New Jersey Department of Human Services
Division of Developmental Disabilities
www.nj.gov/humanservices/ddd

Addressing Enhanced Needs Form

(Completed prior to service delivery and as needed thereafter)

To be completed by the Support Coordinator

Name of Individual: _____ DDD ID#: _____

Service(s): _____

Was the individual assigned the acuity factor? ☐ Yes ☐ No

Please indicate the area in which clinical needs have been identified for this individual:
☐ Medical ☐ Behavioral ☐ Both

If you indicated "medical" or "both" above, please list the medical concerns that need to be addressed by a clinical level of staffing, specialized equipment, etc. in order for this individual to remain safe while receiving services:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

If you indicated "behavioral" or "both" above, please list the behavioral concerns that need to be addressed by a clinical level of staffing in order for this individual and other to remain safe while receiving services:

_____ _____
_____ _____
_____ _____
_____ _____

To be completed by the Service Provider

Name of Service Provider:_____ **Date:** _____

List the concerns indicated by the assessment	**What support will you provide to address these concerns and maximize safety for the individual?**

Completed by (please print name): _____
Signature: _____