New Jersey Department of Human Services

**Division of Developmental Disabilities**

**Support Coordination Agency – ISP Retroactive Change Request (RCR) Form**

**Directions for SCA:**

1. SC completes the RCR form accurately and in its entirety.
2. SC reviews the completed RCR form with service provider (or SDE) and individual/legal guardian, as applicable.
3. SC ensures that the service provider (or SDE) is in agreement with all requested changes and signs the completed RCR form. Live or electric signatures are required. Names that are just typed into the form will not be accepted.
4. SC submits the final RCR form to their supervisor for review.
5. SC Supervisor uploads the signed RCR form into iRecord and ensures that the plan is in an “approved” status prior to submission.
6. SC Supervisor notifies the Division that an RCR Request has been uploaded and is ready for review by sending an email to DDD RCR Helpdesk (Ddd.Ispretroactivechanges@dhs.nj.gov) with the subject line: SCA Name – DDD ID #. **DO NOT INCLUDE THE RCR FORM AS AN ATTACHMENT.**

|  |  |
| --- | --- |
| **SCA:** | **Date of Request:** |
| **SCS:** | **Provider (of service needing change):** |
| **S SC:** | **SCA’s QAS:** |

**THE CHANGE BEING REQUESTED:**

**Service Date Modification** **Incorrect Service Type** **Service not Listed Plan Term Gap**

**Inaccurate Provider Information** **Unit Modification** **Incorrect Rate** **Other**

**Detailed reason for current error (200 character maximum)**:

**REQUIRED INFORMATION:**

**Request #1**

**Participant ID**

**Plan ID**

**Outcome Number**

**Service number**

**Service Start Date**

**Service End Date**

**Total number of units to be:** (Insert number next to correct command)

**Added**

**Removed**

**Total Cost**

**Unit Distribution/Unit Breakdown (List only units rendered as they should appear in the SDR)**

|  |  |
| --- | --- |
| **Service Week Range** | **Total Units** |
|  |  |
|  |  |
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|  |  |

**Any other necessary service details:**

**Supporting documentation uploaded to iRecord. Document name and date of upload:**

**Request #2 (If applicable)**

**Participant ID       Must be same as Request #1**

**Plan ID       Must be same as Request #1**

**Outcome Number**

**Service number**

**Service Start Date**

**Service End Date**

**Total number of units to be:** (Insert number next to correct command)

**Added**

**Removed**

**Total Cost**

**Unit Distribution/Unit Breakdown (List only units rendered as they should appear in the SDR)**

|  |  |
| --- | --- |
| **Service Week Range** | **Total Units** |
|  |  |
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**Any other necessary service details:**

**Supporting documentation uploaded to iRecord. Document name and date of upload:**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*Provider’s Name Printed:**

**Provider Signature to ensure above information is correct:**

**Date of Signature:**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**For internal use only:** Request Approved  Request Denied

**Date Request was completed**:  **Plan ID that requires approval**:

**Request is being sent to DDD IT**  **DDD IT ticket Number:**

**Responsible for the error**: SCA  Provider  iRecord  Other

**Determination Code:** Plan Term Gap  Plan Approved Late  Incorrect Service Entry

Services not Extended Timely  Continuous Services not Entered for the Full Plan Term

Incorrect Provider  Incorrect Procedure Code  Other