**New Jersey Department of Human Services**

**Division of Developmental Disabilities**

**Support Coordinator Monitoring Tool - Quarterly**

Used at least once every three months to document monitoring contact with Individuals and caregivers.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Section 1: Identifying Information** | | | | | | | | | | |
| Individual’s Name: Click to enter text.  DDD ID #: Click to enter text.  NJCAT Score: Self-Care, Behavioral, Medical  Tier: Choose an item. | | Current Program: Choose an item.  Current Living Arrangement: Choose an item.  If Other, please describe: Click to enter text.  Is an Approved ISP in Place? Yes  No | | | | | | | | |
| Name of Support Coordination Agency: Click to enter text. | | | | | | | | | | |
| Name of Assigned Support Coordinator: Click to enter text. | | | | | | | | | | |
| Contact Date: Enter a date. |  | | | | | | | | | |
| Contact Location: Choose an item. | If Other, please describe: Click to enter text. | | | | | | | | | |
| Contact Type: Choose an item. | If Phone, enter the phone #: Click to enter text. | | | | | | | | | |
| Who is the primary contact for this **Quarterly** monitoring? Click to enter text.  Relationship to the Individual: Click to enter text.  If the Individual is not the primary contact, were they involved in the conversation? Yes  No  Please describe or explain: Click to enter text. | | | | | | | | | | |
| Does the Individual currently attend a DDD funded, provider managed day program? Yes  No | | | | | | | | | | |
| If Yes, please enter name of agency and address of program: Click to enter text. | | | | | | | | | | |
| Does the Individual currently reside in a DDD funded, provider managed residential setting? Yes  No | | | | | | | | | | |
| If Yes, please enter name of agency and address of program: Click to enter text. | | | | | | | | | | |
| Does the Individual currently use Self-Directed Employees (SDEs)? Yes  No | | | | | | | | | | |
| If Yes, how many active SDEs? Click to enter text. | | About how many hours/month? Click to enter text. | | | | | | | | |
| **Section 2: Follow Up Items from Previous Months’ Contact** | | | | | | | | | | |
| List follow up items **not** resolved at the time of last contact, indicating the status of each. Ensure all follow up activity is documented in case notes. To add rows, click in the last box, then click the Plus sign, **+**, on the right. | | | | | | | | | | |
| Follow Up Item: Click to enter text.  Completed/Resolved? Yes No  If no, briefly describe the status **and** planned action: Click to enter text. | | | | | | | | | | |
| Follow Up Item: Click to enter text.  Completed/Resolved? Yes No  If no, briefly describe the status **and** planned action: Click to enter text. | | | | | | | | | | |
| Follow Up Item: Click to enter text.  Completed/Resolved? Yes No  If no, briefly describe the status **and** planned action: Click to enter text. | | | | | | | | | | |
| **Section 3: Community Connections** *(Refer to the PCPT regarding community integration, and update as needed)* | | | | | | | | | | |
| 1. What have you been doing outside the home/in the community in the past few months? (For example: movies, shopping, going out to eat, etc.) Click to enter text. | | | | | | | | | | |
| 1. Do you like the things you are currently doing in the community? | | | Yes | |  | | No\* | |  | |
| 1. Do you decide, or with necessary support decide, the community activities you do and with whom you do them (including people you do not live with)? | | | Yes | |  | | No\* | |  | |
| 1. Are there things you are doing now that you would like to do more often, and/or things you are not doing now that you would like to do? | | | Yes\* | |  | | No | |  | |
| **Comments / Follow Up Items *\*Explain each answer with an asterisk. Include follow up items as applicable.*** | | | | | | | | | | |
| Click to enter text. | | | | | | | | | | |
| **Section 4: Relationships** *(Refer to the PCPT regarding important relationships, and update as needed)* | | | | | | | | | | |
| 1. How have you been connecting (For example: by phone, visits, outings in the community, etc.) with the people important to you? Click to enter text. | | | | | | | | | | |
| 1. Are you able to have visitors when you want? | | | Yes | |  | | No\* | |  | |
| 1. When you have visitors, do you have privacy? | | | Yes | |  | | No\* | |  | |
| **Comments / Follow Up Items *\*Explain each answer with an asterisk. Include follow up items as applicable.*** | | | | | | | | | | |
| Click to enter text. | | | | | | | | | | |
| **Section 5: Personal Rights and Autonomy** | | | | | | | | | | |
| 1. Do you have access to your own money, and are you able to spend it on things you like? | | | Yes | |  | | No\* | |  | |
| 1. Do people respect your privacy in your bedroom and in the bathroom? | | | Yes | |  | | No\* | |  | |
| 1. Do you feel respected by people who support you? | | | Yes | |  | | No\* | |  | |
| 1. Do you feel safe at home, in your neighborhood, at work/day program, and during community activities? | | | Yes | |  | | No\* | |  | |
| **Comments / Follow Up Items *\*Explain each answer with an asterisk. Include follow up items as applicable.*** | | | | | | | | | | |
| Click to enter text. | | | | | | | | | | |
| **Section 6: Continuity and Stability with Living Arrangement** | | | | | | | | | | |
| 1. Do you like where you live? | | | Yes | |  | | No\* | |  | |
| 1. Can you have snacks/food when you like? | | | Yes | |  | | No\* | |  | |
| 1. Is there anything happening now that might require a change with your housing?   (For example: behind on rent, significant problems with housemates, desire to live in another setting/location, etc.) | | | Yes\* | |  | | No | |  | |
| 1. Have there been any changes at home recently? (For example: People you live with, new staff, problems with your home/apartment) | | | Yes\* | |  | | No | |  | |
| 1. How do you feel about any changes that may have occurred at home in the last month? | | | | | | | | | | |
| Click to enter text. | | | | | | | | | | |
| **Comments / Follow Up Items *\*Explain each answer with an asterisk. Include follow up items as applicable.*** | | | | | | | | | | |
| Click to enter text. | | | | | | | | | | |
| **Section 7: Employment and Day Services** | | | | | | | | | | |
| 1. How do you normally spend your weekdays? (For example: At a job, day program, retired, etc.) | | | | | | | | | | |
| Click to enter text. | | | | | | | | | | |
| 1. Do you like what you do during the day? | | | Yes | |  | | No\* | |  | |
| 1. Are you interested in changing what you do during the day, or do you want to attend/work for more, or less, hours? (For persons at retirement age, discuss retirement as well.) | | | Yes\* | |  | | No | |  | |
| ***Ask / Answer one of the following:*** | | |  | |  | |  | |  | |
| 1. If you **are not** working now, are you interested in work? | | | Yes\* | |  | | No | |  | |
| 1. If you **are** working now, would you like to explore ways to further career goals and/or work more hours? | | | Yes\* | |  | | No | |  | |
| 1. ***(For the SC)*** If the Individual is **not** working now, but **is** interested, has a referral to DVRS or CBVI been completed? *(Update the Employment Pathway as needed)* N/A  Yes  No\*   If applicable, explain the referral status: Click to enter text. | | | | | | | | | | |
| **Comments / Follow Up Items *\*Explain each answer with an asterisk. Include follow up items as applicable.*** | | | | | | | | | | |
| Click to enter text. | | | | | | | | | | |
| **Section 8: Outcomes and Services** | | | | | | | | | | |
| ***(Ensure all services, including those with non-Division funding sources, are entered in the ISP.)***  **Review ALL** current outcomes and services as they appear in the ISP with the Individual/MT contact. Include services provided by natural supports. If there are **no** funded services in the ISP, **explain** why not. | | | | | | | | | | |
| 1. ***(For the SC)*** Has a verbal review of outcomes and services been completed? | | | | Yes | |  | | No\* | |  |
| 1. Are you receiving **all** services as entered in the ISP? | | | | Yes | |  | | No\* | |  |
| 1. Do you feel your services are helping you make progress toward ISP outcomes? | | | | Yes | |  | | No\* | |  |
| 1. Are there outcomes or services you would like to change, add or remove from your ISP, including changes to any service providers you may use? | | | | Yes\* | |  | | No | |  |
| 1. ***(To be answered by the SC):*** Will the current rate of budget expenditure allow services to continue as needed throughout the entire plan term? | | | | Yes | |  | | No\* | |  |
| **Comments / Follow Up Items *\*Explain each answer with an asterisk. Include follow up items as applicable.*** | | | | | | | | | | |
| Click to enter text. | | | | | | | | | | |
| **Section 9: Health and Safety** | | | | | | | | | | |
| When completing quarterly monitoring with someone in a DDD funded, provider managed residential or day setting, consult with provider staff to complete ***a****.* through ***j****.* below.  When completing quarterly monitoring with someone in a setting **other than** a DDD funded, provider managed setting, complete only items ***f****.* through ***l****.* with the Individual/caregiver. | | | | | | | | | | |
| Name of Service Provider: Click to enter text. | | | | | | | | | | |
| Name and Title of Staff Member: Click to enter text. | | | | | | | | | | |
| Program Name and Type: Click to enter text. | | | | | | | | | | |
| 1. Date of last annual physical: Click to enter text. | | 1. Date of last dental checkup: Click to enter text. | | | | | | | | |
| 1. How has the Individual been made aware of their rights in this program, including choice of roommate (if applicable)? Click to enter text. | | | | | | | | | | |
| 1. Are there any restrictions in this setting affecting the rights of this Individual **not** supported by a specific assessed need and justified in the ISP?   (For example: Access to sharp objects, food, common areas of the home, computer/internet; alarms on doors/windows, privacy locks, etc.) | | | Yes\* | |  | | No | |  | |
| 1. Per the ISP, is all doctor prescribed and/or behavioral data collection occurring? (For example: BSP data, bowel movements, caloric intake, etc.) | | | Yes | |  | | No\* | |  | |
| 1. Have there been recent changes to the supervision levels for this Individual? | | | Yes\* | |  | | No | |  | |
| 1. Have there been changes to your health since last month, including medication changes? (Physical, emotional, behavioral, psychological, etc.) | | | Yes\* | |  | | No | |  | |
| 1. Have you been hospitalized or visited an emergency room since last month? | | | Yes\* | |  | | No | |  | |
| 1. Have you had medical/dental/specialist appointments since last month? | | | Yes\* | |  | | No | |  | |
| 1. If yes, did the doctor/dentist/specialist make any follow up recommendations that are not yet completed and/or scheduled? | | | Yes\* | |  | | No | |  | |
| 1. For Individuals residing in non-provider managed settings, has the importance of routine/preventative medical/dental/specialist appointments been discussed? | | | Yes | |  | | No\* | |  | |
| 1. For Individuals residing in non-provider managed settings, is there an emergency plan if a caregiver/staff are unexpectedly unable to provide care?   ***If yes, ensure this is in the ISP or described in a separate document uploaded in iRecord.***  ***If No, schedule a Planning Team meeting to discuss.*** | | | Yes | |  | | No\* | |  | |
| **Comments / Follow Up Items *\*Explain each answer with an asterisk. Include follow up items as applicable.*** | | | | | | | | | | |
| Click to enter text. | | | | | | | | | | |
| **Section 10: Medicaid Status** *(SC will find status of a. and b. below on Individual’s Demographics tile in iRecord)* | | | | | | | | | | |
| 1. Is the Individual Medicaid eligible? ***(Indicated by green litmus)*** | | | Yes | |  | | No\* | |  | |
| 1. Is the Individual’s Medicaid scheduled to terminate? ***(Indicated by yellow litmus)*** | | | Yes\* | |  | | No | |  | |
| 1. Is the representative payee aware that financial changes could jeopardize Medicaid eligibility? (For example: Retirement of parent, passing of parent, resources over $2,000, etc.) | | | Yes | |  | | No\* | |  | |
| **Comments / Follow Up Items *\*Explain each answer with an asterisk. Include follow up items as applicable.*** | | | | | | | | | | |
| Click to enter text. | | | | | | | | | | |
| **Section 11: Closing Question for the Individual/Caregiver** | | | | | | | | | | |
| Is there anything else you would like me to know right now, or anything else you need assistance with? | | | | | | | | | | |
| Click to enter text. | | | | | | | | | | |
| **Section 12: To be Answered by the Support Coordinator** | | | | | | | | | | |
| This section may be completed without further discussion with the Individual/caregiver. | | | | | | | | | | |
| 1. Are there behaviors or activities happening that planning team members would consider risky, and not adequately addressed in the Individual’s ISP?   (For example: Aggression, elopement, drug/alcohol use, etc.) | | | Yes\* | |  | | No | |  | |
| 1. Have any Incident Reports (IRs) been completed/submitted since last month’s contact? (According to iRecord notes, email notification, conversations, etc.) | | | Yes\* | |  | | No | |  | |
| 1. Has there been an increase or identified patterns in IRs in the past three months? | | | Yes\* | |  | | No | |  | |
| 1. Based on information received during this contact, are there new incidents or allegations of abuse, neglect or exploitation, which require a new IR? | | | Yes\* | |  | | No | |  | |
| 1. Is the Contacts list in iRecord up to date, including Emergency Contacts?   ***If No, please update before the next monitoring contact.*** | | | Yes | |  | | No\* | |  | |
| 1. Does the Individual’s NJCAT tier include the acuity factor? **If yes**, answer questions ***g****.* through ***m****.* in this box. If no acuity is assigned, leave ***g****.* through ***m****.* blank. | | | Yes | |  | | No | |  | |
| 1. Acuity factor/enhanced needs present for: Behavioral Medical Both | | |  | |  | |  | |  | |
| 1. Are all Addressing Enhanced Needs Forms up to date? (CBS, IS, Day Hab, Respite) | | | Yes | |  | | No\* | |  | |
| 1. Does it appear all necessary enhanced supports are in place? | | | Yes | |  | | No\* | |  | |
| 1. If the acuity factor is for Behavioral, is a Behavior Support Plan in place? | | | Yes | |  | | No\* | |  | |
| 1. **If yes**, is the ***current*** Behavior Support Plan uploaded to iRecord? | | | Yes | |  | | No\* | |  | |
| 1. Does the Behavior Support Plan appear to be meeting the Individual’s needs? | | | Yes | |  | | No\* | |  | |
| 1. If for Medical, does the ISP state the diagnosis(es) and describe care needs? | | | Yes | |  | | No\* | |  | |
| **Comments / Follow Up Items *\*Explain each answer with an asterisk. Include follow up items as applicable.*** | | | | | | | | | | |
| Click to enter text. | | | | | | | | | | |
| **Section 13: Areas Requiring Division Assistance** | | | | | | | | | | |
| 1. Is this the **fourth** consecutive month (or more) for which you have not been able to complete a face-to-face visit? | | | Yes\* | |  | | No | |  | |
| 1. Have risk factors been identified for which Division assistance is needed?   (Ex: Significant changes in the Individual’s/caregiver’s support needs, behavioral/medical concerns, housing instability, long-term hospitalization/nursing home admission, etc.)  **If either *a*. or *b*. is Yes, complete/upload an SOS form and notify the** [DDD SCHelpdesk](mailto:DDD.SCHelpdesk@dhs.nj.gov) | | | Yes\* | |  | | No | |  | |
| **Comments / Follow Up Items *\*Explain each answer with an asterisk. Include follow up items as applicable.*** | | | | | | | | | | |
| Click to enter text. | | | | | | | | | | |
| **Section 14: Contact Summary** | | | | | | | | | | |
| Summarize the conversation describing highlights and points of interest or concern for the Individual since the last monitoring contact. Include observations about the environment and the Individual’s interactions **not already** in this document. | | | | | | | | | | |
| Click to enter text. | | | | | | | | | | |
| **Section 15: Completed by** | | | | | | | | | | |
| Name: Click to enter text.  Title: Click to enter text. | | Date: Click to enter a date. | | | | | | | | |
| If completed by someone other than the assigned Support Coordinator, please explain: Click to enter text. | | | | | | | | | | |
| **Section 16: Reviewed by - *SCS review is required for the first 60 days of any new Support Coordinator, when performance issues have been identified and for complicated or difficult situations.*** | | | | | | | | | | |
| Name of SC Supervisor: Click to enter text. | | Review Date: Enter a date. | | | | | | | | |