**New Jersey Department of Human Services**

**DIVISION OF DEVELOPMENTAL DISABILITIES**

**Support Coordination Agency - Individualized Service Plan (ISP) Review Tool**

1. **Identifying Information**

|  |  |
| --- | --- |
| Name of Individual: | DDD ID #: |
| Support Coordination Agency: | Assigned QAS: |
| Support Coordinator: | Support Coordinator Supervisor: |
| ISP Plan Version: | Supervisor’s Date of Review: |
| **Program Type:**  Interim Has DDD Admin approved? Yes No  Supports Program  CCP-FFS  Correct Program has been Verified, if initial plan. If no, return to SC. | **NJ CAT Information:** Assessment Date: Click here to enter text.  Scores: Click here to enter text. Tier: Click here to enter text.  Acuity Factor? Yes No *If yes, below must also be yes.*  **Addressing Identified Clinical Needs Form complete and uploaded?** Yes No  N/A |
| **Plan ID #:** **Submission/Review Details:**  Original plan, first submission Date Assigned to SCA:      Date plan submitted:  Annual plan - Date of plan term:       Date plan submitted: | |
| **Review MMTs to ensure meaningful contact and for verification of needed follow up :**  Month/Year reviewed: **Click here to enter text.** Type of Contact:  Month/Year reviewed: Click here to enter text. Type of Contact:  Month/Year reviewed: **Click here to enter text.** Type of Contact:  Comments: | |

1. **Required Documentation Checklist** (Non-Negotiables) **Anything marked “NO” requires a return to the Support Coordinator**

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| **The Mental Health Pre‐Screening Checklist is completed, signed by SC and a Supervisor and uploaded.** Required for all Initial and Anniversary plans and updated as applicable. |  |  |
| **The Rights and Responsibilities document is completed, signed by the individual/guardian and the SC, and is uploaded.** Required for all Initial and Anniversary plans. |  |  |
| **F3, F6 or DVRS referral confirmation is completed and uploaded.** Required for Initial plans and updated as applicable.  update when appropriateupdate when appropriate. |  |  |
| **If individual has an acuity factor, the Addressing Enhanced Needs Form is completed for each service provider and uploaded.** Required for all Initial and Anniversary plans and revised plans with new Service Provider. |  |  |
| **The signature page is signed by the individual and, if applicable, legal guardian.** Required for all Initial and Anniversary plans and for revisions affecting the budget. |  |  |

1. **Clinical Documents Overview** – This area is used for notes when reviewing NJCAT

**NJ CAT (Clinical Assessment)**

|  |  |
| --- | --- |
| **Area** | **Identified Support Needs** |
| **Self‐Care Needs:** NJ CAT Questions and iRecord Demographics Tab > Health & Nutrition > Self‐Care |  |
| **Behavioral Needs:** NJ CAT Questions and iRecord Demographics Tab > Safety & Supports > Behavior/Sensory Needs |  |
| **Medical Needs:** NJ CAT Questions and iRecord Demographics Tab: Health & Nutrition > Health Hazards/ Concerns; Allergies; Dietary; Medical > Medications |  |

**Mental Health Pre‐Screening Checklist –** Used to guide discussion about any possible indicators that a Mental Health evaluation may be necessary**.**

|  |  |
| --- | --- |
| **Concerns Identified** | **Referral/Supports Needed?** |
|  |  |

1. **Person‐Centered Planning Tool (PCPT) Review**

|  |  |  |
| --- | --- | --- |
| **Area** | **Does the PCPT Reflect the Individual?** | |
| **Relationships:** Includes information about those in the person’s life | Yes | Needs Improvement |
| **Strengths/Qualities:** Contains information about the positive qualities of the individual as shared by the person and those who know them best | Yes | Needs Improvement |
| **Important to:** Includes information about what the person has demonstrated is important to them; clearly shows that a conversation occurred between the SC and individual to help the SC learn more about the person; and provides information that will be useful to a service provider in designing/delivering supports and assisting the individual in achieving their outcomes | Yes | Needs Improvement |
| **Supporter Qualities:** Includes information about what the individual wants in a direct support professional, including personality traits, shared interests, and skills; will be useful in creating a job description, advertising, and interviewing if utilizing a self‐directed employee. | Yes | Needs Improvement |
| **Hopes & Dreams:** Includes the individual’s hopes and dreams for the future (both short‐ and long‐term), as well as their interests; does not include information about services | Yes | Needs Improvement |
| **Communication Styles:** Provides the individual’s communication preferences including ways the person may show emotion using non‐traditional means of communication (e.g. behavior, mannerisms, etc.) | Yes | Needs Improvement |
| **Community Integration:** Includes information about the individual enjoys doing currently in the community and has enjoyed in the past. | Yes | Needs Improvement |
| **Feedback for Improvement** | | |

**STOP HERE AND REVIEW THE ISP.**

1. **Discrepancies**

|  |
| --- |
| **Were all discrepancies between the information in NJCAT, PCPT, and Mental Health Pre‐screening Tool noted in the appropriate tile?**  **Yes No (fill out Below)** |
| **If NO, please identify any discrepancies observed between the NJCAT, Mental Health Pre‐Screening Checklist, PCPT, and/or ISP.** |

1. **Service Review**

|  |  |
| --- | --- |
| **SERVICE REVIEW – Anything marked “NO” requires a return to the Support Coordinator** | **YES/NO/ NA** |
| The individual is enrolled onto the correct program (Interim, SP, CCP) |  |
| The Participant Enrollment Agreement (PEA) has been reviewed, is signed and dated and is the correct document. |  |
| The correct Fiscal Intermediary is listed (If SDE service, enrollment is complete and confirmed by FI through receipt of a welcome packet) |  |
| If CCP, at least one billable service is listed in the plan. If SP, and no billable services are listed, natural/generic services are entered for maximum of 90 days while identifying billable services. |  |
| If the individual has an acuity, Behavioral Supports are not entered in conjunction with Individual Supports, Community Based Supports, Day Habilitation or Out of Home Overnight Respite. |  |
| If CCP, the correct procedure code for Individual Support Services (Daily Rate vs. 15 Mins) is indicated. |  |
| For CCP, if applicable: the “Full Term” check box for Individual Supports (Daily Rate) is selected thus enabling the start date of the service to roll until the date the plan gets approved, eliminating potential gaps in service. |  |
| If Day Hab is being utilized and planning has occurred for entire year, the budget appears to be appropriately utilized.  **Insert amounts**: Emp/Day budget       Emp/Day budget obligated |  |
| If the Retirement box is checked, it is understood that the day/ employment budget will cease. (The Employment Pathway is also be updated to reflect the “not pursuing’ option. ) |  |
| For continuous services (ex. Day Hab, Individual Supports) there are no service gaps between plan terms or service dates.  **Insert dates:** Current Services will end on      and are scheduled in new plan to start on     . |  |
| For each service funded by DDD, the correct service type, frequency, units, and duration are entered as confirmed by the Service Provider(s). |  |
| The Individual, Guardian (if applicable), Support Coordinator and Service Providers were all included in the planning process. |  |
| The DRAFT ISP was sent to all Service Providers and content has been agreed upon. |  |
| This plan is being submitted on time (initial within 30 days; annual before the end of the previous plan term). |  |

1. **ISP Scorecard (to be completed AFTER ISP review) REFER TO ISP SUBMISSION CRITERIA FOR DEFINITIONS AND FOR SCORING**

|  |  |  |
| --- | --- | --- |
| **Area** | **Score (1‐3)** | **Rationale/Examples (Positive and Negative Detail Required- include specific examples)** |
| Outcomes |  |  |
| Employment |  |  |
| Services |  |  |
| Health and Nutrition |  |  |
| Safety and Supports |  |  |
| Person‐Centeredness |  |  |
| Writing Quality |  |  |
| Budget Accuracy |  |  |
| Plan Submission and Revisions |  |  |
| **Total Score:** |  |  |
|  | | |
| **Required revision(s)**  **Best practice suggestion(s):** | | |
| **Additional Reviewer Comments:** | | |
| **My signature below indicates that my SCS has reviewed the tool with me and explained areas of required correction or improvements for future submissions.** | | |
| **Support Coordinator Signature:****Date:** | | |