**New Jersey Department of Human Services**

**Division of Developmental Disabilities**

**Individualized Service Plan (ISP) Revision and Notification Form**

|  |
| --- |
| **Individual Information** |
| Name of Individual: Click to enter text.  | Date of Meeting / Notification of Change: Click to enter text.  |
| DDD ID#: Click to enter text.  | Person Completing Form: Click to enter text.  |
| SCA: Click to enter text.  | Residential Provider: Click to enter text.  |
| SC: Click to enter text.  | Day Provider: Click to enter text.  |

**Choose One:**

**[ ]** Notification of Change only (meeting not held): Indicate needed changes in below sections.

[ ]  Summary of Meeting Minutes -Enter Summary here:Click to enter text.

**Is Revision to the ISP Needed? (Check all that apply):**

**[ ]** Addition/revision/or discontinuation of a service

[ ]  Changes under **Safety & Support** (support settings, mobility/adaptive equipment, behavioral /sensory)

[ ]  Changes under **Health & Nutrition** (high risk allergies, self-care, dietary, health hazards/concerns)

[ ]  Other: Click to enter text.

[ ]  No revision needed

**If Applicable:**

**Changes in Medication**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication**  | **Dosage** | **Frequency**  | **Note** |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |

**Addition, Change or Discontinuation of Doctor’s Order, other than Medication.** (I.e. diet, Ted stockings, etc.)

|  |  |  |
| --- | --- | --- |
| **Original Order (if applicable)** | **New Order or Change in Order** | **Note** |
| Click to enter text. | Click to enter text. | Click to enter text. |

**Changes in Services**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Service(s) Added/Revised** | **Provider Name**  | **Units / Week**  | **Exceptions** | **Start Date** |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |

|  |  |  |
| --- | --- | --- |
| **Service(s) Ending** | **Provider Name**  | **End Date**  |
| Click to enter text. | Click to enter text. | Click to enter text. |
| Click to enter text. | Click to enter text. | Click to enter text. |

**Team Meeting Participants, if Applicable:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Team Member** | **Name** | **Title** | **Date** |
| Individual | Click to enter text. | Click to enter text. | Click to enter text. |
| Legal Guardian  | Click to enter text. | Click to enter text. | Click to enter text. |
| Family Member  | Click to enter text. | Click to enter text. | Click to enter text. |
| Support Coordinator | Click to enter text. | Click to enter text. | Click to enter text. |
| Residential Provider | Click to enter text. | Click to enter text. | Click to enter text. |
| Day Service Provider | Click to enter text. | Click to enter text. | Click to enter text. |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text.  |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text.  |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text.  |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text.  |

**Form Description:**

This form is used to convey all needed changes to the NJISP, such as changes to services, support needs, health, nutrition and/or issues within the plan year. ISP Signatures and approval must be obtained when there are revisions to outcomes, services, providers, units, or start/end dates. Content changes in the NJISP, like a change in prescription medication, behaviors, etc. do not require obtaining a new ISP signature but the Support Coordinator (SC) should ensure that the individual/legal guardian are informed of the changes. Upon receipt of requests for content changes, the SC should ensure that the information is added to the NJISP and is present in the next formal plan revision/development.

**Instructions for Form Use:**

1. The Provider completes this form to memorialize meeting minutes or to provide notification of a needed change to the ISP.
2. If a meeting was held and there are team members who participated by telephone, the Provider will enter their name and indicate phone participation in the signature column of the worksheet.
3. The Provider sends a copy of the completed worksheet to the SC, and includes any assessments used to inform recommended revisions to the service plan (i.e. Unsupervised Time Assessment, Medication Administration Assessment, etc.)
4. The SC uploads a copy to iRecord, with any assessments, if applicable, and revises the plan accordingly.
5. The SC Supervisor (SCS) checks for the presence of an ISP Worksheet in iRecord when reviewing the ISP and ensures that the information is accurately reflected in the service plan.

**Support Coordinator Requests for Form:**

1. If this worksheet is not received, the SC, with the SCS in copy, will email the Provider requesting the completed form within 2 days, using the subject line: **<DDD ID#> - request for ISP Worksheet.** Follow-up efforts should be documented in a Case Note.
2. If the worksheet is not received, the SC, with the SCS and DDD.PPMU@dhs.nj.gov in copy, will email the provider, utilizing the same email chain, requesting the completed form within 2 days. Follow-up efforts should be documented in a Case Note.
3. If after 2-3 additional days, a response is not received, the SC is to move forward with development of the service plan.
	1. The SC, or their SCS, will email DDD.PPMU@dhs.nj.gov and DDD.SCHelpdesk@dhs.nj.gov for follow-up with the Provider and ensure that case notes reflect all requests for information.

**Support Coordinator Use of Form:**

Although developed for use by Providers, an SC has the option to use this form to memorialize meeting minutes outside of a Provider setting.