Support Coordination

Using Person Centered Thinking & Planning to Build on Your Loved One's Current Life

Through…..

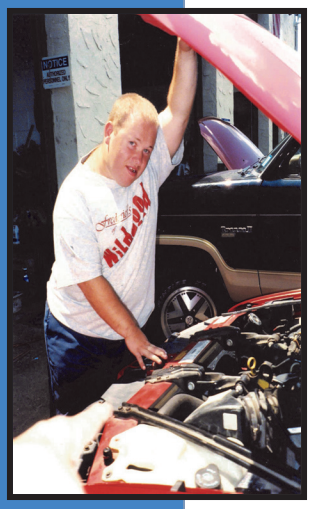
Unique Individualized Planning

Making Informed Choices

Control of the Resources

Support

Teamwork



All Great Success Starts With A Plan
All Great Plans Start With You

The New Jersey Division of Developmental Disabilities (DDD) is offering New Jersey's citizens with disabilities who are living in Developmental Centers opportunities never before available. A new approach to planning, budgeting, and getting connected to the resources, services, and supports necessary to build a life outside of the Developmental Center is being undertaken. This new approach, called Support Coordination, starts with a Person Centered Planning Team that includes:

Family, Friends, Staff & BGS Worker

Peer Mentor

Family Mentor

Your Loved One

Transitional Case Manager

Support Coordinator

The Person Centered Planning Team

Support Coordination Provides

- Unique Individualized *Planning* that's Person Centered
- Information to make Informed *Choices* about the Supports & Services You Need
- *Control* of the Resources to buy just what you need and none of what you don't
- *Support* from a knowledgeable, experienced *Team* to help you work through the tough stuff
- *Mentors* who will share their experiences and be supportive and respectful of yours
- *Education & Networking Opportunities* on this new way of planning, new housing options, and other critical components to make a change successfully

"...planning is indispensable." — Dwight D. Eisenhower

What is a Support Coordinator?

A Support Coordinator is an independent person who has expertise in using multiple methods of facilitating the person centered thinking and planning process. Support Coordinators use their expertise to help build a planning team around the person to support him/her in the development of the individual support plan, focusing on the person's desires, needs, hopes and dreams of how and where they want to live.

Each person will have a completely individualized person-centered plan, with all services and supports crafted by that individual and the team, to meet his/her needs. The provision of every support and service is Outcome based and supportive of the person's documented needs.

What Agencies Provide Support Coordination?

Values Into Action (VIA) (856) 985-6801

Neighbours, Inc. (609) 275-0606

Caregivers of New Jersey (609) 218-0021

"Good fortune is what happens when opportunity meets with planning". — Thomas Alva Edison

"To accomplish great things, we must not only act, but also dream; not only plan, but also believe". – Anatole France

What is a Mentor?

There are two kinds of Mentors— a Peer Mentor and a Family Mentor. They are people who have either lived the experience of transitioning to community living themselves or have supported their own loved one to make significant transitions in their life; be it from a developmental center into the community, from the family home into a home of their own, or other such major changes. They bring knowledge of available resources, person-centered thinking, and creative problem-solving to a person's team that will assist with working through any difficulties or concerns that may arise. They keep us motivated and help us with the fear we might feel by showing us examples of how it worked out for them. They can be a listening ear when you're feeling nervous about something or they can help you sort through all the options you will have when you're feeling too overwhelmed with making a choice and just want some practical insight as to what to do.

How Much Must You Participate?

Your involvement can be as extensive or as limited as you want it to be. Family is always welcome to contribute to the planning process and support the implementation of supports, but not all families are able to do so. That's OK.

You can expect that a Support Coordinator will be in touch with you to provide you the opportunity to be involved in this new way of planning for the person you care about. Whatever your wishes, they will be respected and never judged. If after you determine your level of involvement you need to make a change you are always able to do so.

Person Centered Planning is based on the following ideals:

We each have an individual lifestyle that works for us;

Getting as close to that lifestyle determines how well our life goes;

Discovering that lifestyle & carefully supporting that choice is transformational, supports a person's dignity & respects their personhood.

Who's Who and What Do They Do?

Support Coordinator

A Support Coordinator partners with your loved one, their family, friends, the Bureau of Guardianship Services worker (if applicable), and the person's network of supporters to facilitate planning, budgeting, connection to resources, troubleshooting, and to provide technical assistance in self direction.

Staff

The Staff who have worked closely with your loved one and developed a caring relationship with him/her will join the planning team to share their stories, positive insights, and knowledge. They will go with the person and the planning team off campus as part of the plan development.

Peer Mentor

The Peer Mentor is a critical member of your loved one's team who has experienced living in an institutional setting and can listen with a sensitive ear. They offer your loved one information from a personal experience perspective that will help that person to make choices. Through mentoring, these individuals will support people and their team to strengthen their skills to exercise choice and control of their resources and their lives.

Family Mentor

The Family Mentor is a key member of your loved one's team who can share their personal experience, knowledge of resources, person-centered thinking, and problem-solving techniques to assist the person and their team to work through any concerns that may arise. They are there to encourage choices and be a general support for the family perspective.

DDD Monitor

The DDD Monitor is the 'Check' in the Check and Balance of this process. They review the person centered plan and the supports and services attached to it for completeness and compliance and provide the official DDD 'Approval'.

Transitional Case Manager

The Transitional Case Manager is an integral part of the planning team and acts as the link between the Developmental Center and Support Coordination Agencies. They assist with information gathering, coordinating on and off campus meetings and jump start the plan development through the construction of such parts of the plan as the Relationship Map and the Communication Chart.

What's the Big Deal About This New Approach?

- **Your loved one will have a person centered planning team built around them** that will include you, people who have special relationships with your loved one and other people who work for the person. This team of people are solely invested in what interests the person and what it will mean to them to have a GOOD, full life. The focus of the team is to work FOR your loved one.
- **Your Loved one will have an INDEPENDENT planning team working for him/her.** This will be a collaborative group of people who will engage him/her to participate to whatever extent they can, in developing a plan of support that is personalized and specific to WHO that person is. They will also talk to you, share information, and provide updates so that you all walk through this as partners working TOGETHER. No one person can ever have ALL of the answers, but when working together as a team there isn't anything that can't get sorted out. The TEAM is the key.
- **Your loved one will have a tailored support plan BEFORE the supports & provider are selected** that will incorporate not only how that person's health and safety needs will be met, but
    - What life experiences have shaped who they are today;
    - Their hopes, dreams, family traditions, heritage, faith, likes and dislikes;
    - And most importantly Who they are as a person rather than who they are as a disability or a medical condition

Having the plan first allows a person to select all the supports and services that are suited to their needs, instead of making the person fit into what's available from a particular vendor of supports. You get what you need to have the life you want, not just what's available.

"All you need is the plan, the road map, and the courage to press on to your destination." — Earl Nightingale

"Without leaps of imagination, or dreaming, we lose the excitement of possibilities. Dreaming, after all, is a form of planning" – Gloria Steinem

Your loved one will have an Individual Budget

When we answer the questions:

- HOW does someone want to live?
- WHERE would that be?
- WHAT support needs to be in place to make that successful?

None of that will mean a thing if the person and those who are planning with them don't have control of the resources to make it a reality. With this new process the person will be given a budget and, using that money, the individual, the family and the team will choose what supports they'll use, from whom they will be purchased, where they will be delivered and how they will be done. In the past, the professionals and the system maintained control over the resources for all purchases for supports and services. In this new process, the choosing of supports is done by the team. Supports and services can be purchased from either a single agency or the team can select supports "a la carte"; designing what you want provided by whom you want. If the person becomes dissatisfied with their supports & services, the advantage of having an individual budget is that they can purchase those supports elsewhere. In essence, the money will follow the person, giving them the flexibility and control to create the life they want.

Other Frequently Asked Questions

- **How long will the Support Coordinator be involved with my loved one AFTER they move?** If your loved one chooses support through a single agency, a Community Services Case Manager will become a member of that person's team and the Support Coordinator will transition out of the team 90 days after the move. If your loved one chooses the "a la carte" option, the Support Coordinator continues to be involved along with the DDD state monitor.
- **Who's going to make sure my loved one is OK?** For the first three years following your loved one's move, someone from the Developmental Center who knows them will be part of a team that could include a state monitor and a community services case manager or Support Coordinator. This team will make face to face visits to their new home to see how they're doing and if they are satisfied with their supports and services. These face to face visits will take place at 30, 60, 90 & 180 day intervals during the first six months, then annually up to three years.

If You Want to Work With A Support Coordinator Call Either:

Director of Social Services

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Transitional Case Manager

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