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**New Jersey Department of Human Services**

**Division of Developmental Disabilities**

**Individualized Service Plan (ISP) Review Checklist for Support Coordination Supervisors**

Used for conducting a **quality review** to ensure plan thoroughness and person centeredness; and a **service review** to attest that services are appropriate, entered correctly, and there are no gaps in continuous services.

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| **NAME OF INDIVIDUAL:** Click here to enter text. | **DDD ID #:** Click here | **Plan Version:** Click here |
| Initial Plan / Check if Yes [ ]  Revision due to SCA Re-assignment | Date Assigned to SCA:Click here.  | Date Plan Submitted: Click here.  |
| Anniversary Plan Check if Yes [ ]   | Previous Plan End Date:Click here.  | Date Plan Submitted:Click here.  |
| Plan Result of Tier Change/ Check if Yes [ ]  Waiver Transition/Retirement | Date Plan generated by iRecord: Click here. | Date Plan Submitted:Click here.  |

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| **REQUIRED DOCUMENTS**  |  **YES** |  **NO** |  **NA** |
| 1. If a legal guardian is appointed, guardianship determination is uploaded and legal guardian signature is reflected on all required documents.
 |  [ ]  |  [ ]  |  [ ]  |
| 1. Completed Mental Health Pre‐Screening Checklist is uploaded and signed by a Supervisor. **Required for all Initial and Anniversary plans and updated as applicable.**
 |  [ ]  |  [ ]  |  |
| 1. The Rights & Responsibilities document is signed by the individual/guardian and SC. **Required for all Initial and Anniversary plans.**
 |  [ ]  |  [ ]  |  |
| 1. F3, signed by a DVRS counselor, (or DVRS referral confirmation) or F6 is completed and uploaded. **Required for Initial plans and updated as applicable.**
 |  [ ]  |  [ ]  |  [ ]  |
| 1. The Addressing Enhanced Needs Form, when acuity factor is present, is completed for each service provider and is uploaded with a copy sent to each Provider.

**Required for Initial plans and revised as needed.**  |  [ ]  |  [ ]  |  [ ]  |
| 1. 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. If individual has a Behavior Support Plan, it is reviewed at least annually and is uploaded.
 |  [ ]  |  [ ]  |  [ ]  |

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| **QUALITY REVIEW** |  **YES** |  **NO** |  **NA** |
| 1. ISP Worksheet for Residential Provider, if applicable, reviewed and content included.
 |  [ ]  |  [ ]  |  [ ]  |
| 1. ISP Worksheet for Day Habilitation, if applicable, reviewed and content included.
 |  [ ]  |  [ ]  |  [ ]  |
| 1. If applicable ISP Worksheets were not received from the provider, the SC has uploaded the email chain sent to the provider with DDD.PPMU@dhs.nj.gov in copy.
 |  [ ]  |  [ ]  |  [ ]  |
| 1. ISP indicators meet the minimum standard for quality in accordance with the **ISP and PCPT Submission Criteria Companion Guide**.
 |  [ ]  |  [ ]  |   |
| 1. PCPT indicators meet the minimum standard for quality in accordance with the **ISP and PCPT Submission Criteria Companion Guide**.
 |  [ ]  |  [ ]  |  |
| 1. The Individual, Guardian (if applicable), Support Coordinator and Service Providers (if applicable) were all included in the planning process.
 |  [ ]  |  [ ]  |  |

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| **SERVICE REVIEW**  |  **YES** |  **NO** |  **NA** |
| 1. Individual enrolled onto correct waiver program (Interim, SP, CCP).
 |  [ ]  |  [ ]  |   |
| 1. Participant Enrollment Agreement (PEA) is signed, by Individual and Guardian (if applicable) is dated, and is the correct document.
 |  [ ]  |  [ ]  |  [ ]  |
| 1. At least one billable service is entered. Otherwise, exploratory services are entered for maximum of 90 days to allow time to identify billable services.
 |  [ ]  |  [ ]  |  [ ]  |
| 1. If acuity factor is present, Behavioral Supports are not entered in conjunction with Individual Supports, Community Based Supports, Day Habilitation, or Out of Home Overnight Respite and appropriate procedure code is used.
 |  [ ]  |  [ ]  |  [ ]  |
| 1. For CCP, if applicable, I have verified that the correct procedure code for Individual Supports (Daily Rate) is used and the “Full Term” check box is selected.
 |  [ ]  |  [ ]  |  [ ]  |
| 1. If Day Habilitation is entered, exception weeks are edited to account for program closures and the budget appears to be appropriately utilized.
 |  [ ]  |  [ ]  |  [ ]  |
| 1. For continuous services (ex. Day Hab, Individual Supports) no unplanned service gaps between plan terms or service dates exist.
 |  [ ]  |  [ ]  |  [ ]  |
| 1. EVV statement is present in Service Description Box for all applicable services
 |  [ ]  |  [ ]  |  [ ]  |
| 1. If the Retirement box is checked, the individual does not attend a day hab of any funding source (DDD, Mental Health, Medical Day, DVRS), and the Employment Pathway reflects the “Unemployed - Not Pursuing” option.
 |  [ ]  |  [ ]  |  [ ]  |
| 1. DRAFT Service Detail Report was sent to all Service Providers and Service Provider(s) have confirmed accurate procedure code, frequency, units, and duration entered.
 |  [ ]  |  [ ]  |  [ ]  |
| 1. DRAFT ISP was sent to the Individual, Guardian (if applicable) and to all Service Providers and content has been agreed upon.
 |  [ ]  |  [ ]  |   |

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| **ATTESTATION: My signature below indicates that I have thoroughly reviewed the plan, have addressed any identified issues with the Support Coordinator, all required documents are present and the plan meets Division expectations as described in the ISP and PCPT Submission Criteria Companion Guide**. |
| **Supervisor’s Name:** Click or tap here to enter text. **Date:** Click to enter a date. |
| **Supervisor’s Comments:** The following issues have been addressed with the Support Coordinator (I.e. late plan submission, anything marked “no” prior to final plan submission): Click or tap here to enter text. |