|  |  |
| --- | --- |
| Name of Individual: | Date of Planning Meeting: |
| DDD ID#: | Residential Provider: |
| SC: | SCA: |

**SUPERVISION**

Supervision needs are documented in the Safety and Supports tab under the Support Settings Tile. The *reason* for the supervision need is further documented in the associated tile (I.e. Behavior/Sensory, Mobility/Adaptive equipment, Self-Care, Dietary, Health Hazards/Concerns). Remember to consider support needs around meal time and medication administration.

**Do you have opportunities to be alone?**

At Home: Yes No

Where, When, and for How long?

Are you able to evacuate independently in event of an emergency or would you need assistance?

**(Document under Home):**

In Community: Yes No

Where, When, and for How long?

While in a vehicle: **(Document under Community)** Yes No

Where, When, and for How long?

Do you travel independently? **(Document under Community)** Yes No

Parameters of independent travel:

**Further Meeting discussion / Recommendations:**

**MEDICATION ADMINISTRATION**

If independent with a Medication, the Self-Medicate check box should be checked with each applicable medication under the Medication tile. If not independent, the assistance for each medication must be documented within each medication box.

Do you need help taking your medication? Yes No

Detailed description of the assistance that is needed:

If independent, where is my medication stored, how do I access it and how is it kept safe?

**Further Meeting discussion/Recommendations**:

**FINANCIAL REVIEW**

Assistance with finances is documented under the Support Settings – Community.

What do you like to do with your money?

Do you feel comfortable making purchases on your own? Yes No

Is assistance needed with making purchases or planning for purchases? Yes No

If yes, what do you need assistance with?

Do you know where or how to obtain monies to purchase items you want or need?

Yes No

How much money can you currently hold without staff assisting you?

Do you need assistance with your finances? Yes No

If yes, in what areas?

**Further Meeting discussion / Recommendations:**

**MEAL TIME**

Supports needs are documented in the Health and Nutrition Tab under Dietary and Health Hazards/Concerns tiles

Type of Diet

Is specialized meal prep necessary? No  Yes  Select one: Ground  Chopped  Pureed

Do liquids require thickening? No

Yes  Select one: Nectar/mild thick  Honey/medium thick  Pudding/ extremely thick

**Detailed description of supervision and support needs during meal time:**

**MOBILITY AND PRESCRIBED ADAPTIVE EQUIPMENT**

In addition to the use of crutches, walker, or wheelchair, include detailed description of any assistance needed to assist with mobility and or transfers. Other prescribed adaptive equipment is listed under **Other** and some examples include: glasses, hearing aids, Hoyer Lift, Orthotic shoes, etc.)

Do you need assistance with mobility? Yes No

Do you need assistance with stairs? Yes No

Do you need assistance with transfers, for example, 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**:

Do you have adaptive equipment prescribed for you? Yes No

If yes, what equipment?

**Further Meeting discussion / Recommendations**:

**IMPOSED RESTRICTIONS**

Limited availability or access to anything that should be available or accessible must be included in the ISP under tile associated with the reason for the restriction (I.e. Behavior/Sensory, Mobility/Adaptive equipment, Self-Care, Dietary, Health Hazards/Concerns). For example, not having a mirror available in my bedroom because I will break mirrors and use the pieces to harm myself is listed under Behavior. Note: Restrictions may only occur following discussion and determination by the Planning Team, or in some cases, the appropriate Human Rights Committee.

**Meeting discussion / Recommendations**:

**BEHAVIOR SUPPORT PLAN**

All approved Behavior Support Plans must be uploaded into I Record. If there is a Behavior Plan, it must 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.

**Meeting discussion / Recommendations:**

**Residential Services**

**Identification of Services -** Refer to **Appendix K (Quick Reference Guide to Overlapping Claims for Services)** in theCCP P&P Manual to avoid overlapping claims. Reminder, if an individual is assigned an acuity factor, Behavioral Supports cannot be claimed while providing the following services because those supports are already included within the rate: Individual Supports, Community Based Supports, and Day Habilitation.

|  |  |  |  |
| --- | --- | --- | --- |
| **Applicable Service(s)** | **Provider Name** | **Units Per Week** | **Dates Program is closed, if applicable** |
| **Individual Supports (daily rate)** |  |  |  |
| **Individual Supports (hourly rate)** |  |  |  |
| **Behavioral Supports – Assessment/Development** |  |  |  |
| **Behavioral Supports - Monitoring** |  |  |  |
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**Other services (Assistive Technology, Community Transition Services, Occupational Therapy, PERS, Physical Therapy, Speech, Language, & Hearing Therapy):**

|  |  |  |  |
| --- | --- | --- | --- |
| **Applicable Service(s)** | **Provider Name** | **Units Per Week** | **Start and End Dates** |
|  |  |  |  |
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|  |  |  |  |

**Residential Provider Team Member providing information contained on this document:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Print Name** | **Signature** | **Title** | **Date** |
|  |  |  |  |

**Instructions for Use:**

1. This form is completed by Provider prior to or during the service plan meeting for all individuals that they support residentially.
2. Upon completion of Worksheet, Provider will send copy to Support Coordinator, 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.
   1. The Provider should include any assessments used to inform the development of the service plan (I.e. Unsupervised Time Assessment, Medication Administration Assessment, etc.)
3. The Planning Team members review content at the planning team to ensure that everyone agrees that the information is accurate and sufficient in addressing support and supervision needs.
   1. Based on the discussion of the planning team, this form is revised during the planning team meeting, if determined to be necessary.
4. The Support Coordinator includes information in service plan documents.
5. The Support Coordinator uploads the ISP Worksheet to I record as well as any assessments provided by the Provider.
6. The Support Coordinator Supervisor checks for presence of ISP Worksheet when reviewing the ISP and ensures that the information is accurately reflected in the service plan.

**If the Support Coordinator and / or Legal Guardian/involved family member(s) do not receive the ISP Worksheet from the Provider:**

1. The Support Coordinator or their Supervisor will email the Provider reminding them of requirement to submit a completed worksheet using **<DDD ID#> - request for ISP Worksheet** in the subject line.
2. If a response is not received within 2-3 days, the Support Coordinator or their Supervisor will email the Provider a second time using the same email chain, copying [DDD.PPMU@dhs.state.nj.us](mailto:DDD.PPMU@dhs.state.nj.us) for assistance from the Provider Performance and Monitoring Unit with follow up.
3. If after 2-3 additional days, a response is not received, the SC will upload the email chain to I record in lieu of the ISP Worksheet and move forward with development of the service plan.
   1. The Support Coordinator or their Supervisor will email [DDD.PPMU@dhs.state.nj.us](mailto:DDD.PPMU@dhs.state.nj.us) and [DDD.SCHelpdesk@dhs.state.nj.us](mailto:DDD.SCHelpdesk@dhs.state.nj.us) for follow up with the Provider.

**Best Practice Recommendations to Support Coordination Agencies:**

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 either through a Provider or a Self-Directed Employee (SDE)
* are living with family or a care giver and are seeking respite services
* may be considered at risk of needing emergent services.

For these scenarios, the Support Coordinator would complete this worksheet in conjunction with the family / care giver and would upload the completed worksheet to I Record and complete / revise the ISP accordingly.