**New Jersey Department of Human Services**

**Division of Developmental Disabilities**

**Individualized Service Plan (ISP) Worksheet for Residential Providers**

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| **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.  |

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| **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 Home: (Document this section under Home) [ ] 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 [ ] NoWhere, When, and for How long? Click to enter text.While in a vehicle: [ ] Yes [ ] NoWhere, When, and for How long? Click to enter text.Do you travel independently? [ ] Yes [ ] NoParameters of independent travel: Click to enter text.**Further Meeting discussion / Recommendations**: Click to enter text. |

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| **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 [ ] NoDetailed 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. |

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| **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 [ ] NoIs assistance needed with making purchases or planning for purchases? [ ] Yes [ ] NoIf yes, what do you need assistance with? Click to enter text. Do you know how to obtain monies to purchase items you want or need? [ ] Yes [ ] NoHow much money can you currently hold without staff assisting you? Click to enter text. Do you need assistance with your finances? [ ] Yes [ ] NoIf yes, in what areas? Click to enter text.**Further Meeting discussion / Recommendations:** Click to enter text. |

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| **Meal Time Review** |
| 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 [ ] NoIf 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.  |

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| **Mobility And Prescribed Adaptive Equipment Review** |
| 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 [ ] NoIs assistance needed with transfers, such as moving from one chair to another? [ ] Yes [ ] NoDo you need assistance with getting in or out of a vehicle? [ ] Yes [ ] NoDetailed description of assistance needed for any of the above: Click to enter text.**Do you have adaptive equipment prescribed for you?** [ ] Yes [ ] NoIf yes, list equipment:

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| **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.  |

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| **Community Integration Review** |
| Include within Community Integration tile of PCPT |
| **Have you had the opportunity to engage in community activities of your choice?**  [ ] Yes [ ] NoWhat 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. |

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| **Home and Community Based Settings (HCBS) Modifications Review** |
| Review carefully  |
| The HCBS Final Rule identifies five conditions that provider-owned or controlled residential settings must meet, in addition to the requirements for all HCBS settings. These additional conditions are:1) The living unit must be able to be owned, rented, or occupied under a legally enforceable agreement2) Each individual must have privacy in their living unit, reinforced by lockable entrance doors, choice of roommate, and freedom to furnish the living unit as they choose;3) Each individual must have the freedom and support to control their own schedules, and have access to food at any time; 4) Each individual must be able to have visitors of their choosing at any time; and 5) The setting must be physically accessible to the individual. (*To this, modification is not permitted)*A modification may be necessary if meeting one of these conditions puts the individual or others at serious risk of harm. Any modification must consist of the following six elements: 1. Identification of a specific and individualized assessed need;
2. Documentation of positive interventions and supports and less intrusive methods which were unsuccessful;
3. Documentation in the Individual Service Plan a clear description of the intervention that is directly proportionate to the assessed need;
4. Ongoing data review to measure the ongoing effectiveness of the modification;
5. Established time limits for periodic reviews of the modification to determine if it is still necessary;
6. Informed consent and lack of harm to the individual from the modification.

After reviewing the above, is a modification to the HCBS requirement necessary? [ ] 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.  |

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| **Behavior Support Plan Review** |
| 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.  |

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| **Residential 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. |

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| **Applicable Service(s)** | **Provider Name** | **Units per Week**  | **Start / End Dates, if applicable** |
| Individual Supports (daily rate) | Click to enter text. | Click to enter text. | Click to enter text. |
| Individual Supports (hourly rate) | Click to enter text. | Click to enter text. | Click to enter text. |
| 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. |

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

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| **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. |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |

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| **Residential Provider 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 Residential Provider **with the individual** prior to and in preparation for the anniversary ISP for all individuals that they support residentially. It is used to communicate service and support needs as well as additional regulatory/required 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 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 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 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 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:**

Use of this form to complete or revise the service plan is not required, but is strongly recommended, for individuals not in a residential setting but:

* are receiving Individual Supports in their home through a Provider or a Self-Directed Employee (SDE)
* are living with family or a caregiver and are seeking respite services
* may be considered at risk of needing emergent services

For these scenarios, the SC would complete this worksheet in conjunction with the family/caregiver and would upload the completed worksheet to iRecord and complete/revise the ISP accordingly.