|  |  |
| --- | --- |
| Name of Individual:       | Date of Planning Meeting:       |
| DDD ID#:       | Day Provider:       |
| SC:       | SCA:       |

**SUPERVISION**

Supervision needs are documented in the Safety and Supports tab under the Support Settings Tile. The *reason* for the supervision need is further documented in the associated tile (I.e. Behavior/Sensory, Mobility/Adaptive equipment, Self-Care, Dietary, Health Hazards/Concerns). Remember to consider support needs around meal time and medication administration.

**Do you have opportunities to be alone?**

At Day Service: **(Document under Work)** [ ] Yes [ ] No

Where, When, and for How long?

Are you able to evacuate independently in event of an emergency or would you need assistance?

**(Document under Work):**

In Community: [ ] Yes [ ] No

Where, When, and for How long?

While in a vehicle: **(Document under Community)** [ ] Yes [ ] No

Where, When, and for How long?

Do you travel independently? **(Document under Community)** [ ] Yes [ ] No

Parameters of independent travel:

**Further Meeting discussion / Recommendations:**

**MEDICATION ADMINISTRATION**

If independent with a Medication, the Self-Medicate check box should be checked with each applicable medication under the Medication tile. If not independent, the assistance needed for each medication must be documented within each medication box.

Do you need help taking your medication? [ ] Yes [ ] No

Detailed description of the assistance that is needed:

If independent, where is my medication stored, how do I access it and how is it kept safe?

**Further Meeting discussion/Recommendations:**

**FINANCIAL REVIEW**

Assistance with finances is documented under the Support Settings – Community.

What do you like to do with your money?

Do you feel comfortable making purchases on your own? [ ] Yes [ ] No

Is assistance needed with making purchases? [ ] Yes [ ] No

If yes, what do you need assistance with?

**Further Meeting discussion / Recommendations:**

**MEAL TIME**

Supports needs are documented in the Health and Nutrition Tab under Dietary and Health hazards/concerns tiles

Type of Diet

Is specialized meal prep necessary? No [ ]  Yes [ ]  Select one: Ground [ ]  Chopped [ ]  Pureed [ ]

Do liquids require thickening? No [ ]

Yes [ ]  Select one: Nectar/mild thick [ ]  Honey/medium thick [ ]  Pudding/ extremely thick [ ]

**Detailed description of supervision and support needs during meal time:**

**MOBILITY AND PRESCRIBED ADAPTIVE EQUIPMENT**

In addition to the use of crutches, walker, or wheelchair, include detailed description of any assistance needed to assist with mobility and or transfers. Other prescribed adaptive equipment is listed under **Other** and some examples include: glasses, hearing aids, Hoyer Lift, Orthotic shoes, etc.)

Do you need assistance with mobility? [ ] Yes [ ] No

Do you need assistance with stairs? [ ] Yes [ ] No

Do you need assistance with transfers, for example, moving from one chair to another?

 [ ] Yes [ ] No

Do you need assistance with getting in or out of a vehicle? [ ] Yes [ ] No

Detailed description of assistance needed for any of the above:

Do you have adaptive equipment prescribed for you? [ ] Yes [ ] No

If yes, what equipment?

**Further Meeting discussion / Recommendations**:

**BEHAVIOR SUPPORT PLAN**

All approved Behavior Support Plans must be uploaded into I Record. If there is a Behavior Plan, it must be documented in the ISP under Behavior. The ISP meeting should also include discussion about the need for a Behavior Plan and the review of progress for existing Behavior Plans.

**Meeting discussion / Recommendations:**

**Day Services**

**Identification of Services -** Refer to **Appendix K (Quick Reference Guide to Overlapping Claims for Services)** in theCCP P&P Manual to avoid overlapping claims. Reminder, if an individual is assigned an acuity factor, Behavioral Supports cannot be claimed while providing the following services because those supports are already included within the rate: Individual Supports, Community Based Supports, Day Habilitation. **Note**: Day services cannot exceed 6 hours per day.

|  |  |  |  |
| --- | --- | --- | --- |
| **Applicable Service(s)** | **Provider Name** | **Units Per Week**  | **Dates Program is closed, if applicable** |
| **Behavioral Supports – Assessment/Development** |  |  |  |
| **Behavioral Supports – Monitoring** |  |  |  |
| **Career Planning** |  |  |  |
| **Day Habilitation** |  |  |  |
| **Prevocational Training - Individual** |  |  |  |
| **Prevocational Training - Group** |  |  |  |
| **Supported Employment - Individual** |  |  |  |
| **Supported Employment - Group** |  |  |  |
| **Transportation – (Multi, Single or SDE)** |  |  |  |

**Other services (Assistive Technology, Community Transition Services, Occupational Therapy, PERS, Physical Therapy, Speech, Language, & Hearing Therapy):**

|  |  |  |  |
| --- | --- | --- | --- |
| **Applicable Service(s)** | **Provider Name** | **Units Per Week**  | **Start and End Dates**  |
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**Day Services Team Member providing information contained on this document:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Print Name** | **Signature** | **Title** | **Date** |
|  |  |  |  |

**Instructions for Use:**

1. This form is completed by Day Service Provider prior to or during the service plan meeting for all individuals that they support.
2. Upon completion of Worksheet, Provider will send copy to Support Coordinator, Legal Guardian, and/or involved family member(s) at least 30 days prior to the meeting to allow time for review and preparation for meeting.
	1. The Provider should include any assessments used to inform the development of the service plan (I.e. Unsupervised Time Assessment, Medication Administration Assessment, etc.)
3. The Planning Team members review content at the planning team to ensure that everyone agrees that the information is accurate and sufficient in addressing support and supervision needs.
	1. Based on the discussion of the planning team, this form is revised during the planning team meeting, if determined to be necessary.
4. The Support Coordinator includes information in service plan documents.
5. The Support Coordinator uploads the ISP Worksheet to I record as well as any assessments provided by the Provider.
6. The Support Coordinator Supervisor checks for presence of ISP Worksheet when reviewing the ISP and ensures that the information is accurately reflected in the service plan.

**If the Support Coordinator and / or Legal Guardian/involved family member(s) do not receive the ISP Worksheet from the Provider:**

1. The Support Coordinator or their Supervisor will email the Provider reminding them of requirement to submit a completed worksheet using **<DDD ID#> - request for ISP Worksheet** in the subject line.
2. If a response is not received within 2-3 days, the Support Coordinator or their Supervisor will email the Provider a second time using the same email chain, copying DDD.PPMU@dhs.state.nj.us for assistance from the Provider Performance and Monitoring Unit with follow up.
3. If after 2-3 additional days, a response is not received, the SC will upload the email chain to I record in lieu of the ISP Worksheet and move forward with development of the service plan.
	1. The Support Coordinator or their Supervisor will email DDD.PPMU@dhs.state.nj.us and DDD.SCHelpdesk@dhs.state.nj.us for follow up with the Provider.