**New Jersey Department of Human Services**

**Division of Developmental Disabilities**

**Individualized Service Plan (ISP) Worksheet for Day Habilitation Providers**

|  |  |
| --- | --- |
| **Individual Information** | |
| Name of Individual: Click to enter text. | Date of Meeting: Click to enter text. |
| DDD ID#: Click to enter text. | Provider: Click to enter text. |
| SC: Click to enter text. | SCA: Click to enter text. |

|  |
| --- |
| **Supervision Review** |
| List supervision needs under Safety & Supports tab; Support Settings Tile, with the reason further documented in the associated tile (i.e. Behavior/Sensory, Mobility/Adaptive equipment, Self-Care, Dietary, Health Hazards /Concerns). |
| **Do you have opportunities to be alone?**  At Day Hab: (Document this section under Work) Yes No  Where, When, and for How long? Click to enter text.  Describe the assistance you would need to evacuate in the event of an emergency: Click to enter text.  In Community: (Document this section under Community) Yes No  Where, When, and for How long? Click to enter text.  While in a vehicle: Yes No  Where, When, and for How long? Click to enter text.  Do you travel independently? Yes No  Parameters of independent travel: Click to enter text.  **Further Meeting discussion / Recommendations**: Click to enter text. |

|  |
| --- |
| **Medication Administration Review** |
| If independent, the Self-Medicate check box is checked for each applicable medication under the Medication tile. Otherwise, document a description of assistance for each medication. |
| **Do you need help taking your medication?**  Yes No  Detailed description of the assistance that is needed: Click to enter text.  If independent, where is my medication stored, how do I access it and how is it kept safe? Click to enter text.  Current list of medications is provided as a separate attachment? Yes No  Copies of Annual Physical / Dental have been provided to the SC for upload? Yes No    **Further Meeting discussion/Recommendations:** Click to enter text. |

|  |
| --- |
| **Financial Review** |
| Assistance is listed under Safety & Supports tab; Support Settings tile – Community. |
| **What do you like to do with your money?**  Click to enter text.  Do you feel comfortable making purchases on your own? Yes No  Is assistance needed with making purchases? Yes No  If yes, what do you need assistance with? Click to enter text.  **Further Meeting discussion / Recommendations:** Click to enter text. |

|  |
| --- |
| **Meal Time** |
| Dietary needs are listed under Health & Nutrition Tab |
| **Are you any type of Diet?**  Click to enter text.  Has this been prescribed by a doctor or medical professional? Yes No  If yes, is there a prescription on file? Yes No  Is specialized meal prep necessary? Yes No  If yes, select one: Ground  Chopped  Pureed  Other  Click to enter text.  Do liquids require thickening? Yes No  If yes, select one: Nectar/mild thick  Honey/medium thick  Pudding/ extremely thick  Risks during mealtime are listed under Health & Nutrition Tab; Dietary and/or Health Hazards/Concerns  **Are you considered at risk for:**  Aspiration? No  Yes  If yes, describe: Click to enter text.  Choking? No  Yes  If yes, describe: Click to enter text.  Dehydration? No  Yes  If yes, describe: Click to enter text.  Swallowing Disorder? No  Yes  If yes, describe: Click to enter text.  Supports Needs at mealtime are listed in the Health and Nutrition Tab, under Self-Care tile.  **Have you had any changes in the past year in:**  Support needs at meal time: No  Yes  If yes, describe: Click to enter text.  Chewing and Swallowing: No  Yes  If yes, describe: Click to enter text.  Drinking on own: No  Yes  If yes, describe: Click to enter text.  Feeding Self: No  Yes  If yes, describe: Click to enter text.  Mealtime behaviors (eating too fast/overstuffing mouth/food stealing/etc.): No  Yes  If yes, describe: Click to enter text.  **Further Meeting discussion / Recommendations**: Click to enter text.  Is a referral to the DDD Resource Team recommended due to mealtime concerns? Yes No  If yes, the Support Coordinator should complete & email the [Speech Pathology Consultation Referral](https://www.nj.gov/humanservices/ddd/documents/speech-pathology-consultation-referral.docx) Form to [ddd.resourceteam@dhs.nj.gov](mailto:ddd.resourceteam@dhs.nj.gov). |

|  |
| --- |
| **Mobility And Prescribed Adaptive Equipment** |
| Are listed under Safety & Supports tab; “Other” is selected to describe assistance needed with mobility and or transfers, as well as to list adaptive equipment such as: glasses, hearing aids, Hoyer Lift, Orthotic shoes, adaptive equipment used at mealtime, etc**.** |
| **Do you need assistance with mobility?**  Click to enter text.  Do you need assistance with stairs? Yes No  Is assistance needed with transfers, such as moving from one chair to another? Yes No  Do you need assistance with getting in or out of a vehicle? Yes No  Detailed description of assistance needed for any of the above: Click to enter text.  **Do you have adaptive equipment prescribed for you?** Yes No  If yes, list equipment:   |  |  | | --- | --- | | **Equipment** | **Comments** | | Click to enter text. | Click to enter text. | | Click to enter text. | Click to enter text. | | Click to enter text. | Click to enter text. |   **Further Meeting discussion / Recommendations:** Click to enter text. |

|  |
| --- |
| **Community Integration** |
| Include within Community Integration tile of PCPT |
| **Have you had the opportunity to engage in community activities of your choice?**  Yes No  What types of activities do you enjoy in your community? Click to enter text.  What types of activities would you like to learn more about? Click to enter text.  **Meeting Discussion/Recommendations**: Click to enter text. |

|  |
| --- |
| **Home and Community Based Settings (HCBS) Modifications** |
| Review carefully |
| All settings where HCBS services are delivered are required to be in compliance with the HCBS final rule, including non-residential settings. There are times when a modification to the HCBS setting requirement may be needed based on an individual’s need, such as when there is a need for a rights restriction. Does the individual require a rights restriction or other HCBS modification? If so, please answer the following questions:  Does the individual require a rights restriction or other HCBS modification? Yes No    **If yes, answer the following six questions:**   1. Describe the specific assessed need, and why the modification or restriction is needed:   Click to enter text.   1. Describe positive interventions and less intrusive methods that were attempted but unsuccessful: Click to enter text. 2. Describe the intervention that is directly proportionate to the specific assessed need:   Click to enter text.   1. Describe the ongoing data review to measure the ongoing effectiveness of the modification:   Click to enter text.   1. Describe the established time limits for periodic reviews of the modification to determine if it’s still necessary: Click to enter text. 2. Has informed consent been received from the individual? Will the modification cause no harm?   Yes No  **Meeting discussion / Recommendations**: Click to enter text. |

|  |
| --- |
| **Behavior Support Plan** |
| All approved Behavior Support Plans must be uploaded into I Record and be documented in the ISP under Behavior. The ISP meeting should also include discussion about the need for a Behavior Plan and the review of progress for existing Behavior Plans. |
| **Do you have or are you in need a Behavior Support Plan?** Yes No  **Meeting discussion / Recommendations:** Click to enter text. |

|  |  |
| --- | --- |
| **Day Hab Services** |  |
| **Identification of Services -** Refer to **Appendix K (Quick Reference Guide to Overlapping Claims for Services)** to avoid overlapping claims. Reminder, if an individual is assigned an acuity factor, Behavioral Supports cannot be claimed while providing Individual Supports, Community Based Supports, and Day Habilitation because it is included within the rate. |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Applicable Service(s)** | **Provider Name** | **Units Per Week** | **Dates closed, if applicable** |
| Behavioral Supports – Assessment/Development | Click to enter text. | Click to enter text. | Click to enter text. |
| Behavioral Supports – Monitoring | Click to enter text. | Click to enter text. | Click to enter text. |
| Career Planning (cannot exceed 80 hours / year) | Click to enter text. | Click to enter text. | Click to enter text. |
| Day Habilitation (cannot exceed 30 hours / week) | Click to enter text. | Click to enter text. | Click to enter text. |
| Prevocational Training - Individual | Click to enter text. | Click to enter text. | Click to enter text. |
| Prevocational Training - Group | Click to enter text. | Click to enter text. | Click to enter text. |
| Supported Employment - Individual | Click to enter text. | Click to enter text. | Click to enter text. |
| Supported Employment - Group | Click to enter text. | Click to enter text. | Click to enter text. |
| Transportation – (Multi, Single or SDE) | Click to enter text. | Click to enter text. | Click to enter text. |

Other services (Some examples: Assistive Technology, OT, PERS, PT, Speech, Language, & Hearing Therapy):

|  |  |  |  |
| --- | --- | --- | --- |
| **Applicable Service(s)** | **Provider Name** | **Units per Week** | **Start / End Dates** |
| 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. |

|  |  |  |
| --- | --- | --- |
| **Day Hab Team Member providing information contained on this document:** | | |
| Name: Click to enter text. | Title: Click to enter text. | Date: Click to enter text. |
| Email: Click to enter text. | Phone: Click to enter text. | Alt #: Click to enter text. |

**Instructions for Completion:**

This form is completed by the Day Habilitation Provider **with the Individual** prior to and in preparation for the anniversary ISP for all individuals that they support. It is used to communicate service and support needs, as well as additional information, to the Support Coordinator (SC) for discussion and inclusion in the ISP. This form does not replace the assessments used to develop the ISP.

**Instructions for Distribution and Review:**

1. Upon completion of Worksheet, Provider will send a copy, and will include any assessments used to inform the development of the service plan (I.e. Unsupervised Time Assessment, Medication Administration Assessment, etc.) to SC, Legal Guardian, and/or involved family member(s) at least 30 days prior to the meeting to allow time for review and preparation for meeting.
2. Team members review content at the planning team to ensure that everyone agrees that information is accurate and sufficient in addressing support needs, and the worksheet is revised as necessary.
3. The SC includes information from this worksheet to develop service plan documents.
4. The SC uploads the ISP Worksheet, with any assessments, to iRecord as well as any assessments provided by the Provider.
5. The SC Supervisor (SCS) checks for presence of ISP Worksheet 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 within 20 days prior to the annual meeting, 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 within 2-3 days, the SC, with the SCS and [DDD.PPMU@dhs.nj.gov](mailto: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 will move forward with development of the service plan.
   1. The SC, or their SCS, will email [DDD.PPMU@dhs.nj.gov](mailto:DDD.PPMU@dhs.nj.gov) and [DDD.SCHelpdesk@dhs.nj.gov](mailto:DDD.SCHelpdesk@dhs.nj.gov) for follow-up with the Provider and ensure that case notes reflect all requests for information.