Individualized Service Plan (ISP) Quality Review Checklist

A Quality Review entails checking an ISP for completeness as well as that the plan accurately reflects the individual's needs, preferences, and desires as identified in the NJCAT and PCPT and if not, addressing those areas as applicable. Review the ISP in its entirety ensuring any answers of "No" to the following questions are addressed before submitting for authorization.

Name of Individual: _____ DDD ID: _____

	Yes	No
1. Is each section of the document completed (as applicable)?	☐	☐
2. Are all supporting documents (NJ CAT, PCPT, CCW Sign-Off Form if applicable) complete and up-to-date?	☐	☐
3. Does the document reflect proper spelling/grammar, including the individual's full name?	☐	☐
4. Is the plan submitted on time (Initial: 30 days or Update: Annual)?	☐	☐
5. Are the contents and comments written in a respectful and person-centered manner?	☐	☐
6. When a need or area to address was identified in the PCPT, was it included in the ISP (e.g. if assistance with voting was identified, were supports included in the ISP)?	☐	☐
7. When a need or area to address was identified in the SC Monitoring Tool, was it updated in the ISP (e.g. if the person has achieved a goal, were next steps included in the ISP)?	☐	☐
8. Are the Outcomes linked to strengths, interests, and areas of growth identified in the PCPT?	☐	☐
9. Does each of the Outcomes reflect the desired achievement of the individual (i.e. the skill, ability, goal)?	☐	☐
10. Is at least one of the Outcomes related to employment even if the person is not pursuing employment at this time?	☐	☐
11. Do the Planning Goals indicate the major activities designed to achieve the Outcomes? (i.e. what steps need to be done to reach outcomes; where is help needed to reach outcome?)	☐	☐
12. Are the Outcomes and Planning Goals individualized?	☐	☐
13. Are the Planning Goals measurable and separate from services (i.e. the goal is not a program but a step towards achieving the identified outcome)?	☐	☐
14. Are the services listed needed to help the individual achieve their Planning Goals and Outcomes?	☐	☐
15. For each service funded by DDD, is the correct procedure code included?	☐	☐
16. For each service funded by DDD, is the assessment tool showing a need for the service identified?	☐	☐
17. For each service funded by DDD, is the correct frequency/unit indicated?	☐	☐
18. Does the total amount of services identified remain within the available budget?	☐	☐

19. Is a budget "cushion" maintained to address unanticipated needs during the year?	☐	☐
20. Are only approved providers identified to provide DDD services?	☐	☐
21. Are any religious and cultural preferences/restrictions the person follows clearly noted and addressed in services being provided as applicable?	☐	☐
22. Is the box checked under Employment First Implementation consistent with the information provided through the Employment Pathway discussion in the PCPT?	☐	☐
23. If employment is not currently being pursued, is the reason listed?	☐	☐
24. Are any Health & Safety concerns/needs indicated in the assessment tool or PCPT tool included in the monitoring and support needs table and addressed in services as applicable?	☐	☐
25. Are any special dietary needs clearly indicated and consistent with the assessment tool and PCPT?	☐	☐
26. If the individual uses any adaptive equipment, is the information provided in the plan consistent with the assessment tool and PCPT?	☐	☐
27. Is all of the needed information provided in the Emergency Back-Up Plan (if applicable) to ensure needs are addressed if a provider does not show up or an emergency occurs?	☐	☐
28. As indicated by signatures, were at a minimum, the Individual, Guardian (if applicable), and Support Coordinator present at the plan meeting as required?	☐	☐
29. Are the necessary signatures included?	☐	☐

Supervisor – To Begin Plan Services:

30. Do you authorize the services written in the plan based on your review of the entire plan?	☐	☐ **
**	If No, please review and make the necessary revisions with the support coordinator before submitting to DDD	

Comments: _____

_____

_____

Supervisor's Name: _____
(Please Print)
Supervisor's Signature: _____