The ABC Manual

The Basics of Care Management

A practical resource manual to provide Support Coordinators with the basics (ABCs) of care management, along with resources, tips, and Division information

NEW JERSEY HUMAN SERVICES
Division of Developmental Disabilities

Support Coordination Unit
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Introduction

This manual was developed by the Support Coordination Unit with the objective of providing a supplemental, practical resource document to aid Support Coordination Agencies in providing care management to individuals and families and navigating different subject areas within their role as a member of the Planning Team. The intention is to provide some of the basics, or "ABCs", of care management, along with resources, tips and Division information. This guide is not intended to replace or supersede any content outlined within the Supports Program and Community Care Program Policies & Procedures Manuals or DHS/DDD Policy Circulars. This document is subject to change and will be revised as needed.

Per the Supports Program and Community Care Program Policies & Procedures Manuals, Support Coordination Agencies are required to provide Support Coordination services, which include all of the responsibilities outlined throughout the manuals in providing care management to individuals served – particularly within sections 6, 7, 8, 12 and 17.14. While regulations outline requirements and responsibilities, it is understood that often there is more than one solution to address a concern or issue, so having information is often key to discussion and problem solving.

In this guidebook, topics are arranged in alphabetical order to assist with locating information quickly. Helpful appendixes are included at the end, for reference. Support Coordination Agencies are encouraged to use this manual as both a resource and training document.

The Division is available to provide assistance to Support Coordination Agencies. Many of the topics covered in this guide are those for which DDD would expect a Support Coordination Agency to complete a Seeking Out Support (SOS) Form. This form is completed and submitted in iRecord under the Tools tab, and is the tool through which care management assistance is obtained from the Division. The SOS process allows the Division's Care Management Team to not only assist Support Coordination Agencies with individual situations, but also helps them to be aware of issues faced by Support Coordinators and where training, communication or resource needs might exist. Throughout the guide, you will note the use of "⚠" to highlight scenarios that fall within the scope of notification to the Division through the SOS process. Additionally, the Division has a number of helpdesks to respond to questions and issues. The Directory of Email Helpdesks and Mailboxes can be found on the Support Coordination Information page of the DDD website.

24-Hour Availability and Responsiveness

Per section 17.18.5.10 of the waiver manuals, each Support Coordination Agency (SCA) is responsible for establishing and maintaining 24-hour coverage. If the individual cannot meet with the Support Coordinator during what the agency might consider typical business hours, the Support Coordination Agency must schedule monthly/quarterly/annual contacts/visits, planning meetings, etc. outside of typical hours to accommodate the individual's needs.

The required provision of 24-hour coverage includes a live response to agency phone calls, including on evenings, weekends and holidays. An answering service is acceptable as long as there is timely contact to a Support Coordinator, Support Coordinator Supervisor or Agency Head, who is available to respond to the issue for which outreach was made. Phone prompts, voicemail and/or directions to call 911 or DDD on-call in case of emergency is not acceptable. When an individual/family/legal guardian reaches out to the Support Coordination Agency during an evening, weekend or holiday, with an urgent matter, the information shall be directed to the on-call SCA staff for follow-up. SCA staff must contact the caller and direct them 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 and documented the following business morning/day. See section 17.18.5.10 in the SP and CCP Manuals for additional information.

Notes:

- The Division's Support Coordination Unit maintains on-call phone number(s) for each Support Coordination Agency. SCAs must report any changes immediately to their assigned QAS so the Division has accurate, up to date information.

- Immediate issues of homelessness or risk to health/safety, occurring after business hours or weekends, require Division notification. Notification should be made to the DDD Community Services office for the county where the individual resides. The answering service will contact Division on-call staff, who will return the call to the SCA on-call staff.

Listing of DDD Community Services Offices and 24 hour Phone Numbers

Morris, Sussex, and Warren:	973-927-2600 (Flanders)
Bergen, Hudson, Passaic:	973-977-4004 (Paterson)
Essex, Somerset, Union:	908-226-7800 (Plainfield)
Hunterdon, Mercer, Middlesex:	609-292-1922 (Trenton)
Monmouth, Ocean:	732-863-4500 (Freehold)
Burlington, Camden, Gloucester:	856-770-5900 (Voorhees)
Atlantic, Cape May, Cumberland, Salem:	609-476-5200 (Mays Landing)

To report urgent matters or to make case specific inquiries during state government business hours contact DDD.SCHelpdesk@dhs.nj.gov with the DDD ID # in the subject line. If the matter is urgent, indicate that in the subject line.

County Social Service Agencies also referred to as County Welfare Agencies

Exploring resources through County Social Service Agencies is an essential part of accessing community services. A complete list of New Jersey's County Social Service Agencies and associated programs and resources is found on the Department of Human Services Division of Family Development webpage.

Some common reasons for contacting a County Social Service Agency include seeking assistance with the following:

Medicaid	**NJ SNAP Food Assistance**
Work First New Jersey (WFNJ) Cash Assistance	**Emergency Assistance (EA)**

Notes:

- Emergency Assistance is only available to recipients of General Assistance (GA), Temporary Assistance for Needy Families (TANF) and/or Supplemental Security Income (SSI).
- Each program has an application process and eligibility criteria.

Tips for Support Coordinators and Individuals/Families!

- Start by calling 2-1-1 to discuss general, preliminary information and learn about next steps, which can save time and trouble.
- Call ahead to the county agency's main number to confirm hours and that the county office is the right place to go for assistance with the situation.
- "Walk in" to the County Social Service Agency office and ask to speak with a Social Worker. (Meetings usually occur by "walk-in" and are not normally scheduled by phone.)
- **Important**: An *in-person* screening with a Social Worker at a county office streamlines the process of applying for assistance. Social Service Agency Social Workers are guides to help navigate services available through their office as well as many services in the community.
- Individuals/families can bring a support person along. Often, when seeking assistance in an unfamiliar setting, it is extremely valuable to have a trusted person present who can help with:
  - explaining the situation and articulating the request or the need.
  - listening/understanding the information being given and what to do next.
  - asking questions.

Additional resources are described on the Division of Family Development Emergency/Crisis Resources page, including:

- 988 Suicide & Crisis Lifeline
- Child Abuse/Neglect hotline
- Domestic Violence hotline
- Safe Haven for Infants Protection Act
- Addiction Help (Reach NJ)
- NJ 2-1-1, a webpage **and** hotline for information and resources to assist in an array of areas, including:

Housing	**Utilities**	**Income**
Food	**Health**	**Mental Health**
Legal	**Substance Disorder**	**Children & Families**

DDD Medicaid Waiver Programs

Introduction - What is a Medicaid Waiver?
Medicaid is a federal and state program that provides health coverage to some persons with limited income and resources. A Medicaid waiver is a provision, which allows the government to waive certain rules that usually apply. The intention of a waiver is to allow a state to accomplish certain goals, such as expanding/improving coverage or care for specific target groups.

DDD administers two of New Jersey's Medicaid waiver programs, the Supports Program (SP) and Community Care Program (CCP), for individuals who meet functional criteria for services from DDD. Because DDD-approved Service Providers receive Medicaid funding, individuals must establish and maintain Medicaid eligibility to be enrolled on a DDD waiver. Through enrollment in one of these programs, individuals receive home and community based services based on their assessed needs and individualized budget. While these programs share basic eligibility rules, the Community Care Program has additional eligibility criteria.

Support Program (SP)
The Supports Program is the Division initiative included in the Comprehensive Medicaid Waiver (CMW) that was approved by the Centers for Medicare & Medicaid Services (CMS) on October 1, 2012. The Supports Program provides needed supports and services for DDD eligible individuals living with their families or in other unlicensed settings. It has been designed to help New Jersey better serve adults with developmental disabilities and significantly reduce the number of individuals waiting for supports and services.

The Supports Program provides all enrolled participants with employment/day services and individual/family support services based on their assessed level of need.

All adult individuals who are eligible for both Division services and Medicaid are able to access the Supports Program, provided they maintain their eligibility and are not enrolled on another Waiver, such as Managed Long-Term Services & Supports (MLTSS) or the Community Care Program (CCP).

Supports Program plus Private Duty Nursing (SP+PDN)
Supports Program plus Private Duty Nursing (SP+PDN) is not a separate waiver from the Supports Program. Rather, it is the Supports Program waiver with the additional service of Private Duty Nursing, administered by the Managed Care Organization (MCO). PDN does not come out of the individual's SP budget. Individuals in this group have access to all the services funded through their SP budget, **and** they may receive up to the maximum of 16 hours per day of Private Duty Nursing, depending on their assessed need determined by their MCO. Additional information can be found in the chapter in this guide on Waiver Transitions.

Community Care Program (CCP)
The CCP is an 1115 Medicaid Home and Community Based Services (HCBS) waiver program that permits New Jersey to receive a federal match on an array of approved waiver services and supports to Medicaid beneficiaries to live in the community and avoid institutionalization.

To be eligible for the Community Care Program an individual must also meet the following criteria:

- Level of Care (LOC) criteria must be met for Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/ID). This means that if not for home and community based services provided through the CCP, an individual would qualify to live in an institution. If an individual does not meet the ICF/ID standard, they will not be approved for CCP. For more information, see the chapter in this guide, Level of Care (LOC) Review.
- Be reached on the Community Care Program Waiting List or determined by the Division to be in an emergent circumstance as defined by Division Circular 12 (N.J.A.C. 10:46B).
- An individual enrolled in the CCP cannot simultaneously be enrolled on any other Medicaid waiver program, including the Supports Program and Managed Long-Term Services and Supports (MLTSS).

Two Ways to Access the Community Care Program (CCP) Waiver:

- Through the Waiting List for CCP services
  - Information and instructions about the CCP Waiting List can be found on the Division's Community Care Program Waiting List webpage. The Community Care Program Waiting List Request form is used for additions to the waiting list.
  - When an individual is reached on the Waiting List, someone from the Division's Wait List/Special Projects Unit will contact the family and the SCA. The assigned Division staff from that unit will assist with next steps.
  - See the chapter, Waiting List for CCP Services, for additional information.
- Through the ICM Referral process (See the chapter, Intensive Case Management (ICM) Referrals.)
  - An expedited process for accessing the CCP in emergency situations is initiated through use of the Intensive Case Management (ICM) Referral form. A thorough Division review of the justification is required.
  - After an individual is assigned a worker from the ICM Unit, the SC and the ICM worker will coordinate and collaborate directly with each other.

Difference in Available Services
In addition to budgetary differences, there is a difference in the type of service available through the SP and CCP waivers that provides direct staffing support to an individual in their home and in the community.

The Supports Program may fund the staffing service, *Community Based Supports (CBS),* while the Community Care Program may fund the staffing service, *Individual Supports (IS).* Both services provide direct support and assistance for participants, with or without the caregiver present, in or out of the participant's residence, to achieve and/or maintain increased independence, productivity, enhanced family functioning, and inclusion in the community. Both may be delivered by a Service Provider or a Self-Directed Employee (SDE) through a Base (15 minute) rate.

A key distinction is that Individual Supports, through the CCP, may also be provided through a daily rate to individuals who reside in licensed provider-managed settings such as group homes or supervised apartments, or an unlicensed setting in which two or more individuals live and share staff for three or more hours per day.

Base Rate versus Daily Rate

- Base rate (15 minute rate) is provided in or out of the home to individuals living in their own home, either with family or in one's own apartment and may be delivered by a Service Provider or Self-Directed Employee (SDE).

- Daily rate through a Service Provider (CCP only) is provided in or out of the home to individuals who reside in licensed settings such as group homes or supervised apartments, or an unlicensed setting in which two or more individuals live and share staff for three or more hours per day.

Note: If an individual, receiving in-home supports on the CCP, requests placement in a licensed setting, an ICM Referral is not needed as they are already on the CCP. The SC may make direct referrals to Residential Providers using the Residential Referral Coversheet. (See the chapter, Residential Referrals.)

Resources

- CCP Waiting List Request Form and Instructions page.
- For guidance on using iRecord for waiver enrollment, see the SC Best Practice Guide.
- For additional information on the CCP and Level of Care, see the Community Care Program (CCP) Fact Sheet handout.
- Standards for addition to the CCP Waiting List and the procedures for CCP enrollment are found in Division Circular #8.

Decision-Making: Alternatives to Guardianship and Guardianship

When working with adults with intellectual or developmental disabilities, it is important to keep in mind that, like their adult peers without disabilities, competency to make decisions is assumed, with the individual acting as their own decision-maker. Often, parents are unaware that they do not automatically remain the individual's guardian beyond age 18. It is important to have conversations with parents, family members and the Planning Team about the individual's ability to make informed decisions and the types and amount of supports that may be put in place to assist them. The planning process is the ideal time to ensure a person-centered approach when discussing an individual's ability to make informed decisions.

When an individual requires support with decision-making, the level of assistance should be as little as necessary to assist the person to make an informed decision. Supported Decision-Making (SDM) and other less restrictive means of decision-making support should always be tried before pursuing guardianship. A discussion about decision-making each plan year is important as individuals' needs may change over time.

Per section 7.1.1 of the waiver manuals, "The Support Coordinator shall facilitate a discussion at the annual Planning Team meeting (which includes the individual with IDD) on decision-making. Areas of discussion shall include whether Supported Decision-Making or other less restrictive options than guardianship can be used to support the individual in their decision-making." If the individual has a court appointed legal guardian, discussion shall include "whether the

guardianship remains appropriate and, if not, what changes the Planning Team suggests are needed in that area. In instances where a person has a guardian assigned but the Planning Team believes that they have the capacity to make decisions partially or fully, then actions to restore themselves as their own decision-maker should occur. In circumstances where a person has been assigned a guardian who is no longer viable or available, then the individual with IDD does not automatically resume their own decision-making abilities. Instead, a new proceeding must be made with the court to replace the guardian through the substitute guardianship process. The Support Coordinator will use this opportunity to educate the Planning Team on less restrictive options and provide information and resources to the individual and the Planning Team members."

The outcome of these discussions is to be documented in the ISP. The recommended location for documentation in the ISP is under the Safety & Supports tab / Support Settings / Home.

Discussions about Decision-Making and Alternatives to Guardianship

Types of Decision-Makers

- The individual
- The individual with court judgment
- The individual with supports / Supported Decision-Making (SDM)
- Advance directive
- Representative payee
- Power of attorney
- Guardianship

The Individual

The individual is always at the start and at the center of decision-making. The Planning Team's first consideration about decision-making is whether the individual is able to make decisions independently. Being able to make a decision and always making a "good" or "right" decision are not the same thing. What is considered a "good" or "right" decision versus a "poor" decision is extremely subjective and varies from person to person. Furthermore, everyone has the right to decide on something that others might disagree with. Independent decision-making means demonstrating the capacity to think objectively and weigh different options while making a decision.

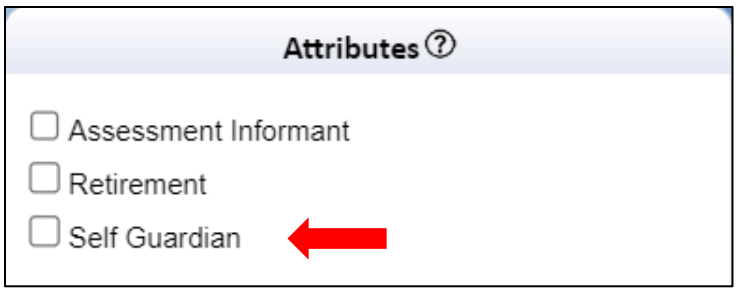
ISP documentation example

"<Individual's name> believes they are able to make informed decisions for themselves at this time, and the Planning Team supports this."

The Individual with Court Judgement

Although this is extremely rare, there are examples of individuals who have obtained a guardianship judgment, indicating that they do not require a guardian. In some of these instances, a court has denied efforts of someone attempting to obtain guardianship. In other instances, a court has terminated or modified a prior guardianship judgment, which had determined an individual was incapacitated.

If it is the case that a court judgment states an individual does not require a guardian, then the iRecord Personal Attributes tile shall reflect this by using the "Self Guardian" checkbox. A copy of the judgment shall be uploaded in iRecord and this shall be described in the ISP. It is only in these instances, and when a court document is present, that "Self Guardian" should be checked in the iRecord Personal Attributes tile.



It is important to note that this is simply an iRecord action. To say that a person is "their own guardian" or a "self guardian" are outdated statements and not person-centered. Instead, one would simply say that the individual does not have a guardian.

The Individual with Supports / Supported Decision-Making (SDM)
Many individuals are able to make informed decisions about their life with support from another person or persons that they trust. These "supporters" can help the individual with a disability understand the options, responsibilities, and consequences of their decisions; obtain and understand information relevant to their decisions; and communicate their decisions to the appropriate people. The supporter cannot, however, make a decision FOR the person with a disability.

The necessary level of support will likely be different in different life areas or with certain types of decisions and should match the amount of support needed at the time. Examples of SDM might include: the use of plain language, information provided in video or audio form, providing time to review and discuss choices, role-playing activities to understand choices, assistance with creating pro and con lists, having a supporter present at important meetings and/or medical appointments, etc.

ISP documentation examples:

"<Individual's name> believes they are able to make informed decisions with support from family, friends and members of the Planning Team as needed, and the Planning Team supports this."

"<Individual's name> recognizes that they usually benefit from the support of family and/or other members of the Planning Team when making decisions, and the Planning Team is in agreement."

Resources on Supported Decision-Making

- The Autism New Jersey website has a page dedicated to Supported Decision-Making.
- The Arc of NJ website has information about guardianship and alternatives to guardianship.
- The Center for Parent Information and Resources website includes an 11-minute video on Supported Decision-Making.
- Department of Health | Advance Directive | Forms & FAQs (nj.gov)
- Planning Ahead for When the "What If" is Now: Emergency Planning for When a Primary Caregiver is Not Able to Provide Support is a tool developed by the Boggs Center to help plan for emergency situations when a primary caregiver is not able to provide support.
- Three New Jersey departments collaborated to develop the handout, Preparing for the Age of Majority: Supported Decision-Making and Other Support Options.

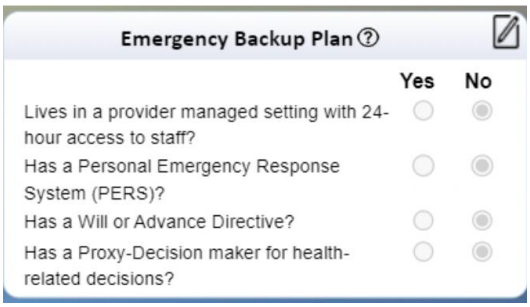
There are other less restrictive means of decision-making supports, such as advance directives, power of attorney, and representative payee.

Advance Directive
An individual may elect to have an advance directive in place should they later become terminally ill, seriously injured, in a coma, in the late stages of dementia or near the end of life. An advance directive is a legal document to help ensure that wishes and preferences for various medical treatments are followed in the event of being unable to make one's own healthcare decisions. An advance directive goes into effect only if a physician has evaluated and determined a person to be unable to understand their diagnosis, treatment options or the possible benefits and harms of the treatment options.
In New Jersey, there are two kinds of advance directives. An individual may have one or both.

- **Proxy Directive (Durable Power of Attorney for Healthcare)** – Proxy Directive.
  Through a Proxy Directive, an individual can appoint someone to make healthcare decisions in the event that they become unable to make decisions themselves. A Proxy Directive goes into effect whether the inability to make healthcare decisions is temporary because of an accident or permanent because of a disease. The person appointed is known as a "healthcare representative" or "proxy decision-maker for health-related decisions".
- **Instruction Directive (Living Will)** – Instruction Directive
  An Instruction Direction is used to tell a physician and family one's wishes and preferences regarding life-sustaining treatment in the event of being unable to make healthcare decisions. It may include a description of beliefs, values, and general care and treatment preferences to guide the physician and family when they have to make healthcare decisions for situations not specifically covered by an advance directive.

A lawyer is not needed to establish an advance directive. An advance directive may be notarized, or it may be signed in front of two adult witnesses who must also sign the document.

If an individual has a proxy decision-maker, the **Proxy Decision-Maker** check box should be selected on the **Contact Attributes** tile in iRecord for the appropriate contact(s). Both types of advance directives are also documented in the **Emergency Backup Plan** tile on Demographics, within the Safety & Supports tab.



Power of Attorney
A power of attorney (POA) is a written document by which one person authorizes someone else (known as the "agent" or "attorney-in-fact") to exercise authority over a range of responsibilities in the person's absence. It may include their financial matters, healthcare decisions, and other personal and/or business affairs. The extent of the agent or "attorney-in-fact" authority to act is defined by the type of POA agreement.

A POA may be established, but only when the person has capacity to agree to allow someone else to act as their agent. If health circumstances cause the principal to become incompetent, the POA ends**,** unless the person specifically authorized the agent to do so through a **"durable"** POA.

A lawyer is not needed for one to assign a POA but it is often recommended. In New Jersey, a notary is needed.

Representative Payee
A representative payee receives and controls the use of Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI) benefits or other state or federal benefits or entitlement program payments on behalf of an individual.

Representative payees are appointed by the local Social Security Administration (SSA) office based on medical documentation that the person is unable to manage their own funds. A representative payee is expected to assist the person with money management and to provide protection from financial abuse and victimization.

Guardianship

If the Planning Team feels that guardianship may be needed, a psychological evaluation, specifically for guardianship, will identify recommendations in regards to areas of decision-making, such as residential, educational, vocational, medical, legal and financial.

A guardian is a person or agency **court appointed** to act on behalf of an incapacitated adult to assure their health, safety and welfare needs are met, and their rights are protected. Guardianship involves a legal process to determine if a person is "incapacitated." The court decides if, due to a physical or mental condition, the individual is substantially unable to manage their affairs, either financial or personal (i.e., making decisions regarding living situation, how care is provided, et cetera). Under a guardianship, someone is appointed to make decisions on behalf of the incapacitated person.

First, the court must determine whether a person is incapacitated. Examples of incapacitation include:

- Mental illness or deficiency
- Physical illness or disability
- Chronic drug use
- Chronic alcoholism
- Developmental disability

Guardianship should be viewed as a solution of last resort, because it removes an individual's fundamental right of self-determination. Once a guardian or co-guardians have been appointed by the Superior Court, only the court can modify or change the guardianship order.

Having a legal guardian does not mean that the individual is no longer involved in decision-making. Legal guardians are required to involve the individual in decision-making to the extent the individual's abilities permit.

Three Types of Guardianship:

Guardianship of the person and estate

- The guardian takes care of the well-being and finances of the person through guardianship.

Guardianship of the person only

- The guardian only takes care of the well-being of the person through guardianship.

Guardianship of the estate only

- The guardian only manages the financial affairs of the person through guardianship.

The court decides if the person needs general or limited guardianship.

- **General** (also referred to as **Plenary** or **Full** guardianship)
  The guardian can exercise all rights and powers of the incapacitated person.
- **Limited** (also referred to as **Partial** guardianship)
  The guardian's role is less intrusive and more individualized. An individual might be assigned a limited guardian to make educational, legal, medical, residential and/or vocational/employment decisions, while retaining the

right to make other types of decisions for themselves. The parameters of limited guardianship are defined within the court order.

Who may serve as Guardian?
The legal guardian (LG) may be a parent, family member or another interested person. More than one person may be appointed as co-guardians. Parents, family members or other interested persons may pursue guardianship either by representing themselves (pro se) or through an attorney. When filing for guardianship, the requestor may ask for a public defender to serve as the court appointed counsel, which will reduce cost. However, a public defender can only be used if the requestor seeks guardian of person only, not property or finances.

If an individual is determined to be in need of a guardian but a parent, family member or other interested person is not possible, the **Bureau of Guardianship Services (BGS)** is available to an individual who is under services with the Division of Developmental Disabilities. BGS may serve as the guardian of the person only, not property or finances.

Resources on Guardianship

- The New Jersey Resources book has additional information beginning on page 99.
- The DDD Webpage contains recommended resources pertaining to guardianship and includes Guardian Fact Sheet (English and Spanish), Role of the Legal Guardian, and Family Guide to the Guardianship Court Process.

Discharge from the Division and Waiver Disenrollment

This chapter will explain the difference of an individual being **discharged** from the Division versus being **disenrolled** from a DDD waiver and explains when one or the other should be pursued.

Discharge from the Division
An individual may be discharged from the Division due to any of the following:

- They no longer meet the functional criteria necessary to be eligible for the Division.
- They choose to no longer receive services from the Division and they/their guardian have signed and submitted a Voluntary Discharge from Division Services form.
- They have not maintained Medicaid eligibility and the DDD Medicaid Unit finds that Medicaid ineligibility cannot be resolved, and advises that the individual is to be discharged.
- They no longer reside in the State of New Jersey.
- They do not comply with Division policies or waiver program requirements.

When an individual is **discharged** from the Division, in addition to no longer having access to Division services, they no longer retain their position on the CCP Waiting List, cannot utilize guardianship services from the Bureau of Guardianship Services (if applicable), and are not eligible for a Supportive Housing Connection housing subsidy (if applicable). If an individual is assigned a guardian through the Bureau of Guardianship Services, or receives a housing subsidy, a review by the Division is needed prior to discharge.

Disenrollment from a Division Waiver
An individual may be may be disenrolled from a Division waiver for any of the following:

- They are not receiving a consistent second service (a waiver service in addition to Support Coordination).
- They are in a nursing home or ICF/ID facility, and may be returning to the community.
- They are in a state psychiatric facility, and are expected to remain there for more than 30 days (does not apply to the psychiatric unit of a community hospital).
- They are incarcerated.
- They are temporarily admitted to a developmental center.
- They do not have Medicaid but are working to resolve the issue.

- Travelling outside of New Jersey for more than 30 days may jeopardize an individual's Medicaid eligibility and enrollment on a Division waiver. See the chapter in this manual on Out-of-State Travel for more information.

When an individual is **disenrolled** from a DDD waiver, they retain their position on the CCP Waiting List and retain guardianship services from the Bureau of Guardianship Services (if applicable), but they no longer have access to Division services and may not retain a Supportive Housing Connection housing subsidy (if applicable). Therefore, if an individual receives any Division service or a housing subsidy, they should not be disenrolled, unless instructed otherwise by the Division.

When disenrollment is appropriate, the Waiver Program Disenrollment Request is used. The user should carefully review the "Notes" on the form, fill out the form in detail and follow instructions for submitting.

Accessing Division Services after Discharge or Disenrollment
If an individual has been **discharged** from the Division and in the future becomes interested in receiving Division services again, the individual/family would contact their Community Services Office Intake Unit. They will need to complete the full application process to reestablish DDD eligibility.

If an individual has been **disenrolled** (but not discharged) from a DDD waiver and in the future is interested in receiving Division services again, the individual/family would contact their Community Services Office Intake Unit. After confirming Medicaid eligibility, the individual would be enrolled to the Supports Program waiver and would have access to Division services.

Discharge and Disenrollment both Require a Change in ISP Plan Status
Both instances, being discharged from Division services **and** being disenrolled from a DDD waiver, require the individual's ISP to be moved to Approved to Inactive (AI) status. See the chapter, Requesting to Change Plan Status to Review to Inactive (RI), for detailed information about submitting a plan to Review to Inactive (RI) status.

Discharge Requests from Residential Providers

Overview
- If a DDD Residential Provider believes they can no longer safely serve an individual, they may submit a discharge request to the Division's Care Management & Provider Support Unit (CMPSU) helpdesk: Ddd.Ppmu@dhs.nj.gov**.**
- Providers must follow the policies outlined in Division Circular #36 and described in the CCP Manual, sections 12.5 and 12.5.1 anytime they are interested in discharging an individual. The agency's discharge policy needs to be described in its policies and procedures manual and should be consistent with Division documents.
- Due diligence involving the Planning Team to address and resolve concerns through strategies, services and supports must be documented and evident prior to making a request for discharge.
- Discharge requests from DDD Residential Providers are reviewed by the CMPSU and the Support Coordination Unit (SCU) to ensure all due diligence attempts have been made. The provider will be informed in writing with the SCA in copy, of whether the request is accepted or denied.
- A provider cannot discharge an individual without the expressed written permission from the Division.
- Providers can contact Ddd.Ppmu@dhs.nj.gov or their CMPSU Liaison with questions.

Note: If a request to move is initiated by the individual or their legal guardian (LG), this is not a Discharge Request. See the chapter, Residential Referrals.

When a Residential Provider Intends to Discharge the Individual
- If a Residential Provider expresses an **intent** to discharge an individual, a Planning Team meeting is needed to discuss the concerns. Planning Team meeting notes must be uploaded in iRecord. It should be noted whether the individual is aware of the discharge request.
- A Residential Provider is **not** to request or advise the SC to conduct a search for an alternate living arrangement.

If a Residential Provider has submitted a Discharge Request

- If the SC is aware that a discharge request **has been submitted** to the Division, the SC is advised to use the SOS Form ⚠ to inform the Division's Support Coordination Unit and request assistance.

Discharge Request Accepted

- If a discharge request is **accepted**, a referral package using the Residential Referral Coversheet should be assembled. See the chapter, Residential Referrals.

Discharge Request Denied

- If a discharge request is **denied**, the SC will coordinate Planning Team meetings as needed to strategize how to best support the individual.
- The SC will facilitate referrals for appropriate supports and continue to fulfill SC requirements.
- If the SCA is being asked to search for an alternate living arrangement (ALA) at the provider's request, reach out to the Support Coordination Unit via the SOS Form. ⚠ CMPSU will be looped in for support, as needed.

Employment and Referrals to Vocational Rehabilitation (DVRS/CBVI)

Employment First

New Jersey is an Employment First state, which means competitive, integrated employment in the general workforce is the first and preferred post-education outcome for everyone. While some people are interested in immediate employment opportunities, others may prefer to take smaller steps toward working. Regardless of one's ambition, every ISP must contain at least one employment-related outcome to assist the individual toward work experience, exposure or attainment, even if the individual is not pursuing employment at the time of the ISP. (Individuals, who retire from both employment and day services, are exempt from needing an employment related outcome in the ISP.)

Historically, individuals with disabilities have had limited employment opportunities. Some people with disabilities and/or their families have misconceptions about employment, which may contribute to unnecessary barriers. Support Coordinators may need to navigate challenging conversations tactfully to address employment concerns such as: perceived risks to safety, fear of losing benefits, cultural considerations, medical or behavioral needs, etc. Productive conversations involve a combination of listening, observing, validating concerns, and educating. Therefore, it is important for the SC to be knowledgeable about employment services from the Division of Vocational Rehabilitation Services (DVRS), the Commission for the Blind and Visually Impaired (CBVI) and DDD.

> **Note**: According to Medicaid standards, supports from Vocational Rehabilitation (VR) agencies, such as DVRS/CBVI, need to be ruled out or exhausted, prior to accessing DDD funded employment services.

Making Referrals for Vocational Rehabilitation (VR)

For individuals interested in pursuing employment, the SC completes a referral to the appropriate VR agency, the Division of Vocational Rehabilitation Services (DVRS) or the Commission for the Blind and Visually Impaired (CBVI).

Referrals to DVRS are completed online at the DVRS website. To apply for Vocational Rehabilitation services from CBVI refer to the CBVI Services webpage for additional information.

The Referral Process:

- Complete the first and third sections of the Employment Determination Form – (F3) and upload in iRecord.
- Forward the Employment Determination Form – (F3) to the VR agency and enter a case note.
- **Important**: Within 10 - 14 days after making the referral, the SC must follow up with the VR agency to ensure the referral was received, and find out the name of the assigned VR counselor.
- The VR agency or counselor will schedule the individual for an initial appointment.
- The SC should follow up with the individual/family and/or the VR counselor after the appointment to ask about the outcome. The SC may attend the appointment, but it is not required.

- The VR counselor will determine whether the agency will offer employment services to the individual. The counselor will indicate this on the Employment Determination Form – (F3) with the anticipated end date of VR services and return it to the SC. The SC should review the completed form carefully and upload in iRecord. Being aware of the timeframe of VR services is important for coordinating a timely transition to DDD funded employment services. (More information below)
- If the SC does not receive the completed Employment Determination Form – (F3), make a diligent effort to obtain the completed form, and document efforts in case notes. (**Reminder**: Do not upload copies of email in iRecord, or paste into case notes.)

When an Employment Non-Referral Form - (F6) to DVRS/CBVI is Acceptable

There are four instances when it is acceptable **not** to make a referral for VR services.

- The individual is already competitively employed in the general workforce and does not need employment supports at this time, or has moved onto Long-Term Follow-Along (LTFA), DDD funded Supported Employment services.
- The individual is of retirement age (65 or older).
- A medical condition or behavioral support need exceeds the supports or services available from DVRS/CBVI at this time (due to substantiated concerns about harm to self or others, which cannot be appropriately mitigated by supports/services).
- The individual/legal guardian understands that employment is the preferred post education outcome. The individual/LG is not interested in pursuing employment at this time.

If one of these scenarios applies, complete the Employment Non-Referral Form to DVRS/CBVI – (F6). Reasons 3 and 4 above require detailed information explaining why a referral is not being made at this time.

If Determined Eligible for Vocational Rehabilitation (VR) Services

If the individual is determined eligible for services from the VR agency (DVRS or CBVI), that agency will fund employment services for a maximum of 18 months or until the individual meets their employment objectives and is stable in a job.

The Supported Employment Service Provider (often referred to as "vendor" by the VR agency) should know when funding from the VR agency will be ending and should contact the SC. The Service Provider and the SC will coordinate so when DDD Supported Employment services should be entered into the ISP. Be aware that not all Supported Employment Service Providers/vendors are approved by both the VR agency and DDD. For continuity of service, at the time of selecting a Service Provider, it may be helpful for the individual/family to be aware the providers that contract with both the VR agency and DDD, in the county where the service will be provided. Otherwise, a new provider would be needed when the service transitions to DDD funding.

Sometimes a DDD eligible individual receives services from a VR agency, which is not aware that the individual is also eligible for DDD services. This can interfere with the service transitioning to DDD funding when it should. Making careful note of information on the completed F3 Form and involving all Service Providers in the ISP planning process will help ensure the funding source transfers at the appropriate time. At that time, if an individual's DDD budget is unable to support the employment service at the same level as was provided by the VR agency, and additional services are needed to maintain employment, use the Supported Employment Funding Request form to request additional funding.

If Not Eligible for Vocational Rehabilitation (VR) Services

If the individual is determined ineligible for services from the VR agency, obtain a completed Employment Determination Form – (F3) from the VR counselor, which indicates this, and upload in iRecord. The Planning Team should consider whether the individual would benefit from DDD-funded Prevocational Training. If not, the SC would work with the individual/family to pursue day activities of their choice. (See below for more information about Prevocational Training.)

If an Eligibility Determination for Vocational Rehabilitation (VR) Services is Delayed

If the evaluation by the VR agency is significantly delayed, document the information received in case notes. DDD funding can be used for Supported Employment services while evaluation from the VR agency is pending. In this situation, it is strongly recommended to use a provider approved by both DDD and the VR agency so funding can switch as needed without changing the provider and the job coach. This option should only be used in two situations:

- When there is a significant delay in the VR agency being able to complete an evaluation.
- If the individual has an immediate job opportunity that may be missed because of the VR agency delay. (Being employed may make the individual ineligible for VR agency services. Situations like this are often addressed on a case-by-case basis.)

Note: Situations like this are uncommon. If Supported Employment seems appropriate before the VR agency completes their evaluation, reach out to DDD.EmploymentHelpdesk@dhs.nj.gov, and they will facilitate communication with the appropriate Division staff.

Prevocational Training

Prevocational Training is designed to help the individual develop strengths and skills that contribute to employment readiness. Prevocational Training is to be curriculum based and time limited. It is **not** meant to be an ongoing alternative to either employment or Day Habilitation. The provider should assess the individual's needs at the outset to help identify skills the individual will work on. The provider should monitor and record the individual's progress and provide regular status updates to the SC. Written status updates are to be uploaded in iRecord, and verbal updates are to be summarized in case notes.

After the individual develops their skills, they should be re-referred to the VR agency. If they qualify for VR services, the individual must accept them. One cannot "opt out" of VR services and instead request similar services from DDD. The individual may use DDD funded Prevocational Training for up to two years if needed. If the individual requires more time to develop employment related / employment readiness skills, the Continuation of Prevocational Training Request form can be used to seek Division approval for the service to continue.

The request will need to show the skills being worked on, the progress being made and explain how the continuation of the service is expected to benefit the individual as they move toward work readiness.

Resources

- See the Best Practice Guide for information about completing the Employment Pathway, entering outcomes/services in the ISP and other important employment-related information.
- The Division of Vocational Rehabilitation Services: DVRS Webpage
- Vocational Rehabilitation services from the Commission for the Blind and Visually Impaired (CBVI): CBVI Services Webpage

Guardianship Referrals to the Bureau of Guardianship Services (BGS)

The Bureau of Guardianship Services (BGS) helps process guardianship applications for DDD eligible individuals and also serves as legal guardian for individuals determined to be in need of a guardian and it is not possible for a parent, family member or other interested person to be the legal guardian.

There are three referral types:

- **Priority**: A priority referral is completed when BGS is needed as the guardian, guardianship has not previously been established, and there is an urgent need for a guardianship determination. Justification for a priority referral needs to be clear and compelling. The guardianship referral process can lengthy. If immediate assistance is needed, complete the priority referral and work to address the current situation.
- **Routine**: The routine category is used when guardianship has not previously been established, the referral is not urgent, and family is available to assist with Supported Decision-Making.
- **Substitute**: If an individual has been adjudicated and determined to be in need of a guardian and their legal guardian is now incapacitated or deceased, a substitute referral is needed immediately. It is important to complete the referral as soon as the guardian is no longer able to continue, as substitute referrals typically take 6-12 months to receive a determination.

How to Submit a Guardianship Referral to BGS
First, if guardianship has not previously been established, a Recommendation for Guardianship Assessment form, completed by a DDD psychologist, will need to be obtained. This is done by submitting the Request for Guardianship Recommendation form. The person making the referral usually receives the Recommendation for Guardianship Assessment within one week.

Then, complete the Bureau of Guardianship Services (BGS) Referral Form and obtain all required supporting documentation. When the referral form and referral package are complete, send all documentation via one (1) email, using the subject line, "(DDD ID#), Guardianship Referral" to the appropriate guardianship liaison as listed on the referral form. Ensure all documentation is uploaded in iRecord.

Guardianship Process and Proof of Service
As stated previously in this guide, establishing guardianship involves a legal process, which culminates in a court hearing and a judge issuing a guardianship judgment. Prior to the court hearing, the SC may have a role in a necessary step of the process, personally presenting or "serving" a packet of guardianship documentation to the individual and certifying that the SC has done so. This is known as "Proof of Service."

Overview of Proof of Service
When the court schedules a guardianship hearing for an individual eligible for DDD services, the assigned DDD Guardianship Liaison will be informed. The liaison forwards the guardianship packet and a blank Proof of Service form to the DDD's Care Management Team, who in turn forwards the documentation to the assigned SC and SCS. The Proof of Service needs to be completed in a timely way, at least within 30 days prior to the hearing. Occasionally, courts schedule a hearing with less than 30 days' notice. When this happens, completing the Proof of Service should be prioritized.

Role of the Support Coordinator (SC)
The SC meets with the individual to explain/discuss the following points related to guardianship:

- The guardianship packet being presented to them is a collection of documents, which support a guardianship proposal. The packet names the proposed guardian(s), the attorney assigned to represent the individual, and indicates the scheduled date and time of the court hearing.
- Explain what guardianship means, that someone will be appointed to help make decisions with/for them.
- Explain that a court hearing is scheduled, and a judge will make a final decision about guardianship.
- Ensure they are aware whom the proposed guardian(s) is/are.
- (The individual will be assigned a lawyer, who will meet with them and represent them in the proceeding.) Let the individual know that someone else will talk with them to make sure that they are okay with the plans for establishing guardianship. If the individual has any concerns about having a guardian and/or who the proposed guardian is, they should be encouraged to discuss the concerns with the lawyer.

The SC is attentive to the following:

- The individual seems to understand to the best of their ability.
  (The SC is **not** being asked to attest to the individual's level of understanding or capacity.)
- Pay attention to whether the individual is in agreement with having a guardian.
- Pay attention to whether the individual is in agreement with who the proposed guardian is.

The SC completes the following:

- Provide a copy of the guardianship packet to the individual (not including the 2-page Proof of Service form).
- Complete and sign the Proof of Service **in BLUE ink** to make clear that it is an original copy.
  (**Do not** ask the individual to co-sign the Proof of Service.)
- Send an electronic copy of the Proof of Service to the DDD guardianship liaison and upload the form in iRecord.
- When a response is received from the guardianship liaison, mail the original copy to the Deputy Attorney General (DAG) as instructed.

If the individual/family is unable to meet in person:

- Meeting with the individual may occur by phone or virtually through a video meeting platform.

- A copy of the guardianship packet may be provided to the individual via email or US Mail.
- If the meeting occurs in a way other than in person, indicate this on the Proof of Service by putting a single line through the words, "personally served" and hand write in the margin how the packet was served to the individual (via phone call or video call).

Role of the Individual

- If the individual is not in agreement with having a guardian, or with who the proposed guardian is, the SC should contact the assigned guardianship liaison or the Bureau of Guardianship services for guidance. The SC may need to speak with the attorney assigned to represent the individual to make them aware of the concerns. The attorney will follow up.
- The individual does not need to attend the hearing, but they have the right to attend if they want to.

Notes:

- Contact the assigned guardianship liaison or the Bureau of Guardianship services with questions or concerns.
- Keep case notes up to date when completing steps in this process.

The Bureau of Guardianship Services

Bureau Chief - Jessica Anastasi, Phone: (609) 631-2213
This office prepares guardianship petitions for court statewide.
Legal Unit address: PO Box 705, Trenton, NJ 08625-0705

Northern Regional Office – Phone: (973) 648-4641
Covers: Bergen, Essex, Hudson, Passaic, Morris, Somerset, Sussex, Union Warren Counties; and Green Brook Regional Center
Central Regional Office – Phone: (609) 631-2209
Covers: Burlington, Hunterdon, Mercer, Middlesex, Monmouth, Ocean Counties; and Hunterdon and New Lisbon Developmental Centers

Southern Regional Office – Phone: (856) 339-6759
Covers: Atlantic, Camden, Cape May, Cumberland, Gloucester, Salem Counties; and Vineland and Woodbine Developmental Centers

Homelessness and Housing Instability

When housing instability leads to a crisis, the Support Coordination Agency can be an effective advocate to ensure a safe and desired plan is achieved. While some housing crises have similarities, every situation is unique. This section provides some guiding principles to help prevent, anticipate and mitigate, assess and manage a crisis, and develop a plan.

Preventing a Housing Crisis

- Many crises may be prevented through consistent care management practices.
- Through monthly contact, the ISP process and service provision, needs are identified and addressed. Through these practices, SCs get to know individuals, their families and their unique circumstances. When there is a healthy rapport, families are more likely to contact SCs with service requests, status updates and to make their needs known.
    - A healthy rapport can be the gateway to discussions regarding back-up/emergency planning. Having these discussions can help avoid confusion and unnecessary delay when a crisis arises.
    - Getting to know the individuals and families on your caseload and developing a strong professional relationship can be a valuable tool when encountering crises!
- Meet with your Supervisor to discuss difficult cases or when you think a crisis may be brewing, and consider reaching out to the Division through the SOS process. ⚠

Anticipating and Mitigating a Housing Crisis

- Sometimes a future crisis can be anticipated by recognizing potential risk factors:

- Elderly caregivers, especially when there are medical concerns or mental status concerns.
- The caregivers seem to be experiencing burnout because of extensive support needs.
- The individual demonstrates aggressive or dangerous behaviors, which have become chronic, and difficult to manage with the services available.
- The individual's medical status has changed significantly and support needs have increased.
- Increased frequency of hospitalization, of either the individual or the caregiver, either medically or psychiatrically.

- Be Proactive! Practical Support Coordination Interventions:
  - Discuss with the family, and encourage internal family discussion, to identify the following: future plans when the caregiver is no longer able to provide care, an emergency plan in the event of an unexpected crisis, emergency contacts. (Most families prefer to be involved in the process of arranging services proactively, rather than reacting to a crisis and being limited by services available at that time.)
  - Identify the supportive people in the individual's life: family, relatives, friends, neighbors, members of a faith community.
  - Encourage the individual/legal guardian to consider addition to the Priority Waiting List for CCP services as soon as they are eligible.
  - Take full advantage of community resources such as mental health counseling, adult medical day care programs, Medicaid funded homemaker services, etc.
  - Utilize the individual's DDD budget to provide supportive services.
  - Encourage the individual/legal guardian to consider out of home respite. Many caregivers are extremely dedicated and demonstrate great endurance when they have support, and can look forward to their next break.
  - When there is a service need, do not delay. Be proactive to introduce services such as Behavioral Supports and Day Habilitation, as appropriate.
  - Keep information up to date. The following documentation is necessary when there is a need for DDD-funded, provider-managed housing or overnight respite. Proactively gathering and maintaining this information is extremely valuable to help respond effectively and efficiently in a crisis:
    - Annual medical, current within the past year, showing:
      - Current Mantoux test (within the past year)
      - Hepatitis B vaccination (or current bloodwork showing Hepatitis B status)
      - Tetanus shot (within the past 10 years)
    - Copies of current prescriptions for:
      - All routine medications, both prescription and over the counter medications
      - All medications given as needed (PRN)
      - Adaptive equipment, if applicable
      - Special diet, if applicable
      - Other medical needs (i.e.: blood pressure monitoring, glucose testing, etc.)
    - Other Documentation:
      - ISP – ensure it is kept up to date
      - Proof of guardianship
      - Permission for Emergency Treatment form
      - Over the Counter Medication form
      - Up to date list of doctors and their contact information
      - NJCAT - ensure it is accurate (Encourage the individual/LG to request a reassessment when needed due to changes in self-care, behavioral or medical support needs.)
      - Relevant reports such as behavioral, medical, psychiatric and psychological evaluations

Eviction by a Landlord

Individuals/families who are facing, or think they are facing, eviction often inform their SC, "We are being evicted." When this occurs, it is imperative to obtain accurate information. If the individual/family has received written notice, obtain a copy, upload in iRecord, notify DDD.housingsubsidy@dhs.nj.gov and complete an SOS Form. ⚠

Additionally, it may be helpful to contact the Community Health Law Project (CHLP) as soon as possible. The Community Health Law Project provides legal and advocacy services to New Jersey residents with disabilities. If an individual is facing the threat of eviction, it is recommended that you contact them immediately after contacting DDD. They are a tremendous resource for guidance, support and obtaining accurate information about tenant's rights.

- **Overview of Eviction Process**
  - Only a judge can order an eviction. A landlord must file an eviction complaint in landlord-tenant court and convince a judge that a tenant should be evicted.
  - There must be good cause to evict a tenant. The landlord must provide written notice specifying what the tenant has done wrong. The notices are called a "Notice to Quit" or "Notice to Cease."
  - **Exception**: Good cause for eviction includes non-payment of rent, which does **not** require a notice to the tenant before an eviction complaint is filed.
  - A Planning Team meeting will likely be vital to consider how to support the individual to satisfy the conditions of the notice.
  - If a judge decides the tenant must be evicted, the judge will enter judgment for possession in favor of the landlord. The tenant will receive a notice called a "Warrant of Removal" no less than three business days later. The Warrant of Removal will indicate the date of the scheduled eviction.
  - An eviction will likely negatively affect a tenant's ability to obtain future housing subsidies.
  - Summary: Obtain accurate information and documentation if available. Notify the Division and contact the CHLP office closest to the individual.

Assessing the Housing Crisis:
Having a thorough understanding of the situation is absolutely necessary, not only to help identify what to do next, but to effectively advocate for the individual and present the case to potential Service Providers.

Start with the Basics	Name, Age, Diagnosis(es), NJCAT score and tier. Which waiver program is the individual on, SP or CCP? With whom do they live, and in what type of setting?
Presenting Problem	Identify the main problem contributing to housing instability. Identify secondary contributing problems.
Behaviors	An effective way to describe behaviors is in terms of these 4 points: first, worst, recent and current. o Describe the first time the behavior occurred / when it began. o Describe the most severe (or worst) time the behavior occurred. o Report the most recent time the behavior occurred. o Explain what is typical currently in terms of frequency, intensity and duration. (Including examples of behaviors and effective interventions is helpful.)
Medical	o Understand the diagnoses well enough to explain to others if needed. o Describe history and progression of a condition as well as the current status. o Describe care needs in detail. o Be sure to state if Private Duty Nursing (PDN) is involved. o Describe the prognosis, or what is expected, if known.
Strengths	o Be able to describe the individual fully, not only in terms of support needs. o Understand the individual's likes, dislikes, preferences, strengths, abilities, likable qualities, preferred free time activities, etc.
Identify Resources	o Personal relationships ▪ Who is involved and available? Family members, friends, neighbors, others? o Service Provider relationships ▪ Which providers are involved now? ▪ Which providers have been involved in the past? ▪ Which providers can be explored? o Know how and when to contact DDD.

Consider these Questions	○ Could the individual's needs be safely met in their own apartment with a housing subsidy, on either the SP or CCP? (If so, pursue a housing subsidy. See Housing Subsidies through DDD and the Housing Assistance webpage.) ○ Is the individual able to live in a boarding home, a residential health care facility or temporarily in a homeless shelter? (Unless there are substantive reasons showing the individual would not be safe in these settings, pursuing one of these options will likely be recommended.)
Consider Extenuating Factors	○ Is Adult Protective Services involved? Should they be? ○ Are there legal issues? ○ Are family dynamics a major consideration? ○ Is the individual making self-defeating, self-sabotaging decisions?

Managing a Housing Crisis

- Review the situation with the SC Supervisor to consider strategies.
- Contact the Division for guidance, support and help with problem solving.
- Ensure the Support Coordinator has a good understanding of the case and the current situation. (See Assessment section below.)
- Ensure an understanding of what the individual/legal guardian is requesting.
- Be familiar with available resources and use them.
- Do not delay. The service system works, but resolution may not be able to happen immediately. Coordinating referrals is a process. When part of the process depends on the Support Coordinator, do not delay.
- Keep in good communication with all parties and document. If the Support Coordinator is not hearing back in a timely way, do not hesitate to follow up.
  - Identify one family member to be the primary contact.
  - Be clear about who is doing what, and the timeframe.

Reach Out to DDD

When faced with a potential or developing crisis, or an immediate, active crisis, contact DDD.

- If the need is immediate, send an email to DDD.SCHelpdesk@dhs.nj.gov. The subject line should include the DDD ID# and a brief description of the situation such as, "Urgent" or "Homelessness". Examples of situations that require immediate outreach to the Division include homelessness or imminent homelessness, immediate threat to health and safety, potential discharge from a hospital or other facility with no place to go.
- If you need to contact the Division outside of normal business hours, see the chapter on 24 Hour Coverage for information about contacting the DDD on-call system.
- If the need is not immediate, complete and submit the SOS Form ⚠ through iRecord.

Planning

Based on a good understanding of the individual, the situation and available resources, work with the Support Coordination Supervisor and the Division's Care Management Team to develop a plan of action. Short-term and long-term planning are often needed simultaneously.

Short-term planning

- Consider what is needed immediately to protect health and safety, and to meet housing and support needs. Consider in-home and out-of-home resources, services supported by the individual's budget, and services provided through county Medicaid.
- Review appropriate supports available through the County Board of Social Services (see ABC Manual on this topic), and consider whether the person's needs could be met in a boarding home or homeless shelter.

Long-term planning

- Keep in mind the plan for long-term stability and follow the steps to get there. Monitor the status closely. If unsure of next steps in the process, reach out to the Division and ask.
- Common long-term solutions may involve the following:
  - an NJCAT reassessment request
  - obtaining a housing subsidy and moving to one's own apartment

- an ICM Referral for addition to CCP, either for an increased in-home budget or placement in a provider-managed setting (see the ABC Manual section on the Community Care Program and the chapter on Intensive Case Management (ICM) Referrals)

Resources

- Community Health Law Project
  - Administration – 185 Valley Street, South Orange (973-275-1175)
  - North Jersey – 650 Bloomfield Ave., Suite 210, Bloomfield (973-680-5599)
  - East Jersey – 65 Jefferson Ave., Suite 402, Elizabeth (908-355-8282)
  - Shore Area – 3301 NJ-66 Building C, Neptune City, NJ (732) 380-1015)
  - Central Jersey – 225 East State Street, Suite 5, Trenton (609-392-5553)
  - South Jersey – 900 Haddon Ave., Suite 400, Collingswood (856-858-9500)
- NJ Department of Community Affairs, Office of Eviction Prevention (OEP)
- Disability Rights NJ
- Legal involvement: The Arc of New Jersey Criminal Justice Advocacy Program
- Legal Services of New Jersey: Providing free legal assistance to people with low-income
- Addition to the CCP Waiting List: CCP Waiting List Information
- Housing Subsidy Program and additional housing resources
- Housing Subsidy Helpdesk: DDD.housingsubsidy@dhs.nj.gov
- Adult Protective Services (APS)
- A listing of Boarding Homes and Residential Healthcare Facilities can be found on the Department of Community Affairs webpage.

Housing Subsidies through DDD

The Supportive Housing Connection (SHC)
Individuals who receive services from DDD may apply for rental assistance through the Supportive Housing Connection (SHC). The SHC, a partnership between the NJ Housing and Mortgage Finance Agency (HMFA) and the NJ Department of Human Services (DHS), was created to administer DHS rental subsidies as a "bridge" to individuals until they are able to access a local, state, or federal housing assistance program.

To receive an SHC housing subsidy, an individual/guardian must agree to monitor local, state, and federal housing assistance programs, such as the Housing Choice Voucher (formerly known as Section 8) waiting list and when they open to accept new applicants, the individual must apply. To be ready for when housing assistance programs/waiting lists open, the individual/guardian must monitor the NJ Department of Community Affairs (DCA) website, local housing authority websites, and local newspapers. When an individual is selected to receive housing assistance through another funding source, the individual must move from the SHC subsidy to the other funding source. This enables the individual to continue to receive housing assistance and the Division to re-allocate the rental subsidy to another eligible individual.

SHC policy and program eligibility is determined by DDD. The SHC administers housing subsidy payments, collects landlord/tenant documents, calculates tenant portions and conducts unit inspections on behalf of DDD. SHC employees are not Division employees.

The housing subsidy is based on the individual's adjusted gross income.

- The individual pays 30% of their adjusted gross income directly to the landlord. DDD and the SHC review the individual's income annually to capture any changes in income.

- If utilities are not included in rent, an additional deduction of $70/month will be applied to their rent contribution.
- The SHC pays the rest of the rent up to the Fair Market Rate (FMR) for the county, by direct deposit directly to the landlord on behalf of DDD. Fair Market Rates are posted in the Published Rent Standards document. Individuals eligible for DDD services may not lease new units with monthly rents that exceed the posted standard.

Example:

Individual income:	$1,000/month
Individual pays 30% of income:	$300/month
Utilities not included in rent:	-$70/month
Rent paid by individual:	$230/month

Participant expectations are outlined on the Rental Subsidy Agreement, which is posted on the Division's DDD Housing Assistance webpage.

Types of Housing Subsidy Requests

Housing Subsidy Requests fall into two categories:

- **New Tenant**
  A new tenant is someone seeking to move into a new unit. On the DDD Housing Subsidy Program Eligibility Determination Form, under Step Two: Proposed Living Arrangement, select "Looking for a New Rental".
- **Existing Tenant**
  An existing tenant is someone who will be remaining in their current unit. On the DDD Housing Subsidy Program Eligibility Determination Form, under Step Two: Proposed Living Arrangement, select "Already in a Rental".

Note: Providers that manage licensed, residential settings (i.e. group homes, supervised apartments) are responsible for arranging housing payments. Support Coordination is not involved with these types of housing payments or with the DDD notification process.

Process for Requesting DDD Housing Subsidy

- The **Planning Team** must meet as described on the DDD Housing Subsidy Program Eligibility Determination Form. Meeting minutes shall be recorded on the ISP Revision and Notification Form and uploaded in iRecord. (Do not simply copy and paste the questions/answers from the determination form to the ISP Revision and Notification Form in lieu of writing meeting minutes. Doing so will cause delays. See the Best Practice Guide chapter, "Support Coordinator Documentation," for information about writing meeting minutes.)
- **The SC uploads** the completed DDD Housing Subsidy Program Eligibility Determination Form in iRecord.
- **The SC emails** the DDD Housing Subsidy Unit, DDD.housingsubsidy@dhs.nj.gov, to notify them the form has been uploaded. Include the DDD ID #, and do not use encryption or send attachments.
  - If approved, the Housing Subsidy Unit will make the referral to the Supportive Housing Connection (SHC).
  - A staff member from the DDD Housing Subsidy Unit will notify the SC of approval or disapproval within (10) business days. In some cases, additional information may be needed.

New Tenant Referral

An individual **approved** by DDD as a new tenant will receive a Welcome Packet from The Supportive Housing Connection (SHC). The individual will have (90) days to identify a rental at or below the Published Rent Standards (PRS).

The first page of the Welcome Packet includes the following:

- the individual's name
- the number of bedrooms approved
- the name and contact information for the assigned SHC staff

Once a rental has been identified, the SC completes and submits the following Welcome Packet documents to the assigned SHC staff:

- Request for Tenancy Approval: a two-page document signed by the individual/legal guardian and the proposed landlord (included in the Welcome Packet)
- DDD Rental Subsidy Agreement
- income verification: current Social Security Administration Award Letter and/or the last four consecutive paystubs
- most recent bank statement
- copy of Birth Certificate and Social Security Card

Next Steps (to be completed within 90 days of receiving the Welcome Packet)

1. Identify a unit within DDD's Published Rent Standards.
2. Proposed landlord and individual/legal guardian complete and sign the Request for Tenancy Approval.
3. Individual/legal guardian signs DDD Rental Subsidy Agreement.
4. Required documents submitted to SHC staff: Request for Tenancy Approval, DDD Rental Subsidy Agreement, Income Verification, Bank Statement, Copies of Birth Certificate/Social Security Card
5. The SHC schedules a unit inspection with the proposed landlord. (The lease is not signed until after the apartment passes inspection.)

Important: The Supportive Housing Connection (SHC) and the DDD Housing Subsidy Unit are two separate entities. SHC staff are not DDD employees and do not recognize DDD-specific language, nor do they have access to iRecord. When communicating with SHC staff, the individual's name will need to be used, not DDD ID #'s.

Tips for Support Coordinators!

- If an individual requires assistance locating an apartment, the individual's budget can be used to fund Community Based Supports/Individual Supports or Supports Brokerage services to help.
- The lease should not be signed until **after** the apartment passes inspection.

One-time Costs: Security Deposits/Furnishings

- If help is needed with one-time costs, such as the security deposit or basic household furnishings, the individual and their support system should apply at the local County Social Service Agency.
  - This process should be started as soon as an apartment is found, as it can take up to 30 days for the Social Service Agency to make a determination.
  - If the County Social Service Agency does not help fund one-time costs, DDD *may* be able to contribute to or cover the cost. To learn more, contact DDD's Housing Subsidy Unit by email at DDD.HousingSubsidy@dhs.nj.gov or by phone at 732-968-4222.
- If the individual decides to move to another apartment at the end of the lease term, they may need to cover the new security deposit while waiting for the old landlord to refund the original deposit.
- Any individual who loses their security deposit, or any portion of it, will not be able to access those funds again.

Existing Tenant Referral

A staff from the DDD Housing Subsidy Unit will request a copy of the current lease. If the individual is approved, the Support Coordinator will receive detailed instructions from the DDD Housing Subsidy Unit on the next steps.

Process for Moving from Provider-Managed to Self-Directed Housing

If the individual is currently residing in a provider-managed setting and is interested in self-directed housing, the SC or Residential Provider must submit verification to the DDD Housing Subsidy Unit that the Planning Team has met and agrees that the proposed placement will meet the individual's current level of need. Use of the Independent Living

Discussion Tool is recommended to guide the SC and Planning Team in discussion to ensure that a safe and supportive plan can be put into place prior to a move. The New Tenant Referral process should be followed.

Annual Recertification

The Supportive Housing Connection sends annual tenant recertification notices and other notifications as needed to the individual and/or their identified primary contact/legal guardian, along with the assigned Support Coordinator. Therefore, it is very important to notify DDD.HousingSubsidy@dhs.nj.gov when there are changes to contact information for the individual or primary contact/legal guardian, or when SCA re-assignment occurs.

When to Contact DDD

Important: DDD should be notified of any of the following by contacting DDD.HousingSubsidy@dhs.nj.gov:

- Contact information changes for the individual or alternate contact (e.g. legal guardian, family member, etc.).
- The individual is reassigned to a different SCA.
- DDD housing assistance is no longer needed.
- The individual would like to move into a new unit.
- The individual would like to add an additional household member.
- The individual has been selected from a HUD waiting list or begins receiving rental assistance from another source that is not DDD-funded.
- The individual moves out of state or no longer receives DDD services.
- The individual receives an eviction notice, a "Notice to Quit" or "Notice to Cease" letter from the landlord.

Tenant Resources

Food Assistance

- New Jersey's Supplemental Nutrition Assistance Program (SNAP)

Utility Assistance

The Low Income Home Energy Assistance Program (LIHEAP) and Payment Assistance for Gas & Electric (PAGE) programs help low to moderate-income residents of NJ with gas and electric bills.

- The LIHEAP Program application may be completed and submitted electronically.
- See the Utility Bills Assistance webpage for information about the PAGE program, an annual assistance program designed to help low to moderate-income, New Jersey households experiencing economic hardship with gas and electric bills.

Cell Phone

- New Jersey Lifeline Program

Internet

- DHS Webpage for Lifeline & Affordable Connectivity Program
- Verizon
- Comcast

Links that may be helpful during Apartment Search

- How to Find Housing: A Guide for Individuals Who Have Been Approved for an SHC Housing Voucher can be found on the Division's Housing Assistance page.
- New Jersey Housing Resource Center
- Hotpads
- Craigslist
- Supportive Housing Association of NJ

Human Rights Committees (HRCs)

The Division requires an objective review of issues that may infringe upon human or civil rights of individuals with IDD through a review by a Human Rights Committee (HRC). Approved providers may elect to develop their own HRC or utilize the HRC established by the Division.

Purpose and Composition

- Individuals with developmental disabilities are entitled to the same human and civil rights enjoyed by all citizens. An HRC review helps balance protection of one's rights and the priority of preserving health and safety.
- The HRC is an advisory body whose recommendations are meant to provide guidance to a Service Provider's administration regarding implementation of a proposed restriction. The committee focuses on assuring due process has been followed, and that the Planning Team acts within the regulations of the Division.
- HRCs generally meet regularly, at least bi-monthly.
- HRCs consist of between 5 and 15 people with different roles. Members of an HRC may include individuals served by DDD, family members of individuals served, people with experience in the field of developmental disabilities or with human rights issues, interested citizens, employees of DDD or Service Provider staff.
- Some Service Providers have an HRC. The DDD HRC reviews referrals for individuals served by providers that do not have their own HRC.

When to Refer to a Human Rights Committee

- HRC referrals are made for a review of cases where the Planning Team proposes or recommends a restriction to anything that should be available/accessible to an individual and requires a review beyond that of the Planning Team, per 10:44A Standards for Community Residences for Individuals with Developmental Disabilities.
- In general, if a specific program has an existing, approved restriction affecting each person in the program, and individuals/families were aware of the restriction when entering the program, an HRC referral is not needed.
- Every situation is different. When in doubt about whether an HRC referral is needed, send an email to the Human Rights Committee Mailbox at DDD.HRC@dhs.nj.gov.

How to Refer to a Human Rights Committee

- If a referral to an HRC is needed, the SC should contact the Service Provider to find out if they have an HRC. For provider HRC's, the provider determines the referral process.
- Otherwise, referrals to the DDD HRC are made by completing the Human Rights Committee Referral Form and submitting it, along with all related documentation, to DDD.HRC@dhs.nj.gov.

What to Expect

- HRC recommendations are meant to assist the Service Provider in making decisions regarding implementation of the proposed restrictive strategies.
- If the effected individual or legal guardian is not in agreement with the recommendations of the HRC or with the final determination of the agency administrator, the individual/LG may attempt to resolve the dispute in writing as described in Division Circular #5 - Human Rights Committees.
- If a provider proceeds with strategies against the advice and recommendations of the HRC, the provider must document substantive reasons for doing so in the individual's record, as well as notify the Division.
- For referrals reviewed by a Service Provider's HRC, it is expected at a minimum that recommendations be shared with the members of the Planning Team.
- For referrals reviewed by the DDD HRC, recommendations are typically provided to the referral source, the SCA, the DDD Support Coordination Unit and the DDD Care Management & Provider Support Unit liaison.

Documentation

- Case notes should reflect all developments, including summaries of relevant discussions, information about HRC referral status and scheduling status, and the agency's final determination regarding HRC recommendations.
- Imposed restrictions must be included in the ISP in the section associated with the reason for the restriction. Imposed restrictions must be supported by a specific assessed need and justified in the ISP, involve the informed consent of the individual/LG, and assurances must be in place that the restriction will cause no harm.

- If a provider is asked to develop a plan to fade the restriction, the SC should be mindful to update the ISP when lesser restrictive measures are implemented.
- Documents, including the HRC Referral Form, Planning Team meeting minutes and written HRC recommendations should be uploaded in iRecord.

Resources

- Referrals to the Human Rights Committee and related inquiries are submitted to DDD.HRC@dhs.nj.gov.
- The HRC Referral Form is found on the Support Coordination Information webpage.
- Inquiries about Behavior Support Plans and requests for reviews by a Behavior Management Committee (BMC) are sent to Ddd.Behavioralservices@dhs.nj.gov.
- Additional information is found in Section 15.5.3 of the Division's Community Care and Supports Program Policy Manuals and in Division Circular #5 - Human Rights Committees.

Incident Reporting (IR)

Mandated Reporting

- Support Coordinators and Service Providers are mandated to notify the Division immediately of all known or alleged reports of abuse, neglect, exploitation and also incidents involving injuries and life-threatening emergencies.
  - If a family or individual reports an incident to the SC and the incident is unrelated to a Service Provider, the SC must report it.
  - If the SC is the **first** entity who learned of an incident or allegation, the SC is responsible for completing and submitting an Incident Report (IR), even if the incident involves a Service Provider.
- The SC must also report allegations of abuse, neglect, or exploitation of an individual that occur in the person's home, and do not involve a Service Provider, to Adult Protective Services (APS) as soon as they become aware.
  - If a Service Provider reports an incident to the SC, it is the Service Provider's responsibility to complete an incident Report (IR), not the SC's. However, SCs *are* required to notify the Office of Risk Management (ORM) of such incidents so the ORM may ensure that the Service Provider reports the incident as required.
- 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 is not reported.
- Failure to immediately report a life-threatening emergency is a violation of Danielle's Law and may result in civil penalties "of $5,000 for the first offense, $10,000 for the second offense and $25,000 for the third and each subsequent offense." For more information, see Division Circular #20A.

Important Definitions

Abuse

Abuse is physical, sexual, or verbal acts against a person served that cause pain, physical or emotional harm, mental distress, injury, anguish, and/or suffering.

Neglect

Neglect is the failure of a caregiver to provide the needed services and supports to ensure the health, safety, and welfare of the service recipient.

Exploitation

Exploitation is any willful, unjust, or improper use of a service recipient or their property/funds, for the benefit or advantage of another; condoning and/or encouraging exploitation of a service recipient by another person.

What to Report

- A complete list of reportable incidents may be found on the Incident Reporting webpage.
- When in doubt, ask the assigned Office of Risk Management (ORM).
- When completing an IR, include all **relevant** detail (who, what, when, and where).

Important: The SC is never to attempt to investigate, or interfere with an investigation, by contacting an involved party either to provide information or to question them regarding an incident.

When to Report

Please refer to the Incident Reporting Levels and Categories Grid for reporting timeframe requirements.

- A+ incidents are to be reported immediately.
- A incidents are to be reported by the close of the business day.
- B incidents are to be reported within 24 hours of learning of the incident.

Do not delay submitting a report if you do not have all the information. Additional information can be added later.

How to Report

Instructions explaining how to transmit IRs securely are described in the UPDOC Instructions. The ORM may contact the SCA to request clarification or additional information. If further information is learned after the initial IR has been submitted, use the Follow-up Report Form to document and submit.

Questions may be Directed to Office of Risk Management:

Plainfield: Bergen, Essex, Hudson, Passaic, Somerset and Union counties
Trenton: Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Sussex and Warren counties
Mays Landing: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester and Salem counties

Plainfield
Main IR Number: 908-561-4587
Fax: 609-341-2342
Email: DDD-CRU.UIRS@dhs.nj.gov

Central Office
Fax: 609-341-2344
Email: DDD-CO.OQM-UIRS@dhs.nj.gov

Trenton
Main IR Number: 609-292-1903
Fax: 609-341-2342
Email: DDD-CRL.UIRS@dhs.state.nj.us

Mays Landing
Main IR Number: 609-476-5080
Fax: 609-341-2340
Email: DDD-SRO.UIRS@dhs.state.nj.us

Documentation Dos and Don'ts

- **Do not** upload Incident Reports in iRecord, and **do not** copy/paste an IR into case notes. IR's are protected risk management documents and are not part of the individual's electronic record.
- **Do** enter a case note summarizing relevant information from the IR, and stating who will be submitting or who has submitted the IR.
- If made aware of an incident, *after* an IR has been completed and submitted, enter a note indicating SC awareness of the IR and describe anticipated follow up. Subsequent notes should show the follow up that has occurred. For example, if a Planning Team meeting is warranted, enter notes showing that the meeting is scheduled and after the meeting occurs. Upload a copy of the meeting minutes in iRecord. The case note can summarize highlights from the meeting, or simply refer the reader to iRecord Documents to review the minutes. Details about the meeting do not need to be duplicated in both case notes and meeting minutes.
- Include relevant information in the next SC Monitoring Tool.

Process Questions - What Happens Next?

- The ORM directs IR's to the appropriate entity for follow up, if needed.
- The reporter/Support Coordinator may be asked additional questions.

- Some incidents require involvement from the Office of Public Integrity and Accountability (OPIA) Incident Verification Unit (IVU) or are routed to the Office of Investigations (OI) for investigation.
- When learning of an incident, consider appropriate follow up steps. For example: If an individual is injured, the SC will likely want to contact the individual, a family member or Service Provider to see how the individual is doing, and consider whether a Planning Team meeting is needed. If there are questions or concerns about how to best support an individual, especially if there is a pattern of incidents, a Planning Team meeting would likely be recommended. The SC, working in collaboration with the Planning Team, should consider whether service changes or additions are needed.
- When in doubt about the SC's role, reach out to the Division via the SOS process.
- Occasionally, a family member may contact the SC to ask about the status or outcome of an investigation. An Investigation Report can be requested by using the Investigation Report Request form. Questions may also be forwarded to the assigned ORM.
- Additional information can be found in the SP and CCP Manuals, and by reviewing Division Circular #14.

Incident Reporting (IR) – Other Reporting Requirements

In addition to reporting to DDD, some incidents or situations require reporting to other entities.

Adult Protective Services
Allegations of abuse, neglect, or exploitation of a vulnerable adult (18 years or older) living in their own home, must be reported to Adult Protective Services (APS) as soon as one becomes aware. Adult Protective Services (APS) programs have been established in each county in New Jersey to receive and investigate such allegations. The DDD Office of Risk Management (ORM) staff can assist with any questions.

The Division of Aging Services webpage has helpful information about the purpose of APS and making referrals.

Law Enforcement Notification
The Incident Reporting Levels and Categories Grid indicates which incidents require law enforcement notification. If needed, SCAs and Service Providers may contact the assigned Office of Risk Management (ORM) for assistance.

Other Reporting Entities

New Jersey's Child Abuse/Neglect Hotline 1-877-NJ ABUSE (1-877-652-2873)

DDD Abuse and Neglect Reporting Hotline 1-800-832-9173
To report suspected abuse, neglect or exploitation of an individual with an intellectual or developmental disability. The DDD Hotline is available 24 hours a day, 7 days a week. Reports can be made anonymously. Detailed information on the reporting process may be found in the Reporting Suspected Abuse, Neglect or Exploitation of an Individual with an Intellectual Developmental Disability document maintained by DDD.

Intensive Case Management (ICM) Referrals

When is a Referral to ICM Needed?
An Intensive Case Management (ICM) Referral is needed any time an individual on the Supports Program, their family or legal guardian requests an in-home, Community Care Program (CCP) budget or residential placement in a provider-managed setting.

Prior to submitting the ICM referral, the SC must review the Community Care Program (CCP) Fact Sheet with the individual/family/legal guardian to ensure that the criteria for a referral are understood.

Information and Tips for Completing the ICM Referral
- For CCP approval, the individual must meet the Level of Care (LOC) standard (see the chapter on LOC Review), and there must be an issue of homelessness or imminent peril, which means that the individual is at immediate risk of serious impact to health and safety, which cannot be resolved through the Supports Program budget.

- If an individual/guardian is requesting residential placement or access to a CCP budget, completing an ICM Referral should be a priority.
- Justification for the ICM Referral needs to be clear and compelling. Include current examples of impact or potential impact to health and safety.
- Clear and thorough responses on the entire ICM Referral form are important, not only for presenting the referral, but also for the Level of Care review.
- Even if the SC does not believe the request will be approved, if the individual/legal guardian insists on it, even after the criteria is reviewed, the SC should complete and submit an ICM Referral.
- If the individual is dually diagnosed, be sure to describe how the **developmental disability** contributes to the need for residential placement or a CCP in-home budget. (The CCP is a **DDD** waiver, not a mental health waiver).
- Keep in mind the ICM Referral and residential placement are processes involving many steps. When part of the process depends on the Support Coordinator, do not delay.
- If the individual and/or their Planning Team feels their needs **could** be met in a boarding home, or in their own apartment with a housing subsidy and Supports Program services, these options should be pursued. If the team feels the individual's needs could **not** be safely met in one of these settings, the ICM Referral will need to explain, in relation to their developmental disability, why not.
- Review the date and accuracy of the last NJCAT. If warranted, request a reassessment. Ask the Planning Team to consider whether a change in Tier and budget would address the emergent issues.

After the ICM Referral Submission

1. The DDD ICM Unit will notify the SC of the assigned ICM Worker who will complete the review.
2. The ICM Worker will meet with the individual and/or legal guardian for an initial face-to-face visit, continue to gather information and present the request for emergency access to the CCP.
3. The SC remains in constant contact and provides regular status updates to the DDD ICM Worker and the individual and family.
4. The SC is responsible to ensure the ISP remains accurate and that any appropriate services are added to the plan as needed.

Roles of the SC and ICM Worker

Particularly when an individual is facing homelessness or imminent peril and multiple workers are involved, it is crucial for everyone to work together towards resolution of the crisis situation. Although there is some ebb and flow between the roles of the SC and the ICM worker, there are some general expectations.

Role of the Support Coordinator	Role of the Intensive Case Manager
Immediately and thoroughly complete ICM referral	Ask questions / Gather as much information as possible
Explore all unused services that are currently available	Become a collaborative member of the Planning Team
Review NJCAT accuracy with Planning Team	Assist with immediate response to health/safety needs
Consider the least restrictive residential options	Assist with placement planning
Keep the individual and Planning Team members updated	

Level of Care (LOC) Review

Level of Care (LOC) refers to the assessed level of assistance an individual requires to meet their health and safety needs and accomplish activities of daily living. Eligibility for certain Medicaid funded services is tied to an individual's LOC designation.

When an individual/legal guardian is requesting addition to the Community Care Program (CCP) Waiver, either due to an emergency or when reached on the Waiting List for CCP Services, the Division must conduct a review to determine whether the individual meets the LOC criteria for Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/ID), meaning that if not for home and community based services provided through the CCP, an individual would qualify to live in an institution.

Individuals, whose NJCAT self-care score is 3 or 4, meet the ICF/ID level of care without requiring further review. Individuals, whose self-care score is 1 or 2, require further review. The Division does this by acquiring and reviewing information about the following:

- a diagnosis of developmental disability or a related condition
- the need for continuous active treatment related to the developmental disability
- the need for a 24-hour plan of care related to the developmental disability
- the need for intensive and consistent training due to an inability to apply skills learned in one environment to a new environment
- whether the individual would require institutionalization, if not for services through the CCP
- whether the individual could be safely supported on the Supports Program

LOC through an ICM Referral

When the Intensive Case Management (ICM) Unit receives an ICM Referral, the case is assigned and a face-to-face visit is scheduled, which may occur virtually or in person. The ICM worker will confirm and gather information needed for an administrative determination about whether emergency criteria are met and for the LOC review.

An ICM Unit Supervisor reconciles and summarizes information from sources such as the ICM Referral, the NJCAT, the ISP and the PCPT and forwards to the appropriate Division staff for an administrative review. If an individual is not in need of immediate placement planning and/or does not meet the ICF/ID standard, they will not be approved for CCP.

If an Emergency is Declared and LOC is Approved:

1. A DDD administrator will enter a case note indicating the outcome of the Level of Care review.
2. Soft enrollment to the CCP in iRecord will be enabled.
3. The ICM will inform the individual/family and SCA by phone and by mail.
4. The SC will need to obtain and upload a new Participant Enrollment Agreement (PEA) form and enroll the individual onto the CCP.
5. The SC will develop the CCP ISP and follow it through to Approval status, which finalizes the individual's enrollment onto the CCP.
6. If the individual/Legal Guardian is requesting out of home placement, the ICM Unit will continue to assist with placement planning until placement has been secured.
7. If the situation stabilizes and the individual desires in-home supports or is not ready to pursue out of home placement, the ICM Unit will discontinue involvement.

LOC through the Waiting List for CCP Services

When an individual is reached on the Waiting List for CCP services, a Transitional Case Manager (TCM) from the Wait List and Special Projects Unit will contact the individual/family and the Support Coordinator to discuss the individual's options. Options may include being evaluated for CCP and remaining in the same living arrangement, pursuing residential placement in a provider-managed setting or making no changes to services/waiver enrollment. The individual's name will eventually be removed from the Waiting List.

If the individual/family would like to be evaluated for CCP, the TCM will review the NJCAT assessment and facilitate a reassessment if needed. If LOC is approved, the Transition Case Management will not remain involved. If the individual/family is interested in residential placement, the SC is responsible to make referrals and provide follow up.

If LOC is denied:

- A DDD administrator will enter a case note indicating the outcome of the Level of Care review.
- The ICM or TCM worker will inform the individual/family and the SCA by phone.
- A letter will be sent to the individual/family explaining why the LOC was denied and instructing how the decision may be appealed.
  - A request to appeal needs to be submitted in writing within 30 days.
  - A Settlement Conference review meeting will be held, and the SC will need to participate.
  - The participants of the Settlement Conference will be informed of the outcome.
- If an individual/family requests an appeal and the appeal is approved, the Division will enable soft enrollment to the CCP in iRecord.

If the individual is denied access to the CCP waiver, the SC will remain responsible to assist the individual by pursuing service options. The SC is encouraged to reach out to the Division for assistance as needed, through the SOS process. ⚠

Tips for Support Coordinators!

- Ensure all documentation for which the SC is responsible, is accurate, complete, detailed and consistent across all forms. This includes the ICM Referral, the ISP and the PCPT.
- When information in the NJCAT is not accurate, ensure accurate information is in the ISP with a brief, appropriate explanation.
- Describe support needs in relation to the individual's developmental disability. (If an individual's need for CCP is described **only** in relation to a mental health diagnosis, LOC will not be approved.)
- Do not delay. The Level of Care review is a process. When information is required or requested, respond in a timely way.

Out-of-State Travel, Impact on Medicaid Eligibility and Services

Per Medicaid regulations, when it is anticipated that an individual will be temporarily out of the state for more than 30 days, the individual/family/legal guardian should contact Medicaid to request the individual's Medicaid continue during the time out of state. Without this notification and request to Medicaid, there is a risk of Medicaid termination.

It is common for Medicaid to approve requests to keep Medicaid intact while traveling outside of New Jersey. Being out of the state for a temporary, defined time period or a specific circumstance is generally acceptable. However, without proper notification, it is possible that Medicaid would be terminated until the individual returns to NJ and can re-establish Medicaid eligibility.

The individual/family/legal guardian will need to inform Medicaid of the trip's anticipated start date, the return date and the reason for the extended time out of state. The individual's MCO (Managed Care Organization) Care Manager should also be informed.

If Medicaid approves the request, the individual's waiver code will remain active, and they will **not be disenrolled** from the DDD waiver program.
If the individual has SSI, and therefore Medicaid eligibility is based on SSI eligibility, they would contact the Social Security Administration (SSA) by calling 1-800-772-1213. SSA will likely not send a written response if the request is approved. SSA would send a response if they determine there is a need to terminate the benefit.

If the individual has county Medicaid (not based on SSI eligibility), contact Ddd.MediElighelpdesk@dhs.nj.gov for assistance to determine to which entity a letter should be sent. Request letters may be submitted via email. A copy of the request letter should be uploaded in iRecord.

During an individual's time out of state, Support Coordinators should be mindful of the following:

- The Planning Team should consider stopping some or all services to conserve the individual's budget.
- The SC remains responsible to complete monthly monitoring (via phone call/video conference). This is important so the SC can remain aware of the return date, as well as status updates about the individual's health and support needs.
- The ISP should be updated as needed so that services are in place when the individual returns.

Division Services while Out of State
If the individual/family requests and is granted approval from Medicaid to keep Medicaid intact while out of state, certain Division services may continue. Services such as Community Based Supports, Individual Supports/base or 15-minute rate and certain Goods and Services such as online classes, may continue within the following parameters:

- The SDE or family must pay all travel expenses for the SDE. There is no reimbursement for airfare, meals, lodging, etc.
- An SDE may not work more than 40 hours per week.
- Services must be provided within the United States.

If an individual is preparing to travel out of state for more than 30 days, and the individual/legal guardian/family does not contact Medicaid, the SC should complete an SOS Form ⚠ through iRecord. The SCA should **not** contact Medicaid to report this.

If the individual does not return to New Jersey on the anticipated/expected date, the individual/family should contact their MCO to inform them. SCAs may contact DDD.MediElighelpdesk@dhs.nj.gov for case specific guidance.

If an individual/legal guardian/family does not respond to attempts to contact and does not participate in monthly monitoring, the SCA's approach should be similar regardless of the individual's whereabouts. The SCA should complete an SOS Form. ⚠

Planning Team, Previously Known as Interdisciplinary Team (IDT)

Overview and Team Composition

- The Planning Team includes the individual, the SC, individual's parent/family members or legal guardian as appropriate, and any Service Provider whose participation is necessary. Additional persons approved by the individual/legal guardian may be included.
- The Planning Team will consist ideally of persons of various backgrounds and roles, with various strengths and insights to support the individual and contribute to the development of the ISP.
- The SC is responsible to schedule and facilitate Planning Team meetings, unless the individual would like to facilitate the meeting themselves.

When does the Planning Team Meet?

The Planning Team meets when developing the ISP.

- Within 10 days of an individual, new to services being assigned to an SCA, the Planning Team should meet. The ISP must be approved within 30 days of assignment.
- iRecord generates the annual plan 60 days before the end of the plan term. The ISP should be approved within 30 days prior to the end of the plan term.
- The Planning Team should meet immediately following an NJCAT reassessment resulting in a tier change. When this occurs iRecord generates a new annual plan.
- The Planning Team should meet immediately following enrollment onto a different waiver (for example, transitioning from SP to CCP). When this occurs iRecord will generate a new annual plan.

When there is a change in the individual's status, services, or there has been a significant event. Monthly contact through the Support Coordinator Monitoring Tools helps identify the need for the Planning Team to convene.

Examples include the following:

- A change in services is needed or anticipated.
- A suspension from program has occurred and planning for re-entry is needed.
- Changes in health/nutrition, or in supervision/support needs.
- Medical or behavioral incidents may warrant a Planning Team meeting.
- All choking incidents.
- When an Unsupervised Time Assessment or Self-Medication Assessment is completed, the Planning Team reviews the findings, prior to revising the ISP.
- Issues or concerns not resolved outside of a formal meeting.

When the Team does not Reach Consensus

- Every effort should be made to reach consensus, but if consensus cannot be achieved, the team should defer to the individual's thoughts, opinions, decisions, preferences, and expressed needs first. To prevent service delays, areas in which consensus *has* been met will be included in the ISP, even if discussion continues in other areas.
- The ISP should be consistent with information provided on the ISP Worksheets. If there are any contradictions, the Planning Team should convene.

Documentation

- SC Monitoring Tools
  - Monitoring tools should be current and accurate. Information that is not current, should not be included.
  - Completing the monitoring tools helps the SC ensure the plan remains up to date and document that the individual is progressing toward the outcomes specified in the plan.
- iRecord Case Notes
  - Case notes should reflect efforts to schedule Planning Team meetings, describe the meeting's purpose and identify who is invited.
  - Case notes should include input from team members who did not participate in the ISP meeting in person.
  - Case notes should reflect that a Planning Team meeting occurred and summarize important updates or pending issues. Notes do not duplicate detailed information from Meeting Minutes uploaded in iRecord.
- The Individualized Service Plan (ISP) should be revised as needed.
  - The ISP should be revised as determined by the Planning Team.
  - The ISP should be revised as needed through information received during monthly monitoring.
  - ISP revisions are documented through use of the ISP Revision and Notification Form.

Resources

- Additional information about Planning Team membership and responsibilities is found in the SP and CCP Manuals, sections 7.2 and 7.3.
- See the ISP Revision and Notification Form for additional information and instructions.

Psychiatric Hospitalizations

When an individual is hospitalized psychiatrically, having a basic understanding of the following factors will help the SC understand their role in the situation, know what to expect and contribute to positive outcomes.

Criteria for Psychiatric Admission
In general, being admitted to an inpatient psychiatric unit means that the individual has been assessed as a danger to their own safety, the safety of others, or to property not their own, and as having a treatable psychiatric condition, which cannot be safely managed in a less restrictive setting.

For individuals with dual diagnosis, it can sometimes be difficult for the treatment team to distinguish between psychiatric and behavioral components of an individual's symptoms. Sometimes, after repeated admissions, the treatment team may determine an individual would not benefit from inpatient psychiatric care, and admission may not be considered the best way to address the individual's needs. In this kind of situation, ensure Behavioral Supports are in place. If a behavior support plan (BSP) *is* in place and additional support may be helpful, use the DDD Resource Team Behavior Analyst Consultation form to request a behavioral consultation. Support Coordinators should employ the services of CARES (described below), and ensure discharge instructions from previous hospitalizations are followed.

Types of Admissions

- Voluntary Admission
  Admission to an inpatient psychiatric unit requires consent from the individual/legal guardian.
- Involuntary Commitment
  - If an individual meets criteria for inpatient psychiatric admission and is offered appropriate inpatient care, but refuses to provide consent, **or** if an individual, who is hospitalized and not safe to be discharged, is insisting on being discharged, the treatment team may seek involuntary commitment. This is a process requiring steps of assessment and review to ensure criteria for involuntary commitment are met and that someone is not involuntarily committed unnecessarily. The last step requires court approval.
  - Involuntary commitment results in a transfer/admission to a short-term care facility (STCF), county, or state hospital. While the commitment lasts, regular court hearings occur to ensure the individual continues to meet commitment criteria and/or to review discharge planning.

Note: When an individual is admitted to a state or county residential psychiatric facility (i.e., state or county psychiatric hospital), the SC should complete an SOS Form. ⚠ If the admission is expected to last more than 30 days, the individual's plan will need to be approved to inactive, and the case will be transferred to the DDD Case Manager who will facilitate the individual's return to the community.

Residential Settings

- Own Home
  - When an individual living in their own home, is psychiatrically hospitalized, the SC would likely learn of this if the family reaches out to inform them, or during monthly monitoring contact. When learning of an unplanned psychiatric hospitalization, the SC and the family should discuss whether additional services are needed to ensure safety and potentially prevent the need for future hospitalizations. The SC should confirm with the family that the individual will return home upon discharge. If the family indicates they are not willing (or might not be willing) to allow the individual to return home, contact the Division immediately. (See disposition issues below.)
  - Unplanned psychiatric hospitalizations require an Incident Report (IR), even if the SC does not learn of it until after the individual has been discharged.
- Provider-Managed Setting
  If the individual lives in a provider-managed setting, the provider would be expected to complete an IR and take the lead in communicating with the hospital.

Disposition Issues
Typically, an individual will be discharged to the setting where they were living prior to admission. Occasionally, this is not a safe option. As soon as the SC is aware that there may be a problem with living arrangements upon discharge, contact the Division **immediately** through the SOS process. ⚠ Situations like this should be prioritized. Heightened coordination will be needed.

Hospital Discharge Planning
Discharge planning begins at the time of admission. Assessment, treatment and discharge planning are ongoing throughout an individual's hospitalization.

In general, discharge criteria requires that the individual is stable, i.e., no longer a threat to themselves, others or property, and that they have a safe place to live.

Discharge plans typically involve the following considerations:

- Where the person will be living.
- Prescriptions for medications provided upon discharge.
- Follow up appointments with a psychiatrist/physician are typically scheduled prior to discharge.
- Other treatment options such as outpatient counseling, attending a mental health day program, or attending an intensive outpatient program (IOP) may be recommended and/or already scheduled prior to discharge.

Roles and Responsibilities
Whether the individual lives in their own home or a provider-managed setting, the primary responsibility for support and follow up typically lies with family or a Service Provider. Families who require support may receive assistance from the Intensive Family Support Services (IFSS) Program, funded by NJ Division of Mental Health and Addiction Services. (More information on IFSS is below.) If an individual lives alone, the SC will likely have a more involved role.

- **Prior** to a psychiatric hospitalization, if the Planning Team recognizes signs of decompensation, meetings are recommended to address concerns. Support Coordinators are encouraged to get to know the individuals served well. The better the SC and Planning Team understand the individuals they support, the better recognized warning signs of decline may be.
- **During** a psychiatric hospitalization, the Support Coordinator is an important part of the team, especially related to discharge planning. The SC is in a unique position to accomplish or assist with the following things:
    - Ensure the ISP is updated regarding support needs, medications and doctor contact information.
    - Ensure the ISP is updated with additional services as appropriate. The team should consider how to use the individual's budget to support new or increased services such as Community Based Supports/Individual Supports base or 15 minute rate, Transportation or Behavioral Supports.
    - The team should also consider whether an increase to the individual's budget is needed to support additional services.
    - Ensure case notes are kept up to date.
    - The SC may facilitate involvement from key Service Providers in discharge planning meetings.
    - The Planning Team may need to problem solve and address questions like these:
        - Where will the individual be living, and with whom?
        - Will the individual be safe there?
        - How will their prescriptions be filled, and how will medications be supervised?
        - What will the follow up services or appointments be, and how will they get there?
        - Is a referral to CARES warranted?
- **After** discharge from an inpatient psychiatric setting, increased monitoring should be provided for a time to see how the individual is doing and whether anything else is needed from the SC.
    - Support the individual as needed to follow through with discharge recommendations.
    - Be flexible. Based on the doctor's or treatment team's recommendations, the Planning Team may need to meet to adjust follow up plans or expectations.

CARES Referral

Crisis Assessment Response and Enhanced Services (CARES) is a program based at Trinitas Regional Medical Center, which provides statewide assistance for individuals with developmental disabilities in mental health or behavioral crisis. A referral to CARES should always be considered when someone is hospitalized psychiatrically. CARES offers the following:

- "direct consultation at the time of crisis in family homes, residential placements, day programs, emergency rooms
- technical support to families, sponsors, DD and mental health Service Providers
- link-up with relevant resources
- training for consumers, families, sponsors and Service Providers
- consultations at psychiatric inpatient units statewide"

Resources

- Intensive Family Support Services (IFSS) - NAMI New Jersey
- National Alliance on Mental Illness (NAMI)
- The New Jersey Division of Mental Health and Addiction Services (DMHAS) Webpage
- New Jersey Comprehensive Mental Health Services Directory
- Program for Assertive Community Treatment (PACT) Services - To learn more, visit: CPC Integrated Health or the Mental Health section of the ABC manual chapter, *Resources in the Community*.
- Trinitas CARES Program - Additional information about CARES is available on the DDD Health and Safety webpage.

Records Requests

An individual's record is considered the property of the Division of Developmental Disabilities (DDD). SCAs should not directly release records (other than the ISP, PCPT or NJCAT) to an individual, legal guardian, or attorney. Planning Team meeting minutes may be distributed to those who attend the meeting and are interested in receiving a copy. Otherwise, a records request to the Division is needed for any component of the individual record.

Components of the Individual Record include:

- Guardianship documents
- HIPAA Forms
- Pre-admission and intake information
- Participant Enrollment Agreement
- Right & Responsibilities Statements
- ICD-10 coding documents
- Past Service Plans (ISP/PCPT, IHP, ELP)
- Mental Health Pre-Screening Checklist
- Medical exams and reports such as Annual Physicals and Annual Dentals
- SC Monitoring Tools
- Case Notes
- Communications/correspondence to or from parent or legal guardian
- Financial records

The following Division records are not public and can only be released upon judicial order:

- Investigations of incidents
- Initial Incident Reports and Incident Follow-up Reports
- Any and all documents and materials related to a pending investigation of an incident

Requesting to Change Plan Status to Review to Inactive (RI)

Introduction

There are a number of scenarios for which an individual's ISP should be made inactive. If it appears appropriate to end the service plan (thus ending services), the Support Coordination Agency should complete an SOS Form ⚠ in iRecord describing the current circumstances in order for the Division to conduct a review. If the Division agrees with inactivating the ISP, the Support Coordinator will be instructed to change the plan status to Review to Inactive (RI), and subsequently, the Division will approve by changing the plan status to Approved to Inactive (AI). Only the Division may approve a plan to be inactive.

When an ISP is "Approved to Inactive" (AI), the Division will also determine whether the individual will also be discharged from DDD. This section describes when an ISP may be submitted to RI, the steps involved and the Division's follow up actions.

Possible Reasons to Request an ISP Review to Inactive (RI):

Living Out of State

When an individual or family is planning to move out of state, they typically inform their SC. Gather information such as when and to where they are moving. Request that the individual/LG complete a Voluntary Discharge from Division Services form indicating the date they intend to move, and upload in iRecord. Document the information on Monitoring Tools and in case notes. **After** the individual/family has moved, obtain verbal confirmation that the move actually occurred, and document in case notes. **Then** submit an SOS Form. ⚠ (Occasionally, an anticipated move does not occur. The Division does not want to approve a plan to inactive and discharge an individual until **after** confirmation is received that the move actually took place.)

Waiver Disenrollment

If an individual/legal guardian reports they are no longer interested in Division services, confirm they are not receiving a Division service, and complete a Waiver Program Disenrollment Request. Upload the form in iRecord and complete an SOS Form. ⚠ SCs should be sure to indicate whether there is current involvement with Adult Protective Services (APS), the police, or if there are other concerning extenuating factors. **Also**, it is very important to indicate whether the individual has a DDD funded housing subsidy or a public guardian through the Bureau of Guardianship Services. This information will determine whether they should be discharged or only made inactive (disenrolled).

Refusing Monitoring Visits

If an individual/family is refusing to meet or to speak with their SC, Support Coordinators should try to determine the reason. Consider asking whether they might prefer to work with a different SC within the agency. If resistance continues, submit an SOS Form ⚠ to seek Division support. As always, document efforts in case notes. Division staff will attempt to make contact and determine how to move forward.

Unable to Contact

If the SC is unable to make contact with the individual/family, be persistent and attempt to contact them by all possible means:

- By phone – search for alternate phone numbers on contact tiles and in case notes.
- By email – search for alternate email addresses.
- By regular mail – send a follow up letter to the last known address stating that you have been attempting to make contact and requesting the individual/family to contact you. (Upload a copy in iRecord.)
- If the individual recently completed the DDD intake process, review notes for information indicating how the intake worker was able to communicate with the individual/family.
- If the individual is receiving services, contact the Service Provider(s) for additional information. A provider may be able to facilitate re-establishing contact.
- Document all efforts in case notes, showing multiple attempts to contact over time.
- If the Support Coordination Agency is still unsuccessful after the above is completed, submit an SOS Form. ⚠

Skilled Nursing Facility or Nursing Home Placement

Approved for Long-Term

- If the PASSR process approves an individual for long-term placement in a Skilled Nursing Facility (SNF), the individual will transfer from a DDD waiver to the Managed Long-Term Services and Supports (MLTSS) waiver.
- Find out from the individual/LG whether the individual will remain in the SNF, or if they are requesting to return to the community.
  - If the individual/LG **does** want to return to the community, document your interactions in case notes. The case will be transferred to the DDD Community Transitions Unit (CTU). The Community Transitions Unit Case Transfer Form (completed by the SC) will be needed, along with the below.
  - If they **do not** request to return to the community, document your interactions in case notes.
- In both of the above situations complete the following:
  - Notify ddd.PASRR@dhs.nj.gov of the dates of all nursing home admissions, discharges, and transfers from rehab to long-term care.
  - Complete the Waiver Program Transfer Request (completed by the SC and signed by the individual/LG).
  - Upload documentation in iRecord and complete an SOS Form. ⚠

Approved for Custodial Care

- If the PASSR process approves the individual for custodial care in a Skilled Nursing Facility (SNF), they are approved to remain in a SNF, **only** until arrangements are made to return to the community. The individual's ISP will need to be approved to inactive, and the case will be transferred to the DDD Community Transitions Unit. Complete the following:
  - The Community Transitions Unit Case Transfer Form (completed by the SC)
  - The Waiver Program Transfer Request (completed by the SC and signed by the individual/LG).
  - Upload documentation in iRecord and complete an SOS Form. ⚠

Stay Will Exceed 180 days (even though not approved for long-term/custodial care)

- An individual in a rehab or nursing facility may remain on a DDD waiver for up to 180 days. If they are not approved for long-term/custodial care, preparations will be needed for a transfer to the MLTSS waiver, **before** the length of stay reaches 180 days.
- The individual's plan will need to be approved to inactive, and the case will be transferred to the DDD Community Transitions Unit. Complete the following:
  - Complete an SOS Form ⚠ when you recognize a situation like this. Do not wait for the 180-day mark.
  - The Community Transitions Unit Case Transfer Form (completed by the SC)
  - The Waiver Program Transfer Request (completed by the SC and signed by the individual/LG).
  - Upload documentation in iRecord and coordinate with the assigned Care Management Monitor regarding how to proceed.

Psychiatric Hospital Admission.

- If an individual is admitted to a state or county residential psychiatric facility (not the psychiatric unit of a general hospital), the individual remains assigned to the SCA for up to 30 days.
- The SC should complete an SOS Form ⚠ as soon as they learn of admission to a residential psychiatric facility.
- If the length of stay is anticipated to be greater than 30 days, the Community Transitions Unit Case Transfer Form will be needed, and the individual's plan will need to be approved to inactive.

At Risk of Losing Medicaid

- It is extremely important to review Medicaid status during monthly monitoring and to document related discussions on the SC Monitoring Tool. As soon as you become aware that an individual may lose Medicaid, complete the Medicaid Eligibility Troubleshooting Form and contact Ddd.Medielighelpdesk@dhs.nj.gov.
- If an individual does lose Medicaid, and you have not done so already, complete the Medicaid Eligibility Troubleshooting Form and contact Ddd.Medielighelpdesk@dhs.nj.gov.
- The Medicaid Eligibility Helpdesk will provide instruction on next steps, and information regarding whether or when the individual's plan may be submitted to RI.

Incarcerated / Non-State Psychiatric Admission
When an SC learns that an individual has been incarcerated or is in a non-state psychiatric hospital, for what will likely be more than 30 days, complete an SOS Form. ⚠ Division review will be needed to determine next steps.

Not Utilizing Services
Individuals who have not received a Division service in addition to Support Coordination, for 90 days may be subject to disenrollment from the CCP or SP Waiver if it is determined, upon further review by the Division, that waiver services are not needed at this time. When this is the case, the individual will be assigned for follow along by the DDD Service Case Management Unit who will assist the individual with services as needed. Support Coordinators should ensure that the requirement of a second service is actively discussed with the individual/family/legal guardian and that such conversations are documented in case notes.

The Following are NOT Reasons to Request to Change Plan Status to RI:

Long-Term Medical Hospitalization

- An individual, who is medically hospitalized, even for an extended time, can remain on a DDD waiver.
- Long-term hospitalization by itself is not a reason for submitting an individual's plan to RI.
- The Support Coordinator remains responsible for monthly monitoring.
- If there is a question while someone is hospitalized, about whether they are appropriate for care in a Skilled Nursing Facility, hospital staff will initiate the PASRR process and if approved, refer to above sections.

Death

If an individual is deceased, the individual's ISP is not to be submitted to RI. Follow the death verification process. Upon completion, the individual's ISP will automatically be approved to inactive; they will be removed from the SCA roster and disenrolled from any waiver program. (See the iRecord User Guide for additional information.)

What Happens Next?

When an individual's ISP is moved to AI (Approved to Inactive) status, but they are not discharged from DDD:

- They will be removed from the SCA roster. (There are rare and special circumstance that the SCA may be asked to retain on roster and remain engaged [and will be paid via voucher]. This is only upon Division approval.)
- They will be disenrolled from the SP or CCP waiver.
- They will be unable to access Division services.
- They will not retain a DDD housing subsidy.
- If interested in Division services in the future, the individual/family will need to contact their Community Services Office Intake Unit to verify eligibility.
- They will retain their status on the DDD Waiting List for CCP services.
- If legal guardianship has been assigned to BGS, they may continue to receive guardianship services. The guardian must be in agreement with approving to inactive.

When an individual is discharged from Division services:

- They will lose their position on the Waiting List for CCP services.
- They will not retain a DDD housing subsidy.
- They are not eligible to receive services through the Bureau of Guardianship Services.
- If interested in Division services in the future, the individual/family will need to contact their Community Services Office Intake Unit to reapply for Division services.

Questions or Special Circumstances
Any time there are questions or concerns about how to proceed with a case as it relates to Review to Inactive, reach out to the Division through the SOS process. ⚠

Residential Referrals

The Residential Referral Coversheet is used for CCP eligible individuals only, when the SC is conducting independent residential referrals, when the SCA is requesting Division assistance with residential referrals, or when DDD has accepted a provider discharge request.

Two Types of Requests, Urgent and Non-Urgent:

Urgent residential referrals are completed in the following situations:

- A **provider discharge request** has been accepted by the Division.
- The individual is on the CCP and is at **risk of homelessness or imminent peril**.
- The Division determines that a placement has failed.

If you are not sure whether an urgent residential referral is needed, reach out to the Division through the SOS process. ⚠ Residential referrals are not needed if the team has identified an alternate vacancy within the same agency.

Use of Form

- Complete the Residential Referral Coversheet in detail. Indicate the reason for being urgent and explain.
- Review the Residential Referral Coversheet Instructions for information and suggestions about completing the coversheet.
- Upload the completed coversheet in iRecord, and email DDD.SCHelpdesk@dhs.nj.gov without attachments. Use the subject line, "Residential Referral, (DDD ID), Urgent".

What Happens Next?

- The assigned staff within the Division's Care Management Team will review the referral. Additional information or clarification may be requested before this team forwards to the DDD Community Development Unit (CDU).
- CDU will assist by making referrals to potential providers.
- If the SCA has been conducting an ALA search based on the individual/legal guardian's request, SC efforts should cease. A status update regarding placement efforts should be provided to the Division's Care Management Team so that CDU referrals are not duplicated.
- The SCA will be updated regarding CDU referrals. The SC is responsible for following up on all referrals, answering questions from prospective providers, setting up meet & greets with Service Providers, ensuring that all needed supports are in the ISP, and scheduling and attending pre-placement meetings when a Residential Provider is identified.

Non-Urgent residential referrals are completed in the following situations:

- An individual on the CCP is requesting placement in a licensed setting for the first time, and the request is not urgent.
- An individual/LG is requesting to move to another Residential Provider due to preference. Examples include a preferred geographic area, a preferred provider, or to move from a group home to a supervised apartment, etc.
    - If a residential transfer is requested due to unresolved concerns in the current placement, a Planning Team meeting is recommended to see if issues can be resolved and/or explore whether an internal transfer within the same agency might be available and appropriate.

Use of Form

- Use the Residential Referral Coversheet form as the coversheet for referral packages. SCs send all non-urgent residential referrals directly to Service Providers.
- Review the Residential Referral Coversheet Instructions for information and suggestions about completing the coversheet.
- The Provider Search database is the primary resource to help identify potential providers. Families are often aware of a provider in which they are interested. SCSs and SC co-workers may also be good sources of information about area resources.

- Division assistance is available through the **File Transfer Program Secure (FTPS)** server. The FTPS server is a secure online site where referral documents can be reviewed by Residential Providers.
  - For FTPS assistance, upload the Residential Referral Coversheet, and email DDD.SCHelpdesk@dhs.nj.gov without attachments. Use the subject line, "Residential Transfer Referral, (DDD ID), FTPS".

What Happens Next?

- The SC should continue conducting independent referrals.
- The SC is responsible for following up on all referrals, answering questions from prospective providers, setting up meet & greets with providers, ensuring that all needed supports are in the ISP, and scheduling and attending pre-placement meetings when a Residential Provider is identified.

Resources in the Community

The opportunity for individuals with developmental disabilities to meaningfully participate in their community is one of the goals of the Division. Additionally, the Home and Community Based Services (HCBS) Final Regulation, issued by the federal Centers for Medicare and Medicaid Services, states that all HCBS must be delivered in settings that are integrated in and support full access to their community. This includes opportunities to seek employment and work in competitive settings within the community, engage in a community life, control personal resources, and receive services in a similar way as individuals who do not receive HCBS.

Exploring and accessing community resources can take **creativity**, **determination** and sometimes a lot of **questions**.

Meeting an individual's unique ID/DD support needs often requires partnership at many levels. Support Coordinators are in a strategic position to assist individuals/families to make connections, form partnerships and forge relationships. These things work together to help connect individuals/families with quality services and supports, and to participate meaningfully in their communities.

The following is a list of starting points when on a quest for information, resources, services, or supports.

Be Creative and Persevere!

- Walk or drive through the individual's neighborhood or town to get to know the community. Be on the lookout for businesses, services, museums, other places of interest, libraries, parks, places of worship, etc.
- Classes – Explore classes at a community college, health club, local business, community center, museum, library or adult education programs.
- Clubs - Search a local newspaper, library or online for clubs or community activities the individual may enjoy such as hiking, sports, dog meet ups, a local park spring clean-up day, etc. With support from family or an SDE, the individual may be able to start a club!
- Lessons - Explore the individual's interests and seek out classes or lessons: swimming, martial arts, music, sewing, personal training, pet grooming, pet training, painting, etc.
- YMCA – Check for the nearest YMCA or other health and wellness facilities such as HealthQuest or health system affiliates, and look into activities and classes.
- Volunteer – Many people find fulfillment, enjoyment and make new friends by volunteering. Seek out opportunities for the individual to volunteer.
  - Consider whether the individual is interested in a volunteer group such as Big Brothers/Big Sisters.
  - Some religious communities have robust programming open to all. Even if an individual does not consider him/herself religious or spiritual, engaging with a faith community can be a great way to meet people and expand a social network.
  - Self-Directed Services - The New Jersey Interactive Map is a user-friendly way to link SDEs/DSPs with individuals/families looking for workers. The service is free to families. Or, consider advertising at a local college or religious community when looking for an SDE.
- Consider whether any of the above could be funded by a Goods and Service request. See Appendix C.

- Keep asking and reaching out. Encourage creativity when meeting with individuals/families. Think outside the box.

Relationships and Networking

- A lot of good information is shared by word of mouth. For example, when searching for a doctor or dentist who might work well with an individual on your caseload, ask co-workers, group home managers or other Service Providers, with whom there is a good rapport, which medical professionals they have had good experiences with. Be aware of which practitioners other individuals/families utilize.
- Encourage individuals/families to do what they can to search for, explore and investigate services for themselves. The SC is expected to provide support to the degree necessary to coordinate services as needed.
- Encourage individuals/families to develop a network with other DDD eligible individuals/families. Some families form informal support groups to discuss ideas and challenges. Some families exchange assistance with caregiving.

County Medicaid

- **County Social Service Agencies, also referred to as County Welfare Agencies** help individuals and families in need access a wide variety of supports. See the ABC Manual chapter on County Social Service Agencies or visit the Division of Family Development website for additional information.
- **Medicaid Managed Care Organization (MCO)**
  Each individual with Medicaid is assigned to an MCO and to an MCO Care Manager. It is a good idea for individuals/families to be familiar with their Care Manager, and it is important for SCs to have the Care Manager's contact information. MCO Care Managers can assist with many things, including:
  - Information and referral for medical and dental providers, who accept the individual's insurance.
  - Information and referral for other clinical services and therapies.
  - Coordinating approvals and referrals for services such as home health aides, private duty nursing (PDN) and adult medical day programs.

Disability Benefits

- **Disability Benefits 101 (DB101) New Jersey** is a website that provides tools and information about health coverage, benefits and employment, aimed to help people with disabilities understand how work and benefits go together. Many people with disabilities fear that taking a job or accepting a promotion will result in losing necessary health care and disability benefits. **DB101** offers FREE tools that provide individually tailored results about how work will affect benefits. The results help support informed choices about how to make work part of a life plan. **DB101** provides:
  - Information: Learn about various benefit programs and rules around work. Get answers to frequently asked questions. Find out how to avoid common pitfalls.
  - Estimators: Get individually tailored results to help plan and set goals for work. Get tips for success based on your individual situation.
  - Experts: Find answers to your questions, connect to community resources and get help understanding your next steps. DB101's "Get Expert Help" button connects you to a real person who can help with understanding your situation and next steps.

  For more information, visit Disability Benefits 101.

Emergency Response Services

- **NJ Register Ready** (NJ's Special Needs Registry for Disasters) allows New Jersey residents with disabilities and their families an opportunity to provide information to emergency response agencies so emergency responders can better plan to serve them in a disaster or other emergency. The information will be held confidentially and securely and only used for emergency response and planning. To learn more, visit NJ Register Ready.

Mental Health

- **Program for Assertive Community Treatment (PACT) Services**, through the Department of Mental Health and Addiction Services (DMHAS), is a team-based program for individuals with serious and persistent mental illness and substance use disorders, who have a history of multiple emergency room visits or psychiatric hospital

admissions in the last 18 months. PACT Teams include a psychiatrist, nurses, clinical social workers, co-occurring specialists, vocational specialists, mental health advocates and peer specialists. PACT Teams provide intensive, in-community treatment and support to assist individuals to stay out of the hospital and improve their functioning in the community. To learn more visit the CPC Integrated Health website.

- PACT services are not a duplication of services since DDD waivers do not cover mental health services. The SC and the PACT Case Manager would coordinate services (similar as with MCO Care Managers) to prevent duplication. If any recommended services are duplicative, a decision should be made regarding which entity, the DDD waiver or the PACT program will provide it, but not both.
- For additional mental health resources and information about managing situations involving psychiatric hospitalizations, see the ABC Manual chapter, Psychiatric Hospitalizations.

State Resources/Agencies

- **The Division of Disability Services (DDS)** is a tremendous resource for information and referral, related to all disabilities (not specifically ID/DD) throughout the state. For more information see the DDS webpage.
  - DDS publishes a New Jersey Resources directory, (in English and Spanish), as well as many other topic specific resources.
  - Information and Referral Specialists are available by calling 1-888-285-3036.
- **The Division of Vocational Rehabilitation Services (DVRS)** provides employment assessment, placement and support services in the community and in workshops. As an Employment First State, DVRS is an important New Jersey resource. Visit the DVRS website for additional information and to make an online referral.
- **The Commission for the Blind and Visually Impaired (CBVI)** provides services to promote education, employment, independent living and eye health for individuals who are blind or visually impaired and their families. For more information see the CBVI webpage.
- **The State Employment and Training Commission** offers many different resources to help people move closer to job and career goals. For more information see the State Employment and Training Commission webpage.

Resources in the Division

DDD Mission Statement

"The Division of Developmental Disabilities assures the opportunity for individuals with developmental disabilities to receive quality services and supports, participate meaningfully in their communities and exercise their right to make choices." This chapter highlights some of the resources available through DDD, which help to support and promote this mission through partnerships with individuals, families and Service Providers.

NEW JERSEY HUMAN SERVICES
Division of Developmental Disabilities

Division of Developmental Disabilities Website

The Division of Developmental Disabilities website contains a wealth of information to assist all stakeholders, including:

Health and Safety

The Health and Safety Information for Individuals, Families, and Providers page contains information and links to the following:

- a variety of webinars on health and safety subjects
- various prevention handouts
- the DDD Resource Team

DDD Resource Team

Consultation with a Behaviorist, Speech Pathologist, or Registered Nurse, is available to staff and families. The Resource Team also provides workshops and trainings. To receive monthly notifications about training opportunities users can email the Resource Team Helpdesk, DDD.ResourceTeam@dhs.nj.gov.

- **Informative flyers for each unit within the DDD Resource Team**
  - Behavior Analysis Unit

- Choking Prevention Unit
- Nursing Support Unit

- **Behaviorist Referral**
  The BCBA Consultation Form is used to request assistance for the residential or day services behaviorist, or a behaviorist providing support in an own home setting. A Resource Team behaviorist provides consultation on behavioral techniques and strategies, and reviews or makes suggestions regarding existing behavior support plans. Submit referrals to DDD.ResourceTeam@dhs.nj.gov and upload a copy of the form in iRecord.
- **Speech Pathology Referral**
  The Speech Pathology Consultation Form is used to request consultation on issues with choking, swallowing, frequent coughing while eating, aspiration, mealtime behavior, weight loss, tube feedings, problems with speech, communication, hearing or hearing aids. Instruction and training on proper diet texture preparation is also available for individuals with prescribed diets. Submit referrals to DDD.ResourceTeam@dhs.nj.gov and upload a copy of the form in iRecord.
- **Registered Nurse (RN) Referral**
  The RN Consultation Form is used to request consultation on a wide range of medical conditions including: seizures, peg tube issues, weight loss, dehydration, non-psychotropic medication review, wound care, staff training on durable medical equipment, bowel obstruction, assistance with understanding medical results, urinary tract infections and transitioning back to a residential placement from a rehabilitation facility. Submit referrals to DDD.ResourceTeam@dhs.nj.gov and upload a copy of the form in iRecord.
- **Available virtual trainings for Support Coordinators and Provider staff**
  - Choking prevention: Complete the Choking Prevention Unit Agency Training Request Form
  - Behavior Support Plans
  - Behavioral Supports
  - Pica
  - Swallowing Disorders and Mealtimes
  - Common health issues in the I/DD Population (Aspiration Pneumonia, Constipation, Dehydration, Seizures, Urinary Tract Infections (UTI), and Pressure Sores).
  - For the **Behavior Supports Series 1-5,** a monthly schedule includes:
    - Functions of Behavior: Understanding Functional Behavior Assessments and Behavior Support Plans
    - Data Collection and Interpretation: Understanding Pica from a Behavioral Perspective and Managing the Environment (optional)
    - Training Behavior Support Plans: Teaching Functional Equivalent Skills
  - To request a training or for inquiries, contact DDD.ResourceTeam@dhs.nj.gov.

Webinars

- DDD Update Webinars schedule and registration links
- Past DDD Update Webinar recordings and slide decks
- Support Coordination Update Webinars schedule and registration links
- Past Support Coordination Update Webinar recordings and slide decks
- Support Coordination Trainings schedule and registration links
- Past Support Coordination Trainings, available through College of Direct Support (CDS), (CDS Login)

Policy Information

- News Updates and Announcements
- The Supports Program Policies and Procedures Manual
- The Community Care Program Policies and Procedures Manual
- The Quick Guide for Families - English and Quick Guide for Families – Spanish
  - These are condensed, easy-to-understand documents summarizing information outlined in both the CCP and SP Policies & Procedures Manuals.
- State Requirements, including:
  - Division Circulars

    - Danielle's Law
    - Stephen Komninos' Law
    - Incident Reporting
- Federal Requirements, including:
    - HCBS Statewide Transition Plan

Information for Individuals and Families

- How to apply for services
- Information about employment for individuals
- Guardianship
- Home and Community Based Services
- Housing Assistance
- Office of Autism
- Self Advocacy
- Transition from School to Adult Life

Information for Providers

- How to apply to become a provider
- Provider Information on various subjects, such as:
    - Webinars and trainings
    - Provider forms
    - Training and Competency Assessments
    - Fingerprinting Information
    - Finances and Claiming
    - Housing Resources
    - Contracting

Support Coordination Information Webpage

Support Coordination Agencies should become especially familiar with the Support Coordination Information webpage, which houses resources specific to Support Coordination, including the following:

- Support Coordination Update Webinars
- Support Coordination Trainings
- Support Coordination Documents and Forms

Helpdesks and Mailboxes

The Directory of Email Helpdesks and Mailboxes can be found on the Support Coordination Information page. It provides a description of Division Helpdesks and Mailboxes to help users know who to contact with inquiries.

Seeking Out Support (SOS) Process

Individualized assistance is always available through the SOS Form ⚠, used by Support Coordinators not only to report urgent situations and request Division involvement but also to request case consultation for any reason.

Provider Search Database

The Provider Search database allows users to search for providers and apply filters to narrow down one's search.

Support Coordinator Role with Arrests, Court Appearances, Subpoenas and Documentation Requests from Attorneys

This section addresses the Support Coordinator's responsibilities and role when an individual they support is arrested or required to appear in court or when a Support Coordinator is requested to appear in court, receives a subpoena, or is contacted by an attorney regarding one of these matters. This includes civil, criminal, family, municipal, or other courts.

An Individual is Arrested

- Notify the Division through the SOS process ⚠ or through the Division's on-call system.
- Submit an Incident Report.
- Ask advocates about legal options, services and bail resources as needed. (See resources below.)
- Review the ISP and update as needed.

Subpoenas and Court Appearances

If a Support Coordinator receives outreach from an attorney, is issued a subpoena to appear in court or is requested to participate in any court or other legal proceeding with or on behalf of an individual, the Support Coordinator should immediately complete an SOS Form ⚠ in iRecord. This includes any request for documentation by advocates, attorneys, or other litigants.

Support Coordinators may not appear in any court as a representative of the Division.

Support Coordination Agencies may reach out to their own legal counsel as needed for guidance on preparing for a court appearance, such as questions to anticipate based on the circumstance and the SC role.

Support Coordinators may provide the individual with relevant referral sources as necessary/appropriate. The Division of Disability Services (DDS) Resource Guide may be helpful in this regard.

Resources

- The Arc of New Jersey Criminal Justice Advocacy Program: 732-246-2525
- Legal Services of New Jersey, Providing free legal assistance to people with low-income.
- The New Jersey Resources directory in English and Spanish

Waiting List for CCP Services

One of the two ways for an individual to be added to the Community Care Program (CCP) waiver is through the priority waiting list for CCP Services. (The other is through the ICM referral process. See the chapter, Intensive Case Management (ICM) Referrals for more information on that topic.)

Priority Waiting List

Addition to the Priority Waiting List (PWL) requires specific criteria to be met. Individuals may be added to the PWL when both parents turn age 55. Requests for individuals whose parents are not yet 55 are considered individually, based on extenuating factors. The Community Care Program (CCP) Waiting List Request form and Division Circular #8 both contain detailed information about waiting list criteria.

General Waiting List

Division Circular #8 explains that assignment to the General Waiting List is made when requested by the individual/family/LG, **or** if the individual does not meet the criteria for assignment to the Priority Waiting List. The General Waiting List helps the Division anticipate future needs. Individuals are not "reached" and offered CCP services from the General Waiting List, only the Priority Waiting List. When an individual/family is interested in moving from the General Waiting List to the Priority Waiting List, a new request is needed.

Requesting Addition to the Waiting List for CCP Services

- Complete the CCP Waiting List Request and obtain copies of supporting documentation, as described on the form.
- Submit the request form in **one** of three ways:
  - Upload the request form and supporting documents in iRecord through the Tools tab, "Submit Waitlist Request" feature; **or**
  - Send an email to Ddd.Ccpwaitlistrequests@dhs.nj.gov with the completed, signed request and supporting documentation attached to the email; **or**
  - Mail the request and supporting documentation to address listed on the request form.
- Submitting the request electronically is preferred.
- When received, staff from the CCP Waiting List Requests helpdesk will confirm the request was received, and:
  - attach a letter advising that the individual was added to the waiting list, **or**
  - advise that the request will be reviewed at the next Waiting List Review Team committee meeting. The scheduled date of that meeting will be included.
- The requestor will receive a letter stating the outcome within 10 business days of the meeting.
- The assigned waiting list date will be the date the request is signed by the individual/LG.
- If you do not receive confirmation of the disposition of the request within 30 days, send a follow up email to Ddd.Ccpwaitlistrequests@dhs.nj.gov.

Resources

- The Community Care Program (CCP) Waiting List Request, Division Circular #8 and additional information can be found on the Community Care Program Waiting List webpage.
- All related questions can be directed to Ddd.Ccpwaitlistrequests@dhs.nj.gov.

Waiver Transitions

An individual may be enrolled on only one waiver at a time. Therefore, when an individual transitions from one waiver to another, coordination is required. This section explains waiver transitions in which SCAs may be involved. If the SC is involved in a case that seems to be an exception or does not seem to fit in one of the following categories, reach out for assistance, either by contacting Ddd.Medielighelpdesk@dhs.nj.gov or through the SOS process.

Types of Waiver Transitions

- SP to CCP
- SP to SP+PDN
- MLTSS to SP+PDN
- MLTSS to SP
- SP+PDN to CCP
- CCP to SP
- CCP to SP+PDN
- CCP to MLTSS

Waiver Transitions

SP to CCP

This may be the most common waiver transition SCAs are involved in. Individuals may move from the SP waiver to the CCP waiver by being reached on the CCP Waiting List, or being deemed in imminent peril through an ICM referral.

If the individual is approved for CCP, complete the Waiver Program Transfer Request. The involved Division unit will provide CCP approval in iRecord (soft enrollment). When an updated Participant Enrollment Agreement (PEA) is uploaded, and CCP is selected, iRecord will generate a new annual ISP. When this ISP is approved, enrollment onto the CCP will be complete.

SP to SP+PDN

Supports Program plus Private Duty Nursing (SP+PDN) is not a separate waiver from the Supports Program. Rather, it is the Supports Program waiver with the additional service of Private Duty Nursing, administered by the Managed Care Organization (MCO). PDN does not come out of the individual's SP budget. Individuals in this group have access to all the services funded through their SP budget, **and** they may receive up to the maximum of 16 hours per day of Private Duty Nursing, depending on their assessed need determined by their MCO.

PDN hours are provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN), not a homemaker/home health aide/personal care assistant. To be eligible for PDN, an individual must be assessed as having a "skilled need," which refers to a care need that may only be provided by a credentialed, skilled caregiver. Two examples of skilled needs include the presence of a tracheostomy requiring suctioning, and gastrostomy feedings complicated by regurgitation and/or aspiration.

Steps:

- The family contacts their Medicaid Managed Care Organization (MCO) to request a nursing assessment.
- The SC completes the Waiver Program Transfer Request to be signed by the individual/legal guardian and
- contacts Ddd.Medielighelpdesk@dhs.nj.gov for assistance.
- If the individual is on the SP and is determined eligible for PDN, the Medicaid Eligibility Helpdesk will coordinate with Medicaid to "turn on" PDN coverage and the SC will be informed.

Important:

- If an individual is receiving PDN enter it in the ISP under Community Based Supports. The service description line is used to identify the PDN hours provided. The payment source is reflected as "Generic."
- In New Jersey, PDN is only available to individuals on the DDD Supports Program (SP) waiver, or the Managed Long-Term Services and Supports (MLTSS) waiver. An adult on the DDD Community Care Program (CCP) waiver is **not** eligible to receive PDN.
- An individual receiving PDN may bring the PDN Provider with them to a DDD day program, **if** the program allows it and is notified ahead of time.

MLTSS to SP+PDN

MLTSS and Private Duty Nursing (PDN) are assessed by the individual's Managed Care Organization (MCO). If the individual would be better served through the Supports Program, the family can request to be disenrolled from MLTSS in order to receive DDD services and continue receiving nursing supports through Medicaid. When the individual is determined to be DDD eligible through the Intake process, they are assigned to an SCA. The SC will develop the ISP and coordinate with the DDD Medicaid Eligibility Helpdesk: Ddd.Medielighelpdesk@dhs.nj.gov. See steps listed below.

If an individual/family has questions about the pros and cons of this transition, contact the DDD Medicaid Eligibility Helpdesk to request **options counseling** for the family. The individual/family can also be encouraged to contact their MCO Care Manager with questions.

Note: Disenrollment from MLTSS can only occur on the last day of a month. To avoid a lapse in service coverage, the ISP will need to be ready for approval on the first day of the following month. When the ISP is approved, enrollment onto the SP waiver is complete.

Steps:

- The SC completes the Waiver Program Transfer Request to be signed by the individual/legal guardian.
  In lieu of completing the Waiver Program Transfer Request, the individual/legal guardian can submit a signed, dated letter to the SC requesting to disenroll from MLTSS and enroll in the SP waiver plus PDN. (It can be as simple as "I am requesting to disenroll from MLTSS and enroll in Supports Program plus PDN.")
- The SC uploads the form or letter in iRecord and sends an email to Ddd.Medielighelpdesk@dhs.nj.gov requesting assistance.
- If approved for PDN, the Medicaid Eligibility Helpdesk coordinates the disenrollment/enrollment dates.

- The SC develops the Individualized Service Plan (ISP) and notifies Medicaid Eligibility Helpdesk when the ISP is ready for approval. (If the SCA is not released to approve their own plans, the SCA will need to contact the DDD SC Helpdesk to explain the situation and request ISP review **prior** to submission to State Review [SR1].)
- The Medicaid Eligibility Helpdesk notifies Medicaid to turn on PDN manually. The MLTSS termination date will be entered into the Medicaid system, scheduled for the last day of the month.
- SC needs to ensure ISP approval on the first day of the following month.

MLTSS to SP

If an individual/family is requesting a transfer from MLTSS to SP but not SP+PDN, ensure that the individual is not receiving Private Duty Nursing services. Then follow the same steps as above (MLTSS to SP+PDN) disregarding statements about PDN. In summary:

- Obtain and upload a written request.
- Contact Ddd.Medielighelpdesk@dhs.nj.gov to assist with the transition.
- Develop the ISP.
- Coordinate with the Medicaid Eligibility Helpdesk regarding the timing of MLTSS termination (the last day of a month) and approval of the ISP (the first day of the next month) to prevent a lapse in coverage.

SP+PDN to CCP

Private Duty Nursing (PDN) is **not** available for adults on the Community Care Program (CCP). Therefore, if an individual/family is interested in transitioning from SP+PDN to CCP, it is important that they understand they will lose their private duty nursing service.

The CCP waiver is accessed only by being reached on the Waiting List or because of imminent peril. For more information, see the sections in this guide, Community Care Program (CCP) and Intensive Case Management (ICM) Referrals.

- **In Home CCP**
  When an individual transitions from SP+PDN to CCP, he/she will lose PDN, but will have access to a larger CCP budget. SC should ensure the individual/family/LG understands the changes transitioning to the CCP would bring, and that they (individual/family/LG) believe the transition is in the individual's best interests.
- **Out of home CCP** (in a DDD funded, provider-managed setting)
  Some DDD providers have the ability to meet individuals' skilled nursing needs in a provider-managed, residential setting. The SC plays a key role to facilitate good communication and the exchange of accurate information with individuals/families and potential providers.

The involved Division unit will provide CCP approval in iRecord (soft enrollment). When the SC uploads an updated Participant Enrollment Agreement (PEA), and selects CCP, iRecord will generate a new annual ISP. Transition from SP+PDN to CCP would be finalized upon approval of the CCP ISP. This can occur on any day of the month. Upon approval of the CCP ISP, Medicaid funded PDN would cease.

CCP to SP

It is uncommon for an individual to transition from CCP to the SP. If the SC is faced with such a request, it is recommended to involve the Division through the SOS Process. ⚠

CCP to SP+PDN

Some individuals under the age of 21 are on the CCP, often because of medical needs, and because of their age are also eligible to receive PDN. To retain PDN after turning 21, they may elect to transition from CCP to SP+PDN. A second scenario includes when a new medical support need arises, and one determines the need for PDN and therefore requests to transition from CCP to SP+PDN.

Steps:

- The SC completes the Waiver Program Transfer Request to be signed by the individual/legal guardian.

In lieu of completing the Waiver Program Transfer Request, the individual/LG can submit a signed, dated letter to the requesting to disenroll from CCP and enroll on the SP waiver with Private Duty Nursing. (It can be as simple as "I am requesting to disenroll from CCP and enroll in SP+PDN.")

- The SC uploads the form or letter in iRecord and sends an email to Ddd.Medielighelpdesk@dhs.nj.gov requesting assistance.
- If approved for PDN, the Medicaid Eligibility Helpdesk coordinates the disenrollment/enrollment dates.
- The change between DDD waivers can occur on any day of the month.
- If a transition from CCP to SP+PDN is occurring because the individual is turning 21, ISP approval will be coordinated to occur on the 21st birthday.

CCP to MLTSS

This transition may occur when an individual is approved for long-term care in a nursing home, or because the family/LG believes that services through MLTSS are more beneficial than CCP for the individual.

Steps:

- The individual is assessed and approved for MLTSS.
- The SC notifies the Medicaid Eligibility Helpdesk requesting guidance. If the individual is being admitted to a nursing home, notify the PASRR team as well at ddd.PASRR@dhs.nj.gov.
- The SC completes the Waiver Program Transfer Request and obtains the individual's/LG's signature on the form, or a separate written request.
- Upload documentation in iRecord and complete an SOS Form ⚠ in iRecord.

Resources

- **Options counseling** is available to individuals/families who have questions about transitioning between MLTSS and a DDD waiver by contacting DDD.MediElighelpdesk@dhs.nj.gov.
- As always, please reach out to the Division with questions or for support and guidance:
  DDD Medicaid Eligibility Helpdesk: DDD.MediElighelpdesk@dhs.nj.gov
  DDD Support Coordination Helpdesk: DDD.SCHelpdesk@dhs.nj.gov or complete an SOS Form.

Appendix A - Commonly Used Acronyms

APS – Adult Protective Services
AWC – Agency with Choice
BGS – Bureau of Guardianship Services
CBVI – Commission for the Blind and Visually Impaired
CCP – Community Care Program
CDU – Community Development Unit
CIMU – Critical Incident Management Unit
CMPSU – Care Management & Provider Support Unit
CMS – Centers for Medicare and Medicaid Services
CTU – Community Transitions Unit
DDD – Division of Developmental Disabilities
DDS – Division of Disability Services
DVRS – Division of Vocational Rehabilitation Services
FFS – Fee-for-Service
FTPS – File Transfer Program Server
HCBS – Home and Community-Based Services
HIPAA – Health Insurance Portability and Accountability Act
HRC – Human Rights Committee
ICF/ID LOC – Intermediate Care Facilities for individuals with Intellectual Disabilities/Level of Care
ICM – Intensive Case Management
IDT – Interdisciplinary Team, currently referred to as Planning Team
IR (formally UIR) – Incident Report (formerly Unusual Incident Report)
ISP (or NJISP) – Individualized Service Plan
LG – Legal Guardian
MCO – Managed Care Organization
MLTSS – Managed Long-Term Services and Supports
MT –Monitoring Tool
NJCAT – New Jersey Comprehensive Assessment Tool
NJ IRMS – New Jersey Incident Reporting Management System
OI – Office of Investigations
OPIA – Office of Public Integrity and Accountability
ORM – Office of Risk Management (the DDD IR Unit)
PA – Prior Authorization
PASRR – Preadmission Screening & Resident Review
PCPT – Person-Centered Planning Tool
PDN – Private Duty Nursing
PEA – Participant Enrollment Agreement
QAS – Quality Assurance Specialist
RCR – Retroactive Change Request
SC – Support Coordinator
SCA – Support Coordination Agency
SCS – Support Coordination Supervisor
SCU – Support Coordination Unit
SDE – Self-Directed Employee
SDR – Service Detail Report
SOS – Seeking out Support
SP – Supports Program
VF/EA – Vendor Fiscal/Employer Agent

Appendix B - Glossary of Terms

Community Care Program (CCP) – a Division of Developmental Disabilities initiative included in the Comprehensive Medicaid Waiver (CMW) that funds community-based services and supports for adults (age 21 and older) with intellectual and developmental disabilities who have been assessed to meet the specified level of care (LOC) for Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/ID) – i.e., an institutional level of care. Formerly known as the Community Care Waiver (CCW).

Community Transitions Unit (CTU) – the Division Unit responsible for coordinating moves from facilities, such as nursing homes and psychiatric hospitals, to residential placements in the community.

Division Circulars – documents issued by the Assistant Commissioner of the Division of Developmental Disabilities, which set policy for the various agencies within the Division. Division Circulars can be found on the Division Circulars page of the Division's website.

Division of Developmental Disabilities (Division or DDD) – the Division within the New Jersey Department of Human Services that coordinates funding for services and supports that assist adults age 21 and older with intellectual and developmental disabilities to live as independently as possible. An overview of DDD is outlined in section 1.2 of the SP and CCP Policies and Procedures Manuals.

Home and Community-Based Services (HCBS) – Medicaid funded services and supports provided to individuals in their own home or community. HCBS programs serve a variety of targeted populations groups, including individuals experiencing chronic illness or individuals with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities.

Individual/Participant – an adult age 21 or older who has been determined to be eligible to receive services funded by the Division of Developmental Disabilities.

Individual Budget – an up-to amount of funding allocated to an eligible individual based on his/her tier assignment in order to provide services and supports. Each individual budget is made up of an Employment/Day budget component and an individual/Family Supports budget component.

Individualized Service Plan (ISP) – the standardized Division of Developmental Disabilities' service planning document, developed based on assessed needs identified through the NJ Comprehensive Assessment Tool (NJCAT); the Person-Centered Planning Tool (PCPT); and additional documents as needed, that identifies an individual's outcomes and describes the services needed to assist the individual in attaining the outcomes identified in the plan. An approved ISP authorizes the provision of services and supports.

iRecord – DDD's secure, web-based electronic health record application.

Level of Care – the assessed level of assistance an individual requires in order to meet his/her health and safety needs and accomplish activities of daily living. Eligibility for certain Medicaid-funded, long-term services and supports is tied to an individual's Level of Care designation.

Medicaid – a federal and state jointly funded program that provides health insurance to parents/caretakers and dependent children, pregnant women, and people who are aged, blind or disabled. These programs pay for hospital services, doctor visits, prescriptions, nursing home care and other healthcare needs, depending on what program a person is eligible for.

NJ Comprehensive Assessment Tool (NJ CAT) – the mandatory needs based assessment used by the Division of Developmental Disabilities as part of the process of determining an individual's **eligibility** to receive Division-funded services and assessing an individual's support needs in three main areas: self-care, behavioral, and medical.

Planning Team – a team of people, with a valuable connection to the individual, who participate in planning meetings and contribute to the development of the PCPT and ISP. At a minimum, the Planning Team includes the individual and Support Coordinator. Parents, family members, friends, Service Providers, coworkers, etc. are also often included in the Planning Team as established by the individual.

Provider Database – a searchable database of approved Service Providers.

Service Provider – the entity or individual who provide the waiver service(s) indicated in the ISP. Service Providers must meet the qualifications and standards related to the service(s) being offered.

Support Coordination Agency (SCA) – an organization approved by the Medicaid and the Division of Developmental Disabilities to provide services that assist participants in gaining access to needed program and state plan services, as well as needed medical, social, educational, and other services.

Support Coordination Supervisor (SCS) – the professional within a Support Coordination Agency that provides oversight and management of Support Coordinators and approves ISPs.

Support Coordinator (SC) – the professional responsible for developing and maintaining the Individualized Service Plan (ISP) with the participant, their family and other Planning Team members, linking the individual to needed services and monitoring the provision of services included in the Individualized Service Plan.

Supports Program – the Division of Developmental Disabilities initiative included in the Comprehensive Medicaid Waiver (CMW) that provides needed supports and services for individuals eligible for DDD who are not on the Community Care Program (CCP) waiver.

Appendix C - Service Review Tips

The following services require review and approval by the DDD Service Approval Team prior to ISP approval:

Assistive Technology

- An approved Medicaid/DDD provider must complete an evaluation.
- Confirmation is needed that the vendor will accept third party payment from the fiscal intermediary.

Community Based Supports/Individual Supports with a Self-Directed Employee (SDE)

- Service Review is required **only** when requesting a rate greater than the capped rate of $25.00 per hour. If requesting a higher rate, a detailed justification will need to be submitted at the time of the request using the Enhanced Reasonable and Customary Wage Request form.

Community Inclusion Services or Individual Supports (IS) Unit rate, for Individuals Receiving IS Daily Rate

- The need for services not covered in the daily rate/overlapping service must be justified. (Refer to the SP and CCP waiver manuals, Appendix K – Quick Reference Guide to Overlapping Claims.)
- These services are requested by using the Community Inclusion Services / Individual Supports 15-minute Rate Request.

Environmental Modifications

- An evaluation must be completed by an approved Medicaid/DDD provider.
- One work estimate is required to be uploaded in iRecord.

Note: If requesting a budget reallocation, a minimum of two estimates are needed.

Goods & Services (G&S)

- Carefully review the SP and CCP waiver manuals for description, service limits, examples, criteria and exclusions.
- G&S providers must serve the general public.
- G&S requests are not submitted for approved Medicaid/DDD providers, except for activity fees.
- Activity fees must include a monthly breakdown of costs and activities. Activity fees are capped at $1,000 per plan term, and $50.00 per activity per person. See the waiver manuals for activity fees criteria.
- Regarding classes (exercise, music, etc.), the business must **primarily** serve the general public.
  May offer classes for ID/DD if following criteria is met:
  - The business may offer classes for individuals with IDD if following criteria is met:
  - A class may not have more than 12 individuals, and attendance is no more than 3 hours per day and 10 hours per week.
- Students seeking college credits need to apply for federal aid through the Free Application for Federal Student Aid (FAFSA) prior to submitting a G&S request. FAFSA results must be submitted with the G&S request.

Transportation Costs

- Single Passenger Rate and Self-Directed Employee rates are reasonable and customary.
- Requests for single passenger transportation are made through the Single Passenger Rate Transportation Request Form, not as a goods & services request.
  - Exception: If a generic provider charges a flat fee/boarding fee, in addition to the per-mile rate, the flat fee/boarding fee is submitted as a Goods and Service Request.
- Transportation provided by a Medicaid/DDD provider transporting two or more people must use Multiple Passenger Transportation Rate.

Questions can be directed to DDD.ServiceApprovalHelpDesk@dhs.nj.gov.

Division of Developmental Disabilities

Quick Reference Guide to Support Coordination Agency Staff Requirements

If documentation of a staff person's experience, background checks, and/or training records has a name different from the staff person's current name (e.g., maiden name), the agency must also have documentation on file verifying that all previously-used names belong to that same staff person (e.g., copy birth certificate, marriage license).

Support Coordination Agency Heads

DDD completes all Agency Head clearances and runs the 2-year archive process for all Agency Heads. When there is a change in the Agency Head, the agency needs to contact DDD to initiate the clearance process for the new Agency Head. Agencies are not allowed to clear Agency Heads on their own. If there *is* a change they should immediately notify DDD.CHRI@dhs.nj.gov for guidance.

Education

Agencies are required to ensure that all providers of support coordination, including supervisors, meet educational requirements as a condition of employment.

Timeline	Requirement	Expected Documentation
At time of hire	**Bachelor's degree or higher in any field** There are no exceptions to the educational requirement. A nursing certificate or lesser degree is not accepted in place of a Bachelor's Degree.	Copy of college degree or final transcript Degrees or transcripts issued by a college or university outside of the United States must be evaluated by a reputable service to establish the U.S. equivalency. One such service for international academic credential evaluations is WES.

Experience

Agencies are required to ensure that all providers of support coordination, including supervisors, have required experience as a condition of employment.

Timeline	Requirement	Expected Documentation
At time of hire	**One year of full-time experience working with individuals with I/DD**. Experience may be paid, volunteer or caring for a family member with I/DD. *If an applicant has experience working in a setting where a percentage of the individuals had I/DD, the SCA may determine that the experience meets the equivalent of one year, full-time experience working with individuals with I/DD.*	A resume clearly describing the equivalence of at least one year of full-time, paid or volunteer experience working with individuals with I/DD or caring for a family member with I/DD.

Mandatory Background Checks

Agencies are required to conduct background checks on all employees, and potential employees (which includes any consultants, interns, volunteers and seasonal employees) who have direct contact with persons served.

Timeline	Requirement	Required Documentation
At time of hire	**Fingerprint-based Criminal History Record Information (CHRI) check**	CHRI clearance letter – available through Fingerprint Approval Retrieval Application (FARA) portal; to download the letter from FARA, the user will need: 1. Transaction Control Number (TCN) from IdentoGO website where initial fingerprint appointment was scheduled 2. Contributor's Case # – specific to the agency, found on the agency's IdentoGO Fingerprint Service Code Form 3. Date of fingerprinting
Every 2 years from month of initial fingerprinting	**Fingerprint-based Archive CHRI check** *Agencies are not responsible for archive CHRI checks for agency heads, as DDD Care Management & Provider Support Unit (CMPSU) completes and maintains these.*	CHRI clearance letter – available through Fingerprint Approval Retrieval Application (FARA) portal; to download the letter from FARA, user will need: 1. Transaction Control Number (TCN) from CHRI Mailbox in response to archive request 2. Contributor's Case # – specific to the agency, found on the agency's IdentoGO Fingerprint Service Code Form 3. Date archive request was submitted to CHRI Mailbox
At time of hire; Ongoing when prompted by email from DHS	**Central Registry of Offenders Against Individuals with Developmental Disabilities** (Central Registry)	**At time of hire:** copy of Central Registry Check Consent Form showing initial check result **Ongoing:** Internal agency documentation should show the following: 1. The date each check was performed 2. The person who completed the review 3. The results of the check
At time of hire (for employees hired after 7/16/2018)	**Child Abuse Record Information (CARI) check** *Agencies are not responsible for CARI check documentation for agency heads, as CMPSU maintains this.*	Initial email received showing employee's clearance and/or the printable record available through NJ CARI Portal.

Mandatory Background Checks – Exclusionary Database Checks

Agencies are required to check that staff, board members, and contracted vendors are not excluded from working with individuals with I/DD or for a Medicaid provider agency (see Appendix I, DDD policy manuals). Agencies may wish to explore other resources/websites that offer "one-stop shop" help completing all required database checks.

Timeline	Requirement	Expected Documentation
At time of hire; Monthly thereafter	**NJ Medicaid Fraud Division Ineligible Provider Report** NJ Medicaid Fraud Division Ineligible Provider Report	In the Ineligible Provider Report, which is updated monthly, use the search function to verify employees are not debarred (ineligible). Agency documentation should include: 1. Date check was performed 2. Person who completed the check 3. Results of the check
At time of hire; Monthly thereafter	**NJ Treasury Debarment Search** NJ Treasury Debarment Search	Select "Professional Debarment Search." Enter employee first or last name and "Start Search." Agency documentation should include: 1. Date check was performed 2. Person who completed the check 3. Results of the check
At time of hire; Monthly thereafter	**Federal Exclusions Database** Federal Exclusions Database	Enter employee first and/or last name Agency documentation should include: 1. Date check was performed 2. Person who completed the check 3. Results of the check
At time of hire; Monthly thereafter	**NJ Division of Consumer Affairs License Verification System** NJ Consumer Affairs Licensure Database	Select **person search** and enter First and Last Name of employee. Agency documentation should include: 1. Date check was performed 2. Person who completed the check 3. Results of the check
At time of hire; Monthly thereafter	**NJ Department of Health Licensee Database** NJ Department of Health Licensee Database	Enter employee's information and search. Agency documentation should include: 1. Date check was performed 2. Person who completed the check 3. Results of the check

Mandatory Training (see Appendix E, DDD policy manuals)

Agencies are required to ensure that all providers of support coordination, including supervisors, successfully complete all support coordination staff training within required timelines.

Timeline	Requirement	Expected Documentation
Prior to delivering services	**SC Orientation: Prerequisite Orientation Lessons**	College of Direct Support Transcript
Prior to delivering services	**SC Orientation Training: Person-Centered Planning & Connection to Community Supports** (two-day live training)	Boggs Center Certificate and/or Transcript
Prior to working with individuals	**DDD Life Threatening Emergencies – Danielle's Law**	College of Direct Support Transcript
Prior to working with individuals	**DDD Stephen Komninos' Law Training**	College of Direct Support Transcript
Prior to working with individuals	**Provider Developed Incident Reporting**	Provider Developed Documentation

Timeline	Requirement	Expected Documentation
Within 90 days of hire	**DDD Shifting Expectations – Changes in Perception, Life Experience & Services**	College of Direct Support Transcript
Within 90 days of hire	**Prevention of Abuse, Neglect & Exploitation:** Modules 1, 3, 4, 5 and 7	College of Direct Support Transcript
Within 90 days of hire	**Provider Developed Orientation** • Overview of the Agency • Mission, philosophy, goals, services and practices • Personnel policies • Safety *(if hired after August 2023)* • Supporting Healthy Lives *(if hired after August 2023)* • Individualized Service Plan Process and Documentation *(if hired after August 2023)* • Individual Support Plans, Progress and Personal Goals *(if hired after August 2023)* • Cultural Competence • Individual Rights • Working with Families • Documentation & record keeping	Provider Developed Documentation and/or College of Direct Support Transcript
Within 90 days of hire	**Medicaid Training for Support Coordinators** (DDD: Medicaid 101)	Provider Developed Documentation and/or College of Direct Support Transcript
Within 90 days of hire	**Support Coordination NJISP Related Modules** CDS Listing: DDSC: NJISP Related • New Jersey Comprehensive Assessment Tool (NJCAT) and Person-Centered Planning Tool (PCPT) Overview • Employment Expectations and Overview • Service Entry and iRecord Overview • Individualized Service Plan Process and Documentation	Provider Developed Documentation and/or College of Direct Support Transcript
Within 90 days of hire	**SC's Guide to Navigating the Employment Service System:** 8 lessons	Provider Developed Documentation and/or College of Direct Support Transcript
Within 90 days of hire	**Cultural Competence Training:** 8 lessons	Provider Developed Documentation and/or College of Direct Support Transcript
Annually	**Professional Development Training** • **Full-time staff – 12 hours per calendar year** • **Part-time staff – 6 hours per calendar year** *(Hours may be prorated based on month of hire.)* *(Full-time is defined as working 30 or more hours per week.)*	Various Trainers - Documentation must include: • Staff name • Title of training • Length of training • Date of training • Name of trainer/agency