**New Jersey Department of Human Services**

**Division of Developmental Disabilities**

**Support Coordinator Monitoring Tool - Monthly**

Used in months when a Quarterly Monitoring Tool is not due, to document monitoring contact with Individuals and caregivers.

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| **Section 1: Identifying Information** | | | | | | |
| Individual’s Name: Click to enter text.  DDD ID #: Click to enter text.  NJCAT Score: Self-Care, Behavioral, Medical  Tier: Choose an item. | | Current Program: Choose an item.  Current Living Arrangement: Choose an item.  If Other, please describe: Click to enter text.  Is an Approved ISP in Place? Yes  No | | | | |
| Name of Support Coordination Agency: Click to enter text. | | | | | | |
| Name of Assigned Support Coordinator: Click to enter text. | | | | | | |
| Contact Date: Enter a date. |  | | | | | |
| Contact Location: Choose an item. | If Other, please describe: Click to enter text. | | | | | |
| Contact Type: Choose an item. | If Phone, enter the phone #: Click to enter text. | | | | | |
| Who is the primary contact for this **Monthly** monitoring? Click to enter text.  Relationship to the Individual: Click to enter text.  If the Individual is not the primary contact, were they involved in the conversation? Yes  No  Please describe or explain: Click to enter text. | | | | | | |
| **Section 2: Follow Up Items from Previous Months’ Contact** | | | | | | |
| List follow up items **not** resolved at the time of last contact, indicating the status of each. Ensure all follow up activity is documented in case notes. To add rows, click in the last box, then click the Plus sign, **+**, on the right. | | | | | | |
| Follow Up Item: Click to enter text.  Completed/Resolved? Yes No  If no, briefly describe the status **and** planned action: Click to enter text. | | | | | | |
| Follow Up Item: Click to enter text.  Completed/Resolved? Yes No  If no, briefly describe the status **and** planned action: Click to enter text. | | | | | | |
| Follow Up Item: Click to enter text.  Completed/Resolved? Yes No  If no, briefly describe the status **and** planned action: Click to enter text. | | | | | | |
| **Section 3: Outcomes and Services** | | | | | | |
| **Review ALL** current outcomes and services as they appear in the ISP with the Individual/MT contact. Include services provided by natural supports. If there are **no** funded services in the ISP, **explain** why not. | | | | | | |
| 1. ***(For the SC)*** Has a verbal review of outcomes and services been completed? | | | Yes |  | No\* |  |
| 1. Are you receiving **all** services as entered in the ISP? | | | Yes |  | No\* |  |
| 1. Do you feel your services are helping you make progress toward ISP outcomes? | | | Yes |  | No\* |  |
| 1. Are there outcomes or services you would like to change, add, or remove from your ISP, including changes to any service providers you may use? | | | Yes\* |  | No |  |
| **Comments / Follow Up Items *\*Explain each answer with an asterisk. Include follow up items as applicable.*** | | | | | | |
| Click to enter text. | | | | | | |
| **Section 4: Continuity and Stability with Living Arrangement** | | | | | | |
| 1. Is there anything happening now that might require a change with your housing?   (For example: behind on rent, significant problems with housemates, desire to live in another setting/location, etc.) | | | Yes\* |  | No |  |
| 1. Have any Incident Reports been completed/submitted since last monitoring interaction? (According to iRecord notes, email notification, conversations, etc.) | | | Yes\* |  | No |  |
| **Comments / Follow Up Items *\*Explain each answer with an asterisk. Include follow up items as applicable.*** | | | | | | |
| Click to enter text. | | | | | | |
| **Section 5: Health and Safety** | | | | | | |
| 1. Have there been changes to your health since last month, including medication changes? (Physical, emotional, behavioral, psychological, etc.) | | | Yes\* |  | No |  |
| 1. Have you been hospitalized or visited an emergency room since last month? | | | Yes\* |  | No |  |
| 1. Have you had medical/dental/specialist appointments since last month? | | | Yes\* |  | No |  |
| 1. If yes, did the doctor/dentist/specialist make any follow up recommendations that are not yet completed and/or scheduled? | | | Yes\* |  | No |  |
| **Comments / Follow Up Items *\*Explain each answer with an asterisk. Include follow up items as applicable.*** | | | | | | |
| Click to enter text. | | | | | | |
| **Section 6: Medicaid Status** *(SC will find status of a and b below on Individual’s Demographics tile in iRecord)* | | | | | | |
| 1. Is the Individual Medicaid eligible? ***(Indicated by green litmus)*** | | | Yes |  | No\* |  |
| 1. Is the Individual’s Medicaid scheduled to terminate? ***(Indicated by yellow litmus)*** | | | Yes\* |  | No |  |
| **Comments / Follow Up Items *\*Explain each answer with an asterisk. Include follow up items as applicable.*** | | | | | | |
| Click to enter text. | | | | | | |
| **Section 7: Areas Requiring Division Assistance** | | | | | | |
| 1. Is this the **fourth** consecutive month (or more) for which you have not been able to complete a face-to-face visit? | | | Yes\* |  | No |  |
| 1. Have risk factors been identified for which Division assistance is needed?   (Ex: Significant changes in the Individual’s/caregiver’s support needs, behavioral/medical concerns, housing instability, long-term hospitalization/nursing home admission, etc.)  **If either *a*. or *b*. is Yes, complete/upload an SOS form and notify the** [DDD SCHelpdesk](mailto:DDD.SCHelpdesk@dhs.nj.gov) | | | Yes\* |  | No |  |
| **Comments / Follow Up Items *\*Explain each answer with an asterisk. Include follow up items as applicable.*** | | | | | | |
| Click to enter text. | | | | | | |
| **Section 8: Closing Question for the Individual/Caregiver** | | | | | | |
| Is there anything else you would like me to know right now, or anything else you need assistance with? | | | | | | |
| Click to enter text. | | | | | | |
| **Section 9: Contact Summary** | | | | | | |
| Summarize the conversation describing highlights and points of interest or concern for the Individual since the last contact. Include observations and impressions **other than** information already included above. | | | | | | |
| Click to enter text. | | | | | | |
| **Section 10: Completed by** | | | | | | |
| Name: Click to enter text.  Title: Click to enter text. | | Date: Click to enter a date. | | | | |
| If completed by someone other than the assigned Support Coordinator, please explain: Click to enter text. | | | | | | |
| **Section 11: Reviewed by – *SCS review is required for the first 60 days of any new Support Coordinator, when performance issues have been identified and for complicated or difficult situations.*** | | | | | | |
| Name of SC Supervisor: Click to enter text. | | Review Date: Click to enter a date. | | | | |