Best Practice Guide

Best Practice Information and Instruction

A Technical Assistance Guide for Support Coordination Agencies

NEW JERSEY HUMAN SERVICES
Division of Developmental Disabilities

Support Coordination Unit
May 2025

Table of Contents

Introduction

The Best Practice Guide is a longstanding, technical-assistance document created by the DDD Support Coordination Unit for Support Coordination Agencies (SCAs) to aid with various aspects of using iRecord to develop Individualized Service Plans (ISPs). Care Management information for SCAs is incorporated into the ABC Care Management Manual, so that the focus of this guide is on best practices regarding technical aspects of the use of iRecord by SCAs.

Topics are arranged in alphabetical order to assist with locating information quickly. Helpful appendixes are included at the end, for reference. SCAs are encouraged to use this guide, along with the iRecord User Guide, as both a training document and a resource. The iRecord User Guide can be accessed by clicking the question mark icon, located in the top left corner of the iRecord home page.

The Best Practice Guide does not replace or supersede any content outlined within the Division's Supports Program (SP) and Community Care Program (CCP) Policy Manuals, is subject to change and is revised as needed.

Death Record

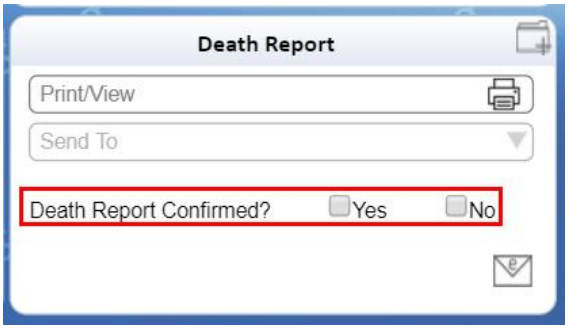
The Death Record interface in iRecord is automatically updated to match current information in the Department of Health (DOH), Office of Vital Statistics and Registry, electronic Death Record system. iRecord generates an individual's death report when the DDD Status has been changed to "deceased", or when the individual has been matched in iRecord with information from DOH. The process normally takes about two weeks, during which time no action is needed by DDD or the SCA. This report is used as a critical document for Incident Reporting and waiver disenrollment.

When the Death Report tile is generated in iRecord, the assigned Support Coordinator (SC) receives an action item on their Due-List, and the SC is responsible for confirming an individual's death. The Support Coordination Supervisor (SCS) receives an alert if the action is not completed within 7 days.

Notes:

- The SC should **never** wait for iRecord to generate the Death Report before submitting an Incident Report (IR). An IR must be submitted immediately following awareness of an individual's death.
- After two weeks from the date of a person's passing, if the Death Report tile still does not appear, the SC should email DDD.SCHelpdesk@dhs.nj.gov to request assistance.
- The SC does not need to submit a Seeking out Support (SOS) Form requesting permission to change the ISP status to Review to Inactive (RI). The plan status automatically changes to Approved-to-Inactive (AI) when the SC confirms the death report as outlined below.

To confirm or deny the validity of the Death Report, the SC must select "Print/View" on the Death Report tile in iRecord to view the individual's death report and use the appropriate checkbox to confirm or deny the death report. (The "Upload Supporting Documents" tab is optional. This step is not required.)



When the SC checks “Yes” and confirms the validity of the Death Report, the following occurs:

- The DDD Status displays “Deceased” on the Participant tile.
- All Medicaid waiver numbers are closed and the individual is disenrolled from their waiver program.
- The individual’s plan status is changed to Approved-to-Inactive (AI).
- A disenrollment email is sent to the HIPAA recipients and Service Providers.
- The SC and SCS receive an email confirming the death of the participant with the death report attached.
- All open Prior Authorizations are suspended.
- SCAs are able to access the individual’s record in iRecord for a period of 30 days, allowing time to upload any pending documentation and add case notes. The PWC (Pending Work Completion) alert item is removed after 30 days.
- The individual’s case with state guardianship services is closed, if applicable.

When the SC checks “No” and denies the validity of the death report, an event is generated for a designated state employee to verify the SC’s action. The SC should check “No” if there is an error and the person is not actually deceased, **or** if the SC notices an error on the death report. Review the Death Report section of the iRecord User Guide for additional details.

Email Validation

All newly entered email addresses require validation in iRecord. This enables the Division to establish secure communication through iRecord with the individual and other approved contacts to ensure information regarding plan changes and Division updates are properly received. Support Coordinators (SCs) are responsible for maintaining accurate records and updating contact information in a timely manner when changes occur.

When an email address is entered in iRecord, an email is automatically sent to that address with a link to validate the email address. This link is valid for 7 days only. If the link expires, an item is created in the SC’s Due-List to re-send the validation email. A warning icon is displayed next to email fields that have not been verified as shown below. Review the Email Validation section of the iRecord User Guide for additional details and step-by-step instructions.

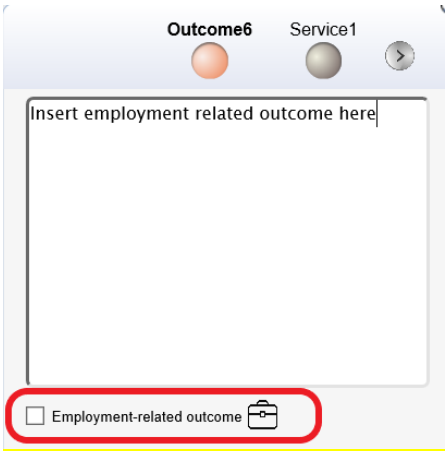
Employment

Employment First

New Jersey is an Employment First state, which means competitive, integrated employment (CIE) in the general workforce is the first and preferred post education outcome for everyone. Per the U.S. Department of Labor, the Workforce Innovation and Opportunity Act (WIOA) defines CIE as work that is performed on a full or part-time basis, for which an individual with a disability is:

- compensated at or above minimum wage, comparable to the customary rate paid to employees without disabilities performing similar duties and with similar training and experience;
- receiving the same level of benefits provided to other employees without disabilities in similar positions;
- at a location where the employee interacts with other individuals without disabilities; and
- presented opportunities for advancement similar to other employees without disabilities in similar positions.

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.



Notes:

- After an employment-related outcome is established, services to support the outcome are identified.
- According to Medicaid standards, supports from Vocational Rehabilitation (VR) agencies 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 webpage. To apply for Vocational Rehabilitation services from CBVI refer to the CBVI Services webpage for additional information.

The Referral Process

- The Support Coordinator (SC) completes the first and third sections of the Employment Determination Form – (F3) and uploads it in iRecord.
- The SC forwards the Employment Determination Form – (F3) to the VR agency and enters a case note.
- **Important**: Within 10 - 14 days after making the referral, the SC follows 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 schedules the individual for an initial appointment.
- The SC follows up with the individual/legal guardian 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 determines whether the agency will offer employment services to the individual. The counselor indicates this on the Employment Determination Form – (F3) with the anticipated end date of VR services and return it to the SC. The SC reviews the completed form carefully and uploads it 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), they 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 Non-Referral for Vocational Rehabilitation (VR) is Acceptable

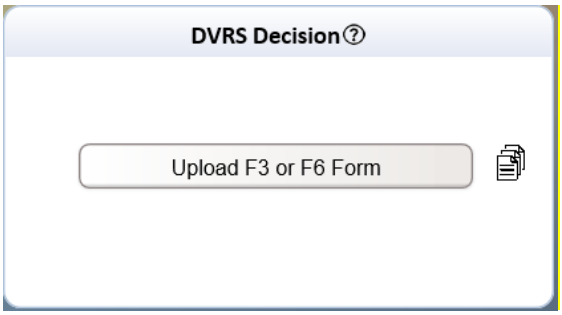
There are four instances when it is acceptable **not** to make a referral for VR services.

- 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, the SC completes 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.

DVRS Decision Tile
One of three documents, the Employment Determination Form – (F3), **or** the Employment Non-Referral Form to DVRS or CBVI – (F6), **or** confirmation of a referral to the vocational rehabilitation (VR) agency, DVRS or CBVI, is completed and uploaded in iRecord prior to plan approval. SCs upload F3 and F6 forms under the Employment Tab / DVRS Decision tile. (Confirmation of a referral to the VR agency is uploaded in iRecord through the Documents tab.)



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 funds 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 coordinate as to when DDD Supported Employment services are entered into the ISP. SCs should 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/ legal guardian to be aware of providers that contract with both the VR agency and DDD, in the county where the service is to be provided. Otherwise, a new provider will 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 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.

Supported Employment
While the majority of waiver services available through the Division are delivered according to a routine schedule (e.g. 24 units daily; 6 units on Monday, Wednesday, and Friday; etc.), Supported Employment – Individual Employment Support services are generally delivered on an as-needed basis, depending on how the individual is doing on the job. As the individual becomes more comfortable with a job and the supervisor is increasingly satisfied with job performance, Supported Employment hours may decrease. Likewise, Supported Employment hours may increase as needed to meet the individual's support needs (for example, new tasks being assigned, having a new supervisor, having trouble at work for any reason).

For additional guidance, refer to Entering Supported Employment-Individual Employment Support Services Into the Individualized Service Plan (ISP) to Address Need for Flexibility, found on the Division's Support Coordination Information webpage.

Note: The **Supported Employment budget component** can be accessed in situations when the individual's budget is unable to sustain the level of Supported Employment services needed for the individual to find or keep a competitive job in the general workforce. The individual must make every effort to utilize their individual budget to cover their Supported Employment needs prior to requesting this additional funding. The Supported Employment budget component may be used for the following services: Supported Employment – Individual Employment Support, Community Based Supports or Individual Supports 15-minute Rate to assist the individual to keep or find a job. SCs use the Supported Employment Funding Request to request this budget component.

If Not Eligible for Vocational Rehabilitation (VR) Services

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

Prevocational Training

Prevocational Training is designed to help the individual develop strengths and skills that contribute to employment readiness. Prevocational Training is curriculum based and time limited. It is **not** to be an ongoing alternative to either employment or Day Habilitation. The provider assesses the individual's needs, skills and areas of growth at the onset. The provider monitors and records the individual's progress and provides regular status updates to the SC. The SC uploads written updates in iRecord and summarizes verbal updates in iRecord 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 SC uses the Continuation of Prevocational Training Justification form to seek Division approval for the service to continue.

The request needs 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.

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 would 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.)

Note: Situations like this are uncommon and are often addressed on a case-by-case basis. If Supported Employment seems appropriate before the VR agency completes their evaluation, SCs are advised to reach out to DDD.EmploymentHelpdesk@dhs.nj.gov to facilitate communication with the appropriate Division staff.

Retirement

There are two instances in which the Retirement checkbox may be used in iRecord.

- The Retirement checkbox may be used when the individual is 65 years of age or older **and** decides to retire from all employment and day services activities, including non-DDD funded services such as adult medical day programs, DVRS-funded workshops, mental health day programs, partial care programs, etc.
- If the individual is **under** age 65 and wants to retire from all employment and day services activities, an Early Retirement Request must be submitted to DDD.EmploymentHelpdesk@dhs.nj.gov. If approved, the Retirement checkbox may be used.

Notes:

- In both instances, the Planning Team meets to ensure budget implications are understood. For more information about budget implications in retirement see the Retirement section in this manual and section 8.7.2 of the Division's policy manuals.
- If the Retirement checkbox is used in error, immediately contact DDD.SCHelpdesk@dhs.nj.gov for correction.

Volunteerism

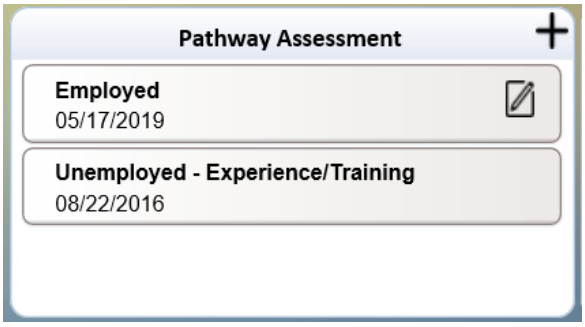
An individual may not work without pay with other employees who ***are*** paid, and have it called "volunteering." This is a form of exploitation. Appropriate forms of volunteerism include volunteering for the good of the community and working alongside other volunteers (e.g. at soup kitchens, food banks, animal shelters, nursing homes, etc.). If the person wishes to volunteer to see if they are interested in a particular kind of work, the focus of the volunteer work should align with their PCPT and move them toward competitive employment or a vocational assessment based on their interests. This should be time limited, and the person should not replace a paid employee.

Employment Pathways and Outcomes

Support Coordinators (SCs) use the Pathway Assessment tile to document employment status and develop an employment-related outcome. Based on an annual discussion, the SC must address all questions within the chosen Pathway and document additional information in iRecord case notes.

The four Employment Pathways are:

- Employed
- Unemployed – Experience/Training
- Unemployed – No Experience/Training
- Unemployed – Not Pursuing

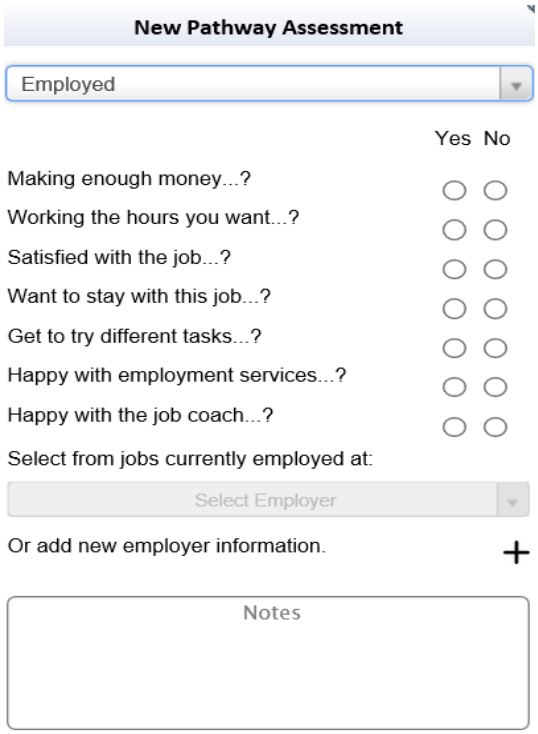


The responses on the Pathway Assessment tile populate the PCPT section, "Employment Path Selection," and the ISP section, "Employment First Implementation." It is best practice to complete **all** Employment tiles (Employment History, DVRS Decision, Career Planning & Unpaid Experiences, Voting, Career-Related Education), even though the information entered on tiles other than Pathway Assessment does not populate the PCPT or ISP.

Employed

The Employment Pathway, "Employed," is selected for individuals who are competitively employed (earning minimum wage or above) in the general workforce. The notes section of this Pathway should include the name (and address, if known) of the employer, details regarding the individual's job responsibilities, number of hours working per week/schedule, overall satisfaction, support needs, and desired changes.

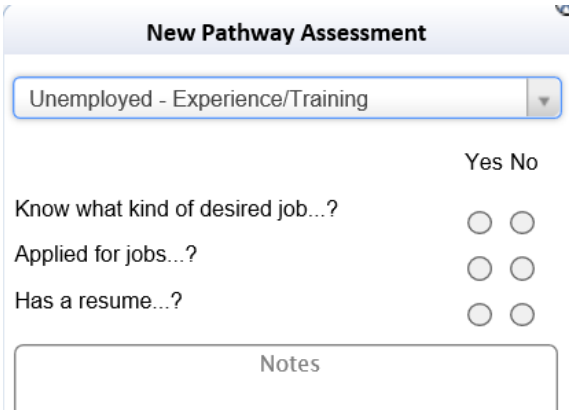
Outcomes may address things like maintaining current employment, increasing hours or salary, learning new job responsibilities, seeking alternative employment, obtaining a promotion, etc.



Unemployed – Experience/Training

The Employment Pathway, "Unemployed – Experience/Training," is selected for individuals who are presently unemployed but have previous training and experience, either paid or unpaid (i.e. through competitive employment, internships, job sampling, work crews, etc.). The notes section of this Pathway should include details of previous experience/training, results of situational assessments or vocational evaluations, address barriers to employment and identify areas of interest.

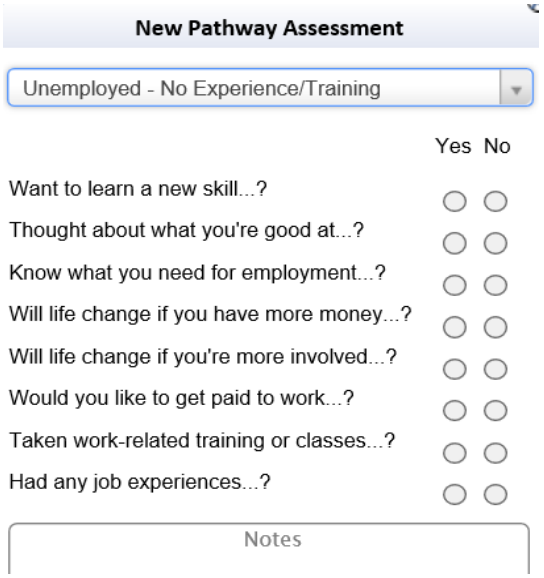
Outcomes may address things like writing a resume, identifying a career path, applying for jobs, becoming employed at a favorite store or local restaurant, etc.



Unemployed – No Experience/Training

The Employment Pathway, "Unemployed - No Experience Training," is selected for individuals who are currently unemployed and have no previous training or experience, either paid or unpaid, but are interested in pursuing employment. The notes section of this Pathway should address barriers to employment and reflect discussions regarding the benefits of employment and seeking employment services.

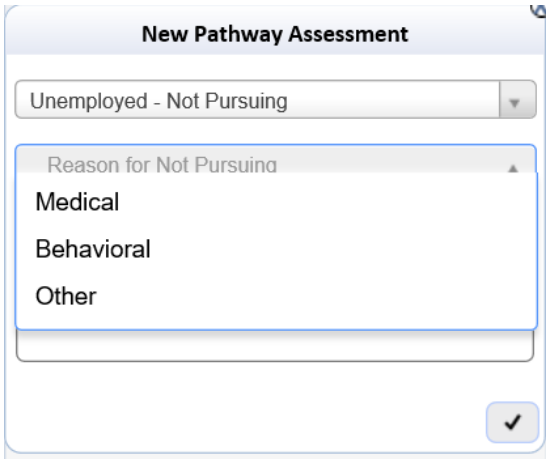
Outcomes may address things like learning what it means to work, exploring employment options through volunteering, preparing for a job interview, being exposed to different career fields, etc.



Unemployed – Not Pursuing

The Employment Pathway, "Unemployed – Not Pursuing," is selected if the individual has chosen to retire because they are 65 or older, or is not pursuing employment at this time because a medical condition or behavioral support need, which exceeds the supports or services available from the vocational rehabilitation agency, as indicated on the Employment Non-Referral Form to DVRS or CBVI – (F6).

Outcomes for retired individuals should not reference getting a job or pursuing employment but can reference how the individual wishes to spends their days. Outcomes may address things like identifying an area of interest and learning employment-related soft skills (e.g. communication, teamwork, work ethic, etc.)



Fiscal Intermediary (FI)

A fiscal intermediary (FI) serves two main functions: managing financial, administrative tasks for an individual choosing to direct services through a Self-Directed Employee (SDE) and acting as a fiscal conduit for purchasing services provided by vendors that are not Medicaid/DDD approved. Examples of vendor services include Goods & Services (G&S), Environmental Modifications, Transportation and Vehicle Modifications. See section 17 in the Division's policy manuals for additional information on these types of services.

In New Jersey, there are two models of FI services:

- The Agency with Choice (AWC) model
- The Vendor Fiscal/Employer Agency (VF/EA) model

Information about current DDD FI vendors can be found on the Division's Self-Directed Services/Self Direction page.

Note: An individual may only use one fiscal intermediary (FI) at a time.

This chapter describes some of the differences between the two models, describes what individuals, families and SCs need to know to have informed conversations and make informed decisions, and explains how to make iRecord entries correctly to avoid billing problems. It may be helpful to review the Side-by-Side Comparison of Self-Directed Employee Models and the SDE Models Frequently Asked Questions document in combination with information in this chapter.

Selecting the Fiscal Intermediary
In both models, an individual may only use one fiscal intermediary (FI) at a time. Therefore, the same FI must be selected for all FI related services. For example, if the AWC model is used for SDE services, then the AWC model must be the FI for vendor services and vice versa; if the VF/EA model is the FI for SDE services, the VF/EA model must be used for vendor services

Important: Overlooking this requirement causes ISP approval problems!

For individuals who are not utilizing SDE services but choose to access services provided by vendors that are not Medicaid/DDD approved (Goods and Services, Environmental Modifications, Transportation and Vehicle Modifications), the VF/EA model is the only FI option. If the individual chooses to hire SDEs in the future, they may choose either FI model.

Changing the Fiscal Intermediary
If the individual/legal guardian elects to switch from one SDE model to another, all FI related services must be changed to the new FI. For example, if an individual who only receives G&S through the VF/EA model, decides they want to hire an SDE in the AWC model, the FI for G&S must be changed to the AWC model when the SDE is added to the plan.

Additional information, including links to recorded trainings regarding both SDE service models, can be found on the Division's Self-Directed Services/Self-Direction webpage.

Important factors when changing the FI:

- Support Coordinators (SCs) are responsible to communicate all FI related changes to community vendors in advance to allow vendors enough time to enroll with the new FI. (For additional information, see the Vendor Enrollment / Vendor Billing section below.
- SDEs transitioning between SDE service models must repeat the hiring process with the new FI, which includes pre-employment background checks (e.g. fingerprinting) and drug screening.
- Submitting an FI referral is initiated in iRecord under the Tools tab. This step is always required to change SDE models. When submitting the FI referral, the ability to add the corresponding FI to the applicable service (e.g. G&S) does not occur until the following day. If the SC attempts to enter the service into the plan the same day the referral is made, an error message appears indicating that the wrong FI was chosen. See the Send Referral section of the iRecord User Guide for more information.
- SCs should not submit FI referrals for multiple FIs simultaneously, as this can cause delays.
- When transitioning to a new FI, new prior authorizations are issued for services with that FI, and all accumulated units for the service with the previous FI are lost. Unused units do not carry over to the new service line and cannot be recouped by retroactive change request.

Self-Directed Employees (SDEs)
Self-Directed Employees (SDEs) are people recruited and offered employment directly by the individual or the individual's Authorized Representative. SDEs may be members of the participant's family, provided that the family member has met the same standards and training requirements as providers who are not relatives. Unlike traditional provider-managed services, for which claims are submitted directly to Medicaid by the provider, self-directed services are billed and paid for through an FI.

SDEs with the AWC Model
SDEs are employed by the FI. A per-member per-month (PMPM) fee is required to participate in the AWC model, which is paid from the individual's budget. The SDE may be eligible for employer-sponsored health benefits.

SDEs with the VF/EA Model
The individual or designee is the Employer of Record and must have an Employment Identification Number (EIN). No employer-sponsored health benefits are available.

In both models, the individual/designee recruits, hires and manages the staff. The individual/designee determines the employee's hourly wage within a "reasonable and customary" range. (Additional information about wages is included below.) The FI conducts employer-related tasks such as timesheet and payroll processing and tax withholding.

Managing Employer with the AWC Model
The term, Managing Employer, applies to the individual or their designated representative responsible for training the SDE(s) to provide support as described in the ISP. The Managing Employer also enters into a co-employer role with the AWC agency, where the Managing Employer informs the SC and the AWC agency of any changes, approves timesheets and timesheet notes for each SDE they hire, arranges and schedules back up SDEs for vacations, holidays and absences due to illness, and works with the AWC agency on all payroll or SDE employment issues.

Employer of Record with the VF/EA Model
The term, Employer of Record, applies to the individual receiving services who must enroll as the Employer of Record (EOR) and obtain a federal Employer Identification Number (EIN) or must designate someone else to enroll as the EOR.

Authorized Representative
An individual may wish to designate an Authorized Representative to speak to the FI on behalf of the individual, if/when necessary, and to complete the following:

- Manage some or all Managing Employer (AWC model) or Employer of Record (VF/EA model) responsibilities on the individual's behalf, **and/or**
- Approve and sign all payment request forms submitted to the FI on behalf of the individual.

Note: In all cases, an Authorized Representative Form is completed and submitted to the applicable FI.

To obtain an Authorized Representative Form:

- **AWC Model**: Contact AWC Customer Service at 1-800-471-8086 or send an email to AwCCustomerService@nj.easterseals.com.
- **VF/EA Model**: Download the Authorized Representative Form, or contact VF/EA Customer Service at 1-844-842-5891 or send an email to njddd-cs@pplfirst.com.

SDE Participation Costs
There are three main costs associated with participation in an SDE model:

Workers' Compensation Insurance

AWC Model

The AWC agency holds the workers' compensation policy for all SDEs in the AWC model. The cost to cover workers' compensation insurance is added to the employee's hourly wage and is paid through the individual's budget. In the AWC model, a separate service line for the workers' compensation policy is not present.

VF/EA Model

The Employer of Record in the VF/EA model is required to carry a worker's compensation policy. The VF/EA agency purchases the worker's compensation policy on behalf of the Employer of Record. The annual cost of the policy ($172) is deducted once per year from the individual's budget and covers all SDEs in the plan. iRecord automatically creates a service line for a period of 365 days for workers' compensation insurance when one or more SDEs in the VF/EA model are added to the ISP. The start date of this service line matches the start of the SDE service line and continues for 365 days, which may exceed the plan term and crossover to the following plan if added mid-plan year. In the next service plan, the workers' compensation service line starts on the following day after 365 days, provided there is still an SDE service at that time. SCAs are unable to edit this service line.

Employer Taxes

In both service models, the cost of employer taxes is added to the employee's hourly wage and is paid through the individual's budget.

Per-Member Per-Month (PMPM) Fee

AWC Model

The state supplements individuals' budgets to partially cover the PMPM fee in the AWC model. The balance of the fee is funded by the individual's budget. Refer to the Agency with Choice (AWC) Per-Member, Per-Month Cost Table for a breakdown of the PMPM cost, and the Per Member Per Month (PMPM) section of the iRecord User Guide for more information.

VF/EA Model

The state supplements the individual's budget to cover the PMPM fee in the VF/EA model. There are no administrative costs deducted from the budget.

Steps for SDE Enrollment with the AWC Model

SDE enrollment with the AWC agency is initiated in one of two (2) ways:

1. The SC submits an FI referral to the AWC agency through iRecord to initiate the enrollment process. See the Send Referral section of the iRecord User Guide for more information.
   -Or-
2. An existing Managing Employer completes an Application Request Form and submits it to awcenrollment@nj.easterseals.com. If the Managing Employer requires assistance to complete this, they can contact an AWC Customer Service Representative at 1-800-471-3086.

Steps for SDE Enrollment with the VF/EA Model

SDE enrollment with the VF/EA agency is initiated in one of three (3) ways:

1. The SC submits an FI referral to the VF/EA agency through iRecord to initiate the enrollment process. See the Send Referral section of the iRecord User Guide for more information.
   -Or-
2. An existing Employer of Record calls VF/EA Customer Service at 1-844-842-5891 to begin the enrollment process.
   -Or-
3. An individual's SC contacts their agency's assigned VF/EA Enrollment Specialist to begin the enrollment process.

A Self-Directed Employee may only begin working when the following conditions have been met:

- The FI confirms the Employer of Record is enrolled (for the VF/EA model with the VF/EA agency).
- The FI confirms the Managing Employer is enrolled (for the AWC model with the AWC agency).

- The FI confirms the Self-Directed Employee has completed the hiring process.
- The FI calculates the billable unit rate and provides it to the SC.
- The SC uses the billable rate (not the hourly wage) to add the SDE service to the Individualized Service Plan (ISP).
- The SC confirms with the FI that the SDE service was added to the ISP, including the start date of that service.
- The ISP is approved.

Enhanced Reasonable and Customary Wage Request
Per section 8.3.2.0.1 of the Division's policy manuals, a Self-Directed Employee's (SDE) hourly wage cannot be less than the New Jersey prevailing minimum way and cannot be more than $25 per hour, unless an enhanced wage is approved. SDEs can provide: Community Based Supports (Supports Program only), Individual Supports 15-minute Rate (Community Care Program only), and Respite (available in both programs). Section 8.3.2.0.1 of DDD's policy manuals contains complete information. SCs use the Enhanced Reasonable and Customary Wage Request to request an enhanced wage.

Live-in Caregivers
SCs are responsible for confirming with the individual/family which staff, if any, are live-in caregivers paid by DDD through the individual's budget. Should a live-in caregiver exist, the SC completes the EVV Live-In Worker Attestation form at the time of service plan development and whenever there is a change in live-in caregiver status. The SC uploads the completed form in iRecord and emails DDDEVV@DHS.NJ.GOV. When entering the service in the ISP, SCs are encouraged to enter a notation in the service description indicating that the service is provided by a live-in caregiver.

Max Wage Error Message
When entering a wage and billable rate into an ISP, SCs may occasionally encounter this error message: "The rate per hour must be greater than the MAX wage per hour and must cover the administrative cost. Max wage is $25/hr. and rate entered is over $25/hr. Adjust maximum wage or rate." The "Per Hour" box under Provider is optional, and it can be left blank in order to proceed. The Unit Rate under "Details" refers to the billable rate. The SC enters the billable rate provided by the FI for each SDE and leaves the "per hour" checkbox empty. Doing so resolves the error message.

SDE Service Documentation
All Medicaid approved Service Providers, including Self-Directed Employees (SDEs), are required to keep documentation to support Medicaid reimbursement. Documentation of services provides evidence that the provider delivered services and delivered them in accordance with the individual's need. The following documents provide additional information and guidance:
Service Documentation Guidance for Self-Directed Employees
Self-Directed Employee Service Documentation Log

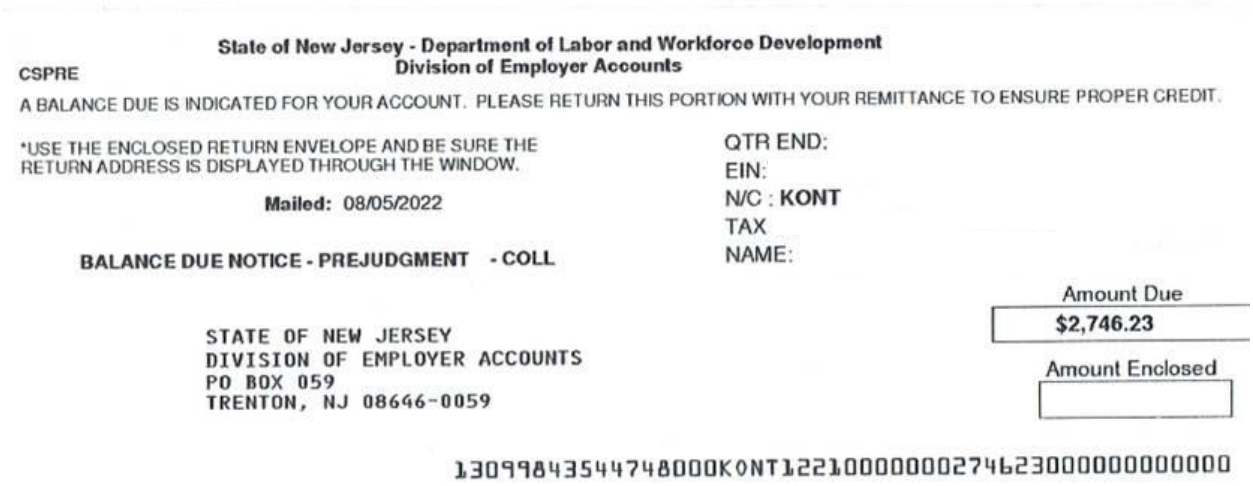
Temporary Allowance for SDE Overtime
Temporary allowance for Self-Directed Employee (SDE) overtime was made available during the Federal Public Health Emergency. It remains in place, and while the Division continues to develop an Overtime Policy, ISPs can continue to include units that constitute premium overtime pay for hours worked in excess of 40 hours in a week for SDEs. Overtime should only be used in emergent or unforeseen circumstances (e.g. last-minute staff call-out, weather event impacting ability for staff to travel, etc.). Overtime is not to be regularly relied on in the ISP. A sufficient number of staff (Self-Directed Employees and/or Direct Support Professionals) need to be in place to meet an individual's care needs without the regular need for overtime. Per DDD's policy manuals, "A self-directed employee may not be regularly scheduled to work more than 16 consecutive hours in a 24-hour period."

Additionally, overnight staff (if in place) must be awake during overnight hours. Sleeping is not a reimbursable service. To deliver and claim for in-home overnight services, the need for awake overnight services must be identified in the ISP.

Electronic Visit Verification (EVV)
The fiscal intermediary may require SDEs to use Electronic Visit Verification (EVV). Inquiries should be directed to the FI.

Short-Term Disability for SDEs
If an SDE is in need of short-term disability, they are responsible for completing and submitting any application for eligibility. The employer is not responsible for paying the SDE while not working. To apply, the SDE needs to complete their portion of the temporary disability leave forms and provide them to their applicable employer (the individual/authorized representative) to complete the employer section. Information related to earned sick leave, temporary disability, family leave benefits, required medical documentation and forms are found on the State of NJ, Department of Labor and Workforce Development webpage.

Tax Information for EORs enrolled in the VF/EA Agency: NJ Department of Revenue or Department of Labor and Workforce Development Collection Notice
If the SCA or an Employer of Record (EOR) in the VF/EA model receives a notice (see the below example) from the Department of Labor or similar notice from the Department of Revenue, indicating to the EOR that there is a delinquent tax balance due, the notice is to be forwarded to TAXNJ@pplfirst.com.



State of New Jersey - Department of Labor and Workforce Development
Division of Employer Accounts

CSPRE

A BALANCE DUE IS INDICATED FOR YOUR ACCOUNT. PLEASE RETURN THIS PORTION WITH YOUR REMITTANCE TO ENSURE PROPER CREDIT.

*USE THE ENCLOSED RETURN ENVELOPE AND BE SURE THE RETURN ADDRESS IS DISPLAYED THROUGH THE WINDOW.

Mailed: 08/05/2022

QTR END:
EIN:
N/C : KONT
TAX
NAME:

BALANCE DUE NOTICE - PREJUDGMENT - COLL

Amount Due
$2,746.23

STATE OF NEW JERSEY
DIVISION OF EMPLOYER ACCOUNTS
PO BOX 059
TRENTON, NJ 08646-0059

Amount Enclosed

130998435447480000K0NT122100000002746230000000000000

A person enrolled with the VF/EA agency as an Employer of Record for DDD services is considered a *household employer*. In New Jersey, household employers are Annual Filers of taxes, not Quarterly Filers (please see NJ Income Tax – Reporting and Remitting). Therefore, the VF/EA agency files taxes annually for every Employer of Record for DDD services.

When an individual enrolls in the DDD Self-Directed Employee Option, the VF/EA agency submits required paperwork to the NJ Department of Revenue identifying the Employer of Record as a household employer. If household employers were incorrectly entered as *quarterly* filers, resulting in a collection notice, the individual/family should forward the notice to TAXNJ@pplfirst.com.

Termination of SDEs
If the individual/EOR/Managing Employer/Authorized Representative wishes to terminate the employment of an SDE, they must notify the fiscal intermediary. Just like any other employee, the SDE is responsible to apply for unemployment benefits through the Department of Labor (DOL) and navigate the process independently. The determination of eligibility is directly communicated to the SDE by the DOL. Unemployment benefits do not affect the individual's budget.

SDE Termination

AWC Model
The Managing Employer/Authorized Representative contacts the AWC Customer Service at 1-800-471-8086 or AwCCustomerService@nj.easterseals.com.

VF/EA Model
The EOR/Authorized Representative completes and submits a SDE Termination Form and submits via email to njddd@pplfirst.com, via fax to 1-844-561-5978, or via mail to Public Partnerships, LLC, Attention: NJ DDD, 8000 Avalon Blvd, Suite 300 Alpharetta, GA 30009.

SDE Activity Fee Reimbursement

Goods & Services (G&S) can be used for activity fees for events and activities available to the general public (i.e. museums, planetariums, zoos, science centers, aquariums, skills building or educational workshops, and cultural events) that are not solely for entertainment or recreational purposes, when other means to pay for these fees are not available for the individual. Activity fees can fund the cost of admission for both the individual and SDE. Activity fees are capped at $1,000.00 per year and $50.00 per person per activity, used for the individual and/or for someone providing support to assist the individual in participating in waiver services in the community.

AWC Model Activity Fee Reimbursement

When adding a G&S service line to the ISP, there is no drop-down option to identify the service as an SDE activity fee. The SDE completes a prepopulated Provider Payment Voucher containing information from the individual's service plan provided by the AWC agency or through the agency's online portal. At all times, copies of receipts must match the reimbursement request amounts and be included at the time of payment request submissions. Once completed, the SDE submits all documents to the AWC agency via fax: 1-888-525-0415 or email: awcprovider@nj.easterseals.com.

VF/EA Model Activity Fee Reimbursement

When the SC adds a G&S service line to the ISP, they use the dropdown option to identify the service as an SDE activity fee. After attending the activity, the SDE submits a Request for Payment form along with copies of receipts to the VF/EA agency for reimbursement. At all times, receipts MUST match the reimbursement request amounts and be included at the time of payment request submissions. Once completed, the SDE submits all documents to the VF/EA agency via fax: 1-844-561-5978 or email: njddd@pplfirst.com. Additional information and instructions on how to fill out a Request for Payment form is available in the Request for Payment Instructions.

Vendor Enrollment / Vendor Billing

Important Reminders

- Prior to adding the service to the ISP, SCs should ensure the community vendor is aware of the billing process and is willing to enroll with and accept payment via fiscal intermediary.
- It is the SC's responsibility to always send the individual/legal guardian and community vendor the approved Service Detail Report (SDR). iRecord does not automatically send the SDR to the community vendor and legal guardian for FI services.

AWC Model Vendor Enrollment

When the AWC agency receives a prior authorization for a service with the vendor identified, the agency reaches out to the vendor and reviews the vendor enrollment process. The vendor must complete and submit the Easterseals Vendor Enrollment Package via fax: 1-888-525-0415 or email: awcprovider@nj.easterseals.com.

AWC Model Vendor Billing

Option 1: The AWC agency provides the vendor with a prepopulated Provider Payment Voucher containing information from the individual's service plan. Prepopulated sections **must** remain intact and are not to be crossed through, "whited-out" or changed in any way. If a mistake is made on a payment form, it must be discarded and restarted with a fresh copy. The payment form should only be submitted once. Payment forms submitted more than once may delay payment. A copy of the community vendor's supporting documentation (i.e. invoice, quote or receipt) must be included with the payment form and the requested amounts must match supporting documentation amounts. Completed Provider Payment Voucher(s) and supporting documentation must be submitted as one document to fax# 1-888-525-0415, or through **one** email to awcprovider@nj.easterseals.com.

Option 2: During time of vendor enrollment, the AWC agency demonstrates how the vendor submits Community Vendor Payment Forms through the agency's online portal.

VF/EA Vendor Enrollment

For a community vendor to enroll with the VF/EA agency and receive payment for services rendered, vendors must complete and submit the Vendor Enrollment Package to fax# 1-844-561-5978 or email to njddd@pplfirst.com.

VF/EA Vendor Billing

Option 1: The community vendor completes and submits a Request for Payment, containing information from the individual's service plan, to the VF/EA agency via email to njddd@pplfirst.com or fax# 1-844-561-5978. A copy of the community vendor's supporting documentation (i.e. invoice, quote or receipt) must be included with the Request for Payment form and the requested amounts must match supporting documentation amounts. Additional information and instructions on how to fill out a Request for Payment form is available in the Request for Payment Instructions.

Option 2: During the time of vendor enrollment, the VF/EA agency demonstrates how the vendor submits Request for Payment forms and supporting documentation through the agency's online portal.

Notes:

- Both the AWC agency and the VF/EA agency are able to access iRecord to view an individual's FI-related services, but only when they are named as the FI and only after a service has been authorized.
- Services are authorized in whole-number units (1, 2, etc.) and must be billed in whole-number units. Fractions of units (1.5, 2.75, etc.) are not paid.
- All FI Payment Request forms require two valid signatures, the individual served/Employer of Record/Authorized Representative (on file with the FI) and the vendor.
- All FI Payment Request forms submitted must include supporting documentation (i.e. vendor invoice, vendor quote, vendor receipt). The total payment requested on the FI Payment Request must match the total cost included on the supporting documentation.
- The total payment requested must be less than or equal to the authorized amount in the service plan.
- Neither FI makes changes to a Payment Request Form. Forms submitted with missing or invalid signatures and/or missing or incorrect information are not processed.
- It is the responsibility of the vendor, individual or the authorized representative to complete applicable portions of Payment Request Forms.
- It is the responsibility of the vendor to submit Payment Request Forms along with the required supporting documentation.
- It is not the SC's responsibility to complete, sign, or submit a vendor's Payment Request Form.
- To contact the AWC agency with questions or concerns, reach out to AWC Customer Service by phone: 1-800-471-3086 or email: AwCCustomerService@nj.easterseals.com. To escalate a concern, email AWC Escalations: AwCAdmin@nj.easterseals.com.
- To contact the VF/EA agency with questions or concerns, reach out to VF/EA Customer Service by phone: 1-844-842-5891 or email: NJDDD-CS@pplfirst.com. To escalate a concern, email VF/EA Escalations: NJDDD-ADMIN@pplfirst.com.
- Including the Division's Fee-For-Service Help Desk: DDD.FeeForService@dhs.nj.gov is optional on all escalated concerns.

Supports Brokerage

Individuals who choose to self-direct their services may desire more assistance than what their SC can provide. Supports Brokerage can offer practical skills training to enable families and participants to independently direct and manage program services, or assist more regularly. Supports Brokerage is only available to participants who self-direct some or all of the services in their Individualized Service Plan (ISP). Supports Brokerage should not be entered in an ISP as a stand-alone service. The only exception to this is when the Supports Broker is assisting the individual in identifying a self-directed service. Supports Brokerage can assist the participant or the participant's family or representative with arranging, directing and managing services and is intended to supplement, **not duplicate**, the Support Coordination service. Please visit the Division's Supports Brokerage webpage for more information.

A Supports Broker may assist the individual and/or family representative with **tasks** related to their self-directed services, such as:

- arranging for, planning, accessing, and managing self-directed services.
- being a responsible employer, which includes recruiting, interviewing, selecting, hiring, supervising, evaluating and, if necessary, separating from (dismissing) a Self-Directed Employee.

- understanding the responsibilities involved with self-directing an individual's services.
- helping the individual's Self-Directed Employees understand how to complete timesheets, including entering service documentation notes.
- making sure the individual and their Self-Directed Employees understand and comply with the rules and regulations associated with self-directed services.

A Supports Broker may also assist the individual in **cultivating community connections** by:

- community mapping.
- facilitating or helping to facilitate Circles of Support.
- learning about the individual's immediate and long-term needs related to self-direction and helping to identify resources including financial, housing, family, enhanced planning, and other resources.
- helping the person to find and access natural and generic supports in their community and build a strong natural support system.

A Supports Broker **does not** complete the following:

- employer-related tasks for the person or their representative. (A Supports Broker may provide assistance or guidance, but does not *complete* these tasks.)
- make referrals to traditional DDD and Medicaid approved service providers, which is the role of the SC. (The role of the Supports Broker is to help the individual self-direct their services.)
- help navigate housing options, unless the person is working to move from a provider-managed residence or from their family home and is planning to use or is using a self-directed service.
- duplicate Support Coordination services.
- provide any service other than Supports Brokerage to the person. Doing so would be a conflict of interest.

Supports Brokerage Authorization Form

In order for a Supports Broker to discuss an individual's self-directed services, employees and/or community vendors, a Supports Brokerage Authorization Form must be completed and submitted to either FI.

- **AWC Model**: The individual/Managing Employer/Authorized Representative completes and submits a Supports Brokerage Authorization Form via email to AwCcustomerservice@nj.easterseals.com. AWC Customer Service can be contacted at 1-800-471-3086 with questions or for assistance.

- **VF/EA Model**: The individual/EOR/Authorized Representative completes and submits a Supports Brokerage Authorization Form via email to njddd@pplfirst.com or via fax# 1-844-561-5978. VF/EA Customer Service can be contacted at 1-844-842-5891 with questions or for assistance.

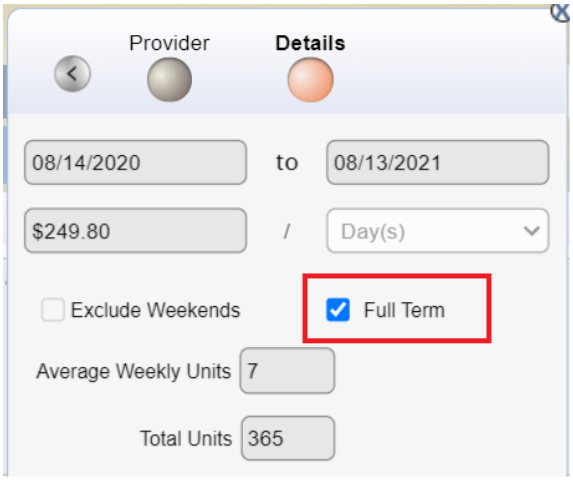
Full Term Checkbox

Using the "Full Term" checkbox locks in 365 as the total number of units for individuals on the CCP and receiving Individual Supports Daily Rate. Using this checkbox is strongly recommended. Individual Supports Daily Rate should always be the first service entered. This ensures units are available for the entire plan year.

For initial CCP plans or new macro CCP plans with an undefined plan term (i.e. NJCAT reassessment or waiver transition), using the "Full Term" checkbox enables the service start date to roll forward until the date the plan is approved.

For anniversary plans or plans *with* a defined plan term, the start and end dates of the service line remain fixed even if plan approval is delayed. Successful use of this option eliminates the need to complete a future plan revision to extend the service end date and reduces the risk of service gaps.

The "Full Term" checkbox is only available for Individual Supports Daily Rate in CCP plans and is found under the Details tab of the service line.



View the Full Term section of the iRecord User Guide for additional details and step-by-step instructions.

Health Insurance Portability and Accountability Act (HIPAA)

Protecting, Disclosing and Sharing Protected Information
The Health Insurance Portability and Accountability Act (HIPAA) established federal standards for protecting sensitive health information from use or disclosure without a patient's consent or knowledge, including personally identifiable information (PII) and protected health information (PHI). PII includes any information that can be directly or indirectly linked to one person, such as a Social Security number, driver's license number, address, email address and biometric data as well as educational, financial and employment information. PHI refers specifically to health information such as medical records, lab reports and hospital bills, as well as any information relating to an individual's past, present or future physical or mental health.

Per DDD policy manuals section 11.5, SCAs are required to train all staff on HIPAA and HIPAA-related document management, meaning that paper documents/electronic records/case records must be stored securely with appropriate safeguards. SCAs are required to develop policies and procedures that include how PHI is managed. Each SCA may have a privacy officer who maintains and safeguards information and manages potential breaches of information.

HIPAA Authorization
An SCA does not need a signed HIPAA authorization to share information with the individual, legal guardian, DDD staff or DDD/Medicaid-approved service providers when fulfilling Support Coordination responsibilities, in alignment with HIPAA regulations.

An SCA ***may not*** disclose information about an individual to anyone other than the individual, their legal guardian, and involved DDD staff and DDD/Medicaid Approved service providers, unless there is a signed authorization in file. The NJ Department of Human Services HIPAA Authorization to Disclose Protected Information is the accepted authorization and is available on the Support Coordination Information webpage.

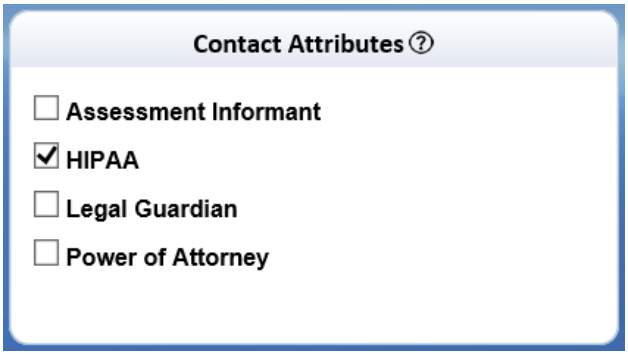
If necessary for the health and safety of an individual, an SCA may share critical information with law enforcement officials, emergency medical professionals, or Adult Protective Services (APS) without written authorization using the 'Minimum Necessary Requirement' guideline per DC53A: HIPAA Uses and Disclosures Policies and Procedures.

Duration of Disclosure
The "Duration of Disclosure" line on the HIPAA form refers to the amount of time the authorization is valid. The date listed may be an expiration **date** or an expiration **event.** The expiration date or event should relate to the purpose of the authorization. For example, an authorization may expire on a specified date, or "one year from the date of the signature," "until the individual no longer receives services from (name of provider)," or "until DDD waiver-program eligibility is terminated."

Support Coordinators (SCs) should ensure the form is properly completed, including the duration of disclosure, before the individual/legal guardian signs the form. If the SC receives the form and finds the duration of disclosure was not completed, the form should be returned for completion.

Privacy rules **require** that a date or event be entered for the authorization to be valid.

iRecord Contact Attributes
To authorize someone as a HIPAA contact in iRecord, the SC must check off "HIPAA" on the Contact Attributes tile for the applicable contact, and when prompted, upload the completed, signed HIPAA Authorization to Disclose Protected Information. The form is not required for service plan (ISP) approval, but it is required prior to sharing protected information. Per Division Circular 53A, the HIPAA form is valid for one year, or until the date specified on the form.



Notes:
- The individual's DDD ID# is not considered PHI and may be included in email, JIRA tickets, etc.
- When DDD reassigns an individual to a new SCA, the receiving agency should review the individual's HIPAA/authorization documents to ensure they are complete and up to date.

Requests for Written (and Electronic) Records
An individual's record is considered the property of DDD. SCAs should not directly release records (other than the ISP, PCPT or NJCAT) to an individual, legal guardian, or attorney without first obtaining a signed HIPAA Authorization to Disclose Protected Information form and submitting it to DDD.SCHelpdesk@dhs.nj.gov or the DDD Community Services office for the individual's county of residence.

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

Incident Reports
Incident Reports and all documents and materials related to incidents and/or pending investigations are not public, and SCs must never upload them to iRecord or release them to anyone except upon judicial order.

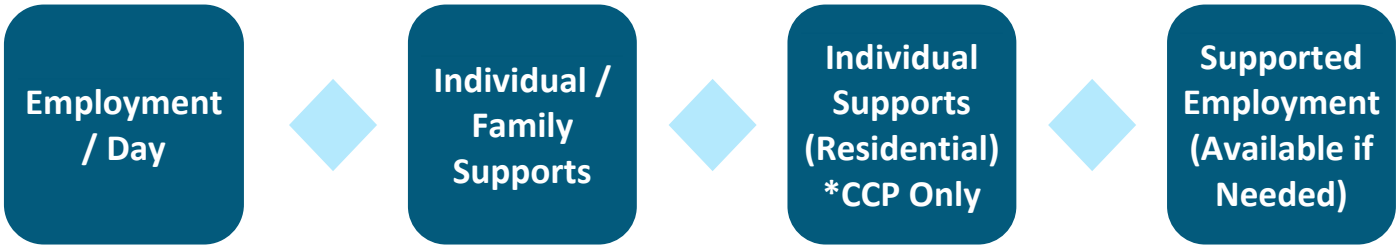
Individual Budgets

Budget Components

Tier assignments determine individual budgets, and budgets are comprised of different components. Some services are funded through one budget component only, while others may be funded through more than one. Information about which budget components fund each specific service is described in the Division's policy manuals, section 17 and Appendix H. The budget components for the Supports Program and Community Care Program are as follows:

Supports Program Budget Components

Community Care Program Budget Components



Supported Employment Component

The Supported Employment budget component is not automatically present but may be requested when the individual's budget does not sustain the level of support needed for the individual to find or keep a competitive job in the general workforce. The individual must make every effort to utilize the individual budget to cover their support needs prior to requesting this additional funding. The Supported Employment budget component may be used for the following services: Supported Employment – Individual Employment Support, Community Based Supports or Individual Supports 15-minute Rate to assist the individual to keep or find a job.

Support Coordinators (SCs) use the Supported Employment Funding Request to request this budget component.

Bump-up Requests in the Supports Program

If an individual enrolled in the Supports Program experiences a temporary change in circumstances, resulting in a need for additional services (e.g. an injury that requires additional supports during the day or hospitalization of a caregiver) and the budget is unable to meet the increased support need, a short-term increase known as a "bump-up," may be available for the temporary situation. Bump-ups are capped at $5,000 per individual, are effective for up to one year, and can be provided only once every three years. Bump-ups are not guaranteed and are not available to individuals enrolled in the Community Care Program.

Bump-Up Request Process

- An individual, family member or SC submits an email requesting a bump-up to DDD.SPBumpUpRequest@dhs.nj.gov with the subject line, "(individual's initials), (DDD ID#)".
- The body of the email must contain the following information:
  - A summary of the current situation
  - The temporary service(s) being requested
  - Length of time a service(s) is needed (start & end dates)

- A breakdown of unit type, frequency, rate, total units and total cost
- Acknowledgement that the individual and/or family member requesting a bump-up is aware that if approved, the additional funding is effective for up to one year, and can only be provided once every three years.

- A determination is rendered within three business days of the initial request, unless additional information or a meeting is requested by the Statewide Intake Director.

Individualized Service Plan (ISP) Development

When an individual is assigned to a SCA, the Support Coordinator (SC) is expected to contact the individual/legal guardian within the timeframe outlined in the agency's Policies & Procedures Manual; the Division generally recommends within three days of assignment. iRecord case notes should be kept up to date to show the SC is actively working with the individual/legal guardian to develop the ISP.

When an individual is assigned to an SCA for the first time (initial assignment), the SC ensures the individual has a copy of, or has access to the Division's policy manual and explain the Participant Enrollment Agreement (PEA). When an SC obtains a signed copy of the PEA from the individual/legal guardian and uploads it in iRecord, "soft-enrollment" to the approved waiver program occurs, and iRecord generates the initial ISP (1.0) in "W" (Work-in-Progress) status. See the Initial Plans section for more information about initial program enrollment.

> **Important**: The ISP must be developed and approved within 30 days of program enrollment.

Draft service plans and Service Detail Reports (SDRs) should be shared with individuals, legal guardians and all Service Providers prior to plan approval to ensure the Planning Team agrees on the services and content in the ISP. Skipping this step may compromise important information and cause claiming problems for the provider requiring correction through future plan revisions. In addition to the timeframes and responsibilities outlined in the Division's policy manuals, SCs are to follow their agency's procedural guidelines and timeframes as outlined in the agency's Policies & Procedures Manual.

Person-Centered Planning Process
The content of an ISP varies for each individual and flows from the person-centered planning process, which involves completion of the Person-Centered Planning Tool (PCPT). In the person-centered planning process, the SC facilitates Planning Team meetings to identify needs and preferences for supports and services through review of the NJ Comprehensive Assessment Tool (NJ CAT) and completion of the PCPT.

See section 17.18.5.3.1 of the Division's policy manuals, the ABC Manual chapter on the Planning Team, and the Boggs Center's Developing Effective Person-Centered Planning Tools and New Jersey Individualized Service Plans guidebook for additional information about ISP development and conducting Planning Team meetings.

> **Note**: ISP Plan Reviews: Guidance for SCAs provides additional guidance and information on plan development, as well as expectations for ISP & PCPT quality standards. All SCs are strongly encouraged to be familiar with this document and to refer to it when developing ISPs and PCPTs. Support Coordination Supervisors (SCSs) should also use it to guide supervisory review of ISPs.

Other helpful resources include the Boggs Center's Person-Centered Planning and Supports webpage, their publication, Exploring Possibilities & Supports: An Information Gathering Toolkit and the Division's Person-Centered Planning webpage.

Person-Centered Language
All service planning documents must be written using person-centered language. This practice is a respectful way to focus on the individual rather than the disability. Using jargon, outdated or disrespectful language and words like "limitations", "suffers from", "unemployable", "is verbal/non-verbal", and "consumer/client/patient" should be avoided.

Contact with Individuals/Legal Guardians
SCs must make initial contact with individuals/legal guardians prior to contacting Service Providers for scheduling Planning Team meetings. All service planning documents must be signed by the individual and legal guardian prior to ISP approval.

Required Documents for ISP Approval
Below is a list of documents, which are required **at least annually**, prior to ISP approval. This applies to macro plans, including all initial plans, anniversary plans and plans resulting from a tier change, waiver transition or the retirement box being checked in iRecord. This also applies to micro plans resulting from SCA reassignment, but does not apply to other plan revisions. Annual documents expire after one year.

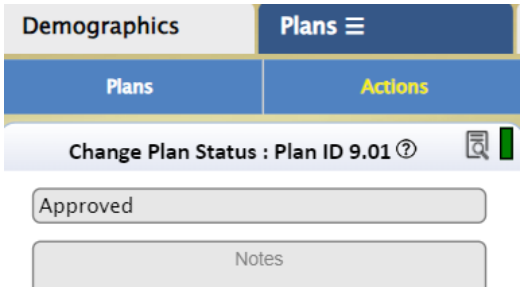
Note: Support Coordination forms and documents are found on the Support Coordination Information webpage.

Document	Requirement
Participant Enrollment Agreement	• Only required for initial waiver enrollment. Physical signatures or verified electronic signatures are required. Typed names in script or other fonts are not accepted. Verbal consent is not acceptable. • The only time a *new* PEA is needed, after initial enrollment, is when the individual is transitioning to a different waiver program, such as from the SP to the CCP.
ISP Review Checklist for Support Coordination Supervisors (SCSs)	• Completed by the SCS only, • Physical signatures not required; verified electronic signatures and typed names for attestation are accepted.
Rights and Responsibilities	• This document is now embedded within the ISP.
Mental Health Pre-Screening Checklist	• Completed by the SC and reviewed by the SCS. Physical signatures are not required.
Employment	One of the following is required to be *current* at the time of ISP approval. Updates to Employment documents occur as needed or when the individual's employment status changes. These are not *annual* documents. b. The Employment Determination Form – (F3), completed and signed by the vocational rehabilitation (VR) counselor. c. The Employment Non-Referral Form to DVRS or CBVI – (F6), completed by the SC. d. Confirmation of a referral to the vocational rehabilitation (VR) agency, DVRS or CBVI.
Addressing Enhanced Needs Form	• Completed for individuals assigned an acuity factor and interested in receiving an acuity-differentiated service: Community Based Supports / Individual Supports, Day Habilitation or Respite. • Completed **prior** to service delivery and updated as needed, or, at a minimum, annually. • Not required for SDEs and services that do not include the acuity rate.
Behavior Support Plan	• If the individual has a behavior support plan, regardless of residential setting, the current plan is uploaded in iRecord / upload type: "BSP-Behavior Support Plan".
ISP Signature Page	The page is signed by the individual and the legal guardian (if applicable). Physical signatures and electronic signatures through the E-sign iRecord feature are accepted. (See the Plan Signature section of the iRecord User Guide for detailed information.)

Annual Medical/Dental Form	• Required for all individuals residing in a licensed, residential setting. • SCs are responsible for uploading the individual's annual physical and dental forms in iRecord, and documenting efforts in iRecord case notes.
ISP Worksheets for Day Services and Residential Providers	• Completed annually for residential and day service providers only. ISP Worksheets are not required when an individual is starting a new day program or moving into a new residential placement. • Physical signatures not required. • Service providers are able to create and utilize digitized versions as long as they contain all required Division components.

Individualized Service Plan (ISP) Status Abbreviations and Definitions

The ISP plan status is changed from one status to another through the Change Plan Status tile under the Plans/Actions Tab.



The table in this section lists iRecord abbreviations and definitions. Review the Change Plan Status section of the iRecord User Guide for additional information.

Note: A user's ability to change the plan status depends on their user role. The User Permissions grid of the iRecord User Guide shows detailed information about user roles and each role's ability to complete various iRecord tasks.

W Work-in-Progress	Appears on the assigned SC's Due-List when a plan is in development. Plans also enter W status when an individual retires, is changing waiver programs or is reassigned to a new SCA.
R Review	Appears on the Support Coordination Supervisor's (SCS) Due-List after an SC submits a plan for review/approval. If iRecord does not allow the plan status to change from W to R, see the Change Plan Status section of the iRecord User Guide to ensure all requirements are met.
RV Revision	Appears on the assigned SC's Due-List for one of two reasons: • The SC may change the plan status from Approved to Revision to make changes to an ISP midway through a plan term. • A plan in Review status may be changed to Revision if it requires changes prior to approval.
A Approved	Plans enter Approved status when a user with the ability to approve an ISP does so. Plans in Approved status do not appear on a Due-List.
SR Service Review	Appears on an assigned Division staff's Due-List after an SCS reviews services for which Division review is required (e.g. Goods & Services), and submits an ISP to Service Review. See the Service Approval section of the iRecord User Guide for detailed information.
RI Review-to-Inactive	Plans are changed to RI status when an SC believes that an individual's plan should be made inactive, **after** receiving permission via the SOS process. Plans in RI status appear on a Division staff's Due-List. See the ABC Manual chapter, "Requesting to Change Plan Status to Review to Inactive (RI)," for detailed information.

AI Approved-to-Inactive	Only plans in RI status can be Approved to Inactive, and only Division staff can approve a plan to inactive in iRecord, after confirming that it is appropriate to do so. Plans in AI status do not appear on a Due-List and are no longer active.
SR1 State Review	SCSs of agencies not released to approve their own plans, submit ISPs to State Review. Plans in SR1 status appear on a Division staff's Due-List. These plans require Division approval.
SR2 High-Level Review	Certain Division staff may change the plan status to SR2, which is solely for internal Division purposes when a higher level review is needed. Plans in SR2 status appear on a Division Supervisor's Due-List.
RR Review to Reinstate	Appears on an assigned Division Staff's Due-List after the SC determines that an individual is returning from an inactive status and enters an iRecord note. After an individual's ISP is changed to Approved to Inactive (AI), the individual remains on the SCA's roster until waiver disenrollment is completed by the Division. The timeframe for this varies. While the individual is still on the SCA's roster, if the SC determines the individual is returning from inactive status, they can change the plan status to Review to Reinstate (RR).

Individualized Service Plan (ISP) Types

This chapter describes the various types of Individualized Service Plans (ISPs), which are generated in different situations. Plans are referred to in two main categories, macro and micro.

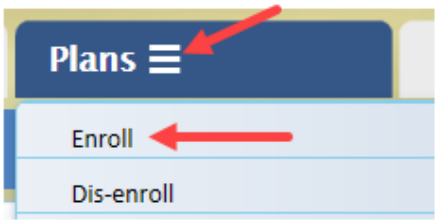
The term "**Macro plan**" refers to a **full ISP**, such as an Initial Plan or an Anniversary Plan, and always has a whole number associated with the plan (i.e. 1.00, 2.00, 3.00, etc.). Macro plans require all components of the ISP to be completed or updated, including all documents required for ISP approval.

The term "**Micro plan**" refers to an existing plan, for which only part requires updating. Throughout the course of a plan term (one full year), a plan may be revised as many times as necessary to update information about support needs and/or to make changes to services. Micro plans always have a decimal number associated with the plan (i.e. 1.01, 1.02, 1.03, etc.).

Important: Once an ISP is approved, plan term dates are set and cannot be edited.

Macro Plan Types

1. Initial Plans
When individuals are assigned to Support Coordination for the first time, the program assignment on the demographics tile is "Legacy" or "CCP Legacy." Individuals whose initial Program assignment is "Legacy," are to be "soft enrolled" into the Supports Program, and individuals whose initial Program assignment is "CCP Legacy," are to be "soft enrolled" into the Community Care Program. "Soft-enrollment" is completed by uploading the signed Participant Enrollment Agreement (PEA) in iRecord under the Plans Tab / Enroll dropdown. PEA signature can be a physical signature or a verified electronic signature. This action can only be completed by a Support Coordinator (SC).



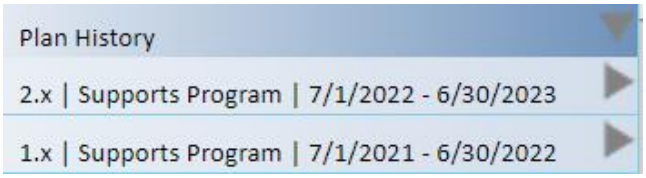
SCs must be sure to select the appropriate program type when uploading the PEA, especially for individuals listed as CCP Legacy. If the SC incorrectly selects Supports Program for a CCP individual, the SC must abort SP Enrollment and re-enroll the individual into CCP. **All** information entered for the Supports Program ISP is be lost and will need to be reentered.

Initial plans must be approved within 30 days of program enrollment.

Note: Completion of SC Monitoring Tools is required beginning the calendar month **following** completion of the initial ISP.

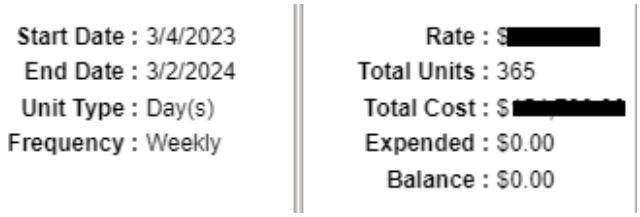
2. Anniversary Plans (plan 2.00, 3.00, 4.00, etc.)
iRecord automatically generates anniversary plans (also referred to as **annual plans**) 60 days prior to the end date of the active plan. Anniversary plan term dates are set for 365 days, and the start date of the new plan is the first day *after* the current plan expires. For example, if the plan term dates for the initial plan (plan 1.00) are 7/1/2021 – 6/30/2022, the plan term dates for the anniversary plan (plan 2.00) will be 7/1/2022 – 6/30/2023.

Anniversary plans should be submitted for approval 30 days prior to the end date of the active plan allowing ample time for review and helping to avoid service gaps.



Leap Year Exception (2004, 2008, etc.)
In a Leap Year iRecord automatically calculates plan term dates and service dates based on a full plan term being 365 days. Continuing the above example, plan term dates for the next anniversary plan (plan 3.00) will be 7/1/2023 – 6/29/2024 and Plan 4.00 term dates would be 6/30/2024 – 6/29/2025.

In the example below, because of the Leap Day, February 29, 2024, end dates are set one calendar day sooner than otherwise.

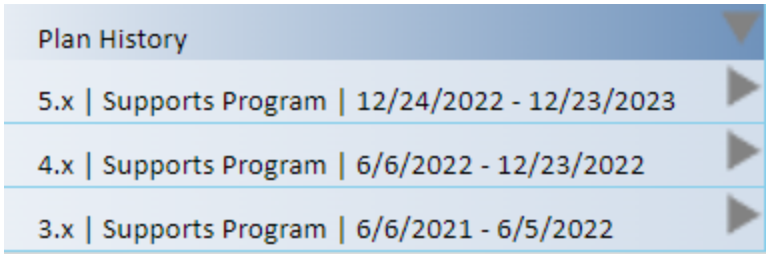


3. NJCAT Reassessment Plans
When an individual receives a new tier as a result of an NJCAT Reassessment or Tier Override, iRecord automatically generates a new macro plan (i.e. 2.0, 3.0, 4.0, etc.). Tier changes result in changes to the budget and reimbursement rates, and have a direct financial impact on Service Providers.
The existing plan remains in effect and providers are not prior authorized for reimbursement at the **new** rate until the **new** plan is approved. These plans cannot be backdated or retroactively changed to recapture any time from the date of the tier change to the date of the new ISP approval.

NJCAT Reassessment Plans are considered high priority and should be approved within 30 days. The day that the new ISP is approved is the end date of the current plan. The following day is the start date of the new plan.

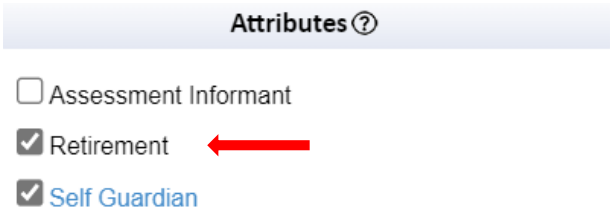
Note: Per the Division's policy manuals, the SCA is expected to continue providing Support Coordination services and monitoring, but is not able to claim for payment until the newly generated ISP is approved.

The below example shows that iRecord generated a new 5.0 plan, mid-way through the plan term of the 4.0 plan. The new plan was approved 12/23/22, and reflects a start date of 12/24/22. The ISP anniversary date for the individual below is now in December.



4. Retirement Plans

If an individual's ISP is in Approved status and the Retirement checkbox is used, the individual's budget changes and iRecord generates a new macro plan. The plan should be approved within 30 days. (If an individual's ISP is ***not*** in Approved status and the Retirement checkbox is used, iRecord generates a micro plan in Revision or RV status.)



Resources for additional important information about retirement:

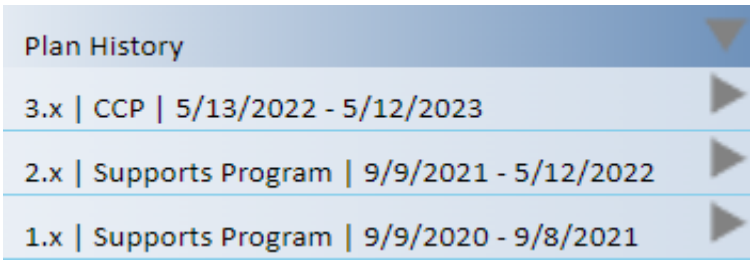
- The Best Practice Guide chapter on Retirement
- The Retirement section in the Employment chapter
- Section 8.7 of the Division's Policy Manuals

Notes:

- If the Retirement checkbox is used in error, contact DDD.SCHelpdesk@dhs.nj.gov for correction.
- For questions about early retirement (prior to age 65) contact DDD.EmploymentHelpdesk@dhs.nj.gov.

5. Waiver Transition Plans

When an individual transfers from one DDD waiver program to another, the ISP needs to be updated. Waiver transition plans should be approved within 30 days of plan creation. When a waiver transition is planned (e.g. SP to CCP), and an individual is "soft enrolled" into a new waiver program, iRecord automatically generates a new macro plan. The day that the new ISP is approved is the end date of the current plan. The following day is the start date of the new plan.



A new Participant Enrollment Agreement (PEA) is to be uploaded in iRecord under the Plans Tab / Enroll dropdown. PEA signature can be a physical signature or a verified electronic signature. This action can only be completed by a SC.

Note: For additional guidance on waiver transitions, please refer to the ABC Manual**.**

Micro Plan Types

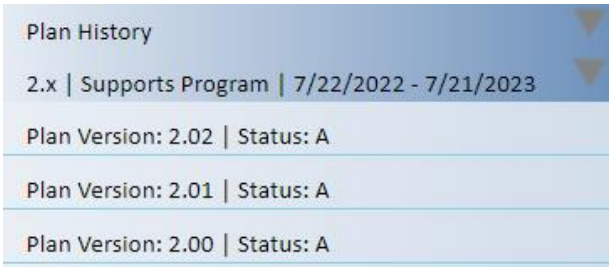
1. Plan Revisions (Plan 2.01, 2.02, 2.03, etc.)
If the individual/legal guardian requests changes to an approved service plan (i.e. add a new service, end a current service, add/remove units to/from an existing service, etc.), the SC must create a plan revision (also referred to as a **micro plan**) by changing the plan status from Approved to Revision.

Important: The active plan remains in effect until the revised plan is approved.

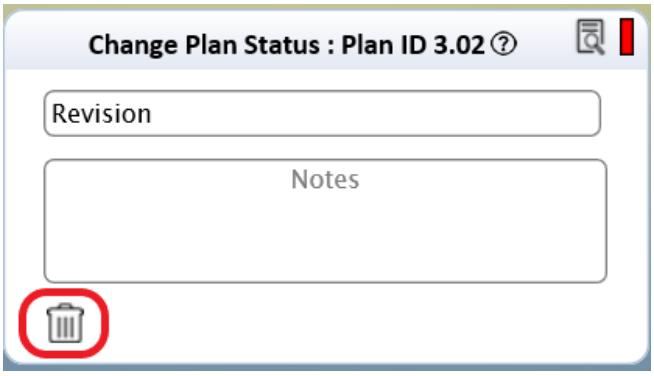
Examples:

- If the revision involves adding a **new** service, the service is not reimbursed until it is entered correctly in the ISP, and the revised plan is approved.
- If the revision involves **terminating** a service, prior authorization for the service ends only when the service is stopped and the revised plan is approved. In the service line, when "Stop Service" is selected, the header of that line displays "Marked for Deletion" **However, this does not stop prior authorization for the service.** The service ***only*** stops when the revised plan is approved. At that point, budget obligations cease for that service, and funds that had been allocated for units in the future are reallocated back into the budget.
- If the revision involves changing/editing an existing service, as explained above, the changes are not in effect until the revised plan is approved.

Example of plan revisions:



If the plan status is changed to Revision, and the revision is not actually needed (e.g. the individual/legal guardian changed their mind), the Support Coordination Supervisor (SCS) has the ability to delete the plan revision by clicking on the trashcan icon on the Change Plan Status tile and clicking Save.



2. Reassignment Plans
When an individual with an approved plan is reassigned to a new SCA, iRecord automatically generates a new **micro** plan. The status is W for Work-in-Progress. The reassignment plan should be treated as a brand new plan, as the receiving SCA assumes responsibility for the quality and the content of the ISP. The ISP and PCPT should be reviewed carefully and updated as needed.

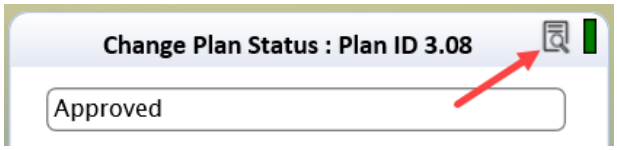
Reassignment plans require all annual documents to be completed as well.

Note: If a reassignment occurs within 30 days of the end date of the ISP, only the anniversary plan is completed, not both the anniversary plan and the reassignment plan.

iRecord Features

Amended ISP
The Amended NJISP feature in iRecord allows the Support Coordinator (SC) to make minor changes to the Individualized Service Plan (ISP) without having to create a plan revision, obtain signatures or submit the plan for SC Supervisor review or approval. It is recommended that SCs share all amended ISPs with each Service Provider associated with the individual's ISP.

Change Log
The Change Log allows the user to view a record of ISP changes for each approved plan revision of a plan term. The Change Log button, which opens the Change Log report, is found on the Change Plan Status tile and is only available for micro plans (e.g. Plan 3.08). The report displays plan updates with every plan revision and a breakdown of changes made since the previous plan version. Review the Change Log section of the iRecord User Guide for additional details.



Due-List and Alerts
The Due-List tile on iRecord's main dashboard displays Due-List items based on iRecord user roles. The "Action Required" column provides a brief description of an action to be performed and the due date, which is calculated based on the event assignment date. For example, SC Due-List items may include Author Plan, Revise Plan, Correct Contact Data, and MC <month>. Support Coordination Supervisor (SCS) Due-List items may include Review Plan, Assign Case, and Assign Supervisor. iRecord automatically navigates the user to the appropriate screen for performing the required action by clicking on the Due-List line item. For example, iRecord directs the user to the individual's plan record for all plan related items. Once the action is performed, the Due-List item is removed. Additional details can be found in the Due-List section of the iRecord User Guide.

The **Alerts** tile on the main Dashboard displays actions that must be performed by another person (or entity). These alerts are pertinent for the user, but the user is not able change the item status because action is required by someone with another role. Examples of SC/SCS alerts include PAD (Plan Approaching Due) - plan not approved since 27 days of creation, NO (Notes Overdue) - monthly contact notes not entered for the previous month(s), ME <number of days> (Medicaid expires in <number of days>), etc.

Only the first six Due-List line items or alerts are displayed by default. The scroll bar on the right hand side of the tile is used to view the remaining items. This can also be done by clicking the square icon to maximize the tile to display the full list. Additional details can be found in the Alerts section of the iRecord User Guide.

Frequent, routine monitoring of Due-List items and Alerts is paramount to ensure important actions are not missed, especially regarding things like Medicaid expirations and service plans due dates.

Litmus Strips
Litmus strip indicators can be found on various iRecord tiles (Participant tile, Change Plan Status tile, Contacts, Assessments, Current Plan Info, Support Coordination, Preferred Pharmacy, Outcome tiles, etc.) and on service lines that require Service Approval. Litmus strip indicators display one of three colors (Green, Yellow, and Red) and inform the user whether all required information is captured to move the plan forward, or alert the user to a concern requiring attention. The meaning of the indicator can be found by either hovering over the litmus strip or viewing the applicable section of the iRecord User Guide.

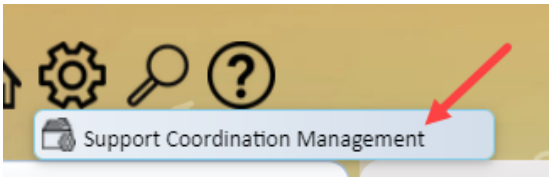
Patch Notes
iRecord enhancements are announced through Patch Notes. It is important to review Patch Notes routinely to stay up to date on all iRecord features and enhancements.

iRecord Setup

Support Coordination Supervisors (SCSs) are responsible for:

- submitting iRecord access requests for new Support Coordinators (SCs).
- deactivating iRecord accounts for SCs no longer employed with the agency.
- updating iRecord user roles when there are changes, for example, when a SV becomes a Supervisor.
- requesting a user be reinstated.

These requests are completed and submitted through the "Support Coordination Management" feature in iRecord. JIRA tickets are not needed.



When a request is completed through iRecord, DDD-IT receives the request, creates a ticket and provides the ticket number (DHD-XXXXX) to the SCS in one of two ways:

- If the SCS has an active JIRA account, DDD-IT assigns the ticket directly to them.
- If the SCS does not have an active JIRA account, DDD-IT sends them an email with the ticket number.

Note: Status updates occur through the existing ticket, not by submitting a new ticket. Creating multiple JIRA tickets for the same request duplicates efforts and causes delays. It is strongly encouraged that all users, especially SCSs, create JIRA accounts to receive live updates on their requests.

Account Creation
SCAs use a form, provided by the Division during the agency onboarding process, to request iRecord access for the agency's initial SCS. iRecord access for all of an agency's subsequent users is requested through iRecord.

To request an iRecord account for a new SC, the SCS follows these steps: From the iRecord home page, the SCS clicks the Gear icon / Support Coordination Management / the User Management button / then clicks Request New User.

The "Request New User" pop-up appears as shown below, and the SCS enters the appropriate information in the fields. ("Middle Name" and "Ext" are not mandatory fields in this pop-up.)

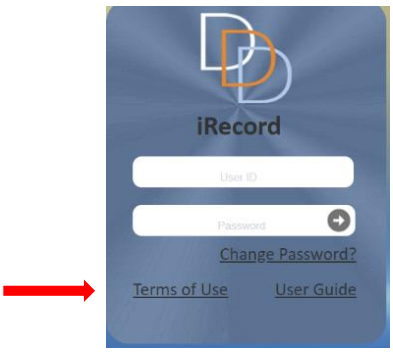
When finished, click  and progress through the following pop-ups. When the pop-ups are complete, the SCS clicks the checkmark. DDD will receive an email with the request to create the account.

When the new account is created, DDD-IT notifies the applicant (not the SCS who submitted the request) via email and provides login credentials and a temporary password. Login information is not to be shared with anyone other than the applicant to maintain the integrity of their credentials and to adhere to security protocols. The process may take several days to complete, as multiple units are involved. Refer to the iRecord User Guide / Register SC for additional, detailed information.

> **Note:** A request for a new iRecord account should not be submitted until the new employee completes the prerequisite orientation and trainings. DDD confirms training requirements are met before creating a new iRecord account. This applies to both new SCs and SCSs. Users can refer to the Quick Reference Guide to Support Coordination Agency Staff Requirements for a detailed summary of staff requirements.

Terms of Use

A link to iRecord **Terms of Use** is included on the DDD iRecord login page and should be reviewed regularly.



> **Important**: SCA Agency Heads are responsible to ensure the following:
> - Each SCA staff understands and follows the iRecord Terms of Use.
> - The SCA's policies & procedures include how Protected Health Information (PHI) is managed.

Account Deactivation

iRecord accounts need to be deactivated when an SCA staff member no longer works for the agency or when a SC (SC) becomes a SCS. Prior to deactivating the account of an SC, all of the assigned cases need to be reassigned. If an account is deactivated and cases have not been reassigned, iRecord moves them to "unassigned."

Important: iRecord accounts should be deactivated promptly. If not, staff members who are no longer employed retain the ability to access iRecord and Protected Health Information, which constitutes a HIPAA violation.

To deactivate an iRecord account, the SCS follows these steps: From the iRecord home page, the SCS clicks the Gear icon / Support Coordination Management / the User Management button / then clicks Deactivate User. Refer to the iRecord User Guide / Deactivate SC for additional, detailed information.

Notes:

- SCSs are advised to reassign an SC's entire caseload *before* deactivating the staff member's iRecord account. If cases are not reassigned, DDD-IT assistance may be needed through a JIRA ticket.
- SCA roster updates are emailed directly to Karen.Bashore@dhs.nj.gov with the agency's assigned QAS in copy.
- Completed Flag Removal Forms are sent to DDD.CHRI@dhs.nj.gov to remove staff from Criminal History notifications.
- The SCS emails CDSTA@rutgers.edu to update the College of Direct Support for the inactive staff member.

Returning SCA Staff

If a previously employed SC or SCS returns to the agency after leaving, background checks must be completed including fingerprinting, Central Registry and CARI checks. Trainings completed in the past do not need to be taken again unless the agency requires it.

To request to reinstate a user, the SCS follows these steps: From the iRecord home page, the SCS clicks the Gear icon / Support Coordination Management / the User Management button / then clicks Request User Reinstate. The SCS completes the pop-up fields and clicks the checkmark when finished. Refer to the iRecord User Guide / Request to Reinstate User for additional, detailed information.

Resetting SCS/SC iRecord Passwords

DDD-IT assistance is required to reset iRecord passwords. The person making the request needs to submit a JIRA ticket. (SCSs cannot submit tickets for SCs, as passwords and login information are not to be shared under any circumstance.) After the password is reset, the user is informed and receives instruction through the comments section of the JIRA ticket.

Note: Resetting an iRecord password does not affect a user's JIRA password.

iRecord Contact Information

It is critical that SCS and SC phone numbers and email addresses are listed correctly in iRecord so staff can be contacted when needed. Phone numbers listed in iRecord should never be disconnected, incorrect, or linked to an agency's main office. Users are able to change their phone numbers directly in iRecord by clicking on their name on the Support Coordination tile and selecting the edit icon. Email addresses must use an official agency domain. Generic email addresses, such as info@scagency.com may not be used. Updating SCA staff email addresses requires a JIRA ticket.

Staff Name Changes

SCA staff who have a legal name change must submit a JIRA ticket for DDD-IT to update the name in iRecord. (A name change also requires staff to be re-fingerprinted under the new name. Questions regarding the fingerprinting process are directed to DDD.CHRI@dhs.nj.gov.)

ISP Signatures

An ISP can be signed physically or electronically by the individual and/or legal guardian. After an ISP is approved, iRecord automatically sends the plan to Service Providers and individuals/legal guardians. Additionally, an approved plan can be sent to contacts with HIPAA authorization through the iRecord Documents tab.

Electronic Signatures - If the SCA has electronic signature capabilities and is able to successfully obtain verified electronic signatures from individuals/legal guardians using reputable software, verified electronic signatures may be used on the following documents: Individualized Service Plan (ISP), ISP Review Checklist for Support Coordination

Supervisors (SCSs), Participant Enrollment Agreement (PEA), Rights and Responsibilities (R&R), Employment Non-Referral Form – (F6), Mental Health Pre-Screening Checklist, and the Addressing Enhanced Needs Form (if applicable). Typed names in script or other fonts are not accepted as electronic signatures.

Individuals/legal guardians are encouraged to utilize e-signature, but it is not required. SCA staff may need to teach individuals/legal guardians how to use e-signature.

Notes:

- Additional guidance is available on the Electronic Signature (e-signature) Fact Sheet.
- Documents such as the ISP, the Participant Enrollment Agreement (PEA), Waiver Program Disenrollment Request and the Goods and Services Request *require* physical or electronic signatures.

ISP Signature/Unable to Reach Legal Guardian – If a private legal guardian (not applicable to public guardians) is unreachable (e.g. out of the country), documentation of three separate attempts to contact them on different dates and varying times, over a two-week period should be made and documented in iRecord case notes. As long as there is documented approval of the Planning Team and individual, the individual may sign or mark the ISP for approval, and the ISP may be approved. The Support Coordinator (SC) clearly notes on the signature page the following: "I have attempted to reach [Guardian's Name], legal guardian, on [Enter three dates/times] and was unsuccessful. Services outlined in the plan are appropriate as per the Planning Team. Plan approval moving forward."

Note: Section 7.5.9.1 of the Division's policy manuals provides additional guidance for circumstances in which signatures are unable to be obtained.

Signature Page Upload – The ISP signature page should be uploaded with the ISP as one document. In circumstances when this may not be possible, the SC may upload the signature page as a separate document as long as it reflects the correct plan version and the ISP date.

Note: Service planning documents must be signed and dated by **both** the individual and legal guardian (if applicable) for plan approval.

JIRA Tickets

All DDD IT related issues and inquiries (e.g. missing prior authorizations, plan status failed messages, login issues, etc.) are submitted as a ticket through the JIRA Service Desk. Before submitting a JIRA ticket, users need to register and create an account using first name, last name and the SCA email address. If a Support Coordinator (SC) works for multiple SCAs, they must create separate JIRA accounts for each agency.

Creating tickets in JIRA is a simple process that allows users to submit tickets, track their status and communicate directly with the assigned IT staff.

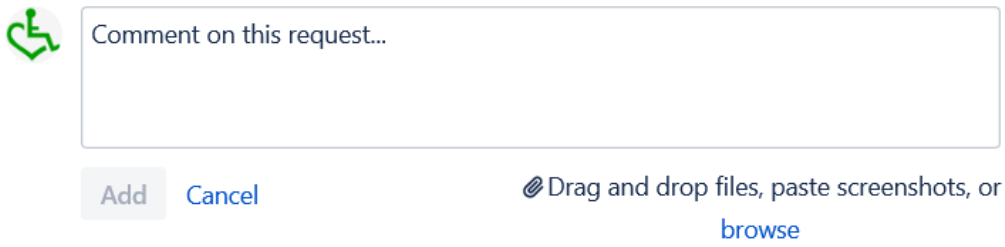
Steps for Creating JIRA Tickets

1. Open JIRA Service Desk/Customer Portal.
   It is recommended to save this link to "favorites" for easy access.
2. Select the applicable category that best describes the issue.
   A description of each category is found directly on the Customer Portal.
3. Complete all required fields.
   a. In the "Description" field, describe the issue in detail, including steps taken prior to encountering the issue.
   b. For iRecord plan related issues, include the individual's DDD ID number, plan version, and outcome/service number.
   c. Uploading an attachment is optional. It is recommended to upload supporting documentation, such as a screenshot of an error message (if applicable) or an email chain, etc.

d. Protected Health Information (PHI) should not be included in the ticket (i.e. the individual's name, date of birth, etc.). A DDD ID number is not considered PHI, so it can be used to identify an individual without violating HIPAA rules.

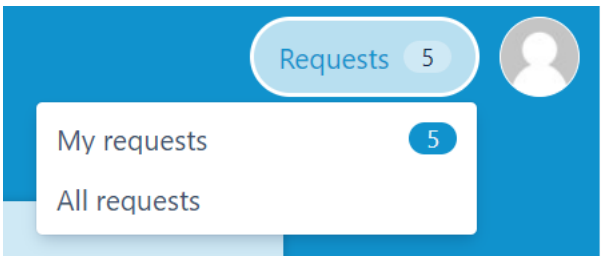
4. Select the "Create" button to submit your ticket.
   a. If the page did not change, the ticket was not submitted. Scroll up to see that all fields are completed.
   b. An auto-generated email confirms submission of the ticket.
   c. **DO NOT** send follow up email to the DDD-IT Mailbox. All communication must be made directly in JIRA.
   d. The assigned ticket number (i.e. DHD-12345) can be found at the top of the page.

The ticket remains open until resolved. If the DDD-IT staff person has any questions, they document the inquiry directly in the ticket and change the ticket status to "waiting for customer." The user receives an auto-generated email every time an action is completed for the ticket. **Do not reply to these emails.** All comments, follow up information, and status inquiries are added directly in the "comment on this request" field of the ticket. The assigned DDD-IT staff person receives an alert notifying them that a comment was added.



Important Reminders:

- Click on the "Requests" box in the upper right hand corner in the Customer Portal to view all open and closed tickets. They will be in chronological order with most recent listed first. Selecting a ticket number directs the user to the summary page for that ticket.



a. **DO NOT** include multiple inquiries in the same ticket. Each issue requires a separate ticket.
b. **DO NOT** create multiple tickets regarding the same issue. This causes confusion and delays.
c. **DO NOT** create a new ticket to request a status update on an existing ticket. Status inquiries must be made directly in the existing JIRA ticket.
d. **DO NOT** email the DDD-IT Mailbox to request a status update on an existing ticket. All status inquiries must be made directly in the existing JIRA ticket.
e. **DO** create a ticket if experiencing iRecord password or login issues. This does not affect your ability to access JIRA as these accounts are separate.
f. Check JIRA often for recent updates and comments.
g. SCs are not able to view tickets created by Division staff. They can only view tickets they create themselves.
h. Prior to submitting a ticket to report iRecord being down or not working properly, please review the "Important Announcements" at the top of the Customer Portal page to see if it is a known issue. If this is the case, you do not need to submit a ticket.
i. DDD-IT is unable to assist with matters related to your personal computers or other home devices.
j. **iRecord Account Creations** - Support Coordination Supervisors (SCSs) must submit all iRecord access requests for new SCs directly in iRecord using the "Support Coordination Management" feature. A JIRA ticket is not needed for this action. However, a ticket should be submitted if this feature is not functioning properly.

k. **iRecord Account Deactivations** - If an SC or SCS is no longer employed with the agency, the SCS is responsible for deactivating their iRecord account immediately. When an account is deactivated, iRecord automatically moves a former SC's cases to "unassigned." If the iRecord account is not deactivated properly or in a timely manner for staff who are no longer employed, they retain the ability to access iRecord and Protected Health Information, which constitutes a HIPAA violation.

Review this training video from the DDD-IT Department for additional information on creating a JIRA Service Desk ticket.

Medicaid Eligibility

Medicaid eligibility is necessary for Division eligibility and to receive Division services. It is important for Support Coordinators (SCs) to regularly review an individual's Medicaid status to confirm continued eligibility. On an individual's Demographics tile, a Yellow or Red litmus can indicate a concern about different things, one of which is Medicaid. A user can hover over the litmus to see the message and should follow up accordingly.

The Medicaid ID# is located on the Demographics tile. Clicking the toolbox icon on that line opens the individual's Waiver and Medicaid History.

Waiver and Medicaid History

Waiver History

Waiver Type	Effective Date	End Date	Updated Date	Action
(07) DDD Community Care Waiver	11/01/1997	-	02/05/1998	

Medicaid History

Medicaid Type	Effective Date	End Date	Updated Date	Action
(220) Categorically Needy Disabilit…	12/01/2004	-	11/18/2004	
(220) Categorically Needy Disabilit…	11/01/1997	11/30/2004	11/17/2004	
(210) Categorically Needy Disabilit…	08/01/1997	10/31/1997	02/05/1998	

Managed Health Care History

Plan Name/HBI Code	Effective Date	End Date	Updated Date
(082) UnitedHealthcare NJ (S2000) New standard Managed Care co…	09/01/2011	-	08/16/2011

From this window the user can see the individual's waiver history, Medicaid history and assigned Managed Care Organization (MCO) history. Any line with an effective date and no end date indicates Medicaid is in effect. The above example shows that the individual is in the Community Care Program (CCP) and Medicaid is active. If there were a yellow litmus on the Demographics tile, it would indicate that Medicaid is scheduled to terminate, and an end date would be entered for a time in the future. A red litmus would indicate that Medicaid has been terminated and is not active. An end date would show when Medicaid was closed/terminated.

If an individual's Medicaid is scheduled to terminate or has been terminated, the SC must complete a Medicaid Eligibility Troubleshooting Form with as much detail as possible and contact Ddd.Medielighelpdesk@dhs.nj.gov immediately. If the individual/legal guardian received a Medicaid termination letter, it should be included with the submission of the troubleshooting form. The SC should follow instruction from the Medicaid Eligibility Helpdesk, which may include advising the individual/legal guardian contact their local Social Security office for SSI or local County Social Service Agency for NJ Medicaid to inquire about how to prevent termination or reestablish Medicaid eligibility.

Notes:

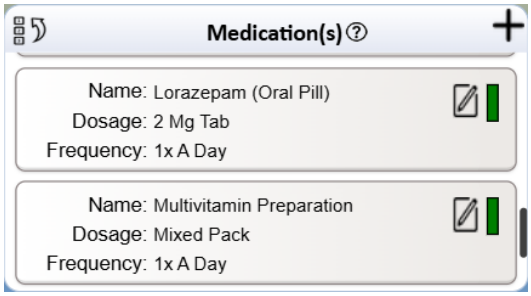
- The SC Monitoring Tools have a Medicaid Status section, which prompts monthly review of the individual's Medicaid status. This provides an opportunity to notice if there are any problems with Medicaid eligibility.

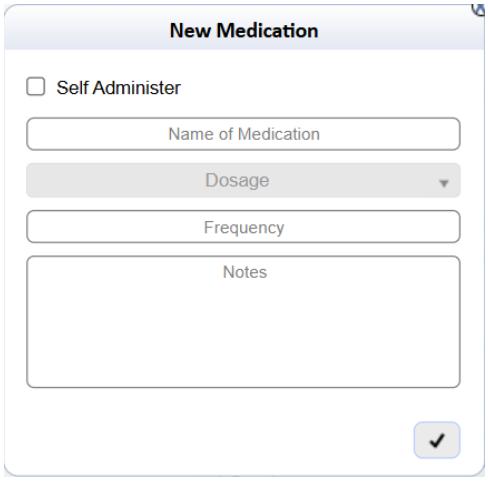
- Individuals/families may bring a trusted support person to an appointment at a County Social Service Agency. SCA staff *may* attend such an appointment, but they are not required to do so.
- Establishing and maintaining Medicaid eligibility is the responsibility of individuals/families. (SCA staff are not responsible to "fix" an individual's Medicaid problems.)

Support Coordinator Monitoring Tool - Monthly
Support Coordinator Monitoring Tool - Quarterly

Medications

Medications are entered one at a time on the Medication(s) tile. Medication names and dosages are automatically available through an iRecord interface with a list maintained by the National Library of Medicine. After selecting the name of the medication and the dosage, Support Coordinators (SCs) enter the frequency manually according to the doctor's order or the information provided by the individual/caregiver/provider. SCs use the Notes section to describe why the medication is prescribed, assistance needed and special instructions, as applicable. The "Self Administer" checkbox indicates whether the individual self-administers the medication. If any assistance is required, this checkbox is left unchecked.





The Medication(s) tile automatically lists medications in alphabetical order, with two medications displayed at a time. The scroll bar allows the user to view the full list.

Important: Medications should always be up to date. Once entered, medication entries can be edited by clicking the "View/Edit Medication" icon.

Troubleshooting

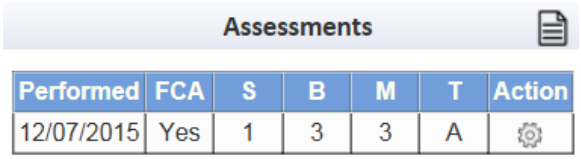
- **Dosage not available** - If the correct dosage of the medication is not listed in the Dosage field, select the closest derivative of the prescribed dosage, and under the Frequency field, enter the correct quantity of dosage along with the frequency. For example, if a medication is prescribed for 100 mg, 3 times a day and the maximum available dosage on the list is 50 mg, the SC enters "50 mg - 2 tabs, 3 times a day" for the frequency.
- **Same medication / different dosages** - If a medication is prescribed with different dosages at different times of day, only one entry can be made for the same medication. Select the smallest of the prescribed dosages, and under the Frequency field, enter the correct quantities of dosage along with the frequency. For example, if a medication is prescribed for 100 mg at 8 am and 200 mg at bedtime, the SC enters, "100 mg – 1 tab at 8 am and 2 tabs at bedtime" for the frequency. The notes section may also be used to clarify information.

NJCAT Assessment and Reassessment

NJCAT Assessment

The New Jersey Comprehensive Assessment Tool (NJCAT) is a mandatory, needs-based assessment used by DDD to identify an individual's support/supervision needs. Results of the NJCAT produce a score in each of the following areas: Self-Care (1-4), Behavioral (1-4), Medical (1-6). The NJCAT results establish an individual's Tier, which determines budget amounts and service reimbursement rates.

Base tiers: A, B, C, D, E (Rare Exception, F)
Acuity-based tiers: Aa, Ba, Ca, Da, Ea (Rare Exception, Fa)



Assessments

Performed	FCA	S	B	M	T	Action
12/07/2015	Yes	1	3	3	A	

When developing the Individualized Service Plan (ISP), Support Coordinators (SCs) summarize (not copy/paste) pertinent information learned from the NJCAT in an individualized, person-centered manner in the related ISP tiles. As support needs change over time, it is expected, that changes are reflected in the ISP and planning documents.

NJCAT Reassessment Requests

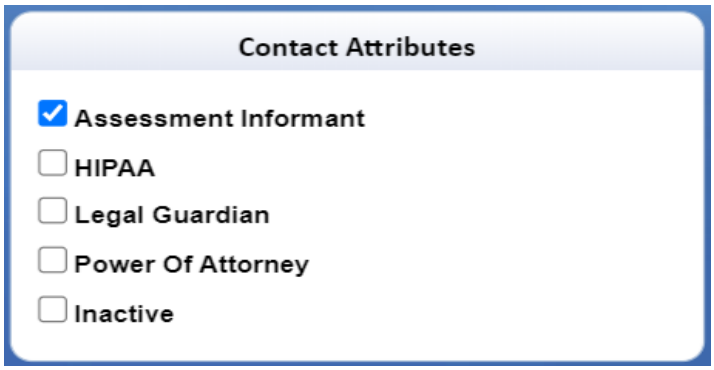
Individuals/legal guardians may request an NJCAT reassessment by following the below steps. Reassessments can result in a reduction in tier level, no change in tier level, or an increase in tier level, based on the information provided. To process a reassessment request, a current Person-Centered Planning Tool (PCPT) and an ISP need to be in place.

1. •The individual/legal guardian requests a copy of the current NJCAT from their Support Coordinator.
2. •The individual/legal guardian reviews the NJCAT and notes any changes directly on the assessment.
3. •The individual/legal guardian completes the Request for NJCAT Reassessment form found on the Division's Assessment for Services webpage.
4. •The "informant" (the person who understands the individual and their support needs best) must be listed as an iRecord contact and identified as an "Assessment Informant" on the Contact Attributes tile. Reassessments cannot proceed if the informant's information is not correct.
5. •The individual/legal guardian submits the completed reassessment request, the NJCAT with their changes and supporting documents **via email** to DDD.DDPIAssessmentRequests@dhs.nj.gov.
6. •Division staff reach out to the "informant" within three (3) business days to acknowledge receipt of the request and provide the Division staff member's name assigned to facilitate the reassessment.
7. •The assigned Division staff member reach out within five (5) business days to schedule a meeting.

Additional information, including an overview of the NJCAT and the Request for NJCAT Reassessment form, can be found on the Division's Assessment for Services webpage.

Notes:

- The NJCAT informant should be the person who understands the individual and their support needs best.
- Prior to submitting the reassessment request, the informant must be listed as a contact in iRecord and identified as an "Assessment Informant" on the Contact Attributes tile. Reassessments cannot proceed if the informant's information is not correct.



- If it is not possible to email the request and supporting documentation, the documents may be mailed to the below address, which will result in a longer processing time.

  Department of Human Services
  Division of Developmental Disabilities
  P.O. Box 726
  Trenton, NJ 08625-0726
  Attention: NJCAT Reassessment Unit

Important: When an NJCAT Reassessment results in a tier change, iRecord generates a new macro plan. These plans are considered high priority and should be approved within 30 days. See the section on NJCAT Reassessment Plans for more information.

Overlapping Services

Services are typically delivered one at a time and cannot be delivered concurrently (at the same time). For service changes, the Support Coordinator (SC) must end the service to be revised in the current plan and add the new service with start date in the revised/new plan to ensure there are no overlapping or duplicate services in the plan. **Appendix K - Quick Reference Guide to Overlapping Claims** in the Division's policy manuals lists exceptions, services that ***are*** permitted to be delivered and claimed for concurrently. As with all services, the need for an overlapping service must be a documented need of the individual, described in the ISP, prior authorized and related to an ISP outcome.

Examples:

- An individual attending a day program full time might also have the service, Community Based Supports (CBS), in the ISP. If the CBS worker were claiming for hours which overlap with the time the individual attends day program, it would be overlapping, and therefore not allowed. If the CBS were occurring outside of day program hours, i.e. evenings or weekends, it would not be overlapping and is allowed.
- An individual with an acuity should not receive Behavioral Supports at their day program or provider-managed residence. This would be considered overlapping because the reimbursement rate due to the acuity is already enhanced to fund the behavioral support need. If Behavioral Supports were delivered in a setting such an own home/family setting, it would not be overlapping and is allowed.

See Appendix K in DDD's policy manuals for a quick reference guide and detailed information on overlapping services.

Attending Day Habilitation at Different Locations with the Same Provider
iRecord does not allow plans to be approved if they include services with overlapping dates and the same service, service provider and procedure code. Therefore, if an individual attends Day Habilitation at different locations with the same provider, the SC enters one service line with the primary location's address and uses the Community Integration tile within the PCPT to document the attendance of both programs. This will avoid claiming issues for the Service Provider. (When submitting claims, the provider is prompted to enter two different NPI numbers. The first is the provider's NPI number. The second is the provider's NPI number of the location where the service occurred.)

Prior Authorizations for Service Providers

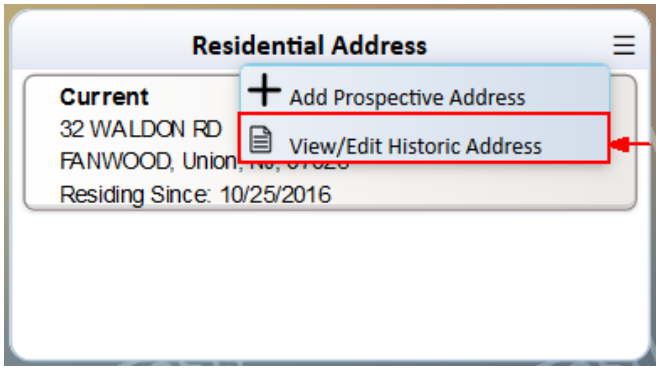
iRecord generates prior authorizations (PAs) for approved services when the payment source in iRecord is "Medicaid" or "FI (Agency)". Prior authorization (PA) statements are generated for each week that falls between the service start date and end date, including partial weeks. For example, if the start date of a service is a Wednesday, the first week's units are from Wednesday to Saturday. Likewise, if the service ends on a Thursday, the last week's units are from Sunday to Thursday. When a plan is in Approved status, PA details are automatically sent on a weekly basis to the Gainwell/Medicaid system for processing. Once processed, the data is sent back to DDD and iRecord is updated accordingly with an approved or rejected status.

When a Service Provider encounters billing problems, they may inform the SCA and ask for assistance. The SCA double checks all details in iRecord and the Service Detail Report (SDR) regarding service entry.

- Concerns with the issuance or approval of prior authorizations are reported through a JIRA ticket to request assistance with correction.
- If there is an error related to unit allocation, the SCA should consider whether a retroactive change request is needed. See the chapter, Retroactive Change Requests, for more information.
- If everything was entered correctly and iRecord and the SDR are accurate, the Service Provider can be redirected to contact Gainwell/Medicaid to request assistance.

Residential Address History

Support Coordinators are able to view and edit an individual's current address, prospective address, and historical addresses by clicking the three lines on the Residential Address tile. All residential addresses are to be up to date and reflected in the Residential Address tile.



Retirement

The Retirement checkbox in iRecord is located under the Demographics tab on the Attributes tile. It is used **only** if an individual is 65 years of age or older **and** decides to retire from **all** employment and day services, including non-DDD funded programs like adult medical day programs, mental health day programs, etc. (For information about *early* retirement, see below.) Support Coordinators (SCs) should **not** automatically select the iRecord Retirement feature only because the individual is 65 years or older, as this causes budget problems. If the Retirement option is checked in error,

immediately email DDD.SCHelpdesk@dhs.nj.gov for assistance. (A JIRA ticket should not be submitted, as this is not a DDD-IT issue.)

When the Retirement checkbox is used, the following occurs:

Supports Program – The individual no longer has access to the Employment/Day budget component, and Day Habilitation services can no longer be added to the plan. Instead, the Employment/Day budget amount is added to the Individual/Family Supports budget component, and Employment Pathways and Employment Outcomes are no longer required.

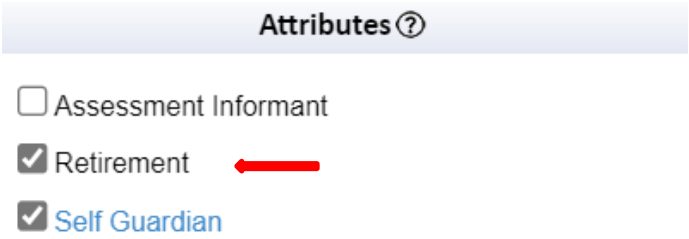
Community Care Program – The individual no longer has access to the Employment/Day budget component, and Day Habilitation services can no longer be added to the plan. Instead, the Individual/Family Supports and Residential budget components increase to the next tier level amount (unless already assigned E or Ea), and Employment Pathways and Employment Outcomes are no longer required.

The assessed tier (A, B, C, etc.) does *not* change, but the budget *amount* increases to the next tier level.

Important: If the individual is 65 or older and wishes to retire from employment but wants to attend a day program, including Non-Division funded day programs (Medical and Partial Care Day Programs, DVRS funded workshops, etc.), the iRecord Retirement checkbox is **not** checked. In this scenario, the SC should update the Employment Pathway Assessment to "Unemployed – not pursuing", select "Retirement" on the Employment Pathway and complete the Employment Non-Referral Form – (F6) with the second option checked, "The individual is of retirement age (65 or older)."

Note: iRecord continues to prompt for an employment outcome. If the individual is retired from employment, but not Day Habilitation, the outcome should not reference the individual getting a job or pursuing employment. It should reference how the individual wishes to spend their days. (The iRecord requirement of having an employment outcome only becomes disabled if the Retirement checkbox is checked.)

Once the Retirement checkbox is checked, iRecord automatically generates a new macro plan (i.e. Plan 3.00, 4.00). The new macro plan **must** be approved within thirty days to avoid claiming and reimbursement issues. Retirement officially takes effect upon plan approval. If an individual decides to come out of retirement and/or wishes to attend any sort of day program, including non DDD-funded day programs, the SC must email DDD.SCHelpdesk@dhs.nj.gov to request assistance with unchecking the Retirement checkbox. The Planning Team meets prior to "unchecking" retirement to ensure that providers are aware and prepared for this change.



Early Retirement
If an individual, who is not yet age 65, wishes to retire from all employment and Day Habilitation activities, the Planning Team meets and uses the ISP Revision and Notification Form to record meeting notes. Also, the Early Retirement Request is completed and submitted to DDD.EmploymentHelpdesk@dhs.nj.gov to request approval for early retirement.

Retroactive Change Requests (RCRs)

Requesting changes to an Individualized Service Plan (ISP) for service dates in the past is known as a retroactive change request (RCR). In some circumstances, with Division assistance, it is possible to close service gaps and correct service entry errors.

RCRs should be avoided when possible and often times can be avoided through correct service entry and timely approval of ISPs.

Reasons to avoid the need for RCRs include:

- Resources are required to complete, submit and process RCRs.
- Not all RCRs are approved, and not all can be completed.
- Retroactive Change Requests are an SCA evaluation indicator, and a pattern of RCRs due to SCA error may require SCA corrective action.

Tips on Avoiding the Need for Retroactive Changes

Complete a thorough review of the sections, Service Entry / Service Considerations and Service Entry Dos and Do Nots, and implement the strategies below to help prevent the need for RCRs.

- Remind individuals, families and Service Providers that services should not be rendered without prior authorization. Services begun without prior authorization, and outside the scope of prior authorization, will not be reimbursed.
- Ensure all current and projected services fall within the individual's annual budget.
- Create an internal auditing system to track anniversary service plans, and anticipate the 60 day window in which to develop an anniversary plan. Use good time management to schedule meetings, finalize the ISP/PCPT, and complete steps required for plan approval to help prevent service disruption and service gaps.
- The Outcomes and Services section of the SC Monitoring Tools prompts a review of all current outcomes and services with the individual/informant. This monthly conversation provides an opportunity for the SC to notice if any services are set to expire and if ISP changes are needed.
- Contact Service Providers to obtain a list/calendar of program closures (i.e. holidays, staff in-service days, etc.), and edit exception weeks accordingly to remove units from the plan and avoid unnecessary budget obligations.
- If SDE services are utilized, ensure the full name of the SDE and accurate wage/billable rate are entered in the ISP **as provided/confirmed by the FI**.
- If the individual receives support from multiple SDEs and they all receive the same billable rate, enter all SDEs into one service line so they can share hours or cover in the event of a call out.
- Create timely plan revisions to stop services during a plan term as needed, which allows unused funds to return to the available budget (i.e. traveling with family out of state). When "Stop Service" is selected, the header of the service line displays "Marked for Deletion." **However, the service is not stopped until the plan is approved**. Prioritize these plan approvals to avoid budget obligations for unused units. (See the section on Plan Revisions for more information.)
  - If funds ***are*** allocated for unused service units in the past, requests to return unused funds to the budget are only considered if there is a clear need for services to protect health/safety and funding is not otherwise available.
    Note: SCs are advised to stop unused services in a timely way to prevent this scenario.
- Support Coordination Supervisors (SCSs) should meet with staff regularly to review rosters, address barriers and ensure deadlines are met.
- SCSs should ensure staff understand iRecord features prior to utilizing them. SCAs should consult the iRecord User Guide or their assigned QAS as needed to help avoid plan issues.

How to submit an ISP Retroactive Change Request (RCR):

- The SCA completes the Retroactive Change Request as soon as a service gap or plan error is identified. This form is found on the Support Coordination Information webpage.
- Ensure the RCR contains all the required information needed to complete the request and ensure the service week dates and units section is completed in its entirety.

- Remember that iRecord reflects a calendar week as Sunday through Saturday.
- Ensure that the form is signed and the provider representative signing the request form is the person identified by the provider to do so (often a billing/fiscal person).
- Ensure the current plan is in Approved status.
- Ensure the Description of Error section contains a concise, detailed description.
- RCRs are submitted to Ddd.Ispretroactivechanges@dhs.nj.gov. **Requests should NOT be sent through a JIRA ticket to the DDD-IT Department**.

SCA Assignments and Reassignments

This chapter describes **initial assignments** to SCAs, when an individual first becomes eligible for DDD services, and **reassignments**, when an individual already assigned to an SCA is reassigned to a different SCA.

Notes:

- Service Providers, including SCAs may **not** submit SCA Change Forms. Only individuals/legal guardians may submit SCA Change Forms.
- For all assignments, the selected SCA outreach is expected to occur within three days.
- SCA reassignments typically occur on the first of the month due to the monthly rate for Support Coordination
- Services.
- SCAs are responsible for their own marketing and are not to rely on Division/iRecord auto-assignments for their business model.

Education Entitlement Considerations

People with intellectual/developmental disabilities are entitled to a free, appropriate public education through the age of 21. This education entitlement applies to the entire school year in which an individual turns 21. (School years run from July 1 to June 30 the following year.)

An individual may ***apply*** to DDD between the ages of 18 and 21.

- Division services may not be provided to individuals prior to their 21st birthday. Uncommon exceptions are described in the sections, Under 21, Enrolled on the CCP and Limited Circumstances, Ages 18 to 21.
- There are limitations to the Division services individuals may receive between the time of turning 21 and the completion of their educational entitlement.
- Even if someone chooses to sign out of school early and not take advantage of their full educational entitlement, the above conditions apply.

Resources

- For additional information on individuals transitioning into adult services, see the Division's webpage on Transition from School to Adult Life.
- For additional information about EPSDT, follow this link to the Medicaid Early and Periodic Screening, Diagnostic, and Treatment webpage.

Assignment Types

1. Initial Assignments

Following the DDD application and eligibility determination process, individuals/legal guardians may choose a preferred SCA, or they may choose to be auto-assigned. Individuals/legal guardians may use either Provider Search database or view the List of Approved Support Coordination Agencies on the DDD website to research and identify first and second

choices of preferred agencies. If a preferred agency serves the county in which the individual resides, has open capacity in that county, and meets the conflict-free care management policy, the Intake Unit assigns the individual to the preferred agency. Otherwise, the individual is auto assigned to an agency with available capacity in the county of residence.

2. Graduate Assignments

During the school year in which an individual graduates, they may be assigned to an SCA up to 6 to 8 weeks prior to their 21st birthday to allow time for planning. The expectation is that services are available immediately upon turning 21. Upon assignment of a graduate, it is important for Support Coordinators (SCs) to learn whether services are being received at home, either through the school or through the Department of Children and Families (DCF) Children's System of Care (CSOC)/Perform Care. If services *are* in place and the graduate's current Service Provider does not serve adults, a new provider must be identified in order for services to continue to be available via the DDD system. It is **vital** to ensure that, if desired by the individual/legal guardian, the same or comparable services are identified through the Division, and are in place through an approved ISP when the individual turns 21 so services continue without a gap.

> **Note:** If the ISP cannot be approved due to the DDD Status reflecting "**DDD Status is at DCF**," SCs should email DDD.SCHelpdesk@dhs.nj.gov for assistance with outreach to the appropriate Intake Unit to have the individual's status updated.

3. Pre-Graduate Assignments

The term "Pre-graduate" applies to an individual who is already 21 years old (meets the age criteria for Division eligibility) but is still under their educational entitlement (has not yet graduated). Division services may begin immediately, but must be coordinated with services available through the school, to avoid duplication.

The Division cannot provide funding for any service that should be provided through the school district until the educational entitlement has been exhausted. Examples of DDD services that are not available until after graduation are Physical Therapy, Occupational Therapy, Speech Therapy, Assistive Technology, Day Habilitation, Supported Employment and Supports Brokerage Services. All other services are available to pre-graduates outside of school hours (evenings, weekends), including: Respite, Behavioral Supports, and Community Based Supports.

In summary, a pre-graduate has access to their full budget (Supports and Employment/Day components) for services not available through the school. The individual/legal guardian should contact DVRS if they are interested in additional employment-related services beyond what the school system is providing.

> **Note:** If the ISP cannot be approved due to the DDD Status reflecting "**DDD Status is at DCF**," SCs should email DDD.SCHelpdesk@dhs.nj.gov for assistance. Helpdesk staff forward the email directly to the appropriate Intake Unit to have the individual's status updated.

4. Under 21, Enrolled on the CCP

A small number of individuals, under 21, are in school and have been determined eligible for DDD services through enrollment on the Community Care Program (CCP) due to a high level of medical need.

If an individual is still in school and under their educational entitlement, the Division cannot provide funding for any service that is or should be provided through the school district until the educational entitlement has been exhausted. Examples of DDD services that are not available until after graduation are Physical Therapy, Occupational Therapy, Speech Therapy, Assistive Technology, Day Habilitation, Supported Employment and Supports Brokerage Services. All other CCP services are available outside of school hours (evenings, weekends), including: Respite, Behavioral Supports, and Individual Supports.

> **Note**: Age criteria should be enabled prior to individual assignment, but if not and the ISP cannot be approved due to the DDD Status reflecting "**Age Criteria Not Met**," SCs should email DDD.SCHelpdesk@dhs.nj.gov for assistance. Helpdesk staff submit a JIRA ticket requesting DDD-IT to enable the age criteria.

5. Under 21, Enrolled on the CCP with Private Duty Nursing (PDN)
In addition to the information above, it is also possible for an individual under 21 and enrolled on the CCP to receive Private Duty Nursing covered by the Managed Care Organization (MCO) through EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) until their 21st birthday. Once they turn 21, they are no longer eligible for EPSDT and instead transition into adult services. As the child approaches their 21st birthday, the Medicaid Eligibility Help Desk (MEHD) communicates with the MCO, individual/legal guardian, and SCA to alert them of the need to begin planning for adult services when the individual turns 21. The individual/legal guardian will need to decide whether they are interested in receiving services through the Division. If interested in Division services, they may elect to remain on the CCP but lose PDN services, as it is not available on the DDD CCP waiver, or they may elect to switch to the SP+PDN so that they can keep PDN services while receiving DDD services. If the individual/legal guardian are not interested in DDD services, they may continue with PDN and other services through MLTSS.

> **Note**: Age criteria should be enabled prior to individual assignment, but if not and the ISP cannot be approved due to the DDD Status reflecting "**Age Criteria Not Met**," SCs can email DDD.SCHelpdesk@dhs.nj.gov for assistance. Helpdesk staff will submit a JIRA ticket requesting DDD-IT to enable the age criteria.

6. Limited Circumstances, Ages 18 to 21
The Division recognizes there may be a small number of individuals ages 18 through 21 who have met both graduation requirements and the goals in their Individualized Education Program (IEP) and are not eligible to remain in high school until age 21. Individuals in this situation may be eligible to enroll in DDD as early as age 18 if they have graduated and are seeking Division services to:

- support immediate enrollment at an institute of higher education or trade school not funded by DDD, and/or
- support established competitive integrated employment.

In both circumstances, services being sought from the Division would not otherwise have been the responsibility of their local education agency (LEA) to provide.

> **Important**: This flexibility does not allow individuals to enroll in Division services before the age of 21 for other reasons such as to enroll in a Division-funded adult day habilitation program.

Individuals who may be required to graduate before age 21 should contact DDD.TransitionHelpdesk@dhs.nj.gov at least six months prior to the anticipated graduation to ensure they would be eligible to access Division services prior to age 21 and to learn about their options. See the Division's policy manuals section 3.1.5 for more information.

7. Reassignments
Reassignments occur for one of three reasons: when an individual already assigned to an SCA submits a request to change to a different SCA, when the assigned SCA is closing or merging with another SCA, or when the Division imposes a sanction due to unresolved underperformance, which affects an agency's census.

At any time, an individual/legal guardian may request to change SCAs by completing a Support Coordination Agency Change Form and indicating their new preferences. If a selected agency provides services in the county in which the individual resides and has open capacity, the individual is reassigned to their preferred agency. If a preferred SCA does not meet these criteria, or if the individual does not have a preferred agency, the individual is automatically reassigned via the DDD/iRecord auto assignment process, to an agency based on the county of residence and available capacity.

SCA change forms and related inquiries are submitted directly by the individual/legal guardian to DDD.SCAChoice@dhs.nj.gov. Once submitted, SCA reassignments typically occur at the beginning of the following month due to the monthly rate for Support Coordination services.

> **Note**: SCAs receive a secure email from the Division whenever an individual is reassigned off their roster. The email lists the individual's DDD ID number and the name of the new SCA. It does not include contact information of the new SCA, only the name. See the example below:

From: DDD.SCHelpdesk@dhs.state.nj.us
Sent: Wed, 13 Nov 2024 14:08:25 -0500
To: (SCA email address)
Cc:
Subject: SC Agency Assignment – (DDD ID)

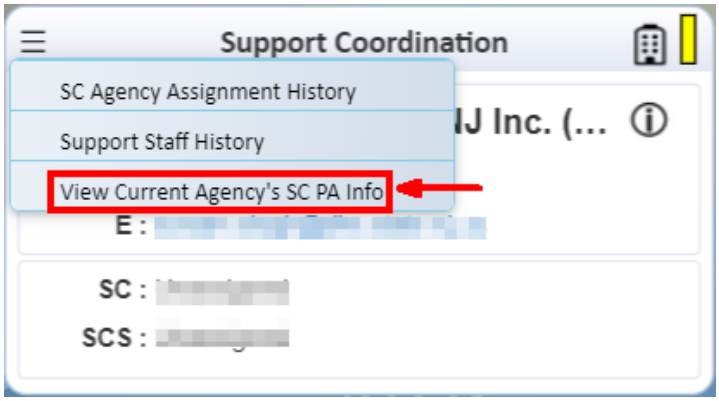
Greetings!
The following participant is no longer assigned to (name of SCA)
for Support Coordination:
DDD ID:
Waiver Program : Supports Program
Note: Auto assigned Agency because of full capacity in primary agency preferred (name of SCA) and secondary agency preference not specified.
The State of New Jersey Division of Developmental Disabilities

SCA Prior Authorization and Claiming

This chapter describes SCA prior authorizations and claiming in various scenarios. All claims for Support Coordination (SC) services for individuals enrolled in the Supports Program (SP) or Community Care Program (CCP) under the Fee-for-Service system are submitted through Gainwell/Medicaid.

Prior Authorization
Prior authorization (PA) for the provision of Support Coordination (SC) services is issued when all waiver eligibility criteria are met: the individual is at least 21 years old, is Medicaid eligible, is enrolled/"soft enrolled" on a waiver (through the upload of a Participant Enrollment Agreement) and the ISP is in Approved status.

PAs are generated on the first of the month on a monthly basis. For partial months, a daily rate PA is issued to the SCA. PAs are automatically sent to Gainwell/Medicaid for processing. Once processed, the details are sent back to the Division, and iRecord is updated with an approved or rejected status. This information can be viewed in iRecord on the Support Coordination tile via the "View Current Agency's SC PA Info" option.



The litmus strip indicator displays the PA status. If a PA is rejected, the user can hover over the litmus strip to view the error description.

- The PA is approved.
- The PA is rejected.
- The PA has been sent to Gainwell/Medicaid and is pending a determination

Even though prior authorizations are sent at the beginning of the month, claims should not be submitted until ***after*** confirming deliverables are met to substantiate the claim. For example, claims for monthly monitoring should only be submitted after confirming that contact was made and the Support Coordinator (SC) Monitoring Tool was completed

and uploaded in iRecord. If a deliverable was not met, a claim should not be submitted, even if a prior authorization was received.

Note: As per section 12.3 (Claim Submission) of the Division's policy manuals, "Claims submitted without adherence to standards outlined in this manual will require Medicaid repayment."

Additional detail regarding SC PAs can be found in the Support Coordination section of the iRecord User Guide.

Claims using the SC Monthly Rate vs. the SC Daily Rate

The **SC Monthly Rate** is used when an individual enrolled in the CCP or SP is assigned to an SCA for the entire month, Support Coordination services have been provided, and within that month deliverables have been met.

The **SC daily rate** is used for initial assignments (see below) and when an individual already enrolled on the SP or CCP is assigned/reassigned to an SCA on any day other than the first of the month, as long as deliverables are met and the newly generated ISP is approved.

Initial Assignments

The Initial ISP (1.0) is generated in "W" (Work-in-Progress) status when the Participant Enrollment Agreement (PEA) is uploaded in iRecord. (See the section, Initial Plans.) When the ISP is approved, prior authorizations are issued retroactive to the date the Participant Enrollment Agreement (PEA) was uploaded, the participant's 21st birthday, or the Medicaid eligibility date, whichever date is the most recent.

If the PEA was uploaded on any day other than the first of the month, claims are submitted using the **SC daily rate** only if there is presence of at least one case note indicating the service(s) provided during the partial month in which the SCA is claiming.

For subsequent months, prior authorization is issued for the **SC Monthly Rate** and claims may be submitted provided required monthly deliverables are present.

> **EXAMPLE**
> An individual's initial assignment to an SCA occurs on January 7, the PEA is uploaded on January 16, and the ISP is approved on February 24. Upon plan approval, prior authorizations are issued to the SCA beginning January 16.
>
> In this scenario, the SCA claims using the SC daily rate from January 16 (date of PEA upload) through January 31, provided there is a daily rate deliverable of a case note (initial meeting with individual or family, work being done on PCPT/ISP, etc.). The SCA claims for February using the SC Monthly Rate after the ISP is approved and may use the SC Monthly Rate for all subsequent months in which the individual is assigned to them for a full month and there is evidence of an approved ISP and uploaded Monitoring Tool.

Note: For initial assignments, completion of SC Monitoring Tools is required beginning the calendar month **following** completion of the initial ISP.

Reassignments

When an individual with an approved plan is reassigned to a new SCA, iRecord automatically generates a new **micro** plan (1.01, 1.02, etc.). The status is W for Work-in-Progress. (See the section, Reassignment Plans for additional information.) The SCA is expected to continue meeting deliverables, but is not able to claim for payment until the newly generated ISP is approved.

Graduate Assignments
A graduate assignment is one that occurs 6-8 weeks prior to an individual's 21st birthday, during the school year in which they graduate. Prior authorization for Support Coordination services is issued once an individual is eligible to receive Division services. When the ISP is approved for an assigned graduate, **daily rate** prior authorization is issued retroactive to the date both age criteria and the Participant Enrollment Agreement (PEA) upload are in place. For example, if the PEA is uploaded on April 9 and the individual's 21rst birthday is April 18, once the ISP is approved, the prior authorization is issued starting April 18 because that is the date when both age and waiver enrollment (from the PEA upload) are in place.

As with all prior authorizations, if it falls on any day other than the first of the month, the daily rate (rather than the monthly rate) for Support Coordination services may be claimed for the remainder of that month.

A payment voucher may be submitted to the Division if the SCA attended the individual's exit IEP meeting prior to the ISP being approved as long as the individual was assigned to the SCA on that date and is there is supporting documentation of attendance (i.e. sign-in sheet). (See the section on Payment Vouchers for more information.)

Pre-Graduate Assignments
A pre-graduate assignment is one that occurs after an individual is already 21 years old but has not yet graduated. Because the individual is 21 years old and fully eligible for Division services, once the ISP is approved, daily rate prior authorization is issued retroactively to the date the Participant Enrollment Agreement (PEA) was uploaded if the upload occurred on any day other than the first of the month. The monthly rate is used thereafter as long as monthly deliverables are met.

Under 21 on the CCP
A small number of individuals, under age 21, are eligible for DDD services and are enrolled on the Community Care Program (CCP). Because the individual is fully eligible for Division services, once the ISP is approved, daily rate prior authorizations are issued retroactive to the date the Participant Enrollment Agreement (PEA) was uploaded if the upload occurred on any day other than the first of the month. The monthly rate is used thereafter as long as monthly deliverables are met.

Individuals Under 21 Enrolled on the CCP, with Private Duty Nursing (PDN) Service
Because an individual is fully eligible for Division services when the ISP is approved, daily rate prior authorizations are issued retroactive to the date the Participant Enrollment Agreement (PEA) was uploaded if the upload occurred on any day other than the first of the month. The monthly rate is used thereafter as long as monthly deliverables are met.

Mid-Month Discharge / Disenrollment
When an individual is discharged from Division services and/or disenrolled from the CCP or SP wavier on any day other than the last day of the month, the SC daily rate is used as long as at least one deliverable is present indicating the service(s) that were provided during the days for which the SCA is claiming.

Mid-Month Waiver Transfer (SP to CCP / CCP to SP)
When an individual is disenrolled from one Division waiver program and enrolled in another Division waiver program on any day other than the first or last day of the month, the SC daily rate is used. If the SCA attempts to claim using the SC Monthly Rate, an error code is received.

> **EXAMPLE**
> An individual transitions from the SP to the CCP, and the CCP ISP is approved on January 15. The SCA must claim using the SC daily rate from January 1 – 14 and again using the SC daily rate from January 15 – 31.

New ISP is Generated
When a new ISP is generated (due to annual ISP, change in individual budget and/or tier assignment, or change in waiver program enrollment), **the SCA cannot claim for completing deliverables unless/until the newly generated ISP is**

approved. Upon plan approval, the SCA can claim, as long as at least one deliverable is present indicating the service(s) that were provided during the days for which the SCA is claiming.

> **EXAMPLE (NJCAT reassessment results in tier increase)**
> On May 17, a new macro plan is generated due to a change in tier, and the SC receives a Due-List item giving 30 days for completion. The new ISP is approved on July 12. In this scenario, the SCA cannot submit claim ***in*** June because the new macro plan was not in approved status within 30 days. After the plan is approved on July 12, the SCA ***can*** submit claim for June, as long as at least one deliverable is present (for example, SC Monitoring Tool is completed) indicating the service(s) that were provided during the days for which the SCA is claiming. Claiming can continue in July, since the ISP is in approved status.

If an Individual Loses Medicaid

If an individual loses Medicaid, the SCA should begin the troubleshooting process immediately by completing the Medicaid Eligibility Troubleshooting Form and submitting it to DDD.MediElighelpdesk@dhs.nj.gov. The SCA documents the guidance received from DDD and any related follow up with individual/guardian in iRecord case notes **and** on the SC Monitoring Tool. DDD.MediElighelpdesk@dhs.nj.gov provides information regarding eligibility status and provides instruction on whether to submit a Voucher Approval Request to the DDD Medicaid Unit. See the Voucher Process when Medicaid Terminates for detailed information. During this process, SCAs are expected to continue meeting monthly deliverables. Once Medicaid coverage is re-established, if there is no gap in Medicaid coverage, the SCA can submit claims directly to Gainwell for the months that Medicaid eligibility status had been terminated and moving forward.

Claims Submitted Directly to Gainwell/Medicaid

Service Providers may submit claims for payment through the NJMMIS (New Jersey Medicaid Management Information System) website. Training on how to submit claims and track their status through NJMMIS can be provided by Gainwell Health Care. Gainwell Provider Services can be reached by calling 800-776-6334 or on the NJMMIS website through the option, “Contact Provider Services”.

Process for Resolving Claim Issues

Issues regarding denied claims, missing prior authorizations, etc. are addressed first with Gainwell/Medicaid. Gainwell Provider Services can be reached by calling 1-800-776-6334. If the issue cannot be resolved at this level, the SCA submits a JIRA ticket under 'Prior Authorizations' with a brief summary of the issue, including the outcome of the call to Gainwell, and the following information:

- DDD ID#
- Plan ID
- PA #
- TCN/ICN
- Error Code
- Procedure Code
- Name of Service
- Claim Dates
- Amount of Claim

Payment Vouchers

SCAs are paid for providing support coordination services to individuals in the Interim program or in specific Division-approved circumstances, through a completed and submitted Payment Voucher.

Interim Payment Voucher Submissions

After ensuring an approved ISP and Monitoring Tools are uploaded in iRecord, SCA payment vouchers for individuals assigned in Interim are submitted via email to DDD.SCHelpdesk@dhs.nj.gov.

Division Approved Voucher Submissions

There are rare circumstances when the Division determines that support coordination services are necessary for the continuity of care to an individual temporarily not enrolled in a DDD waiver program. In these rare circumstances, the Division may direct the SCA to maintain involvement and to submit a payment voucher. In these situations the SCA receives permission/instruction to use the Request to Submit Voucher for Payment form to claim for services and are required to do the following:

a. Continue monthly monitoring and all documentation requirements.
   Note: If face-to-face monitoring visits are not possible (for example, due to incarceration), the face-to-face monitoring requirement is waived.
b. Update the ISP as needed for support needs, outcomes and services.

Voucher Reminders

- Always include the agency's Vendor Identification Number (VIN), which has 11 characters (not to be confused with the EIN, which has 9 characters).
- Ensure the agency address listed on vouchers matches the agency address listed with NJSTART/Treasury.
- Allow up to 45 days for processing.

Additional information about the voucher process is found on the Provider Information page.

Tracking Vouchers Submitted via NJ's Vendor Payment Inquiry

For voucher status updates, utilize the State's **Vendor Payment Inquiry** (VPI) system. This system enables vendors, including SCAs, to see when a payment has been approved and when payment is scheduled to post to their account. It also enables agencies who receive Automated Clearing House (ACH) payments to view information typically available on a check stub.

Steps to Enroll in the Vendor Payment Inquiry (VPI) system

1. Create a MyNewJersey account
   a. Go to the State of New Jersey official webpage.
   b. Scroll down. Under "Popular Services," click "Register a business."
   c. Complete the registration, including identifying a username and password.
2. Review the Vendor Payment Inquiry document for complete instructions on signing up for the VPI application.

SCA Claiming in the Event of an Individual's Death

Because an individual's Medicaid eligibility ends on the date of death, claims for dates of service beyond this date are denied by Medicaid. Prior authorizations for dates of service that fall after the date of death become invalid upon completion of the death verification process. Claims for SC services for the month in which a person dies, are reimbursed at the daily rate up to the date of death. Typically, any post-death services are considered part of the rate and are not reimbursable, which is consistent with other Medicaid processes.

SCA Statewide List and Staff Roster

Support Coordination Agency (SCA) Statewide List

The Division maintains a published List of Approved Support Coordination Agencies (updated weekly) on the Support Coordination (Care Management) page. Each SCA is responsible to ensure the accuracy of counties served, language accommodations and self-approval status. The SCA list indicates the counties each SCA serves based on their current approved Conflict Free Policy. The public SCA List does not account for temporary county capacity closures. Temporary closure of counties is reflected in iRecord, and may be checked through the SCA Tile (map) in iRecord to ensure the counties open and temporarily closed are accurate in the system.

SCAs must report the following changes to the Division:

- Language accommodations: email Karen.Bashore@dhs.nj.gov
- Permanent counties served: email Karen.Bashore@dhs.nj.gov
- Temporary closures to counties served: email Karen.Bashore@dhs.nj.gov

- Errors in the listed self-approval status: email the agency's assigned QAS

If an individual in need of a language accommodation is assigned to an SCA that is unable to accommodate the language, the SCA may not reject the referral as per the zero reject policy. The SCA is permitted to inform the individual/legal guardian that they do not have staff to accommodate their language and suggest/recommend they review the SCA list to select a different agency. However, if the individual/legal guardian wishes to remain with the SCA, the SCA is expected to arrange a language translation service for the individual at the SCA's cost. The individual's budget cannot be used to cover translation services for the SCA. SCAs are not required to have a translation service on "retainer" but should be aware available services if needed.

SCA Roster Updates & Current Staff List
SCAs are responsible to ensure that its staff list is current. All staffing updates, including new staff hires, separations, terminations, resignations and promotions, are emailed directly to Karen.Bashore@dhs.nj.gov with the agency's assigned QAS in copy. The Care Management and Provider Support Unit performs routine quality checks to ensure accuracy of Division information. SCAs should update the Division regarding changes and not wait for a quality check.

> **Important**: If an SCA staff member leaves the agency for any reason, their iRecord account **must be deactivated immediately.** Refer to the section, Account Deactivation, for guidance on deactivations.

SCA Training

Staff Training & Professional Development
SCAs are responsible to ensure that all employees meet staff qualifications, including completion of mandatory trainings.

Staff who provide Support Coordination services must successfully complete the trainings outlined in the Division's policy manuals **Appendix E: Quick Reference Guide to Mandated Staff Training**. Required trainings are provided by the College of Direct Supports, the Boggs Center on Developmental Disabilities and Service Providers. (For a detailed summary of staff requirements, refer to the Quick Reference Guide to Support Coordination Agency Staff Requirements.)

College of Direct Support (CDS)
The College of Direct Support is the online training and learner management system that provides many DDD required trainings and online training modules designed for use by direct support professionals, frontline supervisors, and other disability service professionals, such as Support Coordination staff.

CDS Administrators
SCAs are required to have at least two CDS Administrators within the agency to account for vacation and turnover. All CDS Administrators are required to complete the Boggs Center's CDS Administrator training and must follow procedures described in the CDS Administrator Manual and Division policies. Inquiries and requests for technical assistance can be directed to cdsta@rutgers.edu.

CDS administrators assign trainings to their agency staff in the CDS system.

- For initial registration, Support Coordinators (SCs) contact the agency's CDS Administrator.
- Use the following link to login: CDS Login
- Type in Username
  - First initial of first name, Full last name and last 4 of your Social Security number
  - Example: John Doe (JDoe1234)
- Type in Password
- The default password is ***hello***

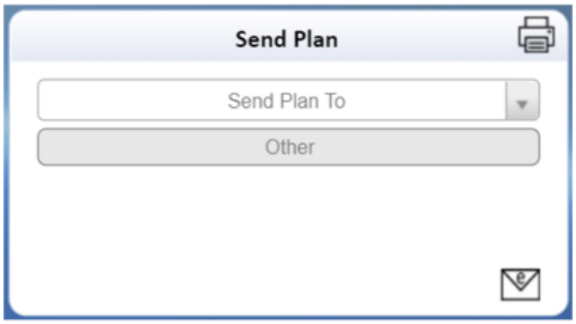
The Boggs Center on Disability and Human Development provides online trainings through their Online Registration System**.**

Division Trainings and Webinars
The Division's Support Coordination Unit, Education & Training Team offers monthly training and education opportunities for SCAs. Agency staff are strongly encouraged to review training calendars, which are distributed monthly. SCA staff can register for upcoming webinars, listen to past webinars, and sign up for training and education opportunities on the Support Coordination Information webpage.

> **Note**: All Support Coordination Supervisors and SCs are encouraged to sign up for DDD Communications Listserv and DDD Support Coordination Listserv.

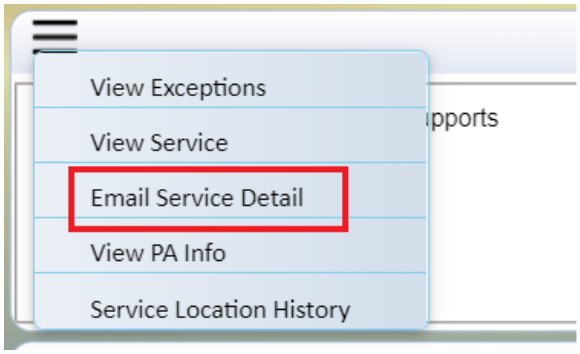
Send Plan Tile

Through the Send Plan tile located under the Plans/Actions Tab, SCs are able to print an individual's ISP or amended ISP and/or email it directly to the individual/legal guardian, HIPAA contacts, and authorized Service Providers. The "Send Plan To" field displays a drop-down list of the available entities and each entity has a check box available for selection. Click on the email icon to email the ISP to the selected entities. To print the ISP, click on the printer icon. Plans that are not in Approved status display a "DRAFT" watermark on all pages. Approved plans *with electronic signatures* do not display the "DRAFT" watermark. View the Send Plan section of the iRecord User Guide for additional details and step-by-step instructions.



Service Detail Reports (SDRs)

SCs are able to send individuals' Service Detail Reports (SDRs) via email directly to the individual, HIPAA contacts, and authorized Service Providers through the "Email Service Detail" feature available in iRecord on the Service menu option found on the left hand side of the service line. After selecting "Email Service Detail," the "Send Service Detail Report" pop-up appears. The "Send Report To" field displays a drop-down list of the available entities and each entity has a check box available for selection. Clicking on the email icon causes an email with the SDR to be sent to the selected entity. For plans **not** in Approved status, the SDR displays a DRAFT watermark on all pages. View the Outcomes section of the iRecord User Guide for additional details and step-by-step instructions.



Service Entry: Assistive Technology, Environmental Modifications, Vehicle Modifications

A service evaluation by the DDD Service Review Unit is required for all Assistive Technology (AT) or Environmental Modifications (EM) requests. It is not required for Vehicle Modification (VM) requests. See the section, Service Evaluations - Assistive Technology, Environmental Modifications, for information about service evaluations.

After a service **evaluation** is completed for Assistive Technology (AT) or Environmental Modifications (EM) and the requested service is ready for completion, the Support Coordinator (SC) completes the Purchase Request for AT, EM or VH form and provides supporting documentation (a copy of the completed evaluation and the quote/estimate from the contractor). Only one quote is needed, but if the estimate is outside the usual and customary range, the request may be denied with instructions to obtain another quote or identify a different contractor.

Service Entry Steps for AT, EM and VM

1. (Step 1 is not needed when entering a VM service.) Under the Tools tab, the SC changes the evaluation status to "Completed" and uploads the copy of the evaluation completed by the Service Provider directly in the Evaluations tile under the Tools tab **and** under the Documents Tab.
   iRecord may indicate that the evaluation status cannot be changed to "Completed" because the end date of the evaluation service line cannot exceed the date of the change. In this case, the plan needs to be revised and the end date of the evaluation service line is changed to the current date. The plan needs to be signed and approved. Once approved, the evaluation status can be changed to "Completed".
2. The SC changes the ISP status to Revision and adds the AT/EM/VM service as a one-time cost for the full plan year allocating the actual unit in the second or third full exception week to allow time for service review and approval. See the One-Time Cost Services section for additional information.
   Non-Division/Medicaid approved providers can be used only if they are registered contractors in NJ. If this type of vendor is being used, the SC enters this service using FI (Agency) as the Payment Source and the name of the FI agency as the provider depending on which SDE model the individual is enrolled in. All invoices are to be submitted directly to the applicable FI.
3. The SC changes the plan status to Review, and the Support Coordination Supervisor (SCS) changes the plan status to Service Review.
   See Submitting an ISP to Service Review for more information.
4. If the service is approved, the plan can be submitted for plan approval via the usual process.
   If the available/remaining applicable budget component does not cover the entire cost of the service, see Budget Flexibilities for information about options.

Unlocking the Assistive Technology or Environmental Modification Procedure Code

If the evaluation for AT or EM is completed or approved **in a previous plan**, the AT or EM procedure code needs to be unlocked before entering the service in the ISP.

Steps for Unlocking the AT or EM Procedure Code

1. The SC submits an evaluation request for the applicable service (AT or EM) through the Evaluations drop down list under the Tools tab using a rate of $0.00, including a note confirming that the rate is entered as $0.00 due to the evaluation already having been completed.
2. If approved in the previous plan, the Evaluation Status appears as "Approved".
3. The SC then adds the evaluation service line into the ISP using a rate of $0.00 and resubmits for plan approval. It is recommended to enter this service for a short duration to avoid the need for Step 3a.
   a. If the evaluation is completed **prior** to the end date of the original evaluation service line, the SC changes the plan status back to Revision to edit the end date to the current date (today's date). Do not "Stop" the service. The plan is then resubmitted for approval. Once approved, go to Step 4.
   b. If the evaluation is completed **after** the end date of the original evaluation service line, go to Step 4.
4. The SC uploads the evaluation documents directly into the Evaluations tile under the Tools tab. This enables the SC to change the evaluation status from "Approved" to "Completed."
5. Once the evaluation status is marked "Completed", the AT or EM procedure codes become available.

The Evaluations section of the iRecord User Guide contains additional details and instructions.

Down Payment
In cases where an Environmental or Vehicle Modification vendor requires a down payment as part of the service, the service can be created with 2 units, with one unit for the down payment. For example, if an EM costs $3,000 and the vendor is requiring a 50% down payment, the SC enters the service using the "one-time cost" method by entering "0" as the average weekly unit. However, the rate is entered as $1,500 and 2 units are added into the second or third exception week to allow for carry over. The total cost of the service line should read $3,000. The rule applies for fiscal intermediaries of both the AWC model and VF/EA model.

Budget Flexibilities
AT, EM and VM services only come out of the Individual/Family Supports component of the budget. If the available amount in this budget component does not cover the entire cost of the service, the individual or family may pay for the difference, spread the cost across plan years/terms, or request the balance from another budget component (if funding is available in an alternative budget component).

> **Note:** When requesting to use funding from another budget component, a minimum of two bids/estimates are required.

Inquiries and budget-flexibility requests are sent to DDD.ServiceApprovalHelpDesk@dhs.nj.gov.

Repairs to a Lift
If a lift needs a repair, the SC can bypass the AT Evaluation Process. The repair can be submitted through Goods and Services. The provider invoice is submitted with the signed Goods and Services Request Form.

Communication Devices
Individuals' budgets may be used for evaluations for communication devices, which allow for communication with the broader community, including day programs. However, the communication device itself, should be funded by State Plan Medicaid. If a recommended communication device is not funded by State Plan Medicaid, it can be requested through a Goods and Services Request.

> **Example:**
> If an individual or family is interested in purchasing a communication device but does not have any knowledge of what types of devices are available or which device would be best suited, the SC can request an Assistive Technology Evaluation (see Service Evaluations section). The evaluation results in a recommendation. If the individual or family already knows which device they want to purchase, an evaluation is not needed.
>
> Once the communication device is decided, a qualified provider is identified so the device can be purchased. If the individual and family wish to use a local business, the SC assists the business to complete enrollment with the fiscal intermediary (FI). (If the individual *is not* using SDEs, the VF/EA agency is the FI. If the individual *is* using SDEs, the FI is the same FI as is used with the SDEs.)
>
> The SC submits the Purchase Request for AT, EM or VH form (as instructed above) and specifies the full cost of the device, including purchase price, taxes, and shipping (if applicable). When DDD approves the request, the SC obtains ISP signatures and has the plan approved in iRecord. The SC then follows up to ensure the Payment Request Form is completed and submitted to the FI so the device can be ordered and the provider can be paid. See the section on Fiscal Intermediary (FI) for more information.

Service Entry / Service Considerations

This chapter provides general advice and tips that apply broadly to services and service entry in iRecord. This chapter also addresses several common questions that arise in different areas of service entry.

Important Reminder: Prior authorization must be obtained before a service is delivered. Services begun or provided without prior authorization will not be reimbursed. Section 8.4 of the Division's policy manuals contains additional information.

Service Entry Practices

Do:

- Ensure services are entered for the full plan term and fit within the budget for the plan year.
- Services must relate to identified needs and support the outcome(s) under which they are listed.
- Review each Service Detail Report (SDR) for each funded service prior to plan approval to ensure accuracy.
- Send all draft ISPs and SDRs to all parties to ensure agreement prior to plan submission and approval. Use iRecord case notes to document outreach and correspondence.
- For individuals receiving Individual Supports Daily Rate:
  - Always list this service **first** to ensure the availability of units.
  - Always use the "Full Term" checkbox in CCP macro plans. This feature locks in the number of units as 365 and ensures the service dates align with the plan term dates, no matter when the plan is approved. See the Full Term Checkbox section for more information.
- For services using a "Daily" unit type (Individual Supports, Out of Home Overnight Respite, Day and Overnight Camp), always list the average weekly unit as 7, regardless of the actual duration, to ensure all days are covered.
- When entering Day Habilitation services, select the "Exclude Weekends" checkbox to adjust units for the first and last exception weeks. For more information, review the Exception Weeks section.
- One-time cost services (for example, annual gym membership, item, evaluation, etc.) are entered so that service duration dates match the plan term dates. "Zero" is the average weekly unit, and one unit is added to the second or third full exception week to allow it to carry over until claiming occurs.
- If the legal guardian is unreachable, follow "Guidance on ISP Signatures" as outlined in the Division's policy manuals, section 7.5.9.1, to avoid signature-related plan delays.

Do Not:

- Do not enter or approve services without confirming service types, rates, frequency, and duration dates with the individual and/or caregivers and Service Provider.
- Do not project start dates for any existing service. The only time to future date a service is if the service is new or scheduled to start on a specific date.
- Do not use the Retirement checkbox in iRecord if the individual attends any sort of Day Program, including non-Division funded day programs (adult medical day programs, DVRS funded workshops, mental health day programs, partial care programs, etc.).

Reminders:

- As always, the Support Coordinator (SC) must ensure that services and supports remain within the allotted budget.
- General questions may be directed to the agency's Division-assigned QAS.
- Case-specific inquiries should follow the SOS process.

Camp Guidelines for Individuals Receiving Individual Supports Daily Rate

Residential Service Providers may only bill for days on which the individual is physically present during any part of the 24-hour period and some level of service is provided. (For more information, see Appendix M of the Division's policy manuals.) For example, if an individual resides in a group home and attends overnight camp Friday evening through Sunday afternoon, billing may occur as follows:

- Friday – Residential Provider and Camp may bill
- Saturday – Only Camp may bill
- Sunday – Residential Provider and Camp may bill

Duplicative Day Services

Per section 8.6 of the Division's policy manuals, the state cannot provide funding for duplicative services. Therefore, when day services are funded by non-Division funding sources, such as Medicaid-funded adult medical day programs, mental health day programs, or DVR funded workshops, adjustments must be made to the individual's Employment/Day budget component. Budget deductions are based on the percentage of time, out of 30 hours, the individual attends a non-Division funded day service. For example, if someone attends an adult medical day program 15 hours per week, 50% of the Employment/Day budget component must be deducted. The remaining 50% may be utilized to fund additional services as needed. If someone attends a medical day program for 30 hours per week, 100% of the Employment/Day budget component must be deducted. This means that the entire Employment/Day budget component is not available for additional services, including services that are considered "non-duplicative" (i.e. Community Based Supports and Individual Supports 15-minute Rate.

The service is entered into the ISP as a natural/generic service using "Day Habilitation" as the service type, "Generic" as the payment source, and "Hour" as the unit type. The average weekly units is entered as the number of hours the individual attends the non-Division funded day program. The name and location of the program should be listed in the Service Description box.

> **Note**: Since the service is entered as a natural/generic service, the funds in the employment/day budget component do not appear as obligated. Therefore, the SC needs to be aware not to enter services into the plan, which require funding already "reserved/allocated" by the non-Division day service.

Electronic Visit Verification (EVV)

EVV is a federal mandate to ensure provider visits for personal care services are occurring, and individuals with disabilities are receiving care they need. EVV statements must be entered in the EVV Description box in iRecord under the "Provider" tab when any of the following services are entered in the ISP:

- Community Based Supports
- Individual Supports 15-minute Rate
- In-Home Respite
- Behavioral Supports
- Habilitative Therapies (Physical Therapy, Occupational Therapy and Speech, Language, & Hearing Therapy)

Notes:

- SCs are encouraged to include the EVV statement within the service description box under the outcome so this information can populate the ISP and be viewable to providers.
- EVV statements are not required for Individual Supports Daily Rate or for non-Division funded services.
- Live-in caregivers are exempt from EVV requirements. When a service is provided by a live-in caregiver, SCs are encouraged to state the presence of a live-in caregiver on the service description line. See the Live-in Caregivers section for more information.

Before adding a new Service Provider to an individual's service plan, SCs must check the Phase I and Phase II Compliance Reports on the Division's Electronic Visit Verification (EVV) webpage to ensure the provider is EVV compliant. Providers noted as **Disengaged**, should not be added to the ISP.

Additional Considerations

- Virtual Services – Services delivered virtually are EVV exempt.
- IS/CBS in the Community – If no in-home visit takes place, services are considered EVV exempt.
- Partial In-Home Service – If any part of a service takes place in the home, the entire service requires EVV.

EVV Methods for Checking In/Out

The following three methods are available to caregivers when checking in at the time of service delivery:

- HHAeXchange App – This is a free app provided through HHAeXchange and is used on a mobile device.
- Telephony – If the free app is not an option, the caregiver could use the individual's landline to call in to HHAeXchange to complete the check-in process upon arrival and departure.

- FOB – If neither of the above methods can be implemented, the provider can request a FOB device by contacting DDDEVV@DHS.NJ.GOV.

Resources

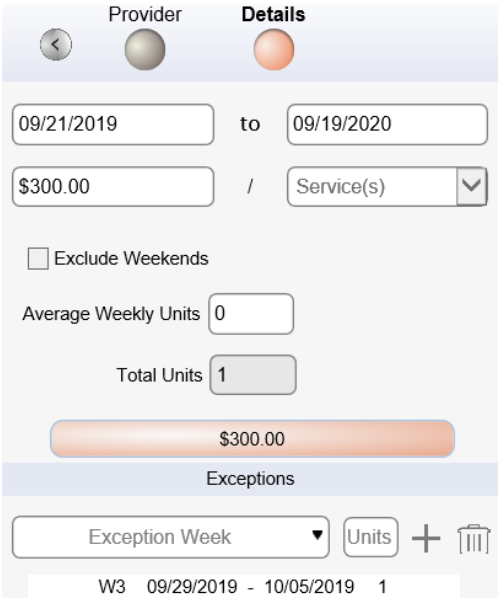
- The Division's Electronic Visit Verification (EVV) webpage contains resources and guidance for SCs, families and providers, including the following:
  a. EVV Checkbox Communication to Support Coordination Agencies
  b. EVV Checkbox Quick Reference Guide
  c. EVV Guidance
- DDD EVV Help Desk: DDDEVV@DHS.NJ.GOV
- HHAeXchange Help Desk: NJSupport@HHAeXchange.com
- The Department of Human Services Electronic Visit Verification (EVV) webpage.

Note: Providers are responsible for addressing all issues related to the app., telephone or FOB. If the individual or family reports any issues to their SC, the SC should follow up with the provider to ensure they are aware. No further action would be needed by the SC.

One-Time Cost Services

One-time cost services (for example, annual gym membership, item, evaluation) are entered in the following way:

1. Service duration dates match the plan term dates.
2. Enter zero (0) as the average weekly unit.
3. Add one (1) unit to the second or third full exception week.
   a. Do not enter this unit anywhere other than near the beginning of the plan term, as the provider is not able to submit billing/receive payment until the unit becomes available.
   b. Ensure the plan is approved prior to the exception week, which contains the unit of service. If plan approval is delayed, it may result in the unit being lost. Support Coordination Supervisors (SCSs) must ensure the unit is available before approving.



Note: The fiscal intermediary will not reimburse a vendor if they submit two separate invoices for one-time cost services because only one unit is entered into the service line. For example, if an environmental modification costs $1000 and the vendor submits an invoice for $800, the FI is unable to reimburse the vendor the remaining $200 due to the unit already being expended. The initial invoice exhausts the authorization if the authorization is for only one unit. SCs should advise vendors, when possible, to submit one invoice for payment in full.

Out-of-State Services
When an individual is traveling out of state, 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 Self-Directed Employee (SDE) or family must pay all travel expenses for the SDE. There is no reimbursement for airfare, meals, lodging, etc. for the SDE or the individual.
- At this time overtime is allowed, but the SDE/DSP may not provide more than 16 hours of services per day (two 8-hour shifts).
- Services must be provided within the United States.
- When an individual is planning to leave New Jersey for more than 30 days, there is a risk of Medicaid termination. See the ABC Manual chapter, Out of State Travel, for additional information.

Payment Sources
All services, including services not funded by the Division, must be included within the ISP. When entering services in iRecord, the correct payment source must be selected from the Payment Source drop down list to avoid claiming issues.

Medicaid – Select **Medicaid** if the service is provided by a DDD approved Service Provider. The cost of the service is reflected in the budget component that supports the service. Services include Day Habilitation, Individual Supports Daily Rate and 15-minute Rate, Community Based Supports, Community Inclusion, Career Planning, Prevocational Training, Supported Employment, Respite, Multiple Passenger Rate Transportation, Behavioral Supports, Cognitive Rehabilitation, Interpreter Services, Supports Brokerage, Physical Therapy, Occupational Therapy, and Speech, Language, & Hearing Therapy.

FI (Agency) – Select **FI (Agency)** for community vendors (non-DDD approved providers) for applicable services. The cost of the service is reflected in the budget component that supports the service. Applicable services include any service provided by a Self-Directed Employee (SDE) and the following: Goods and Services, Assistive Technology, Environmental Modifications, Vehicle Modifications, Single Passenger Rate Transportation, PERS, and Natural Supports Training. See the chapter, Fiscal Intermediary (FI) for more information.

Natural – Select **Natural** when family, friends, neighbors, etc. support the individual without cost to the budget.
Generic – Select **Generic** when an outside entity is providing a service, for which the cost is not directly reflected in the budget expenditure. Examples of Generic services include Personal Preference Program (PPP), Personal Care Assistant (PCA), Partial Care or Medical Day Programs, Private Duty Nursing, etc.

DVRS – Select **DVRS** when services are funded through the Division of Vocational Rehabilitation Services (DVRS), including Long-Term Follow-Along services, Vocational Training, Extended Employment Programs, etc. The cost is not reflected in the budget expenditure.

Personal Preference Program (PPP) & Personal Care Assistant (PCA)
The New Jersey Personal Preference Program (PPP) offers an alternative way for NJ FamilyCare Plan A members who qualify for Personal Care Assistant (PCA) services, to remain in their home and active in their community, and does not require the use of a home health care agency.

PCA services are non-emergency, health-related tasks funded through NJ FamilyCare. Tasks include assistance with activities of daily living (ADLs) and light housekeeping.

Personal Preference Program (PPP)	Personal Care Assistance (PCA)
Able to hire workers, including people the individual knows and trusts such as friends, relatives and neighbors.	Workers are employed by an agency.
NJ FamilyCare Plan A eligible	A doctor's order is needed to receive the service. (One does not have to be permanently disabled.)
Approved for Personal Care Assistant Services (PCA), and need PCA services for at least six months.	Live in a community-based residence (private home, apartment, rooming house, or boarding home) or group home, skill development home, supervised apartment or

	other congregate living program where personal care is not provided as a part of the service package included
Able to self-direct services or choose a representative who can act on their behalf	Have a documented need for hands-on personal care

The VF/EA agency is the fiscal intermediary (FI) for PPP. Individuals who self-direct their services are able to receive services from both programs (DDD and PPP) but separate EIN (Employment Identification Number) numbers must be used. The VF/EA agency handles payroll responsibilities and processes time sheets. The VF/EA agency assigns a financial consultant to the individual to help them navigate the program and to develop a cash management plan. Consultants are required to complete quarterly face-to-face visits to monitor progress, determine satisfaction, and offer assistance.

Important: PPP/PCA and Community Based Supports/Individual Supports 15-min. Rate **may not overlap**. It is recommended to obtain a staffing schedule with the separation of these services clearly shown and upload in iRecord as a supporting document.

Note: PPP and PCA are considered generic services and must be included in the ISP. Per the Division's policy manuals, section 7.5.2.2, "All services, including those services that are not Division-funded, that are required to meet an assessed need must be included within the ISP."

If the individual or family is interested in applying for PPP or PCA, they must contact their Managed Care Organization (MCO) to begin the enrollment process. The phone number can be found on the back of their insurance card.

Contact Information for NJ Family Care Managed Care Organizations (MCOs)

- **Aetna:** 1-855-232-3596
- **Amerigroup:** 1-855-661-1996
- **Horizon NJ Health:** 1-855-465-4777
- **United Health Care:** 1-800-645-9409
- **Well Care:** 1-855-642-6185

Resources:

- Personal Preference Program (PPP) webpage
- The PPP Fact Sheet
- Personal Care Assistant (PCA) Services webpage

Prior Authorizations (PAs)

Prior authorizations (PAs) are created upon plan approval and are automatically generated for each week of service. When a service is added, changed or stopped, a secure email containing the revised ISP and a Service Detail Report showing the start/end dates, total number of units, and procedure codes for services prior authorized is automatically sent to all identified Service Providers and/or the fiscal intermediary (when utilizing an SDE or accessing a waiver service through a business that is not a Medicaid provider). The most recent PA supersedes any previous prior authorizations. Services should not be rendered without prior authorization, and without prior authorization, claims will not be paid.

Important: Per the Division's policy manuals, "In order to ensure that the Service Provider or SDE can receive payment for services they are providing, a prior authorization must be obtained BEFORE the service is delivered. Services begun or provided without prior authorization or outside of the scope of the prior authorization will not be reimbursed."

Unused units can carry over (or "rollover") for future use within the ISP plan year as long as the service and provider that were prior authorized remain the same. Providers are responsible for tracking units rendered and unit accumulation. For additional information see the Division's policy manuals, section 8.4.2, "Unit Accumulation."

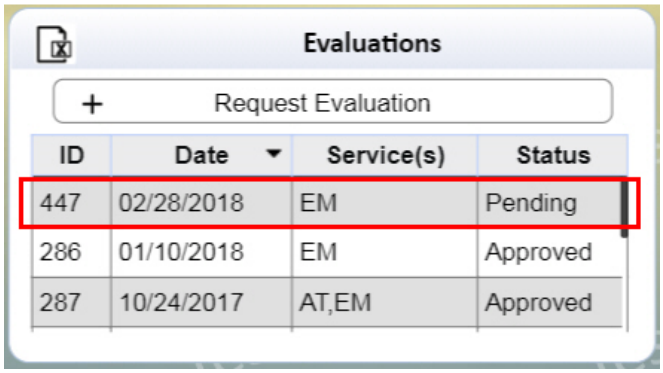
Service Evaluations - Assistive Technology, Environmental Modifications

Service evaluations are required for all Assistive Technology (AT) and Environmental Modifications (EM) requests. It is not necessary for Vehicle Modification (VM) requests.

Steps for Submitting AT and EM Evaluation Requests

1. The Support Coordinator (SC) completes the Assistive Technology/Environmental Modification Evaluation Request Form and uploads it in iRecord under the Documents tab.

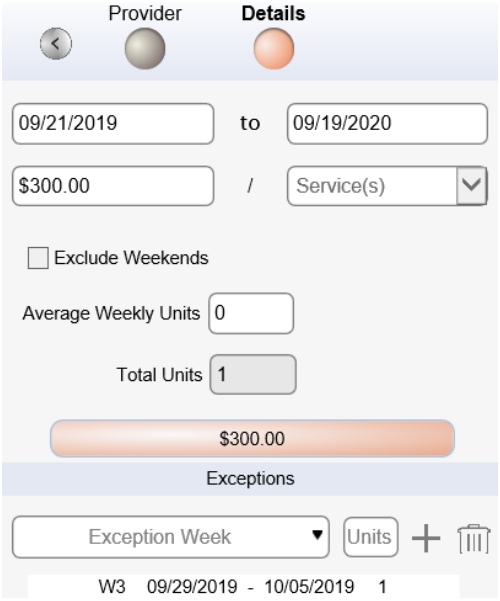
2. The SC submits an evaluation request for the applicable service (AT or EM) by clicking the three lines on the Tools tab and selecting "Evaluations" from the drop down list. When prompted to enter the Service Provider and the evaluation cost, the SC selects the correct service type to unlock a procedure code needed for service entry. When submitted successfully, the request appears in "Pending" status.



Notes:

- The SC is not be able to enter this Service Evaluation request directly into the Service Plan. The Evaluation Procedure Code (T2028HI) is not viewable or accessible until the evaluation request is approved.
- The SC does not have to change the plan status to "Service Review" to submit an evaluation request. iRecord automatically moves the request to Service Review when the evaluation status is "Pending".

3. Once approved through the service approval process, the Evaluation Status appears as "Approved" and the Evaluation Procedure Code (T2028HI) becomes available, allowing the SC to enter the actual Evaluation Service into the service plan as a One-Time Cost.
    1. Service duration dates match the plan term dates.
    2. Enter zero (0) as the average weekly unit.
    3. Add one (1) unit to the second or third full exception week.
        a. Do not enter this unit anywhere other than near the beginning of the plan term, as the provider is not able to submit billing/receive payment until the unit becomes available.
        b. Ensure the plan is approved prior to the exception week, which contains the unit of service. If plan approval is delayed, it may result in the unit being lost. Support Coordination Supervisors (SCSs) must ensure the unit is available before approving.



Note: Service Evaluations can only be completed by a DDD-approved provider. Therefore, Gainwell/Medicaid claiming must be used. Eligible providers are listed in the Provider Search database.

4. Plan approval for the plan containing the evaluation service follows the usual process. When the plan is approved, iRecord automatically changes the evaluation status from "Approved" to "Planned" on the Evaluations tile.

Note: The procedure codes/service types for Assistive Technology (T2028HI22) and Environmental Modifications (S5165HI) are viewable and accessible when the plan containing the **evaluation service** is approved. See the Evaluations section of the iRecord User Guide for additional details and instructions.

Service Review Process

The following services/items must be approved by the DDD Service Approval Team prior to ISP approval:

- Assistive Technology or Environmental Modifications evaluations
  - See Service Evaluations.
- Assistive Technology, Environmental Modifications, or Vehicle Modifications purchases
  - See Service Entry / Purchase Request Form for AT, EM, VM.
- Community Based Supports or Individual Supports with a Self-Directed Employee (SDE) reimbursement rate above what is considered reasonable & customary
  - Use the Enhanced Reasonable and Customary Wage Request form found on the Support Coordination Information webpage.
- Community Inclusion Services or Individual Supports 15-minute Rate when the individual is already receiving Individual Supports Daily Rate
  - See the section, Community Inclusion Services / Individual Supports 15-Minute Rate for Individuals Receiving Individual Supports Daily Rate.
- Goods & Services
  - See Goods & Services iRecord Service Entry.
- Personal Emergency Response System (PERS)
  - See Personal Emergency Response System (PERS).
- Transportation (Single Passenger)
  - See Single Passenger.

Submitting an ISP to Service Review
To submit an ISP to Service Review the Support Coordinator (SC) enters the service into the ISP and changes the plan status to R (Review) for Support Coordination Supervisor (SCS) review. The SCS reviews the service and supporting documentation for accuracy and changes the plan status to SR (Service Review), which prompts the item to appear on a DDD staff Due-List for review and determination. A yellow litmus indicates the plan is in Service Review.

If approved, the litmus is changed to green, and the ISP is returned to Revision status. The SCA may then follow their usual steps for plan approval.

If not approved, the litmus is changed to red, DDD staff enter iRecord case notes to provide an explanation, and the ISP is returned to Revision status. Some denials are because additional information is needed or some other action is required. If the additional information is obtained or the required action is completed, the SCA may want to resubmit the plan to Service Review. However, once a service is rejected, iRecord does not allow Service Review and approval of the **exact same** service. Therefore, to resubmit a plan to Service Review, something about the service line (i.e. the number of units, service dates, service description, etc…) must be changed first. Then iRecord allows the service review to move forward.

> **Note**: See the Service Approval section of the iRecord User Guide for detailed information.

Fair Hearing Rights following Service Review Denials
To meet federal waiver requirements, the Division sends the individual/legal guardian a denial letter with fair hearing rights when a service is formally denied. The denial letter explains the right to appeal the decision through a Fair Hearing before an Administrative Law Judge. The individual/legal guardian has 20 days from the date of the denial letter to request a Fair Hearing. Individuals/legal guardians should follow the instructions provided in the letter to exercise this right.

SCs are responsible to review service requests prior to entering in the ISP to ensure requests meet service definitions and requirements. If the service is not allowable, the SC must inform the individual/legal guardian that the service is not funded through the Division/Medicaid and seek alternate services and funding options.

> **Note**: A Division request for additional information, clarification and/or corrections to a request form is not a formal denial. SCs may be advised to seek other Division services or generic and/or community Medicaid funded resources. Inquires related to service denials may be sent to DDD.ServiceApprovalHelpDesk@dhs.nj.gov.

Service Review Tips

- Assistive Technology
  - An approved Medicaid/DDD provider must complete an evaluation.
  - Confirmation is needed that the vendor accepts third party payment from a 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 is submitted using the Enhanced Reasonable and Customary Wage Request form.
- Community Inclusion Services or Individual Supports (IS) 15-minute 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 Division's policy 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 form.
- 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 Division's policy 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 Division's policy manuals for activity fees criteria.
- For classes (exercise, music, etc.), the business must **primarily** serve the general public.
  - The business may offer classes for individuals with I/DD if the following criteria is met:
    - A class may not have more than 12 individuals.
    - Individuals can attend classes for up to 12 hours per week.
    - See the DDD policy manuals section 17.8.5.1.3 for additional information.
- 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.

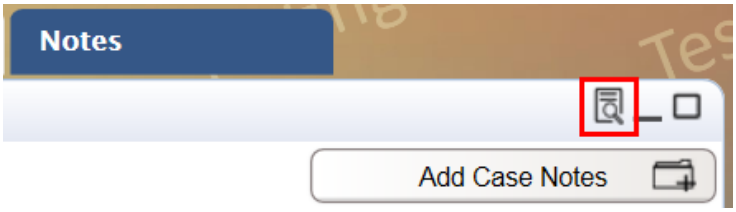
- Transportation Costs
  - Single Passenger Rate and Self-Directed Employee rates are reasonable and customary.
  - Requests for single passenger transportation are made through the Single Passenger Rate Transportation Request, not as a goods & services request.
    - Exception: If a generic provider 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.

Support Coordination Documentation

iRecord Case Notes

Effective communication and documentation are extremely important and valuable in Support Coordination/Care Management Services. iRecord case notes are to be kept up to date and written objectively with an appropriate level of detail. Remember the saying, "If it is not documented, it did not happen." Support Coordinators (SCs) should routinely review individuals' case notes to keep apprised of On-Call notes and other Division entries. Case notes can be viewed individually by clicking on a specific note, or all case notes can be viewed by clicking on the icon shown here:



Case notes should be professionally written, concise, and factual. Case notes are discoverable in litigation and can be seen by Division staff with iRecord access. (When Division involvement or oversight is required, iRecord case notes are often reviewed first.) Email should **not** be copied and pasted directly into case notes. Rather, it is recommended to summarize email in case notes as appropriate/needed. For example, "SC emailed John Smith and Jane Doe from XYZ agency on 3/29/23 to request a status update on Susie. John replied the same day and advised that Susie is doing well and has an upcoming medical appointment in April. No concerns were reported."

When entering an iRecord case note, the user must select the most applicable note **Category** from the drop down list as shown below. The **Note Date** reflects the actual date the contact occurred. iRecord automatically fills in the **Entered Date** to reflect the date the note is entered into iRecord. For example, if a home visit occurred on 6/1/2023 and the note is entered on 6/2/2023, the SC selects the Category "HV – Home Visit Notes" and enter 6/1/2020 as the Note Date.

Note Category Drop-down List:

General Notes	CC – Case Conference Notes
ISP - ISP Meeting Notes	TI/TR – Telephone Call Initiated/Received Notes
UIR – Unusual Incident Notes	Waitlist Notes
DP – Visited Day Program Notes	On-call Notes
FV – Field Visit Notes	OI – Office of Investigation
HV – Home Visit Notes	CI/CR – Correspondence Initiated/Received

Decision-Making

Section 7.1.1 of the Division's policy manuals explains that the SC facilitates discussion at the annual Planning Team meeting regarding the level of decision-making support the individual requires. The following is a list of decision-making supports or "types" with a brief description of each:

Individual – The Planning Team determines the individual appears able to make informed decisions for themselves.

Individual with Supports – The Planning Team determines that the individual appears able to make informed decisions with support from family and/or other Planning Team members, as chosen by the individual. Support should be provided in the least restrictive manner possible.

Individual with Court Judgement – There are rare instances when a court has produced a judgement legally designating the individual as their own guardian. (Documentation should be uploaded in iRecord.)

Proxy Directive (Durable Power of Attorney for Healthcare) (healthcare proxy, living will, medical Power of Attorney) – A proxy decision-maker is a person appointed by the individual to make decisions on their behalf in the event they become incapacitated. All individuals with capacity are encouraged to complete proxy documents. The NJ Department of Health has a Proxy Directive / Designation of Health Care Representative form for formalizing a proxy decision-maker. Other common examples include Durable Power of Attorney for Healthcare and Living Wills. Documentation related to proxy designation should be uploaded in iRecord.

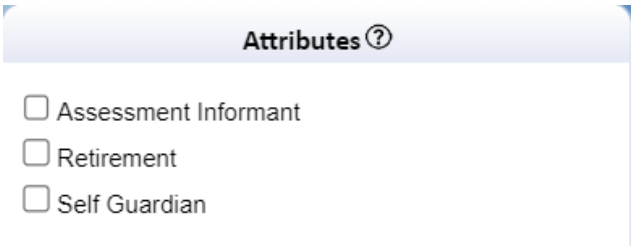
> **Note:** A proxy decision-maker must be designated while the individual has capacity. If it is determined or believed that the individual does not have capacity, they may not formally designate a proxy decision-maker.

Guardianship (Limited / Full) – A guardian is a person or agency legally authorized to act on the behalf of an incapacitated person. Guardianship is determined by a court, and the guardianship judgement specifies the parameters of decision-making of the assigned guardian. SCs use the "Contact Attributes" tile within the Contacts tab to designate the individual's legal guardian(s) and to select the appropriate guardianship type (General or Limited). Checking the "Legal Guardian" box on the Contact Attributes tile prompts the user to upload guardianship documentation in iRecord.

iRecord Documentation

Use the Attributes tile within the Contacts tab in iRecord to indicate decision-making supports as applicable according to the following: Legal Guardian, Power of Attorney or proxy decision-maker. If a legal judgment designates the individual as their own guardian, add them as a Contact and select "Self Guardian" on the Attributes tile.

Important: The "Self Guardian" checkbox is used **only** if there has been a legal judgment naming the individual as competent to be their own guardian. (If no legal guardian is named, leave blank.)

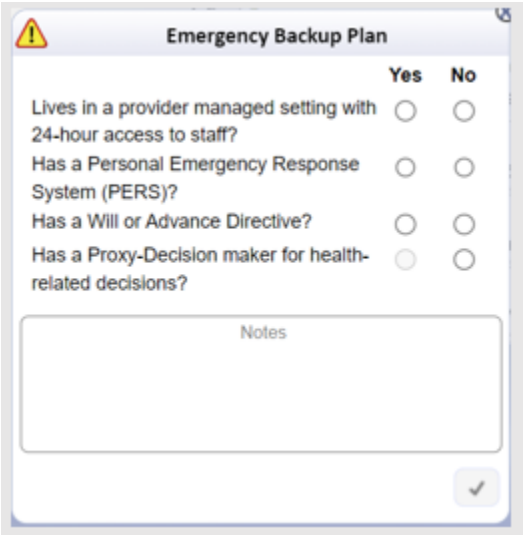


Emergency Backup Plans

iRecord includes an Emergency Backup Plan tile to document the backup plan in the event that necessary supports are unexpectedly unavailable. Macro plans cannot move forward until the Emergency Backup Plan tile is complete. After appropriately answering the Yes/No questions on this tile, the Notes section should describe **detailed** instructions and arrangements for reference if/when needed.

Notes:

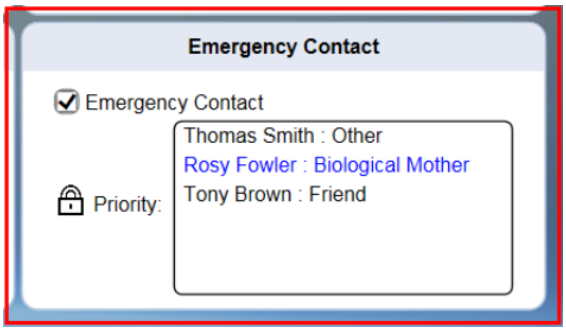
- SCs must ensure iRecord Contacts and Contact Attributes tiles are kept up to date.
- If a proxy decision-maker for health-related decisions is in place, it should first be indicated on the Contact Attributes tile. Then the "Yes" button for that line on the Emergency Backup Plan is enabled. Additional detail is to be included in the Notes box.
- A **successor guardian** is sometimes named as an alternate legal guardian in the event that the first appointed guardian is unable or unwilling to serve as guardian. ***If*** the individual's guardianship paperwork lists successor guardians, the SC documents this within the Relationships tile in the PCPT.



Emergency Contacts

SCs need to ensure all iRecord emergency contact information is up to date, including the emergency contact's full name, relationship to the individual, address, phone number (including alternatives if applicable; i.e. home, cell, work), and email address. To designate a contact as an "Emergency Contact," the SC needs to check the box within the

Emergency Contact tile. If more than one emergency contact is identified, a priority number is assigned to them, with priority number 1 being the highest. To change the priority order, click the "lock" icon, drag the contact to the appropriate position, and re-click the "lock icon" to save. Emergency contacts with the highest priority are listed first. The others are listed in order of decreasing priority.



Incident Reporting (IR)

- Incident Reports **are not** to be uploaded in iRecord, and **are not** to be copied/pasted into iRecord case notes. IR's are protected risk management documents and are not part of the individual's electronic record.
- An iRecord case note may be entered summarizing relevant information from the IR, and stating who is submitting the IR. The iRecord case note category is "UIR – Unusual Incident Notes."
- If a SC is made aware of an incident, ***after*** an IR has been completed and submitted, a case note should be entered to indicate awareness of the IR and to describe anticipated follow up. Subsequent notes will show the follow up that has occurred.
- Relevant status updates should be included in the next SC Monitoring Tool.

SCs and Service Providers are mandated to notify the Division immediately of all known or alleged reports of abuse, neglect and exploitation, as well as incidents involving injuries and life threatening emergencies.

Important Definitions:

- **Abuse** – physical, sexual, or verbal acts against a person served that cause pain, physical or emotional harm, mental distress, injury, anguish, and/or suffering.
- **Neglect** – the failure of a caregiver to provide the needed services and supports to ensure the health, safety, and welfare of the service recipient.
- **Exploitation** – 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 the exploitation of a service recipient by another person.

Reportable Incident Categories include: Abuse, Assault, Criminal Activity, Danielle's Law, Death, Exploitation, Injuries, Medical, Neglect, Operation, Unapproved Restraint, Rights Violation, Suicide Attempts, Sexual Contact, and Walkaways. See the Incident Reporting Levels and Categories Grid for a complete, detailed list.

If an individual or family member does not want to report an incident to an SC, they may utilize the **Abuse and Neglect Hotline** at **1-800-832-9173**. The Hotline is staffed with Office of Risk Management personnel familiar with incident reporting.

For additional information about SCA responsibilities regarding Incident Reporting refer to the Incident Reporting webpage and the ABC Manual.

Meeting Minutes

Meeting minutes are notes that provide a written record summarizing discussions and documenting decisions made by the Planning Team. Meeting minutes ensure there is an accurate record of past meetings for future reference and are shared with team members who didn't attend a meeting, to inform them of the meeting discussion and outcomes. Planning Team meeting minutes are documented on the ISP Revision and Notification Form.

In addition to acting as an official record of what happened during a meeting, minutes of meetings can also provide legal protection by showing due diligence and documenting actions planned by the team. Follow up actions should be documented in iRecord case notes and monitoring tools.

The following outline may help with successfully holding and documenting a Planning Team meeting:

1. **Plan the meeting agenda** or outline in advance and distribute the agenda to the Planning Team members.
2. At the beginning of the meeting, **establish** who will take the meeting minutes.
3. **Record** the date and time of the meeting, and the names of those attending and of those who are absent.
4. Document the **purpose** of the meeting.
5. Use the agenda to keep track of the key points discussed, and summarize the discussion under each point.
6. List action items to indicate who does what and when.
7. Upload meeting minutes in iRecord and share with group members promptly.

Stephen Komninos' Law

New Jersey's Stephen Komninos' Law went into effect on May 1, 2018. This law's requirements include that **all** persons working with people with developmental disabilities "report incidents or suspicions of abuse, neglect or exploitation." Criminal penalties and a monetary fine may apply if a person has reason to believe such an act has been committed and fails to report it. For more information, see the Stephen Komninos' Law page on the NJ Department of Human Services' website.

Support Coordinator (SC) Monitoring Tools

SCs are required to make monthly contact, quarterly face-to-face visits, and an annual home visit, each of which is documented on SC Monitoring Tools (current version January 2023). The date of contact (not the date of upload) must be entered when uploading the document under the Tools Tab in iRecord.

Monthly	Quarterly	Annually
• Contact may occur via Phone / Video Contact*, Face-to-Face Visit or Home Visit. • The Monthly Monitoring Tool may be completed two consecutive months, but not three consecutive months.	• Every three-month period must include at least one face-to-face contact. • Every three-month period must include completion of a Quarterly Monitoring Tool, including contact with providers, if applicable. • Use of the Quarterly Monitoring Tool may, but does not need to, coincide with face-to-face contact.	• At least once per year, monitoring must occur in person, within the home. • It is Best Practice to use the Quarterly Monitoring tool during the annual home visit.

*HIPAA-compliant video conferencing allows SCs to securely communicate with individuals without risking their privacy. A video conferencing platform is considered HIPAA compliant if it has implemented certain technical, administrative, and physical safeguards that meet the privacy and security requirements. The video conferencing platform is able to confirm whether it is considered HIPAA compliant. While secure video conferencing is allowable for monthly contacts, it does not "count" as face-to-face contact.

> **Note:** Monthly contacts are a minimum requirement, but depending on circumstances, more frequent contact may be needed.

When uploading completed Monitoring Tools, SCs are prompted to indicate which tool was used, "M" for Monthly or "Q" for Quarterly. Each three-month period must include completion of a Quarterly Monitoring Tool. After any two consecutive months of selecting "M" to indicate use of the Monthly Monitoring Tool, only "Q" is offered, indicating that use of the Quarterly Monitoring is due. iRecord does not offer an exception to this rule.

If it is not possible to complete monthly monitoring due to an unforeseen or unavoidable circumstance, the SC selects the "Not Completed" option in iRecord for that specific month. The SC should **not** upload a blank MT to remove Due-List items or Alerts. Using the "Not Completed" option removes these Alerts from both the SCs' and Support Coordination Supervisors' (SCS) Due-Lists. SCAs should not submit billing for services that were not rendered, such as billing for canceled appointments or no shows. See section 13 in the Division's policy manuals for additional details.

Support Coordination Supervisors (SCSs) are responsible for reviewing and signing the Monitoring Tools for the first 60 days of any new SC, when performance issues with an SC are identified, and for involved/difficult cases. SCSs should also be doing quality checks on SC Monitoring Tools to ensure they are being completed accurately and follow-up is occurring and documented appropriately.

Transportation

Transportation is a service that can be provided in different scenarios and by different types of staff. Transportation may be used to and from a service location, community outing, workplace, etc. The service may be provided by a contracted vendor, a Direct Support Professional (DSP) or a Self-Directed Employee (SDE).

When adding transportation services to a service plan, Support Coordinators (SCs) first choose which of the following three options reflects the transportation to be provided: Multiple Passenger, Single Passenger or Self-Directed Employee Transportation.

See further down in this chapter for sections on Day Habilitation Claiming and Transportation, Overlapping CBS/IS 15-Minute Rate and Transportation and Out-of-State Transportation. See the Division's Policy Manuals, chapter 17.21 for additional details.

Multiple Passenger
A standard rate per mile per passenger is used when a Medicaid/DDD approved provider is transporting more than one individual using their individualized budget to fund Division services. The multiple passenger rate is utilized for the entire trip, for each individual receiving the service – even when there is only one passenger in the vehicle because of being the first passenger picked up and/or the last passenger dropped off.

Procedure:	Transportation	**Provider:**	Medicaid/DDD Approved Provider
Code:	A0090HI22	**Fiscal Intermediary (FI):**	N/A
Funding Source:	Medicaid	**Unit Type:**	Miles
Claims:	Medicaid	**Rate:**	$0.76

Multiple Passenger Transportation Prior Authorization

a. This transportation option is entered into the ISP the same way that any other service is typically entered. DDD service approval is not necessary. When the ISP is approved, the service is prior authorized.
b. It is the responsibility of the SC to indicate the chosen provider, mileage, dates of service, etc. in the ISP. The identified multiple passenger transportation provider receives prior authorization upon ISP approval and claims to Medicaid (through Gainwell Technologies) for reimbursement of delivered services.

Single Passenger
Due to the reasonable & customary rate, requests for this service must be submitted to the Division for service review and approval prior to use. (iRecord initiates service review when this service is selected.)
This service is entered when:

- a community vendor or Medicaid/DDD approved provider is transporting a single individual during the entire trip, OR
- a community vendor **whose sole or primary business is providing transportation to the general public**, is transporting one or more individuals receiving DDD-funded transportation services.

Procedure:	Transportation	**Provider:**	Public Partnerships
Code:	A0090HI	**Fiscal Intermediary (FI):**	Public Partnerships
Funding Source:	Fiscal Intermediary (FI)	**Unit Type:**	Miles
Claims:	FI (Agency)	**Rate:**	Reasonable & Customary

Single Passenger Transportation Prior Authorization

- The SC enters the transportation service in the ISP using the A0090HI (single passenger rate) procedure code.
- Upon selecting this procedure code, iRecord provides the prompt, "Upload Service Request." The SC uploads the completed Single Passenger Rate Transportation Request in iRecord.
- The SC submits the ISP to Review, and the Support Coordination Supervisor (SCS) reviews and submits to Service Review.
- When the service is approved, the ISP is able to be approved and prior authorization is provided to the fiscal intermediary.
- The transportation provider submits invoices to the fiscal intermediary for payment.

Self-Directed Employee Transportation

For use when a Self-Directed Employee (SDE) is being hired by the individual to provide transportation.

Procedure:	Transportation	**Provider:**	Public Partnerships
Code:	A0090HI52	**Fiscal Intermediary (FI):**	Public Partnerships
Funding Source:	Fiscal Intermediary (FI)	**Unit Type:**	15 Minutes
Claims:	FI (Agency)	**Rate:**	Reasonable & Customary

SDE Transportation Prior Authorization

- All of the standards of hiring SDEs and processing payments apply for this transportation option. The process is conducted in the same manner that any other SDE is identified, hired, entered into iRecord, etc.
- Typical standards related to SDEs apply. For example, employer-related taxes are withheld by the fiscal intermediary on behalf of the employer, and the hours utilized to provide transportation count toward the total hours worked per week. (At this time overtime is allowed.)
- If the rate is outside of what is considered reasonable & customary, the Single Passenger Rate Transportation Request to request approval prior to use.

Important: Transportation is **not** submitted as a goods & services request.
Exception: Per section 17.21.4.3 of the Division's policy manuals, if a generic transportation service has an additional flat or boarding fee, the request to cover that additional cost must go through Goods & Services. (The process to request Goods & Services is described in section 17.10.5.1 of the Division's policy manuals.)

Notes:

- In situations where an individual is in need of one-to-one supports while being transported, usually due to safety concerns, Community Based Supports (CBS) (for individuals in the Supports Program) or Individual Supports (for individuals in the Community Care Program) can be provided in addition to transportation. **These additional services cannot be delivered by the same staff/SDE providing the transportation. The driver solely provides transportation and an additional staff/SDE provides CBS or Individual Supports.**
- The driver can provide additional services, if he/she meets the qualifications to deliver the service, during times in which transportation is not taking place. For example, an SDE can provide transportation services while driving an individual to and from the grocery store. Upon arrival at the grocery store, the same SDE may provide Community Based Supports within the store to assist the individual in completing their shopping (as long as the SDE meets the criteria for providing Community Based Supports). Once shopping is completed, the same SDE can provide transportation services to drive the individual back home or to another location.

Day Habilitation Claiming and Transportation
Per section 17.7.5.9 of the Division's policy manuals, the Day Habilitation rate includes pick up and drop off transportation for individuals residing within the Day Habilitation Provider's defined catchment area. Catchment area and reasonable pick up and drop off hours are submitted to the Division during the provider application and/or Day Habilitation certification process. In situations where the Day Habilitation Provider is providing pick up and drop off transportation, the provider claims for Day Habilitation services beginning when individuals arrive at the Day Habilitation location. (The time spent providing pick up and drop off services is not included in the billing process.) Day Habilitation Providers may only bill for transportation for miles driven beyond the established catchment area.

The Day Habilitation Provider can claim for transportation provided to and from Day Habilitation activities in the community in one of two ways:

- Transportation to and from the community activity is provided and funded through transportation services as long as the Day Habilitation Provider is also Medicaid/DDD approved to provide transportation services and transportation services are prior authorized per the ISP, OR
- Day Habilitation is being provided on the vehicle while traveling to and from the community activity so the service is documented and claimed as Day Habilitation, as long as it has been prior authorized per the ISP.

Notes:

- If transportation is provided to an individual living outside the catchment area by a *separate* transportation provider, the entire trip may be entered and claimed for by the separate transportation provider.
- The Day Habilitation rate includes transportation to the service. Therefore, if an individual lives in the Day Habilitation Provider's established catchment area, Day Habilitation Provider is responsible for providing transportation. The individual is not able to use their budget to purchase transportation services to and from the day program.

Overlapping CBS/IS 15-Minute Rate and Transportation
Community Based Supports (CBS) and Individual Supports 15-minute Rate may **only** be provided **at the same time** as transportation if it has been documented in the service plan that a medical or behavioral need requires provision of CBS/IS 15-minute Rate during transportation by a second support staff (in addition to the driver) to ensure the safety of the individual. It is recommended that SCs and Service Providers review ISPs with CBS/IS 15-minute Rate and transportation services to ensure accuracy. To report compliance issues, email DDD's Care Management & Provider Support Unit at DDD.PPMU@dhs.nj.gov.

Out-of-State Transportation
Transportation can be used out of state through a ride-hailing app, such as Lyft, Uber, etc., as long as the service is provided by a vendor approved to provide third party subcontracting services for single rate transportation and the maximum one-way distance is less than 150 miles. Examples of situations where this may apply include traveling to a neighboring state to visit a family member or friend, or to attend an appointment.

Waiver Services

This chapter provides an overview of selected services, key factors and tips for moving services forward. A complete list of services, along with detailed information, is found in section 17 of the Division's policy manuals.

1. Community Based Supports / Individual Supports 15-Minute Rate

Note: Family members hired as SDEs are required to adhere to the same rules and policies as any SDE or agency-employed DSP.

- Service documentation must be maintained by the SDE/DSP.
- A single SDE/DSP may not be regularly scheduled to work more than 16 consecutive hours within a 24-hour period.
- Overtime is not to be regularly relied on in the Individualized Service Plan (ISP). A sufficient number of staff (Self-Directed Employees and/or Direct Support Professionals) should be in place to meet an individual's care needs without the regular need for overtime.

- To deliver and claim for in-home, overnight services, the individual's service needs for awake, overnight services must be approved by DDD and be clearly identified and articulated in the ISP.
- SDEs/DSPs cannot be reimbursed to support or stay with an individual during hospitalization. This is considered duplicative of the support received in the hospital.

2. Community Inclusion Services/Individual Supports (IS) 15-Minute Rate when Receiving IS Daily Rate

The Community Inclusion Services/Individual Supports 15-minute Rate Request form is used when an individual who receives Individual Supports Daily Rate is in need of additional support through Community Inclusion Services (CIS) or Individual Supports (IS) 15-minute Rate.

A yellow litmus strip automatically appears when these services are entered into an ISP for someone already receiving IS Daily Rate to indicate Division service review is needed. Details regarding the need for both service types must be documented on the request, including a weekly schedule of the days and times the requested services are to be used. See the section, Service Review Process for additional information.

3. Day Habilitation

The Day Habilitation service only draws funding from the Employment/Day budget component and is limited to 30 hours (120 units) per week. Service entry must match the information provided by the Planning Team and/or documented on the Provider ISP Worksheet.

- 6 hours per day = 24 units per day = 120 total weekly units
- 5 hours per day = 20 units per day = 100 total weekly units

Exception weeks

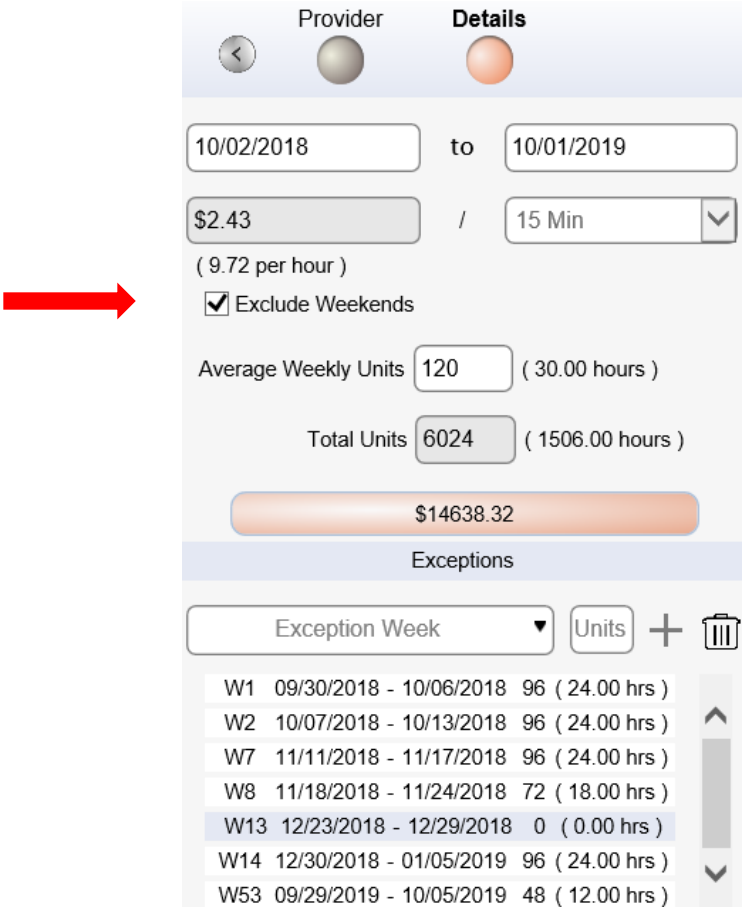
Exception weeks must be selected and edited (units removed) to account for program closures/holidays.
Important: If exception weeks are not entered accurately for the entire plan term, the budget may be over obligated and iRecord will not allow the plan to move forward.

For example, if the individual attends Day Habilitation 6 hours per day/120 units per week and the program is closed for a holiday (one day), 24 units are removed from that week, making that week's total units 96. If the Employment/Day budget component remains over-obligated after **all** units for program closures/holidays are removed, the SC should remove/zero-out units from the last exception week backwards until the service is within budget. Unused/carry over units accumulated throughout the plan year should permit the individual to attend the program during the final days of the plan, for which units were "zeroed out."

Important: The "Exclude Weekends" checkbox is an optional iRecord feature, but its use is strongly encouraged. When selected, iRecord automatically adjusts the units for the first and last exception weeks.

Notes:

- Once the plan is approved, the Support Coordinator (SC) is not able to check or uncheck the Exclude Weekends checkbox.
- The annual Employment/Day budget component is calculated based on the individual's tier. A 5% absentee rate is factored into the Day Habilitation rate to account for time that the individual might not attend the program.
- When Day Habilitation Providers accept an individual to their program, the provider is required to provide the level of service needed to ensure health and safety. An additional one-to-one support staff providing CBS/IS (15-min. Rate) cannot accompany an individual to a day program. (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.)
- Providers are encouraged to attach a program calendar to the ISP Worksheet for Day Habilitation Providers so weekends/holidays/in-service days can be accounted for in Exceptions.



4. Goods & Services

Good & Services (G&S) are services, equipment, or supplies that meet the following criteria:

- Not available through another source/resource, including the Supports Program, Community Care Program, Medicaid state plan, other public funding source, family, friends, co-workers, etc.
- Address a disability-related need identified in the individual's NJCAT assessment, and referenced in the PCPT and ISP
- Decrease the need for other waiver services
- Available to the general public and fully integrated in the community (whether in-person or virtually)
- Do not benefit someone other than the individual

Goods & Services (G&S) are accessed through community vendors who typically offer goods and services to the general public. These venders do not need to become DDD/Medicaid approved providers, but they must complete vendor enrollment through the fiscal intermediary to receive payment. See the chapter, Fiscal Intermediary, for more information. SCs should ensure a community vendor is aware of the billing process and is willing to accept payment via voucher before adding the G&S into the plan.

Important Reminders:

- G&S services are billed through the fiscal intermediary. Therefore, the SC enters this service using FI (Agency) as the Payment Source and the name of the FI agency as the provider depending on the SDE model the individual is enrolled in. See the chapter, Fiscal Intermediary (FI), for information about fiscal intermediaries.
- Students seeking a degree or college credits need to apply for federal aid through the Free Application for Federal Student Aid (FAFSA) prior to submitting the G&S request. FAFSA results must be submitted at the time the G&S Request Form is submitted.
- G&S services related to medical needs or durable medical equipment (DME) must be submitted through the individual's medical insurance and/or Medicaid prior to making the request to DDD. If the request is denied by insurance, the appeals process should be followed before submitting to Service Review. Supporting documents,

including current medical prescription, denial letters and the official outcome of the appeal need to be uploaded with the Goods and Services Request Form.

- Reimbursement for gym membership fees may only be requested for the individual. Requests for family members, staff, or SDEs are not approved.
- Transportation, Vehicle Modifications, and evaluations or purchases of Assistive Technology and Environmental Modifications are **not** submitted under G&S. Each of these services/items have specific procedure codes.

Activity Fees

G&S activity fees can fund the cost of admission for both an individual and a Direct-Support Professional (DSP) for events and activities available to the general public that are not solely for entertainment or recreational purposes. Activity fees are used to assist the individual in participating in waiver services in the community when other means to pay these fees are not available. Activity fees are capped at $1,000.00 per year and $50.00 per person per activity. For more information about activity fees for Self-Directed Employees (SDEs) see the section, SDE Activity Fee Reimbursement, in the fiscal intermediary chapter.

Classes

Funding for individuals to develop/build skills by attending classes that are available to the general public may be available through Goods & Services within the Division's Supports Program and Community Care Program when other means to pay for these classes are not available and those classes meet the specific Goods & Services criteria. An individual may attend classes either in-person or virtually for up to 12 hours per week.

When developing an ISP that includes one or more classes, it is important that the individual and SC understand how the classes are offered and priced. Some classes are offered and priced as individual sessions, with a per-session cost. Other classes are offered and priced as seasonal semesters or bundled/group packages, where multiple sessions are included in one package with a per-package cost. It is also important to understand the community vendor's policies about class attendance and refunds, in case the individual needs to miss a session or decides they no longer want to attend. Once the vendor has been paid, those funds cannot return to the budget.

When entering classes in the ISP under the Goods & Services category, it is essential that the SC knows and correctly enters details about how the classes are offered and priced. Below are two examples:

- Example 1: A community vendor offers 10 class sessions at a cost of $25 per class or session. In this case, the SC adds ten units of service at the unit rate of $25.
- Example 2: A community vendor offers 10 class sessions per semester at a cost of $150 per semester. In this case, the SC adds a single unit of service at the unit rate of $150.

In all cases, the SC enters the community vendor's name and contact information and a brief description of the service (e.g. 10 sessions of virtual cooking class) in the service description field.

Notes about Classes:

- Initial/New Requests: Approvals for **new** classes through Goods & Services are generally given for three months, to allow time for the individual to attend the class (virtually or in-person) and make an informed decision about attending over a longer time period before committing a potentially non-refundable portion of their budget.
- Renewals: After the initial three month approval, if the individual remains interested and would like it to be a longer term service, SCs may submit a service request for the remainder of the plan term. Thereafter, requests for the service to be approved for the full plan term can occur.

Goods & Services - iRecord Service Entry

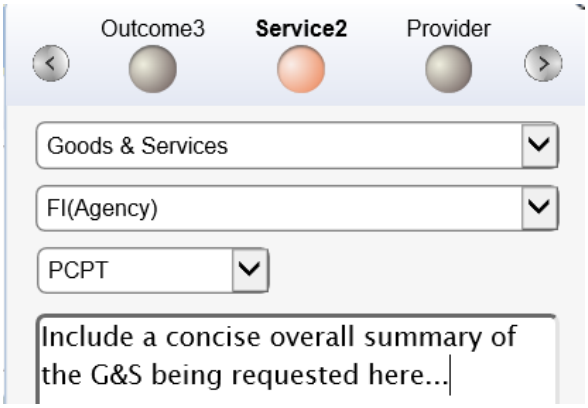
All Goods & Services requests are submitted to the DDD Service Approval Team through the Service Review feature in iRecord.

Notes:

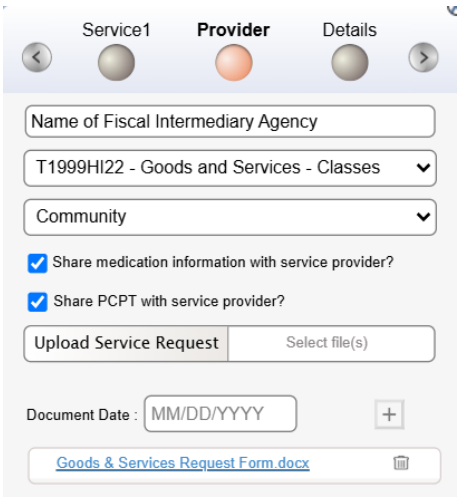
- It is the SC's responsibility to ensure the service request meets the service definition and requirements prior to submission for Division review. If it does not, the SC must inform the individual/legal guardian that the requested service is not funded through the Division and provide alternate options.
- The G&S request must be submitted and approved **before** the service can be accessed/item can be purchased/class can be attended.
- Each service/item is reviewed against standardized criteria. For example, the cost is reviewed against what is reasonable and customary for that specific service/item within the same geographical location.

Steps for Submitting a Goods & Services Request

1. Upload all supporting documentation together as one document in iRecord. Supporting documentation includes the invoice, balance due statement or cost quote together with the signed Goods and Services Request Form.
2. When prompted to enter a case note, include the associated outcome and service number.
3. Enter the Goods & Services directly into the plan under the corresponding Outcome:
   a. Service Type – Goods & Services
   b. Payment Source – FI (Agency)
   c. Service Description Box – Include a concise overall summary of the G&S being requested. Enter the following:
      a. the name and contact information of the vendor (address, phone, email, website)
      b. a summary of the goods and services being requested



4. Select the fiscal intermediary agency as the provider (depending on the SDE model the individual is enrolled in)
   a. Procedure Code - 'T1999HI22 – Goods and Services'.
   b. Enter location according to the G&S type, 'Community' or 'Home'.
   c. After clicking on the plus sign icon, and selecting the file, it appears on the tile.



5. Within the Details tab, enter the remaining information including cost, duration, and frequency.
   Note: When requesting an item or "good" or a yearlong service (i.e. Gym membership), one-time cost service entry must be utilized and described in the One-time Cost Services section.
6. Once the service is entered and all necessary documentation is uploaded, the SC changes the plan status to 'Review'.
7. The Support Coordination Supervisor (SCS) reviews the request and service entry for accuracy and if everything has been entered correctly, changes the plan status to "Service Review". A yellow litmus appears next to the associated Outcome and Service.
8. When a determination is made (Approved or Denied), the DDD service reviewer changes the plan status back to "Revision" (RV). **Note**: The plan is always changed to "Revision" status regardless of the determination or the agency's ability to approve their own service plans.

   If approved, the litmus strip turns green, and the SC follows their typical plan approval process.
   a. Even though a G&S is approved via Service Approval the ISP must be approved before the service starts/item is purchased.
   b. When the ISP is approved, the SC must send the SDR to the vendor and individual/legal guardian.

   If denied, the litmus strip turns red, and the SC reviews the DDD Service Reviewer's notes entered in iRecord case notes.
   a. A request may be denied *pending* additional information, clarification or corrections to the Goods and Services form. This is not a final denial. The DDD reviewer may advise SCAs to explore other resources (i.e. generic and community resources, utilizing the MCO State Plan, or other services that are available in the Division's policy manuals). Inquiries are sent directly to DDD.ServiceApprovalHelpDesk@dhs.nj.gov.
   b. If applicable, resubmit the request with revisions/adjustments, per reviewer's feedback. If revisions to the plan are needed (i.e. change in rates, units, dates), the SC must upload a revised ISP with a new individual/legal guardian signature.
   c. If the request is denied because it does not meet Medicaid criteria, the SC must inform the individual/legal guardian, assist them in understanding why and inform them that they will receive a letter from the Division informing them of their right to Fair Hearing.

   Refer to the Support Coordination Information webpage to access the Goods & Services Request Form and Instructions.

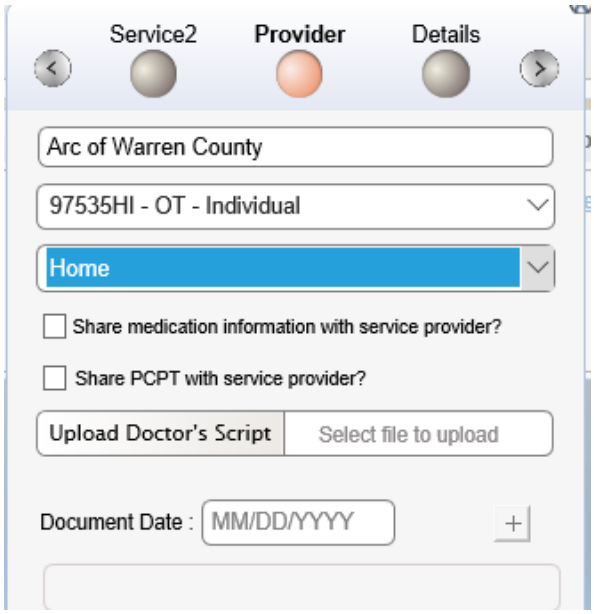
Goods & Services - Budget Flexibilities

The G&S service line draws funding from the Employment/Day and Individual/Family Supports budget components. If the available/remaining budget does not cover the entire cost of the G&S request, the individual or family may pay for the difference, spread the cost across plan years/terms, or request to use funding from an alternate budget component if funding is available. Questions related to this process can be directed to DDD.ServiceApprovalHelpDesk@dhs.nj.gov.

5. Habilitative Therapies in the Fee-for-Service System

Individuals enrolled in the SP or CCP do not require a denial from the individual's Medicaid Managed Care Organization to access Division funded therapies that are habilitative in nature. This includes Physical Therapy, Occupational Therapy, and Speech, Language and Hearing Therapy. As with all medically necessary services, a health care professional must document that the applicable service is necessary for habilitation. When entering the service in iRecord, the Provider section prompts the SC to upload the prescription. The SC must upload a copy of the prescription and medical documentation as one document. After clicking on the plus sign icon, and selecting the file, it appears on the tile.

Updated prescriptions are required annually, and the dates must align with service entry. For example, if a prescription for PT services is written for 6 months, the service dates should also be for 6 months. These therapies are only funded through the Individual/Family Supports Budget component and require EVV (Electronic Visit Verification).



6. Personal Emergency Response System (PERS)
A Personal Emergency Response System (PERS) is an electronic device that enables individuals to call for help in an emergency. The system is connected to the individual's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. Service entry may include the purchase, the installation, a monthly service fee, or all of the above. All PERS requests are subject to prior approval on an individual basis by DDD. Requests for PERS systems go through the same review process as Goods & Services. When an SC enters the service in the ISP, a yellow litmus strip appears until a determination is made.

7. Supports Brokerage
Supports Brokerage is a service provided by trained professionals called Supports Brokers. Supports Brokers work with individuals and/or families who are self-directing some or all of their services and assist with identifying immediate and long-term needs and goals as well as accessing services and supports. Supports Brokers can assist an individuals with arranging, directing, and managing their self-directed services.

The Supports Broker has a variety of responsibilities and provides customized assistance based on the individual's needs, goals, and preferences, with the overall mission of helping the individual achieve self-directed outcomes. The extent of assistance provided by a Supports Broker to an individual or family is specified in the Individual Service Plan (ISP). Supports Brokers supplement, not duplicate, services provided by an SCA or SC.

Additional information about Supports Brokerage can be found through these resources:

- DDD Webinar: Understanding Supports Brokerage Services: An Overview for Support Coordinators
- The Boggs Center Resources / Publications webpage
- The DDD Supports Brokerage webpage

Appendix A - 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 of Developmental Disabilities' 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.

Home and Community-Based Services (HCBS) – Medicaid-funded services and supports that are provided to individuals in their own home or community. HCBS programs serve a variety of targeted populations groups, including individuals experiencing chronical 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 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 their 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, internet-based electronic health record application.

Level of Care – the assessed level of assistance an individual requires in order to meet their 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/caregivers 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 the program a person is eligible for.

NJ Comprehensive Assessment Tool (NJCAT) – 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 on the Planning Team as established by the individual.

Provider Search Database – a searchable database of approved Service Providers.

Service Provider – the entity or individual who provides 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 with the participant, their family, and other 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 in the Community Care Program (CCP).

Appendix B - Commonly Used Acronyms

APS – Adult Protective Services
AWC – Agency with Choice
BGS – Bureau of Guardianship Services
CAR – Support Coordination Unit Communication, Administration & Regulation Team
CCP – Community Care Program
CDU – Community Development Unit
CIMU – Critical Incident Management Unit
CTU – Community Transitions Unit
DDD – Division of Developmental Disabilities
DVRS – Division of Vocational Rehabilitation Services
E&T - Support Coordination Unit Education & Training Team
EQC - Support Coordination Unit Evaluation, Quality & Compliance Team
FFS – Fee-for-Service
HCBS – Home and Community-Based Services
HIPAA – Health Insurance Portability and Accountability Act
ICM – Intensive Case Management
IDT – Interdisciplinary Team, sometimes referred to as Planning Team
IR (formerly 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 – Support Coordinator 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 – Pre-Admission Screening and Resident Review
PCPT – Person-Centered Planning Tool
PDN – Private Duty Nursing
PEA – Participant Enrollment Agreement
QAS – Quality Assurance Specialist
RCR – Retroactive Change Request
RTR – Residential Transfer Referral
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 C - Directory of DDD Units

Care Management & Provider Support Unit
The Care Management component of this unit responds to Seeking Out Support (SOS) Forms and provides case-specific assistance and guidance to Support Coordination Agencies. This group also manages the Support Coordination Helpdesk, DDD.SCHelpdesk@dhs.nj.gov.

The Provider Support component of this unit provides guidance, training and accountability to service providers. This group manages the Provider Helpdesk, DDD.PPMU@dhs.nj.gov

Community Development Unit
Manages the Community Care Program (CCP) waiting list and monitors existing residential vacancies; processes the Residential Referral Coversheet form when it is used to request assistance in urgent situations and or to post a residential referral to the File Transfer Program Secure (FTPS) server, a secure online site for providers to review prospective referrals

Community Transitions Unit
Provides care management for individuals who live in institutional settings and are interested in returning to the community; manages all aspects of an individual's move when they return to the community.

DDD-IT
Responsible for iRecord maintenance and updates, and also responds to requests for assistance through JIRA tickets.

Bureau of Guardianship Services (BGS) / Guardianship Liaisons
BGS, under the Department of Human Services, provides guardianship services for individuals when a court has determined that guardianship is needed and there are no family members able or available to do so. BGS also processes guardianship referrals.

Guardianship liaisons are Division employees who ensure that guardianship referrals are complete before forwarding to BGS for processing. They also coordinate aspects of the guardianship determination process such as Proof of Service. See the ABC Care Management Manual for additional information.

Housing & Resource Development Unit
Works with agencies to expand community resources; ensures Home and Community-Based Services (HCBS) compliance; determines eligibility for Supportive Housing Connection (SHC) housing subsidies.

Intensive Case Management and Intake Unit
Processes Intensive Case Management (ICM) Referral forms and provides intensive assistance with individuals who meet criteria for immediate residential placement.

Intake assists individuals and families through the application processes for DDD services and determines eligibility. Those who are interested in applying for Division services should contact the Community Services Office for the county in which they reside.

NJCAT / Level of Care Unit
Conducts New Jersey Comprehensive Assessment Tool (NJCAT) assessments and reassessments; evaluates individuals' support needs to determine whether they meet level of care criteria for the Community Care Program (CCP).

Office of Education on Self Direction, Waitlist and Special Projects Unit.
Provides education and training for individuals, families, community partners and stakeholders to help people understand how self-directed services can work. For more information, see the Office of Education on Self-Directed Services page.

Involved when an individual is reached on the CCP Waiting List to help individuals and families understand their options and to coordinate the next steps; handles special Division projects as needed.

Office of Risk Management (ORM)
Receives and processes all Incident Reports (IRs), and tracks them for appropriate follow up and closure.

Office of Transition to Adult Life & Employment
Coordinates educational presentations and welcome sessions for individuals and families who are preparing to complete their educational entitlement and are interested in learning what DDD has to offer and are preparing for adult life. See the Transition from School to Adult Life page for additional information.

Manages initiatives in line with New Jersey being an employment-first state; manages the Employment Helpdesk, DDD.EmploymentHelpdesk@dhs.nj.gov, which processes the Continuation of Prevocational Training Justification, the Supported Employment Funding Request and the Early Retirement Request.

PASRR Unit
Conducts Pre-Admission Screening and Resident Review (PASRR) assessments; manages the PASRR Helpdesk, ddd.PASRR@dhs.nj.gov, which should be notified of all nursing home admissions and discharges, and transfers from rehab to long-term care.

Support Coordination Unit
Comprised of three teams that work collaboratively to ensure individuals enrolled in the Division receive high quality services and support through the oversight and quality monitoring of SCAs. Each team has unique and specific functions and responsibilities.

- **Communication, Administration & Regulation (CAR):** Develops SCA/SCU communications (SCA Webinars, newsletters, email, etc.); SCA form and guidance document development and revisions; special projects.
- **Education & Training (E&T):** Develops, coordinates, provides and tracks SCA and SCU training and orientation; determines training and development needs; special projects related to training and development.
- **Evaluation, Quality & Compliance (EQC):** Evaluates and monitors the performance and documentation quality of SCAs; ISP reviews/approvals for unreleased SCAs; provides technical support to SCAs broadly and through the assignment of a Quality Assurance Specialist to each SCA.

Waiver and Quality Unit
Assists with various aspects of Medicaid eligibility and Medicaid waivers, including the following:

- applications for the Community Care Program (CCP) & Supports Program (SP) Medicaid when an individual's income is over the limit for other Medicaid programs
- Medicaid redeterminations
- a Division liaison with Medicaid
- transfers between Medicaid waivers

Manages the Medicaid Eligibility Helpdesk, DDD.MediElighelpdesk@dhs.nj.gov, which processes the Medicaid Eligibility Troubleshooting Form and assists with the following:

- voucher payments when there is a temporary loss of Medicaid
- enrollments onto the Supports Program + Private Duty Nursing (SP+PDN)
- transfers from MLTSS to all DDD waiver programs (CCP, SP, SP+PDN)

Conducts quality review audits and is involved in updating systemic processes when needed.