as reported by the Support Coordination Agency and may institute caseload limits if a particular Support Coordination Agency is not meeting the deliverables or able to fulfill the roles and responsibilities of the Support Coordinator or if there is an overall concern regarding ratios and Support Coordination services.

A Support Coordination Agency must provide services in at least one county and for a minimum of 60 individuals. Support Coordination Agencies providing services in this interim phase are given the opportunity to build their capacity to meet this requirement. Once the Supports Program is operationalized and individuals begin to be enrolled, Support Coordination Agencies will be expected to serve the minimum of 60 individuals.

5.11 Zero Reject & Zero Discharge

The Support Coordination Agency must accept all individuals as assigned and cannot discharge individuals from services. A Support Coordination Agency cannot specialize in providing Support Coordination services to individuals with a particular type of disability or deny services because of the level of support an individual may or may not need. Only the Division may discharge individuals from services. The Support Coordination Agency must notify the Division of circumstances – such as failure to comply with Division eligibility or policies – that may warrant discharge from services.

5.12 Coverage

The Support Coordination Agency must ensure that Support Coordination services are available at all times. At a minimum, these services must be available via phone contact, and an answering service is acceptable as long as there is a Support Coordinator available on-call.



In circumstances where an individual contacts 24 hour services after business hours, emergent cases shall be directed to the on-call Support Coordinator for follow-up. The Support Coordinator must contact the individual and direct him/her to appropriate resources and/or make phone calls, including but not limited to 911, emergency personnel, and other government entities as appropriate. A meeting to develop a contingency plan to address the issue must be held on the following morning/day.

If the individual cannot meet with the Support Coordinator during business hours, the Support Coordination Agency must schedule monthly/quarterly/annual contacts/visits, planning meetings, etc. outside of business hours to accommodate the individual's needs.

6 SERVICE PLAN

It is a requirement that each person who has been determined eligible to receive services from the Division must have an Individualized Service Plan (ISP) written on the document specified in this guide. The plan will be developed by a planning team of appropriate persons to include, but not be limited to, the individual, the Support Coordinator, and the individual's parent or guardian as appropriate. This plan, developed based on assessed needs identified through the NJ Comprehensive Assessment Tool (NJ CAT); the Person-Centered Planning Tool (PCPT); and additional documents as needed, identifies the individual's outcomes and planning goals and describes the services needed to assist the individual in attaining the goals and outcomes identified in the plan. An approved ISP authorizes the provision of safe, secure, and dependable support and assistance in areas that are necessary for the individual to achieve full social inclusion, independence, and personal and economic well-being.

6.1 Operating Principles

The ISP must be in the best interests of the individual served and also must empower individuals. The plan must be centered upon the strengths, resources, and needs of the individual served.

The plan must be based upon evaluations and assessments, the preferences of the individual, and a written statement of the individual's goals and desired future. Needs, goals, and services identified in the plan must be designed to allow the individual to meet his/her personally defined outcomes and function as independently and successfully as possible.

The plan must also address utilizing resources and supports available through the individual and/or within the individual's family, neighborhood, and community. Services funded by the Division will be considered only when other resources and supports are insufficient or unavailable, the services do not meet the needs of the individual, and the services are attributable to the person's disability.

In designing the plan, the planning team should consider the unique characteristics and needs of the individual as expressed by the individual and others who know the person, such as family, friends, service providers, etc. Goals, outcomes, services, and agreements identified in the plan should:

- Recognize and respect rights
- Encourage independence



- Recognize and value competence and dignity
- Respect cultural/religious needs and preferences
- Promote employment and social inclusion
- Preserve integrity
- Support strengths
- Maintain the quality of life
- Enhance all domains/areas of development
- Promote safety and economic security

Division employees and approved service providers must include the individual in problem-solving and decision-making, and ensure that services are provided in a non-intrusive manner.

The planning team functions as an interdisciplinary team. An interdisciplinary team is one in which persons of various backgrounds interact and work together to develop one whole, integrated plan for the individual. An interdisciplinary process encourages mutual sharing of the strengths and insights of all team members, including the individual, rather than reliance on professionals who concentrate on a specific discipline. Planning team members are encouraged to participate in discussions related not only to their primary area of expertise but to all aspects of the individual's life.

6.2 Planning Team Membership

The membership of the planning team will vary depending upon the needs and wishes of the individual.

The planning team will include at a minimum:

- Individual
- Support Coordinator, who shall serve as plan coordinator and provide support to the individual as meeting facilitator or serve as meeting facilitator when the individual will not be fulfilling that role
- Individual's parent/family or legal guardian, as appropriate
- Any service provider and/or additional person(s), approved by the individual, whose participation is necessary to develop a complete and effective plan

The Division encourages the individual to include providers who are currently authorized to serve the individual on the planning team and encourages identified providers to attend the planning meeting(s) when invited to participate as planning team members.

Occasionally, there may be a need for non-participating persons, such as staff in training or observers from monitoring groups, to be present at team meetings. Since these persons are not planning team members, the Support Coordinator shall seek prior approval for their presence from the individual. The Division reserves the right to attend and participate in planning team meetings.



6.3 Responsibilities of Each Team Member

6.3.1 Responsibilities of the Plan Coordinator (Support Coordinator)

The Support Coordinator, as plan coordinator, is responsible for the following tasks:

- Identifying team members – based on the individual’s input – and scheduling meetings of the planning team
- Notifying team members, preferably in writing, of planning team meetings within 5 working days
- Ensuring that copies of all current evaluations and assessments are available to the team members prior to the team meetings, if possible
- Actively participating in team meetings
- Coordinating meetings of the planning team as outlined in section 6.7, when the individual has decided not to facilitate the meeting him/herself
- Writing the ISP in clear and understandable language based upon consensus reached during the team meeting
- Distributing copies of the completed ISP (and upon consent from the individual/person responsible, the PCPT) to all team members and service providers within 3 working days from the date of SC Supervisor approval of the ISP, and ensuring that copies of the ISP are available in all settings where the individual receives services
- Ensuring that all data is entered into the iRecord
- Monitoring and reviewing the ISP
- Completing other assignments as determined by the planning team
- Ensuring the individual receives services to meet medical/functional needs (within the availability of funds for State-funded services)

6.3.2 Responsibilities of the Individual (and guardian, where applicable) as a Planning Team Member

Areas of responsibility include but are not limited to the following:

- Being available to meet for the required ISP planning meeting and reviews
- Providing documentation for eligibility determination/redetermination
- Reporting issues with providers of service including potential/suspected fraud and abuse
- Reporting changes of address
- Reporting changes in individual circumstances which may cause the need for changes to the ISP or effect the provision of services
- Signing appropriate consents
- Providing appropriate documentation to obtain requested assistance from the Division
- Providing other documentation as requested by the Division (i.e. any changes in insurance policies with the effective date, third party liability information, burial insurance policies, etc.)
- Complying with and maintaining Medicaid eligibility



- Informing designated Division personnel of significant temporary or permanent changes to the individual or caregiver that cause the need for a bump-up or reassessment, respectively
- Requesting that the Support Coordinator invite other persons to participate as team members, if necessary

6.3.3 Responsibilities of Other Planning Team Members

Other planning team members are responsible for the following tasks:

- Reviewing provided information related to the individual, including the PCPT, previous ISP(s), available assessments, and evaluation data, as appropriate/relevant
- Actively participating in the planning team meeting and working cooperatively to achieve consensus in the spirit of the ISP operating principles
- Recording data relative to assigned outcomes, as relevant
- Notifying the Support Coordinator and requesting a special team meeting to be scheduled whenever there is a significant change in the individual's status
- Completing other assignments as determined by the planning team

6.4 Components of the Plan of Care

The content of an individual's plan of care will vary depending on the unique characteristics and specific needs of the individual and the individual's service setting. Major components common to all individuals are outlined below.

6.4.1 Assessments/Evaluations

The ISP shall be based on the results of mandated assessments/evaluations and can incorporate additional information from optional discovery tools and evaluations/assessments of the individual.

- *Mandated assessments/evaluations* are tools that are required by the Division and are known as the NJ Comprehensive Assessment Tool (NJ CAT) and the Person-Centered Planning Tool (PCPT). The **NJ CAT** is comprised of the Functional Criteria Assessment (FCA) and the Developmental Disabilities Resource Tool (DDRT).

The FCA is the assessment tool utilized to assess whether newly entering individuals meet the functional criteria to be eligible for the Division or not. This tool assesses individual competencies in the following areas: sensory/motor, cognitive abilities, communication, social interaction and sociability, self-direction, self-care/independent living skills, special behaviors, health, school experience, and employment and determines relative need for services and supports.

The DDRT has a long history of use with individuals with intellectual or developmental disabilities in NJ for assessing individual support needs and determining relative need for



services. The DDRT assesses individual competencies and assists in determining who needs more support and ensures that those with like needs receive a similar level of support.

The Support Coordinator will utilize information provided through the NJ CAT to ensure that outcomes and services written in the ISP are linked to assessed needs identified through the NJ CAT.

The **Person-Centered Planning Tool (PCPT)** is a mandatory discovery tool used to guide the person-centered planning process and assist in the development of an individual's Service Plan. It can be completed by the individual and/or his/her guardian, family, or other people as identified by the individual and/or guardian, or the Support Coordinator can also facilitate the development of the PCPT with input and guidance from the identified team members.

- *Optional Discovery Tools* are additional tools that can be utilized during the discovery process to inform the PCPT and the Service Plan and provide potential caregivers, service providers, etc. with information essential to supporting the individual. These tools can be completed by the individual and/or his/her guardian, family, or other people as identified by the individual and/or guardian. If utilized, the Support Coordinator will compile information from these tools and use it to assist in development of the PCPT and Service Plan.
- Physical exams, psychological evaluations, etc., can also be utilized to inform the ISP. The Division expects that all individuals receive annual physical and dental examinations and that Support Coordinators include this expectation in their planning/monitoring.

6.4.2 Individualized Service Plan

The **Individualized Service Plan (ISP)** utilizes information gathered through the assessments/evaluations described above to identify the individual's needs; describe the needed services to be provided and outcomes to be attained; direct the provision of safe, secure, and dependable support and assistance; and establish outcomes consistent with full social inclusion, independence, and personal/economic well-being. The planning team shall identify and document these areas in the ISP, and needs statements shall be functional statements oriented to the overall outcome envisioned for and by the individual and developed with consideration of the person's strengths and preferences.

- a. *Consumer Information* (Section A) – Demographic, program, emergency, guardianship, healthcare, medical, and diagnosis information are all indicated in this section of the ISP.
- b. *Personally Defined Outcomes and Services* (Section B) – The ISP must indicate the individual's outcomes and services based on assessed need.

Personally Defined Outcome – The personally defined outcome shall reflect the individual's desired achievement based on strengths and preferences and shall be developed without regard to the availability of services or funding sources. Personally defined outcomes change to reflect accomplishments, life transitions, or changes in the individual's status. Note that at least one



personally defined outcome must relate to the employment goals of the individual. There is no limit on the total number of outcomes in any service plan.

Examples of a Personally Defined Outcome include but are not limited to the following: John will work in an office, Susan will maintain friendships, Dan will do his own grocery shopping, and Patrick will learn about nutrition and healthy eating.

OUTCOME DO'S & DON'TS

Do	Don't
Write about the individual's desired achievement	Write about the service/supports needed to achieve the desire
Write in future tense	Write in present or past tense
Write one outcome per outcome	Write/combine multiple outcomes into one
Include at least one employment outcome	Forget to include an employment outcome
Individualize the outcomes	Write the same outcome for everyone

Planning Goal – The planning goal is a major activity designed to achieve the personally defined outcome. There may be multiple planning goals related to one outcome but there can only be one planning goal per service. Planning goals shall be written to address the steps it will take for the individual to reach the personally defined outcome.

Examples of a Planning Goal include but are not limited to the following: Outreach to businesses that match John's skill set through networking, resume distribution, completion of applications, and determining business needs; Susan and her friends will get together for dinner, visits to the museum, the movies, or sporting events once a week; Dan will learn how to make a grocery list and set/stick to a budget for groceries and go to the grocery store to do his weekly shopping; and Patrick will participate in the Healthy Living course at his day program and will cook a healthy dinner for his family once a week.

GOALS DO'S & DON'TS

Do	Don't
Write the steps it takes to reach the outcome	Repeat what has been written as an outcome
Be specific and measurable	Be vague
Write individualized goals	Write the same goals for everyone
Write only one planning goal per service	Write multiple planning goals for the same service
Use person-centered language	Use labels, paternalistic, and/or outdated language

Service(s) – The service is identified to provide the assistance and supports an individual needs to reach the planning goal and personally defined outcome. All services, including those services that are not Division-funded, that are required to meet an assessed need must be included within the ISP. It is possible that a completed ISP will only contain services that are funded through entities other than the Division (for example, initial Supported Employment



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Services funded by DVRS, Medical Day Programs, or Mental Health Day Programs, etc.). In these circumstances, the Division will provide additional review to ensure that Support Coordination services are appropriate for these individuals.

The State cannot provide funding for duplicative services so adjustments must be made to individual budgets in situations where funding is being provided for day services through other State Agencies. At this time, this deduction must be made manually by the Support Coordinator because it may not currently be reflected in iRecord, and the Support Coordinator should not utilize these funds for additional services. If the Support Coordinator needs assistance in making this budget adjustment, his/her supervisor should seek assistance from the SCAs designated Division personnel. The hourly rate for the service multiplied by the number of hours for which this day service is received will be deducted from the individualized budget. The remaining budget can be utilized to fund additional services as needed. Budgets will remain intact if the funds are being utilized for Division funded employment services and supports.

Please note that requests for Family Support services must go through the Division point person. In circumstances when an individual is attending contracted day services, he/she may have access to Family Support services on a case-by-case basis depending on availability of funding within the Division's Regions.

There can only be one planning goal per service.

A list of current Division-funded services is available in Appendix B.

Procedure Code – The procedure code is a series of letters and numbers used by Medicaid to identify the type of service that has been authorized.

Reference Assessment Tool – The assessment tool from which the identified need was indicated is referenced in order to connect the need for service to the individual. Assessment tools include mandated tools such as the PCPT and NJ CAT or optional discovery tools used in the person-centered planning process.

Number of Units – The number of units is the number that will be multiplied with the "frequency" to indicate an approved increment of time, based on the assessed need, for the services that have been indicated on the ISP.

Unit type – The unit type is the predetermined interval of time (15 minutes, 30 minutes, hours, days, etc.) that can be claimed for each particular service.

Rate – The rate is the cost per unit of a commodity or service provided.

Frequency – The frequency is how often (daily, weekly, monthly, etc.) a service will be provided. Please note that "daily" reflects all 7 days of the week rather than business days.



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Duration – The duration is the period of time (starting date to anticipated end date) it is anticipated that the identified service will be required during the year in which the plan will be active.

Provider – The entity or individual who will provide the service. Division-funded services can only be provided by approved providers.

Payment Source – The payment source is the entity (Managed Care Organization, Division of Vocational Rehabilitation Services, State Only, etc.) that will provide funding for those services for which payment is necessary. Resources and supports available within the individual’s family, neighborhood, and community must be considered first. Services funded by the Division will be considered only when other resources and supports are insufficient or unavailable and do not meet the needs of the individual and are attributable to the person’s disability.

- c. *Employment First Implementation* (Section C) – As an Employment First state, “competitive employment in the general workforce is the first and preferred post education outcome for people with any type of disability.” Every ISP must contain at least one employment outcome included in Section B even if the individual is not pursuing employment at the time of the ISP. The Support Coordinator will document the individual’s current employment status based on the discussions that were facilitated through the Employment Pathways section of the PCPT. If employment is not being pursued at the time of the ISP, an explanation must be included in Section C – these plans will be further reviewed by Division personnel to ensure that every effort is being made to assist people in becoming employed.
- d. *Religious/Cultural Information* (Section D) – The individual has the opportunity to share information related to religious/cultural preferences and/or restrictions.
- e. *Health & Safety Information* (Section E) – Information regarding the individual’s health and safety, as indicated through the NJ CAT as well as the planning process will be identified within this section of the ISP.
- f. *Emergency Back-Up Plan* (Section F) – The emergency back-up plan is only required to be completed if the planning team deems necessary. The emergency back-up plan must identify specific arrangements necessary to maintain the health and safety of an individual in the event of a breakdown in the routine plan of care. In the event of a life-threatening emergency, 911 must be called.
- g. *Authorizations & Signatures* (Section G) – Indications of all planning team members who participated in the planning process are identified here. Signatures from the individual, Support Coordinator, SC Supervisor, and guardian (if applicable) must all be included. The Support Coordinator must ensure that the individual has helped with the development of and agrees with the Service Plan, had the ability to choose the services and providers identified in the plan, and is aware of his/her rights and responsibilities as documented in the “Participants Statement of Rights & Responsibilities.” The ISP will be shared with all service providers indicated in the



plan; however, sharing the PCPT with service providers is up to the individual, as indicated in the ISP. If a change in the functional level of the individual indicating that he/she requires less supports has been identified, this information must be noted in this section of the ISP. See also section 6.8.

6.5 Procedures for Resolving Differences of Opinion among Planning Team Members

The planning team must seek to reach consensus in developing the ISP and in developing consistent and/or complementary strategies and methods for implementing the plan. Efforts should be made during team meetings to ensure that all points of view are heard. Differences of opinion can usually be resolved by a thorough discussion of concerns and recommendations. If a team member feels that his or her point of view has not received a complete hearing during a team meeting, he/she is encouraged to discuss his/her concerns privately with the Support Coordinator, who may subsequently reconvene the planning team to readdress the issue. Such methods of informally resolving an issue are encouraged before formal grievance and appeal mechanisms are employed.

The individual will indicate his/her agreement with and approval of the plan by signing the ISP "Authorizations & Signatures" page.

In the event there is disagreement regarding the ISP, the areas in which consensus has been met will be included in the plan so that there will not be a delay in the provision of services related to those areas of consensus.

6.6 Planning Meetings

6.6.1 Notice of Planning Meetings

The Support Coordinator shall notify the planning team, preferably in writing, of team meetings. The date, time, and location of the meetings should be mutually convenient for the individual, Support Coordinator, and other planning team members. The planning team should be notified at least five (5) working days in advance of the meeting. The notification should include the time, date, and place of the meeting and inform the planning team of the purpose of the meeting.

An initial meeting for newly assigned individuals should be arranged within ten (10) days of Support Coordination Agency assignment in order to discuss the arrangements needed for the planning process.

6.7 Meeting Process

In cases when the individual is not fulfilling the role of meeting facilitator, the Support Coordinator shall coordinate the planning team meeting, ensure all planning team members are introduced, explain each team member's responsibilities, and describe the purpose of the meeting. The Support Coordinator shall explain that the planning team will operate as an interdisciplinary team and that every effort will be made to reach consensus, but that in the event consensus cannot be achieved, the areas in which consensus has been met will be included in the plan so that there will not be a delay in service provision.



The Support Coordinator shall ensure that the individual is treated with respect and dignity during the meeting by making sure that comments are directed to the individual in first person rather than third person language, sensitive issues are discussed with respect for privacy and consideration for the individual's dignity, etc. The Support Coordinator shall also ensure that all participants are given an opportunity to provide input and that issues are thoroughly discussed before decisions are reached. Decisions shall be guided by the Division's Mission and Core Principles and the ISP Operating Principles.

The standard agenda for a meeting shall consist of the following:

- Review of PCPT
- Review of the last ISP, if applicable
- Review of professional evaluations and assessments, as needed
- Discussion of the person's current status, preferences, needs, and vision for the future
- Development of long-term outcomes
- Discussion of services needed to attain the long term outcomes
- Discussion of other actions necessary to implement the services, achieve the outcomes, and meet the individual's needs
- Discussion of other special considerations

When special circumstances require a different agenda, the Support Coordinator shall communicate the revised agenda to the team at the beginning of the meeting.

Individual as Facilitator – Prior to the facilitation of the planning meetings, the Support Coordinator should speak with the individual to determine his/her desire to facilitate his/her own planning meetings. Every opportunity will be provided for the individual to facilitate his/her planning meetings if he/she so desires. In circumstances where the individual will be facilitating the meetings, the Support Coordinator will provide support as needed. If the individual chooses not to facilitate the planning meetings, the Support Coordinator will fulfill this role.

Frequency of Meetings – Face-to-face planning meetings/reviews are encouraged whenever possible. The ISP shall be reviewed, as indicated on the Support Coordinator Monitoring Tool, during the Support Coordinator's monthly/quarterly/annual contacts, and more often if necessary, to ensure that the plan remains appropriate and that the individual is making progress toward the goals and outcomes specified in the plan. The planning team shall meet at least annually – to review the current plan and develop a new annual ISP – and more often whenever there is a significant change in the individual's status.

Planning Process – The Support Coordinator has 30 days from the date an individual is initially assigned to the Support Coordination Agency to complete the planning process resulting in an approved ISP. The ISP is developed through a Person-Centered Planning Process. Once assigned, the Support Coordinator will plan with the individual and his/her identified team members through regular contact and communication that includes at least one face-to-face meeting in a mutually convenient location. Through the use of information provided from the NJ Comprehensive Assessment Tool (NJ CAT), the Person-Centered Planning Tool (PCPT), and any other discovery tools that have been utilized, the Support Coordinator will begin to build an ISP that includes identification of the individual's strengths,



preferences, and needs; builds upon the individual's capacity to engage in activities and promote community life; respects the individual's preferences, choices, and abilities; and involves families, friends, and professionals in the planning and delivery of services and supports as needed by the individual. Development of the Service Plan drives the outcomes and services that will be implemented in order to meet the needs of the individual.

Extending 30-Day Timeframe for ISP Completion – the 30-day deadline for completing the ISP can be waived if circumstances warrant additional time for completion. A written request specifying the reasons for the need for an extension must be submitted to the SC Supervisor help desk (see Section 12.3). The Support Coordination Agency will not receive payment for services rendered until the ISP is completed and approved.

6.8 Service Plan Approval

All ISPs will be reviewed by the SC Supervisor and must be signed by the individual/guardian prior to approval. The ISP Quality Review Checklist must be utilized to assist the SC Supervisor in reviewing the ISP for quality. The SC Supervisor must sign and date the ISP Quality Review Checklist and upload the signed document to iRecord. During this interim phase, the SC Supervisor must submit all ISPs to the Division for approval. The required method for submitting the plan to the Division for approval is changing the status of the plan from "Review (R)" to "State Review (SR1)" in iRecord. However, prior to full implementation of the iRecord, plans can be submitted directly to the designated Division personnel.

If changes need to be made to the plan prior to SC Supervisor approval, the SC Supervisor will communicate the need for revisions with the Support Coordinator and approve the plan once the changes are made to his/her satisfaction.

Upon review, the Division may require revisions to the plan prior to approval. These changes will be provided to the SC Supervisor within seven (7) days and must be implemented and returned to the Division. If plan revisions are significant (such as additions/deletions of outcomes, goals, services, providers, etc.), signatures will need to be re-obtained to ensure individual agreement with the plan changes. If the changes are minor (such as spelling/grammar errors, word changes that don't alter the meaning of an outcome or goal, etc.), the Support Coordinator must inform the individual of these changes, but new signatures will not be needed to be obtained. A case note should record when and how the individual was informed of these changes.

6.9 Changes to the Service Plan

Revisions can be made to the Service Plan as needed, such as changes in services, provider choice, demographic information, religious/cultural information, emergency back-up plan, etc. It is not necessary to reconvene the planning team for all changes to the ISP. Signatures and ISP approval must be obtained when there are changes to Section B. Personally Defined Outcomes & Services. To initiate the process, the individual will contact the Support Coordinator to inform him/her of the change in need or provider. The Support Coordinator will make revisions to the plan as needed and obtain signatures as described in section 6.8. For service need changes, the Support Coordinator must end the service to be



revised in the current plan and add the new service with start date in the revised/new plan to ensure there are no overlapping or duplicate services in the plan. This revised plan will be saved in the iRecord as a version of the plan that was revised. However, prior to full implementation of the iRecord, revisions can be made by following the guidelines for the Fiscal Intermediary per the designated Division personnel. The revised plan shall be submitted to the designated DDD personnel for approval per Section 6.8.

6.10 Addressing Changes in Need

As previously stated under the “Role of the Support Coordinator,” the Support Coordinator must ensure that the individual’s services and supports remain within the allotted budget. It is important that the Support Coordinator maintain a budgetary “cushion” within the ISP in order to address unforeseen needs as they arise during the course of the year. However, there may be circumstances where the individual experiences temporary or permanent changes to service/support needs. In these circumstances, the individual must contact the designated Division personnel to request a temporary increase to his/her individualized budget. If the changes to the individual’s service/support needs are ongoing and more permanent, the individual can request a reassessment via writing to the Division. The Support Coordinator cannot be involved in budget determinations. If the individual requires assistance in making these requests, the Division will provide support.

7 COORDINATION OF SERVICES

7.1 Plan Overview

This section describes how the Support Coordinator arranges for and coordinates services, both within and external to the Division, to meet the needs of eligible individuals as identified in the ISP. For services funded by the Division, the section specifies authorization procedures, referral and placement procedures, safety considerations for placements, Support Coordinator responsibilities for coordinating services, and policies and procedures necessary to provide effective, coordinated services with other agencies and programs.

7.2 Plan Coordinator

The Support Coordinator is the plan coordinator and has the responsibility of assisting individuals in accessing services by ensuring that services, activities, and goals identified in the ISP are arranged for and implemented (details on facilitating the person-centered planning process and writing the ISP are provided in Section 6).

7.3 Use of Community Resources

The Support Coordinator shall coordinate activities necessary for the provision of services identified. The Support Coordinator shall begin this process by first examining the services or other assistance which may be provided through existing community resources or family members.



Most communities offer an array of services that may meet the needs of people with developmental disabilities and their families. The type and availability of services will vary, but utilizing these community resources can increase the amount of services an individual receives and may provide services that are not available through the Division. It is the Support Coordinator's responsibility to be aware of community resource information and eligibility requirements for these programs and agencies. Depending on the capabilities of the individual, either contact or provide contact information to individuals and their families when it appears that these resources may benefit the individual and family. Services through community resources may include, but are not limited to, advocacy, adaptive and/or medical equipment, nutrition assistance, housing, legal assistance, recreation, transportation, and utility assistance. A section regarding potential funding sources is included in the PCPT to assist in identification of community resources and information on other resources is available on the Support Coordinator Resource website highlighted in Appendix A.

"New Jersey Resources" and www.njhelps.org can be used to identify government, community organizations, and professionals working to assist people with disabilities. NJ Resources can be accessed on the DDS website at <http://www.nj.gov/humanservices/dds/home/>.

7.4 Selection of Providers & Access to Services

The Support Coordinator will assist, as needed, the individual or the individual's representative in matching approved providers for the services that have been identified to meet the individual's needs as indicated in the ISP. The individual and Support Coordinator (and general public) can access a database of Division approved providers for each service through the Division's website.

While it is unacceptable for the Support Coordinator to select service providers for the individual, he/she is responsible for assisting the individual with identifying criteria that will help narrow the list of available providers. The criteria are based on the needs and preferences of the individual. When beneficial, the Support Coordinator can, and should, contact potential service providers to help facilitate individual research through provider interviews, tours, etc. and determine availability of services.

When an individual needs assistance in identifying or choosing a Division-funded provider, the following process is implemented:

- The planning process identifies the need for services funded by the Division.
- The individual, with assistance from the Support Coordinator as needed, will access the list of available Division-funded providers through the database, Division regional personnel, provider fairs, etc. in order to explore potential providers. Support Coordinators are not permitted to recommend any specific provider. If the Support Coordinator is asked to make a recommendation regarding a provider, this request cannot be granted. The Support Coordinator must be unbiased in contacting providers.
- The Support Coordinator contacts the potential providers to assess availability and documents the choice in the ISP.



- The Support Coordinator verifies or provides contact information to the selected provider and individual to facilitate the introduction of individual and provider and notifies the provider of the service need and the individual's attributes.
- The provider should make contact with the individual or express interest in delivering services to the individual within five (5) working days.
- Once the individual identifies the Division-funded provider of choice, there are several methods to access the services:
 - If the individual is choosing to receive services through a contracted Division provider, the Region will make the referral to the provider.
 - If the individual is self-directing his/her services, Easter Seals will send a welcome packet to the provider.
 - If family support services are needed, the Support Coordinator will contact the Division to arrange.
- The Support Coordinator changes provider selection in the ISP as necessary – due to lack of capacity, inability to meet needs, etc.
- The Support Coordinator follows the ISP approval process described in Section 6.8.
- The Support Coordinator sends a copy of the authorized ISP (and any other relevant and consented to discovery tools, evaluations, etc.) to all service providers identified in the ISP. During this interim phase when standardized rates have not been established, there may be multiple providers' rates visible on the ISP. Therefore, the Support Coordinator must ensure that each provider can only see the rates connected to their particular services. It is recommended that the Support Coordinator "black out" the rates of other providers receiving the ISP.

7.5 Selection & Hiring of Self-Hires

The Self-Hire selection process is designed to be self-directed by the individual. Specific procedures shall be followed in the event an individual identifies or wishes to choose a Self-Hire. The fiscal intermediary (FI) shall be utilized if a Self-Hire is chosen by the individual to manage payroll, tax responsibilities, and other employer obligations related to Self-Hire selection and employment activities.

When an individual chooses a Self-Hire to provide authorized supports as cited in the ISP, the following process shall be followed:

- The Support Coordinator will provide the individual/family with a self-hire packet obtained from Easter Seals
- The individual will complete the packet and send it to Easter Seals
- While Easter Seals reviews the packet for approval, an ISP that does not include the self-hire service(s) can be submitted for approval by the SC Supervisor and DDD in order to remain within the 30-day requirement. In situations where the only service(s) the individual will be receiving are provided by self-hires, the ISP can be submitted with a goal stating that the individual is "pursuing a self-hire" with a "natural" or "generic" service. Once the self-hire has been approved by Easter Seals, the ISP shall be revised as per section 6.9 to include the goal for which the self-hire will provide services, the name of the self-hire, the funding source, etc.



- Easter Seals will review qualifications of the self-hire candidate to ensure he/she meets Division standards
- The Support Coordinator sends a copy of the authorized ISP (and any other relevant and consented to discovery tools, evaluations, etc.) to all self-hires identified in the ISP. There may be multiple self-hires' rates visible on the ISP. Therefore, the Support Coordinator must ensure that each self-hire can only see the rates connected to his/her particular services. It is recommended that the Support Coordinator "black out" the rates of other self-hires receiving the ISP.
- The individual hires, orients, and trains the self-hire
- Easter Seals will ensure training in accordance with Division required qualifications specific to the services he/she will provide
- The individual will review and sign each Self-Hire time sheet, track the hours of service used against the hours of service authorized, report any concerns to the Support Coordinator, and work with the FI and the Division toward resolution.

7.6 Coordination with Other Programs and Agencies

The Support Coordinator is responsible for coordinating services and supports through other programs and entities as appropriate. This can include a variety of programs and entities but require at a minimum the following:

Managed Care Organizations (MCO) Care Managers

Every individual receiving Division services must be eligible for Medicaid and, as such, should have a Managed Care Organization designated to provide services related to his/her acute health needs. The MCO must assign a Care Manager to all individuals with developmental disabilities. The Support Coordinator should identify and reach out to contact this MCO Care Manager to ensure coordination of health care.

Division of Vocational Rehabilitation Services (DVRS)/Commission for the Blind & Visually Impaired (CBVI)

Employment services must be sought through DVRS/CBVI prior to being made available through Division-funding. However, Long-Term Follow-Along (LTFA) services will be provided by the Division even in circumstances where other employment supports were provided by DVRS/CBVI first.

The F3 "Division of Vocational Rehabilitation Services (DVRS) or Commission for the Blind and Visually Impaired (CBVI) Determination Form for Individuals Eligible for the Division of Developmental Disabilities (DDD)" form must be completed by the DVRS/CBVI counselor in order for an individual to access employment services through the Division. In rare cases when an individual is not being referred to DVRS/CBVI, the F6 "Non-Referral to Division of Vocational Rehabilitation Services (DVRS) or Commission for the Blind & Visually Impaired (CBVI) Form" must be completed to describe why the individual is not being referred to DVRS/CBVI. These forms can be found in Appendices D and E.



8 MONITORING

This section provides information regarding individual monitoring requirements. It also discusses mandatory reporting of cases of suspected abuse and neglect and quality assurance activities.

8.1. Mandatory Reviews

Support Coordinators are responsible for ongoing monitoring of all individuals on their caseload through use of the Support Coordinator Monitoring Tool.

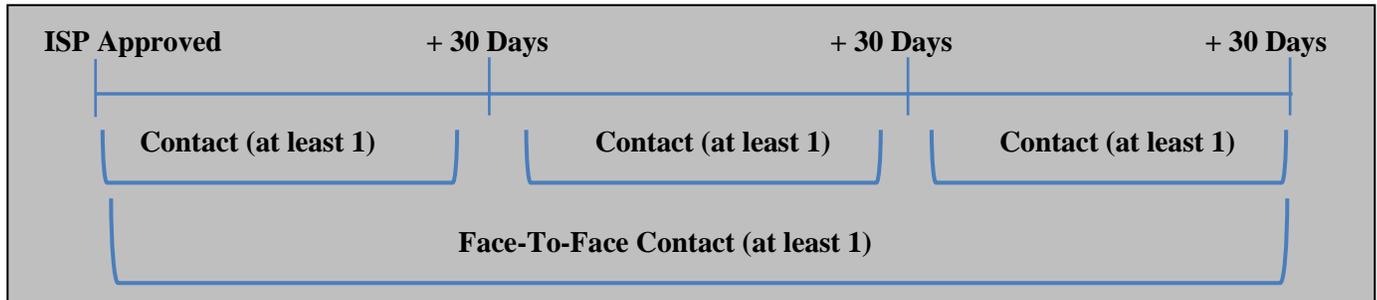
These reviews must occur within specific intervals based on the date from which the ISP was approved. Reviews should be based on the needs of the individual; thus, while reviews must occur within particular timeframes, a structured pattern does not need to be followed. Support Coordinators can conduct reviews based on individual need as long as the minimum requirements of monthly and quarterly face-to-face contacts are met. In cases where an individual needs a face-to-face contact in the first or second month of the quarter, that face-to-face contact will fulfill the requirements for that quarter and does not “restart the clock” in iRecord as illustrated in the graphic “Monitoring Contacts Timeline” below. For example, if an individual is seen face-to-face in the second month of a quarter and is then seen in the first month of the next quarter, this schedule would appropriately meet the minimum requirements for reviews. However, Support Coordinators should be cognizant of gaps between face-to-face contacts so that the timeframe between face-to-face visits does not exceed four (4) months in situations where the individual’s needs did not warrant a face-to-face visit sooner.

- **Monthly Contact** – must be conducted within 30 days from the date of the ISP approval and within every 30 day timeframe thereafter (see graphic below). The Support Coordinator must have, at a minimum, contact with the individual once per month. Face-to-face contact is preferable but contact via the telephone is acceptable. Email, Skype, or other methods of communication are not acceptable at this time to meet the mandatory minimum monitoring requirements. Information gathered/observed during this contact must be documented in the Support Coordinator Monitoring Tool. The Support Coordinator must document any additional contact beyond the required monthly through case notes. Follow-up that has occurred based on the monthly contact can be documented in case notes or subsequent Support Coordinator Monitoring Tools. The ISP must be revised as necessary.
- **Quarterly Contact** – must be conducted within 90 days from the date of the ISP approval and within every 90 day timeframe thereafter (see graphic below). The Support Coordinator must have, at a minimum, one quarterly face-to-face visit with the individual. These quarterly contacts shall include at least one home visit annually and may also include a review of the setting where the individual receives services. The annual home visit can be conducted any time within 365 days from the date of the ISP approval. Information gathered and observed during this contact must be documented in the Support Coordinator Monitoring Tool. The Support Coordinator must document any additional contact beyond the required quarterly contact through case notes. Follow-up that has occurred based on the quarterly contact can be



documented in case notes and/or subsequent Support Coordinator Monitoring Tools. The ISP must be revised as necessary.

Monitoring Contacts Timeframe



- **Annual ISP** – All individuals who are eligible for Division services and programs shall have, at a minimum, a new ISP annually. The Support Coordinator shall facilitate the person-centered planning process with the planning team, continually update and revise the ISP if service needs have changed during the course of the year, and write a new ISP annually. Information gathered and documented in case notes and/or on the Support Coordinator Monitoring Tool throughout the year must be considered in reviewing, revising, and writing new ISPs. If the monthly and quarterly minimal requirements have already been met (including the annual home visit), a Support Coordinator Monitoring Tool does not need to be completed in the same month as the annual ISP.

If an individual is not adhering to the monitoring contact requirements, the Support Coordination Agency should contact the designated Division personnel in order to address the issue.

8.2 Plan Review Elements

The following applicable elements must be addressed by the Support Coordinator whenever the planning team reviews the ISP or services:

- Review the individual's current services and ISP to determine the type, recommended amount, received amount, and cost of each service.
- Review all progress reports, evaluations, assessments, recommendations, nursing reports, incident reports, and monitoring records received to determine if services are being provided appropriately.
- Gather information obtained in circumstances in which interaction with or assessment/observation of individual services was done.
- Assess, in conjunction with the individual, the services being provided, progress toward outcomes, and any problems or service needs from the individual's perspective. Discuss satisfaction with services and providers including service gaps and the back-up plan where appropriate.
- Discuss new or previously identified risks and the prevention of those risks.



- Discuss with the provider/other team member's progress toward outcomes and any concerns. Review the data on outcomes to assess the individual's progress and identify any barriers to achievement of those outcomes.
- Discuss changes in the individual's medical/functional status including any behavioral health needs. If necessary, contact the Managed Care Organization's (MCO) care management to discuss any changes in the individual's health.
- Discuss services the individual is receiving from entities other than the Division (i.e. DVRS, DDS, MCO, etc.). Coordinate care with these entities as appropriate.
- If the Support Coordinator's assessment indicates changes to the current ISP or services are necessary, discuss the changes and the rationale for the changes with the individual. This is especially critical if the changes may result in a reduction or termination of service.

8.3 Mandatory Reporting of Abuse/Neglect

Division Circular #14 requires the reporting of unusual incidents. All individuals providing services to Division eligible individuals must report incidents in the required time frames and cooperate in investigations. Allegations of abuse, neglect, and exploitation require the Support Coordinator to notify the Division by telephone immediately (use the telephone number from the "Support Coordinators Guide to Unusual Incident Reporting" found on the Division's website at

<http://www.nj.gov/humanservices/ddd/documents/Documents%20for%20Web/SC%20GUIDE%20TO%20INCIDENT%20REPORTING%20Rev%2012%2013.pdf>.

Allegations of abuse, neglect, and exploitation remain allegations unless substantiated by investigation. If it appears the state Criminal Justice code has been violated, local law enforcement officials must be notified.

Failure to immediately report allegations of abuse, neglect, or exploitation is considered a disorderly person's offense and can result in a fine of \$350 for each day that the abuse, neglect, or exploitation was not reported.

8.4 Quality Assurance Responsibilities

Support Coordinators may become aware of quality assurance issues during the course of their work, e.g. licensing standards which are out of compliance, inappropriate implementation of programs, or serious incidents not being reported. The Support Coordinator must report problems to the designated Division personnel and document these concerns in a case note and/or the Support Coordinator Monitoring Tool.

9 CURRENT DIVISION SERVICES

The current list of services available through Division funding is located in Appendix B.



10 PAYMENT FOR SUPPORT COORDINATION SERVICES

Until final rates are established through the formal rate study (expected in 2014), an interim rate of \$200.00 per month per individual assigned to the Support Coordination Agency has been established for Support Coordination. Monthly payment will be issued upon completion of mandated provision of services per individual. Only submission of a completed ISP or the Support Coordinator Monitoring Tool will suffice in order for payment to be issued. Partial payments and incomplete work will not be reimbursed. To receive payment, the Support Coordination Agency must submit a properly completed payment voucher as described in Appendix C.

11 DOCUMENTATION GUIDELINES

This section describes the documentation tools that are required for Support Coordination services. Establishing and maintaining accurate records is critical. In a transition to a Medicaid based fee-for-service system, supporting documentation for all services rendered will become even more essential.

In addition, assessments, tools, and service plans must be aligned so that the service plan directly relates to identified needs from the assessment.

All documentation must be HIPAA compliant. For example, paper documents/case records must be stored securely with appropriate safeguards, and the individual's written authorization for release of information must be obtained before any protected health information can be shared.

There are serious consequences to fraudulent documentation; thus, providers must take precautions to ensure compliance with all applicable laws and regulations. Common documentation errors include, but are not limited to, the following:

- Billing for services not rendered such as billing for canceled appointments or no shows
- Billing for misrepresented service such as services provided by unqualified staff or incorrect dates of service
- Billing for duplicate services
- Serious record keeping violations such as falsified records or no record available
- Missing signatures
- Developing a service plan that does not relate to the assessment/evaluation
- Reusing identical content in multiple notes, plans, tools, documents, etc.

Documentation is considered unacceptable if it is missing altogether (such as missing notes) or illegible.

11.1 Making Corrections to Documents

11.1.1 Paper Documents

- Deletions, erasures, and whiting out errors is not permitted
- Content can only be changed by the original writer



- Corrections must be made by the person who originally wrote the document with one line through the error including initials and date of correction

11.1.2 Electronic Documents

- Documents uploaded/entered into iRecord cannot be altered once submitted. An additional case note explaining the correction must be entered into the system.

11.2 Required Support Coordination Documents

- Support Coordination Case Conference Guide – refer to section 5.8
- Support Coordinator Monitoring Tool – refer to section 8.1
- Person-Centered Planning Tool (PCPT) – refer to section 6.4.1
- Individualized Service Plan (ISP) – refer to section 6.4.2
- Participants Statement of Rights & Responsibilities – refer to section 6.4.2 under “Authorizations & Signatures”
- ISP Quality Review Checklist – refer to section 6.8
- Payment Voucher – refer to section 10 and Appendix C
- F3 Form – DVRS or CBVI Determination Form for Individuals Eligible for DDD – refer to section 7.6
- F6 Form - Non-Referral to DVRS or CBVI Form

11.3 Other/Related Documents

- Support Coordination Agency Selection Form – refer to section 5.8
- NJ Comprehensive Assessment Tool (NJ CAT) – refer to section 6.4.1
- Optional Individual Discovery Tools – refer to section 6.4.1
- Easter Seals Self-Hire Packet – refer to section 7.5
- Unusual Incident Report – refer to section 8.3
- Division Circulars – found at:
<http://www.nj.gov/humanservices/ddd/news/publications/divisioncirculars.html>
- Satisfaction Surveys - to be developed

12 RESOURCES/TECHNICAL ASSISTANCE

Additional information and guidance related to Support Coordination can be accessed through the following resources:

12.1 The Division’s Role during Interim Phase

12.1.1 Continuity of Care Management

The Division is happy to provide information to ensure a smooth transfer from Case Management to Support Coordination during this interim phase. Division Case Managers will provide professional and courteous customer service to Support Coordination Agencies. This information transfer can be



documented through the Case Conference Guide. In addition, there are helpful resources noted below for further support.

12.1.2 Intensive Case Management Support

For situations where an individual requires more extensive care management, the Support Coordinator can contact their designated Division personnel for additional assistance. This Division staff member will consult with an appropriate Regional staff person to identify resources and information in order to assist with troubleshooting the situation.

12.1.3 Unusual Incident Reporting (UIR)

UIR Coordinators are available in each Region to provide assistance with recording of incidents – including forms, timeframes, types of incidents, role of the Support Coordinator, etc. Contact information is available in the “Support Coordinators Guide to Unusual Incident Reporting.”

12.1.4 ISP Approval

As of January 2014, changes were made in order to increase the efficiency of the approval process. After submission of a plan that has been approved by the SC Supervisor, Division personnel will review the plan for required elements versus areas in need of improvement. Feedback will be provided to the SC Supervisor with the expectation that required plan elements, at a minimum, will be addressed prior to plan resubmission. The Division expects that feedback related to areas in need of improvement will be reflected in future plans.

12.1.5 iRecord Support

To report technical problems with the iRecord, or request technical assistance, select the “Feedback” link at the top of the screen as shown below:



Alternatively, if the feedback button is not available any technical inquiries can be sent to the DDD service desk at DDD.ITRequests@dhs.state.nj.us. This address may be used to report bugs, suggest future functionality or request technical assistance. For assistance with content of plans or how to write plans, please contact the designated Division point person.

12.2 General Resources, Information, & Clarification

- Support Coordination Resource Page- <http://rwjms.rutgers.edu/boggscenter/projects/njisp.html>
- Support Coordination Help Desk – DDD.SCHelpdesk@dhs.state.nj.us
- iRecord Help Desk – DDD.ITRequests@dhs.state.nj.us
- iRecord Tutorials – <http://rwjms.rutgers.edu/boggscenter/projects/njisp.html>
- Designated Division Personnel – as assigned per region
- Medicaid Eligibility Help Desk – DDD.MediElighelpdesk@dhs.state.nj.us
- Person-Centered Planning/Thinking
 - www.inclusion.com
 - www.learningcommunity.us



- www.capacityworks2.com
- Elizabeth M. Boggs Center on Developmental Disabilities - http://rwjms.rutgers.edu/boggscenter/training/person_centered.html

12.3 Supervisory Resources, Information, & Clarification

- Support Coordination Resource Page- <http://rwjms.rutgers.edu/boggscenter/projects/njisp.html>
- Support Coordination Help Desk – DDD.SCHelpdesk@dhs.state.nj.us
- SC Supervisor Help Desk – DDD.SCSupervisorSupport@dhs.state.nj.us

13 COMMUNICATION/FEEDBACK

In an effort to streamline communication and provide the most effective support to Support Coordination Agencies, the Division has established the following protocol for requesting direction and clarification pertaining to the process and delivery of Support Coordination services:

Step 1: Support Coordination Help Desk – DDD.SCHelpdesk@dhs.state.nj.us

This is the first point of contact for general information related to Support Coordination policies, training, forms, and questions about assignment of monitors.

Step 2: Support Coordination Monitors

Each Support Coordination Agency is assigned a designated Division personnel known as a Support Coordination Monitor. This staff person reviews and approves ISPs and provides quality improvement feedback and clarification of specific Division policies.

Step 3: SC Supervisor Support Help Desk – DDD.SCSupervisorSupport@dhs.state.nj.us

This help desk should be used for issues that have not be resolved through steps 1 and 2 and should be utilized after those levels of communication have been exhausted.

Step 4: Direct Communication at Administrative Level of Support Coordination Services

When all other levels of communication have not resolved the issue, communication should be sent directly to Christine James, Director of Quality Improvement & System Reform, at Christine.James@dhs.state.nj.us or 609-631-2274.



Appendix A – Support Coordination Information & Resources Page

<http://rwjms.rutgers.edu/boggscenter/projects/njisp.html>

This webpage provides information and resources to Support Coordination Agencies that have been approved by the NJ Division of Developmental Disabilities (Division) to provide Support Coordination Services. The information found here includes required documentation, useful tools, tutorials, and other resources to assist Support Coordinators as they help people with intellectual and developmental disabilities access needed supports and services. It is intended for the use of approved Support Coordinators per Division guidelines.

Please note that this web page will be updated regularly to add helpful resources as they become available and to update existing resources as new information is revised or added. Emails will be sent to support coordinators and/or their supervisors when important additions have been made.

[Division Support Coordination Updates](#) – links Support Coordinators to important information and updates provided by the Division of Developmental Disabilities.

[iRecord Tutorials](#) – links Support Coordinators and their organization’s management to video tutorials developed by the Division to provide step-by-step instructions on use of the iRecord.

[Documents Used by Support Coordinators](#) – links Support Coordinators to documents that are required and/or recommended for use in plan development, review, and monitoring of supports and services (e.g. NJISP, PCPT, Monitoring Tool, ISP Quality Review Checklist, etc.).

[Additional Information and Helpful Resources](#) – links Support Coordinators to information and resources that they will find useful in helping the person locate and connect to qualified service providers. It also contains information related to Division of Developmental Disabilities, Department of Vocational Rehabilitation Services, and other state and private organizations for which supports, services, and information can be obtained.



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Appendix B – Current DDD Services (February 2014)

Procedure Code	Services	Description	Limits	Self-Hire?
A7027HI	Assistive Technology - Assessment	Assists in determining the needs of an individual, defining the most suitable or appropriate assistive technology for the individual, and recommending training and follow-up services. The purpose of any device should be to aid in increasing, maintaining, or improving functional capabilities in order to perform everyday activities.		N/A
S5165AT	Assistive Technology	An item, piece of equipment or product system, whether acquired commercially, modified or customized that is used to increase, maintain, or improve functional capabilities of participants.	<ul style="list-style-type: none"> Must meet applicable standards of manufacture design and installation and are subject to prior approval on an individual basis by DDD 	N/A
S5165EMA	Environmental Modification - Assessment	Assists in determining the needs of an individual, defining the most suitable or appropriate environmental modification for the individual. The purpose of the modification is to ensure the health, welfare and safety of the participant or to enable the participant to function with greater independence in the home.		N/A
S5165EM	Environmental Modification	The purpose of the modification is to ensure the health, welfare and safety of the participant or to enable the participant to function with greater independence in the home.	<ul style="list-style-type: none"> Excluded items are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation. 	N/A
T2015R	Habilitation - Self-Designed Day Programs Paid on a <i>Daily Rate</i>	Community based habilitation services, paid on a <i>daily rate</i> , designed by the individual/family in order to develop maintain and/or maximize their independence in self-care, physical and emotional growth, socialization, communication and vocational skills.	<ul style="list-style-type: none"> Up to 25 hours/week Direct Support Professionals that are Self-Hires cannot be used to provide this service as there is no daily rate established. 	No



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Procedure Code	Services	Description	Limits	Self-Hire?
T2015HIR	Habilitation - Self-Designed Day Programs Paid on an <i>Hourly Rate</i>	Community based habilitation services, paid on an <i>hourly rate</i> , designed by the individual/family in order to develop maintain and/or maximize their independence in self-care, physical and emotional growth, socialization, communication and vocational skills.	<ul style="list-style-type: none"> Up to 25 hours/week 	No
T2015A	Habilitation - Activity Costs	Self-designed day activity costs of individual and staff that must be clearly linked to specific habilitative interests outlined in the participant's plan	<ul style="list-style-type: none"> Limited to \$40 per event for the participant (or up to \$80 if an additional fee is required for staff member) Activity costs cannot include yearly memberships or season passes 	No
T2015C	Habilitation - Classes	Habilitation classes, in a group setting, that provide an opportunity for participants to achieve outcomes of improved health, increase social and emotional growth and to maximize vocational potential.	<ul style="list-style-type: none"> Up to 25 hours/week Classes must be non-matriculating Class/course of study cannot lead to a degree or certificate DSP Agency or Self-Hire cannot be used to deliver the service, but can accompany the participant in order to provide support and assistance in areas of self-care and socialization 	No
T2020	Habilitation – Facility Based Habilitation	Facility based habilitation services that are aimed toward developing, maintaining and/or maximizing the participant's independent functioning in self-care, physical and emotional growth, socialization, communication, and vocational skills.	<ul style="list-style-type: none"> Up to 25 hours/week DSP Agency or Self-Hire cannot be used to deliver the service, but can accompany the participant in order to provide support and assistance in areas of self-care and socialization 	No



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Procedure Code	Services	Description	Limits	Self-Hire?
T2015M	Habilitation - Gym Membership	Monthly membership fees that are required by a health club facility so that the participant can access the amenities offered by the facility in order to achieve outcomes of improved health (habilitation).	<ul style="list-style-type: none"> • Membership is for the participant only • Startup/signup fees cannot be covered by this service • DSP may accompany the participant to the gym to provide assistance but at no extra cost. • 	No
T2015S	Habilitation - One-on-one Tutoring/ Instruction, Specialized Skill	Habilitation that is provided on a one-on-one instructional level that affords the opportunity for participants to achieve outcomes of improved health, increase social and emotional growth and to maximize vocational potential.	<ul style="list-style-type: none"> • Up to 25 hours/week • DSP Agency or Self-Hire cannot be used to deliver the service, but can accompany the participant in order to provide support and assistance in areas of self-care and socialization 	No
H2016ISE	Individual Supports - Direct Care Professional (DSP); Agency Hired or Self-Hired	Services that include self-care and habilitation related assistance provided in the participant's home, family home, or other community-based setting.	<ul style="list-style-type: none"> • All available resources must be utilized before requesting Individualized Services • Participant can receive up to 16 hours of individual supports per day • Support hours while the participant is on vacation is limited to 16 hours a day for up to 14 days per year. • Parent/Stepparent, Spouse, Guardian, Co-Guardian, or a relative residing in the participant's residence cannot be hired. 	Yes
H2016ISEA	Individual Supports - Activity Cost Reimbursement while Providing Individual Supports	Reimbursable activity costs for Self-Hire and/or Agency provided DSP while providing individual supports. The participant must pay for their own activity costs. Activity costs for support staff accompanying a participant to an activity in which the participant would not be able to attend without assistance.	<ul style="list-style-type: none"> • Yearly memberships/season passes to activities are excluded • Reimbursable costs cannot exceed \$40 a day • Food/meals for the DSP is not reimbursable • Parent/Stepparent, Spouse, Guardian, Co-Guardian, or a relative residing in the participant's residence cannot be hired. 	Yes



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Procedure Code	Services	Description	Limits	Self-Hire?
S5161PD	Personal Emergency Response System (PERS) - Equipment	An electronic device that enables participants to secure help in an emergency. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated.	<ul style="list-style-type: none"> All PERS shall meet applicable standards of manufacture, design, and installation PERS are subject to prior approval on an individual basis by DDD. 	No
S5161IT	PERS - Installation and/or Testing	The cost associated with the installation of and/or the testing of a PERS device. The electronic device that enables participants to secure help in an emergency.	<ul style="list-style-type: none"> All PERS shall meet applicable standards of manufacture, design, and installation PERS are subject to prior approval on an individual basis by DDD. 	No
S5161	PERS - Monitoring Cost	Monthly service fees associated to monitor the electronic device and the response center, which is staffed by trained professionals.	<ul style="list-style-type: none"> All PERS shall meet applicable standards of manufacture, design, and installation PERS are subject to prior approval on an individual basis by DDD. 	No
SF01	Saturday/Sunday Recreation Programs and After Care Programs	Programs designed to provide aftercare and weekend recreation activities designed to develop, maintain and/or maximize the individual's independent functioning in self-care, physical and emotional growth, socialization, communication, and vocational skills.		N/A
T100522	Respite - Delivered at an <i>Hourly Rate</i>	Short-term services provided to participants unable to care for themselves that are furnished because of the absence or need for relief of those persons who normally provide care for the participant.	<ul style="list-style-type: none"> Room and Board costs will not be paid when services are provided in the participant's home. Parent/Stepparent, Spouse, Guardian, Co-Guardian, or a relative residing in the participant's residence cannot be hired. 	Yes



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Procedure Code	Services	Description	Limits	Self-Hire?
S9125OH	Respite - <i>Overnight</i> Respite in a Participant's Own Home	Short-term services provided to participants unable to care for themselves that are furnished because of the absence or need for relief of those persons who normally provide care for the participant.	<ul style="list-style-type: none"> Room and Board costs will not be paid when services are provided in the participant's home. Parent/Stepparent, Spouse, Guardian, Co-Guardian, or a relative residing in the participant's home. 	Yes
T100522C	Respite – Camp	Short-term services provided to participants unable to care for themselves that are furnished because of the absence or need for relief of those persons who normally provide care for the participant in a camp setting.		N/A
T100522B	Respite - Self-Hire Benefits for Respite	Self-Hire benefits for respite.		N/A
T2018	Supported Employment - Job Development / Pre-placement	Job development/pre-placement assist participants to obtain and maintain a job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which the participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.	<ul style="list-style-type: none"> Individual has to be determined ineligible for employment services from DVRS. The phase of employment should not exceed 20 hours. DSP Agency or Self-Hire cannot be used to deliver the service, but can accompany the participant in order to provide support and assistance in areas of self-care and socialization. 	No
T2018F	Supported Employment - Follow Along	Follow along Job Coaching activities occur after the pre-placement and intensive training phase is completed. Job Coaching provides support services needed on an ongoing basis to support, maintain and strengthen a participant's competitive employment.	<ul style="list-style-type: none"> Limited to 20 hours per month Number of hours of job coaching cannot exceed 50% of the hours the participant works. DSP Agency or Self-Hire cannot be used to deliver the service, but can accompany the participant in order to provide support and assistance in areas of self-care and socialization. 	No
T2002HI	Transportation - Mileage Reimbursement for Transportation Companies	These services all a participant to access to/from waiver supports in the community. The selected service chosen must be the most cost effective means of transportation that the participant is able to access.	<ul style="list-style-type: none"> The need for transportation must be directed related to accessing the services and fulfilling the outcomes specified in the service plan. Reimbursement will only be available for transportation provided in NJ, New York, Pennsylvania and Delaware 	N/A



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Procedure Code	Services	Description	Limits	Self-Hire?
T2015T	Transportation Individual Supports - Mileage Reimbursement for Providing Transportation for Self-Hired DSP	Mileage reimbursement for Self-Hires providing transportation to and from a waiver service in their personal vehicle at .31 per mile.	<ul style="list-style-type: none"> The need for transportation services must be directly linked to accessing the services and fulfilling the outcomes specified in the service plan. Parent/Stepparent, Spouse, Guardian, Co-Guardian, or a relative residing in the participant's residence cannot be hired. 	Yes
A0090HI	Transportation Individual Supports - Mileage Reimbursement for Providing Transportation for Agency Hired DSP	Mileage reimbursement for Agency hired DSP that are providing transportation to and from a waiver service in their personal vehicle or agency vehicle. This is used when the agency is not qualified to provide transportation as Transportation Company.	<ul style="list-style-type: none"> The need for transportation services must be directly linked to accessing the services and fulfilling the outcomes specified in the service plan. The maximum mileage reimbursement rate is .31 per mile. 	No
S5165VMA	Vehicle Modifications - Assessment	Assessment to an automobile or van that is the participant's primary means of transportation in order to accommodate the special needs of the participant.	<ul style="list-style-type: none"> All modifications are subject to prior approval by DDD. The following are specifically excluded: (1) adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant; (2) purchase or lease of a vehicle; (3) regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications 	N/A
S5165VM	Vehicle Modifications	Vehicle modifications/ adaptations are specified by the service plan, and are necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.	<ul style="list-style-type: none"> The following are specifically excluded: (1) adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant; (2) purchase or lease of a vehicle; (3) regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications 	N/A



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DDD CONTRACTED SLOT

Procedure Code	Services	Description	Limits	Self-Hire?
N/A (Program ID)	Adult Training (AT) –	Provider based day habilitation services designed to develop, maintain and/or maximize the individual’s independent functioning in self-care, physical and emotional growth, socialization, communication, and vocational skills.	<ul style="list-style-type: none"> • Up to 25 hours/week • Does not include services or training which the individual is entitled to under other federal or state programs 	N/A
N/A (Program ID)	Adult Training (AT) Special Needs	Provider based day habilitation services designed to develop, maintain and/or maximize the individual’s independent functioning in self-care, physical and emotional growth, socialization, communication, and vocational skills.	<ul style="list-style-type: none"> • Up to 25 hours/week • Does not include services or training which the individual is entitled to under other federal or state programs 	N/A
N/A (Program ID)	Corporate Respite	Short-term services provided to participants unable to care for themselves that are furnished because of the absence or need for relief of those persons who normally provide care for the participant.		N/A
N/A (Program ID)	Family Supports – Respite	Short-term services provided to participants unable to care for themselves that are furnished because of the absence or need for relief of those persons who normally provide care for the participant.		N/A

Appendix C – Payment Voucher & Instructions

	PAYMENT VOUCHER		DOCUMENT			BATCH			ACTG. PER.	FY	
			TC	AGY	NUMBER	TC	AGY	NUMBER			
			PP START MO DY YR	SCHED PAY MO DY YR		CHK CAT	OFF LIAB	F A	RF TY TY	CK(A) FL	VENDOR ID NUMBER
CONTRACT NO	AGENCY REF	BUYER	(B) TERMS	PAYEE: SEE INSTRUCTIONS FOR COMPLETING ITEMS (A) THROUGH (G)			(C) TOTAL AMOUNT				
(D) PAYEE NAME AND ADDRESS					(E) SEND COMPLETED FORM TO:						
(F) PAYEE DECLARATIONS CERTIFY THAT THE WITHIN PAYMENT VOUCHER IN ALL ITS PARTICULARS, THAT THE DESCRIBED GOODS OR SERVICES HAVE BEEN FURNISHED OR RENEDED AND THAT NO BONUS HAS BEEN GIVEN OR RECEIVED ON ACCOUNT OF SAID DOCUMENT.											
					→→→→	PAYEE SIGNATURE					
							PAYEE TITLE		BILLING DATE		
LINE NO	CD	AGY	NUMBER	LINE	(G) PAYEE REFERENCE						
1											
2											
3											
1	FUND	AGCY	ORG CODE	SUB-ORG	APPR UNIT	ACTIVITY CD	OBJECT CD	SUB-OBJ	REV SRCE	SUB-REV	PROJECT/JOB NO
2											
3											
1	RPT CT	BS ACT	DT	DESCRIPTION	QUANTITY	AMOUNT			ID	PF	TX
2											
3											
ITEM NO.	COMMODITY CODE/DESCRIPTION OF ITEM				QUANTITY	UNIT	UNIT PRICE	AMOUNT			
.					-	-	-	-			
.					-	-	-	-			
.					-	-	-	-			
TOTAL								-			

CERTIFICATION BY RECEIVING AGENCY: I certify that the above articles have been received or services rendered as stated herein.

Signature

Title

Date

CERTIFICATION BY APPROVAL OFFICER: I certify that this Payment Voucher is correct and just, and payment is approved.

Authorized Signature

Title

Date

PAYEE INSTRUCTIONS
ITEMS A THROUGH G ARE TO BE COMPLETED BY PAYEE

A VENDOR IDENTIFICATION NUMBER

Complete the payee identification field with the federal employer identification number assigned to the business or the social security number if the payee is an individual.

B TERMS

The terms of sale, such as "net," "2% fifteen days," etc.

C TOTAL AMOUNT

Enter the total amount of this payment voucher.

D PAYEE NAME AND ADDRESS

The name of the individual or company to whose name the check shall be drawn and the complete address where the check shall be mailed.

E SEND COMPLETED FORM TO:

The Department, Division, Bureau or Institution to whom the materials or services were furnished.

F PAYEE DECLARATION

Payee must sign the declaration and date the payment voucher is prepared.

G PAYEE REFERENCE NUMBER

Payee must show his **own** invoice or billing number or any other identification for reference purposes. **This information is recorded on the check stub and aids the payee to identify the invoices which have been paid.** Do not use more than 30 characters.

PAYEE IS TO COMPLETE THE SCHEDULE OF ITEMS OR SERVICES SHOWING QUANTITY, UNIT, DESCRIPTION, UNIT PRICE AND AMOUNT. IF THE NUMBER OF ITEMS EXCEEDS THE SPACE, ATTACH A SCHEDULE SHOWING THE REQUIRED INFORMATION.

TO INSURE PROMPT PAYMENT, SEND COMPLETED PAYMENT/VOUCHER TO THE
DEPARTMENT/AGENCY SHOWN IN ITEM

VENDORS MAY BE ENTITLED TO INTEREST ON PAYMENT VOUCHERS IF PAYMENT IS NOT MADE WITHIN 60 DAYS OF THE DATE OF ACCEPTANCE OF A PROPERLY EXECUTED PAYMENT VOUCHER OR RECEIPT OF GOODS OR SERVICES, WHICHEVER IS LATER. **E** INQUIRIES SHOULD BE MADE DIRECTLY TO THE DEPARTMENT OR AGENCY **E** SHOWN IN ITEM

Appendix D – F3 Form

Division of Vocational Rehabilitation Services (DVRS) or Commission for the Blind and Visually Impaired (CBVI) Determination Form for Individuals Eligible for the Division of Developmental Disabilities (DDD) – F3 Form

This form is currently under revision and will be added as soon as it is finalized. Please use the current version of the F3 Form that can be found in the Standards for Supported Employment Services manual at <http://www.nj.gov/humanservices/ddd/services/ses/>.

Appendix E – F6 Form

Non-Referral to Division of Vocational Rehabilitation Services (DVRS) or Commission for the Blind & Visually Impaired (CBVI) Form

In accordance with New Jersey’s Employment First Policy, meaning that: “Competitive employment in the general workforce is the first and preferred post education outcome for people with any type of disability.” The Division of Developmental Disabilities (DDD) will refer every individual to the Division of Vocational Rehabilitation Services (DVRS) or Commission for the Blind & Visually Impaired (CBVI) **except** when one of the following criteria is met:

Individual is of retirement age

Medical condition/behavioral issues preclude the individual from working at this time (due to substantiated concerns about harm to self or others which cannot be appropriately mitigated by supports/services)

Please explain:

Individual is not interested in pursuing employment at this time and understands this may result in limitations on other DDD-funded services.

Please explain what needs to change in order for the individual to pursue employment:

Name of Individual: _____

DDD ID: _____

Support Coordinator/DDD Case Manager

Date