Division of Developmental Disabilities

New Jersey Individualized Service Plan (NJISP)

Plan Version : X.XX

Individual Name

ID :
A/G :
DOB :
County :
Program :

Medicaid ID :
Medicaid Type :

DDD Status:
Waiver Enrollment Date:

Address

H :
W :
C :
E :

Diagnosis

Primary :

Secondary :

Support Coordination

Values Into Action
SC :
P :
E :

Guardianship

H : N/A
W : N/A
C : N/A
E : N/A

H : N/A
W : N/A
C : N/A
E : N/A

Preferred Hospital

Primary Care Physician

Administrative Service Organization (ASO)

Care Manager :

Managed Care Organization (MCO)

Private Insurance

Member #
Group #

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Outcome 1

Service 1 : <SERVICE NAME>

Procedure : Code : Reference : Claims :	Provider : Location :	Start Date : End Date : Unit Type : Frequency :	Rate : Total Units : Total Cost :

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Outcome 2

Service 1 : <SERVICE NAME>

Procedure : Code : N/A Reference : Claims : N/A	Provider : Location : N/A N/A	Start Date : End Date : Unit Type : Frequency :	Rate : N/A Total Units : Total Cost : N/A

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Outcome 3

Service 1 : <SERVICE NAME>

Procedure : Code : N/A Reference : Claims : N/A	Provider : Location : N/A N/A	Start Date : End Date : Unit Type : Frequency :	Rate : Total Units : Total Cost :

Employment First Implementation

Please note that New Jersey is an Employment First State, meaning that: "Competitive employment in the general workforce is the first and preferred post education outcome for people with any type of disability." In conjunction with this policy, at least one plan outcome must be related to employment, the pursuit ofemployment, or the exploration of employment unless the individual is of retirement age.

Employment Plan : Determine whether or not employment services are needed to maintain current job. If employment services are provided identify areas in which the employee needs support,must improve due to supervisor feedback, wants to improve, etc. and indicate on the Intervention Plan & Service Log. Include these outcomes and any services that are needed to accomplish these outcomes in the Service Plan.
Voting Plan :

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Nutrition and Health Needs

Allergies

Dietary

HealthHazards

SelfCare

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Safety and Support Needs

Behavior

Mobility

ReligiousCultural

SupportSettings

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Emergency Contacts

Order/Priority to be Called	Name	Relationship	Primary Contact	Secondary Contact
1				
2				
3				

Special Instructions:

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Medication

Medication	Dosage	Frequency	Notes	Self Medicates

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Team Members Present / Participating in Developing the Individualized Service Plan

Name	Relationship / Agency	Primary Contact

Authorizations & Signatures

My signature upon this document attests to the following:

Participant:

Signature: _____

Name:

Date: _____

Guardian / Legal Representative (if applicable):

Signature: _____

Name: _____

Date: _____