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**New Jersey Department of Human Services**

**Division of Developmental Disabilities**

**Support Coordination Unit**

**Independent Living Discussion Tool**

Use of this form is recommended when an Individual is interested in moving to a setting that is not licensed. It is intended to guide the Support Coordinator and planning team in discussion to ensure that a safe and supportive plan can be put into place prior to the move.

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| **BACKGROUND INFORMATION** | | | | | | | |
| Date of Meeting: Click or tap to enter a date. | | | Purpose of Meeting: Choose an item. | | | | |
| Name of Individual: Click or tap here to enter text. | | | DDD ID # Click or tap here to enter text. | | | | |
| Supports Program  Community Care Program | | | Date of Birth:       Age: | | | | |
| Self-Care- Behavioral-Medical Score:  Tier: | | | Current type of living arrangement:  Choose an item. | | | | |
| Name of Legal Guardian:  Ensure guardianship judgment is uploaded. | | | Will living arrangement be alone or shared? Choose an item.  If space will be shared, who with?  Enter full name(s) and relationship here | | | | |
| **SUPPORT COORDINATION AGENCY INFORMATION** | | | | | | | |
| Name of Support Coordination Agency:  Click or tap here to enter text. | | | Name of Division Quality Assurance Specialist:  Click or tap here to enter text. | | | | |
| Name of Support Coordinator:  Click or tap here to enter text. | | | Phone Number: | | | Email: | |
| Name of SC Supervisor:  Click or tap here to enter text. | | | Phone Number: | | | Email: | |
| **SUPERVISION AND SUPPORT NEEDS / NEED FOR PERSONAL GUIDANCE AND SELF PRESERVATION** | | | | | | | |
| Expected prerequisites should include discussion of and documented evidence that the individual is:   * Capable of self-preservation in emergencies; * Capable of self-administration of medication or can direct assistance; * Self-sufficient with safety at home, including fire safety and minor first aid; * Self-sufficient with personal hygiene; * Capable of telephone use; and * Has basic shopping skills.   **SUPERVISION NEEDS WHILE AT HOME**     1. Where, when, and for how long may individual be alone while at home? 2. Is there a documented health or mental health problem requiring supervision of the person for the protection of themselves or others? Yes No 3. In this new setting, if a primary means for support/supervision is a family member/care giver/SDE what is the back-up plan if they cannot arrive to provide support?   The above information should also be documented in ISP under Support Settings - Home  4. Will services that are being identified be sufficient to address support needs? Yes No  *If no, additional planning may be needed prior to a move.* | | | | | | | |
| **SUPERVISION NEEDS WHILE IN THE COMMUNITY**   1. Where, when, and for how long may individual be alone while in the community? 2. Is there a documented health or mental health problem requiring supervision of the person for the protection of themselves or others? Yes No 3. Can Individual travel independently? Yes No 4. Parameters of independent travel: 5. Is there a history of problematic sexual behaviors, Megan’s Law charges, and/or fire setting behavior? 6. Is specialized medical care or on site nursing required?   The above information should also be documented in ISP under Support Settings - Community   1. Will services being identified be sufficient to address support needs? Yes No   *If no, additional planning may be needed prior to a move.* | | | | | | | |
| **MEDICATION ADMINISTRATION**   1. Does Individual need help taking medication? Yes No 2. Detailed description of the assistance that is needed:   The above information should also be documented in ISP within the medication box for each medication.  If independent with a medication, the self-medicate check box should be checked with each applicable medication.   1. Will services that are being identified be sufficient to address support needs? Yes No   *If no, additional planning may be needed prior to a move.* | | | | | | | |
| **FINANCIAL REVIEW**   1. Does Individual need assistance with finances? Yes No 2. If yes, in what areas? 3. Does the Individual have a Representative Payee? Yes No   If yes, who?   1. The above information should also be documented in ISP under Support Settings – Community. 2. Can the Individual afford other costs associated with living on own, such as food, utilities, toiletries, household items and furnishings? Yes No   *If the answer is no to either of the above two questions, If no, additional planning may be needed prior to a move.*   1. If a concern pertains to a reported risk of financial exploitation, has a referral been made to a representative payee program, if they don’t already have one? Yes No  N/A   If no, please explain: Click or tap here to enter text. | | | | | | | |
| **SUPERVISION NEEDS AT MEAL TIME**   1. Please describe assistance needed with meal prep: Click here to enter text. 2. Please describe assistance needed with meal planning: Click here to enter text. 3. Please describe assistance needed with food shopping: Click here to enter text. 4. Please describe assistance needed with eating: Click here to enter text.   The above information should also be documented in the ISP under the Health & Nutrition - Dietary and/or Health Hazards/Concerns   1. Will services that are being identified be sufficient to address support needs? Yes No   *If no, additional planning may be needed prior to a move.* | | | | | | | |
| **SUPPORTS AND SERVICES NEEDED IN PROPOSED SETTING**  Ensure that all services (both generic and thru the budget) are listed to address any need(s).  Each service type requires a response even if service is not presently being utilized. | | | | | | | |
| **Service Type/ Provider of Service** | **Provider Name** | **Frequency/Duration** | | **Funding Source** | **Cost per plan year** | | **Comment**  **\*Complete column even if service is not received** |
| **Community Based Supports (CBS) / Individual Supports (IS)** | Click or tap here to enter text. | Click here to enter text. | | Click here to enter text. | Click here to enter text. | | Choose an item.  Comment:  Click or tap here to enter text. |
| **Natural Supports** | Click or tap here to enter text.  Relationship:  Click or tap here to enter text. | Click here to enter text. | | Natural / Generic | N/A | | Choose an item.  Comment:  Click or tap here to enter text. |
| **Self-Directed Employee(s)** | Click or tap here to enter text.  Relationship:  Click or tap here to enter text. | Click here to enter text. | | Click here to enter text. | Click here to enter text. | | Choose an item.    Comment:  Click or tap here to enter text. |
| **Day Hab/Community Inclusion/**  **Employer** | Click or tap here to enter text. | Click here to enter text. | | Click here to enter text. | Click here to enter text. | | Choose an item.  Comment:  Click or tap here to enter text. |
| **Mental Health Services** | Click or tap here to enter text. | Click here to enter text. | | Click here to enter text. | Click here to enter text. | | Choose an item.  Comment:  Click or tap here to enter text. |
| **Personal Preference Program (PPP) or Personal Care Attendant (PCA)** | Click or tap here to enter text.  Relationship:  Click or tap here to enter text. | Click here to enter text. | | Click here to enter text. | Click here to enter text. | | Choose an item.  Comment:  Click or tap here to enter text. |
| **Behavioral Supports including CARES, DDHA, Serv** | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. | Click or tap here to enter text. | | Choose an item.  Comment:  Click or tap here to enter text. |
| **Other Services** | Click or tap here to enter text. | Click here to enter text. | | Click here to enter text. | Click here to enter text. | | Choose an item.  Comment:  Click or tap here to enter text. |
| 1. Total estimated annual cost of identified services 2. Total annual budget 3. Does the estimated cost for services fit within the annual budget? Yes No   *If no, additional planning may be needed prior to a move.* | | | | | | | |
| Are there any barriers to necessary services being in the ISP? Yes No  If yes, please describe:  *If yes, additional planning may be needed prior to a move.* | | | | | | | |
| Is there additional information about this request? Click or tap here to enter text. | | | | | | | |

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| **Attendance of Planning Team Members** | |
| **Name** | **Title / Relationship** |
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**INSTRUCTIONS**

1. Upon completion of meeting, Support Coordinator uploads form to I Record.
2. Support Coordinator makes any necessary revisions to ISP to ensure that services are available as discussed by the planning team.
3. If assistance or discussion is needed, please submit an SOS to: [DDD.SCHelpdesk@dhs.nj.gov](mailto:DDD.SCHelpdesk@dhs.nj.gov)

**Note:** If the Individual presently resides in a licensed setting and they and the Provider wish to have the setting unlicensed, the request from the residential provider to un-license the setting must be submitted to their assigned Program Developer.