**DEPARTMENT OF HUMAN SERVICES - DIVISION OF DEVELOPMENTAL DISABILITIES**

**Self-Directed Respite Transition Plan**

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| Date:       | Consumer Name:       | Date of Birth:       |
| Name of individual/contact completing this form:       | Relationship to Consumer:       |
| Contact Telephone:       | Contact Telephone:       | Contact Email:       |
| County where consumer resides:       |
| ***Agency Currently Providing Self Directed Respite*** | Agency Name:      Comments:       |
| ***Agency Selected to Provide Future Respite Services; If Different from Above***  | Agency Name:      Comments:       |
| ***Service Selected to Replace Self Directed Respite*** | **PLEASE CHECK ONE BOX ONLY**The agency is in the process of hiring the person the family was paying: [ ] You have asked the agency to recruit a worker to provide respite: [ ] You have selected the use of the fiscal intermediary (Easter Seals): [ ] You have requested a site based group respite program: [ ] Comments:       |
| ***Additional Comments*** | Please share any additional information regarding the need for respite services:       |
| **Please email this completed form to the DDD Self Directed Respite Helpdesk at** **DDD.SelfDirectedRespiteHelpdesk@dhs.state.nj.us****DDD staff will be in contact with you to assist.** |