New Jersey Department of Human Services
INDIVIDUAL SERVICE AGREEMENT

1. Service ☐Start: _____ *Effective Date* ☐Revise: _____ *Effective Date* ☐Stop: _____ *Effective Date*

2. Participant: _____ 3. ID Number: _____

4. Address: _____ 5. Telephone No.: _____

_____ 6. Date of Birth: _____

7. Program: ☐ JACC ☐ Other (specify): _____

8. Care Manager No.: _____

The following service has been authorized for the above client according to the schedule and cost shown.

	Service	
9. Service name		
10. Code		
	Initial	**Revise**
11. Unit of Service		
12. Units per Visit		
13. Frequency of Service		
14. Total Units per Week		
15. Authorized Cost per Unit		
16. Authorized Cost per Week		
17. Authorized Cost per Month (weekly cost X 4.33)		

Provider:

- DHS will pay only for those services authorized and provided pursuant to program rules.
- This notice confirms arrangements for services made by the Care Manager. You must submit an invoice at the conclusion of service or end of each month of service.
- If there is a change in the participant's condition, contact the Care Manager immediately.
- Contact the Care Manager if you note errors in the above information or if you have any questions.

18.	Specifications:
19.	☐ Stop Services - Reason:
20.	☐ Resume Services - Date:
21.	☐ Other - Specify:

22. Provider Name	23. Provider EIN No.
24. Provider Signature and Title (Optional for Traditional and Non-Traditional Providers)	Date
25. Care Manager's Name and Title	Date

Flow:
1. Authorizing Care Manager completes, signs, and sends to Service Provider.
2. Care Coordinator forwards to DoAS Billing Agent.
3. ADHS Provider is required to sign on Line 24 and returns to Care Manager.
4. ADHS Provider sends copy of this form with PA request to ADHS Central Office.