**DEPARTMENT OF HUMAN SERVICES - DIVISION OF DEVELOPMENTAL DISABILITIES**

**Self-Directed Respite Transition Plan**

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| --- | --- | --- | --- | --- |
| Date: | Consumer Name: | | | Date of Birth: |
| Name of individual/contact completing this form: | | | | Relationship to Consumer: |
| Contact Telephone: | | | Contact Telephone: | Contact Email: |
| County where consumer resides: | | | |
| ***Agency Currently Providing Self Directed Respite*** | | Agency Name:  Comments: | | |
| ***Agency Selected to Provide Future Respite Services; If  Different from Above*** | | Agency Name:  Comments: | | |
| ***Service Selected to Replace Self Directed Respite*** | | **PLEASE CHECK ONE BOX ONLY**  The agency is in the process of hiring the person the family was paying:  You have asked the agency to recruit a worker to provide respite:  You have selected the use of the fiscal intermediary (Easter Seals):  You have requested a site based group respite program:  Comments: | | |
| ***Additional Comments*** | | Please share any additional information regarding the need for respite services: | | |
| **Please email this completed form to the DDD Self Directed Respite Helpdesk at** [**DDD.SelfDirectedRespiteHelpdesk@dhs.state.nj.us**](mailto:DDD.SelfDirectedRespiteHelpdesk@dhs.state.nj.us)  **DDD staff will be in contact with you to assist.** | | | | |