**New Jersey Department of Human Services**

**Division of Developmental Disabilities**

**Human Rights Committee Referral Form**

Used for making referrals to the DDD Human Rights Committee.

**Purpose of the DDD Human Rights Committee**

The purpose of the DDD Human Rights Committee is to operate as an objective review board in protecting the human and civil rights of Individuals with developmental disabilities. Specifically, the Committee offers advisement in difficult situations, where action is required and there may be implication to the rights of the Individual. Information about Human Rights Committees can be found in Division Circular #5. Referrals to the DDD Human Rights Committee are made using the form below.

**Instructions**

* The DDD Human Rights Committee (HRC) meets on the 1st Thursday and/or 3rd Monday of each month. The Committee Chair can call an emergency meeting as needed. At least seven (7) business days prior to the monthly meeting, submit one (1) email with the completed referral form **and** all supporting documentation attached, using the subject line, “Human Rights Committee Referral” to the Human Rights Committee Mailbox, DDD.HRC@dhs.nj.gov.
* A referral is complete **only** when all documentation related to the reason for the referral is submitted. This includes current evaluations/consultations, supporting evidence (i.e. data sheets), IDT Notes, prescriptions for non-highly restrictive mechanical restraints (see Division Circular #20), etc.
* Behavior Support Plans using level III techniques require review by a Behavior Management Committee (BMC) prior to submitting the Human Rights Committee Referral Form. When referring such a case to the HRC, review by a BMC shall be completed first. (See Division Circulars #4 and #18 for more information.) A request for review by the DDD BMC can be sent via email, using the subject line, “Behavior Management Committee Referral” to the Behavioral Services Helpdesk, Ddd.Behavioralservices@dhs.nj.gov.
* At least one involved person, with knowledge of pertinent information related to the Individual, **must** attend the Human Rights Committee meeting to present the case. At this time, meetings are held via Microsoft Teams. Meeting invitations are sent to all attendees one week prior to the meeting.
* When making a referral to the HRC, ensure all involved parties are aware. This includes Support Coordination, Service Providers, the Individual/Legal Guardian/involved family members.
* Reach out to the Human Rights Committee Mailbox, DDD.HRC@dhs.nj.gov, with any questions.

**Links to Division Circulars:**

* [Division Circular 4](https://www.nj.gov/humanservices/ddd/assets/documents/circulars/DC4.pdf): Division of Developmental Disabilities Organizational Rules
* [Division Circular 5](https://www.state.nj.us/humanservices/ddd/assets/documents/circulars/DC5.pdf): Human Rights Committees
* [Division Circular 18](https://www.nj.gov/humanservices/ddd/assets/documents/circulars/DC18.pdf): Behavior Management Committee
* [Division Circular 20](https://www.nj.gov/humanservices/ddd/assets/documents/circulars/DC20.pdf) : Mechanical Restraint and Safeguarding Equipment

|  |
| --- |
| **Referral to DDD Human Rights Committee** |
| Individual Information |
| Individual’s Name: Click to enter text.DDD ID Number: Click to enter text.Individual’s Age: Click to enter text. | NJCAT Score: Click to enter text.Tier: Click to enter text.Assessment Date: Click to enter text. |
| Guardianship Status: Choose an item. | Legal Guardian’s Name: Click to enter text. |
| Phone Number: Click to enter text. | Email Address: Click to enter text. |
| Please describe the Individual’s current living arrangements: |
| Click to enter text. |
| Clinical Information and Support Needs |
| List all Diagnoses (intellectual and/or developmental disabilities, mental health, medical): |
| Click to enter text. |
| List all prescribed medications:**Note**: If current Medication Administration Records (MARs) are included with the referral, medications do not need to be listed here. Skip to the next question. ***(To add rows, click on the last row and click the Plus Sign: +)*** |
| Name of Medication | Dosage | Frequency | Notes |
| Click to enter. | Click to enter. | Click to enter. | Click to enter. |
| Click to enter. | Click to enter. | Click to enter. | Click to enter. |
| Click to enter. | Click to enter. | Click to enter. | Click to enter. |
| Click to enter. | Click to enter. | Click to enter. | Click to enter. |
| Click to enter. | Click to enter. | Click to enter. | Click to enter. |

|  |
| --- |
| Describe the supports required in each of the following areas: |
| 1. Self-Care: Click to enter text.
 |
| 1. Supervision in the community: Click to enter text.
 |
| 1. Behavioral: Click to enter text.
 |
| 1. Medical: Click to enter text.
 |
| List current services and Service Provider names: |
| Click to enter text. |
| Referral Information |
| Describe the reason for the referral: |
| Click to enter text. |
| Describe behavioral and/or medical concerns related to this request: |
| Click to enter text. |
| Describe previous and current interventions and outcomes: |
| Click to enter text. |
| Has this matter been reviewed by a Behavior Management Committee? Yes [ ]  No [ ]  |
| If Yes, describe the outcome: Click to enter text. |
| Has this case been reviewed by any other committee or entity (internal/external)? Yes [ ]  No [ ]  |
| If Yes, describe the outcome: Click to enter text. |
| Describe the **Individual’s** preferences/wishes related to the request: |
| Click to enter text. |
| Describe the **Legal Guardian’s** preferences/wishes related to the request: |
| Click to enter text. |
| Will the Individual be invited to participate in the meeting? Yes [ ]  No [ ]  |
| Please explain: Click to enter text. |
| Will the Legal Guardian/family member(s) be invited to participate in the meeting? Yes [ ]  No [ ]  |
| Please explain: Click to enter text. |

|  |
| --- |
| Please list supplemental documentation submitted with this referral: |
| Click to enter text. |
| Referral Source and Support Coordinator Information |
| Name of person initiating the referral: Click to enter text. |
| Title: Click to enter text. | Date of Referral: Click to enter a date. |
| Phone Number and Email Address: Click to enter text. |

|  |
| --- |
| Support Coordination Agency’s Name: Click to enter text. |
| Support Coordinator’s Name, if different from above: Click to enter text. |
| Phone Number and Email Address: Click to enter text. |
| Support Coordinator Supervisor’s Name: Click to enter text. |
| Phone Number and Email Address: Click to enter text. |
| ***To be completed by the Committee Chairperson:*** |
| Date of HRC Meeting:Click to enter a date. | Date recommendations were shared with attendees:Click to enter a date. |
| Does the ISP/IHP require updating? Yes [ ]  No [ ]  If Yes, please describe: |
| Click to enter text. |
| Further follow-up needed from OOL, BMC, OI, Other? Yes [ ]  No [ ]  If Yes, please describe: |
| Click to enter text. |
| HRC Recommendations: |
| Click to enter text. |