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| cid:image002.jpg@01DA9C9B.873348C0 | **Community Inclusion Services /**  **Individual Supports 15-Minute Rate Request** |

Use this form when an individual receiving Individual Supports Daily Rate is in need of additional support through Community Inclusion Services (CIS) or Individual Supports (IS) 15-minute Rate.

**Instructions**

1. The Support Coordinator (SC) uploads the completed form in iRecord, naming it **CIS/IS Request**.
2. The SC enters the requested service into the Individualized Service Plan (ISP) and changes plan status to Review (R) for review by the Support Coordination Supervisor (SCS).
3. The SCS reviews the completed form and the ISP. If no changes are needed, the SCS changes plan status to Service Review (SR), which prompts the item to appear on a DDD staff Due-List for review and determination.
4. The SC/SCS should monitor iRecord for the outcome. (Send inquiries or requests for expedited review to [DDD.ServiceApprovalHelpDesk@dhs.nj.gov](mailto:DDD.ServiceApprovalHelpDesk@dhs.nj.gov).)

Refer to Appendix K in the CCP policy manual for information on overlapping services.

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| **Identifying Information** | | | | | | | | |
| Individual: Enter text.  DDD ID: Enter text. | | | | Date: Enter a date. | | | | |
| Name of the agency providing IS Daily Rate: Enter text. | | | | | | | | |
| This request is for **(select one):**  Community Inclusion Services (delivered in a group setting not to exceed six individuals)  Individual Supports 15-minute Rate (provided by an agency)  Individual Supports 15-minute Rate (provided by a Self-Directed Employee [SDE]) | | | | | | | | |
| **Service Request Information** | | | | | | | | |
| Name of the agency or SDE to provide the service: Enter text. | | | | | | | | |
| Name of the agency representative or SDE who provided information to the SC about this request: | | | | | | | | |
| Name: Enter text. | | | | Relationship to Individual: Enter text. | | | | |
| Explain in detail the staffing support to be provided, including where the service will take place (i.e., place of employment, gym, place of worship, home, medical visits, etc.): Enter text. | | | | | | | | |
| Explain in detail why the support need cannot be met through Individual Supports Daily Rate:  Enter text. | | | | | | | | |
| Where is the need for this service referenced in the NJCAT and PCPT? Enter text. | | | | | | | | |
| Will the service increase the individual’s involvement in the community? | | | | | | | Yes  No | |
| If Yes, please explain: Enter text. | | | | | | | | |
| Have natural and generic supports been explored? | | | | | | | Yes  No | |
| If Yes, explain the outcome. If no, explain why not: Enter text. | | | | | | | | |
| Will the requested service be used in combination with part-time Day Habilitation or employment hours? If Yes, enter the intended hours for each: | | | | | | | Yes  No | |
| Day Habilitation: Enter text. | | | | CIS / IS 15-minute Rate: Enter text. | | | | |
| Employment: Enter text. | | | | CIS / IS 15-minute Rate: Enter text. | | | | |
| Is the requested service in place of Day Habilitation services or employment? | | | | | | | Yes  No | |
| Is the individual interested in Day Habilitation services or employment? | | | | | | | Yes  No | |
| If Yes to both questions, list the Day Habilitation providers that were explored and the referral outcomes: | | | | | | | | |
| Enter text. | | | | | | | | |
| Complete a schedule showing the days and times the requested service would be used: | | | | | | | | |
| Sunday | Monday | Tuesday | Wednesday | | Thursday | Friday | | Saturday |
| Enter text. | Enter text. | Enter text. | Enter text. | | Enter text. | Enter text. | | Enter text. |
| **For Community Inclusion Services (CIS) only**: | | | | | | | | |
| Does the schedule total more than 30 hours per week? | | | | | | | Yes  No | |
| Does this include transportation time to and from activities? | | | | | | | Yes  No | |
| **Individual Supports Daily Rate Provider Information** | | | | | | | | |
| *Questions in this section require information from the IS Daily Rate provider.*  *Do not include identifying information of individuals other than the person named above.* | | | | | | | | |
| Name of IS Daily Rate provider representative who is the main source of IS Daily Rate information? | | | | | | | | |
| Name: Enter text. | | | | Relationship to Individual: Enter text. | | | | |
| How many individuals live in the group setting? Enter text. | | | | | | | | |
| Do any individuals in the setting receive CIS / IS 15-minute Rate in addition to IS Daily Rate? | | | | | | | Yes  No | |
| If Yes, how many? Enter text. | | | | | | | | |
| Do any individuals in the setting receive CIS with the same provider at the same time? | | | | | | | Yes  No | |
| If Yes, how many? Enter text. | | | | | | | | |
| Is this request related in any way to staffing shortages or scheduling challenges the  IS Daily Rate provider is experiencing? | | | | | | | Yes  No | |

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| **Support Coordinator Attestation** | |
| **By submitting this form, the Support Coordinator attests to the following:**   * **Information on this form was obtained in collaboration with the involved Individual Supports Daily Rate provider.** * **To the best of my knowledge, all information on this form is accurate and true.** * **I acknowledge that deliberate false statements or omissions on this form may be considered Medicaid fraud and subject to investigation.** | |
| Support Coordination Agency: Enter text. | |
| Support Coordinator: Enter text. | Phone Number: Enter text.  Email Address: Enter text. |