



New Jersey Department of Human Services
Division of Developmental Disabilities
www.nj.gov/humanservices/ddd



Supports Program Policies & Procedures Manual

Supports Program Policies & Procedures Manual, Version 9.0 – April 2024

Section	Description of Changes
Overall Manual	<ul style="list-style-type: none"> • General grammatical, typo corrections, updates to form names, email addresses, and links where applicable, etc.
Section 1	<ul style="list-style-type: none"> • Added the term self-directed services, in addition to self-direction, to the description of persons for whom this manual applies. • Added the definition of Competitive Integrated Employment under Employment First.
Section 3	<ul style="list-style-type: none"> • Added criteria describing limited circumstances where a person ages 18 through 21 may receive division services • Revised individual budgets to reflect rate increases since last revision.
Section 6	<ul style="list-style-type: none"> • Added detail about Support Coordination Agency (SCA) and Division responsibilities when a person changes SCAs or if an SCA is undergoing corrective action.
Section 7	<ul style="list-style-type: none"> • Added more information on Supportive Decision Making.
Section 8	<ul style="list-style-type: none"> • Revised individual budgets for retirement to reflect rate increases since last revision. • Updated data related to Reasonable and Customary wages. • Simplified language related to Interpreter Services, Supports Brokerage, and Transportation self-directed employee rates. • Added that a self-directed employee may not to be regularly scheduled to work more than 16 consecutive hours in a 24-hour period. • Removed reference to COVID-19 Legislation allowing an additional year of educational entitlement as it is no longer applicable.
Section 9	<ul style="list-style-type: none"> • Added information for DDD/Medicaid Approved Providers about how they can update their information in the publicly available Provider Search database.
Section 11	<ul style="list-style-type: none"> • Better defined which Policy and Procedure Manual sections are needed for which service type. • Added more detail around the return of client records by Support Coordination Agencies. • Re-worded Organizational Governance section to be more easily understood. Added that Board Members must also adhere to background check requirements found in Section 15.1.2.
Section 13	<ul style="list-style-type: none"> • Added timeframes for the uploading of documentation to iRecord by Support Coordinators.
Section 15	<ul style="list-style-type: none"> • Updated Investigations and Follow Up section to more clearly communicate that Support Coordination Agencies, unless otherwise directed, need to complete investigations for incidents involving abuse, neglect, or exploitation in connection with delivery of services provided by them.
Section 16	<ul style="list-style-type: none"> • Clarified that Sanctions for a Support Coordination Agency can include a reduction in census.
Section 17	<ul style="list-style-type: none"> • Added to first page of section that a Direct Support Professional and/or Self-Directed Employee may not to be regularly scheduled to work more than 16 consecutive hours in a 24-hour period. • Edited to Support Coordination service definition to reflect that the Division may impose a reduction of census, that trainings required by the Division must be completed per the timeframes listed in Appendix E, and that Support Coordination Agency (SCA) Heads must meet the criteria of a Supervisor in order to act as one. Additionally, added that enforcement of a minimum SCA census of 60 clients after 12 months of operation will be enforced starting on April 1, 2025. • Updated the Respite service definition
Appendix	<ul style="list-style-type: none"> • Updated definition of Self-Directed Employee in Appendix A to add that they are paid by a DDD approved Fiscal Intermediary. • Updated listing of forms in Appendix D. • Updated Quick Reference Guide to Mandated Staff Training in Appendix E. • Updated rates to reflect increases since last revision in Appendix H. • Updated Appendix I with most recent version of Medicaid Newsletter. • Added Appendix S – Quick Guide to Required Content Areas for Provider Policy and Procedure Manuals

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INTRODUCTION

1.1 Supports Program Policy Manual

The purpose of the New Jersey Division of Developmental Disabilities (Division) Supports Program Policy Manual is to provide additional clarity on practices governing the Supports Program within the approved Comprehensive Medicaid Waiver (CMW).

This manual contains the current policies and practices governing all aspects of the Supports Program including but not limited to eligibility, care management, service delivery and standards, and quality assurance. These policies apply to all individuals enrolled in the Supports Program, and this manual has been developed to provide uniform direction and guidance to individuals, families, Division personnel, and service providers.

The Division adheres to all State and federal laws, regulations, and rules that relate to the operation of the Division and the programs it administers. The Division is required to develop policies and procedures for program operations that conform to State and federal requirements.

The Division will review/revise the Supports Program policies as needed. Questions or requests for manual revisions should be directed to the Division's Supports Program Help Desk at DDD.FeeForService@dhs.nj.gov.

In addition to following the policies and procedures described in this manual, compliance with all applicable Division Circulars is required. Division Circulars are available at <https://nj.gov/humanservices/ddd/providers/staterequirements/circulars/>.

This manual applies to policies and procedures utilized by individuals who elect self-direction/self-directed services and/or provider-managed services who have shifted fully into this Fee-for-Service system.

1.2 Overview of the Division of Developmental Disabilities

1.2.1 Mission and Goals

The Division of Developmental Disabilities assures the opportunity for individuals with developmental disabilities to receive quality services and supports, participate meaningfully in their communities and exercise their right to make choices.

This mission and Division goals are founded within these Core Principles:

- Ensure Health and Safety while Respecting the Rights of Individuals
- Promote and Expand Community-Based Supports and Services to Avoid Institutional, Segregated and Out-of-State Services
- Promote Individual Choice, Natural Relationships and Equity in the Provision of Supports and Services
- Ensure Access to Needed Services From Other State and Local Agencies
- Support Provider Agencies in Achieving Core Principles
- Ensure that Services are High in Quality and Culturally Competent
- Ensure Financial Accountability and Compliance with all Laws and Ethical Codes
- Ensure Clear, Consistent Communication and Responsiveness to Stakeholders
- Promote Collaboration and Partnerships with Individuals, Families, Providers and All Other Stakeholders

1.2.2 Key Themes

In addition to the Core Principles described in Section 1.2.1, all services and supports provided through Division funding are based on the following key themes which have emerged through the ongoing realization of the Division's New Vision for Support Across the Life Course.

Individual Choice

The Division is committed to providing increased opportunities for individuals with developmental disabilities to make individualized, informed choices and self-direct their services. Choice is not unlimited, however, and individuals enrolled in Division-funded programs will be expected to meet all requirements and comply with all standards and policies outlined in this manual and through the Participant Enrollment Agreement found in Appendix D. The Division respects individuals' rights to make choices that may differ from those desired by the people around them, including family, friends, and professional staff. Individuals with developmental disabilities have the right to assume risk in their own lives.

Shift from Segregated Settings/Supports to Integrated Supports

Individuals with developmental disabilities in New Jersey should have the opportunity – like everyone else – to fully participate in their local communities. The Division provides a variety of home and community-based supports and services to individuals with developmental disabilities to assist them in realizing full community participation and continues to reform the system to enhance community-based services and minimize the need for segregated or institutional services.

Employment Focus

Historically, individuals with intellectual and developmental disabilities have been either unemployed or underemployed. In an effort to address this issue, New Jersey has adopted an employment focused approach to encourage discussions around employment for the individuals it serves. As a result, Division personnel, Support Coordinators, planning team members, etc. need to begin with the presumption that everyone receiving Division-funded supports and services must have the opportunity for competitive integrated employment (CIE) in the general workforce. The Workforce Innovation and Opportunity Act (WIOA) defines [CIE](#) as work that is performed on a full or part-time basis for which an individual with a disability is:

- Compensated at or above minimum wage and comparable to the customary rate paid to employees without disabilities performing similar duties and with similar training and experience;
- Receiving the same level of benefits provided to other employees without disabilities in similar positions;
- At a location where the employee interacts with other individuals without disabilities; and
- Presented opportunities for advancement similar to other employees without disabilities in similar positions.

Outcomes related to an individual's path to employment must be indicated in the Individualized Service Plan and a facilitated discussion to determine which path is appropriate for each individual will be assisted through use of the Pathway Assessment within the employment sections captured in iRecord. If someone has indicated that employment is not currently being pursued, an explanation as to why employment is not an option at this time along with information regarding what needs to change in order for employment to be pursued must be provided. Additional policies, practices, and standards continue to be revised or developed as a result of this directive.

1.2.3 Division of Developmental Disabilities Responsibilities

- Determine individual eligibility
- Meet and comply with waiver assurances
- Ensure assessment is available and completed
- Identify individual budget "up to" amounts
- Assign the chosen Support Coordination Agency or auto assign, as applicable
- Approve service providers in collaboration with Medicaid
- Monitor service providers to ensure standards, policies, etc. are being met
- Provide approval/denial for identified services that cannot be approved by the SC Supervisor
- Provide ongoing quality assurance of the service plan and provision of services
- Initiate service provider termination with Medicaid, as applicable
- Discharge individuals from the Division or dis-enroll individuals from the Supports Program, as applicable

2 VISIONING A LIFE COURSE – TRANSITIONING TO ADULTHOOD

As a student moves from the school system into the adult service system, it is important to plan for their future by ascertaining their vision for life as an adult and assisting them in identifying services and supports that may be needed to reach that vision. The Division has made a commitment to support this planning on an ongoing basis by supplementing the efforts of the New Jersey Department of Education and local school districts in assisting students with the transition into adulthood. To that end, the Division’s *Planning for Adult Life* project assists students with intellectual and developmental disabilities between the ages of 16-21 and their families in charting a life course for adulthood. As such, informational sessions, webinars, and resource guides/materials on various topics - including but not limited to: employment, postsecondary education, housing, legal/financial planning, self-direction and advocacy, and accessing the adult service system - can be found at www.planningforadulthood.org. The Division also disseminates information targeted to “aging out” youth each year and begins the process of support coordination assignment as early as April of the year in which a young person is aging out of the school system to allow a seamless transition into adult services once they graduate. Finally, the Division works closely with the Department of Children & Families (DCF) to transition students aging out of DCF’s Children’s System of Care (CSOC) to ensure that there is no disruption in services.

3 DIVISION OF DEVELOPMENTAL DISABILITIES ELIGIBILITY

This section outlines the criteria for eligibility for the Division and the process used to apply for services and determine eligibility.

3.1 Requirements for Division Eligibility

The eligibility criteria to receive services from the Division are described in Division Circular #3 (N.J.A.C. 10:46) which establishes guidelines and criteria for determination of eligibility for services to individuals with developmental disabilities. Below represents key elements:

- An individual must be determined eligible for services before the Division can provide services.
- An individual must meet the functional criteria of having a developmental disability.
 - In general, individuals must document that they have a chronic physical and/or mental impairment that:
 - manifests in the developmental years, before age 22;
 - is lifelong; and
 - substantially limits them in at least three of these life activities: self-care; learning; mobility; communication; self-direction; economic self-sufficiency; the ability to live independently
- In order to receive Division services, individuals are responsible to apply, become eligible for, and maintain Medicaid eligibility.
- An individual must establish that New Jersey is their primary residence at the time of application.
- At 18 years of age individuals may apply for eligibility. At 21 years of age, eligible individuals may receive Division services.
- The determination of an applicant's eligibility for Division services shall be completed as expeditiously as possible.

3.1.5 Limited Circumstances Where a Person Ages 18 through 21 May Receive Division Services

Under the Individuals with Disabilities Education Act (IDEA), students with disabilities, ages 3 through 21 are entitled to a free, appropriate public education (FAPE). Students are entitled to receive the special education and related services identified through their Individualized Education Program (IEP), as determined by the IEP team. The IEP contains goals aligned with academic achievement, and behavioral and functional performance, as well as post-secondary goals related to training, education, employment and, if appropriate, independent living. The local educational agency (LEA) is responsible for ensuring all services are provided at no cost to the student or parents. **The level of services and protections provided under the IDEA to students with disabilities are not equivalent to those offered through the New Jersey Division of Developmental Disabilities' (Division) adult service system as Division services are not an entitlement.** For this reason, individuals with disabilities who have established eligibility for Division services receive them when they turn 21 and are no longer eligible to receive services in the public education system under the IDEA.

The Division recognizes that each year there may be a small number of eligible young adults with developmental disabilities ages 18 through 21 who have met both graduation requirements and the goals in their Individualized Education Program (IEP) and are not eligible to remain in high school until age 21. An individual, if eligible for Division services, may be eligible to enroll in the Division as early as the age of 18 if they have graduated and are seeking Division services to:

- Support immediate enrollment at an institute of higher education or trade school not funded by the Division of Developmental Disabilities; and/or
- Support established competitive integrated employment.

In both of the above circumstances, the services being sought from the Division would not otherwise have been the responsibility of their LEA to provide. Please note that this flexibility does **not** allow individuals to enroll in Division services before the age of 21 for other reasons such as enrolling in a Division-funded adult day habilitation program.

If you feel the above circumstance applies to you we strongly suggest you contact a Division Representative for Options Counseling at least six months prior to your anticipated graduation. This is to ensure that you would be eligible to access Division Services before electing to graduate prior to the age of 21. Please email DDD.TransitionHelpdesk@dhs.nj.gov for more information.

There are also organizations in New Jersey such as the [SPAN Parent Advocacy Network](#) and [The Arc of New Jersey Family Institute](#) that can assist families with children who receive special education and related services if you have questions about the IEP process.

3.2 Intake/Application Process

To receive services funded by the Division, an individual must apply to become eligible. This process can begin once the individual reaches 18 years of age; however, Division-funded services and supports will not be available until the individual reaches 21 years of age. Eligibility criteria are outlined in Section 3.1 and 3.1.5 of this manual.

There are two versions of the application to determine eligibility:

You must use the Full Application for Determination of Eligibility if either:

- a. You did not apply before for developmental disability services from either the NJ Division of Developmental Disabilities or the NJ Children’s System of Care (PerformCare), OR
- b. You received a service through the NJ Children’s System of Care (PerformCare) but never completed PerformCare’s *Application for Determination of Eligibility for Children Under Age 18*.

You may use the Short Application for Determination of Eligibility if either:

- a. You applied before for developmental disability services through the NJ Division of Developmental Disabilities (DDD) and were notified by DDD that you were eligible, OR
- b. You applied before for developmental disability services through the NJ Children’s System of Care (PerformCare) and were notified by PerformCare that you were eligible.

The application process begins by contacting the Division Community Services Office representing the region in which the individual resides or downloading the application from the Division website at <https://www.nj.gov/humanservices/ddd/individuals/applieservices/>. Upon request, the intake worker can provide assistance in completing the application.

3.2.1 Application

Depending on which application is completed (Full or Short) all or some of the following application forms might be completed and signed as part of a complete application package:

- **Application for Eligibility** – The person completing the application must sign this form;
- **ICD/10 Form** – Completed by a medical professional;
- **Health Information Portability and Accountability Act (HIPAA) documents;**
 - **Notice of Privacy Practices and Acknowledgement Form** – Please read the Department of Human Services Notice of Privacy Practices and sign the Acknowledgement Form;
 - **Authorization for Disclosure of Health Information to Family and Involved Persons** – Gives the Division permission to talk with people the Applicant chooses about their health information. This form must be completed and signed;
 - **Authorization for the Release of Health Information** – Gives the Division permission to send copies of the Applicant’s health records to people or organizations chosen by the Applicant. This form must be completed and signed;

- **Consent Form** – for use with any documentation related to the developmental disability and/or functional limitations.

3.2.2 Additional Documents

In addition to the application, the individual must include as many of the available documents below that relate to their disability. The more documentation that is provided, the easier it will be to process the application.

3.2.2.1 Documentation of Developmental Disability

- Medical Documentation of Disability
- Physician’s Statement
- Most Recent Psychological Evaluation (+ IQ Scores)
- All Available Psychological Reports
- Most Recent Child Study Team or School Reports

3.2.2.2 Legal Documentation of Age, US Citizenship, NJ Residency

- Photocopy of Birth Certificate
- Photocopy of Social Security Card *or* Proof of US Citizenship *or* Green Card
- Photocopy of one of the following:
 - Voter Registration form
 - Pay Stub
 - W2 form
 - Real Estate Tax Bill
 - Permanent Change of Station Orders to New Jersey (if the individual’s legal guardian is in the U.S. Military Service)

3.2.2.3 Other Documents

- Photocopy of Guardianship Order (if applicable)
- Photocopy of Medicaid Card
- Division of Vocational Rehabilitation Services (DVRS) Records/Evaluations
- SSI annual award letter
- Letter certifying Medicaid eligibility

If there are questions about whether or not the individual may meet the criteria for Division eligibility, contact the Division [Community Services Office](#), and a Division Intake Staff member there will discuss your situation and guide you through the process for applying for eligibility.

3.3 Eligibility Determination Process

More detailed information regarding the eligibility determination process can be found in Division Circular #3 (N.J.A.C. 10:46). Specifically, information regarding timeframes associated with the process can be found in N.J.A.C. 10:46 – 4.1 and 4.2.

When the application is complete, the intake worker will create a case file for the individual. The application, including all necessary documentation (listed in Section 3.2), will be reviewed to determine that the individual has met the initial requirement.

When the application has been determined to be complete, the intake worker will refer the individual and/or family/responsible person, or guardian, if applicable, to complete the New Jersey Comprehensive Assessment Tool (NJ CAT) to begin the process of determining whether or not the individual meets the functional criteria – functional limitations in at least three or more areas of the major activities of daily living – to be eligible for the Division. The NJ CAT is comprised of the Functional Criteria Assessment (FCA) and the Developmental Disabilities Resource Tool (DDRT).

The FCA portion of the NJ CAT will be used to assess the seven areas of major activities of daily living (self-care; learning; mobility; communication; self-direction; economic self-sufficiency; the ability to live independently), and will be used to make a preliminary determination whether the individual has functional limitations in at least three of these areas.

To complete the NJCAT, a trained DDD facilitator will conduct a face-to-face meeting with the individual and their guardian. The individual/guardian may also wish to have other family members, service providers and/or caregivers participate as well.

The facilitator will access the NJCAT online and, as prompted by the screen, will verbally ask each NJCAT question. The facilitator will enter each answer online only after the answer has been agreed upon by all meeting participants.

When all questions have been answered, the facilitator will submit the completed NJCAT electronically to the Rutgers University Developmental Disabilities Planning Institute (DDPI), where scores are tabulated and the tier is established.

Once the NJ CAT has been completed, the intake team will make a final decision concerning eligibility.

- If the applicant is found to have met the functional criteria, along with the other identified eligibility criteria listed in Section 3.2, the intake worker will verify Medicaid eligibility.
- If there is any question of functional eligibility, a face-to-face interview will be conducted and the intake worker may refer the case to a psychologist, if necessary. Following the interview or psychologist review, the matter will be reviewed by the Statewide Intake Coordinator and the Intake Review Team (IRT). If the IRT finds that the individual is functionally eligible, the intake worker will verify Medicaid coverage. If the IRT finds that the individual is not functionally eligible, the intake worker will advise the individual by letter.
- If the individual is found ineligible, the intake worker will advise the individual by letter.

If the applicant has Medicaid at the time of their application to the Division and has been found to have met the functional criteria, a full eligibility letter will be sent to the individual.

If the applicant does not have Medicaid eligibility, a letter will be sent to the individual that will indicate that they do meet functional criteria but must be Medicaid eligible in order to receive Division-funded services. Once the intake worker receives proof of Medicaid coverage, a full eligibility letter will be sent to the individual.

If found eligible, Division-funded services and supports will be made available once the individual reaches the age of 21.

3.4 Tiering & Acuity Factor

Results of the NJ CAT are calculated and summarized into a score based on the following main areas: self-care, behavior, and medical. This resulting score establishes the “tier” in which each individual has been assigned based on their support needs.

These tiers will be used to determine the individual’s budget amount as well as to determine the reimbursement rate a provider will receive for that individual for particular services. There are five base tiers: A, B, C, D, & E (as well as an exception tier – Tier F – to be utilized in very rare cases). In addition, an acuity differentiated factor will be added to the tier for individuals with high clinical support needs based on medical and/or behavioral concerns. The acuity-based tiers are Aa, Ba, Ca, Da, Ea (and again, an exception Fa).

3.4.1 Acuity Factor Requirements

When an individual has been assigned the acuity differentiated factor, the Support Coordinator must complete the Support Coordinator section of the Addressing Enhanced Needs Form (Appendix D) to indicate, to the best of their knowledge, the areas that need to be supported by the service provider(s) when the individual is receiving their services. This information will be based on the Support Coordinator’s review of the NJ CAT and will be submitted

to the service provider as part of the process to determine individual and provider compatibility and to assist the provider in understanding the individual’s behavioral/medical needs. Once the Support Coordinator has completed their section of the form, it will be submitted to the service provider rendering the acuity differentiated service (i.e., individual supports, community based supports, day habilitation, and/or respite) to complete the Service Provider section of the Addressing Enhanced Needs Form (Appendix D) to communicate how they plan to provide the clinical level of support (through staffing, equipment, etc.) to ensure the individual’s safety. This form is first completed prior to service delivery but can be revised as the provider learns more about the individual. The individual/guardian shall have the opportunity to be involved in the process. Copies of the completed form will be uploaded to iRecord by the Support Coordinator, kept in the individual file maintained by the service provider. This form shall be updated at least annually and revised more frequently during the plan year as necessary.

When an individual is assigned the acuity differentiated factor and resides in their own home it is presumed that agency staff hired by the individual (should that be preferred over utilizing self-directed employees) will provide the medical and/or Behavioral Supports Monitoring needed during service delivery. However, as multiple agencies, a combination of agency and self-directed employees, or varying hours of agency staff may be used, Behavioral Supports Assessment/Plan development as described in section 17.2 of this manual, if needed, may be accessed separately to ensure a consistent behavior support plan across providers and settings. As such, before staff (self-directed employees or otherwise) are deployed to work with the individual they shall have received reasonable training in the needs of the individual and, as applicable, the behavioral support plan and how to complete any needed data collection associated with that plan. It is the responsibility of the individual/family/support coordinator to provide the current ISP, BSP, etc. to the agency and communicate their expectations for the service.

3.5 Individual Budgets

Individual budgets, based on tiering, for participants enrolled in the Supports Program include the following components: Employment/Day Supports, Individual/Family Supports, Direct Support Professional (DSP) Service (funding allocated to individual budgets for the purpose of providing a legislatively mandated DSP wage increase. Only applies to services as indicated in Section 17 and is used when all other budget categories are depleted), and Supported Employment (as needed). Some services included in an individual’s Service Plan can be funded through multiple budget components, while others can only be funded by one of the components. Individuals enrolled in the Supports Program will have access to the following budget amounts (with the addition of the Supported Employment component as needed) associated with the tier in which they are assessed:

Tier	Employment/Day	Individual/Family Supports	Supported Employment	Total Individual Budget
A	\$20,564	\$7,442	Available as needed	\$28,006
Aa	\$28,628	\$7,442	Available as needed	\$36,070
B	\$26,208	\$14,883	Available as needed	\$41,091
Ba	\$36,519	\$14,883	Available as needed	\$51,402
C	\$32,429	\$14,883	Available as needed	\$47,312
Ca	\$45,159	\$14,883	Available as needed	\$60,042
D	\$48,096	\$22,324	Available as needed	\$70,420
Da	\$66,932	\$22,324	Available as needed	\$89,256
E	\$63,821	\$22,324	Available as needed	\$86,145
Ea	\$88,820	\$22,324	Available as needed	\$111,144

Information about which services can be purchased through which budget component is included for each service described in Section 17. Support Coordination services and Financial Management services are administrative costs that do not come out of the individual budget.

The individual budget covers the service plan year. For example, if an individual’s ISP is approved in May, the individual budget will provide funding for services until the next annual ISP is completed and approved in May of the following year. If the individual experiences changes in their level of care, behavior, or medical needs during the course of the plan year, a NJ CAT reassessment should be requested as described in Section 3.6.

3.5.1 Requesting the Supported Employment Component of the Individual Budget

The Supported Employment component of the individual budget can be accessed in situations when the individual budget does not sustain the level of Supported Employment – Individual Employment Support needed in order for the individual to find or keep a competitive job in the general workforce. The individual must make every effort to utilize his/her individual budget to cover his/her Supported Employment needs prior to requesting this additional funding. To request the Supported Employment component, the Support Coordinator must submit a completed Supported Employment Funding Request form (Appendix D) to DDD.EmploymentHelpdesk@dhs.nj.gov. This form will be reviewed by the Division to ensure that other available services would not be able to provide the level of support necessary for the individual to remain employed. The Division may request or conduct an observational evaluation on the job site to assist in the determination process and/or provide technical guidance as needed. The Division will inform the individual and Support Coordinator of the determination. Other Division funded services remain available while this determination is being made.

3.5.2 Bump-Up

If the individual experiences changes in life circumstances that result in a need for additional temporary services (an injury that requires additional supports to provide assistance during the day or hospitalization of the individual’s caregiver, for example) that exceed his/her individual budget, a short-term increase in the budget, known as a “bump up,” may be available to improve the situation. This bump-up is capped at \$5,000 per individual, will be effective for up to one year, and can only be provided once every three years. A bump-up request can only be submitted for individuals currently enrolled in the Supports Program (SP).

The process for submitting a request for a bump-up is as follows:

1. An individual, family member or Support Coordinator must submit an email requesting a bump-up to the following address DDD.SPbumpUpRequest@dhs.nj.gov, which must contain the individual’s initials and DDD ID# in the subject line. The Statewide Intake Coordinator will review the information requested and provided and make a determination
2. The body of the email must contain the following information:
 - Summary of the current situation
 - The temporary service(s) being requested
 - Length of time a service(s) will be needed (start & end dates)
 - A breakdown of unit type, frequency, rate, total units, total cost
 - Acknowledgement that the individual and/or family member requesting a bump-up is aware that if approved the additional funding will be effective for up to one year, and can only be provided once every three years.
3. A determination will be rendered within 3 business days of the initial request, unless additional information or meeting is requested by the Statewide Intake Director.

3.6 Requesting NJ CAT Reassessment

Individuals/guardians may request a reassessment at any time. Please note that, based on the responses provided, a reassessment may result in a reduction in tier level, no change in tier level, or an increase in tier level.

The process for submitting a request to be reassessed is as follows:

1. The individual/guardian requests a copy of the most recently completed NJ CAT from their Support Coordinator;
2. The individual/guardian reviews the NJ CAT and notes any changes directly on the assessment;
3. The individual/guardian completes the “Request for Reassessment Form” found on the Division’s website under “FFS Information/Resources” at <https://nj.gov/humanservices/ddd/individuals/applyservices/assessment/>;
4. The individual/guardian submits the completed “Request for Reassessment Form,” NJ CAT changes, and any supporting documents to the assessment request email address at:

DDD.DDPIAssessmentRequests@dhs.nj.gov or mail the documents to the following address:

Department of Human Services
Division of Developmental Disabilities
P.O. Box 726
Trenton, NJ 08625-0726
Attention: NJ CAT Reassessment Unit

5. The Division designee assigned to the mailbox will reach out to the designated “informant” within three (3) business days from the initial contact to acknowledge receipt of request and provide the name of the Division staff person assigned to facilitate the reassessment;
6. The Division staff person assigned to facilitate will reach out within five (5) business days to discuss scheduling a meeting date.

3.7 Redetermination of Eligibility

The Division may reevaluate an individual’s eligibility at any time.

Individuals must maintain Medicaid eligibility to remain eligible for Division services.

3.8 Eligibility Appeal Rights

Individuals who have been determined ineligible for Division services may appeal the decision in accordance with the provisions of Division Circular #3 (N.J.A.C. 10:46-5.1) and Division Circular #37, “Appeals Procedure” (N.J.A.C. 10:48 et seq.).

An initial appeal shall be made in writing to:

Assistant Commissioner
Division of Developmental Disabilities,
P.O. Box 726,
Trenton, NJ 08625-0726

3.9 Discharge from the Division

An individual may be discharged from the Division due to any of the following:

- They no longer meet the functional criteria necessary to be eligible for the Division;
- They choose to no longer receive services from the Division;
- They do not maintain Medicaid eligibility;
- They no longer reside in the State of New Jersey; or
- They do not comply with this manual, Division policies or waiver program requirements.

An individual who has been discharged from Division services must go back through the intake process to be reinstated.

3.10 Moving from the Supports Program to the Community Care Program

Enrollment in the Supports Program is available to any individual who has been determined eligible for Division services.

Enrollment in the Community Care Program (CCP) is only available to an individual determined eligible for Division services who also meets the required level of care for the program (See section 5.1.2 in the Community Care Program Policies & Procedures Manual) and who either (a) has been reached on the Community Care Program Waiting List (See section 5.1.3 of the Community Care Program Policies & Procedures Manual) or (b) has been determined by the Division to be in an emergent circumstance as defined by [Division Circular 12](#) (N.J.A.C. 10:46B).

The Support Coordinator can initiate the process for requesting Division review of an emergent circumstance, and subsequent level of care review, by contacting their agency’s assigned Division QAS.

4 OVERVIEW OF THE SUPPORTS PROGRAM

The Supports Program is the Division initiative included in the Comprehensive Medicaid Waiver (CMW) that was approved by the Centers for Medicare & Medicaid Services (CMS) on October 1, 2012. The CMW provides statewide reform for Medicaid services, shifts the focus of services and supports to community-based, and allows New Jersey to draw down increased federal funds.

The Supports Program provides needed supports and services for adult individuals, 21 and older, living with their families or in other unlicensed settings. It has been designed to help New Jersey better serve adults with developmental disabilities and significantly reduce the number of individuals waiting for supports and services.

The Supports Program will provide all enrolled participants with employment/day services and individual/family support services based on their assessed level of need. Individuals and their families will have the flexibility to choose the options and opportunities for support services that will best meet their needs with the assistance of Support Coordinators who will assist them in developing an Individualized Service Plan and link them to appropriate services.

With the exception of individuals enrolled in another Home & Community Based Setting (HCBS) or Managed Long Term Services & Supports (MLTSS) program (including the CCP), all adult individuals who are eligible for both Division services and Medicaid will be able to access the Supports Program.

4.1 Supports Program + Private Duty Nursing (PDN)

In circumstances where an individual has been assessed by the Managed Care Organization (MCO) to need Private Duty Nursing (PDN) but is better served through services available through the Supports Program rather than those services available through Managed Long Term Services and Supports (MLTSS), they can be enrolled in the Supports Program and receive PDN through Medicaid. This individual would not be enrolled in MLTSS as federal rules prohibit enrollment on more than one waiver program at a time.

To be eligible for Supports Program + PDN, an individual must meet the criteria described in Section 5.1 and qualify to receive PDN services. In order to qualify to receive PDN services, the individual's MCO will conduct the NJ Choice Assessment to determine whether or not the individual meets level of care for PDN. If the individual does meet level of care, then the MCO will conduct another assessment to determine the amount of PDN the individual can receive through their MCO. The enrollment process for the Supports Program + PDN is described in Section 5.2.1. Once the individual is deemed eligible for the Supports Program + PDN, the MCO and Division will work together to coordinate services.

5 SUPPORTS PROGRAM ELIGIBILITY AND INDIVIDUAL ENROLLMENT

5.1 Eligibility for the Supports Program

In addition to meeting the requirements for Division eligibility (as described in Section 3.1), an individual eligible for the Supports Program must meet the following criteria:

- At least 21 years old
- Deemed eligible for Division services as described in Section 3.3
- Has and maintains Medicaid eligibility
- Lives in an unlicensed setting – own home or family home
- Is not currently enrolled in another HCBS or MLTSS program (including the CCP) or, if enrolled in another program, agrees to dis-enroll in order to enroll in the Supports Program

5.1.1 Allowable Types of Medicaid for the Supports Program

- Supplemental Security Income Medicaid
- Workability Medicaid
- NJ FamilyCare
- Supports Program Medicaid Only

5.1.1.1 Accessing Supports Program Medicaid Only

If an individual is not receiving Medicaid through SSI, WorkAbility, or NJ Care or has a type of Medicaid not approved for waiver enrollment (typically someone who is not eligible for Medicaid as a “Disabled Adult Child – DAC”), the individual will need to apply for Supports Program Medicaid Only. The process for accessing Supports Program Medicaid Only is as follows:

- The Supports Program Notice of Expected Admission (NOEA) gets completed by the Support Coordinator and submitted to the Supports Program Unit
- The Supports Program Unit reviews the NOEA to ensure it is completed accurately and contains all necessary information and then forwards the information to the Division’s Waiver Unit
- The Division’s Waiver unit sends a Medicaid application packet to the family
- The family completes the Medicaid application packet and sends it back to the Division’s Waiver unit
- The Division’s Waiver unit submits the completed application and supporting documents to the Institutional Support Services (ISS) staff at Medicaid
- ISS processes the Medicaid packet, determines if the individual meets the financial requirements for the Supports Program Medicaid, and determines if the individual is Medicaid eligible
- Once ISS determines the individual is Medicaid eligible, they notify the Division’s Waiver unit who then forwards that information to the Supports Program Unit
- The Supports Program Unit then initiates the process to enroll the individual into the Supports Program

Additional information about Medicaid eligibility and the Division can be found on the Division’s website at <https://nj.gov/humanservices/ddd/individuals/applyservices/medicaid/>.

5.2 Individual Enrollment into the Supports Program

The following steps will be taken to enroll an individual into the Supports Program:

- The individual will go through the intake and eligibility determination process (outlined in Sections 3.2 and 3.3) and be assigned a budget amount based on the assessed level of need found through completion of the NJ Comprehensive Assessment Tool (NJ CAT) – if the most recent completion of the NJ CAT was done more than 2 years prior to enrollment into the Supports Program, a reassessment may be conducted;
- When the individual has completed the Intake/Application process and is determined eligible to receive DDD services, their assigned Intake Worker will provide them with a Support Coordination Agency

Selection Form to complete. Once completed, the form is returned to the Intake Worker for assignment to a Support Coordination Agency;

- Upon receipt of the Support Coordination Agency Selection Form, the Division will confirm that the individual meets the eligibility criteria for the Supports Program;
- The individual will be assigned a Support Coordination Agency through the process described in Section 6.1.2;
- The Support Coordinator will ensure that the individual has access to or a copy of the Supports Program Policies & Procedures Manual and will explain the Participant Enrollment Agreement and obtain a signed copy from the individual/guardian;
- Once the Support Coordinator obtains the signed Participant Enrollment Agreement, the individual will be enrolled into the Supports Program and the Support Coordinator will follow procedures described in this manual to assist the individual in accessing services.

5.2.1 Enrollment into the Supports Program + Private Duty Nursing (PDN)

As described in Section 4.1, individuals who have been assessed to be eligible for PDN but are better served by the Supports Program than Managed Long Term Services and Supports (MLTSS) can enroll in the Supports Program and still receive PDN through Medicaid funding. The process to access the Supports Program + PDN is described in the following sections.

5.2.1.1 Individual Already Enrolled in MLTSS

When an individual has been enrolled in MLTSS in order to access PDN services but their needs can be better met through the Division, they can choose to disenroll from MLTSS and enroll in the Supports Program + PDN. The process to enroll this individual into the Supports Program + PDN is as follows:

- The Division is informed that the individual wishes to enroll in the Supports Program + PDN
- Division staff reviews the individual's information to ensure that they meet all eligibility criteria for the Division as well as the Supports Program
- If the individual meets Supports Program enrollment criteria, Options Counseling is provided by a Division staff person or Support Coordinator
- The individual submits a request to disenroll from MLTSS to their assigned Managed Care Organization (MCO) Care Manager
- Once the Division is notified that the request for disenrollment has been received, the Division initiates the enrollment process
- The Division coordinates with MLTSS to transition individual from MLTSS services to Supports Program + PDN

5.2.1.2 Individual Not Currently Enrolled in MLTSS

When an individual is not currently enrolled in MLTSS, is in need of PDN services, and is better served by the Division, they can enroll in the Supports Program + PDN. The process to enroll this individual into the Supports Program + PDN is as follows:

5.2.1.2.1 Individual is Currently Enrolled in the Supports Program

- The Division is informed that the individual wishes to enroll in the Supports Program + PDN
- Individual requests a nursing assessment through his/her MCO Case Manager
- MCO Case Manager requests NJ Choice Assessment to determine PDN eligibility
- Individual is informed of the result of the NJ Choice
- Support Coordinator adds PDN to the ISP as a generically funded service and communicates with the individual's MCO Case Manager to ensure PDN services are being provided

5.2.1.2.2 Individual is Not Currently Enrolled in the Supports Program

- The Division is informed that the individual wishes to enroll in the Supports Program + PDN
- Division staff reviews the individual's information to ensure that they meet all eligibility criteria for the Division as well as the Supports Program

- If the individual meets Supports Program enrollment criteria, Options Counseling is provided by a Division staff person or Support Coordinator and enrollment into the Supports Program is initiated
- The Division is informed that the individual wishes to enroll in the Supports Program + PDN
- Individual requests a nursing assessment through their MCO Case Manager
- MCO Case Manager requests NJ Choice Assessment to determine PDN eligibility
- Individual is informed of the determination regarding nursing eligibility
- Support Coordinator adds PDN to the ISP as a generically funded service and communicates with the individual's MCO Case Manager to ensure PDN services are being provided

5.2.1.2.3 Individuals Approaching 21 Needing to Continue Private Duty Nursing (PDN)

If an individual turning 21 is no longer eligible for nursing services because they are turning 21 and are deemed eligible for PDN, they can be enrolled in the Supports Program + PDN upon their 21st birthday. The process to enroll this individual into the Supports Program + PDN is as follows:

- The Division is made aware that someone eligible for Division services is turning 21 and needs to continue nursing services
- Division staff reviews the individual's information to ensure that they meet all eligibility criteria for the Division as well as the Supports Program
- A referral form is submitted to the Supports Program Unit
- The Supports Program Unit submits referral to the MCO in order to assess for nursing and complete the NJ Choice
- Division staff initiate obtaining documents necessary for Supports Program enrollment (i.e. Support Coordination Agency Selection Form)
- Up to 60 days prior to the individual's 21st birthday, they will be assigned a Support Coordination Agency
- The Support Coordinator uploads the signed Participant Enrollment Agreement to iRecord, begins facilitating the PCPT, and develops the ISP in order for ISP approval to be completed on the individual's 21st birthday
- The Division continues to track individuals awaiting Supports Program + PDN enrollment in order to keep updated
- Support Coordinator adds PDN to the ISP as a generically funded service and communicates with the individual's MCO Case Manager to ensure PDN services are being provided

5.3 Individual Responsibilities

In addition to following the terms and conditions of the Supports Program as outlined in the Participant Enrollment Agreement, the individual is responsible for the following:

- Maintaining/keeping allowable Medicaid coverage to continue services
- Meeting with the Support Coordinator and providing all information necessary to ensure that the Individualized Service Plan can be created within 30 days of Supports Program enrollment
- Participating in the development of the ISP and sharing in any decision making associated with the plan
- Following the individual budget according to Waiver guidelines
- Providing/completing all required paperwork and following the policies and procedures in this manual
- Contacting the Support Coordinator in the event that a change in service provider is wanted/needed
- Contacting the Support Coordinator if there are changes in the individual's life that may require a change to the ISP or services
- Participating in monthly phone contacts and quarterly visits with the SC and understanding that these visits are mandatory and may occur in the home, day program, or place of employment as agreed upon with the SC and that, annually, at least one of these quarterly visits must take place in the home

5.4 Individual Disenrollment from the Supports Program

As outlined in the Participant Enrollment Agreement, the State may disenroll an individual from the program and/or discontinue all payment, as applicable, to a provider/self-directed employee, if one or more of the following circumstances occur:

- (a) The participant has not provided all information and documents required;

- (b) The Support Coordinator or the State has reasonable cause to believe that the participant has been or is engaged in willful misrepresentation, exploitation, or Medicaid fraud or abuse related to the provision of services under the Participant Enrollment Agreement;
- (c) The participant seeks payment for unauthorized or inappropriate charges;
- (d) The participant refuses to allow, or does not participate in, monthly, quarterly, and annual contacts/visits conducted by the Support Coordinator in accordance with guidelines provided in the Supports Program Policies & Procedures Manual;
- (e) The participant fails to submit on a timely basis documents and records required in relation to the provision of services;
- (f) The participant fails to report changes in care needs and financial circumstances that may affect eligibility;
- (g) The participant is no longer Medicaid eligible;
- (h) The participant has moved out of the State;
- (i) The participant no longer meets the Level of Care for the Supports Program;
- (j) The participant has enrolled in another HCBS or MLTSS program (including the CCP).
- (k) The participant has failed to abide by any terms of the Participant Enrollment Agreement;
- (l) The participant is not accessing Supports Program services other than Support Coordination for greater than 90 days¹.
- (m) The participant chooses to voluntarily disenroll from the Division and/or the Supports Program.

5.4.1 Individual Disenrollment Process

In the event that a participant chooses to voluntarily disenroll from Division services, they will provide signed documentation stating their intention to disenroll from all Division services, including waiver services, by submitting the [Voluntary Discharge from Division Services](#) form (Appendix D).

In the event of non-voluntary disenrollment, the Division will provide written notification to the participant.

The State shall provide 30 days notice to the participant in the event of disenrollment or discontinuation of payment due to (a), (d), or (e) above. During this 30-day time period, the Support Coordinator and Division will provide assistance and support as needed to help the individual in addressing the issue(s) for which they are being disenrolled. If the issue(s) have been resolved within those 30 days, the individual's waiver status may not be terminated.

The following process will be followed to address (l) above:

- When an ISP is developed without Supports Program services, the Support Coordinator will explain to the individual that they will be disenrolled if Supports Program services are not accessed within 90 days.
- During monthly monitoring (in the month after the ISP is approved and the following month, if applicable), the Support Coordinator will determine the status of accessing Supports Program services and remind the individual of disenrollment if the individual continues not to access Supports Program services.
- At 60 days without a Supports Program service other than Support Coordination, the Support Coordination Agency will provide written notification to the individual explaining that the Division will be notified that the individual is not utilizing Supports Program services and the disenrollment process will begin at 90 days if the individual continues not to access Supports Program services.
- At 90 days without a Supports Program service other than Support Coordination, the Support Coordination Agency will notify the Division and provide information about any extenuating circumstances (such as lack of availability of services).
- The Division will send written notification to the individual (and copy the Support Coordinator) explaining that they will be dis-enrolled from the Supports Program if they are not in need of Supports Program services within the next 10 days.
- If the Division or Support Coordinator does not receive a response by the date indicated in the notification, the Division will dis-enroll the individual from the Supports Program, indicate the reason for disenrollment in iRecord notes, and notify the Support Coordination Agency.

¹ Due to lack of need rather than difficulty in accessing services due to lack of capacity/availability

- Individuals who do not voluntarily dis-enroll from the Supports Program are notified in writing and are entitled to the opportunity to request a Fair Hearing as governed by Medicaid regulations.

In the event that an individual is dis-enrolled from the Supports Program, the Support Coordination Agency (SCA) will receive alerts through iRecord, and the Support Coordinator (or someone designated by the SCA) shall notify all service providers supporting the individual within 24 hours of notification of disenrollment. In addition, after 30 days the providers will automatically be updated with an ISP that has been approved to “inactive” and services will be ended as of that date.

6 CARE MANAGEMENT

Care management for Supports Program services is provided through Medicaid/Division approved Support Coordination Agencies². This section provides a summary of the Support Coordinator’s responsibilities. More detailed information about Support Coordination services is provided in Section 17.19.

6.1 Selection and Assignment of a Support Coordination Agency

Each person eligible to receive services through the Supports Program must have a Support Coordinator².

6.1.1 Choosing a Support Coordination Agency

The individual has the opportunity to choose their preferred Support Coordination Agency from a database (<https://irecord.dhs.state.nj.us/providersearch>) of approved agencies. Guides to assist individuals and families in choosing a Support Coordination Agency are available at <http://rwjms.rutgers.edu/boggscenter/projects/infopeopleandfamilies.html>. When the individual has completed the Intake/Application process and is determined eligible to receive DDD services, their assigned Intake Worker will provide them with a Support Coordination Agency Selection Form to complete. The individual will indicate their preferred Support Coordination Agency on the Support Coordination Agency Selection Form. Once completed, the form is returned to the Intake Worker for assignment to a Support Coordination Agency. As long as the selected agency provides support coordination services in the county in which the individual resides, has capacity to add the individual to its services, and meets the conflict free policy described in Section 17.18.5.7, the Division will assign the preferred Support Coordination Agency. If the individual does not indicate a preference or the preferred Support Coordination Agency does not meet the previously mentioned criteria to serve the individual, the Division will auto assign the Support Coordination Agency based on location and available capacity.

A list of Medicaid/DDD approved Support Coordination Agencies can be generated through the Provider Search Database at <https://irecord.dhs.state.nj.us/providersearch>.

To find a Support Coordination Agency using the [Provider Search Database](#) follow these steps:

- Select the “Filter” dropdown menu to the right of your screen
- Check the “Support Coordination” box under the “Service” dropdown menu
- Check the county in which the individual resides under the “County Served” dropdown menu
- Check the Language preferred, as applicable
- Click on the magnifying glass to the right of the “Filter” dropdown menu and a list of approved Support Coordination Agencies will be generated
- This list can be printed or exported to an excel spreadsheet by clicking on the applicable icon found to the left of your screen under the “Name, Service” box

Once assigned, the Support Coordination Agency will identify a Support Coordinator within its agency. The individual can inform the Support Coordination Agency of any preference they may have in Support Coordinator, but there is no guarantee that the Support Coordination Agency will be able to assign the preferred Support Coordinator to the individual.

6.1.2 Process for Assigning a Support Coordination Agency

Assignment of the Support Coordination Agency is conducted through the following process:

- The individual receives the Support Coordination Agency Selection Form from their Intake Worker;
- The individual/guardian/family completes and submits the Support Coordination Agency Selection Form as directed. Please note that Support Coordination Agency Selection Forms will only be accepted when completed by the individual/guardian/family;
- A Support Coordination Agency is assigned by the Division after submission of the Support Coordination Agency Selection Form based on the indicated preference or through auto assignment if no preference is

² On occasion, Case Managers with the Division may be utilized in more intensive situations or during transitions from institutional settings to community settings.

indicated or in cases where the preferred agency does not meet the criteria indicated in Section 17.19 to serve the individual;

- A secure email notification of assignment is provided to the Support Coordination Agency (the individual or a designee will also receive an email regarding Support Coordination Agency assignment if their email address was included within the Support Coordination Agency Selection Form);
- The Support Coordination Agency will identify a Support Coordinator within the agency;
- The assigned Support Coordinator will contact the individual to introduce themselves and begin the planning process.

6.1.3 Changing Support Coordination Agencies

If the individual wishes to change Support Coordinators, they must follow the policies/procedures set forth by the Support Coordination Agency to request a change in Support Coordinator. The Support Coordination Agency should make every effort to accommodate the request and assign a new Support Coordinator to the individual but is not obligated to do so.

Because the rate for Support Coordination services is monthly, the individual must commit to a calendar month of services from the assigned Support Coordination Agency before a change can be conducted. If the individual wishes to change Support Coordination Agencies, they must indicate that request on the [Support Coordination Agency Change Form](#) and submit it to the Division by following the directions indicated on the form. Typically, Support Coordination reassignments are conducted on the 1st of the month due to the monthly rate for Support Coordination Services. The reassignment process will follow the assignment process indicated in Section 6.1.2.

As soon as the new Support Coordination Agency is assigned, the previous Support Coordination Agency will no longer have access to the individual's information or be able to upload associated documents for that individual on iRecord. All information already gathered and developed – including contact and demographic information, planning documents such as the Person-Centered Planning Tool (PCPT) and ISP, monitoring tools, etc. – will become available to the newly assigned Support Coordination Agency through iRecord. In the event the previously assigned Support Coordination Agency (SCA) has not uploaded documentation to iRecord, a hard copy of all applicable documents must be distributed to the SCA's Division-assigned Quality Assurance Specialist within three business days. Examples of documentation include monitoring tools, case notes, and service planning documents. The previous SCA may not contact individuals previously served or send letters, notification, or other communication without prior approval from the Division.

In the event that a Support Coordination Agency closes, is suspended or terminated, is sanctioned by the Division with a reduction of census, otherwise dis-enrolls, etc. the Division will notify the individual of the need to reassign their Support Coordination Agency and provide the Support Coordination Agency Selection Form. The new Support Coordination Agency will be assigned as described in Section 6.1.2. Support Coordination Agencies in the process of disenrollment are prohibited from involvement in the new Support Coordination Agency selection process for the individuals affected. The Division will provide all communication regarding disenrollment, choice of agency, and process to individuals and/or families directly.

6.2 Role of the Support Coordinator

The Support Coordinator manages Support Coordination services for each individual by performing the following four general functions: individual discovery, plan development, coordination of services, and monitoring. These functions are further described in Section 17.18.

6.3 Responsibilities of the Support Coordinator

The Support Coordinator is responsible for:

- Using and coordinating community resources and other programs/agencies in order to ensure that waiver services funded by the Division will be considered only when the following conditions are met:
 - Other resources and supports are insufficient or unavailable;
 - Other services do not meet the needs of the individual; and
 - Services are attributable to the person's disability.

- Accessing these community resources and other programs/agencies by:
 - Utilizing resources and supports available through natural supports within the individual's neighborhood or other State agencies;
 - Developing a thorough understanding of programs and services operated by other local, State, and federal agencies;
 - Ensuring these resources are used and making referrals as appropriate; and
 - Coordinating services between and among the varied agencies so the services provided by the Division complement, but do not duplicate, services provided by the other agencies.
- Developing a thorough understanding of the services funded by the Division and ensuring these services are utilized in accordance with the parameters defined in Section 17 of this manual.
- Interviewing the individual and ensuring they are at the center of the planning process and in determining the outcomes, services, supports, etc. that they desire. Also interviewing, if appropriate, the family or other involved individuals/agency staff; reviewing/compiling various assessments or evaluations to make sure this information is understandable and useful for the planning team to assist in identifying needed supports; and facilitating completion of discovery tools, if applicable.
- Scheduling and facilitating planning team meetings in collaboration with the individual; informing the individual and parent/guardian that the service provider(s) can be part of the planning team, asking the individual and parent/guardian if they would like to include the service provider(s) at the ISP meeting, and inviting the service provider(s) to the ISP meeting; writing the PCPT and ISP; and distributing the ISP (and PCPT when the individual consents) to the individual, all team members, and the identified service providers; and reviewing the ISP through monitoring conducted at specified intervals.
- Ensuring that, for individuals assigned an acuity, that the Addressing Enhanced Needs Form is updated at least annually and revised more frequently during the plan year as necessary. The individual/guardian shall have the opportunity to be involved in the process. See Section 3.4 for more information.
- Ensuring that there has been a discussion regarding a behavior plan for individuals with behavioral concerns and that a behavior plan is in place as needed, particularly when the individual is assigned acuity due to behavior. This shall be documented in the individual's ISP.
- Ensuring that there has been a discussion regarding the medical needs of the individual and that these needs are documented in the ISP. This is to include the need for data collection of bowel movements, urine output, seizure activity, etc. Should the planning team agree that such data collection is medically necessary, and the individual's primary care physician provides a prescription for it, this shall also be documented in the ISP along with the responsible party who will record and store the information.
- Writing the PCPT and ISP; and distributing the ISP (and PCPT when the individual consents) to the individual, all team members, and the identified service providers; and reviewing the ISP through monitoring conducted at specified intervals.
- Annual completion of the Participant Rights and Responsibilities form with the individual/guardian, uploading it to iRecord, and providing a signed copy minimally to the individual/guardian, residential, and day service provider (as applicable).
- Obtaining authorization from the SC Supervisor for Division-funded services.
- Monitoring and following up to ensure delivery of quality services, and ensuring that services are provided in a safe manner, in full consideration of the individual's rights. This includes ensuring that for individuals residing in provider-owned or controlled residential settings (i.e., Group Homes, Supervised Apartments, etc.) and/or attending day habilitation programs, pre-vocational programs and group supported employment programs that any restriction (Examples include, but are not limited to: Inability to access food at any time due to a medical disorder; Inability to have access to items due to PICA) is supported by a specific assessed need and justified in the person-centered service plan (i.e. ISP). Please see section 11.7 *Home and Community Based Services (HCBS) Settings Compliance* for more information.
- Notifying the Division's HCBS Helpdesk at DDD.HCBShelpdesk@dhs.nj.gov if they are notified that a provider-owned or controlled setting is not in compliance with section 11.7 *Home and Community Based Services (HCBS) Settings Compliance*.
- Maintaining a confidential case record that includes but is not limited to the NJ Comprehensive Assessment Tool (NJ CAT), completed Support Coordinator Monitoring Tools, PCPTs, ISPs, notes/reports, annual

satisfaction surveys, annual physical and dental examinations (for those who reside in a licensed residential program), and other supporting documents uploaded to the iRecord for each individual served.

- Ensuring individuals served are free from abuse, neglect, and exploitation; reporting suspected abuse or neglect in accordance with specified procedures; and providing follow-up as necessary.
- Ensuring that incidents are reported in a timely manner in accordance with policy and follow-up Responsibilities are identified and completed.
- When a Support Coordinator is alerted that an individual assigned them has had an interaction with law enforcement/court system that results in a criminal charge, summons, or complaint they will discuss the availability of resources with the individual/guardian. This may include, but not be limited to: [The Arc of New Jersey Criminal Justice Advocacy Program](#); Resources listed in the *Legal and Advocacy Services* section of the most recent publication of [NJ Resources](#); etc. The Support Coordinator shall assist with the submission of a referral based on the expressed preference of the individual/guardian and document in an iRecord case note.
- Notifying the individual, planning team, and service provider and revising the ISP whenever services are changed, reduced, or services are terminated.
- Reporting any suspected violations of contract, certification or monitoring/licensing requirements to the Division.
- Entering required information into iRecord in an accurate and timely manner.
- Ensuring that individuals/families are offered informed choice of service provider.
- Linking the individual to service providers by providing information about service providers; assisting in narrowing down the list of potential service providers; reaching out to providers to confirm service capacity, determine intake/eligibility requirements, gather and submit referral information as needed, establish provider capacity to implement strategies to reach identified ISP outcomes, and confirm start date, units of service, etc.
- Becoming aware of items/documentation the service provider will need prior to serving the individual and assist/ensure they are provided prior to the start of services.
- Notifying the individual regarding any pertinent expenditure issues.
- Conducting contacts on a monthly basis, face-to-face visits on a quarterly basis, and in-home face-to-face home visit on an annual basis that includes review of the ISP and is documented on the Support Coordinator Monitoring Tool.
- Completing/entering notes/reports as needed.
- Providing support, as needed, in relation to supporting the individual in their decision making as outlined in section 7.1.1 *Individual as Decision Maker*.
- Reporting data to the Division as required and upon request.
- At the direction of Division staff, completion of surveys that may be required, etc.
- Including the Individual Supports – Daily Rate service provider in the planning process.
- Alerting the planning team that, with a doctor’s order, certain charting can occur as medically necessary such as food intake, blood glucose levels, etc.
- Ensuring involved service provider(s) have received notification to begin services.
- Ensuring that the individual is aware of different housing options that can be utilized in the community (including those that are not disability specific) so that they are supported in the least restrictive setting based on their individual needs and preferences. This includes assisting them in application for housing assistance.
- In relation to Electronic Visit Verification (EVV), the Support Coordinator shall be responsible for confirming with the individual/family which staff, if any, are live-in caregivers paid by DDD through the participant’s individual budget. Should a live-in caregiver exist, the Support Coordinator shall complete the Live-In Caregiver Attestation form at the time of service-plan development, whenever there is a change in live-in caregiver status and annually thereafter. Once complete, the form shall be uploaded to iRecord.

6.4 Support Coordinator Deliverables

The deliverables listed below serve as documentation that services were provided within the month in order for the Support Coordination Agency to claim for services. However, the monthly rate received for providing Support

Coordination services includes all of the responsibilities required as the entity providing care management for all individuals served as outlined throughout this manual – particularly within Sections 6, 7, 8, 12, and 17.18.

- Monthly contact documented on the Support Coordinator Monitoring Tool
- Quarterly face-to-face contact documented on the Support Coordinator Monitoring Tool
- Annual home visit documented on the Support Coordinator Monitoring Tool
- Completed PCPT & approved ISP by 30 days from date the individual is enrolled onto the CCP or when a new ISP is generated due to annual ISP date, changes to the individual budget, a change in the individual's tier assignment, or a change in waiver enrollment (going from the CCP to the Supports Program, for example). In circumstances where a new plan is generated, the SCA is expected to continue meeting deliverables, such as completing the monthly contacts, but will not be able to claim for payment for completing these deliverables unless/until the newly generated ISP is complete.

If meeting the previously mentioned deliverables is delayed due to the individual (or family) failing to comply with attending meetings, participating in mandated contacts, allowing access to the home for visits, etc., the Support Coordinator should notify the individual that non-compliance regarding Division policy will be reported to the Division. If non-compliance continues, the SC Supervisor shall upload a Seeking Out Support (SOS) form and email the Support Coordination Help Desk at DDD.SCHelpdesk@dhs.nj.gov to ensure follow-up with the individual to determine the reasons why non-compliance has occurred. Ongoing non-compliance for circumstances beyond those that may be unavoidable (such as hospitalization) may result in termination from Division services. Information regarding these incidents of non-compliance, attempted or successful contacts with the individual (or family), reasons for non-compliance, etc. shall be documented through case notes entered into iRecord.

Updates related to any and all significant events should be documented in case notes by the Support Coordinator. Documentation should be timely and frequent for high risk or high acuity situations. Case Notes shall be up to date at all times with the most recent contact or events occurring with the individual.

If meeting these deliverables is delayed due to system issues with the Division, the SC Supervisor shall notify the Support Coordination Help Desk at DDD.SCHelpdesk@dhs.nj.gov.

6.5 Community Transitions & Support Coordination

6.5.1 Transitions to Institutions from Community Settings

When an individual is transitioned from a community setting into an institutional setting (nursing home, ICF/ID, etc.) for the purpose of rehabilitation, respite, etc. if there is an assigned Support Coordinator, the Support Coordinator will retain the case up to 180 days from the date of admission. The Support Coordinator must then transition the individual to a Division Case Manager.

This transition will proceed as follows:

- Support Coordination will complete monthly monitoring in accordance with established Support Coordinator Responsibilities and Deliverables as described in Section 13.
- Support Coordination will conduct all placement activities to transition the individual back to the community if the individual is returning to their original placement or a new placement is identified.
- If the individual has not transitioned after being in an institutional setting for 180 days, Support Coordination will transfer the case to a Division Case manager to complete the transition using the Community Transitions Unit Case Transfer Form (Appendix D).
 - Support Coordination will forward request to have case assigned to the assigned Division Monitoring Team through the DDD SC Helpdesk.
 - The assigned Division Monitoring Team will forward the form to the Community Transitions Unit.
 - The case will be reassigned in iRecord from the Support Coordination Agency to the Division.
 - The Community Transitions Unit will then be responsible for all placement activities.
- If long term placement in a Skilled Nursing Facility (SNF) occurs, an individual will be placed on an inactive caseload as they will no longer be eligible for Waiver services.

6.5.2 Transitions from Institutional to Community Settings

When an individual moves from an institutional setting (nursing home, developmental center, ICF/ID, etc.) to a community placement, a transition from a Division Case Manager to a Support Coordinator in the community may take place. This transition will proceed as follows:

- Before discharge from the institution, the Division Case Manager will develop a service plan that remains in place for 90 days.
- The Division Case Manager will continue to work with the individual for a period of 90 days from the date of the community placement.
- Upon placement in the community, the individual will select a Support Coordination agency (or be auto-assigned based on preference) following Support Coordination selection procedures described in Section 6.1.2.
- 30 days following the date of the community placement, a Support Coordinator will be assigned to overlap with the Division Case Manager for the remaining 60 days to ensure continuity of care.
- The Division Case Manager will be the primary person responsible for the transition during the first 60 days, after which the Support Coordinator will become the primary person responsible for the individual’s transition and service planning process. The Case Manager will be responsible for ensuring the Support Coordinator is apprised of the individual’s background, important health indices, and any other pertinent information during a case review before the 60-day period ends. The Case Manager will provide support and assistance to the Support Coordinator to ensure a smooth transition of care management services.
- The Support Coordinator will be responsible for developing a new service plan within the first 30 days of assignment and then monitoring every 30 days thereafter in accordance with established Support Coordinator Responsibilities and Deliverables as described in Section 13.
- At the conclusion of 90 days, the Division Case Manager will be removed from the case unless serious health and safety issues warrant a longer transition period. The Support Coordinator will then be solely assigned and responsible for the monitoring of the individual and the new service plan will commence.
- Upon the approval of the Support Coordinator service plan, billing will shift from the Case Management to Support Coordination. At no time will both services be claimed.

Days	Care Management Roles
0 – 30 Days	Division Case Manager responsible, Support Coordination Agency selected
0 – 60 Days	Division Case Manager responsible, Support Coordinator assigned after 30 days
60 – 90 Days	Support Coordinator responsible, Division Case Manger providing assistance
90+ Days	Support Coordinator responsible, Division Case Manager removed

6.5.2 Transitions from Community Settings to Hospitalization

When an individual already utilizing Support Coordination services is hospitalized, the Support Coordinator continues to provide services for up to 30 days. When an institutional setting placement lasts more than 30 days, but is considered short term, the Support Coordinator must transition the individual to a Division Case Manager for monitoring. If long term placement in a Skilled Nursing Facility (SNF) occurs, an individual will be placed on an inactive caseload as they will no longer be eligible for Supports Program services. This transition will proceed as follows:

- Prior to the 30th day of hospitalization, the Support Coordination Supervisor must notify the assigned Division staff of the potential need for Division Case Management assignment.
- Once the Division Case Manager is assigned, the Support Coordinator must ensure that the Case Manager is apprised of the individual’s background, important health indices, and any other pertinent information during a case review, and revise the service plan to stop any ongoing services.
- The Division Case Manager will then be responsible for the continued monitoring of the individual until such time that the person is discharged. During this time, the Support Coordination Agency cannot bill for Support Coordination services.
- Upon discharge from an institutional setting beyond 30 days, the procedure for Transitions from Institutions to Community Placement will be followed to ensure continuity of care during the transition back to Support Coordination. The discharge date will begin the 90-day transition period and the Support Coordinator will revise the service plan as applicable as described in Section 7.8.

7 SERVICE PLAN

It is a requirement that each person who has been determined eligible to receive services from the Division has an Individualized Service Plan (ISP) developed in iRecord according to the standards specified in this policy manual and through Support Coordination Orientation and other training opportunities. The plan will be developed by a planning team of appropriate persons to include, but not be limited to, the individual, the Support Coordinator, and the individual's parent or guardian as appropriate. It is highly recommended that identified providers are also included within the planning team unless the individual has indicated that they do not wish to include the provider. The Support Coordinator shall inform the individual and individual's parent or guardian as appropriate that the service providers can be included on the planning team and ask the individual/family/guardian if they want the service provider(s) to be included in the ISP meeting. If providing residential services (Individual Supports – Daily Rate), the provider must be included on the planning team. This plan, which is developed based on assessed needs identified through the NJ Comprehensive Assessment Tool (NJ CAT); the Person-Centered Planning Tool (PCPT); and additional documents as needed, identify the individual's outcomes and describes the services needed to assist the individual in attaining the outcomes identified in the plan. An approved ISP authorizes the provision of safe, secure, and dependable support and assistance in areas that are necessary for the individual to achieve full social inclusion, independence, and personal and economic well-being.

7.1 Operating Principles

The ISP must be in the best interests of the individual served and also must empower individuals. The plan must be centered upon the strengths, resources, and needs of the individual served.

The plan must be based upon evaluations and assessments, the preferences of the individual, and a written statement of the individual's personally defined outcomes. Services identified in the plan must be designed to allow the individual to meet their personally defined outcomes and function as independently and successfully as possible.

The plan must also address utilizing resources and supports available through natural supports within the individual's neighborhood or other State agencies. Services funded by the Division will be considered only when other resources and supports are insufficient or unavailable, the services do not meet the needs of the individual, and the services are attributable to the person's disability.

In designing the plan, the planning team should consider the unique characteristics and needs of the individual as expressed by the individual and others who know the person, such as family, friends, service providers, etc. Outcomes, services, and providers identified in the plan should:

- Recognize and respect rights;
- Encourage independence;
- Recognize and value competence and dignity;
- Respect cultural/religious needs and preferences;
- Promote employment and social inclusion;
- Preserve integrity;
- Support strengths;
- Maintain the quality of life;
- Enhance all domains/areas of development;
- Promote safety and economic security.

Support Coordinators and approved service providers must include the individual in problem-solving and decision-making, and ensure that services are provided in a non-intrusive manner.

The planning team functions as an interdisciplinary team. An interdisciplinary team is one in which persons of various backgrounds interact and work together to develop one whole, integrated plan for the individual. An interdisciplinary process encourages mutual sharing of the strengths and insights of all team members, including the individual, rather than reliance on professionals who concentrate on a specific discipline. Planning team members are encouraged to participate in discussions related not only to their primary area of expertise but to all aspects of the individual's life.

7.1.1 Individual as Decision Maker

Support Coordinators and approved service providers must include individuals with intellectual and developmental disabilities (IDD) in problem solving and decision-making. Support Coordinators, and others invited to be part of the person's Planning Team, should provide sufficient information to ensure that individuals can make informed decisions and are supported to do so in the least restrictive manner. Support Coordinators can encourage independent decision-making and self-determination for persons with IDD by fostering exposure and understanding in important life categories that may include residential, medical, educational, vocational and legal areas. This includes understanding the resources available to individuals.

Alternatives to Guardianship

Some may assume guardianship is the only option available to protect the interests of individuals with IDD. However, it is important to recognize that most people with IDD can manage their own affairs with support, assistance and guidance from others, such as family and friends.³ The appointment of a guardian is a serious matter and must not be based solely on a person's age, disability, or perceived ability to understand context and make decisions independently. It is the avenue of last resort for many reasons, including but not limited to:

- It limits an individual's autonomy over how to live and from whom to receive supports to carry out that choice;
- It transfers the individual's rights of autonomy to another individual or entity; and
- Many individuals with IDD experience guardianship as stigmatizing and inconsistent with their exercise of adult roles and responsibilities.

Like their peers without disabilities, individuals with IDD are presumed competent once they turn 18 years old. As necessary and based on their individual needs, they may need assistance to develop as decision-makers through education, supports, and life experiences. Supported Decision-Making (SDM) (e.g., use of plain language, information provided in video or audio form, time to review and discuss choices, role-playing activities to understand choices, assistance with creating pros and cons lists, having a supporter present at important medical meetings and/or medical appointments, etc.) and other less restrictive means of decision-making supports (e.g., health-care proxies, advance directives, powers of attorney, etc.) should be tried before pursuing guardianship. Support Coordinators and service providers should also consult with professionals as appropriate for support and advice in assisting individuals with IDD with SDM. For example, a governmental agency might be consulted concerning benefits or services.

SDM allows individuals with disabilities to make choices about their own lives with support from a team of people they choose. In practice, many persons without disabilities engage in similar consultative practices throughout their lives to help them make challenging decisions. SDM is an alternative to guardianship; instead of having a guardian make a decision for the person with the disability, the person with the disability is supported to make their own decisions.⁴

Resources on Supported Decision Making and Other Supports:

- <https://www.parentcenterhub.org/buzz-feb2020-issue2/> - Includes an 11-minute video on Supported Decision Making.
- <https://www.autismnj.org/article/supported-decision-making-as-an-alternative-to-guardianship/>
- <https://www.thearcfamilyinstitute.org/resources/guardianship-go-bag.html?page=2>
- <https://www.nj.gov/education/specialed/parents/docs/GuardianshipBrochure2.pdf>

The Support Coordinator shall facilitate a discussion at the annual Planning Team meeting (which includes the individual with IDD) on decision-making. Areas of discussion shall include whether SDM or other less restrictive options than guardianship can be used to support the individual in their decision-making. This discussion shall also include less-common circumstances where consent may potentially be needed for a medical (e.g. general anesthesia for a dental procedure) or legal matter (e.g. signing a lease or residency agreement) will be addressed.

³ <https://www.aaid.org/news-policy/policy/position-statements/guardianship>

⁴ <https://supporteddecisions.org/about-supported-decision-making/>

If there is no guardian in place and an emergency presents, Support Coordinators can work with Administrators at DDD, who have authority to grant informed consent in certain limited circumstances involving the medical, psychiatric, surgical or dental treatment of individuals with IDD. Guidelines for this emergency consent process are set forth in [N.J.S.A. 30:4-7.2](#) and [N.J.S.A. 30:4-7.3](#); they require that a licensed physician, psychiatrist, surgeon or dentist certify that the treatment to be performed is essential and beneficial to the general health and welfare of an individual with IDD or will improve their opportunity for recovery or prolong or save their life.

Guardianship

If the Planning Team determines that less-restrictive methods have been attempted without success or are otherwise not realistic based on the needs of the individual, the Support Coordinator shall facilitate a discussion on guardianship. This conversation shall take place with the individual present at the annual Planning Team Meeting, or earlier based on individual circumstances.

Please note that only the court can appoint a guardian and the Support Coordinator's role is to initiate a discussion and engage in next steps at the direction of the individual and their Planning Team. Next steps could include a referral through the DDD Liaison to the Bureau of Guardianship Services (BGS) (see below). In all cases a licensed, independent clinician completes assessment(s) verifying guardianship need prior to any guardianship proceedings being filed in court and the individual with IDD is provided legal counsel to protect their rights at the time of a guardianship hearing to assert their wishes.

In this option of last resort, the Planning Team shall determine whether the consensus is that guardianship may be needed and, if so, whether limited or full (plenary) guardianship may be needed. Limited guardianship preserves an individual's rights to make decisions in certain life areas, appointing a guardian to assist a person in areas deemed to require assistance. Life areas that might require decision-making through guardianship, or less restrictive options, may include educational, vocational, residential, legal, or medical decisions.

In circumstances where a person has already been assigned a guardian, they shall discuss whether the guardianship remains appropriate and, if not, what changes the Planning Team suggests are needed in that area. The outcome of this discussion is to be documented in the ISP. In instances where a person has a guardian assigned but the Planning Team believes that they have the capacity to make decisions partially or fully, then actions to restore themselves as guardian should occur.

In circumstances where a person has been assigned a guardian who is no longer viable or available, then the individual with IDD does not automatically resume their own decision-making abilities. Instead, a new proceeding must be made with the court to replace the guardian through the substitute guardianship process. The Support Coordinator will use this opportunity to educate the Planning Team on less restrictive options and provide information and resources to the individual and the Planning Team members.

Guardianship may be obtained privately by the family or through the Bureau of Guardianship Services (BGS). More information about guardianship can be found at <https://nj.gov/humanservices/ddd/individuals/guardianship/>. If it is determined that guardianship, substitute guardianship, or restoration of guardianship should be obtained through BGS, the Support Coordinator shall complete the needed referral material to initiate the process (See Guardianship section under Support Coordination Documents and Forms at <https://nj.gov/humanservices/ddd/providers/support/> for more information). Support Coordination Agencies shall also assist with completion of paperwork, service, and other activities related to the establishment of guardianship when indicated, as well as for those less restrictive options.

Some information in this section was derived from numerous sources, including the [American Association on Intellectual and Developmental Disabilities](#), the [Arc of New Jersey](#), the [Center for Public Representation](#), the [National Research Center for Supported Decision Making](#), and the [New Jersey Council on Developmental Disabilities](#).

7.2 Planning Team Membership

The membership of the planning team will vary depending upon the needs and wishes of the individual.

The planning team will include at a minimum:

- Individual;
- Support Coordinator, who shall serve as plan coordinator and provide support to the individual as meeting facilitator or serve as meeting facilitator when the individual will not be fulfilling that role;
- Individual's parent/family or legal guardian, as appropriate;
- Any service provider and/or additional person(s), approved by the individual, whose participation is necessary to develop a complete and effective plan.

The Division encourages the individual to include providers who are currently authorized to serve the individual on the planning team and encourages identified providers to attend the planning meeting(s) when invited to participate as planning team members. At a minimum, the Support Coordinator must contact the provider to ensure they are capable of implementing the strategies necessary to assist the individual in progressing toward their personally defined outcomes, accurate information regarding services, units, start/end dates, etc. are entered into the plan, and that there is agreement regarding acceptance into the services offered by the provider and the date in which services will begin.

Occasionally, there may be a need for non-participating persons, such as staff in training or observers from monitoring groups, to be present at team meetings. Since these persons are not planning team members, the Support Coordinator shall seek prior approval for their presence from the individual. The Division reserves the right to attend and participate in planning team meetings.

7.3 Responsibilities of Each Team Member

7.3.1 Responsibilities of the Plan Coordinator (Support Coordinator)

The Support Coordinator, as plan coordinator, is responsible for the following tasks:

- Ensuring that the individual is at the center of the planning process;
- Identifying team members – based on the individual's input – and scheduling meetings of the planning team;
- Notifying team members, preferably in writing, of planning team meetings within 5 working days;
- Ensuring that copies of all current evaluations and assessments are available to the team members prior to the team meetings, if possible;
- Actively participating in team meetings;
- Coordinating meetings of the planning team as outlined in Section 8.3.1, when the individual has decided not to facilitate the meeting themselves;
- Writing the PCPT as a result of the person-centered planning process and by incorporating previously developed person-centered planning documents (from schools, other States, family members, etc.);
- Writing the ISP in clear and understandable language based upon consensus reached during the team meeting;
- Distributing copies of the completed ISP (and upon consent from the individual/person responsible, the PCPT) to all team members and service providers within 3 working days from the date of SC Supervisor approval of the ISP, and ensuring that copies of the ISP are available in all settings where the individual receives services;
- Ensuring that all data is entered into the iRecord;
- Monitoring and reviewing the ISP;
- Completing other assignments as determined by the planning team;
- Ensuring the individual receives services to meet medical/functional needs (within the availability of funds for State-funded services);
- Other relevant responsibilities as outlined in Section 6.3 of this manual.

7.3.2 Responsibilities of the Individual (and guardian, where applicable) as a Planning Team Member

Areas of responsibility include but are not limited to the following:

- Being available to meet for the required ISP planning meeting and reviews. If the guardian is unavailable for planning meetings, then they should be available for discussion outside of the meeting and to sign the ISP upon completion;
- Providing documentation for eligibility determination/redetermination;
- Actively participating in planning meetings;
- Reporting issues with service providers including potential/suspected fraud and abuse;
- Reporting changes of address;
- Reporting changes in individual circumstances which may cause the need for changes to the ISP or effect the provision of services;
- Signing appropriate consents;
- Providing appropriate documentation to obtain requested assistance from the Division;
- Providing documentation of annual physical and dental exams for individuals residing in a licensed residential setting;
- Providing other documentation as requested by the Division (i.e. any changes in insurance policies with the effective date, third party liability information, burial insurance policies, etc.);
- Complying with and maintaining Medicaid eligibility;
- Informing the Intake Director in the Division's Community Services Office serving the region in which the individual resides of significant temporary or permanent changes to the individual or caregiver that cause the need for a bump-up or reassessment, respectively;
- Requesting that the Support Coordinator invite other persons to participate as team members, if necessary.

7.3.3 Responsibilities of the Service Provider as a Planning Team Member (when included)

Areas of responsibility include but are not limited to the following:

- Providing details regarding the services available within their agency;
- Contributing to the development of outcomes specific to the services they will be or are already providing;
- Assisting with the establishment of units, start/end dates, etc. for identified services and confirming their accuracy within the ISP;
- Reporting changes in individual service needs/preferences that may cause the need for changes to the ISP or effect the provision of services.
- Providing documentation of annual physical and dental exams for individuals residing in the provider's licensed residential setting.

7.3.4 Responsibilities of Other Planning Team Members

Other planning team members are responsible for the following tasks:

- Reviewing provided information related to the individual, including the PCPT, previous ISP(s), available assessments, and evaluation data, as appropriate/relevant;
- Actively participating in the planning team meeting and working cooperatively to achieve consensus in the spirit of the ISP operating principles;
- Recording data relative to assigned outcomes, as relevant;
- Notifying the Support Coordinator and requesting a special team meeting to be scheduled whenever there is a significant change in the individual's status;
- Completing other assignments as determined by the planning team.

7.4 Development of the Individualized Service Plan

The ISP must be developed and approved within 30 days of Supports Program enrollment. The content of an individual's service plan stems from the person-centered planning process and will vary depending on the unique characteristics and specific needs of the individual and the individual's service settings. The ISP shall be based on

the results of mandated assessments/evaluations and can incorporate additional information from optional discovery tools and evaluations/assessments of the individual.

7.4.1 Assessments/Evaluations

7.4.1.1 Mandated assessments/evaluations

These tools are required by the Division and are known as the NJ Comprehensive Assessment Tool (NJ CAT) and the Person-Centered Planning Tool (PCPT).

7.4.1.1.1 New Jersey Comprehensive Assessment Tool (NJ CAT)

The **NJ CAT** is comprised of the Functional Criteria Assessment (FCA) and the Developmental Disabilities Resource Tool (DDRT).

The FCA is the assessment tool utilized to assess whether newly entering individuals meet the functional criteria to be eligible for the Division or not. This tool assesses individual competencies in the following areas: sensory/motor, cognitive abilities, communication, social interaction and sociability, self-direction, self-care/independent living skills, special behaviors, health, school experience, and employment and determines relative need for services and supports.

The DDRT has a long history of use with individuals with intellectual or developmental disabilities in NJ for assessing individual support needs and determining relative need for services. The DDRT assesses individual competencies and assists in determining who needs more support and ensures that those with like needs receive a similar level of support.

The Support Coordinator will review the NJ CAT with the planning team, at a minimum, on an annual basis to ensure that outcomes and services included in the ISP are warranted by assessed need.

7.4.1.1.2 Person-Centered Planning Tool (PCPT)

The **Person-Centered Planning Tool** (PCPT) is a mandatory discovery tool used to guide the person-centered planning process and assist in the development of an individual's Service Plan. The Support Coordinator will facilitate the development of the PCPT with input and guidance from the identified team members. The PCPT can be provided to the individual and/or their guardian, family, or other people as identified by the individual and/or guardian prior to the planning meeting in order to assist them in becoming familiar with the PCPT and begin thinking about information that will be provided to assist in completing the PCPT. Individuals may also have participated in the person-centered planning process through other entities, such as their school. Information gathered through these previous person-centered planning experiences can be very relevant to include in the PCPT, too. Any information provided when an individual, family, etc. completes the PCPT prior to meeting with the Support Coordinator will be discussed during the person-centered planning meeting(s) and used to inform the PCPT completed by the Support Coordinator.

Information gathered through the PCPT informs the outcomes written into the ISP, should align with results of the NJ CAT, and provides information related to service needs. The Support Coordinator writes the PCPT as part of the initial plan and must review with the individual/guardian and planning team and update annually to identify changes and inform the annual ISP. The PCPT must be updated annually and be comprehensive.

7.4.1.1.2.1 Components of the PCPT

7.4.1.1.2.1.1 Relationships

This section (sometimes referred to as a "circle of support" provides the opportunity for the individual and planning team members to identify people that are loved, important, and/or relevant to the individual's life. The relationship

of each person included in this section – family, supporters at home and in the community, friends, and supporters at work, school, day services – is included.

7.4.1.1.2.1.2 Strengths and Qualities

The individual's positive qualities, achievements, areas that they like about themselves and others like about them, and things the individual does well are documented here.

7.4.1.1.2.1.3 Important to the Individual

Routines, places to go, things to do, people to see, and recreational pursuits that are of importance to the individual are provided in this section. Information provided here should include activities the individual enjoys doing with their free time, hobbies, and things the individual misses when not around or available.

7.4.1.1.2.1.4 Hopes & Dreams

This section includes likes/dislikes, interests, short-term goals and aspirations, and long-term hopes and dreams. Information about the ultimate destination for the individual. Information about how the individual sees themselves having fun in the future, what they see themselves doing, where they want to be living, whether they want to be added to the CCP Wait List, etc. would be included here.

7.4.1.1.2.1.5 Supporter Qualities

This section provides an explanation of what others – family, friends, staff, etc. – need to know in order to provide the ideal support to the individual in a variety of settings under a variety of circumstances, and the skills, personality characteristics, knowledge, etc. that someone providing supports for the individual would need or benefit from having. Information in this section can be used to inform a job description for a Self-Directed Employee or for a provider to know the qualities valued by the individual.

7.4.1.1.2.1.6 Community Integration

The information in this section will assist the people supporting the individual in accessing the community as fully as possible. Previous experience in the community, interests, extent of interaction with people, and current activities in the community are included in this section. Discussion on potential opportunities for community integration shall occur.

7.4.1.1.2.1.7 Communication Styles

Information about how the individual communicates is captured in this section of the PCPT. Details about whether or not the individual can read and/or write and the extent to which the individual can do so along with how the individual will let someone know their emotions (happy, sad, excited, angry, etc.), health status (hungry, thirsty, sick, in pain, etc.), wants/needs/choices, understanding, and lack of desire/interest are documented in this section.

7.4.1.1.2.1.8 Ideas/To Do List

This section provides the opportunity for the individual, planning team, and Support Coordinator to brainstorm ideas of how the information gathered through the PCPT can be used to develop meaningful activities – employment/career, education/learning, entertainment/fun, home life, responsibilities, and well-being – that are in line with the individual's interests, qualities, strengths, hopes/dreams, support needs, etc. This information then leads to identification of outcomes in the ISP and the services and providers that can assist the individual in accomplishing those outcomes.

7.4.1.1.3 Annual Reviews/Discussions

7.4.1.1.3.1 Pathway to Employment

Provides an annual discussion to assist in determining where the individual is on their path to employment; identifying potential barriers, concerns, fears, and reasons that the individual isn't working or pursuing employment; and establishing next steps in the employment process which become employment outcomes in the ISP.

- Path 1: Already Employed – This path is completed when the individual is currently working competitively in the general workforce. Answers to the questions in this section help determine the individual's satisfaction level with their current job and establish outcomes and service needs related to maintaining their current job; finding a new or additional job; increasing hours, salary, or tasks; seeking a promotion, etc.
- Path 2: Unemployed & Has Paid/Unpaid Experiences/Training – This path is completed when the individual is not currently working but has worked, interned, job sampled, participated in work crews or group placements (enclaves), had work-related training, etc. in the past. Answers to the questions in this section help determine what is preventing the individual from using this experience and training to lead to employment. Outcomes and service needs addressing these areas that have prevented the individual from successfully finding and maintaining employment must be included in the ISP.
- Path 3: Unemployed & Has No Exposure to Paid/Unpaid Experiences/Training – This path is completed when the individual is not currently working and has never worked, had work experiences or training, and may never have considered employment as a viable option. Answers to the questions in this section help the individual start discussing employment and the benefits of working and helps determine if the individual is interested in pursuing employment at this time. This section can also provide ideas for employment outcomes that can be developed for individuals who have medical or behavioral concerns that prevent them from being able to pursue employment at this time.
- Path 4: Unemployed – Not Pursuing – This path is selected only if the individual has chosen to retire because they are 65 or older or will not currently be pursuing employment due to medical condition/behavioral issues precluding the individual from working at this time due to substantiated concerns about harm to self or others which cannot be appropriately mitigated by supports/services.

7.4.1.1.3.2 Voting

This section provides questions used to guide a discussion with the individual about their right to vote and determine interest level and support needs related to voting.

7.4.1.1.3.3 Mental Health Pre-Screening

The questions in this section are used to guide a discussion with the individual about any possible indicators that a mental health evaluation may be necessary.

7.4.1.2 Optional Discovery Tools

Optional Discovery Tools are additional tools that can be utilized during the discovery process to inform the PCPT and the Service Plan and provide potential caregivers, service providers, etc. with information essential to supporting the individual. These tools can be completed by the individual and/or their guardian, family, or other people as identified by the individual and/or guardian. Schools and other entities the individual was previously associated with may also utilize person-centered planning to gather information leading to the development of the Individualized Education Plan or other documents. If utilized, the Support Coordinator will compile information from these tools and use it to assist in development of the PCPT and Service Plan.

Physical exams, psychological evaluations, etc., can also be utilized to inform the ISP. All individuals residing in licensed residential settings are to receive an annual physical and dental examination as well as any follow-up care directed by their treating physician. This is highly recommended for persons not interacting with those settings as

well. Preventative care based on gender and age is also best practice. Support Coordinators are reminded to discuss the importance of annual medical and dental exams on the SC planning/monitoring tool and to collect/upload these documents to iRecord when they are available.

7.4.2 Planning Meetings

7.4.2.1 Notice of Planning Meetings

The Support Coordinator shall notify the planning team of team meetings. Written confirmation of scheduled meetings is preferred. The date, time, and location of the meetings should be mutually convenient for the individual, Support Coordinator, and other planning team members. The planning team should be notified at least five (5) working days in advance of the meeting. The notification should include the time, date, and place of the meeting and inform the planning team of the purpose of the meeting.

An initial meeting for newly assigned individuals should be arranged within ten (10) days of Support Coordination Agency assignment in order to discuss the arrangements needed for the planning process.

7.4.2.2 Meeting Process

In cases when the individual is not fulfilling the role of meeting facilitator, the Support Coordinator shall coordinate the planning team meeting, ensure all planning team members are introduced, explain each team member's responsibilities, and describe the purpose of the meeting. The Support Coordinator shall explain that the planning team will operate as an interdisciplinary team and that every effort will be made to reach consensus, but that in the event consensus cannot be achieved, deference should be paid to the individual's thoughts, opinions, decisions, preferences, and expressed needs first. In order to prevent delays in service provision, the areas in which consensus has been met will be included in the plan if discussions are still continuing about other areas.

The Support Coordinator shall ensure that the individual is treated with respect and dignity during the meeting by making sure that comments are directed to the individual in first person rather than third person language, sensitive issues are discussed with respect for privacy and consideration for the individual's dignity, etc. The Support Coordinator shall also ensure that all participants are given an opportunity to provide input and that issues are thoroughly discussed before decisions are reached. Decisions shall be guided by the individual, the Division's Mission and Core Principles, and the ISP Operating Principles.

The standard agenda for a meeting shall consist of the following:

- Review of PCPT;
- Review of the last ISP, if applicable;
- Review of professional evaluations and assessments, as needed;
- Discussion of the person's current status, preferences, needs, and vision for the future;
- Development of long-term outcomes;
- Discussion of services needed to attain the long term outcomes;
- Discussion of other actions necessary to implement the services, achieve the outcomes, and meet the individual's needs;
- Discussion of other special considerations;
- Review of Medicaid status and the importance to comply with all correspondence including redetermination requests and notify the SC of any expected changes in benefits (e.g., increase due to a parent retiring).

When special circumstances require a different agenda, the Support Coordinator shall communicate the revised agenda to the team at the beginning of the meeting.

Individual as Facilitator – Prior to the facilitation of the planning meetings, the Support Coordinator should speak with the individual to determine their desire to facilitate their own planning meetings. Every opportunity will be provided for the individual to facilitate their planning meetings if they so desire. In circumstances where the individual will be facilitating the meetings, the Support Coordinator will provide support as needed. If the individual chooses not to facilitate the planning meetings, the Support Coordinator will fulfill this role.

Frequency of Meetings – Face-to-face planning meetings/reviews are encouraged whenever possible. The ISP shall be reviewed, as indicated on the Support Coordinator Monitoring Tool, during the Support Coordinator’s monthly/quarterly/annual contacts, and more often if necessary, to ensure that the plan remains appropriate and that the individual is making progress toward the outcomes specified in the plan. The planning team shall meet at least annually – to review the current plan and develop a new annual ISP – and more often whenever there is a significant change in the individual’s status.

Planning Process – The Support Coordinator has 30 days from the date an individual is enrolled into the Supports Program or a new ISP is generated (due to annual ISP date, change in the individual budget, change in the individual’s tier assignment, or enrollment on a different waiver) to complete the planning process resulting in an approved ISP. The ISP is developed through a Person-Centered Planning Process. Once assigned, the Support Coordinator will plan with the individual and their identified team members through regular contact and communication that includes at least one face-to-face meeting in a mutually convenient location. Through the use of information provided from the NJ Comprehensive Assessment Tool (NJ CAT), the Person-Centered Planning Tool (PCPT), and any other discovery tools that have been utilized and can include past results of person-centered planning, the Support Coordinator will begin to build an ISP that includes identification of the individual’s strengths, preferences, and needs; builds upon the individual’s capacity to engage in activities and promote community life; respects the individual’s preferences, choices, and abilities; and involves families, friends, and professionals in the planning and delivery of services and supports as needed by the individual. Development of the Service Plan drives the outcomes and services that will be implemented in order to meet the needs of the individual.

In circumstances where time is needed to further explore service needs, research and confirm the appropriate service providers, hire Self-Directed Employees (SDE), determine eligibility with other State agencies or funding sources before determining the need for Division-funded services, etc., the ISP can include outcomes related to working on these areas and still be approved within the 30-day timeframe without specifics about services and/or providers. The services and providers that have already been identified and confirmed should be included in the ISP so services and supports are not delayed while the Support Coordinator, individual, family, or other identified team members are conducting this additional activity as noted in the ISP. However, individuals who have only received Support Coordination services for 90 days may be subject to disenrollment from the Supports Program if it is determined, upon further review by the Division, that Supports Program services are not needed at this time.

Extending 30-Day Timeframe for ISP Completion – the 30-day deadline for completing the ISP can be waived if circumstances warrant additional time for completion. A written request specifying the reasons for the need for an extension must be submitted to the SC Supervisor help desk. The written request as well as the approval/denial of the request will be recorded in iRecord. The Support Coordination Agency will not receive payment for services rendered until the ISP is completed and approved.

7.5 Components of the Individualized Service Plan (ISP)

The Individualized Service Plan (ISP) utilizes information gathered through the assessments/evaluations described above to identify the individual’s needs; describe the needed services to be provided and outcomes to be attained; direct the provision of safe, secure, and dependable support and assistance; and establish outcomes consistent with full social inclusion, independence, and personal/economic well-being. The planning team shall identify and document these areas in the ISP, and needs statements shall be functional statements oriented to the overall outcome envisioned for and by the individual and developed with consideration of the person’s strengths and preferences.

Information comprising the ISP is entered directly into iRecord and includes the following areas:

7.5.1 Participant Information

Demographic information about the individual which includes DDD ID#, age, date of birth, county of residence, program information, Medicaid ID and type, DDD eligibility status, contact information, diagnosis information, Support Coordination Agency, guardianship information (if applicable), and medical contact information are all indicated in this area of the ISP.

7.5.2 Outcomes and Services

The ISP must indicate the individual's outcomes and services based on assessed need.

7.5.2.1 Outcome

The outcome shall reflect the individual's desired achievement based on strengths and preferences and shall be developed without regard to the availability of services or funding sources. Outcomes change to reflect accomplishments, life transitions, or changes in the individual's status. Note that at least one outcome must relate to the employment goals of the individual. There is no limit on the total number of outcomes in any service plan.

7.5.2.2 Service(s)

The service is identified to provide the assistance and supports an individual needs to reach the outcome. All services, including those services that are not Division-funded, that are required to meet an assessed need must be included within the ISP.

7.5.2.3 Payment Source

The payment source for the provider (Medicaid, FI, DVRS, natural, generic, etc.) is indicated here. Services funded by the Division will be considered only when other resources and supports are insufficient or unavailable and do not meet the needs of the individual and are attributable to the person's disability.

7.5.2.4 Reference

The assessment tool from which the identified need was indicated is referenced in order to connect the need for service to the individual. Assessment tools include mandated tools such as the PCPT and NJ CAT or optional discovery tools used in the person-centered planning process.

7.5.2.5 Provider

The entity or individual who will provide the service(s) indicated in the ISP. Division-funded services can only be provided by approved providers.

7.5.2.6 Procedure Code

The code is a series of letters and numbers used by Medicaid to identify the type of service that has been authorized. The codes for each service are provided in Section 17 of this manual and within the Supports Program Services Quick Reference Guide available in Appendix H.

7.5.2.7 Location

The location is where the service will be provided if applicable.

7.5.2.8 Start & End Dates

The dates between which the provider is prior authorized to provide services and receive funding.

7.5.2.9 Unit Type

The unit type is the predetermined interval of time that can be claimed for each particular service. Services that are a one-time item, such as Environmental Modifications, will list "service(s)" as the unit type rather than a time interval.

7.5.2.10 Frequency

The frequency is weekly since prior authorizations are provided on a weekly basis.

7.5.2.11 Rate

The rate is the cost per unit of a service provided. A list of the standardized rates for all services is available in the Supports Program Services Quick Reference Guide in Appendix H.

7.5.2.12 Total Units

The approved increment of time, based on the assessed need, for the services that have been indicated on the ISP.

7.5.2.13 Total Cost

The amount that will be provided from the individualized budget to fund this service.

7.5.3 Employment First

In an effort to address the issues of unemployment or underemployment for individuals with intellectual and developmental disabilities and encourage discussions around employment for each individual served, every ISP must contain at least one employment outcome even if the individual is not pursuing employment at the time of the ISP.

These outcomes can fall into a wide range of areas from already employed and working toward further development of a career, maintaining employment, unemployed but looking for employment, or unemployed and gaining or improving upon skills, characteristics, behaviors, etc. that will assist the individual in successfully working.

The Support Coordinator will document the individual's current employment status and employment plan based on the Pathway to Employment discussion that is facilitated annually during development of the ISP. Based on the individual's employment status, the planning team will develop employment outcomes that make sense for the individual. For example, for individuals who are already competitively employed, the outcome can relate to maintaining their current employment or working toward further development of a career. For those individuals that are unemployed or not competitively employed, the outcome can include finding competitive employment or gaining, improving, and/or developing skills marketable or habilitative skills, characteristics, behaviors, communication, etc. that will assist the individual in successfully working. As is the case with any outcome included in the ISP, it is understood that employment outcomes may take years to achieve and involve lifelong skill development.

Both DDD and non-DDD funded services can assist an individual in progressing toward their employment outcomes identified in the plan. DDD services intended to support employment outcomes include, but are not limited to, Career Planning, Day Habilitation, Pre-Vocational Training, and Supported Employment.

If employment is not being pursued at the time of the ISP, an explanation must be included in the ISP – these plans will be further reviewed by the Division's Support Coordination Quality Assurance Specialist to ensure that every effort is being made to assist people in becoming employed.

7.5.4 Voting Plan

Information regarding the individual's interest in voting and supports needed related to that is included here.

7.5.5 Health & Nutrition Needs

Information regarding allergies, dietary needs, health hazards/concerns, and self-care concerns as indicated through the NJ CAT as well as the planning process will be identified within this section of the ISP.

7.5.6 Safety & Supports Needs

Information regarding behavior/sensory needs, mobility/adaptive equipment, communication, religious/cultural information, and support settings based on information provided through the NJ CAT and the planning process will be included in this section of the ISP.

7.5.7 Emergency Contacts

Information about emergency contacts (in preferred order of contact) and their contact information is provided in this section of the ISP.

7.5.8 Medication

A list of medication, dosage, frequency, notes, and ability to self-medicate or not is provided in this section.

7.5.9 Authorizations & Signatures

Indications of all planning team members who participated in the planning process are identified here. Planning team members must always include the individual and Support Coordinator at a minimum. Signatures from the

individual/guardian/legal representative (as applicable) must all be included. The Support Coordinator must ensure that the individual has been a full participant in the planning process and is aware of their rights and responsibilities as documented in the “Participant Statement of Rights & Responsibilities” and indicated through the list of items with which the individual’s signature attests to agreement. The ISP and Participants Statement of Rights and Responsibilities form will be shared with all service providers indicated in the plan; however, sharing the medications section of the ISP and/or the PCPT with service providers is up to the individual, as indicated in the ISP.

7.5.9.1 Guidance on ISP Signature

In all cases, contact with the legal guardian is the very first contact made by the Support Coordinator once an individual is assigned to a Support Coordination Agency.

Signature Not Obtained

1. If private or public guardian(s) has given verbal agreement to the ISP this can be documented in a case note identifying the date of verbal approval and the ISP may be approved. The ISP Signature Page shall include the physical signature or “mark” of the individual as well as the signature of the Support Coordinator. The Support Coordinator will clearly note on the signature page the following: *“Verbal permission from [GUARDIAN NAME], legal guardian, was provided to me on [DATE] to move forward with plan approval. Services outlined in plan are appropriate as per Planning Team.”* Physical signature page from the guardian shall be obtained as soon as practicable. **NOTE: Verbal approval may ONLY be used in circumstances where thoughtful planning has occurred but due to unforeseen circumstances approval is needed to avoid lapse in service.**
2. If private guardian (not applicable to public guardian) is unreachable (e.g. out of the country), documentation of three separate attempts on varying dates and times over a two-week period to contact them shall be made and memorialized in case notes. In this instance, as long as there is documented approval of the planning team and individual, the individual may sign or mark the ISP for approval and the ISP can be approved. The Support Coordinator will clearly note on the signature page the following: *“I have attempted to reach [GUARDIAN NAME], legal guardian, on [ENTER THREE DATES/TIMES] and was unsuccessful. Services outlined in the plan are appropriate as per the Planning Team. Plan approval moving forward.”* Efforts to contact guardian must continue and proper documentation to include a signature page obtained as soon as practicable. **NOTE: ISP approval without guardian signature may ONLY occur in unforeseen circumstances where approval is needed to avoid lapse in service.**
3. If private guardian (not applicable to public guardian) is unable to sign (e.g. medically incapacitated or deceased) this shall be documented in a case note. The Support Coordinator will also make efforts to obtain a note from the treating physician documenting this issue whenever possible. As long as there is documented approval of the planning team, the individual may sign or mark the ISP for approval. The Support Coordinator will clearly note on the signature page the following: *“[GUARDIAN NAME], legal guardian, is medically incapacitated and unable to sign this ISP. Services outlined in the plan are appropriate as per the planning team. Plan approval moving forward.”* If there is an existing family member who has started the legal process to become guardian (it may be an email stating that they are interested in pursuing guardianship), that person’s input related to the ISP may be sought and their signature added to the ISP as well. In this circumstance, a Substitute Guardianship referral must immediately be submitted.**

**All referrals come through the guardianship liaison. The liaisons are familiar with the required documents and track the guardianships that are in process. In the event that a medical emergency arises, there are statutory provisions that permit the Division to provide consent in the absence of a guardian.

7.5.9.2 Signature Page Upload

The signature page of the ISP may be uploaded as a separate document in circumstances that do not allow one complete document to be obtained. This ISP signature page must have the plan version and date that corresponds with the ISP. All attempts to upload the complete ISP along with the signature page should be made.

7.6 Resolving Differences of Opinion among Planning Team Members

The planning team must seek to reach consensus in developing the ISP and in developing consistent and/or complementary strategies and methods for implementing the plan. Efforts should be made during team meetings to ensure that all points of view are heard. Differences of opinion can usually be resolved by a thorough discussion of concerns and recommendations. If a team member feels that their point of view has not received a complete hearing during a team meeting, they are encouraged to discuss their concerns privately with the Support Coordinator, who may subsequently reconvene the planning team to readdress the issue.

The individual will indicate their agreement with and approval of the plan by signing the ISP “Authorizations & Signatures” page.

In the event there is disagreement regarding the ISP, deference should be paid to the individual first. The areas in which consensus has been met will be included in the plan so that there will not be a delay in the provision of services related to those areas of consensus.

In circumstances where the individual or family disagree with information written into the ISP, the Support Coordinator shall write a case note indicating the area(s) in which there is disagreement.

7.7 Service Plan Approval

All ISPs will be reviewed by the Support Coordination Supervisor and a copy signed by the individual/guardian must be uploaded to iRecord prior to approval. The *ISP Review Checklist for Support Coordination Supervisors* must be utilized to assist the Support Coordination Supervisor in reviewing the ISP for quality. The Support Coordination Supervisor must sign and date the ISP Quality Review Checklist and upload the signed document to iRecord.

Once a Support Coordination Agency has been authorized to approve the ISP without submitting it to the Division, the Support Coordination Supervisor will be the approving party. If changes need to be made to the plan prior to SC Supervisor approval, the SC Supervisor will communicate the need for revisions with the Support Coordinator and approve the plan once the changes are made to their satisfaction.

For those agencies not authorized to approve their own plans, the SC Supervisor must submit all ISPs to the Division for approval. The required method for submitting the plan to the Division for approval is changing the status of the plan from “Review (R)” to “State Review (SR1)” in iRecord.

Upon review, the Division may require revisions to the plan prior to approval. These changes will be provided to the SC Supervisor within seven (7) days and must be implemented and returned to the Division. If plan revisions are significant (such as additions/deletions of outcomes, services, providers, etc.), signatures will need to be re-obtained to ensure individual agreement with the plan changes. If the changes are minor (such as spelling/grammar errors, word changes that don’t alter the meaning of an outcome or goal, etc.), the Support Coordinator must inform the individual of these changes, but new signatures will not be needed to be obtained. A case note should record when and how the individual was informed of these changes.

7.8 Service Approvals by the Division

The following services/items must be approved by the Division prior to being included in an approved ISP:

- Evaluations for Assistive Technology or Environmental Modifications (initiated in iRecord by selecting “Evaluations” from the dropdown menu provided through the “Tools” tab and providing information related to the need);
- Goods & Services (initiated in iRecord when “Goods & Services” is selected as a service);
- Services of Assistive Technology, Environmental Modifications, or Vehicle Modifications;
- Single Passenger Transportation (initiated in iRecord when selecting this service);
- Self-Directed Employee Rate above/below what is considered reasonable & customary (iRecord sends notification for review when rate entered appears to be outside of the reasonable & customary range);

- Individual Supports at the 15-minute rate when the individual is already receiving Individual Supports at the daily rate by the same provider (CCP only);
- Community Inclusion Services when the individual is already receiving Individual Supports at the daily rate;
- Retirement before the age of 65.

The Support Coordinator will follow instructions provided to initiate the review process with the Division and Division staff will review the request(s) and provide a determination within 10 business days of receipt of request. It is recommended that the Support Coordinator complete the ISP without the items in need of Division approval. Once the ISP is approved, it can be revised to add the items in need of Division approval. Completing this process in this order will expedite the ISP approval process without holding up services that are not in need of Division approval.

7.9 Changes to the Service Plan

Revisions can be made to the Service Plan as needed, such as changes in services, provider choice, demographic information, religious/cultural information, etc. It is not necessary to reconvene the planning team for all changes to the ISP. Signatures and ISP approval must be obtained when there are changes/additions to outcomes, services, providers, units, or start/end dates. To initiate the process, the individual will contact the Support Coordinator to inform them of the change in need or provider. The Support Coordinator will make revisions to the plan as needed and obtain signatures as described in Section 7.5.9. For service need changes, the Support Coordinator must end the service to be revised in the current plan and add the new service with start date in the revised/new plan to ensure there are no overlapping or duplicate services in the plan. This revised plan will be saved in iRecord as a version of the plan that was revised.

8 ACCESSING SERVICES

This section describes how the Support Coordinator arranges for and coordinates services, both within and external to the Division, to meet the needs of eligible individuals as identified in the ISP. While this manual focuses on the process for providing Division-funded services, the use of natural supports, community resources, and generic services/supports is critical in order to meet all the needs of individuals eligible for the Division and extend the individualized budget as far as possible. Services funded by the Division will be considered only when other resources and supports are insufficient or unavailable and do not meet the needs of the individual and are attributable to the person's disability. Information about use of these non-Division services/supports can be found in Section 8.2.

8.1 Identification of Needed Services

The Support Coordinator utilizes information provided through the NJ CAT, PCPT, and other discovery and/or assessment tools to identify service needs associated with the outcomes developed in collaboration with the individual through the person-centered planning process and indicated in the ISP. These services, along with their provider(s), are identified through the ISP. The ISP is developed by the Support Coordinator and must be developed and approved within 30 days of Supports Program enrollment. The process for developing the ISP is explained in Section 7.4.

8.2 Use of Community Resources and Non-Division-Funded Services

Once service needs have been identified, the Support Coordinator shall begin examining the services or other assistance which may be provided through other State agencies, existing community resources, or family members.

8.2.1 Community Resources

Most communities offer an array of services that may meet the needs of people with developmental disabilities and their families. The type and availability of services will vary, but utilizing these community resources can increase the amount of services an individual receives and may provide services that are not available through the Division. It is the Support Coordinator's responsibility to be aware of community resource information and eligibility requirements for these programs and agencies. Depending on the capabilities of the individual, either contact or provide contact information to individuals and their families when it appears that these resources may benefit the individual and family. Services through community resources may include, but are not limited to, advocacy, adaptive and/or medical equipment, nutrition assistance, housing, legal assistance, recreation, transportation, and utility assistance. Information on other resources is available on the Support Coordination information & Resources website.

"New Jersey Resources," www.njhelps.org, and www.nj211.org can be used to identify government, community organizations, and professionals working to assist people with disabilities. NJ Resources can be accessed on the Division of Disability Services (DDS) website at <http://www.nj.gov/humanservices/dds/home/>.

8.2.2 Coordination with Other State Programs and Agencies

The Support Coordinator is responsible for coordinating services and supports through other programs and entities as appropriate. This can include a variety of programs and entities but requires at a minimum the following:

Managed Care Organizations (MCO) Care Managers

Every individual receiving Division services must be eligible for Medicaid and, as such, should have a Managed Care Organization designated to provide services related to their acute and behavioral healthcare needs. The MCO must assign a Care Manager to all individuals with developmental disabilities. The Support Coordinator should identify and reach out to contact this MCO Care Manager to ensure coordination of health care⁵.

⁵ Does not preclude the individual/family from contacting the MCO Care Manager

Division of Vocational Rehabilitation Services (DVRS)/Commission for the Blind & Visually Impaired (CBVI)

Employment services must be sought through DVRS/CBVI prior to being made available through Division funding. However, Long-Term Follow-Along (LTFA) services will be provided by the Division even in circumstances where other employment supports were provided by DVRS/CBVI first. The DVRS/CBVI Counselor will indicate the availability of DVRS/CBVI services by completing the Employment Determination Form (F3 form) and providing it to the Support Coordinator. Employment services that are not available through DVRS/CBVI and are provided by the Supports Program will be provided by the Division. If an individual is not seeking employment services, the Support Coordinator will complete the Employment Non-Referral Form to DVRS or CBVI (F6 form). Individuals are able to access DVRS/CBVI and Division services at the same time.

8.3 Accessing Division-Funded Services

The Support Coordinator will collaborate with the individual to identify Division-funded services that are needed.

The services available through the Supports Program are as follows:

- Assistive Technology
- Behavioral Supports
- Career Planning
- Cognitive Rehabilitation
- Community Based Supports
- Community Inclusion Services
- Day Habilitation
- Environmental Modifications
- Goods & Services
- Interpreter Services
- Natural Supports Training
- Occupational Therapy
- Personal Emergency Response System (PERS)
- Physical Therapy
- Prevocational Training
- Respite
- Speech, Language, and Hearing Therapy
- Support Coordination*
- Supported Employment – Individual Employment Support
- Supported Employment – Small Group Employment Support
- Supports Brokerage
- Transportation
- Vehicle Modification

****Please note – Support Coordination services are not direct services funded through the individualized budget and are not included under “services” in the ISP.***

Each Division-funded service the individual will be utilizing is written into the ISP. Once the ISP is approved by the Support Coordination Supervisor (and Division in circumstances where the SCA has not been released to approve their own plans or services need that additional step of approval), the ISP serves as prior authorization for the services.

Each Division-funded service and the standards associated with it are further described in Section 17.

8.3.1 Utilizing a Service Provider

The individual selects each service provider they prefer to provide the services included in the ISP. The Division encourages the individual to research service providers through phone calls, interviews, provider fairs, site visits, word of mouth, marketing materials, etc. prior to selecting the service provider. To assist in this effort, the Division has developed a provider search database that includes all Medicaid/DDD approved service providers. Service providers can be identified through this database by county and/or services for which they are approved to provide and can be accessed at <https://irecord.dhs.state.nj.us/providersearch>.

While the Support Coordinator cannot select the service providers or recommend any specific provider for the individual, they shall assist the individual, as needed, in researching service providers, matching approved service providers for the services that have been identified to meet the individual’s needs as indicated in the ISP. In addition, the Support Coordinator is responsible for assisting the individual with identifying criteria that will help narrow the list of available providers. The criteria are based on the needs and preferences of the individual. The Support Coordinator shall contact potential service providers to help facilitate individual research through provider

interviews, tours, meetings, etc.; schedule intake meetings; assist the individual/family in providing any referral information required by the service provider; communicate with the service provider to ensure that they are capable of meeting the strategies necessary to assist the individual in progressing toward the outcomes indicated in the ISP and identify the service details (type of service, units, etc.); and determine availability of services unless the individual/family has indicated that they prefer to do this research and schedule these meetings instead of the Support Coordinator.

If a service provider cannot be located due to lack of capacity within the individual's area, lack of ability to meet the individual's particular needs, lack of providers for a particular service, etc., the Support Coordinator must report that information to their assigned Division SC Quality Assurance Specialist. The Division will track this information in order to assure that adequacy of network is addressed.

8.3.1.1 Referral to the Selected Service Provider

Collaboration between the Support Coordinator and identified service provider(s) is necessary in order to ensure that the service provider can effectively serve the individual by meeting their needs and providing services that will help them progress toward their outcomes. As outlined below, the Support Coordinator must reach out to the identified service provider(s) prior to beginning services in order to set up any required intake interviews, tours, visits, etc., and provide any documentation that may be required in order for the service provider(s) to determine whether the individual meets the criteria necessary for admission into their programs. In addition, the Support Coordinator must remain in contact with the service provider(s) during development of the ISP in order to ensure that everyone is in agreement about start dates, service provision, units, dates, etc. and provide a copy of the draft ISP to the service provider(s) for review and agreement prior to delivery of services. This process will ensure agreement across everyone involved and eliminate many errors that can occur when this collaboration is not followed. Once the individual selects their preferred service provider, the following process will be implemented in order to refer the individual to the provider and access services:

- The Support Coordinator must contact the potential provider to notify the provider of the individual's interest in accessing services through them and follow the intake/eligibility determination process that may be required by the potential provider;
- The Support Coordinator must communicate applicable outcomes indicated in the ISP and discuss the provider's ability to assist the individual in progressing toward those outcomes. The Support Coordinator shall describe the service needs of the individual, share the individual's attributes, determine availability of services; arrange intake/eligibility meetings; and/or identify any documents/information the service provider requires as part of the referral process.
- When the service provider requires an intake interview, referral packet, tour, etc. in order to determine individual eligibility, the Support Coordinator shall assist in meeting these requirements by scheduling meetings and assisting the individual in providing the potential service provider with any information/documentation that the service provider requires as part of the referral process;
- The service provider must inform the individual and/or Support Coordinator of their interest in delivering services to the individual within five (5) working days of the initial contact;
- The Support Coordinator confirms that the potential service provider meets the individual's needs and has the capacity to provide services to the individual by the date on which the individual is in need of the services. If the individual is assigned the acuity differentiated factor, the Addressing Enhanced Needs Form (Appendix D) must be completed by the Support Coordinator and service provider as described in Section 3.4. This form is optional for Support Coordinators and service providers if the individual does not have the acuity factor but may be helpful to address needs;
- The selected service provider indicates acceptance or denial into the service;
- The Support Coordinator selects the confirmed service provider(s), start dates, units of service, etc. in the ISP;
- The Support Coordinator needs to be aware of items/documentation the service provider will need prior to serving the individual and assist/ensure they are provided prior to the start of services;

- The Support Coordinator sends a copy of the approved ISP (and any other relevant and consented to discovery tools, evaluations, etc.) to all service providers identified in the ISP and receives confirmation of its accuracy from the service provider;
- A prior authorization is distributed electronically to the confirmed service provider once the ISP is approved;
- Services begin as per the start date, units, frequency, duration, etc. indicated in the prior authorization

8.3.2 Hiring a Self-Directed Employee (SDE) “Self-Hires”

Self-Directed Employees (SDE) are people who are recruited and offered employment directly by the individual using the service or by the individual’s authorized representative. For purposes of this section, the term “individual” is meant to encompass both the individual and authorized representative. In essence, the SDE is a staff person of the individual and is hired to perform waiver services for which SDEs are qualified. Service qualifications and limitations can be found in the service-specific descriptions in the Supports Program Services section of this manual (Section 17).

An individual choosing to hire a self-directed employee is responsible to understand and comply with all applicable federal and state labor, wage and employment laws, whether the individual is the employer of record (Vendor Fiscal/Employer Agent model) or the co-employer (Agency with Choice). For more information on this, please contact your selected fiscal intermediary. A self-directed employee may not be regularly scheduled to work more than 16 consecutive hours in a 24-hour period.

The individual is responsible for creating the job description, setting the hours of employment, managing the SDE, and determining the continuation or termination of employment. Assistance with these tasks and the overall arranging, directing, and managing of services provided by a SDE can be obtained through Supports Brokerage if needed. The Supports Brokerage service is funded through the individual budget and is further described in Section 17.20. As is the case with all services in both the Community Care Program and Supports Program, a prior authorization must be obtained prior to delivery of services through the SDE in order for funding for those services to be provided. Thus, if an individual negotiates with a SDE to work outside of what is prior authorized in the Individualized Service Plan (ISP), the individual is responsible for payment and all employer-related functions.

Management of employment-related functions, including items such as timekeeping, payroll, tax withholding, and compliance with applicable labor laws and regulations, is the responsibility of a Fiscal Intermediary (FI), a non-governmental entity under contract with the State of New Jersey. FI management of SDE functions is limited to services prior authorized in the ISP. FI policies and procedures and information will be maintained, updated, and communicated by the appropriate FI through various methods which may include a manual, handbook, enrollment packet, and website.

8.3.2.0.1 Establishing a Self-Directed Employee (SDE) Hourly Wage for Services Where the Direct Support Professional Service Applies

The Division offers the choice for individuals to utilize Self-Directed Employees (SDEs) for several services. Some of these services (Community Based Supports and Respite) are provided as a discrete service by Direct Support Professionals (DSPs) employed by service providers. These services are denoted in Appendix H with the caption *DSP Service Applies*. The Division supports comparable wages between SDEs and Direct Support Professionals (DSPs) performing these services.

A Reasonable and Customary (R&C) wage range, as opposed to a static rate, has been adopted for SDEs performing Community Based Supports and/or Respite to allow the ability to scale SDE wages based on DSP wages. The most recent (at the time of this document’s publication) [National Core Indicators State of the Workforce Survey](#) reflects data from 2022. It demonstrates (See *Method II* found on page 40 of that document) an average hourly DSP wage of \$17.94. Since that time, DSP wages in New Jersey have increased by about \$1.25 on January 1, 2023 and an additional \$1.75 on January 1, 2024. This projects the current DSP average wage in New Jersey to be about \$20.94 per hour.

Using the above information and the data below, the established R&C wage range for an SDE shall be the prevailing minimum wage up to \$25.00 per hour for the services of Community Based Supports and/or Respite. An SDE may not be paid a wage above \$25.00 per hour unless they meet the standard for an Enhanced R&C wage set forth below. The \$25.00 per hour wage was arrived at by reviewing May 2023 (most recent data available at time of publication) data from the U.S. Bureau of Labor Statistics for the State of New Jersey (https://www.bls.gov/oes/current/oes_nj.htm). This data demonstrated a mean hourly wage for the following occupations as listed below:

- Home Health and Personal Care Aides - \$17.53 per hour
- Healthcare Support Workers, All Other - \$23.27 per hour
- Personal Care and Service Workers, All Other - \$23.71 per hour

An Enhanced R&C wage range of the prevailing minimum wage up to \$35.00 per hour is available in certain circumstances for certain professionals for the services of Community Based Supports and/or Respite. The availability of the Enhanced R&C wage is not solely based on the presence, or lack of, an individual being assigned an acuity. The \$35.00 per hour wage was arrived at by reviewing May 2021 (most recent data available at time of publication) data from the U.S. Bureau of Labor Statistics for the State of New Jersey (https://www.bls.gov/oes/current/oes_nj.htm). This data demonstrated a mean wage for the following occupations as listed below:

- Substance Abuse, Behavioral Disorder, and Mental Health Counselors - \$32.33 per hour
- Licensed Practical and Licensed Vocational Nurses - \$32.03 per hour

For SDEs who are a Registered Nurse, an Enhanced R&C wage range of the prevailing minimum wage up to \$50.00 per hour is available in certain circumstances for the services of Community Based Supports and/or Respite. The availability of the Enhanced R&C wage is not solely based on the presence or absence of an individual being assigned an acuity. The \$50.00 per hour wage was arrived at by reviewing May 2023 (most recent data available at time of publication) data from the U.S. Bureau of Labor Statistics for the State of New Jersey (https://www.bls.gov/oes/current/oes_nj.htm). This data demonstrated a mean wage for the following occupation as listed below:

- Registered Nurses - \$49.02 per hour

The Enhanced R&C wage range may be granted in the following circumstances:

- The individual has a documented enhanced medical care and/or enhanced behavioral care need as described in the Enhanced Medical Care Need(s) and/or the Enhanced Behavioral Care Need(s) section below; AND
- The individual requires care provided by an SDE whose education comports with the SDE Education below **and** this education is closely related to the documented enhanced medical and/or enhanced behavioral care need of the individual.

Enhanced Medical Care Need(s):

- An enhanced medical care need is, as determined by the Division, one that cannot be supported without the SDE possessing a higher level of education.
- Documentation of enhanced medical care need(s) must include any of the following that apply:
 - The information contained within the Addressing Enhanced Needs Form (AENF);
 - SDE shift notes/service documentation documenting the medical care provided to an individual;
 - Support Coordination Monthly Monitoring Tools that contain discussion/documentation of care need;
 - As applicable, documentation (including but not limited to) of:
 - Medically based hospitalizations;
 - Significant increase and or/change in medical appointments/physician oversight;
 - Whether the individual has been assessed for medical needs that require skilled nursing care (Registered Nurse, Licensed Practical Nurse);
 - Other information specific to the individual circumstance.

Enhanced Behavioral Care Need(s):

- An enhanced behavioral care need is, as determined by the Division, one that cannot be supported without the SDE possessing a higher level of education. In all circumstances, a current behavior support plan should be in place as described in Section 17.2 – Behavior Supports – of this manual. The behavior support plan may require an SDE to complete regular data tracking, consistently implement the individual’s behavior support plan, etc.
- Documentation of enhanced behavioral care need(s) must include any of the following that apply:
 - The information contained within the Addressing Enhanced Needs Form (AENF);
 - SDE shift notes/service documentation documenting the care provided to an individual;
 - Support Coordination Monthly Monitoring Tools;
 - As applicable, documentation (Including but not limited to) of:
 - Emergency Room/Mental Health Screening;
 - Hospitalization(s) of the individual for reasons related to their behavioral health needs;
 - Property damage resulting from behaviors engaged in by the individual;
 - Aggression by the individual towards self/others, including staff, which have resulted in injury;
 - Elopement by the individual;
 - Legal involvement.
 - Other information specific to the individual circumstance.

Enhanced Wage SDE Education Requirements:

To receive an Enhanced R&C wage, the SDE must possess a matriculated degree/advanced degree in a medical and/or behavioral subject area closely related to the identified enhanced need of the individual. Years of experience may not be used as an equivalent to a matriculated/advanced degree.

Documentation is required and must include one or more of the following: Official copies of educational transcript(s); Certification(s); or License(s).

Establishing Enhanced R&C Wage

Eligibility for the Enhanced R&C wage must be determined by the Division before it can be offered to an SDE. This consists of:

1. The Division verifying that there is documentation of an enhanced medical and/or behavioral need; and
2. The Division determining that the SDE meets the required Education/Credentialing Factors as described in this section.

Individuals/guardians who believe their *identified* SDE meets the criteria for an enhanced wage should work with their Support Coordinator to submit the [Enhanced Reasonable and Customary Wage Request Form](#). They should indicate *Combined Approval* as the request type in Section 1 and complete the entire form. Upon receipt of a sufficiently detailed submission, the Division will review and render a determination within seven (7) business days.

The Division recognizes that there may be instances where approval for the Enhanced R&C wage range may be needed in order to identify an SDE. In these circumstances, please indicate Pre-Approval as the request type in Section 1 and follow the corresponding instructions completing sections 1, 2 and 3. Upon receipt of a sufficiently detailed submission, the Division will review and render a determination within seven (7) business days.

Once Pre-Approval is obtained, the individual/guardian may then solicit an SDE using the Enhanced R&C wage range and assume the Enhanced R&C wage will be granted contingent on the selected SDE meeting the SDE Education requirements as determined by the Division.

Upon selection of an SDE, re-submission of the Enhanced Reasonable and Customary Wage Request Form for Final Approval will need to occur so that the Division can verify that SDE possesses the required education. Upon receipt of a sufficiently detailed submission, the Division will review and render an expedited determination.

Salary Increases

Salary increases above the maximum standard(s) listed in this section will not be granted. For this reason, it is recommended that individuals/families not establish an hourly wage at the maximum amount so that they have the ability to provide pay increases over time within the established wage range.

8.3.2.0.2 Establishing a Self-Directed Employee (SDE) Hourly Wage for Services Where the Direct Support Professional Service Does Not Apply

The Division offers the choice for individuals to utilize Self-Directed Employees (SDEs) for several services. Some of these services (Interpreter Services, Supports Brokerage, and Transportation) are not provided as a discrete service by Direct Support Professionals (DSPs) employed by service providers. For these services, the following shall be used to establish the hourly wage for the corresponding service:

Interpreter Services – This service has an established rate for American Sign Language (ASL) and Other – Non-ASL (Please see Interpreter Services Definition and Appendix H) and is not provided as a discrete service by a DSP. Therefore, the SDE wage shall not exceed the established Interpreter Services rate.

Supports Brokerage – This service has an established base rate (see Supports Brokerage Service Definition and Appendix H) and is not provided as a discrete service by a DSP. Therefore, the SDE wage shall not exceed the established Supports Brokerage rate.

Transportation – This service, when used for an SDE, reimburses the SDE for their time providing transportation as well as their mileage (Please see Transportation Service Definition and Appendix H). It is not offered in the same way to DSPs as they are reimbursed for mileage only. Therefore, the SDE wage for Transportation shall be negotiated on a case-by-case basis. The approved wage for Transportation may be lower than the established SDE wage for another service as a result.

8.3.2.1 Selecting SDE Service Delivery

If an individual is in need of one of the services that is available through an SDE (Community Based Supports, Interpreter Services, Respite, Supports Brokerage, or Transportation), the Support Coordinator will present the options of utilizing a SDE or a provider agency. The Support Coordinator will also explain the two SDE models available – **Vendor Fiscal/Employer Agent** or **Agency with Choice**, as outlined in the documentation developed and maintained by the FI for each of these models. Information about these options can also be found at <https://nj.gov/humanservices/ddd/individuals/community/selfdirected/>.

Selecting the Vendor Fiscal/Employer Agent SDE Model

In the Vendor Fiscal/Employer Agent SDE model, the individual must enroll as the employer of record or identify someone else (typically a family member or friend) to enroll as the employer of record. If the individual elects to use the Vendor Fiscal/Employer Agent SDE model, the Support Coordinator, individual and family (as applicable) will conduct a preliminary review to confirm that a SDE will be able to sufficiently meet the needs of the individual and provide the service in accordance with the service description, limitations, and standards. The Support Coordinator will submit an Individual Referral through iRecord to the FI for the Vendor Fiscal/Employer Agent SDE model. Upon receipt of the Individual Referral, the FI will initiate the employer of record and SDE enrollment processes and register the individual and any authorized representatives for the FI-developed orientation. The following major areas will be covered by the orientation curriculum:

- A description of the services offered by and the roles and responsibilities of the FI;
- Process for ensuring the SDE meets qualifications to deliver the service;
- Roles, responsibilities, and rights of the individual;
- Roles, responsibilities, and rights of the SDE; and
- Required documentation.

The individual will receive an employer enrollment packet from the FI. This packet will contain the forms necessary for the individual to enroll as the employer of record and appoint the FI as the agent for employment-related matters. The FI will assist the individual in completing these forms. In circumstances when the individual has a SDE

candidate in mind, the SDE candidate will receive an employee enrollment packet. The FI will collect and process the documents with the appropriate federal and New Jersey agencies to enroll the SDE.

In circumstances when the individual does not have a particular SDE candidate in mind, the individual is responsible for recruitment of candidates. If needed, the Support Coordinator will assist the individual in obtaining Supports Brokerage services to provide assistance with or undertake the search for a SDE.

Please note that in this model one Employer Identification Number (EIN) is used. If an individual accesses services through the Personal Preference Program (PPP), administered by the Division of Medical Assistance and Health Services (DMAHS), an additional EIN is required.

Wages and Benefits in the Vendor Fiscal/Employer Agent SDE Model

The SDE's hourly wage is determined by the individual, subject to minimum-wage laws, at a rate that is considered reasonable and customary for the service being delivered. In the Vendor Fiscal/Employer Agent SDE model, the FI will mark up the identified hourly wage to cover the cost of employer-related taxes and will use the marked-up wage to calculate the Fee-for-Service billable rate. The wage and the mark-up for employer-related taxes are funded through the individual budget. The FI will verify that hourly wages are in compliance with federal and NJ Department of Labor and Workforce Development (NJ DLWD) rules and compute standard payroll deductions that will be applied to the SDE's paycheck. Employer-sponsored health benefits are not available to SDEs in the Vendor Fiscal/Employer Agent model. However, the individual can choose to include within the hourly wage an amount that may enable the SDE to purchase healthcare or health benefits privately or through a government-run, and potentially subsidized, exchange.

The SDE can only receive payment for rendering services that have been prior authorized through an approved ISP. Any services, including overtime, exceeding those indicated in the ISP will not be reimbursed through the individual's budget. One SDE cannot provide more than 40 hours of service for an individual per week. If an individual requires services that will go beyond those 40 hours in a week, another SDE or a provider agency must be utilized to deliver those additional hours of service. It is the individual's responsibility, along with the Support Coordinator and Supports Broker when utilized, to ensure that SDE schedules do not require payment of overtime.

Individuals who are receiving services from an SDE in the Vendor Fiscal/Employer Agent SDE model must pay an annual fee to maintain a workers' compensation policy. This annual fee (determined by the NJ Compensation Rating and Inspection Bureau) is deducted from the individual budget at the time the initial SDE-delivered service is added to the plan or at the time a plan that includes an SDE-delivered service renews.

SDE Hiring in the Vendor Fiscal/Employer Agent SDE Model

Once the FI is notified of SDE selection, it will assist the SDE with obtaining, completing, and submitting the required forms with the intent to complete the process to become approved to provide that service within two (2) weeks of referral. The required information, forms, and instructions that will be distributed to SDEs include but are not limited to the following:

- Introductory letter;
- Worker checklist;
- Employment application;
- I.R.S. Form W-4 Withholding Allowance Certificate;
- U.S. BCIS Form I-9 Employment Eligibility Verification Form;
- DHS PDS 1006 Worker Agreement or PDS 1008 for Goods and Services (considered the Medicaid agreement);
- Permission for pre-employment checks of criminal background and the Central Registry of Offenders Against Individuals with Developmental Disabilities;
- Worker timesheets, instructions, due dates, and pay schedule;
- New Jersey New Hire Reporting form;
- Form for determination of tax exemptions;
- Notice of direct deposit and debit card payment options and sign-up instructions.

The FI will provide the forms within one (1) business day of receipt of the Individual Referral from the Support Coordinator and will process the completed forms within two (2) business days of receipt. The FI will process the background checks required for the service (using the forms and process supplied by the Division) and will also ensure that SDEs complete the mandated staff training applicable to the service(s) being delivered (as explained for each specific service in Section 17 and referenced in the Quick Reference Guide to Mandated Staff Training and Professional Development in Appendix E), including providing instructions for accessing trainings through the College of Direct Support. Through the duration of the SDE's employment, the FI will repeat background checks as required or requested by the Division or individual.

Once it is confirmed that service delivery qualifications/requirements are met and the individual and SDE forms are processed, the FI will notify the Support Coordinator that the SDE can begin work, and will provide the Support Coordinator with the Fee-for-Service billable rate (wage plus mark-up for employment-related taxes). The Support Coordinator will enter the SDE information and the FFS billable rate into the ISP and a prior authorization will be generated and emailed to the FI upon the ISP approval. The Support Coordinator will notify the individual of plan approval.

The FI will maintain adequate records for each individual as well as all the SDE-specific employment records (e.g. timekeeping, payroll, tax withholding). This will include the determination of appropriate tax withholding and payroll deductions.

Self-directed employees may be members of a participant's family provided that the family member has met the same standards as providers who are unrelated to the individual.

SDE Termination in the Vendor Fiscal/Employer Agent SDE Model

The individual may terminate the SDE any time by notifying the SDE and Support Coordinator. The Support Coordinator will revise the ISP to reflect the change to another SDE or to a service provider or end services if they are no longer required. In the Vendor Fiscal/Employer Agent SDE model, it is the responsibility of the employer of record to inform the SDE of termination. The Support Coordinator will notify the FI within two (2) business days so the FI can complete the NJ DLWD Reason for Separation Notice within ten (10) calendar days, and process and deposit final payments, etc.

If the individual has decided to no longer utilize SDEs and will no longer be acting as an employer, the Support Coordinator will notify the FI and the FI will take the necessary steps to close the employer record in the FI's system, process and deposit final tax payments, and terminate the workers' compensation policy (the annual fee for the workers' compensation policy is not refundable). The FI cannot close an Employer Identification Number (EIN) business account on behalf of an individual. To close an EIN business account with the Internal Revenue Service (IRS), the individual must write a letter to the IRS requesting to close the EIN business account (see www.irs.gov).

The Division reserves the right to suspend or terminate the ability to use SDEs by any individual/ authorized representative or the ability of someone to serve as a SDE at any time due to non-compliance with roles and responsibilities, CCP standards and qualifications as contained in this manual, or other waiver documentation; fraud and abuse; or failure to continue meeting the service standards and qualifications, including background checks. If the Division initiates suspension or termination, the Division will immediately notify the individual, Support Coordinator (SC), and FI and the SC or Division will revise the ISP as necessary to end prior authorization as appropriate.

Payroll Processing in the Vendor Fiscal/Employer Agent SDE Model

Timesheets and instructions for their completion will be developed, distributed, collected, verified, and processed by the FI. Copies of timesheets and associated payroll documents will be maintained by the FI. The FI will process payroll checks biweekly, within five (5) business days after receipt of the timesheet for the relevant period and will make payment directly to the SDE via check, electronic deposit or debit card. This process includes the processing and distributing of all federal and New Jersey payroll, employment, and withholding taxes and reports (e.g. federal and State income tax withholding, Medicare, Social Security, unemployment, temporary disability, family leave).

Payments to SDEs will include a remittance advice showing gross wages and net wages following withholdings and other deductions.

The FI is responsible for managing improperly cashed or issued payroll checks, stopping payment on checks, and re-issuance of lost, stolen or improperly cashed checks. The FI will also process all judgment, garnishments, tax levies or related holds on SDE pay that may be required by federal or New Jersey law. This includes researching, investigating, and resolving all tax notice from the I.R.S., NJ DLWD, and NJ Division of Revenue and Enterprise Services. The individual or SDE impacted should contact the FI directly using the provided contact information if any of these issues arise.

The FI is required to pay SDEs for every hour worked pursuant to the Division's prior authorization. FI services are procured by the State for use by participants for processing and recordkeeping functions related solely to State-authorized services. State funding for services is limited to the hours and rates authorized in the ISP and will be prior authorized each week. Participants are not permitted to approve more hours than the Division has prior authorized for the relevant time period without a change to the ISP that has been submitted by the Support Coordinator and approved. If the SDE's timesheet is submitted to the FI with hours exceeding those authorized, it will be considered invalid and will not be paid. The FI will notify the employer of record and SDE within one (1) day of receiving the timesheet. An individual or SDE involved in multiple overages within a one-year period will be barred from participation. In the event that a SDE is overpaid, the FI will identify the overage and institute recovery proceedings.

Employees in the Vendor Fiscal/Employer Agent model receive paid sick leave. Please contact the FI for more information related to accrual, maximum hours earned, etc.

Selecting the Agency with Choice SDE Model

If the individual utilizing an SDE elects to use the Agency with Choice model, the Support Coordinator will conduct a preliminary review with the individual and family (as applicable) to confirm that a SDE will be able to sufficiently meet the needs of the individual and provide the service in accordance with the service description, limitations, and standards. The Support Coordinator will also confirm that the individual's budget can support the projected per-member per-month (PMPM) fee needed to participate in the Agency with Choice SDE model. The PMPM fee is based on whether and how many of an individual's SDEs elect employer-sponsored health benefits. An Individual Referral should not be made to the Agency with Choice SDE model unless/until a SDE candidate has been identified. Please see Appendix P for PMPM information.

The Support Coordinator will submit an Individual Referral through iRecord to the FI for the Agency with Choice SDE model. Upon receipt of the Individual Referral from the Support Coordinator, the FI will initiate the enrollment process and register the individual and any authorized representatives for the FI-developed orientation. The following major areas will be covered by the FI orientation curriculum:

- A description of the services offered by and the roles and responsibilities of the FI;
- Process for ensuring the SDE meets qualifications to deliver the service;
- Roles, responsibilities, and rights of the individual;
- Roles, responsibilities, and rights of the SDE; and
- Required documentation.

The individual will receive an enrollment packet. This packet will contain the forms necessary for the individual to enroll. The FI will assist the individual in completing these forms. The SDE candidate will receive a separate enrollment packet. The FI will collect and process the documents with the appropriate federal and New Jersey agencies to enroll the SDE.

If needed, the Support Coordinator will assist the individual in obtaining Supports Brokerage services to provide assistance with or undertake the search for an SDE.

8.3.2.2 Wages and Benefits in the Agency with Choice SDE Model

Wages are determined by the individual, subject to minimum-wage laws, at a rate that is considered reasonable and customary for the service being delivered. In the Agency with Choice SDE model, the FI will mark up the identified hourly wage to cover the cost of employer-related taxes and workers' compensation insurance. It will use the marked-up wage to calculate the Fee-for-Service billable rate. The wage and the mark-up for employer-related taxes and workers' compensation are funded through the individual budget. The FI will verify that hourly wages are in compliance with federal and NJ Department of Labor and Workforce Development (NJ DLWD) rules and compute standard payroll deductions that will be applied to the SDEs paycheck. All components of the wage come from the budget assigned to the individual. Employer-sponsored health benefits and paid time off are available to SDEs in the Agency with Choice SDE model. The per-member, per-month fee deducted from the individual's budget to participate in the Agency with Choice SDE model covers all the costs associated with these benefits and is based on whether and how many of an individual's SDEs elect employer-sponsored health benefits.

The SDE can only receive payment for rendering services that have been prior authorized through an approved ISP. Any services, including overtime, exceeding those indicated in the ISP will not be reimbursed through the State. One SDE cannot provide more than 40 hours of service for an individual per week. If an individual requires services that will go beyond those 40 hours in a week, another SDE or a provider agency must be utilized to deliver those additional hours of service. It is the individual's responsibility, along with the Support Coordinator, to ensure that SDE schedules do not require payment of overtime.

SDE Hiring in the Agency with Choice SDE Model

Once the FI is notified of SDE selection, it will assist the SDE with obtaining, completing, and submitting the required forms with the intent to complete the process to become approved to provide that service within two (2) weeks of referral. The required information, forms, and instructions that will be distributed to SDEs include but are not limited to the following:

- Introductory letter;
- Worker checklist;
- Employment application;
- I.R.S. Form W-4 Withholding Allowance Certificate;
- U.S. BCIS Form I-9 Employment Eligibility Verification Form;
- DHS PDS 1006 Worker Agreement or PDS 1008 for Goods and Services (considered the Medicaid agreement);
- Permission for pre-employment checks of criminal background, Child Abuse Registry Information (CARI), and the Central Registry of Offenders Against Individuals with Developmental Disabilities;
- Worker timesheets, instructions, due dates, and pay schedule;
- New Jersey New Hire Reporting form;
- Form for determination of tax exemptions; and
- Notice of direct deposit and debit card payment options and sign-up instructions.

The FI will provide the forms within one (1) business day of notification by the Support Coordinator and will process the completed forms within two (2) business days of receipt. The FI will process the background checks required by the service (using the forms and process supplied by the Division) and will also ensure that SDEs complete the mandated staff training applicable to the service(s) being delivered (as explained for each specific service in Section 17 and referenced in the Quick Reference Guide to Mandated Staff Training and Professional Development in Appendix E), including providing access to training provided through the College of Direct Support. Through the duration of the SDE's employment, the FI will repeat background checks as required or requested by the Division or individual.

Once it is confirmed that service delivery qualifications/requirements are met and the individual and SDE forms are processed, the FI will notify the Support Coordinator that the SDE can begin work and will provide the Support Coordinator with the Fee-for-Service billable rate. The Support Coordinator will enter the SDE information and the FFS billable rate into the ISP and a prior authorization will be generated and emailed to the FI upon the ISP approval. The Support Coordinator will enter the SDE information and the FFS billable rate into the ISP and a

prior authorization will be generated and emailed to the FI upon the ISP approval. The Support Coordinator will notify the individual of plan approval.

The FI will maintain adequate records for each individual as well as all the SDE-specific employment records (e.g. timekeeping, payroll, tax withholding). This will include the determination of appropriate tax withholding and payroll deductions.

Self-Directed employees may be members of a participant's family provided the family member has met the same standards as providers who are unrelated to the individual.

8.3.2.4 SDE Termination in the Agency with Choice SDE Model

The individual may terminate the SDE any time by notifying the SDE and Support Coordinator. The Support Coordinator will revise the ISP to reflect the change to another SDE or to a service provider or end services if they are no longer required. In the Agency with Choice SDE model, the individual may inform the SDE that they no longer wish to receive services from the SDE. It is the responsibility of the FI/employer of record to inform the SDE of termination. The Support Coordinator will notify the FI within two (2) business days so the FI can complete the NJ DLWD Reason for Separation Notice within ten (10) calendar days, and process and deposit final payments, etc.

If the individual has decided to no longer utilize SDEs, the Support Coordinator will notify the FI and the FI will take the necessary steps to close the individual's record, and process and deposit final tax payments.

The Division reserves the right to suspend or terminate the ability to use SDEs by any individual/ authorized representative or the ability of someone to serve as an SDE at any time due to non-compliance with roles and responsibilities, CCP standards and qualifications as contained in this manual, or other waiver documentation; fraud and abuse; or failure to continue meeting the service standards and qualifications, including background checks. If the Division initiates suspension or termination, the Division will immediately notify the individual, Support Coordinator (SC), FI, and the SC or Division will revise the ISP as necessary to end prior authorization as appropriate.

8.3.2.5 Payroll Processing in the Agency with Choice SDE Model

Timesheets and instructions for their completion will be developed, distributed, collected, verified, and processed by the FI. Copies of timesheets and associated payroll documents will be maintained by the FI. In the Agency with Choice SDE model, timesheets are submitted weekly and payroll is processed biweekly, within five (5) business days after receipt of the second week's timesheet for the relevant period. The FI will make payment directly to the SDE via electronic deposit or pay card. This process includes the withholding, processing and distributing of all federal and New Jersey payroll, employment, and other required deductions and reports (e.g. federal and State income tax withholding, Medicare, Social Security, unemployment, temporary disability, family leave). Payments to SDEs will include a remittance advice showing gross wages and net wages following withholdings and other deductions.

The FI will also process all judgment, garnishments, tax levies or related holds on SDE pay that may be required by federal or New Jersey law. This includes researching, investigating, and resolving all tax notices from the I.R.S., NJ DLWD, and NJ Division of Revenue and Enterprise Services. The individual or SDE impacted should contact the FI directly using the provided contact information if any of these issues arise.

The FI is required to pay SDEs for every hour worked pursuant to the Division's authorization. FI services are procured by the State for use by participants for processing and recordkeeping functions related solely to State-authorized services. State funding for services is limited to the hours and rates authorized in the ISP and will be prior authorized each week. Participants are not permitted to approve more hours than the Division has prior authorized for the relevant time period without a change to the ISP that has been submitted by the Support Coordinator and approved. If the SDE's timesheet is submitted to the FI with hours exceeding those authorized, it will be considered invalid and will not be paid. The FI will notify the employer of record and SDE within one (1) day of receiving the timesheet. An individual or SDE involved in multiple overages within a one-year period will

be barred from participation. In the event an SDE is overpaid, the FI will identify the overage and institute recovery proceedings. Employees in the Agency with Choice model are eligible for paid time off depending on the number of hours worked per week and the number of years worked for the employer of record. Please contact the FI for more information.

8.3.2.6 Mandated SDE Training

The SDE shall comply with any relevant licensing and/or certification standards required for the service they are providing. The individual may be compensated for the time spent completing the training and payment for those courses that require a fee will be covered by the Division. A non-computer based version of the training provided through the College of Direct Support (CDS) will be made available to the SDE upon request. All SDEs shall complete the following training:

8.3.2.6.1 DDD System Mandatory Training Bundle – Within six months of hire

The following training is available through the College of Direct Support (CDS). Additional information about CDS is available in Section 11.4.1.

- DDD Shifting Expectations: Changes in Perception, Life Experience, & Services
- Prevention of Abuse, Neglect, & Exploitation Module
 - CDS Maltreatment Prevention and Response: Lesson 1: The Direct Supports Professional Role
 - CDS Maltreatment Prevention and Response: Lesson 3: What is Abuse?
 - CDS Maltreatment Preventions and Response: Lesson 4: What is Neglect?
 - CDS Maltreatment Prevention and Response: Lesson 5: What is Exploitation?
 - CDS Maltreatment Prevention and Response: Lesson 7: The Ethical Role of the DSP
- DDD Life Threatening Emergencies (Danielle’s Law)

8.3.2.6.2 Individual/Family Developed Orientation – Within six months of hire

Topics covered should assist the SDE in getting to know the individual and may include the following suggestions:

- Great things about the individual;
- Areas of importance to the individual;
- Best ways to support the individual;
- Information about how the individual communicates;
- Individual rights;
- Working with families;
- Incident reporting.

8.3.2.6.3 Medication (unless medications are not being distributed) – Prior to administering medications

The following training is available through the College of Direct Support (CDS). Additional information about CDS is available in Section 11.4.1.

- Introduction;
- An Overview of Direct Support Roles in Medication Support;
- Medication Basics;
- Working with Medications;
- Administration of Medications and Treatments;
- Follow-up, Communication, and Documentation of Medications.

8.3.2.6.4 Medication Practicum (unless medications are not being distributed) – Prior to administering medications

- On-site competency assessment conducted by the individual/family.

8.3.2.6.5 Cardiopulmonary Resuscitation (CPR) and Standard First Aid – Within six months of hire

Must be from a nationally certified training program for CPR and for Standard First Aid following the guidelines provided in Section 11.4.2.

8.3.2.6.6 CPR and Standard First Aid Recertification – Every two years

Staff shall submit documentation of successful completion of recertification in CPR and Standard First Aid in accordance with the recertification timeframes established by the certified training program and following the guidelines provided in Section 11.4.2.

8.3.2.6.7 Specialized Staff Training – Within six months of hire, as needed

Staff that work with individuals with medical restrictions, special instructions, or specialized needs shall receive training to meet those needs. Topics in this area shall be addressed to meet the individual's needs and may include but are not limited to the following:

- Specialized diets/mealtime needs – including eating techniques, consistency of foods, nutritional supplements, food thickeners, the use of prescribed equipment, chair positioning, the level of supervision needed, etc.;
- Mobility procedures and safe use of mobility devices;
- Seizure management and support;
- Assistance, care, and support for individuals with identified specific needs related to physical and/or medical conditions;
- Assistance, care, and support for individuals with identified mental health and/or behavioral needs (must comply with relevant Division policies).

8.3.2.6.8 Behavior Plan (if applicable because the SDE is working with individual(s) who have a behavior plan) – Within six months of hire

8.3.3 Accessing/Continuing Needed Services upon 21st Birthday

Services and supports are primarily covered through the school district until the individual exhausts their educational entitlement upon graduation *after* their 21st birthday. However, some additional services that are not provided by school districts (respite or private duty nursing, for example) are sometimes provided through the Department of Children & Families (DCF) Children's System of Care (CSOC) or other entities until the individual's 21st birthday. At that time, the Division can continue some of these services provided through CSOC and other entities as long as the individual is eligible for the Division of Developmental Disabilities. To access services upon the 21st birthday, the individual should contact the Intake Unit at his/her Division Community Services Office to inform the Division that they are turning 21 in a month or two and will need to continue accessing respite services, for example. If the individual is already eligible for Division services, the intake worker will provide the Support Coordination Agency Selection Form and instruction in order for the individual to be assigned to a Support Coordination Agency up to 60 days prior to their 21st birthday. Upon assignment, the Support Coordinator will begin developing the ISP in order to ensure that the continued service is available through Division funding, if needed, upon the individual's 21st birthday. Please note that the Division cannot provide funding for any services that should be provided through the school district until the educational entitlement has been exhausted (at graduation after the 21st birthday). If the individual is not eligible for Division services, the intake worker will provide information on the eligibility determination process as described in Section 3.

8.4 Prior Authorization of Services

To ensure the service provider or SDE can receive payment for the services they are providing, a prior authorization must be obtained BEFORE the service is delivered. Services begun or provided without prior authorization or outside of the scope of the prior authorization will not be reimbursed. Medicaid must receive a prior authorization from the Division before they will remit payment for a claim. Prior authorizations are created upon approval (or modification) of the ISP and automatically generated for each week of service. A secure email containing the approved ISP and a Service Detail Report detailing the start/end dates, number of units, and procedure codes for services prior authorized for delivery is automatically generated to all identified service providers and/or the FI in circumstances when the individual is utilizing a SDE or accessing a waiver service through a vendor that is not a Medicaid provider.

Medicaid sends a letter to providers whenever a prior authorization is created, changed, or revoked. The most recent prior authorization supersedes any previous prior authorizations. Without a prior authorization, it is possible that a claim will not be paid.

8.4.1 Rounding of Service Units

Providers must comply with Newsletter Volume 28 No. 01 released in February 2018 and found in Appendix L of this manual.

CCP providers are allowed to add non-continuous units of billable sessions together. This requires careful documentation supporting the time the individual sessions were provided. These times may not be estimated. The provider may then add non-continuous units together to reach a total. Since units are 15 minutes in length, the initial unit of service less than 15 minutes may be billed as one unit. Beyond the initial unit, service times less than half of the unit shall be rounded down while service times equal to or greater than half shall be rounded up.

For example, 53 minutes would consist of three full 15-minute units and a partial unit of 8 minutes. Eight minutes is greater than half of the 15-minute unit. This total may be rounded up to four full units. A total of 52 minutes would consist of three full 15-minute units and a partial unit of 7 minutes. Seven minutes is less than half of the unit. This total would be rounded down to three full units. The total used for rounding may only include services provided that calendar day.

The Division of Medical Assistance and Health Services anticipates proposing regulations to address these issues.

8.4.2 Unit Accumulation

Prior authorized units of service that have not been utilized can carry over for future use within the ISP plan year as long as the service and provider that were prior authorized remain the same. If prior authorized units of service are not utilized, due to an unscheduled absence, unexpected program closure, lack of need for that service that particular week, etc., the service provider or SDE remains prior authorized to provide those carry-over units at any time within the ISP plan year. For example, if 40 units of Supported Employment – Individual Employment Support are prior authorized for 2/21/2016 through 2/27/2016, but only 32 units are utilized that week, the individual can use the 8 carry-over units for Supported Employment – Individual Employment Support (as long as it is with the same provider) at any time throughout the remainder of the ISP.

Service providers and SDEs must track units used compared to units authorized in order to ensure payment for all services rendered. An individual may decide to include additional units at the start of a service in order to create flexibility in their schedule or account for an unexpected change in service needs from week to week. For example, someone attending a program that provides Community Inclusion Services, Prevocational Training, and Day Habilitation may need flexibility to account for their preferences in activities from day to day. This individual may include a few additional units for each of these services so they can use carry over units of Prevocational Training (i.e. to switch from one service to another when they are not interested in participating in certain waiver activities).

Another example would be someone including some additional units for Supported Employment – Individual Employment Support to cover a future need for additional units of service in a week when they are learning a new job task or gets a new supervisor.

Carry-over units cannot be edited after the week in which they were originally assigned has passed so the individual and Support Coordinator should be cautious about frontloading units that won't be able to be used in the future if the individual changes services (from Supported Employment to Day Habilitation, for example) or providers, or is in need of additional units of service in another area.

8.4.3 Back-Up SDEs

Individuals may prior authorize more than one SDE – at the same pay rate – to be called in as a back-up in circumstances where the scheduled SDE is unexpectedly unable to provide the service (due to illness, for example) by including the names of multiple SDEs in the same ISP. Multiple SDEs can continue to be utilized at different pay rates when they are scheduled separately to provide that particular service (for example, the back-up SDE fills in during a week when the primary SDE is on vacation. This change is known ahead of time and included in the

ISP so the back-up SDE may be receiving a lower pay rate than the SDE used more frequently, with more experience, etc.).

8.5 Delivery of Services

Services will be delivered and documented in accordance with the standards described in Section 11 Service Provision and specific to each service as described in Section 17.

8.6 Duplicative Services

The State cannot provide funding for duplicative services so adjustments must be made to the Employment/Day Services component of individual budgets in situations where funding is being provided for day services through other State Agencies. Examples of these programs include but are not limited to Medical Day programs, Extended Employment programs, or Mental Health Partial Day Programs. In circumstances where an individual is accessing these duplicative services, the percentage of time – based on a 30 hour week – they are spending in the program that is not funded by the Division will be deducted from the employment/day component of the individual budget. For example, if someone is attending a Medical Day program for 15 hours per week, 50% of the employment/day component of their budget will be deducted. The remaining budget can be utilized to fund additional services as needed.

8.7 Retirement

An individual enrolled in the Supports Program can retire at the age of 65 if they choose. There are two potential areas of retirement. Individuals who are competitively employed in the general workforce may choose to retire from work but continue participating in their other day services/activities (Day Habilitation, Community Based Supports, classes through Goods & Services, etc.) or choose to retire from all types of day activities. Individuals who are not competitively employed in the general workforce may choose to retire from all day activities. Of course, individuals may continue working and/or accessing day activities past the age of 65 and for as long as they choose, as long as they remain eligible for DDD services.

8.7.1 Retirement from Employment

If the individual who is 65 or older is competitively employed in the general workforce and wishes to retire from working, the Support Coordinator will change the individual's status within the Employment Pathway Assessment to "Unemployed – Not Pursuing" and select "retirement" as the reason for not (or in this case no longer) pursuing employment. When this selection is made, an employment outcome will no longer be required in the ISP, but there will not be any additional changes to the planning process or the individual budget. Other day activities the individual may be experiencing with DDD services would continue, could increase to replace time the individual was working, etc.

8.7.2 Retirement from Employment/Day Services

If the individual who is 65 or older has chosen to retire from all day activities, the Support Coordinator will check the "retirement" box within the "More Info" tile under the "Personal" tab in iRecord. The individual will continue to access their full individual budget (including the portion previously utilized for employment and day habilitation services) to provide funding for alternative services and supports. The Division recognizes that these services are likely to shift to in-home services and supports at this point. If the individual seeking retirement is not yet 65 years of age, the Support Coordinator will be directed to follow the early retirement procedure upon selection of the retirement box. This process includes submitting the "Request for Retirement Form" to DDD.EmploymentHelpdesk@dhs.nj.gov to provide details regarding the reason for retirement to the Division for review and approval.

9 PROVIDER ENROLLMENT

The Supports Program is implemented using a Medicaid based, Fee-for-Service model. Acceptance of applications to become an approved provider for Supports Program services is ongoing and open. To deliver services available through the Supports Program, the provider must meet all the qualifications and standards associated with the particular service(s) the provider wishes to offer. These qualifications and standards are described for each service in Section 17. Once approved to deliver services, the provider will receive compensation through a Fee-for-Service model. It is the provider's responsibility to market to potential participants and their families. The Division does not guarantee participants.

9.1 Prior to Submitting an Application to Become a Medicaid/DDD Approved Provider

- **Review the Supports Program Service Descriptions, Limitations, and Qualifications** available in Section 17 Supports Program Services. It is critical that all service providers are familiar with and understand the definitions, limitations, and qualifications for the service(s) they are interested in providing in order to ensure that they are within the guidelines of the waiver.
- **Review the Supports Program Policies & Procedures Manual**
Approved service providers must assure Medicaid and the Division that they will follow the policies and procedures governing the Supports Program as described in this manual. In addition, provision of services within the Supports Program must meet any Division standards specific to a particular service as described in Section 17 of this manual.
- **Review additional informational materials and resources**
Information on a variety of topics, including becoming a provider, is available on the [Division's website](#). The steps to becoming a provider are included on the [Apply to Become a Provider](#) page of the Division's website.

9.2 Submitting an Application to Become a Medicaid/DDD Approved Provider

An organization/agency/provider that is primarily in business to provide social/human services and supports to a segment of the population (in this case, individuals with intellectual and developmental disabilities) will become Medicaid approved providers and claim directly through Medicaid. The Combined Application (Medicaid/DDD) and the process for becoming an approved service provider are available on the [Apply to Become a Provider](#) page.

9.2.1 Application Process

- Apply for a National Provider Identifier (NPI) for the administrative location of the provider as well as each location from which services are delivered. If services are delivered in the community, the administrative NPI will be utilized. This process goes quickly when applying through the National Plan and Provider Enumeration System (NPPES) website at <https://nppes.cms.hhs.gov>.
- Complete the Combined Application (Medicaid/Division) available on the [Apply to Become a Provider](#) page. This single application serves the purposes of (1) applying to become an approved Medicaid provider and (2) applying to become approved for the specific services the agency or individual plans to provide. The application can be completed online but must be printed and mailed to Gainwell Technologies Provider Enrollment Unit at P.O. Box 4804, Trenton, NJ 08650-4804.
- Keep a copy of the original completed Combined Application for ease of processing service or location additions/addendums.

An application packet consists of the following information:

- Application Cover Letter - (DDD-SP-ACL 3-25-2013);
- Request for National Provider Identifier (NPI);
- Signature Authorization Form;
- Provider Start Date Form;
- Provider Application - (FD-20);
- DDD Provider Agreement - (DDD-SP-PA 3-25-2013);
- Disclosure of Ownership and Control Interest Statement (06/19/2012);
- W-9 Tax Form;

- Notice to Enrollee;
- Affirmative Action Survey;
- Authorization for Automatic Payments & Deposits;
- Agreement of Understanding;
- DDD Statement of Intent (DDD-SP-SOI 03-25-2013) form including an accurate verification code from the Division’s website <https://nj.gov/humanservices/ddd/providers/apply/>;
- Business Associate Agreement (HIPAA 200-B);
- Additional required documents indicated on the “Required Documents list” generated when the potential provider selects the services for which they would like to become approved to provide.

9.2.2 Adding Services

A service provider can apply to become approved to offer additional services at any time by submitting the Combined Application indicating the new services they would like to offer.

9.2.3 Adding Service Locations

The Combined Application must be completed and submitted in order to add a new location.

9.2.5 Adding Service Locations

The Division maintains a publicly available web-based Provider Search database found at <https://irecord.dhs.state.nj.us/providersearch>. Provider Search is a tool used by individuals, families, Support Coordinators and other stakeholders to locate providers who are DDD/Medicaid-approved to render services. To ensure that Provider Search is a helpful tool, it is important that DDD/Medicaid approved service providers keep their information updated – especially noting services that they may be approved to render but are not providing. The Division recommends service providers update their information at least every six months.

Below are the steps that a service provider is to use to update their information:

- Go to Provider Search located at <https://irecord.dhs.state.nj.us/providersearch>. A service provider can search for their agency to access the current information available, if needed;
- Download the Provider Data Spreadsheet found under *Message of the Day* (Top right corner of page);
- Open the Provider Data Spreadsheet and enter the updated description for the service provider. Please note there is a 570-character limit.
- Save the Provider Search Spreadsheet and email it to DDD.ProviderHelpdesk@dhs.nj.gov.
- DDD Provider Helpdesk staff will update the narrative within five business days.

9.3 Business Entity/Individual Practitioner

An organization or enterprising entity engaged in commercial, industrial, or professional activities that are offered to the general public, or an individual who offers a skilled service for which they have received education and/or licensing, as appropriate, will receive payment for services that utilize a “reasonable & customary rate” instead of standardized rates through the Fiscal Intermediary and does not need to submit a Medicaid/DDD application at this time. SDEs should follow the process outlined in Section 8.3.2 of this manual. Approval of other business entities or individual practitioners to receive payment for services will be conducted by the Support Coordinator, Support Coordination Supervisor, Fiscal Intermediary, and/or Division staff at the time in which the individual is requesting the service. This process will be based on criteria specific to each service as described in Section 17.

10 FISCAL INTERMEDIARY (FI)

Fiscal Intermediary (FI) services for the Supports Program serves two main functions. The FI manages the financial aspects of the Supports Program on behalf of an individual choosing to direct their services through an SDE. In addition, the FI acts as a conduit for an organization or enterprising entity that is not a Medicaid provider but engages in commercial, industrial, or professional activities that are offered to the general public and will be available to individuals enrolled in the SP.

10.1 Vendor Fiscal/Employer Agent Model

The current Fiscal Intermediary providing the Vendor Fiscal/Employer Agent Model for the Department of Human Services is Public Partnerships LLC (PPL).

In the Vendor Fiscal/Employer Agent Model, the individual or a designee is the common law employer of record and must have an Employment Information Number (EIN). The FI will provide administrative services which include but are not limited to procurement of workers' compensation; withholding state income and employment taxes; collecting, verifying, and processing worker time sheets; and preparing and distributing payroll checks to the SDE.

Please refer to Section 8.3.2 for additional information about the FI as it relates to utilizing SDEs.

10.2 Agency with Choice Model

The current Fiscal Intermediary providing the Agency with Choice Model for the Department of Human Services is Easterseals New Jersey.

The Agency with Choice Model allows the individual or designee to recruit their own employees who are, in turn, employed by the FI (Easterseals New Jersey in this case). It is a joint employment arrangement in which the individual or designee is responsible for managing the staff and the FI's responsibilities include but are not limited to handling the employment-related finances, benefits (as applicable), and paperwork. A per-member per-month (PMPM) fee is required to participate in the Agency with Choice Model which is paid from the individual budget.

Please refer to Section 8.3.2 for additional information about the FI as it relates to utilizing SDEs.

10.3 Fiscal Intermediary as Fiscal Conduit

In addition to providing services associated with Self-Directed Employees, the FI acts as a fiscal conduit making non-routine, non-payroll purchase transactions for services (for example, Goods & Services, Environmental Modifications, Transportation, and Vehicle Modifications) that can be provided by vendors that are not Medicaid/DDD approved.

If the individual is not utilizing any SDEs to render services, the FI will be PPL. If the individual is utilizing SDEs to provide services, the FI will be the same as the one chosen by the individual or designee – PPL if the individual has selected the Vendor Fiscal/Employer Agent Model and Easterseals NJ if the individual has selected the Agency with Choice Model.

11 ADDITIONAL PROVIDER REQUIREMENTS

11.1 Policies & Procedures Manual

All approved service providers must develop, maintain, implement, and be able to produce for Division review at any time, a Policies & Procedures Manual governing their organization. These policies and procedures shall be designed in accordance with the Supports Program and Community Care Program (CCP) Policy & Procedures Manuals and applicable Division Circulars.

Policies & Procedures should be internally consistent, include procedures that are specific, detailed, and include assignment of responsibilities, timeframes and other important details. They should be easy to read, understand and follow. Policies & Procedures should be reviewed at least annually and updated as needed to reflect current state and federal requirements.

To assist providers in developing/maintaining their Policies & Procedures Manual, the following areas have been identified in connection to the Community Care Program and Supports Program Policies & Procedures Manuals and applicable Division Circulars and must be addressed as applicable to the provider. This applies to: DDD/Medicaid-approved Support Coordination Agencies and service providers that deliver direct care services, including: Behavioral Supports; Career Planning; Community Based Supports; Community Inclusion Services; Day Habilitation; Prevocational Training (Individual and Group); Respite; and Supported Employment (Individual and Group).

- **Organizational Governance** – Outlines the business classification/structure, illustrates the table of organization inclusive of job descriptions for all titles and clearly denotes how the business will ensure conflict free operations at the agency level and at the staff level (which may include the use of outside activity documentation or other documentation from employees); see Section 11.2 Organizational Governance Policy;
- **Personnel** – Addresses how the agency will verify, hire and train personnel in accordance with all Division, state, and federal requirements. Policies will define method for conducting required background checks (initial and ongoing), identification of CDS administrator (at least 2), compliance with Komnino’s Law (2-hour notification, drug testing, etc.), criminal history, central registry, Child Abuse Registry Information (CARI), federal exclusion check (See Appendix I), NJ Treasurer’s exclusion database check, NJ Division of Community Affairs (if applicable), NJ Department of Health (if applicable), State Debarment check (See Appendix I), driver’s abstract, system ensuring completion of initial and ongoing mandated training including IR, method for verifying staff qualifications;
- **Admission** – Outlines the criteria for acceptance, method to establish level of supervision, appeal process / grievance procedure, waiting list for admission, communication of necessary information to prospective individual, and denotes title/role responsible for actions;
- **Suspension** – Outlines the process for making determination (determining reasons are met, warning process, etc.), reason for suspension, timeline and process for return to services, appeal process / grievance procedure and denotes title/role responsible for actions;
- **Discharge** – Describes the potential reason for discharge; process for making the determination (determining that reasons are met, warning process, etc.); notification to individual, caregiver, Support Coordinator, the Division, etc.; appeal process / grievance procedure and denotes title/role responsible for actions;
- **Reporting Incidents** (Division Circular #14) – Adopting standardized policy and agency defines training staff on procedure, notifications necessary, steps to record and report the incident, follow up on incident when required and denotes title/role responsible for actions;
- **Complaint/Grievance Resolution or Appeals Process** – Outlines the steps to file a complaint/grievance, two levels of appeal for complaint/grievance, one level to involve the executive director, documentation completed when process is followed and denotes title/role responsible for actions;
- **Complaint Investigation** (Division Circular #15) – Describes staff that are responsible for investigation, process to interview staff, reporting requirements once investigation is complete, time frames involved with

investigation, process for disciplinary action due to results of investigation and denotes title/role responsible for actions;

- **HIPAA & Protected Health information (PHI)** – Establishes a uniform system to implement the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 as it relates to Privacy Practices and consistent with Division Circulars and denotes title/role responsible for actions;
- **Emergency Procedure** – Addresses Life Threatening Emergencies (Division Circular #20) Policy and Procedure; staff training, recording incident, etc.; notification practices (the Division, administration, other staff, family, guardians, etc.); evacuation process (if applicable); mechanism to ensure everyone is evacuated and accounted for; staff roles and responsibilities; mechanism to ensure everyone has been moved to a safe location and is accounted for (shelter in place policy, if applicable); completion of IR and denotes title/role responsible for actions;
- **Medication Administration** (if medication is distributed while rendering service) – Details the process to store on/off site, procedure for administration of medication, prescribed/OTC medications documentation, staff responsibilities (training requirements / storage), notification if necessary (reporting of errors / definition of errors / IR completion), notification of administration of PRN/OTC medication, staff training to include practicum; denotes title/role responsible for direct administration, training, and Quality Assurance oversight;
- **Reporting Medicaid Fraud/Waste/Abuse** (Division Circular #54) – Adopting standardized policy that addresses definition of Medicaid Fraud/Waste/Abuse, staff roles and responsibilities, process to identify concerns, staff designated to receive all reports of concern, system to report to required entity, notification that should be made, addressing annual training requirement and denotes title/role responsible;
- **Human Rights** (Division Circular #5) – Addresses whether the provider will create its own internal Human Rights Committee (HRC) or utilize Division HRC, outline system to review concerns regarding an individual’s rights, system to review Behavior Support Plans (as necessary), staff roles and responsibilities, documentation needed, notification needed and addresses agency’s assurance of protecting Individual Rights across all operations aspects consistent with Home and Community Based Settings rules and denotes title/role responsible;
- **Financial Management and Billing** – Outlines the operational steps for conducting Internal Controls for claim submission, billing process, oversight of recordkeeping, monitoring expenditure controls and addressing Internal Financial controls that help ensure fiscal sustainability, financial reporting, audit requirements and monitoring fiscal sustainability criteria, and clearly defines staff roles and responsibilities;
- **Quality Management Plan** – Outlines system for continuously assessing and improving service delivery, inclusive of internal and external process to measure customer satisfaction, method to evaluate areas for improvement / goals for the year, plan for improvement via Quality Management Report (additional information can be found in Section 15.4).

Providers of indirect or Allied Health professional services that do not provide additional direct care services must follow the modified requirements outlined in Appendix S of this manual. These services include: Assistive Technology; Cognitive Rehabilitation; Environmental Modifications; Goods & Services; Interpreter Services; Natural Supports Training; Occupational Therapy; Personal Emergency Response System; Physical Therapy; Speech, Language, and Hearing Therapy; Transportation; and Vehicle Modifications.

Please refer to Appendix S – Quick Guide to Required Content Areas for Provider Policy and Procedure Manuals for additional detail on content requirements.

11.2 Organizational Governance Policy

All DDD/Medicaid-approved service providers, regardless of their designation as for-profit or not-for-profit, must:

1. Maintain and be able to produce for Division review at any time, document(s) that outline the organization’s governance that oversees the operations of the organization in such manner as will assure effective and ethical management;
2. If requested, disclose and make public all Board member/stockholder names, affiliations, and any potential conflicts of interest. This must include the requirement that, at a minimum, all board member/stockholder names be made publicly available on the organization’s website;

3. Demonstrate compliance with all legislation and regulations of corporate governance and financial practices as prescribed by the organization's corporate designation (profit, non-profit).

Providers found at any time to be in violation of their Board Policies, including but not limited to all the above requirements, and background check requirements for Board Members described in 15.1.2, may be dis-enrolled as an approved provider of Division services.

11.3 Documentation of Qualifications

All approved service providers must maintain documentation that can be provided at the request of the Division to demonstrate continued compliance with qualification requirements. Personnel files that include relevant licenses, certifications, proof of completion of mandated training, etc. shall be maintained and available for Division review at any time.

In addition, all approved service providers must adhere to documentation requirements specific to each service, as detailed in Section 17, and maintain participant files for each individual receiving services (these files can be maintained with an electronic health record).

Providers using an electronic health record (EHR) or other electronic systems will remain in compliance if all information required in documents is captured somewhere and can be shown/reviewed during an audit.

11.4 Staff Orientation, Training, and Professional Development

Providers must comply, at a minimum, with the service specific mandatory training and professional development indicated in Section 17 and Appendix E. It is the provider's responsibility to ensure that their employees understand the mandatory training and provide additional training and/or enhancements to the mandatory training as needed. Service providers are expected to provide employees with orientation that includes but is not limited to an overview of the organization's mission, philosophy, goals, services, and practices, personnel policies of the provider agency, understanding the ISP and using information documented in it to individualize strategies and services, documentation and recordkeeping, and training relevant to health and safety.

11.4.1 Accessing Training through the College of Direct Support (CDS)

The College of Direct Support (CDS) is an online training and learner management system. The Division uses the CDS to provide and track training. The CDS contains more than 30 online training modules designed for use by direct support professionals, frontline supervisors, and other disability service professionals. Providers are given access to CDS after enrollment with the Division.

Approved service providers must have a CDS Agency Administrator. Each agency shall have two CDS Administrators to account for vacation and turnover. Each provider may have a maximum of four CDS Administrators. All Agency CDS Administrators are required to complete [training](#) offered through The Boggs Center on how to use the system and must follow the procedures as described in the [CDS Administrator Manual](#) and training related policies set forth by the Division. Technical Assistance is provided to Agency CDS Administrators through contacting cdsta@rutgers.edu. Additional information on using the College of Direct Support including: Learner Manual, instructional webinars, Agency Guide: Using the CDS for Pre-Service Training, the NJ Career Path, etc. can be found on [The Boggs Center Workforce Development webpage](#).

11.4.2 CPR and First Aid Training Entities

For services that mandate CPR and/or First Aid training, providers may choose a training entity that meets current Emergency Cardiovascular Care (ECC) guidelines, through which certification in Standard First Aid and CPR is obtained. The ECC Guidelines provide recommendations regarding how to resuscitate victims in the event of a cardiovascular emergency.

Providers shall obtain, and make available for inspections and/or audits, documentation that the training entity utilizes a curriculum in compliance with the ECC guidelines. The documentation shall be a statement, on the entity letter head, that their training content/curriculum meets the ECC Guidelines.

Additionally, providers shall ensure staff competency through the successful completion of a standard First Aid and CPR course which shall include:

- In-person course with a certified instructor; on-line certifications are not acceptable; and
- Successful completion of a skills test/practicum.

Re-certification every two (2) years to include skills and competency assessment

11.5 Health Insurance Portability and Accountability Act (HIPAA)

Service providers must be in compliance with HIPAA and ensure their staff is trained on HIPAA and all documentation is HIPAA compliant. For example, paper documents/case records must be stored securely with appropriate safeguards, and the individual's written authorization for release of information must be obtained before any protected health information can be shared.

11.6 Return of Client Records

Service providers must maintain and retain individual client records in accordance with Division Circular #30, Records Confidentiality. When a service provider type other than Support Coordination needs to return records to the Division, the provider shall contact its agency liaison within the Provider Performance and Monitoring Unit (PPMU). If an agency is unsure of who their PPMU liaison is they should contact DDD.PPMU@dhs.nj.gov.

A Support Coordination Agency (SCA) needing to return records to the Division shall contact its Quality Assurance Specialist (QAS) assigned by the Division. This includes previously assigned SCAs that have not uploaded documentation to iRecord or are otherwise dis-enrolling. Documentation should be sent to the assigned QAS within three business days. If a Support Coordination Agency is unsure who their assigned QAS is they should contact DDD.SCHelpdesk@dhs.nj.gov.

11.7 Home and Community Based Services (HCBS) Settings Compliance

All waiver services funded by the Division are Home and Community Based Services (HCBS) made possible by New Jersey's participation in the Comprehensive Medicaid Waiver. In accordance with the [Home and Community Based Services \(HCBS\) Settings Final Rule](#) and [42 CFR § 441.301](#) all HCBS must be delivered in settings that are integrated in, and support full access to, their community. This section is a summary of the HCBS Settings Final Rule.

The following Home and Community Based Services Requirements apply to all settings (Day and Residential) where HCBS services are delivered:

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan (i.e. ISP) and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- The setting facilitates individual choice regarding services and supports, and who provides them.

In addition to the above qualities, the following additional conditions must be met in provider-owned, managed or controlled residential settings:

- The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State

must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

- Each individual has privacy in their sleeping or living unit.
- Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
- Individuals sharing units have a choice of roommates in that setting.
- Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
- Individuals are able to have visitors of their choosing at any time.
- The setting is physically accessible to the individual.

Any modification of the additional conditions must be supported by a specific assessed need and justified in the person-centered service plan (i.e. ISP). The following requirements must be documented in the person-centered service plan (i.e. ISP):

- Identify a specific and individualized assessed need; Document the positive interventions and supports used prior to any modifications to the person-centered service plan; Document less intrusive methods of meeting the need that have been tried but did not work; Include a clear description of the condition that is directly proportionate to the specific assessed need; Include regular collection and review of data to measure the ongoing effectiveness of the modification; Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated; Include the informed consent of the individual; Include an assurance that interventions and supports will cause no harm to the individual.

Home and community-based settings do not include the following:

- A nursing facility; an institution for people with mental illness; an intermediate care facility for individuals with intellectual disabilities; a hospital; or
- Any other locations that have qualities of an institutional setting. This includes:
 - Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;
 - Any setting that is located in a building on the grounds of, or immediately adjacent to, a public institution; or
 - Any other setting that has the effect of isolating individuals receiving Medicaid Waiver HCBS from the broader community of individuals not receiving Medicaid HCBS.

Should an individual or interested party feel that the setting where Division funded services are received is not compliant with the Home and Community Based Services (HCBS) Settings Final Rule, please contact the Division at DDD.HCBShelpdesk@dhs.nj.gov and/or notify the individual's Support Coordinator/Case Manager. Non-compliance with the HCBS Settings Rule can also be reported by calling the Division at 1 (800) 832-9173. The Division will review the submission and contact the service provider to address areas of non-compliance.

11.8 Emergency Preparedness and Response Plan (EPRP)

In accordance with P.L. 2021, [Chapter 292](#), the NJ Department of Human Services (DHS) provides an [Emergency Preparedness and Response Plan for Licensed Providers of Services to Individuals with Intellectual and Developmental Disabilities](#) (EPRP). A Licensed Service Provider is any entity licensed, certified, or otherwise authorized by DHS to provide services to individuals with intellectual and developmental disabilities and encompasses all service types.

The EPRP was created in consultation with the NJ Department of Health (DOH), Ombudsman for Individuals with Intellectual or Developmental Disabilities and Their Families, Licensed Service Providers (LSPs), and the State Office of Emergency Management.

The EPRP:

- Establishes guidelines and best practices for the general and specific operations, activities, and procedures that are to be undertaken or implemented by LSPs during a public emergency;
- To the extent feasible, identifies the means, methods, and channels through which licensed service providers may obtain personal protective equipment (PPE) and other equipment or services that are critical to the maintenance of ongoing operations during the course of a public emergency;
- Addresses various possible public emergency scenarios and provides for the application of differing standards and best practices for each, as appropriate, while highlighting the standards, best practices, and resource sourcing methods that are applicable for the purposes of any currently declared public emergency; and
- Is consistent with, and incorporates, any relevant guidance that is published by the U.S. Department of Health and Human Services, the federal Centers for Disease Control and Prevention, and any other federal agencies that are involved in the remediation of public emergencies.

DHS shall revise the plan and post on its website, at a minimum, every two years from date of publication and as soon as possible/needed following the declaration of any new public emergency in the State. A new public emergency in the State is defined as one that is officially recognized and declared by the Governor of New Jersey or by the President of the United States. All LSPs must also continue to be in compliance with any other applicable state or federal requirements, including but not limited to, DHS Licensing requirements.

All providers funded by the Division should ensure that they have plans in place for more uncommon emergencies like cyber-attacks, hurricanes, tornadoes, etc. so that they have continuity in operations, etc. as well as an emergency plan for unexpected staff losses.

Please review the following for more information:

- [Emergency Preparedness and Response Plan for Licensed Providers of Services to Individuals with Intellectual and Developmental Disabilities \(EPRP\)](#)
- [EPRP Presentation \(Slides\)](#)
- [EPRP Presentation \(Recording\)](#)

11.9 Infection Control and Prevention

All DDD/Medicaid approved service providers must follow the most current infection prevention and control information/guidance from the [Centers for Disease Control and Prevention \(CDC\)](#), [Occupational Safety and Health Administration \(OSHA\)](#), and [New Jersey Department of Health \(NJ DOH\)](#) on health issues that impact the population(s) they serve. This includes, but is not limited to: COVID-19, Influenza, etc. In all circumstances, DDD/Medicaid approved providers shall cooperate with Federal, State, and Local health officials.

12 SERVICE PROVISION

12.1 Service Provider Responsibilities

- Develop and maintain a Policy and Procedure Manual that complies with the requirements outlined in the SP/CCP manuals, Division directives, policies, circulars, and procedures.
- Develop strategies in collaboration with the individual receiving services to assist the individual in reaching their outcomes.
- Complete and maintain documentation as required to support Medicaid billing and Division requirements.
- Claim for services according to Medicaid (Gainwell Technologies) standards and guidance.
- Provide services and supports within the parameters indicated in the ISP and the Service Detail Report.
- Become familiar with the individual's vision, outcomes, needs, etc. and provide services and supports accordingly.
- Participate as a member of the Planning Team.
- Complete, maintain, and submit reporting documents as required.
- Be responsive to Division needs/requests as they relate to special projects.
- Comply with monitoring, auditing, and quality assurance measures conducted by the Division and/or Medicaid/Gainwell Technologies.
- Comply with provider qualifications, policies, standards, procedures and training requirements specific to the service being provided as described for each service in Section 17.

12.2 Documenting Progress toward ISP Outcomes

At least one personally defined outcome will be provided within the ISP for each service the individual is going to receive. The service provider must collaborate with the individual to develop strategies used to progress toward reaching the outcome(s) related to the service(s) they are providing and maintain documentation of the individual's progress using Division required service delivery documentation. This documentation is unique to the service and further described in Section 17 and Appendix D.

12.3 Claim Submission

The following factors must be in place prior to claim submission for Medicaid service:

- Compliance with the requirements outlined in Section 12 of this manual;
- Proper documentation of service delivery of service along with any deliverable documents necessary to substantiate the claim in the case of an audit. Services may have specific deliverable documents (such as strategies, time sheets, behavior plans) relevant to delivery of that service. Details about these documents are provided in Section 17;
- The service that was provided has a valid prior authorization;
- The claim must include participant information and service information (such as Medicaid ID, diagnosis, procedure code, rate etc.) which can be found within the service plan and service detail report;
- Staff are properly trained, vetted, and credentialed to deliver services rendered.

**** Claims submitted without adherence to standards outlined in this manual will require Medicaid repayment****

Service providers may submit claims for payment through the NJMMIS site (www.njmmis.com) or through a software solution which can perform bulk electronic claim submission.

Training on how to submit claims and track their status through the NJMMIS site can be provided by Gainwell Technologies. Gainwell Technologies provider services can be reached by calling 800-776-6334 or on the NJMMIS website through the option "Contact Provider Services".

12.4 Subcontracting Services

The use of sub-contracting by a Medicaid/DDD approved provider is precluded unless the provider is contracting with a qualified temporary employment agency for temporary staff to provide behavioral supports, community

based supports (SP), day habilitation, individual supports (CCP), interpreter services, occupational therapy, physical therapy, and/or speech, language, & hearing therapy services in order to ensure compliance with staffing requirements. In this case the provider and subcontractor must follow Newsletter Volume 30 No. 19 included in Appendix P.

A qualified temporary employment agency that will provide one or more of the identified services for a provider must submit the combined Medicaid/DDD provider application to Gainwell Technologies for approval. The temporary employment agency shall be screened and assigned a NJFC Medicaid Provider ID Number by Gainwell Technologies. The Medicaid/DDD approved agency providing temporary employees (acting as a subcontractor) shall maintain a vendor contract with the Medicaid/DDD enrolled provider that has requested the temporary staffing services (acting as a contractor). This contract shall outline that the contractor shall complete the GAINWELL TECHNOLOGIES billing in exchange for the required services from the subcontractor. The contract shall also outline reimbursement rates, contain a description of needed staff profiles and attestation to assure continuous vetting of current employees to ensure minimum requirements continue to be met. At no time shall that contract violate Medicaid/DDD requirements. The contract shall be subject to review by DDD and DMAHS.

The subcontractor is responsible for ensuring that any individuals under contract and temporarily employed for staffing purposes fully satisfy all applicable State, federal, and any other licensure and certification requirements, including those regulations incorporated within the Medicaid/DDD combined application. Failure to assure that all such requirements are met, which are consistent with N.J.A.C. 10:49-9.8(d), may result in either or both actions listed below:

1. DMAHS may recover from the enrolled contractor the NJFC Medicaid reimbursement paid by the Program to the provider for any service rendered by an employee not meeting such requirements; and/or
2. The contractor or subcontractor may be subject to any applicable civil or criminal sanctions and/or penalties.

If a DDD provider has any questions concerning this Newsletter, please contact DDD at 609-633-1482. For questions related to provider enrollment, please contact the Gainwell Technologies Provider Enrollment Unit at 609-588-6036.

12.5 Discontinuing Services

In order for a provider to discontinue services with an individual, the following steps must occur:

- The service provider must notify the individual, guardian, family of their intention to end services;
- The service provider must provide the reasons for which they can no longer serve the individual – these reasons should align with the provider’s Policies & Procedures related to discharge;
- The service provider must notify the individual’s Support Coordinator at least 30 days prior to discontinuing services so the Support Coordinator can assist the individual in accessing a replacement provider(s) and/or service(s) as needed and revise the ISP; and
- The service provider will continue to support the individual until they find services to replace those that will be discontinued and find a new service provider(s) that meets the individual’s needs and can coordinate services beginning with that new provider(s).

12.5.2 Provider Ready Directory

The [Provider Ready Directory](#) (PRD) is a listing of providers who have indicated a willingness to take over operation of a day setting when the current provider is unable to do so. Qualified DDD/Medicaid Approved Providers can request to be added to the PRD by submitting a Letter of Interest following the process outlined [here](#) (Please note that application to the directory may be submitted at any time). The PRD provides a mechanism to preserve operation of service locations so continuity of services can be maintained and personal choice of individuals served is respected. Many factors impact the ability to exercise the Provider Ready Directory including

asset ownership, corporate structure, availability of a willing Alternate Provider, the number of impacted programs, the needs of persons served, etc.

In the event that a DDD/Medicaid Approved provider operates a Day Services Program (Certified Day Habilitation program or Pre-Vocational program) and intends on closing one or more service locations they are required to notify the Division Assistant Commissioner and Provider Performance and Monitoring Unit (PPMU) in writing before any changes occur, including the relocation of persons served. This shall be provided on agency letterhead at least 60 (sixty) days before any changes occur. This correspondence shall be sent by email to DDD-CO.LAPO@dhs.nj.gov and DDD.PPMU@dhs.nj.gov. A physical copy of the letter shall be mailed to:

Assistant Commissioner
Division of Developmental Disabilities
PO Box 726
Trenton, NJ 08625-0726

13 MONITORING (Participant)

This section provides information regarding individual monitoring requirements and mandatory reporting of cases of suspected abuse and neglect. In addition, information regarding a service provider's responsibility to report quality assurance issues to the Division is provided.

The individual should notify the Division if they and/or their family or caregiver have not received contact from his/her Support Coordinator monthly or had the opportunity to meet with their Support Coordinator.

13.1 Mandatory Monitoring

As an enrolled participant in the Supports Program, the individual must participate in monthly phone contacts and quarterly visits with the Support Coordinator and understand that these visits are mandatory and may occur in the home, day program, place of employment, etc. as agreed upon with the Support Coordinator and that, annually, at least one of these quarterly visits must take place in the home. If the individual needs assistance in participating in this monitoring and the guardian or parents are not always available, a designee familiar with the individual and their services can fill this role. The Support Coordinator is responsible for conducting ongoing monitoring of all individuals on their caseload. At a minimum the following monitoring must occur:

- **Monthly Contact** – must be conducted within the next calendar month from the date of the ISP approval and within every calendar month thereafter. The Support Coordinator must have, at a minimum, contact with the individual once per calendar month. Face-to-face contact is preferable but contact via the telephone or HIPAA compliant video conferencing is acceptable. Email, texting, or other methods of communication are not acceptable to meet the mandatory minimum monitoring requirements. However, email can be utilized to gather information prior to the monthly contact in order to streamline the process. Email must remain confidential and HIPAA compliant and be documented through case notes in iRecord. Information gathered/observed during this contact must be documented in the Support Coordinator Monitoring Tool and uploaded in iRecord no later than the last day of the following month. Claiming should not occur before the deliverable, contact, and documentation that fulfills the requirement of a Support Coordinator Deliverable, have all been met. The Support Coordinator must document any additional contact beyond the required monthly through case notes. Follow-up that has occurred based on the monthly contact can be documented in case notes or subsequent Support Coordinator Monitoring Tools. The ISP must be revised as necessary.
- **Quarterly Face-to-Face Contact** – must be conducted during the third calendar month from the date of the ISP approval and every three months thereafter. The Support Coordinator must have, at a minimum, one quarterly face-to-face visit with the individual. These quarterly contacts shall include at least one home visit annually and at least one visit to the location in which an individual is receiving a particular service for more than 16 hours per week on a regular basis. The Support Coordinator must contact the provider to schedule the quarterly visit ahead of time. Information gathered and observed during this contact must be documented in the Support Coordinator Monitoring Tool and uploaded in iRecord no later than the last day of the following month. Claiming should not occur before the deliverable, contact, and documentation that fulfills the requirement of a Support Coordinator Deliverable, have all been met. The Support Coordinator must document any additional contact beyond the required quarterly contact through case notes. Follow-up that has occurred based on the quarterly contact can be documented in case notes and/or subsequent Support Coordinator Monitoring Tools. The ISP must be revised as necessary.
- **Annual Face-to-Face Home Visit** – must be conducted any time within one year from the date of the ISP approval. Information gathered and observed during this contact must be documented in the Support Coordinator Monitoring Tool and uploaded in iRecord no later than the last day of the following month. Claiming should not occur before the deliverable, contact, and documentation that fulfills the requirement of a Support Coordinator Deliverable, have all been met. The Support Coordinator must document any additional contact beyond the required annual home visit through case notes. Follow-up that has occurred based on the annual home visit can be documented in case notes and/or subsequent Support Coordinator Monitoring Tools. The ISP must be revised a necessary.

- **Annual ISP** – All individuals who are eligible for Division services and programs shall have, at a minimum, a new ISP annually. The Support Coordinator shall facilitate the person-centered planning process with the planning team, continually update and revise the ISP if service needs have changed during the course of the year, and write a new ISP annually. Information gathered and documented in case notes and/or on the Support Coordinator Monitoring Tool throughout the year must be considered in reviewing, revising, and writing new ISPs. If the monthly and quarterly minimal requirements have already been met (including the annual home visit), a Support Coordinator Monitoring Tool does not need to be completed in the same month as the annual ISP.

13.2 Plan Review Elements

The following applicable elements must be addressed by the Support Coordinator whenever the planning team reviews the ISP or services:

- Review the individual’s current services and ISP to determine the type, recommended amount, received amount, and cost of each service.
- Review the NJ CAT and all progress reports, evaluations, assessments, recommendations, nursing reports, incident reports, and monitoring records received to determine if services are being provided appropriately.
- Gather information obtained in circumstances in which interaction with or assessment/observation of individual services was done.
- Assess, in conjunction with the individual, the services being provided, progress toward outcomes, and any problems or service needs from the individual’s perspective. Discuss satisfaction with services and providers, including service gaps and the back-up plan where appropriate.
 - Support Coordinators should develop an emergency back-up plan with individuals and families in the event that current supports are no longer available. Emergency back-up plans can be documented on the ISP form or included in the demographic section of iRecord. Emergency back-up plans should consider support needs as well as the need for proxy decision-makers, if appropriate.
- Discuss new or previously identified risks and the prevention of those risks.
- Discuss with the individual, provider/other team member’s progress toward outcomes and any concerns. Review the data on outcomes to assess the individual’s progress and identify any barriers to achievement of those outcomes.
- Discuss changes in the individual’s medical/functional status including any behavioral health needs. If necessary, contact the Managed Care Organization’s (MCO) care management to discuss any changes in the individual’s health.
- Discuss services the individual is receiving from entities other than the Division (i.e. DVRS, DDS, MCO, etc.). Coordinate care with these entities as appropriate.
- If the Support Coordinator’s assessment indicates changes to the current ISP or services are necessary, discuss the changes and the rationale for the changes with the individual. This discussion is especially critical if the changes may result in a reduction or termination of service.

13.3 Service Provider’s Quality Assurance Responsibilities

Service providers – including Support Coordinators – may become aware of quality assurance issues during the course of their work, e.g. licensing standards that are out of compliance, inappropriate implementation of programs, serious incidents not being reported, or billing/claim irregularities. The service provider must report problems to the Division and document these concerns in a case note and/or the Support Coordinator Monitoring Tool.

14 PROVIDER FISCAL SUSTAINABILITY

The Division is responsible for ensuring that each provider agency is in compliance with the terms and conditions of program participation. Financial measurements complement and inform Division action taken around quality metrics, as well as potentially providing a leading indicator of program performance. Although financial success alone is not an indicator of program quality, the fee-for-service reimbursement model renders it a necessary condition for sustainable and high-quality service delivery.

The requirements in this section are finance specific. Program compliance and performance are addressed in other auditing and reporting requirements.

14.1 Financial Reporting Requirements

Fee-for-service payments for Community Care Program (CCP) and Supports Program (SP) services are not deemed to be Federal awards for federal audit purposes. The Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance), 2 CFR §200.502(i) states that: “Medicaid payments to a sub-recipient for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended under this part unless a state requires the funds to be treated as Federal awards expended because reimbursement is on a cost reimbursement basis.”

Claims made by provider agencies for CCP and SP services are paid at a fixed rate by the State’s Medicaid Fiscal Agent according to prior authorizations generated by individual service plans. In contrast, payments to provider agencies under a DHS Third-Party contract continue to be governed by the DHS Contract Policy and Information Manual and the Contract Reimbursement Manual (CRM).

Audited Financial Statements

All provider agencies that claim \$100,000 or more in combined reimbursement for Community Care Program and Supports Program services within their fiscal year must have annual financial statement audits performed in accordance with Generally Accepted Auditing Standards (GAAS). All provider agencies that expend \$100,000 through DHS Third-Party contracts must continue to have annual financial statement audits performed in accordance with Generally Accepted Government Auditing Standards (GAGAS) pursuant to DHS Contract Manual and DHS Policy Circular P7.06.

All provider agencies that claim less than \$100,000 in combined reimbursement for Community Care Program and Supports Program services and, or expend less than \$100,000 through cost reimbursement contracts within their fiscal year are subject to audit by the Department of Human Services or its representatives at DHS’ discretion.

All provider agencies remain subject to audit by federal, DHS and state partner or oversight agencies regardless of reimbursement or expenditure totals.

Audited financial statements include a balance sheet as of the close of the fiscal year, as well as an income statement and cash flow statement for the fiscal year. Detailed and explanatory notes in the financial statements should be consistent with industry standard and be accompanied by a report by independent certified public accountants.

Audited financial statements must be made available to the Division upon request.

14.2 Notifications

The Provider Agency shall notify the DHS Office of Auditing by email at DHSOffice.OfAuditing@dhs.nj.gov and DDD Provider Helpdesk by email at DDD.ProviderHelpdesk@dhs.nj.gov within five business days of receiving a draft or final audit report that contains a qualified opinion or an exception to an unqualified opinion (e.g., going concern, scope limitation, disagreement with management, GAAP compliance).

The Provider Agency shall notify the Division within five business days of the occurrence of any event that it reasonably anticipates will materially impact the business, assets, liabilities, financial condition or prospects of the

Provider Agency. This notice shall specify the nature and duration of the event and what action the Provider Agency intends to take to maintain operations and service delivery.

The Provider Agency shall notify the Division within five business days of the occurrence of any default or event of default on any financial instrument or other obligation. This notice shall specify the nature and duration of the default and what action the Provider Agency intends to take to remedy the default.

The Provider Agency shall notify the Division within five business days of the occurrence of any material change in the amounts available through insurance policies or self-insurance reserves to cover risk and liabilities that are typical to service providers of a similar size and scope in the industry. This notice shall specify the nature and duration of the change and what action the Provider Agency intends to take to mitigate the risk.

The Provider Agency shall notify the Division within five business days of the occurrence of the filing, or threat or intent to file, of any actions, suits or proceedings, including audit and tax findings, against the Provider Agency that (a) relate to services provided to the Division pursuant to this manual, (b) relate to tangible or intangible property, including real estate, necessary for the delivery of services to the Division, or (c) are reasonably likely to be determined adversely to the Provider Agency, and, if so adversely determined, could reasonably be expected to have a material impact on operations and service delivery. This notice shall specify the nature of the occurrence and what action the Provider Agency intends to take to mitigate the risk.

14.3 Fiscal Sustainability Criteria

The below calculations must be submitted annually by all provider agencies with more than \$100,000 in annual combined billing to DDD. This includes all revenue received from DDD through Medicaid Fee-for-Service Billings, support coordination, and any contract revenue.

Agencies must utilize the [DDD Fiscal Sustainability Template](#) when submitting these criteria. The criteria shall be submitted to DDD.WaiverFinancialReports@dhs.nj.gov.

Deadlines for Submission

Provider agencies are required to submit Financial Sustainability Criteria at the end of each State Fiscal Year. The deadline for submission is 120 calendar days after the close of a given State Fiscal Year (June 30). For agencies whose fiscal years do not align with the State Fiscal Year (July 1 through June 30), submissions are due 120 calendar days after the agency's specific fiscal year has ended, beginning with the agency specific fiscal year occurring after June 30, 2019.

Provider agencies are encouraged to develop their own internal metrics and are permitted to submit these as supplements to the required reports.

Operations

Primary Reserve Ratio = Expendable net assets / Total expenses

Measures liquid resources in relation to overall expenses, effectively indicating a provider agency's ability to withstand adverse changes in the business climate without selling assets or borrowing. A ratio of .4 or higher is advisable (expendable net assets would cover about five months of expenses).

Operating Reliance Ratio = Program revenues / Total expenses

Measures how effectively the organization could pay all expenses from program revenues alone. Ratios will vary across provider agencies depending on the number of unique funding sourcing a provider agency has. A ratio of "1" is a good outcome, but the Division recognizes that many provider agencies may use other revenue to maintain operations.

Liquidity & Activity

Quick Ratio = (Cash + Accounts receivable + Short-term investments) / Current liabilities

Demonstrates if short-term assets are sufficient to pay current liabilities. A ratio of “1” or higher indicates that a business is able to meet its short-term liabilities.

Average Collection Period = Days in period * Average claims receivable / Total claims

Calculates the approximate amount of time it takes for the provider agency to receive payments owed. Typically, this calculation is performed by businesses that sell on credit. Within the context of CCP fiscal reporting, this metric is referring specifically to fee-for-service claims for waiver services. Given that claims can be submitted daily and will be paid bi-weekly this figure should be under 30 days unless the provider agency has substantial reserves or is experiencing problems with claim processing.

Financing

Debt Ratio = Total debt / Total assets

Reflects the proportion of assets funded by debt. Ratios will vary across provider agencies depending on the mix of services provided. The Division recognizes that certain types of services require more intensive capital investment and thus may result in higher debt levels. Analysis of this measurement should also take into account the volatility of a provider agency’s cash flows.

Interest Coverage Ratio = EBIT / Interest expense

Calculates how many times the provider agency’s earnings before interest and taxes (EBIT) could cover its debt expense. A ratio of “1.5” or higher indicates that the business should have sufficient earnings to service its debt.

15 QUALITY ASSURANCE, TECHNICAL ASSISTANCE, & AUDITING

15.1 Service Provider Quality Management

Quality management in a service provider agency requires a comprehensive strategy that includes planning, implementing, evaluating, and improving on systems and agency practices that lead to enhanced outcomes for individuals served. The Division of Developmental Disabilities expects that all service providers will be able to demonstrate a comprehensive quality management system in the agency that includes employee development and training; background and exclusion checks; auditing and fraud detection; incident and risk management; adherence to human rights standards; performance and outcomes measurements for service improvement; and an annual quality management plan that details the agency's goals and quality improvement practices.

15.1.1 Employee Development & Training

Supported and well-trained staff in service provider agencies are essential to positive outcomes obtained by individuals with developmental disabilities. Employee development includes strategies to recruit and retain staff and to enhance the professional and personal growth of staff. This can include methods such as ongoing learning and skill development, implementing motivating strategies, and increasing supervisory support and coaching on the job. Focus on career development, increased skills, and reducing staff turnover are core elements of employee development programs. While employee development programs should include more than just minimum standards, the Division requires all staff to complete mandated training topics and to obtain a minimum amount of ongoing training per year. Mandated training will be hosted through the College of Direct Support (CDS). See training requirements under services in Section 17. In addition, agencies will be required to collect and monitor data related to staff turnover and retention rates.

15.1.2 Mandated Background & Exclusion Checks

Service providers are required to check that staff hired, Board of Directors, and contracted vendors utilized are not excluded from working with individuals with developmental disabilities or within a Medicaid provider agency in accordance with the newsletter found in Appendix I. For services provided through the Fiscal Intermediary (FI), such as SDEs providing Community-Based Supports or vendors providing Assistive Technology, the FI will be responsible for checking all applicable federal and State databases.

Initial and on-going Criminal History Background Checks (State and Federal) must comport with [Division Circular #40 – Background Checks](#) (N.J.A.C. 10:48A).

15.2 Incident Reporting & Risk Management

When an unusual incident occurs, the primary responsibility is to provide protection to the individual. If emergency medical care is needed, or if the person is in a life threatening emergency, call 911. See Division Circular 20A for details.

In addition, anyone providing services to individuals eligible for Division services must report incidents within the required timeframes and cooperate with investigations and follow-up to incidents. N.J.S.A. 30:6D-73 et seq., known as the *Central Registry of Offenders Against Individuals with Developmental Disabilities*, stipulates that failure to immediately report allegations of abuse, neglect, or exploitation is considered a disorderly person's offense and can result in a fine of \$350 for each day that the abuse, neglect, or exploitation is not reported. For complete details on the Division's full policy, a chart of incident categories and incident codes, incident and follow up reporting forms, and instructions, see Division Circular 14.

15.2.1 Reporting Incidents

Sufficient information about the incident must be gathered to complete an initial incident report. **However, if all information is not available, reporting of the incident should not be delayed.** The missing information should be submitted as soon as possible in a follow-up report. Staff of the IR Units may ask Support Coordinators and Service Providers for more information in order to fully understand the nature of an incident. Alleged incidents of abuse, neglect, or exploitation remain allegations unless substantiated by investigation. See below for additional information about investigations.

15.2.1.1 Individuals/Families

Individuals and their families may report incidents to their Support Coordinator. **Support Coordinators and service providers are mandated to notify the Division immediately of all known or alleged reports of abuse, neglect, and exploitation.** Definitions of abuse, neglect, and exploitation are as follows:

- **Abuse** – physical, sexual, or verbal acts against a person served that cause pain, physical or emotional harm, mental distress, injury, anguish, and/or suffering.
- **Neglect** – the failure of a caregiver to provide the needed services and supports to ensure the health, safety, and welfare of the service recipient.
- **Exploitation** – any willful, unjust, or improper use of a service recipient or their property/funds, for the benefit or advantage of another, condoning and/or encouraging the exploitation of a service recipient by another person.

If an individual or family member does not want to report an incident to a Support Coordinator, they may utilize the **Abuse and Neglect Hotline** at **1-800-832-9173**. The Hotline is staffed with Office of Risk Management personnel familiar with incident reporting.

15.2.1.2 Support Coordination Agencies

The below provides the processes to be followed by Support Coordinators in reporting incidents. In any case, Support Coordinators are required to write a case note summarizing the incident in iRecord and categorizing it as a IR note.

15.2.1.2.1 Incident is Unrelated to the Service Provider

If a family or individual reports an incident to the Support Coordinator and the incident is unrelated to the Service Provider, the Support Coordinator must complete a typed incident report form and follow-up reports associated with Division Circular #14 and send them to the Incident Reporting (IR) unit that corresponds to the county where the individual resides. There are two means by which an incident report can be submitted to an IR unit:

- UPDOC – a web-based application that is the preferred means for sending an incident report to the appropriate IR unit, listed below. The instructions for UPDOC are available at http://www.state.nj.us/humanservices/ddd/documents/ddd%20web%20current/CIRCULARS/DC14/uir_updoc_instructions_and_ra_assignments.pdf.
- Faxing the incident report to the appropriate IR Unit, as follows:
 - **Mays Landing IR Unit (Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, and Salem counties): 609-341-2340.**
 - **Plainfield IR Unit (Bergen, Essex, Hudson, Passaic, Somerset, and Union counties): 609-341-2342.**
 - **Trenton IR Unit (Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Sussex, and Warren counties): 609-341-2343.**
 - **ORM Central Office (out-of-state IRs): DDD-CO.OQM-UIRS@dhs.nj.gov**

In addition to reporting to the IR unit, the Support Coordinator must also report allegations of abuse, neglect, or exploitation of an individual that occur in the person's home and do not involve a service provider to Adult Protective Services (APS) as soon as they become aware. There is an APS office in every county. Information about Adult Protective Services, including contact information is available at:

<http://www.state.nj.us/humanservices/doas/documents/APS%20flyer.pdf>.

15.2.1.2.2 Incident is Related to or Reported by the Service Provider

If a service provider reports an incident to the Support Coordinator, the Support Coordinator is not required to complete an incident report (IR) as that is the responsibility of the service provider. However, Support Coordinators are required to notify the applicable IR unit of such incidents so that the IR unit can ensure the service provider reports the incident as required.

15.2.1.3 Service Provider

Service Providers are required to report incidents to an applicable IR unit using the incident report forms associated with Division Circular 14 and to notify the guardian, HIPAA authorized family, and the Support Coordinator. Service providers are encouraged to use UPDOC to submit incident report forms and follow up reports; they may fax the form to the appropriate IR unit if they are unable to use UPDOC. Instructions for UPDOC are available at http://www.state.nj.us/humanservices/ddd/documents/ddd%20web%20current/CIRCULARS/DC14/uir_updoc_instructions_and_ra_assignments.pdf and see above for related fax numbers.

15.2.2 Investigations and Follow Up

Investigations of unusual incidents will occur in accordance with DHS policies and procedures, including the involvement of the Office of Investigation (OI) or Critical Incident Management Unit (CIMU) as appropriate. The Office of Investigation directly investigates the most serious allegations of abuse, neglect, and exploitation as well as several types of incidents related to major injuries and deaths. The Critical Incident Management Unit conducts administrative review of investigations conducted by service providers and Support Coordination Agencies (SCAs).

Any incident of abuse, neglect, or exploitation that occurs in connection with the delivery of services by a service provider or SCA must be investigated by the respective service provider or SCA unless otherwise advised by the Office of Investigation or the Critical Incident Management Unit. The IR unit to which the incident of abuse, neglect, or exploitation was reported will advise the service provider or SCA where and how to send its investigation report, either to the Office of Investigation or to the Critical Incident Management Unit.

Regardless of the type of incident, follow up is required. The objectives of a follow-up to an incident are to document the actions taken to protect the individual and to reduce the likelihood of the incident occurring again. Sometimes actions taken at the time of the incident will be sufficient to achieve that objective and the incident can be closed when it is reported. In some situations, follow-up actions may be planned immediately but implemented at a later date. Documentation of the completion of those actions may be necessary to close the incident. The IR unit to which the incident was reported will determine additional information and/or follow-up needed based on the specifics of the incident, and will advise the service provider or SCA accordingly.

Any and all documents and materials related to a pending or closed investigation are not public and can only be released upon judicial order. This includes, but is not limited to: Investigations of unusual incidents; Initial Unusual Incident Reports; and Unusual Incident Follow-Up Reports.

15.2.2.1 Role of Adult Protective Services

Allegations of abuse, neglect, or exploitation of an individual that occur in the person's home and do not involve a Service Provider must be reported to Adult Protective Services (APS) by the Support Coordinator and/or Service Provider as well as to the IR unit, as soon as they become aware. The IR staff will notify the Support Coordinator if the Service Provider has reported an allegation to APS and has not made that notification.

15.2.2.2 Law Enforcement Notification

Refer to the chart of incident categories and codes available in Division Circular 14 for a list of what types of incidents require law enforcement notification. If assistance is needed in notifying law enforcement for these types of incidents, Support Coordinators and service providers may call the IR unit that corresponds to the county in which the individual lives.

15.2.3 Assistance with Unusual Incident Reporting

IR Coordinators are available in each Region to provide technical assistance with recording of incidents (including forms, timeframes, types of incidents, role of the Support Coordinator, etc.). IR Coordinators review all available information and determine whether remedial action is needed or was already taken. Use the following telephone numbers corresponding to the county in which the individual lives, and ask to speak to an IR Coordinator.

County of Residence	IR Unit Phone Number
Hunterdon, Mercer, Middlesex, Monmouth, Ocean	(609) 292-1903
Bergen, Hudson, Morris, Passaic, Sussex, Warren	(973) 927-2111
Atlantic, Camden, Burlington, Cape May, Cumberland, Salem, Gloucester	(609) 476-5080
Essex, Somerset, Union	(908) 561-4587

15.3 Performance & Outcome Measures

15.3.1 Quality Focus Groups

As part of formulating a comprehensive quality management strategy for the Division in accordance with the CMS Quality Framework, a series of focus groups were held with stakeholders representing individuals with disabilities, their family members, and service providers. These groups helped to provide a forum for voicing what individuals with disabilities want in their lives, what they need from service providers, and how the Division should measure and use quality data gathered from the service system. After collating data obtained from the quality focus groups, an online survey was distributed to capture additional feedback from stakeholders in these same areas. A summary report compiled by The Boggs Center on Developmental Disabilities with the results of the quality focus groups and survey results, as well as next steps in the development of the Division's quality management strategy, was released in late Summer 2015.

www.state.nj.us/humanservices/ddd/documents/stakeholder_input_report_on_quality_improvement.pdf

15.3.2 National Core Indicators

Since 2007, the Division has worked with the National Core Indicators Project (NCI). Sponsored by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and managed by the Human Services Research Institute (HSRI), the National Core Indicators will serve as the basis of a systems performance measurement system for the Division. The Quality Improvement Unit is responsible for managing and staffing the NCI project. Division staff conduct information gathering activities including face-to-face interviews and emailed/mailed surveys. NCI performance indicators include approximately 100 individual, family, systemic, cost, and health and safety outcomes - outcomes that are important to understanding the overall health of developmental disabilities agencies. Many of the individual NCI data elements have potential implications for discovery, remediation, and improvement regarding service planning and delivery. Sources of information include individual survey (e.g. empowerment and choice issues), and family surveys (e.g. satisfaction with supports). The core indicators also provide information for many of the desired outcomes identified in the Home and Community Based Services Quality Framework. The NCI surveys have been expanded, and service providers are expected to cooperate with Division staff conducting surveys.

15.3.3 Customer Satisfaction Measures

Service providers are required to design and implement customer satisfaction measures with results reported to the Division on at least an annual basis. Measures may include surveys, complaint and grievance resolution, or other evidence.

Customer satisfaction measures must be in line with the CMS Home & Community Based Services (HCBS) Quality Framework, which includes the following seven broad areas:

- Participant access;
- Participant-centered service planning and delivery;
- Provider capacity and capabilities;
- Participant safeguards;
- Participant rights and responsibilities;
- Participant outcomes and satisfaction;
- System performance.

For more information, see

<https://www.nasddd.org/wp-content/uploads/2021/03/HCBSQualityFrameworkrev06-05-1.pdf>

Support Coordination Agencies may utilize “Evaluating Your Support Coordination Services: A Tool for People with Disabilities” to identify useful measures to include in their own surveys. This document is available at <http://rwjms.rutgers.edu/boggscenter/projects/documents/AToolForEvaluatingSupportCoordinationServicesFinal.pdf>.

As the Division continues to develop an overall quality management strategy, examples and additional elements may be provided as necessary to measure common elements across agencies.

15.4 Quality Management Plan

The Division requires an annual Quality Management Plan for each service provider detailing goals for the year, implementation strategies, evaluation of strategies, and indicators of systemic improvements made as a result of analysis. This includes detailing quality improvement strategies used in the agency, including staff training, policy updates, and service process improvements. As the Division continues to develop its own overall quality management strategy, examples and additional elements may be provided as necessary to measure common elements across agencies.

15.4.1 Data Collection & Reporting

Data from agency incident reports should be collected and a trend analysis conducted on at least an annual basis. Additional areas for data collection and reporting related to the agency’s Quality Management Plan are required.

15.5 Division Oversight & Quality Monitoring

The Division is required to implement oversight and monitoring of Division approved service providers. As such, agencies will be subject to audits and formal reviews of fiscal and programmatic functions. The Division will evaluate services and require corrective action when necessary. Evaluative strategies and actions by the Division will include, but are not limited to:

- Monitoring and addressing characteristics and behaviors affecting the health and safety of individuals
- Monitoring the use of restrictive interventions and unusual incidents
- Monitoring and preventing instances of abuse, neglect, and exploitation of individuals
- Evaluating appropriate level of care and access to services
- Monitoring of deliverables and related documentation required by service type
- Monitoring of credentialing requirements by service type
- Monitoring training requirements
- Monitoring of service plans, including assessed needs met and revisions made when necessary
- Monitoring service delivery in accordance with service plans
- Monitoring individual choice and trends in referrals by support coordination agencies
- Monitoring individual and family satisfaction with services
- Monitoring individual outcomes and goal attainment
- Trend analysis of issues identified on monitoring tools and required follow-up
- Involuntary capacity closure for services not being rendered in compliance with Division standards
- Monitoring and auditing Medicaid claims data
- Monitoring service provider Quality Management Plans and required data reporting

Provider agencies should ensure that agency documents meet requirements and be prepared to submit to the Division upon request. Documents may include, but are not limited to the following: Quality Management Plan, Quality Management Meeting Minutes, Quality Management Annual Report, Customer Satisfaction Surveys, Customer Satisfaction Survey results and action plan and any other applicable document.

See also Provider Disenrollment in Section 16.

15.5.1 Auditing

Ongoing evaluation of service providers will occur to ensure compliance with Division standards and Medicaid claiming through routine audits or other methods. This includes monitoring compliance with mandated background and exclusion checks (see Section 15.1.2) as well as personnel and training standard as indicated in this manual (see Section 17). Monitoring for criminal history background checks will be in accordance with regulation 10:48A-3.6 (Background Checks – Monitoring). Methods of monitoring may include on-site visits, interviews with staff or contractors, questionnaires, DHS/DDD Licensing and Certification inspections, reviews of policies and procedures, trend analysis or other methods as deemed appropriate by the Division’s Quality Improvement Office. All service providers will be subject to both fiscal and programmatic reviews and audits on a regular basis by both Medicaid and the Division or the Division’s designee (external auditing firms, etc.).

Day Habilitation programs must be certified, which will require formal reviews and on-site inspections. See Section 17.7.3 for detailed information.

Residential programs will continue to be licensed and subject to published licensing regulations. Current requirements can be found at: <https://www.state.nj.us/humanservices/providers/rulefees/regs/>.

15.5.2 Fraud Detection

Division Policy on Fraud, Waste, & Abuse includes sanctions for providers when fraudulent claims are made as well as whistleblower protections for staff reporting:

<http://www.state.nj.us/humanservices/ddd/documents/ddd%20web%20current/CIRCULARS/DC54.pdf>

Division Policy on Fraud, Waste, & Abuse includes sanctions for providers when fraudulent claims are made as well as whistleblower protections for staff reporting:

<https://nj.gov/humanservices/ddd/assets/documents/circulars/DC54.pdf>. Agencies where potential fraud is detected will be subject to Medicaid Fraud & Abuse investigations and policies as well as the Provider Disenrollment Policy, found in Section 16. While NJ Medicaid providers are not currently required to implement Compliance programs, the Medicaid Fraud Division strongly encourages providers whose payments from the Medicaid program exceed \$100,000 per year to implement a compliance program. Please go to the following websites for additional information:

- Medicaid Fraud Division information: <https://www.nj.gov/comptroller/about/work/medicaid/>
- Provider Compliance Program information: [NJ Office of the State Comptroller](#)

15.5.3 Human Rights Committee (HRC)

The Division requires an objective review of Issues that may infringe upon human or civil rights of individuals with intellectual and/or developmental disabilities through a Human Rights Committee review. Approved providers can opt to develop an internal HRC or utilize the Division’s established Human Rights Committee.

Internal HRCs must align with the requirements outlined in Division Circular #5 <https://www.nj.gov/humanservices/ddd/assets/documents/circulars/DC5.pdf> and be identified in the agency’s approved Behavior Policy and Procedure Manual. All minutes from HRC meetings are required to be submitted to DDD.HRC@dhs.nj.gov for review.

The referral form for Division HRC can be found at:

<https://www.nj.gov/humanservices/ddd/assets/documents/providers/human-rights-committee-referral.docx>.

Questions about this requirement can be sent to DDD.HRC@dhs.nj.gov.

15.6 Technical Assistance

The Division is committed to providing quality services to individuals with developmental disabilities and therefore will provide technical assistance to service providers to improve performance. Service providers may be moved to

the Provider Disenrollment process for poor performance or lack of improvement in core areas. See policy in Section 16 for details.

Division staff will be assigned to agencies based on area of technical assistance required. Areas may include Employment, Day Habilitation, Behavior Policy & Planning, Human Rights, Service Plan Development, Quality Improvement, Compliance/Fiscal Auditing, or other core areas as identified in reviews or audits.

16 PROVIDER DISENROLLMENT

The Division of Developmental Disabilities (Division) reserves the right to dis-enroll any provider in its entirety or any one or more of its services in the event the provider does not meet or is in violation of any of the Division's policies, standards, and/or requirements. When warranted, the Division may impose sanctions, such as limiting the location of service, including expansion, as well as the acuity level of individuals served. The Division will dis-enroll providers in accordance with NJAC 10:49-11 concerning suspension, debarment, and disqualification of providers. Additional details about this process can be found in the Medicaid Administrative Manual available at <http://www.lexisnexis.com/hottopics/njcode/>.

Providers may be immediately dis-enrolled, including additional sanctions, whenever it is determined that the agency has:

- Jeopardized the safety and welfare of the program participants;
- Materially failed to comply with the terms and conditions of the Provider Agreement;
- Compromised the fiscal or programmatic integrity of the Provider Agreement, including evidence of fraudulent activity reportable to the Medicaid Fraud and Abuse Unit;
- Impeded or failed to cooperate with State or federal investigation(s).

The provider is responsible for complying with all Division standards during the disenrollment process, whether voluntary or involuntary. Failure to do so could result in a report to Medicaid Fraud and Abuse for neglect of duties.

16.1 Voluntary Provider Disenrollment – Provider Initiated

1. Providers of all services other than residential who wish to dis-enroll as a Division-approved provider must notify the Assistant Commissioner, Division of Developmental Disabilities, in writing, with a copy to the designated staff coordinating agency approvals. This notification must include the number of people served, the service location(s), and a plan to transfer services and supports. This transfer plan includes but is not limited to information such as timeframes, notification of Support Coordinators, process for transferring information to newly selected providers, etc. The dis-enrolling provider does not select or identify the provider to which individuals served will transfer. This process will be conducted by the individuals' Support Coordinators with assistance from the Division as needed.
2. The Assistant Commissioner or designee will review the transfer plan and will approve or negotiate an acceptable plan within ten (10) business days of the notification to the Division.
3. Once the transfer plan is approved by the Assistant Commissioner or designee, the provider will begin the transfer, with a transition period lasting at least 60 days from plan approval. Certain circumstances, including where an agency serves more than 50 individuals, may require a longer timeframe for transition.

16.1.1 Provider & Support Coordinator Transition Responsibilities

1. The provider is required to follow through on the transfer plan approved by the Division to ensure participant health, welfare, and safety. This plan must include transfer of individual files to new providers as identified.
2. The provider is responsible to make arrangements to ensure continuity of care prior to closure. This includes notification to the individual's Support Coordinator in writing of an agency closure including timeframes.
3. The Support Coordinator will notify the individual and family/guardian, as applicable, and assist with coordination of a new service provider.
4. The provider must follow up with individuals/families to ensure they have made contact with the Support Coordinator and are actively being assisted with the transition to a new provider.
 - a. If the agency to close is a Support Coordination Agency (SCA), the Division will provide the individuals/families with the SCA Agency Selection Form and assist with identifying a new agency.
5. Failure by the service provider or Support Coordination agency to comply with any of the above requirements could result in a report to Medicaid Fraud and Abuse for neglect of duties.
6. At least 30 days prior to the disenrollment date, the provider will fill out the online disenrollment paperwork and forward to the designated staff coordinating agency approvals.

7. The designated staff coordinating agency approvals will transfer the paperwork to the Office of Provider Enrollment, Division of Medical Assistance & Health Services (DMAHS), at least 15 days before the disenrollment date.

16.2 Involuntary Provider Disenrollment – System Initiated

Providers may be subject to sanctions or exclusionary actions in addition to disenrollment based on the severity of the circumstance in the event of any of the following occurrences or for the reasons stated in N.J.A.C. 10:49-11.1:

- Corrective action is not implemented in a timely manner or to the satisfaction of the Division;
- Issues identified during suspension are not satisfactorily addressed;
- Failure to comply with the terms and conditions of the Provider Agreements (DMAHS and DDD), any relevant Division Policy & Procedure Manuals, and federal and state law;
- Failure to provide or maintain quality services to Medicaid beneficiaries within accepted practice standards of the Division;
- A record of failure to perform or of unsatisfactory performance in accordance with the quality oversight process and/or licensing statutes;
- Criminal activity on the part of the approved provider agency, its officers, board members, or employees subject to offenses listed in NJAC 10:49-11.1;
- Submission of fraudulent claims, submission of false information, or disregard to timely submission of claims;
- Sanctions or financial actions taken by third parties against the approved provider agency that jeopardize the intent or fulfillment of the Provider Agreement;
- Failure to submit reports, records, and audits either upon request or in the event of an incomplete submission; and/or
- Disqualification by some other department/agency within the State of New Jersey or exclusion from participation in any Medicaid program of another state.

The provider may be **immediately** dis-enrolled and excluded from rendering supports and services to individuals, without the opportunity for corrective action, whenever it is determined that the provider agency has:

- Jeopardized the safety and welfare of the program participants;
- Materially failed to comply with the terms and conditions of the Provider Agreement;
- Compromised the fiscal or programmatic integrity of the Provider Agreement, including evidence of fraudulent activity reportable to the Medicaid Fraud and Abuse Unit; and/or
- Impeded or failed to cooperate with State or federal investigation(s).

16.2.1 Technical Assistance & Remediation

- The Division may provide technical assistance to a provider to correct issues identified before initiating the involuntary provider disenrollment process unless fraudulent activity or other serious issue is discovered.
- The technical assistance and expected remediation will be at the discretion of the Division and will be targeted for 30 days, with extended timeframes in extenuating circumstances. Corrective action required by the Division may include a temporary capacity closure to new individuals until the remediation is complete to the satisfaction of the Division.
- If the issue warrants immediate corrective action or issues still exist after the identified timeframe for the technical assistance, the Division will initiate the involuntary provider disenrollment process.

16.2.1.2 Involuntary Provider Disenrollment Process

The involuntary provider disenrollment process begins with the opportunity for corrective action unless fraudulent activity or serious issues are discovered, in which case the provider may be moved to immediate sanctions and disenrollment.

16.2.1.2.1 Corrective Action

1. The Division will advise the provider of any deficiencies in writing and a corrective action response from the provider is due within 10 business days of receipt.

2. A copy of the deficiency notice will be forwarded to the Office of Provider Enrollment, Division of Medical Assistance and Health Services (DMAHS). DMAHS will forward a letter to the provider notifying them that their provider number is in jeopardy.
3. The provider will be given **up to** 90 days to implement the corrective action response. The Division will document all verbal communication during this time period and all decisions, direction, and mandates will be documented via written communication.
4. If the provider fails to implement the corrective action plan either timely, or to the satisfaction of the Division, the Director of the Waiver and Quality Unit (DDD) and the Office of Provider Enrollment (DMAHS) will be notified in writing by the Division designated staff coordinating agency approvals and the decision to move the provider to suspension and/or disenrollment will be made.
5. Providers that do not comply with timeline requirements and Corrective Action requirements should expect sanctions, up to and including, Division recommendation for closure.

16.2.1.2.2 Sanctions

1. Sanctions to the provider may include limiting the location of service, including any expansion; limiting the acuity level of individuals served; a reduction of census; and/or suspension of claiming ability for all or particular services.
2. Providers are expected to continue to provide services to individuals unless the Division or Medicaid determines otherwise. In situations where services will cease during the provider's sanction, the individual's Support Coordinator will be notified by the Division to assist in transitioning to a new provider.
3. The Division will sanction a provider via written notice within ten (10) days of the effective date.

16.2.1.2.2.1 Suspensions

- Notices for suspension of payments will advise the following:
 - a) Effective date suspension is imposed;
 - b) Reasons for the suspension or a statement declining to give such reasons and setting forth the Division's position regarding the suspension;
 - c) State that the suspension is for a temporary period pending the completion of an investigation and any legal proceedings that may ensue; and
 - d) An opportunity for a hearing if so requested.
- If legal proceedings do not commence or the suspension is not removed within 60 days of the date of notice, the provider will be given a statement with the above information for continuation of the suspension. Where a suspension by one Division has been the basis for suspension by another Division, the latter shall note that fact as a reason for its suspension.
- A suspension shall not continue beyond 18 months from its effective date unless civil or criminal action regarding the alleged violation has been initiated within that period, or unless disenrollment action has been initiated. The suspension may continue until the legal proceedings are completed.
- A suspension may include all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances.
- The Division will notify the Office of Provider Enrollment, DMAHS, of the suspension and whether the intent is to also impose pre-pay status for the course of the suspension or some other determined time-period. Pre-pay status allows for submission of claims during the suspension time with retroactive payments once the outcome of the provider is determined.

16.2.1.2.3 Disenrollment

1. The provider will be advised by the Office of Provider Enrollment, DMAHS, of the following in a notice for disenrollment:
 - a) Reason for the disenrollment;
 - b) Provider's right to request an appeal with timeframes and procedures;
 - c) Effective date of the impending disenrollment; and/or
 - d) That a request for an appeal of the decision for disenrollment does not preclude the determined disenrollment from being implemented.

2. The provider may be required to participate in a plan for transition of services – including return of individual files – as defined by the Division, and once the transfer is complete, Medicaid will close the provider number.
3. The Office of Provider Enrollment at DMAHS will copy the Division on the notice for the provider disenrollment and terms.

16.2.1.3 Appeals & Reinstatement

16.2.1.3.1 Appeals Process

1. A provider may be granted a hearing because of the denial of a prior authorization request or issues involving the provider's status, for example, suspension, disenrollment, and other status, as described in *NJAC 10:49-11.1*, or issues arising out of the claims payment process (*NJAC 10:49-9.14*).
2. The Office of Provider Enrollment, DMAHS, will notify the provider in writing of the disenrollment stating the reason and referencing the violation as stated in either of the Provider Agreements or state regulation and a copy will be sent to the Division. In the case of suspension, the Division will notify the provider in writing.
3. The provider has 20 days from the date of the letter to contact the Office of Legal & Regulatory Affairs by certified and regular mail of their intent to appeal. The address for the Office of Legal & Regulatory Affairs is included in the disenrollment notice.

16.2.1.3.2 Reinstatement

1. Reinstatement of a provider will occur per Medicaid policies and procedures.
2. If reinstated, the provider may receive retroactive payment for services provided per Medicaid decision.

16.3 Disenrollment Communication

During a time of disenrollment transition, whether voluntary or involuntary, or under a corrective action plan, providers must agree to the following:

- The service provider or Support Coordination Agency may not notify individuals served or send letters, notification, or other communication without prior authorization from the Division. This *excludes* communication related to individual monitoring, plan development/revisions, service plan specifics, or the individual's health or safety. Any communication regarding the presence or status of corrective action plans or potential disenrollment of the agency is strictly prohibited.
- Due to the stricter provisions of conflict-free requirements for Support Coordination Agencies, an individual's information may not be shared with other Support Coordination Agencies for the express purpose of marketing or referral of services, even with the individual's consent. In addition, Support Coordination Agencies in the process of disenrollment are prohibited from involvement in the new Support Coordination Agency selection process for the individuals affected. The Division will provide all communication regarding disenrollment, choice of agency, and process to individuals and/or families directly.
- In the event of service providers who communicate service options to individuals upon disenrollment, individuals must always be notified of choice of agency in any communication.

17 SUPPORTS PROGRAM SERVICES

The services available through the Supports Program are as follows:

- Assistive Technology
- Behavioral Supports
- Career Planning
- Cognitive Rehabilitation
- Community Based Supports
- Community Inclusion Services
- Day Habilitation
- Environmental Modifications
- Goods & Services
- Interpreter Services
- Natural Supports Training
- Occupational Therapy
- Personal Emergency Response System (PERS)
- Physical Therapy
- Prevocational Training
- Respite
- Speech, Language, and Hearing Therapy
- Support Coordination*
- Supported Employment – Individual Employment Support
- Supported Employment – Small Group Employment Support
- Supports Brokerage
- Transportation
- Vehicle Modification

****Please note – Support Coordination services are administrative in nature and are not funded through the individualized budget. They are not included under “services” in the ISP.***

This section provides service descriptions, limitations, qualifications, and standards for each service.

Services typically are delivered one at a time and cannot be delivered concurrently (during the same period of time). For a list of exceptions where certain services are permitted to be delivered and claimed for concurrently, please see Appendix K: Quick Reference Guide to Overlapping Claims for Supports Program Services. As with all CCP services, the need for the overlapping service must be a documented need of the individual, memorialized in the ISP, prior authorized and related to an ISP outcome.

A Direct Support Professional and/or Self-Directed Employee may not to be regularly scheduled to work more than 16 consecutive hours in a 24-hour period.

17.1 Assistive Technology

Procedure Codes	Units	Additional Descriptor	Budget Component
T2028HI	Single	Evaluation	Individual/Family Supports
T2028HI22	Single	Purchase, Customize, Repair, Replace, Train	Individual/Family Supports
T2029HI	Single	Remote Monitoring	Individual/Family Supports

Please refer to Appendix H for current rates.

17.1.1 Description

Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes: (A) the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; (B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants; (C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; (D) ongoing maintenance fees to utilize the assistive technology (e.g., remote monitoring devices); (E) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the Service Plan; (F) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and (G) training or technical assistance for professionals or other individuals who provide services to, or who are employed by participants.

17.1.2 Service Limits

All Assistive Technology services and devices shall meet applicable standards of manufacture, design and installation and are subject to prior approval on an individual basis by the Division. Prior approval will be based on the functional evaluation as described above. Items covered by the Medicaid State Plan cannot be purchased through this service.

17.1.3 Provider Qualifications

All providers of Assistive Technology services must comply with the standards set forth in this manual.

In addition, AT providers must meet at least one of the following:

- Occupational Therapists must be licensed per N.J.A.C. 13:44K -OR-
- Physical Therapists must be licensed per N.J.A.C. 13:39A -OR-
- Speech/Language Pathologist must be licensed per N.J.A.C. 13:44C -OR-
- Assistive Technology Specialist, bachelor's degree in technical services or rehabilitation services related field and a minimum of 1-year working with individuals with ID/DD and is certified by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)

In addition AT Vendors/Business Entities must:

- Be an established business as a medical supplier or assistive technology supplier in New Jersey -or-
- Have license, certification, registration, or authorization from the New Jersey Department of Consumer Affairs or any other endorsing entity and Liability Insurance -or-
- Be an out-of-state medical or assistive technology supplier who is an approved Medicaid provider in their state of residence

17.1.4 Examples of Assistive Technology Activities

*Please note that examples are not all inclusive of everything that can be funded through this service

- Evaluation of AT or environmental modification needs
- Purchasing, leasing, acquiring AT
- Designing, fitting, customizing devices
- Repairing or replacing devices
- Ongoing maintenance fees
- Training or technical assistance for the individual, family, guardians, professionals, etc. to use the technology

17.1.5 Assistive Technology Policies/Standards

In addition to the standards set forth in this manual, the service provider and staff must comply with relevant licensing and/or certification standards.

17.1.5.1 Need for Service and Process for Choice of Provider

The need for Assistive Technology will be identified through the NJ Comprehensive Assessment Tool (NJ CAT) and the person-centered planning process documented in the Person-Centered Planning Tool (PCPT). In addition, the following steps must be completed in order to access Assistive Technology:

- The Support Coordinator will assist the individual in identifying an approved Assistive Technology provider to conduct an evaluation;
- The Support Coordinator will submit a request to conduct the Assistive Technology evaluation through iRecord for Division review and approval;
- If an AT evaluation has already been conducted (through school, for example), the Support Coordinator should include that information within the details of the submitted request and upload the evaluation into the “Documents” tab;
- The Division will review the evaluation request and provide a determination. The determination may be to skip the evaluation if needed information is already available (through a previous evaluation, for example).
- If “approved,” by the Division, the Support Coordinator will add Assistive Technology to the ISP and utilize the Assistive Technology Evaluation procedure code (T2028HI).
- Upon approval of the ISP, the Assistive Technology provider conducts the evaluation as prior authorized and submits the completed evaluation and supporting documents to the Support Coordinator.
- Once the evaluation has been completed (or if the evaluation step has been skipped as approved by the Division), the Support Coordinator will submit a request for the Division to review and approve the Assistive Technology itself.
- Once the Assistive Technology is approved, the Support Coordinator will add Assistive Technology to the ISP using procedure code T2028HI22 (purchase, customize, repair, train).
- The Assistive Technology provider will render services as prior authorized by the approved ISP and claim to Medicaid (if a Medicaid provider) or submit an invoice to the Fiscal Intermediary (if not a Medicaid provider).

Questions or concerns that are related to this process can be directed to the Service Approval Help Desk at DDD.ServiceApprovalHelpdesk@dhs.nj.gov.

17.1.5.2 Documentation & Recordkeeping

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, and number of units of the delivered service for each individual and must align with the prior authorization received for the provision of services.

17.2 Behavioral Supports

Procedure Codes	Units	Additional Descriptor	Budget Component
H0004HI22	15 minutes	Assessment/Plan Development	Either
H0004HI	15 minutes	Monitoring	Either

Please refer to Appendix H for current rates.

17.2.1 Description

Individual and/or group counseling, behavioral interventions, diagnostic evaluations or consultations related to the individual's developmental disability and necessary for the individual to acquire or maintain appropriate interactions with others provided by the Behavior Supports provider at the Assessment/Plan Development rate. Intervention modalities must relate to an identified challenging behavioral need of the individual. Specific criteria for remediation of the behavior shall be established. The provider(s) shall be identified in the Service Plan and shall have the minimum qualification level necessary to achieve the specific criteria for remediation. Behavioral Supports includes a complete assessment of the challenging behavior(s), development of a structured behavioral modification plan, implementation of the plan, ongoing training and supervision of caregivers and behavioral aides, and periodic reassessment of the plan.

17.2.2 Service Limits

Behavioral Supports services are offered in addition to and do not replace treatment services for behavioral health conditions that can be accessed through the State Plan/MBHO and mental health service system. Individuals with co-occurring diagnoses of developmental disabilities and mental health conditions shall have identified needs met by each of the appropriate systems without duplication but with coordination to obtain the best outcome for the individual.

17.2.3 Provider Qualifications

All providers of Behavioral Supports services must comply with the standards set forth in this manual. In addition, Behavioral Supports providers shall complete State/Federal Criminal Background checks, Central Registry checks for all staff, drug tests as applicable under Stephen Komminos' Law, and ensure that all staff successfully completes the training described in Section 17.2.5.3.

In addition, staff conducting assessments, developing behavior support plans, and evaluating their effectiveness must:

- Have demonstrated experience in positive behavior support and/or applied behavior analysis -AND-
- 1 year working with people with developmental disabilities -AND-
- Meet or be under the supervision of at least one of the following:
 - Board Certified Behavior Analyst – Doctoral (BCBA-D) -OR-
 - Board Certified Behavior Analyst (BCBA) -OR-
 - With 1 year of supervised experience working with individuals with developmental disabilities involving behavioral assessment and the development of behavior support plans:
 - Master's degree and the completion of requisite coursework from a BACB approved course sequence program -OR-
 - Clinician holding NADD Clinical certification -OR-
 - Master's or Bachelor's degree in applied behavioral analysis, psychology, special education, social work, public health counseling, or a similar degree AND under the supervision of a BCBA-D or BCBA.

In addition, staff responsible for monitoring the implementation of the behavior support plan and training/supervising caregivers must have demonstrated experience in positive behavior support and/or applied behavior analysis and 1 year working with people with developmental disabilities and meet the following criteria or be under the supervision of someone that does:

- Board Certified Assistant Behavior Analyst (BCaBA) in accordance with BACB standards -OR-

- Registered Behavior Technician (RBT) in accordance with BACB standards -OR-
- Direct Support Professional (DSP) holding NADD DSP Certification -OR-
- Bachelor's degree in applied behavior analysis, psychology, special education, social work, public health, or a similar degree

17.2.4 Examples of Behavioral Supports Activities

*Please note that examples are not all inclusive of everything that can be funded through this service

17.2.4.1 Examples of Assessment/Plan Development Activities

- Behavioral assessment
- Development of behavior support plan
- Dissemination of plan
- Initial training and supervision of caregivers
- Training, oversight, and coordination with staff performing monitoring activities
- Periodic re-training and supervision of caregivers
- Review of raw and/or aggregated data associated with plan
- Periodic reassessment of behavioral support plan
- Revision of plan when required

17.2.4.2 Examples of Monitoring Activities

- Monitoring the implementation of plan by caregivers
- Incidental correction and re-training of caregivers
- Review data collection practices for integrity

17.2.4.3 Need for Human Rights Committee (HRC) Review

The Division requires an objective review of issues that may infringe upon human or civil rights of individuals with intellectual and/or developmental disabilities through a Human Rights Committee review as outlined in Section 15.5.3 of this manual. Questions regarding this requirement can be sent to DDD.HRC@dhs.nj.gov.

17.2.5 Behavioral Supports Policies/Standards

In addition to the standards set forth in this manual, the service provider and staff must comply with relevant licensing and/or certification standards as well the requirements outlined in Division Circulars 5, 18, 19, 20, and 34.

17.2.5.1 Need for Service and Process for Choice of Provider

The need for Behavior Supports will typically be identified through the NJ Comprehensive Assessment Tool (NJ CAT) and the person-centered planning process documented in the Person-Centered Planning Tool (PCPT). Once this need is identified, an outcome related to the result(s) expected through the participation in Behavioral Supports will be included in the Individual Service Plan (ISP) and the Behavioral Supports provider will develop strategies to assist the individual in reaching the desired outcome(s). Individuals and families are encouraged to include the Behavioral Supports provider, as practicable, in the planning process to assist in identifying and developing applicable outcomes.

The Behavioral Supports provider can require/request referral information that will assist the provider in offering quality services. Once the Support Coordinator has informed the provider that the individual has selected them to provide Behavioral Supports, the provider has five (5) working days to contact the individual and/or Support Coordinator to express interest in delivering services.

Prior to service provision, consistent with Division Circular #34, providers are required to have a Division-approved Behavior Supports Policy and Procedure. The Policy should be submitted to DDD.Behavioralservices@dhs.nj.gov for approval.

The agency identified to provide this service along with details regarding the extent of the service hours, duration, frequency, etc. will be noted in the ISP providing prior authorization for the identified service provider to perform this service. A copy of the approved ISP and Service Detail Report will be provided to the identified service provider.

17.2.5.2 Minimum Staff Qualifications

The service provider shall meet the minimum staff qualifications and training set forth in this manual. Qualifications and training shall be documented either in the employment application, resume, reference check, or other personnel document(s).

17.2.5.3 Mandated Staff Training & Professional Development

The service provider shall comply with any relevant licensing and/or certification standards. Agency Trainers must have a minimum of 1 year experience in the field or 1 year experience in training. In addition, all staff providing Behavioral Supports shall successfully complete the training outlined in Appendix E: Quick Reference Guide to Mandated Staff Training.

17.2.5.4 Documentation and Reporting

Demonstration of completion of all mandated staff training must be documented through certificates of attendance/completion; sign-in sheets from the training entity, provider, or trainer; information maintained through the College of Direct Support, etc. and made available upon request of the Division.

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, and number of units of the delivered service for each individual and must align with the prior authorization received for the provision of services.

17.2.5.5 Medication Standards

If the provider is distributing medications while delivering this service, the “Medication” standards described under Day Habilitation Section 17.7.5.8 or Prevocational Training Section 17.15.5.7 (these standards are the same for both services) shall be followed.

17.2.5.6 Quality Assurance/Monitoring

The Division will conduct quality assurance and monitoring of Behavioral Supports providers in accordance with the requirements of the Supports Program Quality Plan.

17.3 Career Planning

Procedure Codes	Units	Additional Descriptor	Budget Component
H2014HI	15 minutes	NA	Either (DSP Service applies)

Please refer to Appendix H for current rates.

17.3.1 Description

Career planning is a person-centered, comprehensive employment planning and support service that provides assistance for program participants to obtain, maintain or advance in competitive employment or self-employment. It is a focused, time-limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. The outcome of this service is documentation of the participant's stated career objective and a career plan used to guide individual employment support. If a participant is employed and receiving supported employment services, career planning may be used to find other competitive employment more consistent with the person's skills and interests or to explore advancement opportunities in their chosen career.

17.3.2 Service Limits

This service is available to participants in accordance with the DDD Supports Program Policies & Procedures Manual and as authorized in their Service Plan. This service is available to participants at a maximum of 80 hours per Service Plan year. If the participant is eligible for services from the State's Division of Vocational Rehabilitation Services, these services must be exhausted before Career Planning can be offered to the participant.

17.3.3 Provider Qualifications

All providers of Career Planning services must comply with the standards set forth in this manual. In addition, all staff providing Career Planning services must be a Certified Rehabilitation Counselor (CRC), Professional Vocational Evaluator (PVE), Certified Vocational Evaluator (CVE) or Employment Specialist that has successfully completed all Division-approved training mandated for an employment specialist/job coach as further described in Section 17.3.5.5. Career Planning providers shall complete State/Federal Criminal Background checks, Central Registry checks for all staff, drug tests as applicable under Stephen Komninos' Law, and ensure staff are a minimum of 20 years of age and possess a valid driver's license and abstract (not to exceed 5 points) if driving is required.

17.3.4 Examples of Career Planning Activities

*Please note that examples are not all inclusive of everything that can be funded through this service

- Determination of career direction through interest inventories, situational assessments, etc.
- Development of a plan that states the career objective and guides individual employment support

17.3.5 Career Planning Policies/Standards

In addition to the standards set forth in this manual, the service provider and staff must comply with relevant licensing, regulatory, and/or certification standards.

17.3.5.1 Career Planning Overview

The career planning process utilizes the individual's dreams, outcomes, personal preferences, interests, and needs to help the individual figure out the types of employment they want to pursue and develop a plan to assist them in getting there. The focus of the career planning process is on identifying what the job seeker wants to do rather than a lack of skills or limitations that they may have. Upon identification of the desired employment outcome, the career plan will identify support needs necessary toward reaching that outcome. Each individual's career planning service is unique to that individual's plan and demonstrates increasing involvement in the employment market, development of community connections, and continued movement toward inclusive settings and community employment.

The goals of Career Planning services include:

- Developing a career path that leads to maintained employment in the general workforce

- Furthering an individual’s career through increased wages earned, receipt of employment benefits, increased working hours, promotions, etc.
- Increasing an individual’s satisfaction with their career direction in circumstances where the individual is unsatisfied with their current job

17.3.5.2 Best Practices in Career Planning

- Utilizing a person-centered approach to discover the individual’s likes/dislikes, job preference goals, strengths/skills, and support needs in order to develop a career plan;
- Partnering with the individual and people they already know to identify creative methods leading to the end result of employment within the career path of choice;
- Identifying a network of people/connections who can provide assistance, leads, support, etc. to accomplish employment within the career path of choice;
- Developing a written plan that will guide the individual in negotiating/meeting their needs;
- Finding a new approach to the individual’s career path; and/or
- Connecting to the individual’s community and discovering additional resources.

17.3.5.3 Need for Service and Process for Choice of Provider

Career Planning services can be provided to anyone who is unable to identify a desired career path or job and has expressed an interest to work competitively in the general workforce. The need for Career Planning services will typically be identified through the Pathway to Employment discussion that takes place annually during the person-centered planning process and is documented in iRecord and in the ISP. Once this need is identified, an outcome related to exploring career options and developing a path to competitive employment in the general workforce will be included in the Individual Service Plan (ISP) and the Career Planning provider will develop a career plan that must include, at a minimum, indication of the individual’s career goal, a detailed description/outline of how the individual is going to achieve that goal, and identification of areas where employment support may be needed.

This service can only be accessed through the Division if it is not available through the Division of Vocational Rehabilitation Services (DVRS) or Commission for the Blind & Visually Impaired (CBVI) – as documented on the Employment Determination Form - (F3) (Appendix D).

It is recommended that the individual research potential service providers through phone calls, meetings, office visits, etc. to select the service provider that will best meet their needs.

The Career Planning service provider can require/request referral information that will assist the provider in offering quality services. Once the Support Coordinator has informed the provider that the individual has selected them to provide Career Planning, the provider has five (5) working days to contact the individual and/or Support Coordinator to express interest in delivering services.

The agency identified to provide this service along with details regarding the extent of the service hours, duration, frequency, etc. will be noted in the ISP providing prior authorization for the identified service provider to perform this service. A copy of the approved ISP and the Service Detail Report will be provided to the identified service provider.

17.3.5.4 Minimum Staff Qualifications

The service provider shall meet the minimum staff qualifications and training set forth in this manual. Qualifications and training shall be documented either in the employment application, resume, reference check, or other personnel document(s).

17.3.5.4.1 All Staff

- Minimum 20 years of age; – AND –
- Complete State/Federal Criminal Background checks and Central Registry checks;
- Valid driver’s license and abstract (not to exceed 5 points) if driving is required.

17.3.5.4.2 Executive Director or Equivalent

- Bachelor's Degree; - OR -
- High school diploma and 5 years' experience working with people with developmental disabilities, two of which shall have been supervisory in nature.

17.3.5.4.3 Program Management Staff/Supervisors

- Graduated from an accredited college or university with a Bachelor's degree, or higher, in Education, Social Work, Psychology or related field, plus one (1) year of successful experience in human services or employment services, **or**
- Graduated from an accredited college with an Associate's degree, plus two (2) years of successful experience in human services, **or**
- Graduated with a high school diploma or equivalent and five (5) years of experience in occupational areas similar to those being offered at the program. A combination of college or technical school may be substituted for experience on a year for year basis.
- Have a clear understanding of the demands and expectations in business and industry.

17.3.5.4.4 Certified Rehabilitation Counselors (CRC), Professional Vocational Evaluator (PVE), Certified Vocational Evaluator (CVE), or Employment Specialist

- Education level necessary to maintain CRC, PVE, or CVE status;
- Have an Associate's degree or higher in a related field from an accredited college or university or have a high school diploma or equivalent with three (3) years of related experience;
- Be familiar with the demands and expectations of business and industry.

17.3.5.5 Mandated Staff Training & Professional Development

The service provider shall comply with any relevant licensing and/or certification standards. Agency Trainers must have a minimum of 1 year experience in the field or 1 year experience in training. All staff providing Career Planning services shall successfully complete the training outlined in Appendix E: Quick Reference Guide to Mandated Staff Training.

17.3.5.6 Documentation & Reporting

Demonstration of completion of all mandated staff training must be documented through certificates of attendance/completion; sign-in sheets from the training entity, provider, or trainer; information maintained through the College of Direct Support, etc. and made available upon request of the Division.

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, and number of units of the delivered service for each individual and must align with the prior authorization received for the provision of services.

Career Planning services must result in an individualized written career plan. The Career Planning provider can develop the preferred format for this plan but must include, at a minimum, indication of the individual's career goal, a detailed description/outline of how the individual is going to achieve that goal, and identification of areas where employment support may be needed.

17.3.5.7 Medication Standards

If the provider is distributing medications while delivering this service, the "Medication" standards described under Day Habilitation Section 17.7.5.8 or Prevocational Training Section 17.15.5.7 (these standards are the same for both services) shall be followed.

17.3.5.8 Quality Assurance and Monitoring

The Division will conduct quality assurance and monitoring of Career Planning providers in accordance with the requirements of the Supports Program Quality Plan.

17.4 Cognitive Rehabilitation

Procedure Codes	Units	Additional Descriptor	Budget Component
97532HI	15 minutes	NA	Individual/Family Supports

Please refer to Appendix H for current rates.

17.4.1 Description

A systematic, functionally-oriented service of therapeutic cognitive activities, based on an assessment and understanding of the person's brain behavior deficits. Services are directed to achieve functional changes: by (1) reinforcing, strengthening or re-establishing previously learned patterns of behavior, or (2) establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Therapeutic interventions include but are not limited to direct retraining, use of compensatory strategies, use of cognitive orthotics and prostheses. Activity type and frequency are determined by assessment of the participant, the development of a treatment plan based on recognized deficits, and periodic reassessments. Cognitive therapy can be provided in the individual's home or community settings.

17.4.2 Service Limits

Daily limits as delineated by the participant's Service Plan. Frequency and duration of service must be supported by assessment and included in the participant's Service Plan. CRT may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants. Both group and individual sessions may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the participant's clinical record. This service must be coordinated and overseen by a CRT provider holding at least a master's degree. All individuals who provide or supervise the CRT service must complete six hours of relevant ongoing training in CRT and or brain injury rehabilitation. Training may include, but is not limited to, participation in seminars, workshops, conferences, and in-services.

17.4.3 Provider Qualifications

All providers of Cognitive Rehabilitation services must comply with the standards set forth in this manual. In addition, Cognitive Rehabilitation providers shall complete State/Federal Criminal Background checks and Central Registry checks for all staff, drug tests as applicable under Stephen Komninos' Law, and ensure that all staff successfully completes the Division mandated training.

In addition, staff providing Cognitive Rehabilitation services must meet the following:

- Certified Brain Injury Specialist (CBIS) through the Academy of Certified Brain Injury Specialists (ACBIS) – AND –
- Complete 6 hours of relevant ongoing training on Cognitive Rehabilitation Therapy or brain injury rehabilitation - AND - at least one of the following:
 - Master's degree in an allied health field from an accredited institution where the degree is a prerequisite for licensure or certification
 - Bachelor's degree in an *allied rehabilitation field from an accredited institution where the degree is sufficient for licensure, certification or registration
 - Master's or Bachelor's degree in an *allied rehabilitation field from an accredited institution where the degree is insufficient for licensure, certification, or registration or when such is not available must be supervised by a qualified professional

*Applicable allied rehabilitation degree programs include: counseling, education, medicine, neuropsychology, OT, PT, psychology, recreation therapy, social work, special education and speech-language pathology.

Supervisors of Cognitive Rehabilitation Services must meet at least one of the following:

- Cognitive Rehabilitation Therapy providers holding at least a Master's degree
- Certification by the Society for Cognitive Rehabilitation

- Rehabilitation professional that is licensed or certified

17.4.4 Examples of Cognitive Rehabilitation Activities

*Please note that examples are not all inclusive of everything that can be funded through this service

- Direct retraining
- Compensatory strategies
- Cognitive orthotics and prostheses

17.4.5 Cognitive Rehabilitation policies/standards

In addition to the standards set forth in this manual, Cognitive Rehabilitative services must be performed under the guidelines described in the New Jersey practice arts for occupational and physical therapists

17.4.5.1 Need for Service and Process for Choice of Provider

To access Cognitive Rehabilitation services, the NJ Comprehensive Assessment Tool (NJ CAT) must indicate that the individual has an acquired non-degenerative or traumatic brain injury and an appropriate medical prescription must be obtained. In addition, the following steps must be completed in order to access Cognitive Rehabilitation:

- The Support Coordinator uploads a copy of the medical prescription to iRecord
- The individual/family reaches out to the primary insurance carrier to request Cognitive Rehabilitation therapy
- If the primary insurance carrier approves the Cognitive Rehabilitation, the individual will access this therapy through their primary insurer and follow the process required by that insurer
- If the primary insurer denies the Cognitive Rehabilitation therapy, the individual will receive (or must request) a denial letter or Explanation of Benefits (EOB) document
- The individual will submit the primary insurer’s denial letter or EOB to the Support Coordinator
- The Support Coordinator will upload the denial letter or EOB to iRecord and assist the individual in identifying providers of Cognitive Rehabilitation therapy
- The Support Coordinator will include Cognitive Rehabilitation in the ISP as is done for other services
- When the ISP is approved, the prior authorization will be emailed to the provider and the Support Coordinator will submit the denial letter or EOB from the primary carrier to the service provider that has been identified in the ISP to provide Cognitive Rehabilitation
- The prior authorized service provider (identified in the ISP) will request the “Bypass Letter Request Form” from OSC.tplunit@osc.nj.gov
- The service provider completes the Bypass Letter Request Form, attaches the explanation of benefits (EOB) for the denied service (either for exhausted benefits or non-coverage), and submits the documents to the OSC
- Staff at the OSC will review the information and issue a Bypass Letter if appropriate
- The service provider will submit claims for rendered services along with the Bypass Letter to Gainwell Technologies for payment

17.4.5.2 Documentation & Recordkeeping

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, and number of units of the delivered service for each individual and must align with the prior authorization received for the provision of services.

17.4.5.3 Medication Standards

If the provider is distributing medications while delivering this service, the “Medication” standards described under Day Habilitation Section 17.7.5.8 or Prevocational Training Section 17.15.5.7 (these standards are the same for both services) shall be followed.

17.5 Community Based Supports

Procedure Codes	Units	Additional Descriptor	Budget Component
H2021HI	15 minutes	Base	Either (DSP Service applies)
H2021HI22	15 minutes	Acuity	Either (DSP Service applies)
H2021HI52	15 minutes	Self-Directed Employee	Either (DSP Service applies)

Please refer to Appendix H for current rates.

17.5.1 Description

Services that provide direct support and assistance for participants, with or without the caregiver present, in or out of the participant's residence, to achieve and/or maintain the outcomes of increased independence, productivity, enhanced family functioning, and inclusion in the community, as outlined in their Service Plan. Community-Based Supports are delivered one-on-one with a participant and may include: assistance with community-based activities and assistance to, as well as training and supervision of, individuals as they learn and perform the various tasks that are included in basic self-care, social skills, and activities of daily living.

17.5.2 Service Limits

Self-directed employees providing Community Based Support Services may be members of a participant's family provided the family member has met the same standards as providers who are unrelated to the individual.

For information on determining the Reasonable and Customary Wage for an SDE please review section **8.3.2.0.1 – Establishing a Self-Directed Employee (SDE) Hourly Wage Where the Direct Support Professional Service Applies.**

17.5.3 Provider Qualifications

All providers of Community Based Supports must comply with the standards set forth in this manual. In addition, Community Based Supports providers shall complete State/Federal Criminal Background checks and Central Registry checks for all staff, drug tests as applicable under Stephen Komminos' Law, and ensure that all staff successfully completes the Division mandated training, are a minimum of 18 years of age, and possess a valid driver's license and abstract (not to exceed 5 points) if driving is required.

If the Community Based Supports provider is a Home Health Agency or Health Care Service Firm, they must meet the following additional license or accreditation requirements:

- Licensed per N.J.A.C. 8:42 and Certified by the Centers for Medicare and Medicaid Services -OR-
- Accredited by one of the following:
 - New Jersey Commission on Accreditation for Home Care Inc. (CAHC)
 - Community Health Accreditation Program (CHAP)
 - Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
 - National Association for Home Care and Hospice (NAHC)
 - National Institute for Home Care Accreditation (NIHCA)

17.5.4 Examples of Community Based Supports Activities

*Please note that examples are not all inclusive of everything that can be funded through this service

- Support from staff to enable an individual to attend an event, take a class, etc.
- Support from staff to assist an individual participating in activities such as: assistance in completing activities of daily living, ordering off a menu, purchasing items, learning basic cooking, laundry skills, etiquette, travel training, accessing activities in the community, etc.
- One-on-one tutoring
- Support on a job site to assist in basic self-care, social skills, and activities of daily living.
 - **Please note that Community Based Supports can be used in addition to but cannot replace Supported Employment services (such as job coaching). Supported Employment services must be*

provided in accordance with the standards described in Section 17.20 by professionals who have completed the Employment Specialist/Job Coach series of trainings. For example, Community-Based Supports can be provided to assist an individual on a job site with safety awareness, remaining focused on work tasks, self-care needs, eating lunch, etc., but cannot assist the individual or their supervisor in learning work tasks, setting up accommodations to complete work tasks, or the training associated with learning new aspects of their job duties. Those activities must be conducted by an appropriately qualified and approved Supported Employment provider.

17.5.5 Community Based Supports Policies/Standards

In addition to the standards set forth in this manual, the service provider and staff must support and implement individual behavior plans, as applicable, and comply with relevant licensing and/or certification standards.

17.5.5.1 Need for Service and Process for Choice of Provider

The need for Community Based Supports will typically be identified through the NJ Comprehensive Assessment Tool (NJ CAT) and the person-centered planning process documented in the Person-Centered Planning Tool (PCPT). Once this need is identified, an outcome related to the result(s) expected through the participation in Community Based Supports will be included in the Individual Service Plan (ISP) and the Community Based Supports provider will develop strategies to assist the individual in reaching the desired outcome(s). Individuals and families are encouraged to include the Community Based Services provider in the planning process to assist in identifying and developing applicable outcomes.

It is recommended that the individual research potential service providers through phone calls, meetings, visits, etc. to select the service provider that will best meet their needs.

The Community Based Supports provider can require/request referral information that will assist the provider in offering quality services. Once the Support Coordinator has informed the provider that the individual has selected them to provide Community Based Supports, the provider has five (5) working days to contact the individual and/or Support Coordinator to express interest in delivering services.

The agency identified to provide this service along with details regarding the extent of the service hours, duration, frequency, etc. will be noted in the ISP providing prior authorization for the identified service provider to perform this service. A copy of the approved ISP and Service Detail Report will be provided to the identified service provider.

17.5.5.2 Minimum Staff Qualifications

The service provider shall meet the minimum staff qualifications and training set forth in this manual. Qualifications and training shall be documented either in the employment application, resume, reference check, or other personnel document(s).

- Minimum 18 years of age – AND –
- Complete State/Federal Criminal Background checks and Central Registry checks
- Valid driver's license and abstract (not to exceed 5 points) if driving is required

17.5.5.3 Mandated Staff Training & Professional Development

The service provider shall comply with any relevant licensing and/or certification standards. Agency Trainers must have a minimum of 1 year experience in the field or 1 year experience in training. All staff providing Community Based Supports shall successfully complete the training outlined in Appendix E: Quick Reference Guide to Mandated Staff Training.

17.5.5.4 Documentation and Reporting

Demonstration of completion of all mandated staff training must be documented through certificates of attendance/completion; sign-in sheets from the training entity, provider, or trainer; information maintained through the College of Direct Support, etc. and made available upon request of the Division. Supervisors shall conduct and document use of competency and performance appraisals in the content areas addressed through mandated training.

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, and number of units of the delivered service for each individual and must align with the prior authorization received for the provision of services.

17.5.5.4.1 Community Based / Individual Supports Log

The provider of Community Based Supports, in collaboration with the individual, must indicate the strategies the Community Based Supports provider will be using to assist the individual in reaching their outcome(s) indicated in the ISP. These strategies along with information about individualized activities experienced during service delivery and progress toward the individual's related outcome(s) must be indicated on the Community Based / Individual Supports Log available in Appendix D.

17.5.5.5 Medication Standards

If the provider is distributing medications while delivering this service, the "Medication" standards described under Day Habilitation Section 17.7.5.8 or Prevocational Training Section 17.15.5.7 (these standards are the same for both services) shall be followed.

17.5.5.6 Quality Assurance/Monitoring

The Division will conduct quality assurance and monitoring of Community Based Supports providers in accordance with the requirements of the Supports Program Quality Plan.

17.6 Community Inclusion Services

Procedure Codes	Units	Additional Descriptor	Budget Component
H2015HIU1	15 minutes	Tier A	Either (DSP Service applies)
H2015HIU2	15 minutes	Tier B	Either (DSP Service applies)
H2015HIU3	15 minutes	Tier C	Either (DSP Service applies)
H2015HIU4	15 minutes	Tier D	Either (DSP Service applies)
H2015HIU5	15 minutes	Tier E	Either (DSP Service applies)

Please refer to Appendix H for current rates.

17.6.1 Description

Services provided outside of a participant's home that support and assist participants in educational, enrichment or recreational activities as outlined in their Service Plan that are intended to enhance inclusion in the community. Community Inclusion Services are delivered in a group setting not to exceed six (6) individuals.

17.6.2 Service Limits

Community Inclusion Services are limited to 30 hours per week. Transportation to or from a Community Inclusion Service site is not included in the service.

17.6.3 Provider Qualifications

All providers of Community Inclusion Services must comply with the standards set forth in this manual. In addition, all Community Inclusion Services providers shall complete State/Federal Criminal Background checks and Central Registry checks for all staff, drug tests as applicable under Stephen Komminos' Law, and ensure that all staff successfully completes the Division mandated training, are a minimum of 18 years of age, and possess a valid driver's license and abstract (not to exceed 5 points) if driving is required.

If the Community Inclusion Services provider is a Home Health Agency or Health Care Service Firm, they must meet the following additional license or accreditation requirements:

- Licensed per N.J.A.C. 8:42 and Certified by the Centers for Medicare and Medicaid Services; -OR-
- Accredited by one of the following:
 - New Jersey Commission on Accreditation for Home Care Inc. (CAHC).
 - Community Health Accreditation Program (CHAP).
 - Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
 - National Association for Home Care and Hospice (NAHC).
 - National Institute for Home Care Accreditation (NIHCA).

17.6.4 Examples of Community Inclusion Services Activities

*Please note that examples are not all inclusive of everything that can be funded through this service

- Small group outings to community festivals, museums, book clubs, theater groups, cultural events, holiday celebrations, sporting events, etc.
- Small group leisure activities in the community
- Small group educational activities in the community

17.6.5 Community Inclusion Services Policies/Standards

In addition to the standards set forth in this manual, the service provider and staff must support and implement individual behavior plans, as applicable, and comply with relevant licensing and/or certification standards.

17.6.5.1 Need for Service and Process for Choice of Provider

The need for Community Inclusion Services will typically be identified through the NJ Comprehensive Assessment Tool (NJ CAT) and the person-centered planning process documented in the Person-Centered Planning Tool

(PCPT). Once this need is identified, an outcome related to the result(s) expected through the participation in Community Inclusion Services will be included in the Individual Service Plan (ISP) and the Community Inclusion Services provider will develop strategies to assist the individual in reaching the desired outcome(s). Individuals and families are encouraged to include the Community Inclusion Services provider in the planning process to assist in identifying and developing applicable outcomes.

It is recommended that the individual research potential service providers through phone calls, meetings, visits, etc. to select the service provider that will best meet their needs.

The Community Inclusion Services provider can require/request referral information that will assist the provider in offering quality services. Once the Support Coordinator has informed the provider that the individual has selected them to provide Community Inclusion Services, the provider has five (5) working days to contact the individual and/or Support Coordinator to express interest in delivering services.

The agency identified to provide this service along with details regarding the extent of the service hours, duration, frequency, etc. will be noted in the ISP providing prior authorization for the identified service provider to perform this service. A copy of the approved ISP and Service Detail Report will be provided to the identified service provider.

17.6.5.2 Minimum Staff Qualifications

The service provider shall meet the minimum staff qualifications and training set forth in this manual. Qualifications and training shall be documented either in the employment application, resume, reference check, or other personnel document(s).

- Minimum 18 years of age; – AND –
- Complete State/Federal Criminal Background checks and Central Registry checks;
- Valid driver's license and abstract (not to exceed 5 points) if driving is required.

17.6.5.3 Mandated Staff Training & Professional Development

The service provider shall comply with any relevant licensing and/or certification standards. Agency Trainers must have a minimum of 1 year experience in the field or 1 year experience in training. All staff providing Community Inclusion Services shall successfully complete the training outlined in Appendix E: Quick Reference Guide to Mandated Staff Training.

17.6.5.4 Documentation and Reporting

Demonstration of completion of all mandated staff training must be documented through certificates of attendance/completion; sign-in sheets from the training entity, provider, or trainer; information maintained through the College of Direct Support, etc. and made available upon Division request. Supervisors shall conduct and document use of competency and performance appraisals in the content areas addressed through mandated training.

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, and number of units of the delivered service for each individual and must align with the prior authorization received for the provision of services.

Standardized documents are available in Appendix D. Providers using an electronic health record (EHR) or billing system that cannot duplicate these standardized documents will remain in compliance if all the information required on these documents is captured somewhere and can be shown/reviewed during an audit.

17.6.5.4.1 Community Inclusion Services – Individualized Goals

The provider of Community Inclusion Services, in collaboration with the individual, must develop strategies for each personally defined outcome related to the Community Inclusion Services that the service provider has been chosen to provide as indicated in the ISP. These strategies must be completed within 15 business days of the date the individual begins to receive Community Inclusion Services from the provider and must be documented on the Community Inclusion Services – Individualized Goals document. Strategies must be revised any time there is a

modification to the ISP that changes the service specific outcome(s) and when the annual ISP is approved. These strategy revisions must be completed within 15 business days of the ISP modification or approval of the annual ISP.

17.6.5.4.2 Community Inclusion Services – Activities Log

The Community Inclusion Services provider will complete the Community Inclusion Services – Activities Log on each date services are delivered to indicate which strategies were addressed that day and provide a notation of activities done to address the strategy and what occurred that day as these activities were conducted.

17.6.5.4.3 Community Inclusion Services – Annual Update

On an annual basis, according to the individual’s ISP plan year, the Community Inclusion Services provider will provide a summary of that year’s services by completing the Annual Update. This annual documentation will assist in the development of the ISP for the upcoming year.

17.6.5.5 Medication Standards

If the provider is distributing medications while delivering this service, the “Medication” standards described under Day Habilitation Section 17.7.5.8 or Prevocational Training Section 17.15.5.7 (these standards are the same for both services) shall be followed.

17.6.5.6 Quality Assurance/Monitoring

The Division will conduct quality assurance and monitoring of Community Inclusion providers in accordance with the requirements of the Supports Program Quality Plan.

17.7 Day Habilitation

Procedure Codes	Units	Additional Descriptor	Budget Component
T2021HIUS	15 minutes*	Tier A	Employment/Day (DSP Service applies)
T2021HIU1	15 minutes*	Tier A/Acuity Differentiated	Employment/Day (DSP Service applies)
T2021HIUR	15 minutes*	Tier B	Employment/Day (DSP Service applies)
T2021HIU2	15 minutes*	Tier B/Acuity Differentiated	Employment/Day (DSP Service applies)
T2021HIUQ	15 minutes*	Tier C	Employment/Day (DSP Service applies)
T2021HIU3	15 minutes*	Tier C/Acuity Differentiated	Employment/Day (DSP Service applies)
T2021HIUP	15 minutes*	Tier D	Employment/Day (DSP Service applies)
T2021HIU4	15 minutes*	Tier D/Acuity Differentiated	Employment/Day (DSP Service applies)
T2021HIUN	15 minutes*	Tier E	Employment/Day (DSP Service applies)
T2021HIU5	15 minutes*	Tier E/Acuity Differentiated	Employment/Day (DSP Service applies)

Please refer to Appendix H for current rates.

*A 5% absentee rate is factored into the Day Habilitation rates to account for time that individuals may not attend program.

17.7.1. Description

Services that provide education and training to acquire the skills and experience needed to participate in the community, consistent with the participant’s Service Plan. This may include activities to support participants with building problem-solving skills, self-help, social skills, adaptive skills, daily living skills, and leisure skills. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Services are provided during daytime hours and do not include employment-related training. Day Habilitation may be offered in a center-based or community-based setting.

17.7.2 Service Limits

Day Habilitation does not include services, activities or training which the participant may be entitled to under federal or state programs of public elementary or secondary education, State Plan services, or federally funded vocational rehabilitation. Day Habilitation is limited to 30 hours per week.

17.7.3 Provider Qualifications

All providers of Day Habilitation services must comply with the standards set forth in this manual. In addition, Day Habilitation providers shall complete State/Federal Criminal Background checks and Central Registry checks for all staff, drug tests as applicable under Stephen Komminos’ Law, and ensure that all staff successfully completes the Division mandated training, are a minimum of 18 years of age, and possess a valid driver’s license and abstract (not to exceed 5 points) if driving is required.

17.7.3.1 Day Habilitation Certification

All Day Habilitation service providers shall only operate after receiving a valid Day Habilitation Certification and becoming an approved Medicaid/DDD provider for Day Habilitation services.

Day Habilitation Certification is required for each specific site, is time limited, and is non-transferable.

17.7.3.1.1 Provisional Certification

Prior to submitting the Combined Application to become a Medicaid/DDD provider for Day Habilitation services, providers are required to obtain Provisional Day Habilitation Certification. This one-year certification verifies that the agency's Day Habilitation services have met the minimum requirements to provide Day Habilitation services at each location in which these services will be offered.

Prior to the expiration of the one-year provisional certification, a full audit of the provider's day habilitation services will be conducted in order to determine ongoing certification.

17.7.3.1.2 Ongoing Certification

Upon expiration of the Day Habilitation Certification, an audit of the provider's Day Habilitation services will be conducted in order to determine ongoing certification. Audits will be conducted for all sites operated by each provider. Providers will receive a day habilitation certification based on the lowest score obtained through the auditing process. Certifications will be issued as follows:

- **5 Year Certification** – All sites obtain compliance scores of 86% and above in both critical and significant standards
- **3 Year Certification** – One or more sites obtain compliance scores between 85% and 70% in critical and/or significant standards
- **Conditional Certification** – One or more sites receive compliance scores of 69% or below in critical and/or significant standards

17.7.4 Day Habilitation Activities Guidelines

The Division of Developmental Disabilities encourages best practices and engaging activities in day habilitation services (day programs) and offers the following guidance as a starting point for day habilitation service providers in planning and executing comprehensive activities in their programs.

17.7.4.1 General Guidelines

Day habilitation service providers should include activities that follow the following general guidelines:

- **Be Age-Appropriate;**
- **Offer Variety & Choice;**
- **Emphasize Community Experiences; and**
- **Focus on Small Groups and Individual Interactions and Experiences.**

17.7.4.1.1 Examples of Activities

*Please note that examples are not all inclusive of everything that can be funded through this service

Activities should be individualized based on likes, dislikes, areas of interests, desires, dreams, etc. as documented in the Person-Centered Planning Tool (PCPT). The following list is not exhaustive, but is simply to generate ideas on the types of activities that can occur and assist with the development of positive programming.

17.7.4.1.1.1 Community Experiences

Some of the following community experiences can assist in developing personal interests:

- Shopping – budgeting, money management
- Restaurants – ordering from menus, personal choices, paying the bill
- Sports/fitness events and activities
- Library, Book clubs
- Health fairs
- Museums
- Cultural events
- Travel and community safety, use of public transportation
- Theater, community concerts
- Community festivals
- Holiday celebrations

- Parks, walking, picnics
- Community gardens

17.7.4.1.1.2 Activities

- Cooking, meal preparation, food safety
- Money management
- Health, fitness
- Laundry
- Personal hygiene
- Classes on skill development
 - Advocacy
 - Assertiveness
 - Communication
 - Choices, decision-making
 - Problem-solving
 - Boundaries
 - Healthy sexuality
 - Relationship building
- Developing personal interests
 - Cards and competitive/collaborative games
 - Painting, artwork, drawing, constructing models, needlecraft, jewelry design, sculpting, woodworking, scrapbooking, photography
 - Theater, filmmaking
 - Dancing, music, playing instruments, singing
 - Horticulture, gardening, terrariums
 - Athletics, sports, fitness
 - Reading, books, poetry
 - Computer and other devices/technology, social media experience
- Current events
- Telling time
- Cleaning

17.7.5 Day Habilitation Policies/Standards

In addition to the standards set forth in this manual, the service provider and staff must support and implement individual behavior plans, as applicable, and comply with relevant licensing and/or certification standards.

17.7.5.1 Need for Service and Process for Choice of Provider

The need for Day Habilitation services will typically be identified through the NJ Comprehensive Assessment Tool (NJ CAT) and the person-centered planning process documented in the Person-Centered Planning Tool (PCPT). Once this need is identified, an outcome related to the result(s) expected through the participation in Day Habilitation services – including outcomes that may be employment-related – will be included in the Individual Service Plan (ISP) and the Day Habilitation service provider will develop strategies to assist the individual in reaching the desired outcome(s). Individuals and families are encouraged to include the Day Habilitation provider in the planning process to assist in identifying and developing applicable outcomes.

It is recommended that the individual research potential service providers through phone calls, meetings, visits, etc. to select the service provider that will best meet their needs.

The Day Habilitation service provider can require/request referral information that will assist the provider in offering quality services. Once the Support Coordinator has informed the provider that the individual has selected them to provide Day Habilitation services, the provider has five (5) working days to contact the individual and/or Support Coordinator to express interest in delivering services.

The agency identified to provide this service along with details regarding the extent of the service hours, duration, frequency, etc. will be noted in the ISP providing prior authorization for the identified service provider to perform this service. A copy of the approved ISP and Service Detail Report will be provided to the identified service provider.

17.7.5.2 Minimum Staff Qualifications

The service provider shall meet the minimum staff qualifications and training set forth in this manual. Qualifications and training shall be documented either in the employment application, resume, reference check, or other personnel document(s).

17.7.5.2.1 All Staff

- Minimum 18 years of age; – AND –
- Complete State/Federal Criminal Background checks, Child Abuse Registry Information (CARI) checks, and Central Registry checks;
- Valid driver's license and abstract (not to exceed 5 points) if driving is required.

17.7.5.2.2 Executive Director or Equivalent

- Bachelor's Degree or high school diploma (or equivalent); – AND –
- 5 years' experience working with people with developmental disabilities, 2 of which shall have been supervisory in nature.

17.7.5.2.3 Program Management Staff/Supervisors

- High school diploma or equivalent; – AND –
- 1 year experience working with people with developmental disabilities.

17.7.5.2.4 Direct Service Staff

- High school diploma or equivalent.

17.7.5.2.5 Professional Services Staff (nurses, psychologists, therapists), if applicable

- Credentials for their profession required by Federal or State law.

17.7.5.3 Mandated Staff Training & Professional Development

The service provider shall comply with any relevant licensing and/or certification standards. Agency Trainers must have a minimum of 1 year experience in the field or 1 year experience in training. All staff providing Day Habilitation services shall successfully complete the training outlined in Appendix E: Quick Reference Guide to Mandated Staff Training.

17.7.5.4 Documentation and Reporting

Demonstration of completion of all mandated staff training must be documented through certificates of attendance/completion; sign-in sheets from the training entity, provider, or trainer; information maintained through the College of Direct Support, etc. and made available upon request of the Division. Supervisors shall conduct and document use of competency and performance appraisals in the content areas addressed through mandated training.

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, and number of units of the delivered service for each individual and must align with the prior authorization received for the provision of services.

Standardized documents are available in Appendix D. Providers using an electronic health record (EHR) or billing system that cannot duplicate these standardized documents will remain in compliance if all the information required on these documents is captured somewhere and can be shown/reviewed during an audit.

17.7.5.4.1 Day Habilitation – Individualized Goals

The provider of Day Habilitation services, in collaboration with the individual, must develop strategies to assist the individual in reaching the outcome(s) related to the Day Habilitation services that the service provider has been chosen to provide as indicated in the ISP. While Centers for Medicare & Medicaid Services (CMS) guidance states that “day habilitation may not provide for the payment of services that are vocational in nature (i.e., for the primary purpose of producing goods or performing services),” Day Habilitation strategies can be designed to assist in progressing toward employment-related outcomes by providing education and training to acquire skills and experience that will potentially lead to the individual participating in the workforce (examples may include but are not limited to strategies to build social skills, address personal grooming concerns, increase attention to tasks, follow directions, etc.). These strategies must be completed within 15 business days of the date the individual begins to receive Day Habilitation services from the provider and must be documented on the Day Habilitation Individualized Goals Log. Strategies must be revised any time there is a modification to the ISP that changes the service specific outcome(s) and when the annual ISP is approved. These strategy revisions must be completed within 15 business days of the ISP modification or approval of the annual ISP.

17.7.5.4.2 Day Habilitation – Activities Log

The Day Habilitation provider will complete the Day Habilitation – Activities Log on each date services are delivered to indicate which strategies were addressed that day and provide a notation of activities done to address the strategy and what occurred that day as these activities were conducted.

17.7.5.4.3 Day Habilitation – Annual Update

On an annual basis, according to the individual’s ISP plan year, the Day Habilitation provider will provide a summary of that year’s services by completing the Annual Update. This annual documentation will assist in the development of the ISP for the upcoming year.

17.7.5.5 Service Settings

When day habilitation activities are being conducted in a center, the following standards must be met for the building (site):

- Day Habilitation services shall take place in a non-residential setting and separate from any home or facility in which any individual resides;
- The service provider shall comply with all local, municipal, county, and State codes;
- The Certificate of Continued Occupancy (CCO) or Certificate of Occupancy (CO) or other documentation issued by local authority shall be available on site and a copy shall be posted;
- The service provider shall be in compliance with the Americans with Disabilities Act (ADA) requirements;
- Municipal fire safety inspections shall be conducted consistent with local code and maintained on file;
- Exit signs shall be posted over all exits;
- The site shall have a fire alarm system appropriate to the population served;
- The site shall have sufficient ventilation in all areas;
- The site shall have adequate lighting;
- The facility shall be maintained in a clean, safe condition, to include internal and external structure;
 - Aisles, hallways, stairways, and main routes of egress shall be clear of obstruction and stored material;
 - Floors and stairs shall be free and clear of obstruction and slip resistant;
 - Equipment, including appliances, machinery, adaptive equipment, assistive devices, etc. shall be maintained in safe working order;
 - Adequate sanitary supplies shall be available including soap, paper towels, toilet tissue.
- The service provider shall ensure that health and sanitation provisions are made for food preparation and food storage;
 - The service shall maintain appropriate local or county Department of Health certificates, where appropriate.
- Prior to relocating a site used to provide Day Habilitation services, potential sites must be reviewed and approved by the Division. Requests for site review and approval shall be directed through the Division designee.

17.7.5.6 Medical/Behavioral

17.7.5.6.1 Individual Medical Restrictions/Special Instructions

Individuals receiving day habilitation services may have a variety of medical restrictions or special instructions related to their health and safety. Information about these restrictions or special instructions shall be included in the Individualized Service Plan, shared with identified service providers, and documented in the individual file.

Day Habilitation service providers shall:

- Maintain current documentation of medical restrictions or special instructions within the individual file and on the emergency card;
- Ensure that all personnel understand, follow, and are trained as needed in all medical restrictions or special instructions associated with the individuals receiving services;
- Comply with N.J.A.C. 10:42, Division Circular #20 “Mechanical Restraint & Safeguarding Equipment” when utilizing safeguarding equipment (e.g. braces, thoracic jackets, splints, etc.) necessary to achieve proper body position and balance; and
- Adhere to any special dietary and/or texture requirements (e.g. feeding techniques, consistency of foods, the use of prescribed feeding equipment, level of supervision needed when eating, etc.) as ordered by the physician and/or documented in the ISP.

17.7.5.6.2 Illness/Contagious Conditions

- If an individual arrives for day habilitation services in apparent ill health or becomes ill during day habilitation service hours, the service provider shall:
 - Require that the individual be removed from services for symptoms including but not limited to fever, vomiting, diarrhea, body rash, sore throat and swollen glands, severe coughing, eye discharge, or yellowish skin or eyes;
 - Notify the caregiver; and
 - Document actions in the individual record.
- If an individual is suspected of having a contagious condition, the individual shall be removed from services until a physician’s written approval/clearance is obtained as documented in the individual file. The service provider shall ensure exposed individuals and their primary caregiver or guardian are notified of related signs and symptoms.
- If an individual requires emergency treatment at a hospital or other facility during day habilitation service hours, day habilitation service staff shall remain with the individual until the caregiver or guardian arrives.

17.7.5.7 Emergencies

17.7.5.7.1 Emergency Plans

The provider shall develop written plans, policies, and procedures to be followed in the event of an emergency evacuation or shelter in place (for circumstances requiring that people remain in the building) and ensure that all staff are sufficiently trained on these plans, policies, and procedures. Emergency numbers shall be posted by each telephone. Emergency cards must be kept up to date and maintained in a central location so they are available and portable in emergencies.

17.7.5.7.2 Emergency Procedures

At a minimum, procedures shall specify the following:

- Practices for notifying administration, personnel, individuals served, families, guardians, etc.;
- Locations of emergency equipment, alarm signals, evacuation routes;
- Description of evacuation procedure for all individuals receiving services – including mechanism to ensure everyone has been evacuated and is accounted for, meeting location(s), evacuation routes, method to determine reentry, method for reentry, etc.;
- Description of shelter in place procedure for all individuals receiving services – including mechanism to ensure everyone has been moved to a safe location and is accounted for, destinations within the building

for various emergencies, routes to designated destinations, method to determine clearance to exit the building, method for exiting, etc.;

- Reporting procedures in accordance with Division Circular #14 “Reporting Unusual Incidents;”
- Methods for responding to Life-Threatening Emergencies in accordance with Division Circular #20A “Life Threatening Emergencies.”

17.7.5.7.3 Evacuation Diagrams

An evacuation diagram specific to the facility/program location shall be posted conspicuously throughout the facility. At a minimum these diagrams must consist of the following:

- Evacuation route and/or nearest exit;
- Location of all exits;
- Location of alarm boxes (pull station); and
- Location of fire extinguishers.

17.7.5.7.4 Emergency Drills

Drills for a variety of emergencies (fire, natural disaster, etc.) shall be conducted regularly to ensure individuals receiving Day Habilitation services understand the emergency procedures. At a minimum emergency drills shall meet the following criteria:

- Rotated between the variety of potential emergencies given the location and population served;
- Conducted monthly with individuals served present;
- Varied as to accessible exits; and
- Documented to include date, time of drill, length of time to evacuate, number of individuals participating, name(s) of participating staff, problems identified, corrective actions for problems, and signature of person in charge.

17.7.5.7.5 Emergency Cards

The Day Habilitation service provider shall maintain an Emergency Card for each individual. This card will consolidate relevant emergency, health, and medical information provided by the ISP into one, readily available and portable document in case of emergencies. The provider shall verify the information provided by the ISP and review and update the Emergency Card at least annually. The Emergency Card shall include, at a minimum, the following information:

- Individual’s Name;
- Individual’s Date of Birth;
- Individual’s DDD ID Number;
- Emergency Contact Information;
- Guardianship Information, if applicable;
- Diagnosis;
- Medications, if applicable;
- Individual Medical Restrictions/Special Instructions, if applicable;
- Medical Contact Information;
 - Primary Physician Information;
 - Preferred Hospital.
- Healthcare Contact Information; and
 - Managed Care Organization (MCO) Information;
 - Private Insurance, if applicable;
 - Administrative Services Organization (ASO), if applicable.
- Support Coordinator Contact Information.

17.7.5.7.6 Emergency Consent for Treatment Form

The provider shall discuss the individual’s wishes related to emergency treatment and obtain a signed general statement of consent for emergent care that includes but is not limited to the following:

- Medical or surgical treatment;
- Hospital admission;

- Examination and diagnostic procedures;
- Anesthetics;
- Transfusions; and
- Operations deemed necessary by competent medical clinicians to save or preserve the life of the named individual in the event of an emergency.

17.7.5.7.7 First Aid Kit

Each day habilitation site shall maintain a first aid kit which minimally includes the following items:

- Antiseptic;
- Rolled gauze bandages;
- Sterile gauze bandages;
- Adhesive paper or ribbon tape;
- Scissors;
- Adhesive bandages (Band-Aids); and
- Standard type or digital thermometer.

17.7.5.8 Medication

The service provider shall comply with the Division-approved Medication Module

17.7.5.8.1 Medication Policies & Procedures

Day Habilitation service providers must develop written policies and procedures specific to the following:

- Prescription, over-the-counter (OTC) and “as needed” (PRN) medications;
- Storage, administration and recording of medications;
- Definition and reporting of errors, emergency medication for life threatening conditions and staff training requirements.

17.7.5.8.2 Storage

On-Site

- All prescription medication shall be stored in the original container issued by the pharmacy and shall be properly labeled.
- All OTC medication shall be stored in the original container in which they were purchased and the labels kept intact.
- The service provider shall supervise the use and storage of prescription medication and ensure a storage area of adequate size for both prescription and non-prescription medications is provided and locked.
- The medication storage area shall be inaccessible to all persons, except those designated by the service provider
 - Designated staff shall have a key to permit access to all medications, at all times and to permit accountability checks and emergency access to medication; and
 - Specific controls regarding the use of the key to stored medication shall be established by the service provider.
- Each individual’s prescribed medication shall be separated and compartmentalized within the storage area (i.e. Tupperware, Zip-loc bags, etc.).
- If refrigeration is required, medication must be stored in a locked box in the refrigerator or in a separate locked refrigerator.
- Oral medications must be separated from other medications.
- OTC medications must be stored separately from prescription medications in a locked storage area.

Off-Site

- Medications must be stored in a locked box/container.
- Each individual’s prescribed medication shall be separated and compartmentalized within the locked container; the container must be with staff at all times; locking medications in the glove-compartment is not permitted.
- Special storage arrangements shall be made for medication requiring temperature control.

- Designated staff shall have a key to permit access to all medications at all times and to permit accountability checks and emergency access to medication.
- The service provider must ensure that all medication to be administered off-site is placed in a sealed container labeled with the following:
 - The individual's name; and
 - The name of the medication.

17.7.5.8.3 Prescription Medication

A copy of the prescription shall be on record stating:

- The individual's full name;
- The date of the prescription;
- The name of the medication;
- The dosage; and
- The frequency.

17.7.5.8.3.1 Documentation

- Written documentation shall be filed in the individual record indicating that the prescribed medication is reviewed at least annually by the prescribing physician, i.e. prescriptions current within one year.
- A Medication Administration Record (MAR) shall be maintained for each individual receiving prescription medication
 - The service provider shall transcribe information from the pharmacy label onto the Medication Administration Record (MAR);
 - If the exact administration time the medication is to be administered is not prescribed by the physician, determination of the time shall be coordinated with the caregiver and then recorded on the MAR i.e. at mealtimes;
 - The staff person who prepares the medication must administer the medication and document it on the Medication Administration Record (MAR) immediately or upon return to the facility; and
 - Any change in medication dosage by the physician shall be immediately noted on the current MAR by staff, consistent with the provider's procedure.
- Verbal orders from a physician shall be confirmed in writing within 24 hours or by the first business day following receipt of the verbal order and the prescription shall be revised at the earliest opportunity; and
- All medications received by the adult day service shall be recorded at the time of receipt including the date received and the amount received i.e. 30 pills, 1- 5 oz tube, etc.

17.7.5.8.3.2 Supplies

- An adequate supply of medication must be available at all times; as a general guideline, refill the medication when a 5-day supply remains.
- For individuals who are supported through services which are not associated with a facility, the dosage of medication for the day must be provided in a properly labeled pharmacy container
 - The dosage;
 - The frequency;
 - The time of administration; and
 - The method of administration.

17.7.5.8.3.3 Emergency Administration of Prescription Medication

Service providers shall ensure the safety of individuals who have a history of severe life-threatening conditions requiring the administration of prescription medication in emergency situations. Examples include, but are not limited to:

- Severe allergic reaction (called anaphylaxis) which requires the use of epinephrine via an "epi-pen" injection.
- Cardiac conditions requiring the administration of nitroglycerin tablets.

Staff shall follow life-threatening emergency procedures and the orders/protocol established by the physician

17.7.5.8.4 PRN (as needed) Prescription Medication

PRN prescription medication must be authorized by a physician. The authorization must clearly state the following:

- The individual's full name;
- The date of the prescription;
- The name of the medication;
- The dosage;
- The interval between doses;
- Maximum amount to be given during a 24-hour period;
- A stop-date, when appropriate; and,
- Under what conditions the PRN medication shall be administered.

17.7.5.8.4.1 Administration of PRN

- Determine the time the previous PRN medication(s) was given (through caregiver);
- Must be approved by the supervisory staff or designee, before administering;
- Must be administered by the staff person who prepares the medication;
- Followed by checking in with the individual 1-2 hours after administration to observe effect of PRN; and
- Convey time PRN was given by the day habilitation provider to the caregiver.

17.7.5.8.4.2 Documentation

- Administration of the medication, including time of administration, must be documented by the staff person who prepared it on the Medication Administration Record (MAR) immediately or upon return to the facility;
- Results of checking on individual 1-2 hours after administration to observe if the PRN is working.

17.7.5.8.5 PRN Over the Counter (OTC) Medication

17.7.5.8.5.1 Administration of PRN – OTC

- Can only be done when an OTC form signed by the physician is on file and includes the following:
 - Conditions under which the OTC is to be given;
 - The type of medication;
 - The dosage;
 - The frequency;
 - Maximum amount to be given during a 24-hour period; and
 - Under what conditions to administer additional OTC.
- Determine the time the previous OTC medication was given (through caregiver);
- Must be administered by the staff person who prepares the medication; and
- Convey the time the OTC was given by the day habilitation provider to the caregiver.

17.7.5.8.5.2 Documentation

- Administration of the OTC medications must be documented by the staff person who prepared it on a Medication Administration Record (MAR) separate from the one utilized for prescription medication

17.7.5.8.6 Self-Medication

Individuals receiving medication shall take their own medication to the extent that it is possible, as noted in iRecord and communicated through the Support Coordinator, and in accordance with the day habilitation service provider's procedures

17.7.5.8.6.1 Documentation

The following information shall be maintained in the individual's record:

- The name of the medication;
- The type of medication(s);
- The dosage;
- The frequency;

- The date prescribed; and
- The location of the medication.

17.7.5.8.5.2 Storage

- Medication shall be kept in an area that provides for the safety of others, if necessary.
- Each individual who administers their own medication shall receive training and monitoring by the service provider regarding the safekeeping of medications for the protection of others, as necessary.

17.7.5.9 Transportation

The Day Habilitation rate includes pick up and drop off transportation for individuals residing within the Day Habilitation provider's defined catchment area within reason of the day habilitation services operational hours. Catchment area and reasonable pick up and drop off hours are submitted during the provider application and/or day habilitation certification process. In situations where the Day Habilitation provider is providing pick up and drop off transportation, the provider will claim for Day Habilitation services beginning when the individual has arrived at the location in which Day Habilitation is started (the time providing pick up and drop off services is not included in the billing process). Day habilitation providers are only able to bill for transportation for miles driven beyond the established catchment area.

The Day Habilitation provider can choose to claim for transportation provided to and from Day Habilitation activities that are planned in the community in one of the following two ways:

- Transportation to and from the community activity is provided and funded through Transportation services as long as the Day Habilitation provider is also Medicaid/DDD approved to provide Transportation services and Transportation services are prior authorized per the ISP – OR –
- Day Habilitation is being provided on the vehicle while traveling to and from the community activity so the service is documented and claimed as Day Habilitation as long as the services have been prior authorized per the ISP.

At no time may individuals receiving services be left alone in a vehicle. An individual is not considered to be alone when staff is just outside the vehicle assisting individuals as they are getting on and/or off the vehicle.

17.7.5.9.1 Vehicles

All vehicles utilized by the Day Habilitation provider to transport individuals receiving services shall:

- Comply with all applicable safety and licensing regulations of the State of New Jersey Motor Vehicle Commission regulations;
- Be maintained in safe operating condition;
- Contain seating that does not exceed maximum capacity as determined by the number of available seatbelts and wheelchair securing devices;
- Be wheelchair accessible by design and equipped with lifts and wheelchair-securing devices which are maintained in safe operating condition when transporting individuals using wheelchairs;
- Be equipped with the following:
 - 10:BC dry chemical fire extinguisher;
 - First Aid kit;
 - At least 3 portable red reflector warning devices;
 - Snow tires, all weather use tires, or chains when weather conditions dictate.

17.7.5.9.1.1 Maintenance

The day habilitation provider shall develop a preventative maintenance system and conduct monthly, at a minimum, review of the condition of vehicles.

17.7.5.9.2 Policies & Procedures

The day habilitation provider shall develop transportation policies and procedures that include but are not limited to the following:

- Emergency/accident procedures that include notification per agency and insurance company processes

- Pick up/drop off processes – catchment area, times, waiting period, supervision needed for drop off and process when someone is not home to provide necessary supervision;
- Suspension
 - Reasons for suspension – must be explained and signed off by individual;
 - Process for making determination – determining that reasons are met, warning process, determining length of suspension, notification to individual, caregiver, SC, DDD, etc.;
 - Return to transportation; and
 - Appeal process.
- Cancellations
 - Due to the day habilitation provider – weather, program closures, etc.
 - Due to the individual – illness, decision not to go to day habilitation that day, etc.

17.7.5.10 Service Provider Policies & Procedures Manual

Day Habilitation service providers shall develop, maintain, and implement a manual of written policies and procedures to ensure that the service delivery system complies with the standards governing day habilitation services. These policies and procedures shall be designed in accordance with the Supports Program and Community Care Program (CCP) Policy & Procedures Manuals and applicable Division Circulars. At a minimum, the following areas must be addressed within the service provider’s policies & procedures manual:

- Unusual Incident Reporting;
- Investigations in compliance with DC#15 “Complaint Investigations in Community Programs;”
- Complaint/grievance resolution procedures for individuals receiving services, which shall have a minimum of 2 levels of appeal, the last of which shall, at a minimum, involve the executive director;
- Emergency plans;
- Life-threatening emergencies in compliance with #20A;
- Health/Medical;
- Medication administration (including procedures for self-medication);
- Transportation;
- Personnel; and
- Admission, Suspension, Discharge.

17.7.5.11 Day Habilitation Service Admission

The Support Coordinator will assist the individual in researching Day Habilitation service providers and indicate the provider of choice in the ISP. Each Day Habilitation service provider is responsible for establishing an admission process and developing criteria for acceptance into their Day Habilitation services.

17.7.5.11.1 Provider Admission Policies and Procedures

The Day Habilitation service provider shall develop, maintain, and implement admission policies and procedures. These policies and procedures shall be made readily available to prospective participants and their Support Coordinators and, at a minimum, include the following:

- Pre-admission process – in-person meeting, tour of services, documentation, physical exam, etc.;
- Criteria for acceptance – diagnosis/disability type, tier, etc.;
- Appeal process;
- Admission process – determining start date, submission of referral packet;
- Waiting list; and
- Program rules and expectations, rights and responsibilities.

17.7.5.11.2 Prior Authorization for Day Habilitation Services

The Support Coordinator will identify the need for Day Habilitation services through review of the NJ Comprehensive Assessment Tool (NJ CAT) and the person-centered planning process facilitated by the Person-Centered Planning Tool (PCPT). Once this need is identified, an outcome(s) related to the results expected through participation in Day Habilitation services will be included in the Individualized Service Plan (ISP). The Support Coordinator will assist the individual in identifying potential Day Habilitation providers based on knowledge of the

individual's needs; criteria provided by the individual; the individual's research conducted with service providers through phone calls, face-to-face meetings, tours, etc.; and the provider's written admission policies and procedures. Upon confirmation of a Day Habilitation service provider, the Support Coordinator will indicate the chosen provider in the ISP along with units, frequency, and duration of the Day Habilitation service and submit the completed ISP to the Support Coordination Supervisor for approval. A prior authorization for services will be generated and sent to the chosen Day Habilitation service provider when the ISP has been approved. The Day Habilitation provider cannot receive reimbursement for services rendered until this prior authorization has been generated. The Support Coordinator will also send the approved ISP to providers indicated in the ISP within 3 business days of approval.

17.7.5.12 Day Habilitation Suspension/Discharge

17.7.5.12.1 Suspension

The Day Habilitation service provider shall develop, maintain, and implement suspension policies and procedures. These policies and procedures shall be explained to individuals to ensure they understand them and shall, at a minimum, include the following:

- Reasons for suspension – must be explained and signed off by individual;
- Process for making determination – determining that reasons are met, warning process, determining length of suspension, notification to individual, caregiver, SC, DDD, etc.;
- Return to services; and
- Appeal process.

17.7.5.12.2 Discharge

The Day Habilitation service provider shall develop, maintain, and implement discharge policies and procedures. These policies and procedures shall be explained to individuals to ensure they understand them and shall, at a minimum, include the following:

- Reasons for discharge – must be explained and signed off by individual;
- Process for making determination – determining that reasons are met, warning process, determining length of suspension, notification to individual, caregiver, SC, DDD, etc.;
- Appeal process.

17.8 Environmental Modifications

Procedure Codes	Units	Additional Descriptor	Budget Component
S5165HI	Single	NA	Individual/Family Supports

Please refer to Appendix H for current rates.

17.8.1 Description

Those physical adaptations to the private residence of the participant or the participant's family, based on assessment and as required by the participant's Service Plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

17.8.2 Service Limits

All services shall be provided in accordance with applicable State or local building codes and are subject to prior approval on an individual basis by the Division. Excluded items are those adaptations or improvements to the home that are of general utility, not of direct medical or remedial benefit to the participant, for aesthetics, beautification or medically contraindicated. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

17.8.3 Provider Qualifications

All providers of Environmental Modification services must comply with the standards set forth in this manual.

In addition, Environmental Modifications providers must meet the following:

- Contractors must be registered contractors per N.J.S.A. 56:8-136; -AND-
- Licensed in the State of NJ for specific service to be rendered (i.e. Electrical, plumbing, general contractor); -AND-
- Service provided must be provided in accordance with applicable state or local building codes.

17.8.4 Examples of Environmental Modifications

*Please note that examples are not all inclusive of everything that can be funded through this service

- Ramps
- Grab-bars
- Widening of doorways
- Modifications of bathrooms
- Emergency generator for equipment for life-sustaining equipment (i.e. ventilator)
- Stair lifts
- Ceiling track systems for transfers

17.8.5 Environmental Modifications Policies/Standards

In addition to the standards set forth in this manual, the service provider and staff must comply with relevant licensing and/or certification standards.

17.8.5.1 Need for Service and Process for Choice of Provider

The need for an Environmental Modification will be identified through the NJ Comprehensive Assessment Tool (NJ CAT) and the person-centered planning process documented in the Person-Centered Planning Tool (PCPT). In addition, the following steps must be completed in order to access Environmental Modifications:

- The Support Coordinator will assist the individual in identifying an approved Assistive Technology provider to conduct an evaluation in order to ensure the Environmental Modification will benefit the individual and is completed correctly for the individual's needs;
- The Support Coordinator will submit a request to conduct the Assistive Technology evaluation through iRecord for Division review and approval;
- The Division will review the evaluation request and provide a determination. This determination may be to skip the evaluation if needed information is already available (through a previous evaluation, for example);
- If "approved," by the Division, the Support Coordinator will add Assistive Technology to the ISP and utilize the Assistive Technology Evaluation procedure code (T2028HI);
- Upon approval of the ISP, the Assistive Technology provider conducts the evaluation as prior authorized and submits the completed evaluation and supporting documents to the Support Coordinator;
- Once the evaluation has been completed (or if the evaluation step has been skipped as approved by the Division), the Support Coordinator will submit a request and additional details for the Division to review and approve the Environmental Modification itself;
- Once the Environmental Modification is approved, the Support Coordinator will add Environmental Modification to the ISP; and
- The Environmental Modification provider will render services to the specifications outlined in the Environmental Modification Evaluation as prior authorized by the approved ISP and claim to Medicaid (if they are a Medicaid provider) or submit an invoice to the Fiscal Intermediary (if not a Medicaid provider).

If the available/remaining Individual/Family Supports budget does not cover the entire cost of the Environmental Modification, the individual/family may pay for the difference, divide the cost between plan years/terms, or request the balance from another component of the budget in order to get the work completed. When requesting to use funding from a budget component other than Individual/Family Supports a minimum of 2 bids/estimates are required.

Questions or concerns that are related to this process can be directed to the Service Approval Help Desk at DDD.ServiceApprovalHelpdesk@dhs.nj.gov.

17.8.5.2 Documentation & Recordkeeping

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, and number of units of the delivered service for each individual and must align with the prior authorization received for the provision of services.

17.9 Goods & Services

Procedure Codes	Units	Additional Descriptor	Budget Component
T1999HI22	Single	NA	Either

Please refer to Appendix H for current rates.

17.9.1 Description

Goods and Services are services, equipment or supplies, not otherwise provided through natural supports or generic resources, the Supports Program, or through the State Plan, which address an identified need (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; and/or promote inclusion in the community; and/or increase the participant's safety in the home environment; and, the participant does not have the funds to purchase the item or service or the item or service is not available through another source. Goods and Services are purchased from the participant's budget and paid and documented by the fiscal intermediary.

17.9.2 Service Limits

Experimental or prohibited treatments are excluded. Goods and Services must be based on assessed need and specifically documented in the Service Plan. If a Goods and Services request is not approved, a letter documenting the reason for the denial will be provided to the individual or their guardian and uploaded in iRecord. This denial letter will contain language regarding the right to appeal the decision through a Fair Hearing before an Administrative Law Judge. *An individual has 20 days from the date of the denial letter to request a Fair Hearing.* Individuals/Guardians should follow the instructions provided in the letter to exercise this right. Goods and Services Request Forms that are not completed properly will be returned with a request for additional information. A request for additional information is not a denial.

17.9.3 Provider Qualifications

All providers of Goods & Services must exist primarily to serve the general public. If a provider primarily exists to serve individuals with disabilities, that provider must become a Medicaid/DDD approved provider for other services detailed through Section 17 of this manual and receive payment through claims submitted to Medicaid. If the entity seeking funding through Goods & Services exists primarily to serve the general public, as applicable, they must also comply with the standards set forth in this manual. In addition, staff providing Goods & Services must meet the qualifications/standards mandated by the relevant industry from which the specific service is being provided.

17.9.4 Examples of Goods & Services

*Please note that examples are not all inclusive of everything that can be funded through this service

- Fingerprinting, drug testing costs needed to be considered for a job but not otherwise covered by DVRS
- Garage door opener for access/egress to home
- Microwave oven to assist someone in cooking their own meals specifically for individuals who live in the community on their own/non-congregate setting
- Classes, attended in-person or virtually, within the general public located in the community
- Durable medical equipment that is not covered after exhausting all insurance appeal processes
- Activity Fees (for example, museums, aquariums, planetariums, zoos, cultural events, skills building or educational workshops)
- Flat rate/boarding fees associated with transportation services
- Security Deposit
- Gym memberships (monthly) when monthly billing is available

17.9.5 Goods & Services Policies/Standards

In addition to the standards set forth in this manual, the service provider and staff must comply with relevant licensing and/or certification standards.

17.9.5.1 Need for Service and Process for Choice of Provider

The need for Goods & Services will typically be identified through the NJ Comprehensive Assessment Tool (NJ CAT) and the person-centered planning process documented in the Person-Centered Planning Tool (PCPT). **All Goods & Services require Division approval in order for prior authorization to be provided for the purchase of the Goods & Services.** The following steps must be completed in order to access Goods & Services:

- The Support Coordinator will assist the individual in identifying entities from which they can access the needed Goods & Services;
- The Support Coordinator will add Goods & Services to the ISP prompting submission of the request for Goods & Services which will be submitted and reviewed by the Division;
- The Division will review the request to ensure it meets Goods & Services criteria, ask for supporting documentation or additional information as needed, and provide a determination;
- Upon Division approval, the SCA will follow the process to approve the ISP;
- Once the ISP is approved, the prior authorization will be automatically sent to the Fiscal Intermediary;
- The Support Coordinator should send the Service Detail Report (and ISP if appropriate and agreed upon by the individual) to the entity that will be providing the approved Goods & Services; and
- The Goods & Services provider will render services as prior authorized by the approved ISP and submit an invoice through the FI for payment.

If the available/remaining Individual/Family Supports budget does not cover the entire cost of the Goods and Service request, the individual/family may pay for the difference, divide the cost between plan years/terms or request to use funding from a budget component other than Individual/Family Supports (assuming available funding in the alternate budget component).

17.9.5.1.1 Goods & Services Criteria

A request for Goods & Services will be reviewed against the following criteria to determine approval:

- Need is disability-related;
- Addresses an identified need;
- Decreases the need for other services or promotes community inclusion or increases safety in the home;
- Not available through another entity including natural supports or generic resources;
- Fully integrated (Whether attended in-person or virtually);
- Employment-related;
- Does not benefit someone other than the individual; and
- Available to the general public and not specifically designed for people with disabilities.

17.9.5.1.2 Goods & Services Exclusions

The following items can never be accessed through Goods & Services:

- Purely entertainment or solely for recreation or entertainment;
- Political in nature or lobbying;
- Personal items/services not related to the disability;
- Gift cards;
- Vacation expenses;
- General food, clothing, beverages;
- Room & board;
- Hotel, motel, bed & breakfast, etc.;
- Personal Training;
- Cash;
- Gambling, alcohol, tobacco;
- Experimental or prohibited treatments;
- Service Animals;
- Utility bills; and/or
- Warranties or service contracts.

7.9.5.1.3 Criteria to Utilize Goods & Services to Fund Classes⁶

Funding for an individual to develop/build skills by attending classes that are available to the general public can be made available through Goods & Services within the Division's Community Care Program when other means to pay for these classes are not available for the individual.

Classes may be funded through Goods & Services when the following criteria are met:

- The class is attended by the general public –OR–
- The class is offered by an entity whose primary audience is the general public and takes place in an open and integrated setting in a location that enables the individual to interact with the general public

In addition to the above, the following criteria apply:

- These classes, attended in-person or virtually, are limited to no more than 12 individuals with intellectual and developmental disabilities attending the class at the same time. Individuals can attend classes for up to 12 hours per week – AND –
- The requirements necessary to access Goods & Services are met – AND –
- The class is linked to an assessed need for the individual – AND –
- The class will develop skills that will directly lead to employment in a particular career – OR –
- The class will assist the individual in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings, per the Centers for Medicare and Medicaid Services (CMS) core service definition of "habilitation."

Justification regarding how the class will meet the criteria of leading to employment or the core service definition of habilitation will be completed and submitted by the Support Coordinator while completing the Individualized Service Plan (ISP) and documented through iRecord. A Free Application for Federal Student Aid (FAFSA) must be completed if the individual is enrolling as a part time (6 credits) or full time (12 credits) student in a matriculated program through a college/university. Results of the FAFSA application shall be provided at the time of the request. Once approved by the Support Coordination Supervisor, the justification must be reviewed and approved by the Division and will be prior authorized through the approved ISP and claimed through the Fiscal Intermediary using the procedural code for Goods & Services.

17.9.5.1.4 Criteria to Utilize Goods & Services to Fund Activity Fees

Funding for activity fees necessary to pay for attendance at various events available to the general public (for example museums, planetariums, zoos, science centers, aquariums, skills building or educational workshops, and cultural events) that are not solely for entertainment or recreational purposes can be made available through Goods & Services within the Division's Community Care Program when other means to pay for these fees are not available for the individual. Activity fees can be used to fund the cost of admission for both the participant and a Direct Support Professional. There is a \$1,000.00 cap per year on activity fees (while the annual allowance for activity fees is up to \$1,000.00, rarely will the costs of activities amount to exactly \$1,000.00 for plan year) and a \$50.00 cap per person for any single activity used for the individual and/or for someone providing support to assist the individual in participating in waiver services in the community.

The Support Coordinator must submit a Goods & Services Request to DDD that documents the planned/proposed activity and the associated fee. The activities must be indicated in the PCPT. When invoicing the fiscal intermediary

⁶ Entities that primarily serve people with disabilities can also provide lessons/experiences or information that can be similar to that described as "Goods & Services" above. These providers would offer these lessons/experiences through other waiver services such as day habilitation or prevocational training. For example, a cooking class offered by a social/human services provider would be provided through "day habilitation services" or a basic computer class would be provided through "prevocational training" services. When these other services are offered by social/human service providers primarily serving people with intellectual and developmental disabilities, they are prior authorized through the approved ISP and claimed directly by the Medicaid provider using the procedural code identified for that particular service.

for an activity fee, a copy of the activity receipt must be submitted and be equal to or less than the amount entered in the service plan.

17.9.5.2 Minimum Staff Qualifications

Staff providing goods & services must meet the qualifications associated with the relevant profession, business, or industry and the provision of that good or service.

17.9.5.3 Mandated Staff Training & Professional Development

The goods & services provider shall comply with any relevant industry standards and licensing and/or certification standards.

17.9.5.4 Documentation and Reporting

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, and number of units of the delivered service for each individual and must align with the prior authorization received for the provision of services.

17.9.5.5 Medication Standards

If the provider is distributing medications while delivering this service, the “Medication” standards described under Day Habilitation Section 17.7.5.8 or Prevocational Training Section 17.15.5.7 (these standards are the same for both services) shall be followed.

17.9.5.6 Quality Assurance/Monitoring

The Division will conduct quality assurance and monitoring of Goods & Services in accordance with the requirements of the Supports Program Quality Plan.

17.10 Interpreter Services

Procedure Codes	Units	Additional Descriptor	Budget Component
T1013HI22	15 minutes	American Sign Language	Individual/Family Supports
T1013HI	15 minutes	Other Spoken Language	Individual/Family Supports
T1013HI52	15 minutes	Self-Directed Employee	Individual/Family Supports

Please refer to Appendix H for current rates.

17.10.1 Description

Service delivered to a participant face-to-face to support them in integrating more fully with community-based activities or employment. Interpreter services may be delivered in a participant's home or in a community setting. For language interpretation, the interpreter service must be delivered by an individual proficient in reading and speaking in the language in which the participant speaks.

17.10.2 Service Limits

Interpreter services may be used when natural interpretive supports are not available.

17.10.3 Provider Qualifications

All providers of Interpreter Services must comply with the standards set forth in this manual. In addition, Interpreter Services providers shall complete State/Federal Criminal Background checks and Central Registry checks for all staff, drug tests as applicable under Stephen Komminos' Law, and ensure that all staff successfully completes the Division mandated training, are a minimum of 18 years of age, and are proficient in reading and speaking the language being interpreted.

In addition, staff providing Sign Language Interpreter Services must meet the following:

- Successfully passed the New Jersey Division of the Deaf and Hard of Hearing (DDHH) Screening -OR-
- Certified by the National Registry of Interpreters for the Deaf

17.10.4 Interpreter Services Policies/Standards

In addition to the standards set forth in this manual, the service provider and staff must comply with relevant licensing and/or certification standards.

17.10.4.1 Need for Service and Process for Choice of Provider

The need for Interpreter Services will typically be identified through the NJ Comprehensive Assessment Tool (NJ CAT) and the person-centered planning process documented in the Person-Centered Planning Tool (PCPT). Once this need is identified, an outcome related to the result(s) expected through the participation in Interpreter Services will be included in the Individual Service Plan (ISP) and the Interpreter Services provider will develop strategies to assist the individual in reaching the desired outcome(s). Individuals and families are encouraged to include the Interpreter Services provider in the planning process to assist in identifying and developing applicable outcomes.

It is recommended that the individual research potential service providers through phone calls, meetings, visits, etc. to select the service provider that will best meet their needs.

The Interpreter Services provider can require/request referral information that will assist the provider in offering quality services. Once the Support Coordinator has informed the provider that the individual has selected them to provide Interpreter Services, the provider has five (5) working days to contact the individual and/or Support Coordinator to express interest in delivering services.

The agency identified to provide this service along with details regarding the extent of the service hours, duration, frequency, etc. will be noted in the ISP providing prior authorization for the identified service provider to perform

this service. A copy of the approved ISP and Service Detail Report will be provided to the identified service provider.

17.10.4.2 Minimum Staff Qualifications

The service provider shall meet the minimum staff qualifications and training set forth in this manual. Qualifications and training shall be documented either in the employment application, resume, reference check, or other personnel document(s).

- Minimum 18 years of age; – AND –
- Complete State/Federal Criminal Background checks and Central Registry checks; -AND-
- Proficient in reading and speaking the language being interpreted; -OR-
- For sign language interpretation – successfully passed the New Jersey Division of the Deaf and Hard of Hearing (DDHH) Screening OR Certified by the National Registry of Interpreters for the Deaf.

17.10.4.3 Mandated Staff Training & Professional Development

The service provider shall comply with any relevant licensing and/or certification standards. In addition, all staff providing Interpreter Services shall successfully complete the following training:

17.10.4.3.1 SDEs

For SDEs, any additional training mandated, and provided by, the individual/family shall be completed within the time period as specified by the individual/family.

For information on determining the Reasonable and Customary Wage for an SDE please review section **8.3.2.0.2 – Establishing a Self-Directed Employee (SDE) Hourly Wage Where the Direct Support Professional Service Does Not Apply.**

17.10.4.4 Documentation and Reporting

Demonstration of completion of all mandated staff training must be documented through certificates of attendance/completion; sign-in sheets from the training entity, provider, or trainer; information maintained through the College of Direct Support, etc. and made available upon request of the Division.

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, and number of units of the delivered service for each individual and must align with the prior authorization received for the provision of services.

17.10.4.5 Medication Standards

If the provider is distributing medications while delivering this service, the “Medication” standards described under Day Habilitation Section 17.7.5.8 or Prevocational Training Section 17.15.5.7 (these standards are the same for both services) shall be followed.

17.10.4.6 Quality Assurance/Monitoring

The Division will conduct quality assurance and monitoring of Interpreter Services providers in accordance with the requirements of the Supports Program Quality Plan.

17.11 Natural Supports Training

Procedure Codes	Units	Additional Descriptor	Budget Component
S5110HI	15 minutes	NA	Individual/Family Supports

Please refer to Appendix H for current rates.

17.11.1 Description

Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, individual is defined as: “any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a participant.” Training includes instruction about treatment regimens and other services included in the Service Plan, use of equipment specified in the Service Plan, and includes updates as necessary to safely maintain the participant at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the participant. All training for individuals who provide unpaid support to the participant must be included in the participant’s Service Plan. Natural Supports Training may be delivered to one individual or may be shared with one other individual.

17.11.2 Service Limits

This service may not be provided in order to train paid caregivers. When delivered by a Direct Service Professional (DSP), the DSP must have a minimum of two years’ experience working with individuals with developmental disabilities. When delivered by a licensed professional, the licensed professional must have a license in psychiatry, physical therapy, occupational therapy, speech language pathology, social work, or must be a registered nurse or a degreed psychologist.

17.11.3 Provider Qualifications

All providers of Natural Supports Training must comply with the standards set forth in this manual.

In addition, staff providing Natural Supports Training must meet at least one of the following:

- Licensed Registered Nurses must be licensed per N.J.S.A. 45:11-23;
- Licensed Psychiatrist must be licensed per N.J.A.C. 13:35;
- Licensed Physical Therapist must be licensed per N.J.A.C. 13:39A;
- Licensed Social Worker must be licensed per N.J.A.C. 13:44G;
- Clinical Psychologist must be licensed per N.J.A.C. 13:42;
- Licensed Speech Therapist must be licensed per N.J.A.C. 13:44C;
- Licensed Occupational Therapist must be licensed per N.J.A.C. 13:44K; or
- Bachelor's degree in technical services or rehabilitation services related field and a minimum of 1-year working with individuals with ID/DD and is certified by RESNA.

In addition, Home Health Agencies or Health Care Service Firms providing Natural Supports Training must meet the following license or accreditation requirements:

- Licensed per N.J.A.C. 8:42 and Certified by the Centers for Medicare and Medicaid Services; -OR-
- Accredited by one of the following:
 - New Jersey Commission on Accreditation for Home Care Inc. (CAHC);
 - Community Health Accreditation Program (CHAP);
 - Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
 - National Association for Home Care and Hospice (NAHC).

17.11.4 Examples of Natural Supports Training

*Please note that examples are not all inclusive of everything that can be funded through this service

- Training on use of AT device
- Training on a hooyer lift
- Training on ambulation/transfer techniques

- Training on dietary/eating techniques
- Training on diabetes management
- Training on implementation of behavior plan
- Training on PT or OT activities at home

17.11.5 Natural Supports Training Policies/Standards

In addition to the standards set forth in this manual, the service provider and staff must comply with relevant licensing and/or certification standards.

17.11.5.1 Need for Service and Process for Choice of Provider

The need for Natural Supports Training will typically be identified through the NJ Comprehensive Assessment Tool (NJ CAT) and the person-centered planning process documented in the Person-Centered Planning Tool (PCPT). Once this need is identified, an outcome related to the result(s) expected through the participation in Natural Supports Training will be included in the Individual Service Plan (ISP) and the Natural Supports Training provider will develop strategies to assist the individual in reaching the desired outcome(s). Individuals and families are encouraged to include the Natural Supports Training provider in the planning process to assist in identifying and developing applicable outcomes.

It is recommended that the individual research potential service providers through phone calls, meetings, visits, etc. to select the service provider that will best meet their needs.

The Natural Supports Training provider can require/request referral information that will assist the provider in offering quality services. Once the Support Coordinator has informed the provider that the individual has selected them to provide Natural Supports Training, the provider has five (5) working days to contact the individual and/or Support Coordinator to express interest in delivering services.

The agency identified to provide this service along with details regarding the extent of the service hours, duration, frequency, etc. will be noted in the ISP providing prior authorization for the identified service provider to perform this service. A copy of the approved ISP will be provided to the identified service provider.

17.11.5.2 Minimum Staff Qualifications

The service provider shall meet the minimum staff qualifications and training set forth in this manual. Qualifications and training shall be documented either in the employment application, resume, reference check, or other personnel document(s).

- Licensed Registered Nurses must be licensed per N.J.S.A. 45:11-23;
- Licensed Psychiatrist must be licensed per N.J.A.C. 13:35;
- Licensed Physical Therapist must be licensed per N.J.A.C. 13:39A;
- Licensed Social Worker must be licensed per N.J.A.C. 13:44G;
- Clinical Psychologist must be licensed per N.J.A.C. 13:42;
- Licensed Speech Therapist must be licensed per N.J.A.C. 13:44C;
- Licensed Occupational Therapist must be licensed per N.J.A.C. 13:44K; or
- Bachelor's degree in technical services or rehabilitation services related field and a minimum of 1-year working with individuals with ID/DD and is certified by RESNA.

17.11.5.3 Mandated Staff Training & Professional Development

The service provider shall comply with any relevant licensing and/or certification standards. In addition, all staff providing Natural Supports Training shall successfully complete the following training:

17.11.5.3.1 Within 30 Days of Hire

- Overview of Developmental Disabilities –accessible through the *College of Direct Support*.
- Prevention of Abuse, Neglect, and Exploitation –accessible through the *College of Direct Support*.
- Life Threatening Emergencies (Danielle’s Law) as per Division Circular #20A “Life Threatening Emergencies.”

17.11.5.4 Documentation and Reporting

Demonstration of completion of all mandated staff training must be documented through certificates of attendance/completion; sign-in sheets from the training entity, provider, or trainer; information maintained through the College of Direct Support, etc. and made available upon request of the Division.

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, and number of units of the delivered service for each individual and must align with the prior authorization received for the provision of services.

17.11.5.4.1 Natural Supports Training Log

The provider of Natural Supports Training must maintain documentation of the participants receiving training, topics covered, and content on the Natural Supports Training Log.

17.11.5.5 Medication Standards

If the provider is distributing medications while delivering this service, the “Medication” standards described under Day Habilitation Section 17.7.5.8 or Prevocational Training Section 17.15.5.7 (these standards are the same for both services) shall be followed.

17.11.5.6 Quality Assurance/Monitoring

The Division will conduct quality assurance and monitoring of Natural Supports Training providers in accordance with the requirements of the Supports Program Quality Plan.

17.12 Occupational Therapy

Procedure Codes	Units	Additional Descriptor	Budget Component
97535HIUN	15 minutes	Group – Blended	Individual/Family Supports
97535HI	15 minutes	Individual	Individual/Family Supports

Please refer to Appendix H for current rates.

17.12.1 Description

The scope and nature of these services do not otherwise differ from the Occupational Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of occupational therapy services under the approved State Plan are exhausted. The provider qualifications specified in the State plan apply. Occupational Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants.

17.12.2 Service Limits

These services are only available as specified in participant’s Service Plan and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups. A group session is limited to one therapist with a maximum of five participants and may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the participant's clinical record.

17.12.3 Provider Qualifications

All providers of Occupational Therapy must comply with the standards set forth in this manual. In addition, Occupational Therapy providers shall complete State/Federal Criminal Background checks and Central Registry checks for all staff, drug tests as applicable under Stephen Komminos’ Law, and ensure that all staff successfully completes the Division mandated training.

In addition, staff providing Occupational Therapy services must meet the following:

- Licensed Occupational Therapists must be licensed per N.J.A.C. 13:344K; -or-
- Licensed Occupational Therapy Assistant must be licensed per N.J.A.C. 13:44K.

In addition Licensed, Certified Home Health Agencies providing Occupational Therapy services must meet the following license or accreditation requirements:

- Licensed per N.J.A.C. 8:42 and Certified by the Centers for Medicare and Medicaid Services.

17.12.4 Examples of Occupational Therapy Activities

*Please note that examples are not all inclusive of everything that can be funded through this service

- Occupational therapy activities as prescribed by the appropriate health care professional.

17.12.5 Occupational Therapy Policies/Standards

In addition to the standards set forth in this manual, Occupational Therapy services must be performed under the guidelines described in the New Jersey practice arts for occupational and physical therapists.

17.12.5.1 Need for Service and Process for Choice of Provider

The need for Occupational Therapy will be identified through the NJ Comprehensive Assessment Tool (NJ CAT), the person-centered planning process documented in the Person-Centered Planning Tool (PCPT), and an appropriate medical prescription. In addition, the following steps must be completed in order to access Occupational Therapy:

17.12.5.1.1 Occupational Therapy is for Habilitation

- The Support Coordinator will review the NJ CAT to identify an indication that the Occupational Therapy is needed;
- The Support Coordinator uploads a copy of the medical prescription and documentation that the Occupational Therapy is necessary for habilitation provided by an appropriate health care professional to

iRecord – this information may be provided through two separate documents or all within the prescription;

- The Support Coordinator will include Occupational Therapy in the ISP as is done for other services;
- Occupational Therapy is prior authorized, delivered, and claimed.

17.12.5.1.2 Occupational Therapy is for Rehabilitation

- The Support Coordinator will review the NJ CAT to identify an indication that the Occupational Therapy is needed;
- The Support Coordinator uploads a copy of the medical prescription provided by an appropriate health care professional to iRecord;
- The individual/family reaches out to the primary insurance carrier/MCO to request Occupational Therapy;
- If the primary insurance carrier/MCO approves the Occupational Therapy, the individual will access this therapy through their primary insurer and follow the process required by that insurer;
- If the primary insurer/MCO denies the Occupational Therapy, the individual will receive (or must request) an Explanation of Benefits (EOB);
- The individual will submit the primary insurer/MCO's EOB to the Support Coordinator;
- The Support Coordinator will upload the EOB to iRecord and assist the individual in identifying providers of Occupational Therapy;
- The Support Coordinator will include Occupational Therapy in the ISP as is done for other services;
- When the ISP is approved, the prior authorization will be emailed to the provider and the Support Coordinator will submit the EOB from the primary carrier/MCO to the service provider that has been identified in the ISP to provide Occupational Therapy;
- The prior authorized service provider (identified in the ISP) will request the "Bypass Letter Request Form" from OSC.tplunit@osc.nj.gov;
- The service provider completes the Bypass Letter Request Form, attaches the explanation of benefits (EOB) for the denied service (either for exhausted benefits or non-coverage), and submits the documents to the OSC;
- Staff at the OSC will review the information and issue a Bypass Letter if appropriate;
- The service provider will submit claims for rendered services along with the Bypass Letter to Gainwell Technologies for payment.

17.12.5.2 Documentation & Recordkeeping

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, and number of units of the delivered service for each individual and must align with the prior authorization received for the provision of services. Occupational Therapy providers are expected to maintain general notes required of Medicaid providers.

17.12.5.3 Medication Standards

If the provider is distributing medications while delivering this service, the "Medication" standards described under Day Habilitation Section 17.7.5.8 or Prevocational Training Section 17.15.5.7 (these standards are the same for both services) shall be followed.

17.13 Personal Emergency Response System (PERS)

Procedure Codes	Units	Additional Descriptor	Budget Component
S5160HI	Single	Purchase/Installation/Testing	Individual/Family Supports
S5161HI	Month	Response Center Monitoring	Individual/Family Supports

Please refer to Appendix H for current rates.

17.13.1 Description

PERS is an electronic device that enables program participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein. The service may include the purchase, the installation, a monthly service fee, or all of the above.

17.13.2 Service Limits

All PERS shall meet applicable standards of manufacture, design and installation and are subject to prior approval on an individual basis by DDD.

17.13.3 Provider Qualifications

All providers of PERS must comply with the standards set forth in this manual.

In addition, PERS providers must meet the following:

- Certified by the Centers for Medicare and Medicaid Services.
- UL/ETL Approved Devices.

17.13.4 Examples of PERS Activities

*Please note that examples are not all inclusive of everything that can be funded through this service

- PERS equipment
- Cost of installation and testing
- Monthly cost of response center services

17.13.5 PERS Policies/Standards

In addition to the standards set forth in this manual, the service provider and staff must comply with relevant licensing and/or certification standards.

17.14.5.1 Need for Service and Process for Choice of Provider

The need for PERS will be identified through the NJ Comprehensive Assessment Tool (NJ CAT) and the person-centered planning process documented in the Person-Centered Planning Tool (PCPT). Once this need is identified, an outcome related to the result(s) expected through the use of the relevant PERS will be included in the Individual Service Plan (ISP).

17.14 Physical Therapy

Procedure Codes	Units	Additional Descriptor	Budget Component
S8990HIUN	15 minutes	Group – Blended	Individual/Family Supports
S8990HI	15 minutes	Individual	Individual/Family Supports

Please refer to Appendix H for current rates.

17.14.1 Description

The scope and nature of these services do not otherwise differ from the Physical Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of physical therapy services under the approved State Plan are exhausted. The provider qualifications specified in the State plan apply. Physical Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants.

17.14.2 Service Limits

These services are only available as specified in participant’s Service Plan and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups. A group session is limited to 1 therapist with 5 participants and may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the participant's clinical record.

17.14.3 Provider Qualifications

All providers of Physical Therapy services must comply with the standards set forth in this manual. In addition, Physical Therapy providers shall complete State/Federal Criminal Background checks and Central Registry checks for all staff, drug tests as applicable under Stephen Komninos’ Law, and ensure that all staff successfully completes the Division mandated training.

In addition, staff providing Physical Therapy services must meet the following:

- Licensed Physical Therapists must be licensed per N.J.A.C. 13:39A; -OR-
- Licensed Physical Therapy Assistant must be licensed per N.J.A.C. 13:39A.

In addition Licensed, Certified Home Health Agencies providing Physical Therapy services must meet the following license or accreditation requirements:

- Licensed per N.J.A.C. 8:42 and Certified by the Centers for Medicare and Medicaid Services.

17.14.4 Examples of Physical Therapy Activities

*Please note that examples are not all inclusive of everything that can be funded through this service

- Physical therapy activities as prescribed by the appropriate health care professional.

17.14.5 Physical Therapy Policies/Standards

In addition to the standards set forth in this manual, Physical Therapy services must be performed under the guidelines described in the New Jersey practice arts for occupational and physical therapists.

17.14.5.1 Need for Service and Process for Choice of Provider

The need for Physical Therapy will be identified through the NJ Comprehensive Assessment Tool (NJ CAT), the person-centered planning process documented in the Person-Centered Planning Tool (PCPT), and an appropriate medical prescription. In addition, the following steps must be completed in order to access Physical Therapy:

17.14.5.1.1 Physical Therapy is for Habilitation

- The Support Coordinator will review the NJ CAT to identify an indication that the Physical Therapy is needed;

- The Support Coordinator uploads a copy of the medical prescription and documentation that the Physical Therapy is necessary for habilitation provided by an appropriate health care professional to iRecord – this information may be provided through two separate documents or all within the prescription;
- The Support Coordinator will include Physical Therapy in the ISP as is done for other services;
- Physical Therapy is prior authorized, delivered, and claimed.

17.14.5.1.2 Physical Therapy is for Rehabilitation

- The Support Coordinator will review the NJ CAT to identify an indication that the Physical Therapy is needed;
- The Support Coordinator uploads a copy of the medical prescription provided by an appropriate health care professional to iRecord;
- The individual/family reaches out to the primary insurance carrier/MCO to request Physical Therapy;
- If the primary insurance carrier/MCO approves the Physical Therapy, the individual will access this therapy through their primary insurer and follow the process required by that insurer;
- If the primary insurer/MCO denies the Physical Therapy, the individual will receive (or must request) an Explanation of Benefits (EOB);
- The individual will submit the primary insurer/MCO’s EOB to the Support Coordinator;
- The Support Coordinator will upload the EOB to iRecord and assist the individual in identifying providers of Physical Therapy;
- The Support Coordinator will include Physical Therapy in the ISP as is done for other services;
- When the ISP is approved, the prior authorization will be emailed to the provider and the Support Coordinator will submit the EOB from the primary carrier/MCO to the service provider that has been identified in the ISP to provide Physical Therapy;
- The prior authorized service provider (identified in the ISP) will request the “Bypass Letter Request Form” from OSC.tplunit@osc.nj.gov;
- The service provider completes the Bypass Letter Request Form, attaches the explanation of benefits (EOB) for the denied service (either for exhausted benefits or non-coverage), and submits the documents to the OSC;
- Staff at the OSC will review the information and issue a Bypass Letter if appropriate;
- The service provider will submit claims for rendered services along with the Bypass Letter to Gainwell Technologies for payment.

17.14.5.2 Documentation & Recordkeeping

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, and number of units of the delivered service for each individual and must align with the prior authorization received for the provision of services. Physical Therapy providers are expected to maintain general notes required of Medicaid providers.

17.14.5.3 Medication Standards

If the provider is distributing medications while delivering this service, the “Medication” standards described under Day Habilitation Section 17.7.5.8 or Prevocational Training Section 17.15.5.7 (these standards are the same for both services) shall be followed.

17.15 Prevocational Training

Procedure Codes	Units	Additional Descriptor	Budget Component
T2015HI22	15 minutes	Individual	Employment/Day (DSP Service applies)
T2015HIUS	15 minutes	Tier A*	Employment/Day (DSP Service applies)
T2015HIUR	15 minutes	Tier B*	Employment/Day (DSP Service applies)
T2015HIUQ	15 minutes	Tier C*	Employment/Day (DSP Service applies)
T2015HIUP	15 minutes	Tier D*	Employment/Day (DSP Service applies)
T2015HIUN	15 minutes	Tier E*	Employment/Day (DSP Service applies)

Please refer to Appendix H for current rates.

*Tiered rates for Prevocational Training are utilized when services are being provided to groups of 2-8 individuals

17.15.1 Description

Services that provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services may include training in effective communication with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; and general workplace safety and mobility training. Prevocational Training is intended to be a service that participants receive over a defined period of time and with specific outcomes to be achieved in preparation for securing competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational Training services cannot be delivered within a sheltered workshop. Supports are delivered in a face-to-face setting, either one-on-one with the participant or in a group of two to eight participants.

17.15.2 Service Limits

This service is available to participants in accordance with the DDD Supports Program Policies & Procedures Manual and as authorized in their Service Plan. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401) or P.L. 94-142. Prevocational Training is limited to 30 hours per week. Transportation to or from a Prevocational Training site is not included in the service.

17.15.3 Provider Qualifications

All providers of Prevocational Training services must comply with the standards set forth in this manual. In addition, Prevocational Training providers shall complete State/Federal Criminal Background checks and Central Registry checks for all staff, drug tests as applicable under Stephen Komminos' Law, and ensure that all staff successfully completes the Division mandated training, are a minimum of 18 years of age, and possess a valid driver's license and abstract (not to exceed 5 points) if driving is required.

17.15.4 Examples of Prevocational Training

*Please note that examples are not all inclusive of everything that can be funded through this service

- Job Clubs
- Basic computer skill classes
- Developing effective communication with supervisors, coworkers, customers

- Learning about and developing skills related to professional conduct, attire, following directions, attending to task, solving problems at the worksite
- Improving/learning workplace safety
- Volunteer experiences (in compliance with the *Fair Labor Standards Act*) – If Prevocational Training services are being utilized to support an individual in a volunteer position, please ensure that the relationship with the entity for which the individual is volunteering is not what Wage & Hour would consider an “Employment Relationship.” If it is an Employment Relationship, the individual must be compensated for the work they are completing as any other employee would be. Unpaid experiences can take place to conduct vocational exploration or assessment as defined in the “Interagency Agreement Between Wage and Hour Division in the U.S. Department of Labor and the Division of Vocational Rehabilitation Services in the NJ Department of Labor and Workforce Development, and the Commission for the Blind and Visually Impaired and the Division of Developmental Disabilities in the NJ Department of Human Services” found in Appendix N. It is likely that services related to these vocational exploration or assessment experiences would fall under Supported Employment or Career Planning.

17.15.5 Prevocational Training Policies/Standards

In addition to the standards set forth in this manual, the service provider and staff must support and implement individual behavior plans, as applicable, and comply with relevant licensing and/or certification standards.

17.15.5.1 Need for Service and Process for Choice of Provider

The need for Prevocational Training will typically be identified through the NJ Comprehensive Assessment Tool (NJ CAT) and the Pathway to Employment discussion that takes place during the person-centered planning process and is documented in the Person-Centered Planning Tool (PCPT). Once this need is identified, an outcome related to the result(s) expected through the participation in Prevocational Training will be included in the Individual Service Plan (ISP) and the Prevocational Training service provider will develop strategies to assist the individual in reaching the desired outcome(s). Individuals and families are encouraged to include the Prevocational Training service provider in the planning process to assist in identifying and developing applicable outcomes. With the exception of services provided to assist someone in volunteering in their community or college programs/classes designed to be taken from start to finish over a set period of time, Prevocational Training services are limited to two (2) years. If the individual needs to continue receiving Prevocational Training services – for activities other than volunteering – beyond 2 years or the set period of time for the college program/classes, the Support Coordinator and Prevocational Training provider must submit the completed “Continuation of Prevocational Training Justification” form to the Division at DDD.EmploymentHelpdesk@dhs.nj.gov for approval. If Prevocational Training services are approved to extend beyond the second year, the Support Coordinator and Prevocational Training provider must submit justification every year thereafter in order to continue extending the need for Prevocational Training.

This service can only be accessed through the Division if the specific services being provided through Prevocational Training are not available through the Division of Vocational Rehabilitation Services (DVRS) or Commission for the Blind & Visually Impaired (CBVI). If it is a service that is provided through DVRS or CBVI, documentation that it is not available to the individual must be provided by the DVRS/CBVI counselor on the Employment Determination Form - (F3) and submitted to the Support Coordinator in order to make the funding available through the Division. If DVRS/CBVI does not offer the particular service that will be offered through Prevocational Training, there is no need for the Employment Determination Form - (F3) to be completed and submitted.

It is recommended that the individual research potential service providers through phone calls, meetings, visits, etc. to select the service provider that will best meet their needs.

The Prevocational Training service provider can require/request referral information that will assist the provider in offering quality services. Once the Support Coordinator has informed the provider that the individual has selected them to provide Prevocational Training, the provider has five (5) working days to contact the individual and/or Support Coordinator to express interest in delivering services.

The agency identified to provide this service along with details regarding the extent of the service hours, duration, frequency, etc. will be noted in the ISP providing prior authorization for the identified service provider to perform this service. A copy of the approved ISP and Service Detail Report will be provided to the identified service provider.

17.15.5.2 Minimum Staff Qualifications

The service provider shall meet the minimum staff qualifications and training set forth in this manual. Qualifications and training shall be documented either in the employment application, resume, reference check, or other personnel document(s).

- Minimum 18 years of age; – AND –
- Complete State/Federal Criminal Background checks and Central Registry checks;
- Valid driver's license and abstract (not to exceed 5 points) if driving is required.

17.15.5.3 Mandated Staff Training & Professional Development

The service provider shall comply with any relevant licensing and/or certification standards. Agency Trainers must have a minimum of 1 year experience in the field or 1 year experience in training. All staff providing Prevocational Training shall successfully complete the training outlined in Appendix E: Quick Reference Guide to Mandated Staff Training.

17.15.5.4 Documentation & Reporting

Demonstration of completion of all mandated staff training must be documented through certificates of attendance/completion; sign-in sheets from the training entity, provider, or trainer; information maintained through the College of Direct Support, etc. and made available upon request of the Division. Supervisors shall conduct and document use of competency and performance appraisals in the content areas addressed through mandated training.

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, and number of units of the delivered service for each individual and must align with the prior authorization received for the provision of services.

Standardized documents are available in Appendix D. Providers using an electronic health record (EHR) or billing system that cannot duplicate these standardized documents will remain in compliance if all the information required on these documents is captured somewhere and can be shown/reviewed during an audit.

17.15.5.4.1 Prevocational Training – Individualized Goals

The provider of Prevocational Training, in collaboration with the individual, must develop strategies to assist the individual in reaching each outcome related to the Prevocational Training that the service provider has been chosen to provide as indicated in the ISP. These strategies must be completed within 15 business days of the date the individual begins to receive Prevocational Training from the provider and must be documented on the Prevocational Training Individualized Goals Log. Strategies must be revised any time there is a modification to the ISP that changes the service specific outcome(s) and when the annual ISP is approved. These strategy revisions must be completed within 15 business days of the ISP modification or approval of the annual ISP.

17.15.5.4.2 Prevocational Training – Activities Log

The Prevocational Training provider will complete the Prevocational Training – Activities Log on each date services are delivered to indicate which strategies were addressed that day and provide a notation of activities done to address the strategy and what occurred that day as these activities were conducted.

17.15.5.4.3 Prevocational Training – Annual Update

On an annual basis, according to the individual's ISP plan year, the Prevocational Training provider will provide a summary of that year's services by completing the Annual Update. This annual documentation will assist in the development of the ISP for the upcoming year.

17.15.5.5 Service Settings

When prevocational training activities are being conducted in a center, the following standards must be met for the building (site):

- Prevocational Training services shall take place in a non-residential setting and separate from any home or facility in which any individual resides;
- The service provider shall comply with all local, municipal, county, and State codes;
- The Certificate of Continued Occupancy (CCO) or Certificate of Occupancy (CO) or other documentation issued by local authority shall be available on site and a copy shall be posted;
- The service provider shall be in compliance with the Americans with Disabilities Act (ADA) requirements;
- Municipal fire safety inspections shall be conducted consistent with local code and maintained on file;
- Exit signs shall be posted over all exits;
- The site shall have a fire alarm system appropriate to the population served;
- The site shall have sufficient ventilation in all areas and, if applicable;
- The site shall have adequate lighting;
- The facility shall be maintained in a clean, safe condition, to include internal and external structure
 - Aisles, hallways, stairways, and main routes of egress shall be clear of obstruction and stored material;
 - Floors and stairs shall be free and clear of obstruction and slip resistant;
 - Equipment, including appliances, machinery, adaptive equipment, assistive devices, etc. shall be maintained in safe working order;
 - Adequate sanitary supplies shall be available including soap, paper towels, toilet tissue.
- The service provider shall ensure that health and sanitation provisions are made for food preparation and food storage:
 - The service shall maintain appropriate local or county Department of Health certificates, where appropriate.

17.15.5.6 Emergencies

When prevocational training activities are being conducted in a center, the following standards must be met to ensure health and safety:

17.15.5.6.1. Emergency Plans

The provider shall develop written plans, policies, and procedures to be followed in the event of an emergency evacuation or shelter in place (for circumstances requiring that people remain in the building) and ensure that all staff are sufficiently trained on these plans, policies, and procedures. Emergency numbers shall be posted by each telephone. Emergency cards must be kept up to date and maintained in a central location so they are available and portable in emergencies.

17.15.5.6.2 Emergency Procedures

At a minimum, procedures shall specify the following:

- Practices for notifying administration, personnel, individuals served, families, guardians, etc.;
- Locations of emergency equipment, alarm signals, evacuation routes;
- Description of evacuation procedure for all individuals receiving services – including mechanism to ensure everyone has been evacuated and is accounted for, meeting location(s), evacuation routes, method to determine reentry, method for reentry, etc.;
- Description of shelter in place procedure for all individuals receiving services – including mechanism to ensure everyone has been moved to a safe location and is accounted for, destinations within the building for various emergencies, routes to designated destinations, method to determine clearance to exit the building, method for exiting, etc.;
- Reporting procedures in accordance with Division Circular #14 “Reporting Unusual Incidents;” and
- Methods for responding to Life-Threatening Emergencies in accordance with Division Circular #20A “Life Threatening Emergencies.”

17.15.5.6.3 Evacuation Diagrams

An evacuation diagram specific to the facility/program location shall be posted conspicuously throughout the facility. At a minimum these diagrams must consist of the following:

- Evacuation route and/or nearest exit;
- Location of all exits;
- Location of alarm boxes (pull station); and
- Location of fire extinguishers.

17.15.5.6.4 Emergency Drills

Drills for a variety of emergencies (fire, natural disaster, etc.) shall be conducted regularly to ensure individuals receiving Prevocational Training services understand the emergency procedures. At a minimum, emergency drills shall meet the following criteria:

- Rotated between the variety of potential emergencies given the location and population served;
- Conducted monthly with individuals served present;
- Varied as to accessible exits; and
- Documented to include date, time of drill, length of time to evacuate, number of individuals participating, name(s) of participating staff, problems identified, corrective actions for problems, and signature of person in charge.

17.15.5.6.5 Emergency Cards

The Prevocational Training service provider shall maintain an Emergency Card for each individual. This card will consolidate relevant emergency, health, and medical information provided by the ISP into one, readily available and portable document in case of emergencies. The provider shall verify the information provided by the ISP and review and update the Emergency Card at least annually. The Emergency Card shall include, at a minimum, the following information:

- Individual's Name;
- Individual's Date of Birth;
- Individual's DDD ID Number;
- Emergency Contact Information;
- Guardianship Information, if applicable;
- Diagnosis;
- Medications, if applicable;
- Individual Medical Restrictions/Special Instructions, if applicable;
- Medical Contact Information;
 - Primary Physician Information;
 - Preferred Hospital.
- Healthcare Contact Information;
 - Managed Care Organization (MCO) Information;
 - Private Insurance, if applicable;
 - Administrative Services Organization (ASO), if applicable.
- Support Coordinator Contact Information.

17.15.5.6.6 Emergency Consent for Treatment Form

The provider shall discuss the individual's wishes related to emergency treatment and obtain a signed general statement of consent for emergent care that includes but is not limited to the following:

- Medical or surgical treatment;
- Hospital admission;
- Examination and diagnostic procedures;
- Anesthetics;
- Transfusions;
- Operations deemed necessary by competent medical clinicians to save or preserve the life of the named individual in the event of an emergency.

17.15.5.6.7 First Aid Kit

Each prevocational training site shall maintain a first aid kit which minimally includes the following items:

- Antiseptic;
- Rolled gauze bandages;
- Sterile gauze bandages;
- Adhesive paper or ribbon tape;
- Scissors;
- Adhesive bandages (Band-Aids);
- Standard type or digital thermometer.

17.15.5.7 Medication

The service provider shall comply with the Division-approved Medication Module

17.15.5.7.1 Medication Policies & Procedures

Prevocational Training service providers must develop written policies and procedures specific to the following:

- Prescription, over-the-counter (OTC) and “as needed” (PRN) medications;
- Storage, administration and recording of medications;
- Definition and reporting of errors, emergency medication for life threatening conditions and staff training requirements.

17.15.5.7.2 Storage

On-Site

- All prescription medication shall be stored in the original container issued by the pharmacy and shall be properly labeled.
- All OTC medication shall be stored in the original container in which they were purchased and the labels kept intact.
- The service provider shall supervise the use and storage of prescription medication and ensure a storage area of adequate size for both prescription and non-prescription medications is provided and locked.
- The medication storage area shall be inaccessible to all persons, except those designated by the service provider
 - Designated staff shall have a key to permit access to all medications, at all times and to permit accountability checks and emergency access to medication;
 - Specific controls regarding the use of the key to stored medication shall be established by the service provider.
- Each individual’s prescribed medication shall be separated and compartmentalized within the storage area (i.e. Tupperware, Ziploc bags, etc.).
- If refrigeration is required, medication must be stored in a locked box in the refrigerator or in a separate locked refrigerator.
- Oral medications must be separated from other medications.
- OTC medications must be stored separately from prescription medications in a locked storage area.

Off-Site

- Medications must be stored in a locked box/container.
- Each individual’s prescribed medication shall be separated and compartmentalized within the locked container; the container must be with staff at all times; locking medications in the glove-compartment is not permitted.
- Special storage arrangements shall be made for medication requiring temperature control.
- Designated staff shall have a key to permit access to all medications at all times and to permit accountability checks and emergency access to medication.
- The service provider must ensure that all medication to be administered off-site is placed in a sealed container labeled with the following:
 - The individual’s name;

- The name of the medication.

17.15.5.7.3 Prescription Medication

A copy of the prescription shall be on record stating:

- The individual's full name;
- The date of the prescription;
- The name of the medication;
- The dosage; and
- The frequency.

17.15.5.7.3.1 Documentation

- Written documentation shall be filed in the individual record indicating that the prescribed medication is reviewed at least annually by the prescribing physician, i.e. prescriptions current within one year.
- A Medication Administration Record (MAR) shall be maintained for each individual receiving prescription medication.
 - The service provider shall transcribe information from the pharmacy label onto the Medication Administration Record (MAR).
 - If the exact administration time the medication is to be administered is not prescribed by the physician, determination of the time shall be coordinated with the caregiver and then recorded on the MAR i.e. at mealtimes.
 - The staff person who prepares the medication must administer the medication and document it on the Medication Administration Record (MAR) immediately or upon return to the facility.
 - Any change in medication dosage by the physician shall be immediately noted on the current MAR by staff, consistent with the provider's procedure.
- Verbal orders from a physician shall be confirmed in writing within 24 hours or by the first business day following receipt of the verbal order and the prescription shall be revised at the earliest opportunity.
- All medications received by the adult day service shall be recorded at the time of receipt including the date received and the amount received i.e. 30 pills, 1- 5 oz tube, etc.

17.15.5.7.3.2 Supplies

- An adequate supply of medication must be available at all times; as a general guideline, refill the medication when a 5-day supply remains.
- For individuals who are supported through services which are not associated with a facility, the dosage of medication for the day must be provided in a properly labeled pharmacy container
 - The dosage;
 - The frequency;
 - The time of administration;
 - The method of administration.

17.15.5.7.3.3 Emergency Administration of Prescription Medication

Service providers shall ensure the safety of individuals who have a history of severe life-threatening conditions requiring the administration of prescription medication in emergency situations. Examples include, but are not limited to:

- Severe allergic reaction (called anaphylaxis) which requires the use of epinephrine via an "epi-pen" injection.
- Cardiac conditions requiring the administration of nitroglycerin tablets.

Staff shall follow life-threatening emergency procedures and the orders/protocol established by the physician

17.15.5.7.4 PRN (as needed) Prescription Medication

PRN prescription medication must be authorized by a physician. The authorization must clearly state the following:

- The individual's full name;
- The date of the prescription;

- The name of the medication;
- The dosage;
- The interval between doses;
- Maximum amount to be given during a 24-hour period;
- A stop-date, when appropriate; and
- Under what conditions the PRN medication shall be administered.

17.15.5.7.4.1 Administration of PRN

- Determine the time the previous PRN medication(s) was given (through caregiver);
- Must be approved by the supervisory staff or designee, before administering;
- Must be administered by the staff person who prepares the medication;
- Followed by checking in with the individual 1-2 hours after administration to observe effect of PRN;
- Convey time PRN was given by the prevocational training provider to the caregiver.

17.15.5.7.4.2 Documentation

- Administration of the medication, including time of administration, must be documented by the staff person who prepared it on the Medication Administration Record (MAR) immediately or upon return to the facility.
- Results of checking on individual 1-2 hours after administration to observe if the PRN is working.

17.15.5.7.5 PRN Over the Counter (OTC) Medication

17.15.5.7.5.1 Administration of PRN – OTC

- Can only be done when an OTC form signed by the physician is on file and includes the following:
 - Conditions under which the OTC is to be given;
 - The type of medication;
 - The dosage;
 - The frequency;
 - Maximum amount to be given during a 24-hour period;
 - Under what conditions to administer additional OTC.
- Determine the time the previous OTC medication was given (through caregiver);
- Must be administered by the staff person who prepares the medication;
- Convey the time the OTC was given by the prevocational training provider to the caregiver.

17.15.5.7.5.2 Documentation

- Administration of the OTC medications must be documented by the staff person who prepared it on a Medication Administration Record (MAR) separate from the one utilized for prescription medication.

17.15.5.7.6 Self-Medication

Individuals receiving medication shall take their own medication to the extent that it is possible, as noted in iRecord and communicated by the Support Coordinator, and in accordance with the prevocational training service provider's procedures.

17.15.5.7.6.1 Documentation

The following information shall be maintained in the individual's record:

- The name of the medication;
- The type of medication(s);
- The dosage;
- The frequency;
- The date prescribed; and
- The location of the medication.

17.15.5.7.5.2 Storage

- Medication shall be kept in an area that provides for the safety of others, if necessary.
- Each individual who administers their own medication shall receive training and monitoring by the service provider regarding the safekeeping of medications for the protection of others, as necessary.

17.15.5.8 Quality Assurance and Monitoring

The Division will conduct quality assurance and monitoring of Prevocational Training providers in accordance with the requirements of the Supports Program Quality Plan.

17.16 Respite

Procedure Codes	Units	Additional Descriptor	Budget Component
T1005HI	15 minutes	Base	Individual/Family Supports (DSP Service applies)
T1005HI52	Daily	Overnight Tier A	Individual/Family Supports (DSP Service applies)
T1005HIU1	Daily	Overnight Tier Aa	Individual/Family Supports (DSP Service applies)
T1005HIUS	Daily	Overnight Tier B	Individual/Family Supports (DSP Service applies)
T1005HIU2	Daily	Overnight Tier Ba	Individual/Family Supports (DSP Service applies)
T1005HIUR	Daily	Overnight Tier C	Individual/Family Supports (DSP Service applies)
T1005HIU3	Daily	Overnight Tier Ca	Individual/Family Supports (DSP Service applies)
T1005HIUQ	Daily	Overnight Tier D	Individual/Family Supports (DSP Service applies)
T1005HIU4	Daily	Overnight Tier Da	Individual/Family Supports (DSP Service applies)
T1005HIUP	Daily	Overnight Tier E	Individual/Family Supports (DSP Service applies)
T1005HIU5	Daily	Overnight Tier Ea	Individual/Family Supports (DSP Service applies)
T2036HI22	Daily	Day Camp Only (up to 6 hrs/day)	Individual/Family Supports (DSP Service applies)
T2036HI	Daily	Overnight Camp (covers day + overnight camp)	Individual/Family Supports (DSP Service applies)
S9125HI	Daily	In-Home CCR Only	Individual/Family Supports (DSP Service applies)
T1005HIU8	15 minutes	Self-Directed Employee	Individual/Family Supports (DSP Service applies)

Please refer to Appendix H for current rates.

17.16.1 Description

Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Respite may be delivered in multiple periods of duration such as partial hour, hourly, daily without overnight, or daily with overnight. Respite may be provided in the participant's home, a DHS licensed group home, or another community-based setting approved by DHS. Some settings, such as a hotel, may be approved by the State for use when options using other settings have been exhausted.

17.16.2 Service Limits

Room and board costs will not be paid when services are provided in the participant's home. For out of home respite services, providers are responsible to pay for room and board costs incurred during the respite period without additional financial obligation to the individual receiving services. Activity fees may be assessed but may not include fees to pay for staff costs.

Respite at a hotel shall not exceed two consecutive weeks and 30 days per year. Additional fees for meals or the hotel are the responsibility of the service provider. Activity fees may be assessed but may not include fees to pay for staff costs.

Respite is not permitted to be utilized as a solution to resolve homelessness, hospital disposition issues or other situations that do not include the return to the previous caregiver. Scenarios that meet any of the criteria described above must be brought to the attention of the Division immediately.

17.16.3 Provider Qualifications

All providers of Respite services must comply with the standards set forth in this manual. In addition, Respite providers shall complete State/Federal Criminal Background checks and Central Registry checks for all staff, drug tests as applicable under Stephen Komminos' Law, and ensure that all staff successfully completes the Division mandated training.

Providers of Camp Respite (Day and/or Overnight) must also follow the New Jersey Youth Camp Standards N.J.A.C. 8:25.

17.16.4 Respite Options

Traditionally, the Division has applied the label “respite” to a variety of programs, services, and activities. Individuals enrolled in the Supports Program can continue to access the vast majority of these programs and services through Respite services in circumstances where those services meet the service description for Respite or through the variety of other services available through the Supports Program when the services provided meet those service descriptions instead. For example, a program that has traditionally been referred to as a Saturday Drop Off Program and considered Respite, may actually be considered Day Habilitation if activities provided during the program are designed to assist the individuals who attend with developing social or leisure skills. If this program provides assistance to a group of 2-6 individuals who are going to the museum on that Saturday, it may be considered Community Inclusion Services. If it is a place where individuals go on a Saturday in order to ensure that they are cared for in order to provide some relief to their caregiver(s), it would be considered Respite. It is important for the provider to clearly match the services they are providing to the descriptions provided in this manual in order to determine which service is actually being provided.

17.16.4.1 Base Respite (15-Minute Unit)

Base Respite is provided in or out of the individual's home.

17.16.4.2 Overnight Respite

Overnight Respite can be provided within a setting licensed under 10:44A, a setting that has been approved by the Division, or within a hotel.

Overnight Respite will be claimed at the daily rate aligned with the individual's tier. Daytime hours will be provided by an approved provider of the service that is being provided during the day – Supported Employment, Day Habilitation, Community Based Supports, Community Inclusion Services, etc.

Respite is not permitted to be utilized as a solution to resolve homelessness, hospital disposition issues or other situations that do not include the return to the previous caregiver. Scenarios that meet any of the criteria described above must be brought to the attention of the Division immediately.

17.16.4.3 Day Camp Respite

Day Camp Respite is utilized by camps that only provide camp during daytime hours. This service can be provided for up to 6 hours per day. An additional 2 hours per day of Base Respite can be provided by the same provider if needed.

17.16.4.4 Overnight Camp Respite

Overnight Camp Respite is utilized by camps that provide day and overnight camp services.

17.16.4.5 In-Home Community Care Residence Respite

Respite provided in a setting licensed under 10:44B.

17.16.4.6 Self-Directed Employee (SDE) Respite

Respite provided in or out of the home by someone who has been hired by the individual.

For information on determining the Reasonable and Customary Wage for an SDE please review section **8.3.2.0.1 – Establishing a Self-Directed Employee (SDE) Hourly Wage Where the Direct Support Professional Service Applies.**

17.16.5 Respite Policies/Standards

In addition to the standards set forth in this manual, the service provider and staff must support and implement individual behavior plans, as applicable, and comply with relevant licensing and/or certification standards.

17.16.5.1 Need for Service and Process for Choice of Provider

The need for Respite services will typically be identified through the NJ Comprehensive Assessment Tool (NJ CAT) and the person-centered planning process documented in the Person-Centered Planning Tool (PCPT). Individuals and families are encouraged to include the Respite provider in the planning process to assist in identifying and developing applicable outcomes.

It is recommended that the individual research potential service providers through phone calls, meetings, visits, etc. to select the service provider that will best meet their needs.

The Respite provider can require/request referral information that will assist the provider in offering quality services. Once the Support Coordinator has informed the provider that the individual has selected them to provide Respite, the provider has five (5) working days to contact the individual and/or Support Coordinator to express interest in delivering services.

The agency identified to provide this service along with details regarding the extent of the service hours, duration, frequency, etc. will be noted in the ISP providing prior authorization for the identified service provider to perform this service. A copy of the approved ISP will be provided to the identified service provider.

17.16.5.2 Minimum Staff Qualifications

The service provider shall meet the minimum staff qualifications and training set forth in this manual. Qualifications and training shall be documented either in the employment application, resume, reference check, or other personnel document(s).

- Minimum 18 years of age; – AND –
- Complete State/Federal Criminal Background checks and Central Registry checks;
- Valid driver's license and abstract (not to exceed 5 points) if driving is required.

17.16.5.3 Mandated Staff Training & Professional Development

The service provider shall comply with any relevant licensing and/or certification standards. Agency Trainers must have a minimum of 1 year experience in the field or 1 year experience in training. All staff providing Respite shall successfully complete the training outlined in Appendix E: Quick Reference Guide to Mandated Staff Training.

17.16.5.4 Documentation and Reporting

Demonstration of completion of all mandated staff training must be documented through certificates of attendance/completion; sign-in sheets from the training entity, provider, or trainer; information maintained through the College of Direct Support, etc. and made available upon request of the Division.

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, number of units of the delivered service, and a case note for each individual and must align with the prior authorization received for the provision of services.

17.16.5.5 Medication Standards

If the provider is distributing medications while delivering this service, the “Medication” standards described under Day Habilitation Section 17.7.5.8 or Prevocational Training Section 17.15.5.7 (these standards are the same for both services) shall be followed.

17.16.5.6 Quality Assurance/Monitoring

The Division will conduct quality assurance and monitoring of Respite providers in accordance with the requirements of the Supports Program Quality Plan.

17.17 Speech, Language, and Hearing Therapy

Procedure Codes	Units	Additional Descriptor	Budget Component
92507HIUN	15 minutes	Group – Blended	Individual/Family Supports
92507HI	15 minutes	Individual	Individual/Family Supports

Please refer to Appendix H for current rates.

17.17.1 Description

The scope and nature of these services do not otherwise differ from the Speech Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of speech therapy services under the approved State Plan are exhausted. The provider qualifications specified in the State plan apply. Speech, Language or Hearing Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants.

17.17.2 Service Limits

These services are only available as specified in participant’s Service Plan and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups. Group sessions are limited to one therapist with five participants and may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the participant's clinical record.

17.17.3 Provider Qualifications

All providers of Speech, Language, and Hearing Therapy services must comply with the standards set forth in this manual. In addition, Speech, Language, and Hearing Therapy providers shall complete State/Federal Criminal Background checks and Central Registry checks for all staff, drug tests as applicable under Stephen Komminos’ Law, and ensure that all staff successfully completes the Division mandated training.

In addition, staff providing Speech, Language, and Hearing Therapy must meet the following:

- Licensed Speech Therapists must be licensed per N.J.A.C. 13:44C.

In addition Licensed, Certified Home Health Agencies providing Speech, Language, and Hearing Therapy services must meet the following license or accreditation requirements:

- Licensed per N.J.A.C. 8:42 and Certified by the Centers for Medicare and Medicaid Services.

17.17.4 Examples of Speech, Language, and Hearing Therapy Activities

*Please note that examples are not all inclusive of everything that can be funded through this service.

- Speech, language and hearing therapy activities as prescribed by the appropriate health care professional.

17.17.5 Speech, Language, and Hearing Therapy Policies/Standards

In addition to the standards set forth in this manual, Speech, Language, and Hearing Therapy services must be performed under the guidelines described in the New Jersey practice arts for occupational and physical therapists.

17.17.5.1 Need for Service and Process for Choice of Provider

The need for Speech, Language, and Hearing Therapy will be identified through the NJ Comprehensive Assessment Tool (NJ CAT), the person-centered planning process documented in the Person-Centered Planning Tool (PCPT), and an appropriate medical prescription. In addition, the following steps must be completed in order to access Speech, Language, and Hearing Therapy:

17.17.5.1.1 Speech, Language, and Hearing Therapy is for Habilitation

- The Support Coordinator will review the NJ CAT to identify an indication that the Speech, Language, and Hearing Therapy is needed;
- The Support Coordinator uploads a copy of the medical prescription and documentation that the Speech, Language, and Hearing Therapy is necessary for habilitation provided by an appropriate health care

professional to iRecord – this information may be provided through two separate documents or all within the prescription;

- The Support Coordinator will include Speech, Language, and Hearing Therapy in the ISP as is done for other services;
- Speech, Language, and Hearing Therapy is prior authorized, delivered, and claimed.

17.17.5.1.2 Speech, Language, and Hearing Therapy is for Rehabilitation

- The Support Coordinator will review the NJ CAT to identify an indication that the Speech, Language, and Hearing Therapy is needed;
- The Support Coordinator uploads a copy of the medical prescription provided by an appropriate health care professional to iRecord;
- The individual/family reaches out to the primary insurance carrier/MCO to request Speech, Language, and Hearing Therapy;
- If the primary insurance carrier/MCO approves the Speech, Language, and Hearing Therapy, the individual will access this therapy through their primary insurer and follow the process required by that insurer;
- If the primary insurer/MCO denies the Speech, Language, and Hearing Therapy, the individual will receive (or must request) an Explanation of Benefits (EOB);
- The individual will submit the primary insurer/MCO’s EOB to the Support Coordinator;
- The Support Coordinator will upload the EOB to iRecord and assist the individual in identifying providers of Speech, Language, and Hearing Therapy;
- The Support Coordinator will include Speech, Language, and Hearing Therapy in the ISP as is done for other services;
- When the ISP is approved, the prior authorization will be emailed to the provider and the Support Coordinator will submit the EOB from the primary carrier/MCO to the service provider that has been identified in the ISP to provide Speech, Language, and Hearing Therapy;
- The prior authorized service provider (identified in the ISP) will request the “Bypass Letter Request Form” from OSC.tplunit@osc.nj.gov;
- The service provider completes the Bypass Letter Request Form, attaches the explanation of benefits (EOB) for the denied service (either for exhausted benefits or non-coverage), and submits the documents to the OSC;
- Staff at the OSC will review the information and issue a Bypass Letter if appropriate;
- The service provider will submit claims for rendered services along with the Bypass Letter to Gainwell Technologies for payment.

17.17.5.2 Documentation & Recordkeeping

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, and number of units of the delivered service for each individual and must align with the prior authorization received for the provision of services. Speech, Language, and Hearing Therapy providers are expected to maintain general notes required of Medicaid providers.

17.17.5.3 Medication Standards

If the provider is distributing medications while delivering this service, the “Medication” standards described under Day Habilitation Section 17.7.5.8 or Prevocational Training Section 17.15.5.7 (these standards are the same for both services) shall be followed.

17.18 Support Coordination

Procedure Codes	Units	Additional Descriptor	Budget Component
T2024HI	Monthly	Month	NA
T2024HI52	Daily	Daily	NA

Please refer to Appendix H for current rates.

17.18.1 Description

Services that assist participants in gaining access to needed program and State plan services, as well as needed medical, social, educational and other services. Support Coordination is managed by one individual (the Support Coordinator) for each participant. The Support Coordinator is responsible for developing and maintaining the Individualized Service Plan with the participant, their family, and other team members designated by the participant. The Support Coordinator is responsible for the ongoing monitoring of the provision of services included in the Individualized Service Plan.

17.18.2 Service Limits

All Supports Program participants receive monthly contact with their Support Coordinator. The Support Coordinator cannot be legal guardians of the participant, or other individuals who reside with the participant.

17.18.3 Unit Distinction for Support Coordination

There are two types of units available for Support Coordination services – a monthly rate and a daily rate. The authorization letter and spreadsheet will indicate which unit should be utilized for individuals assigned to the SCA.

17.18.3.1 Monthly Unit/Rate

The vast majority of claiming for Support Coordination services will be using the monthly rate. This rate is utilized whenever an individual enrolled on the CCP or in the Supports Program is assigned to a SCA on the first of the month and for each subsequent month in which Support Coordination services have been provided and deliverables (an approved ISP or completed Monthly Monitoring Tool) have been met and the individual has remained assigned to the SCA.

*Please note that when a new ISP is generated due to annual ISP date, changes to the individual budget, a change in the individual's tier assignment, or a change in waiver enrollment (going from the CCP to the Supports Program, for example). In circumstances where a new plan is generated, the SCA is expected to continue meeting deliverables, such as completing the monthly contacts, but will not be able to claim for payment for completing these deliverables unless/until the newly generated ISP is complete.

17.18.3.2 Daily Unit/Rate

The daily rate for Support Coordination services is used whenever an individual enrolled on the CCP or Supports Program is assigned to a SCA on any day other than the first of the month or if an individual is discharged from the CCP or Supports Program on any day other than the last of the month. The daily rate goes back to the date in which the Participant Enrollment Agreement has been uploaded (once the ISP has been approved) and is only utilized for the first month in which the SCA has been assigned. A deliverable of at least one case note indicating the service(s) that were provided during the days in which the SCA is claiming must be entered in iRecord.

17.18.4 Provider Qualifications

All providers of Support Coordination, including Supervisors, must comply with the standards set forth in this manual **and** meet the following qualifications:

- Bachelor's Degree or higher in any field (Please note that degrees and/or transcripts issued by a college or university outside of the United States must be evaluated by a reputable evaluation service) - and-
- 1 year of experience working with individuals with intellectual and/or developmental disabilities (I/DD).

- The experience must be the equivalent of a year of full-time documented experience working with individuals with I/DD;
- This experience can include paid employment, volunteer experience, and/or being a family caregiver of an individual with an I/DD;
- If a job applicant has experience with a different population but some percentage includes individuals with I/DD, the SCA may determine that this experience meets the requirement of one year full time experience working with individuals with I/DD. - and-
- Support Coordination Supervisors must meet all of the qualifications of a Support Coordinator; - and-
- Support Coordination Supervisors cannot be related by blood or marriage to anyone whose plan they will supervise or sign off on; - and-
- State, Federal Criminal Background checks, Child Abuse Registry Information (CARI) checks, and Central Registry checks; - and-
- Successfully complete Support Coordination Staff trainings required by the Division within the timeframes listed in Appendix E of this manual.
- Note: For an Agency Head to be able to fill in or function as a Support Coordination Supervisor they must meet all of the above requirements.

17.18.5 Support Coordination Policies/Standards

In addition to the standards set forth in this manual, the service provider and staff must comply with relevant licensing and/or certification standards.

Notification to the Division’s Support Coordination Unit is expected for operational issues which may have impact on agency operations and/or the individuals served. Back-up plans should be included in communications as appropriate. Examples of significant operational issues include, but are not limited to, Agency Head unavailability, Supervisor absence and no back-up in place, no Support Coordinator, etc.

17.18.5.1 Role of the Support Coordination Supervisor (SC Supervisor)

The SC Supervisor does not have a caseload and provides oversight and management of the Support Coordinators.

17.18.5.2 Responsibilities of the Support Coordination Supervisor

The SC Supervisor is responsible for:

- Assigning Support Coordinators to individuals who have been assigned to the Support Coordination Agency;
- Ensuring that caseloads are at the proper capacity to meet all deliverables;
- Reviewing and approving all Individualized Service Plans (ISP), utilizing the ISP Quality Review Checklist, and obtaining approval for the ISP from the Division;
- Ensuring that resources other than those funded by the Division have been explored and are either not available or not sufficient to meet the documented need;
- Ensuring that services are provided in accordance with the service definitions and parameters outlined in Division policy;
- Reviewing and signing, as appropriate, the Support Coordination Monitoring Tool. At a minimum the tool must be reviewed and signed during the following circumstances:
 - First 60 days of any new Support Coordinator;
 - When performance issues with a Support Coordinator are identified;
 - Involved/difficult cases.
- Conducting internal monitoring and oversight of Support Coordination Agency documentation and practices;
- Acting as the liaison with designated Division personnel;
- Ensuring compliance with all qualifications, standards, and policies related to Support Coordination as explained in this guide;

- Remaining up-to-date and in compliance with policy changes and updates posted on the Support Coordination Resource Page.

17.18.5.3 Role of the Support Coordinator

The Support Coordinator manages Support Coordination services for each participant. Support Coordination services are services that assist participants in gaining access to needed program and State plan services, as well as needed medical, social, educational and other services. The Support Coordinator is responsible for developing and maintaining the Individualized Service Plan with the participant, their family (if applicable), and other team members designated by the participant. The Support Coordinator is responsible for the ongoing monitoring of the provision of services included in the Individualized Service Plan.

The Support Coordinator writes the Individual Service Plan based on assessed need and the person-centered planning process with the individual and the planning team. The Support Coordinator links the individual to needed services and supports and assists the individual in identifying service providers as needed. The Support Coordinator also ensures that the services and supports remain within the allotted budget and monitor the delivery of services.

The Support Coordinator’s role can be divided into the following 4 general functions: individual discovery, plan development, coordination of services, and monitoring.

17.18.5.3.1 Individual Discovery

Individual discovery is the process by which the Support Coordinator, in conjunction with the individual and planning team, gathers and evaluates information in order to assist the individual to determine his/her outcomes, supports, and service needs. This function begins once the individual is assigned a Support Coordinator and occurs concurrently with other functions. This process and the tools used to facilitate it are further described in section 7.4.1 “Assessments/Evaluations.”

17.18.5.3.2 Plan Development

This function involves the process by which the Support Coordinator facilitates a planning team to develop the Person-Centered Planning Tool (PCPT) and Individualized Service Plan (ISP). The PCPT is a person-centered plan which identifies needed outcomes, supports, and services. The ISP directs the provision of those supports and services. Section 6 details the policies and procedures necessary to complete this function.

17.18.5.3.3 Coordination of Services

This function includes activities necessary to obtain the supports and services identified in the ISP. Coordination of services requirements are outlined in Section 6.

17.18.5.3.4 Monitoring

Monitoring is the process by which the Support Coordinator ensures that the individual progresses toward identified outcomes and receives quality supports and services as outlined in the ISP and in accordance with the Division’s mission and core principles. Section 13 describes specific responsibilities for accomplishing the monitoring function.

17.18.5.4 Responsibilities of the Support Coordinator

The Support Coordinator is responsible for:

- c. Using and coordinating community resources and other programs/agencies in order to ensure that waiver services funded by the Division will be considered only when the following conditions are met:
 - Other resources and supports are insufficient or unavailable;
 - Other services do not meet the needs of the individual; and
 - Services are attributable to the person’s disability.
- Accessing these community resources and other programs/agencies by:
 - Utilizing resources and supports available through natural supports within the individual’s neighborhood or other State agencies;
 - Developing a thorough understanding of programs and services operated by other local, State, and federal agencies;

- Ensuring these resources are used and making referrals as appropriate; and
- Coordinating services between and among the varied agencies so the services provided by the Division complement, but do not duplicate, services provided by the other agencies.
- Developing a thorough understanding of the services funded by the Division and ensuring these services are utilized in accordance with the parameters defined in Section 17 of this manual.
- Interviewing the individual and ensuring they are at the center of the planning process and in determining the outcomes, services, supports, etc. that they desire. Also interviewing, if appropriate, the family or other involved individuals/agency staff; reviewing/compiling various assessments or evaluations to make sure this information is understandable and useful for the planning team to assist in identifying needed supports; and facilitating completion of discovery tools, if applicable.
- Scheduling and facilitating planning team meetings in collaboration with the individual; informing the individual and parent/guardian that the service provider(s) can be part of the planning team, asking the individual and parent/guardian if they would like to include the service provider(s) at the ISP meeting, and inviting the service provider(s) to the ISP meeting; writing the PCPT and ISP; and distributing the ISP (and PCPT when the individual consents) to the individual, all team members, and the identified service providers; and reviewing the ISP through monitoring conducted at specified intervals.
- Ensuring that, for individuals assigned an acuity, the Addressing Enhanced Needs Form is updated at least annually and revised more frequently during the plan year as necessary. The individual/guardian shall have the opportunity to be involved in the process. See Section 3.4 for more information.
- Ensuring that there has been a discussion regarding a behavior plan for individuals with behavioral concerns and that a behavior plan is in place as needed, particularly when the individual is assigned acuity due to behavior. This shall be documented in the individual's ISP.
- Ensuring that there has been a discussion regarding the medical needs of the individual and that these needs are documented in the ISP. This is to include the need for data collection of bowel movements, urine output, seizure activity, etc. Should the planning team agree that such data collection is medically necessary, and the individual's primary care physician provides a prescription for it, this shall also be documented in the ISP along with the responsible party who will record and store the information.
- Writing the PCPT and ISP; and distributing the ISP (and PCPT when the individual consents) to the individual, all team members, and the identified service providers; and reviewing the ISP through monitoring conducted at specified intervals.
- Annual completion of the Participants Rights and Responsibilities form with the individual/guardian, uploading it to iRecord, and providing a signed copy minimally to the individual/guardian, residential, and day service provider (as applicable).
- Obtaining authorization from the SC Supervisor for Division-funded services.
- Monitoring and following up to ensure delivery of quality services, and ensuring that services are provided in a safe manner, in full consideration of the individual's rights. This includes ensuring that for individuals residing in provider-owned or controlled residential settings (i.e., Group Homes, Supervised Apartments, etc.) and/or attending day habilitation programs, pre-vocational programs and group supported employment programs that any restriction (Examples include, but are not limited to: Inability to access food at any time due to a medical disorder; Inability to have access to items due to PICA) is supported by a specific assessed need and justified in the person-centered service plan (i.e. ISP). Please see section 11.7 *Home and Community Based Services (HCBS) Settings Compliance* for more information.
- Notifying the Division's HCBS Helpdesk at DDD.HCBShelpdesk@dhs.nj.gov if they are notified that a provider-owned or controlled setting is not in compliance with section 11.7 *Home and Community Based Services (HCBS) Settings Compliance*.
- Maintaining a confidential case record that includes but is not limited to the NJ Comprehensive Assessment Tool (NJ CAT), completed Support Coordinator Monitoring Tools, PCPTs, ISPs, notes/reports, annual satisfaction surveys, annual physical and dental examinations (for those who reside in a licensed residential program), and other supporting documents uploaded to the iRecord for each individual served.
- Ensuring individuals served are free from abuse, neglect, and exploitation; reporting suspected abuse or neglect in accordance with specified procedures; and providing follow-up as necessary.
- Ensuring that incidents are reported in a timely manner in accordance with policy and follow-up responsibilities are identified and completed.

- When a Support Coordinator is alerted that an individual assigned them has had an interaction with law enforcement/court system that results in a criminal charge, summons, or complaint they will discuss the availability of resources with the individual/guardian. This may include, but is not be limited to: [The Arc of New Jersey Criminal Justice Advocacy Program](#); Resources listed in the *Legal and Advocacy Services* section of the most recent publication of [NJ Resources](#); etc. The Support Coordinator shall assist with the submission of a referral based on the expressed preference of the individual/guardian and document in an iRecord case note.
- Notifying the individual, planning team, and service provider and revising the ISP whenever services are changed, reduced, or services are terminated.
- Reporting any suspected violations of contract, certification or monitoring/licensing requirements to the Division.
- Entering required information into the iRecord in an accurate and timely manner.
- Ensuring that individuals/families are offered informed choice of service provider.
- Linking the individual to service providers by providing information about service providers; assisting in narrowing down the list of potential service providers; reaching out to providers to confirm service capacity, determine intake/eligibility requirements, gather and submit referral information as needed, establish provider capacity to implement strategies to reach identified ISP outcomes, and confirm start date, units of service, etc.
- Becoming aware of items/documentation the service provider will need prior to serving the individual and assist/ensure they are provided prior to the start of services.
- Notifying the individual regarding any pertinent expenditure issues.
- Conducting contacts on a monthly basis, face-to-face visits on a quarterly basis, and in-home face-to-face home visit on an annual basis that includes review of the ISP and is documented on the Support Coordinator Monitoring Tool.
- Completing/entering notes/reports as needed.
- Providing support, as needed, in relation to supporting the individual in their decision making as outlined in section 7.1.1 *Individual as Decision Maker*.
- Reporting data to the Division as required and upon request.
- At the direction of Division staff, completion of surveys that may be required, etc.
- Including the Individual Supports – Daily Rate service provider in the planning process.
- Alerting the planning team that, with a doctor’s order, certain charting can occur as medically necessary such as food intake, blood glucose levels, etc.
- Ensuring involved service provider(s) have received notification to begin services.
- Ensuring that the individual is aware of different housing options that can be utilized in the community (including those that are not disability specific) so that they are supported in the least restrictive setting based on their individual needs and preferences. This includes assisting them in application for housing assistance.
- In relation to Electronic Visit Verification (EVV), the Support Coordinator shall be responsible for confirming with the individual/family which staff, if any, are live-in caregivers paid by DDD through the participant’s individual budget. Should a live-in caregiver exist, the Support Coordinator shall complete the Live-In Caregiver Attestation form at the time of service-plan development, whenever there is a change in live-in caregiver status and annually thereafter. Once complete, the form shall be uploaded to iRecord.

17.18.5.5 Support Coordinator Deliverables

- Monthly contact documented on the Support Coordinator Monitoring Tool.
- Quarterly face-to-face contact documented on the Support Coordinator Monitoring Tool.
- Annual in-home face-to-face visit documented on the Support Coordinator Monitoring Tool.
- Completed PCPT & approved ISP within 30 days from date the individual is enrolled onto the Supports Program or when a new ISP is generated due to annual ISP date, changes to the individual budget, a change in the individual’s tier assignment, or a change in waiver enrollment (going from the Supports Program to the CCP, for example). In circumstances where a new plan is generated, the SCA is expected to continue meeting deliverables, such as completing the monthly contacts, but will not be able to claim for payment for completing these deliverables unless/until the newly generated ISP is complete.

If meeting the previously mentioned deliverables is delayed due to the individual (or family) failing to comply with attending meetings, participating in mandated contacts, allowing access to the home for visits, etc., the Support Coordinator should notify the individual that non-compliance regarding Division policy will be reported to the Division. If non-compliance continues, the SC Supervisor shall upload a Seeking Out Support (SOS) form and email the Support Coordination Help Desk at DDD.SCHelpdesk@dhs.nj.gov to ensure follow-up with the individual to determine the reasons why non-compliance has occurred. Ongoing non-compliance for circumstances beyond those that may be unavoidable (such as hospitalization) may result in termination from Division services. Information regarding these incidents of non-compliance, attempted or successful contacts with the individual (or family), reasons for non-compliance, etc. shall be documented through case notes entered into iRecord.

Further, updates related to any and all significant events should be documented in case notes by the Support Coordinator. Documentation should be timely and frequent for high risk or high acuity situations. Case Notes should be up to date at all times with the most recent contact or events occurring with the individual.

17.18.5.6 Mandated Staff Training & Professional Development

Approved Support Coordination Agencies are responsible for ensuring that all SC Supervisors on staff meet the qualifications, including completion of mandatory training, necessary to deliver Support Coordination services. Providers offering Support Coordination Services shall successfully complete the training outlined in Appendix E: Quick Reference Guide to Mandated Staff Training.

17.18.5.7 Conflict Free Care Management

According to the Centers for Medicare & Medicaid Services (CMS), care management services must be “conflict-free,” which has the following characteristics: there is a separation of care management from direct services provision; there is a separation of eligibility determination from direct services provision; and anyone who is conducting independent evaluations, assessments and the plan of care cannot be related by blood or by marriage to the individual or any of their paid caregivers.

Support Coordination Agencies must ensure that they are in compliance with the Conflict Free Policy. The full policy is available on the Division’s website at: <https://nj.gov/humanservices/ddd/assets/documents/services/2022-1-6-SCA-Conflict-Free-Policy.pdf>.

17.18.5.8 Caseloads & Capacity

Currently, there are no mandated caseload ratios, but the Support Coordination Agency must be able to meet the deliverables and fulfill the roles and responsibilities outlined in Sections 6.1 and 6.2. In addition, the Division will monitor caseload ratios as reported by the Support Coordination Agency and may institute caseload limits or a reduction in census if a particular Support Coordination Agency is not meeting the deliverables or able to fulfill the roles and responsibilities of the Support Coordinator or if there is an overall concern regarding ratios and Support Coordination services.

Effective April 1, 2025, any Support Coordination Agency operating for 12 months or longer must serve a minimum of 60 individuals and serve at least one county. Support Coordination Agencies serving less than 60 individuals after one year of operation may not continue operations unless extenuating circumstances have been determined by the Division. The Division of Developmental Disabilities is not responsible for referring individuals to a Support Coordination Agency to meet this or any other metric.

17.18.5.9 Zero Reject & Zero Discharge

The Support Coordination Agency must accept all individuals as assigned and cannot discharge individuals from services. A Support Coordination Agency cannot specialize in providing Support Coordination services to individuals with a particular type of disability or deny services because of the level of support an individual may or may not need. Only the Division may discharge individuals from services. The Support Coordination Agency must notify the Division of circumstances – such as failure to comply with Division eligibility or policies – that may warrant discharge from services.

17.18.5.10 Coverage

The Support Coordination Agency must ensure that Support Coordination services are available at all times. At a minimum, these services must be available via phone contact, and an answering service is acceptable as long as there is a Support Coordinator available on-call. There must be live response to phone calls – answering machines, phone prompts and other mechanical responses are not acceptable.

In circumstances where an individual contacts 24-hour services after business hours, emergent cases shall be directed to the on-call Support Coordinator for follow-up. The Support Coordinator must contact the individual and direct them to appropriate resources and/or make phone calls, including but not limited to 911, emergency personnel, and other government entities as appropriate. A meeting to develop a contingency plan to address the issue must be held on the following morning/day.

If the individual cannot meet with the Support Coordinator during business hours, the Support Coordination Agency must schedule monthly/quarterly/annual contacts/visits, planning meetings, etc. outside of business hours to accommodate the individual's needs.

17.18.5.11 Quality Assurance Responsibilities

Support Coordinators may become aware of quality assurance issues during the course of their work, e.g. licensing standards which are out of compliance, inappropriate implementation of programs, or serious incidents not being reported. The Support Coordinator must report problems to the designated Division SC Quality Assurance Specialist and document these concerns in a case note and/or the Support Coordinator Monitoring Tool.

17.18.5.12 Documentation Guidelines

Demonstration of completion of all mandated staff training must be documented through certificates of attendance/completion; sign-in sheets from the training entity, provider, or trainer; information maintained through the College of Direct Support, etc. and made available upon request of the Division.

Establishing and maintaining accurate records is critical and supporting documentation for all services rendered is essential.

In addition, assessments, tools, and service plans must be aligned so that the service plan directly relates to identified needs from the assessment.

All documentation must be HIPAA compliant. For example, paper documents/case records must be stored securely with appropriate safeguards, and the individual's written authorization for release of information must be obtained before any protected health information can be shared.

There are serious consequences to fraudulent documentation; thus, providers must take precautions to ensure compliance with all applicable laws and regulations. Common documentation errors include, but are not limited to, the following:

- Billing for services not rendered such as billing for canceled appointments or no-shows;
- Billing for misrepresented services such as services provided by unqualified staff or incorrect dates of service;
- Billing for duplicate services;
- Serious recordkeeping violations such as falsified records or no record available;
- Missing signatures;
- Developing a service plan that does not relate to the assessment/evaluation;
- Reusing identical content in multiple notes, plans, tools, documents, etc.

Documentation is considered unacceptable if it is missing altogether (such as missing notes) or illegible.

17.18.5.12.1 Making Corrections to Documents

Paper Documents

- Deletions, erasures, and whiting out errors is not permitted;
- Content can only be changed by the original writer;
- Corrections must be made by the person who originally wrote the document with one line through the error including initials and date of correction.

Electronic Documents

- Documents uploaded/entered into iRecord cannot be altered once submitted. An additional case note explaining the correction must be entered into the system.

17.18.5.12.2 Required Support Coordination Documents

- Support Coordinator Monitoring Tool;
- Person-Centered Planning Tool (PCPT);
- Individualized Service Plan (ISP);
- Participant Statement of Rights & Responsibilities;
- ISP Quality Review Checklist;
- Employment Determination Form - (F3);
- Employment Non-Referral Form to DVRS or CBVI - (F6).

17.18.5.12.3 Other Related Documents

- Support Coordination Agency Selection Form;
- NJ Comprehensive Assessment Tool (NJ CAT);
- Optional Individual Discovery Tools;
- Participant Enrollment Agreement;
- SDE Enrollment Packet for the Financial Management Service/Fiscal Intermediary being used;
- Unusual Incident Report;
- Division Circulars – found at: <https://nj.gov/humanservices/ddd/providers/staterequirements/circulars/>
- Satisfaction Surveys - to be developed.

17.18.6 Resources/Technical Assistance

Additional information and guidance related to Support Coordination can be accessed through the resources in this section.

17.18.6.1 Intensive Case Management Support

For situations where an individual requires more extensive care management, the Support Coordinator can contact their designated Division SC Quality Assurance Specialist for additional assistance. This Division staff member will consult with an appropriate Regional staff person to identify resources and information in order to assist with troubleshooting the situation.

17.18.6.2 Unusual Incident Reporting (UIR)

IR Coordinators are available in each Region to provide assistance with recording of incidents – including forms, timeframes, types of incidents, role of the Support Coordinator, etc. Contact information is available in the “Support Coordinators Guide to Incident Reporting.”

17.18.6.3 iRecord Support

To report technical problems with the iRecord, or request technical assistance, select the “Feedback” link at the top of the screen

Alternatively, if the feedback button is not available any technical inquiries can be sent to the Division service desk at DDD.ITRequests@dhs.nj.gov. This address may be used to report bugs, suggest future functionality or request technical assistance. For assistance with content of plans or how to write plans, please contact the designated Division point person.

17.18.6.4 General Resources, Information, & Clarification

- Support Coordination Resource Page- [Support Coordination \(rutgers.edu\)](#);
- Support Coordination Help Desk – DDD.SCHelpdesk@dhs.nj.gov;
- iRecord Help Desk – DDD.ITRequests@dhs.nj.gov;
- Designated Division SC Quality Assurance Specialist – as assigned per agency;
- Medicaid Eligibility Help Desk – DDD.MediElighelpdesk@dhs.nj.gov;
- Person-Centered Planning/Thinking;
 - www.inclusion.com;
 - www.learningcommunity.us;
 - The Boggs Center on Developmental Disabilities
http://rwjms.rutgers.edu/boggscenter/training/person_centered.html.

17.18.6.5 Supervisory Resources, Information, & Clarification

- Support Coordination Resource Page- <http://rwjms.rutgers.edu/boggscenter/projects/njisp.html>
- Support Coordination Help Desk – DDD.SCHelpdesk@dhs.nj.gov

17.18.7 Communication/Feedback

In an effort to streamline communication and provide the most effective support to Support Coordination Agencies, the Division has established the following protocol for requesting direction and clarification pertaining to the process and delivery of Support Coordination services:

Step 1: Support Coordination Help Desk – DDD.SCHelpdesk@dhs.nj.gov

This is the first point of contact for general information related to Support Coordination policies, training, forms, and questions about assignment of monitors.

Step 2: Support Coordination Monitors/Supervisors

Division Monitors and Supervisors in the Support Coordination Unit provide case consultation and review/approve service plans for those agencies not yet authorized to approve their own plans.

Step 3: Support Coordination Quality Assurance Specialists

Each Support Coordination Agency is assigned a designated Division Quality Assurance Specialist who provides technical assistance and training to SC Supervisors and provides feedback on quality improvement.

Step 4: Direct Communication at Administrative Level of Support Coordination Services

When all other levels of communication have not resolved the issue, communication should be sent directly to the Director, Support Coordination and Care Management Unit.

17.19 Supported Employment – Individual & Small Group Employment Support

Procedure Codes	Units	Additional Descriptor	Budget Component
T2019HI	15 minutes	Individual	Either AND SE Component as needed (DSP Service applies)
T2019HIUS	15 minutes	Tier A*	Either (DSP Service applies)
T2019HIUR	15 minutes	Tier B*	Either (DSP Service applies)
T2019HIUQ	15 minutes	Tier C*	Either (DSP Service applies)
T2019HIUP	15 minutes	Tier D*	Either (DSP Service applies)
T2019HIUN	15 minutes	Tier E*	Either (DSP Service applies)

Please refer to Appendix H for current rates.

*Tiered rates for Supported Employment – Small Group Employment Supports are utilized when Supported Employment services are being provided to groups of 2-8 individuals.

17.19.1 Descriptions

17.19.1.1 Supported Employment – Individual Employment Support

Activities needed to help a participant obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The service may be delivered for an intensive period upon the participant’s initial employment to support the participant who, because of their disability, would not be able to sustain employment without supports. Supports in the intensive period are delivered in a face-to-face setting, one-on-one. The service may also be delivered to a participant on a less intensive, ongoing basis (“follow along”) where supports are delivered either face-to-face or by phone with the participant and/or their employer. Services are individualized and may include: training and systematic instruction, job coaching, benefit support, travel training, and other workplace support services including services not specifically related to job-skill training that enable the participant to be successful in integrating into the job setting.

17.19.1.2 Supported Employment – Small Group Employment Support

Services and training activities provided to participants in regular business, industry and community settings for groups of two to eight workers with disabilities. Services may include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Services must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities. Services may include: job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefit support, travel training and planning.

17.19.2 Service Limits

17.19.2.1 Supported Employment – Individual Employment Support

This service is available to participants in accordance with the DDD Supports Program Policies & Procedures Manual and as authorized in their Service Plan. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401) or P.L. 94-142. Supported Employment – Individual Employment Support is

limited to 30 hours per week. Transportation to or from a Supported Employment site is not included in the service. When Supported Employment is provided at a work site in which people without disabilities are employed, payment will be made only for the adaptations, supervision and training required for participants as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting or for incentive payments, subsidies or unrelated training expenses.

17.19.2.2 Supported Employment – Small Group Employment Support

This service is available to participants in accordance with the DDD Supports Program Policies & Procedures Manual and as authorized in their Service Plan. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401) or P.L. 94-142. Supported Employment – Small Group Employment Support is limited to 30 hours per week. Transportation to or from a Supported Employment site is not included in the service. When Supported Employment is provided at a work site in which people without disabilities are employed, payment will be made only for the adaptations, supervision and training required for participants as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting or for incentive payments, subsidies or unrelated training expenses.

17.19.3 Provider Qualifications

All providers of Supported Employment services (Individual or Small Group Employment Support) must comply with the standards set forth in this manual. In addition, Supported Employment providers shall complete State/Federal Criminal Background checks and Central Registry checks for all staff, drug tests as applicable under Stephen Komminos' Law, and ensure staff successfully completes the Division mandated training, are a minimum of 20 years of age, and possess a valid driver's license and abstract (not to exceed 5 points) if driving is required.

17.19.4 Examples of Supported Employment Activities

*Please note that examples are not all inclusive of everything that can be funded through this service

17.19.4.1 Supported Employment – Individual Employment Support

- Training and systematic instruction
- Job coaching
- Benefit support/planning
- Job development
- Travel training
- Training that will enable an individual to be successful in integrating on a job setting (even where not specifically related to job skills)
- Job site analysis

17.19.4.2 Supported Employment – Small Group Employment Support

- Mobile crews / crew labor
- Group placement (enclaves)
- Social enterprises in which employees are making at least minimum wage
- On-site job training
- Job development
- Job site analysis

17.19.5 Supported Employment Policies/Standards

In addition to the standards set forth in this manual, the service provider and staff must support and implement individual behavior plans, as applicable, and comply with relevant licensing and/or certification standards.

17.19.5.1 Supported Employment Overview

The Division believes that all individuals with a developmental disability can fulfill their employment aspirations and achieve social and economic inclusion through employment opportunities. The Division further believes that

all individuals with developmental disabilities are entitled to the same competitive wages, work conditions, and career development as their co-workers. In other words, “Real Jobs for Real Pay.”

17.19.5.1.1 Phases of Supported Employment

Supported Employment services are typically provided in three phases: pre-placement, intensive job coaching, and long-term follow-along (LTFA). These phases are conducted based on individual needs and are not required for everyone receiving Supported Employment services.

17.19.5.1.1.1 Pre-Placement Phase

Services utilized to assist the job seeker in identifying a career path and potential job matches and finding competitive employment in the general workforce. Activities conducted in this phase of Supported Employment include but are not limited to the following:

- Assessments – particularly situational assessments (also known as trial work experience, community-based vocational assessment, job sampling) to identify the individual’s strengths, skills, preferences, support needs, etc.;
- Vocational profile development – details areas of career interest; identifies strengths, skills, preferences, support needs; and provides a plan for finding employment;
- Job development – utilizing assessment information to target jobs available in the local labor market and link the job seeker with job opportunities consistent with their interests, abilities, and identified work goal. Some activities may include meeting with employers, proposing a potential employee to the employer, etc.;
- Development/improvement of job seeking skills – assistance with resume development, building interview skills, assisting with networking, completing applications, etc.;
- Addressing concerns/barriers – assisting the job seeker in understanding how to maintain benefits while working, explaining work incentives available through the Social Security Administration, explaining WorkAbility – NJ’s Medicaid Buy-In Program, linking the individual to transportation options, etc.;
- Job site analysis – the systematic study of a specific job that is conducted by observing a worker performing their job and making note of the tasks and duties performed by the worker as well as determining the skill, educational, and experience requirements necessary for the job and the safety and work culture of the environment in which this job is performed;
- Outreach to businesses – setting up interviews (and/or trial work periods for individuals with limited interview skills), explaining the benefits of hiring the job seeker, arranging customized employment opportunities, identifying and proposing support needs as applicable, job carving, job restructuring, etc.

17.19.5.1.1.2 Intensive Job Coaching Phase

Services utilized once the job seeker has become employed to assist the employer in teaching the job, communicating standards, and supporting the employee as well as assist the newly hired employee in learning the job, understanding how to perform their work tasks to the standard of the employer, and integrating into the work site. Activities conducted in this phase of Supported Employment include but are not limited to the following:

- Assistance with orientation and new hire activities;
- On-site job coaching;
- Direct training on job duties/tasks;
- Developing strategies, interventions, jigs, accommodations, and natural supports
- Travel training;
- Supporting the employee in communicating with the employer;
- Fading from the job site as the employer becomes more skilled at their job and independent.

17.19.5.1.1.3 Long-Term Follow-Along Phase (LTFA)

Services utilized once the employee is stabilized on the job and can perform their job independently with the strategies, interventions, jigs, accommodations, and natural supports that have been established. Activities conducted in this phase of Supported Employment include but are not limited to the following:

- Ongoing and regular on- or off-site support to ensure job stabilization continues;
- Address changes to job duties/tasks;

- Meet standards of a new supervisor;
- Address issues/concerns that come up;
- Assist in career planning (promotions, salary increases, new tasks/jobs, other job opportunities, etc.).

17.19.5.2 Need for Service and Process for Choice of Provider

Supported Employment services can be provided to anyone who is in need of assistance in finding or keeping competitive employment in the general workforce. The need for Supported Employment services will typically be identified through the Pathway to Employment discussion that takes place during the person-centered planning process and documented in the Person-Centered Planning Tool (PCPT). Once this need is identified, an outcome related to finding and/or keeping competitive employment in the general workforce will be included in the Individual Service Plan (ISP) and the Supported Employment provider will develop strategies to assist the individual in reaching the desired outcome(s).

This service can only be accessed through the Division if it is not available through the Division of Vocational Rehabilitation Services (DVRS) or Commission for the Blind & Visually Impaired (CBVI) – as documented on the Employment Determination Form - (F3). The Pre-Placement and Intensive Job Coaching phases of Supported Employment are typically provided by DVRS or CBVI; however, these phases are always available through the Division if the individual cannot access them through DVRS or CBVI. The Long-Term Follow-Along (LTFA) phase of Supported Employment – if needed – is always provided through the Division. In circumstances where an individual is receiving Division funding during the LTFA phase of Supported Employment but loses their job and needs employment services to provide assistance in finding a new job, the individual must go to DVRS/CBVI to determine eligibility (even if they were not previously eligible for employment services through DVRS/CBVI). While going through the eligibility determination process or awaiting services to be arranged through DVRS/CBVI, the Division will provide funding for Supported Employment services. Once the individual is deemed eligible for DVRS/CBVI, the funding will switch back to them. If the individual is not eligible for DVRS/CBVI services, the Division will continue to fund them. The Support Coordinator must be informed by the individual, family, and/or Supported Employment provider of this change in employment. The Support Coordinator will revise the ISP as needed to reflect changes to Supported Employment service needs if applicable and ensure that the individual has sought out DVRS/CBVI services by uploading the referral and resulting F3 forms to iRecord.

It is recommended that the individual research potential service providers through phone calls, meetings, office visits, etc. to select the service provider that will best meet their needs.

Due to potential issues related to employee/employer relationships, confidentiality, conflicts of interest, etc., an individual in need of Supported Employment – Individual Employment Support services to assist them in maintaining employment with a service provider will need to access those Supported Employment – Individual Employment Support services from a Supported Employment provider separate from the one that is employing the individual.

However, if the individual employed by the service provider is part of a crew, enclave, group placement, etc. and in need of Supported Employment – Small Group Employment Support services, the Supported Employment – Small Group Employment Services can be provided by the service provider that is employing them. Group placements are encouraged to occur in the community within business entities serving the general public, but they can occur within the service provider’s building/complexes as long as the individuals are working in areas where they do not also receive programming from the service provider and are paid at least minimum wage.

The Supported Employment service provider can require/request referral information that will assist the provider in offering quality services. Once the Support Coordinator has informed the provider that the individual has selected them to provide Supported Employment services, the provider has five (5) working days to contact the individual and/or Support Coordinator to express interest in delivering services.

The agency identified to provide this service along with details regarding the extent of the service hours, duration, frequency, etc. will be noted in the ISP providing prior authorization for the identified service provider to perform this service. A copy of the approved ISP will be provided to the identified service provider.

17.19.5.3 Minimum Staff Qualifications

The service provider shall meet the minimum staff qualifications and training set forth in this manual. Qualifications and training shall be documented either in the employment application, resume, reference check, or other personnel document(s).

17.19.5.3.1 All Staff

- Minimum 20 years of age; – AND –
- Complete State/Federal Criminal Background checks and Central Registry checks;
- Valid driver’s license and abstract (not to exceed 5 points) if driving is required.

17.19.5.3.2 Executive Director or Equivalent

- Bachelor’s Degree; - OR -
- High school diploma and 5 years’ experience working with people with developmental disabilities, two of which shall have been supervisory in nature.

17.19.5.3.3 Program Management Staff/Supervisors

- Graduated from an accredited college or university with a Bachelor’s degree, or higher, in Education, Social Work, Psychology or related field, plus one (1) year of successful experience in human services or employment services; **or**
- Graduated from an accredited college with an Associate’s degree, plus two (2) years of successful experience in human services; **or**
- Graduated with a high school diploma or equivalent and five (5) years of experience in occupational areas similar to those being offered at the program. A combination of college or technical school may be substituted for experience on a year for year basis;
- Have a clear understanding of the demands and expectations in business and industry.

17.19.5.3.4 Employment Specialist

- Have an Associate’s degree or higher in a related field from an accredited college or university or have a high school diploma or equivalent with three (3) years of related experience.
- Be familiar with the demands and expectations of business and industry.

17.19.5.4 Mandated Staff Training & Professional Development

The service provider shall comply with any relevant licensing and/or certification standards. Agency Trainers must have a minimum of 1 year experience in the field or 1 year experience in training. All staff providing Supported Employment services shall successfully complete the training outlined in Appendix E: Quick Reference Guide to Mandated Staff Training.

17.19.5.5 Documentation and Reporting

Demonstration of completion of all mandated staff training must be documented through certificates of attendance/completion; sign-in sheets from the training entity, provider, or trainer; information maintained through the College of Direct Support, etc. and made available upon request of the Division. Supervisors shall conduct and document use of competency and performance appraisals in the content areas addressed through mandated training.

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, and number of units of the delivered service for each individual and must align with the prior authorization received for the provision of services.

Standardized documents are available in Appendix D. Providers using an electronic health record (EHR) or billing system that cannot duplicate these standardized documents will remain in compliance if all the information required on these documents is captured somewhere and can be shown/reviewed during an audit.

17.19.5.5.1 Supported Employment Services – Pre-Employment Service Log

The provider of Supported Employment services, in collaboration with the individual, must develop strategies to assist a job seeking individual in obtaining competitive employment in the general workforce in an area related to applicable ISP outcomes and document the related activities and progress on the Supported Employment Services – Pre-Employment Service Log each time a service is delivered.

17.19.5.5.2 Supported Employment Services – Intervention Plan and Service Log

The provider of Supported Employment Services, in collaboration with the individual and their employer, must identify areas in which the employed individual needs to improve in order to remain employed. The areas that need to be addressed/improved along with the strategy that will be utilized to correct these issues must be documented on the first page of the Supported Employment Services – Intervention Plan & Service Log. The Supported Employment provider will also document the services that were provided and progress the individual has made toward their outcomes and meeting employer standards on the second page of the Supported Employment Services – Intervention Plan and Service Log during each date in which services are provided.

17.19.5.6 Medication Standards

If the provider is distributing medications while delivering this service, the “Medication” standards described under Day Habilitation Section 17.7.5.8 or Prevocational Training Section 17.15.5.7 (these standards are the same for both services) shall be followed.

17.19.5.7 Quality Assurance and Monitoring

The Division will conduct quality assurance and monitoring of Supported Employment providers in accordance with the requirements of the Supports Program Quality Plan.

17.20 Supports Brokerage

Procedure Codes	Units	Additional Descriptor	Budget Component
T2041HI22	15 minutes		Individual/Family Supports
T2041HIU7	15 minutes	Self-Directed Employee	Individual/Family Supports

Please refer to Appendix H for current rates.

17.20.1 Description

Service/function that assists the participant (or the participant’s family or representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage program services. Examples of skills training include providing information on recruiting and hiring direct care workers, managing workers and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that participants understand the responsibilities involved with directing their services.

17.20.2 Service Limits

This service is available only to participants who self-direct some or all of the services in their Service Plan and is intended to supplement, but not duplicate, the Support Coordination service. The extent of the assistance furnished to the participant or designated representative is specified in the Service Plan. The Supports Brokerage services cannot be paid to legal guardians, parents, or spouses of the participant. Legal guardians or other natural supports can provide the service at no cost to the state. Entities rendering Division-funded Supports Brokerage services are prohibited from:

- Providing another waiver service to an individual for whom they are providing Supports Brokerage. In circumstances where another service is to be provided by the same provider there must be at least a six-month gap between the provision of Supports Brokerage and the start of the alternate service.
- Facilitating placements/moves from any provider-managed licensed setting without the full documented agreement of the individual/guardian and awareness of pertinent team members including the residential provider and Support Coordinator.
- Finding and connecting individuals with community resources on behalf of a provider agency (such as day habilitation providers, individual/community-based supports provider agencies, etc.).

For information on determining the Reasonable and Customary Wage for an SDE please review section **8.3.2.0.2 – Establishing a Self-Directed Employee (SDE) Hourly Wage Where the Direct Support Professional Service Does Not Apply**.

17.20.3 Provider Qualifications

All providers of Supports Brokerage must comply with the standards set forth in this manual. In addition, Supports Brokerage providers shall complete State/Federal Criminal Background checks, Child Abuse Registry Information (CARI) checks, and Central Registry checks for all staff, drug tests as applicable under Stephen Komminos’ Law, and ensure that all staff successfully completes the Division mandated training, are a minimum of 18 years of age, possess a valid driver’s license and abstract (not to exceed 5 points) if driving is required, and have at least two years of demonstrated experience working with individuals with ID/DD in a planning or coordination role.

If the Supports Brokerage provider is a Home Health Agency or Health Care Service Firm, they must meet the following additional license or accreditation requirements:

- Licensed per N.J.A.C. 8:42 and Certified by the Centers for Medicare and Medicaid Services; -or-
- Accredited by one of the following:
 - New Jersey Commission on Accreditation for Home Care Inc. (CAHC);
 - Community Health Accreditation Program (CHAP);
 - Joint Commission on Accreditation of Healthcare Organizations (JCAHO);

- National Association for Home Care and Hospice (NAHC);
- National Institute for Home Care Accreditation (NIHCA).

17.20.4 Examples of Supports Brokerage Activities

*Please note that examples are not all inclusive of everything that can be funded through this service

- Providing information on recruiting and hiring workers
- Assisting with developing advertisements, flyers, and other recruiting materials as needed for hiring staff
- Providing support with the completion of applicant screenings
- Providing assistance to complete and submit self-directed related paperwork to fiscal agent.
- Assist with managing Self-Directed Employees (SDEs) and self-directed services paid through use of one of the Division’s fiscal intermediaries (e.g., Goods and Services)
- Assist with interviewing potential applicants, along with the person with disabilities and/or designee

17.20.5 Supports Brokerage Policies/Standards

In addition to the standards set forth in this manual, the service provider and staff must comply with relevant licensing and/or certification standards, including professional development.

17.20.5.0.1 Examples of Supports Brokerage Responsibilities

The Supports Broker responsibilities include, but are not limited, to:

- Meeting with the planning team to discuss the plan needs, preference, and goals related to self-direction/self-directed services and determine the supports the Supports Broker will provide.
- Assisting individuals who self-direct some, or all, of their services in a manner that supplements, but does not duplicate, the Support Coordination Service.
- Operating and communicating under the instruction of the individual in collaboration with members of their circle of support as directed by them:
 - Assist the individual with managing employer-related tasks such as:
 - Recruitment, interviewing, and hiring;
 - Determining pay rates for self-directed employees;
 - Training for self-directed employees;
 - Writing of Job Descriptions;
 - Developing materials to help self-directed employees understand their role of listening to and supporting the individual to live independently in their home, be included in the community, and provide support in ways that are needed and preferred;
 - Assist the individual with communicating support needs and preferences as needed;
 - Scheduling self-directed employees;
 - Supervising self-directed employees;
 - Reviewing health and safety issues;
 - Understanding employer-related duties/responsibilities;
 - Identification/remediation of problems with self-directed employees that are directly related to participant needs as per job description.
 - Securing resources and completing paperwork necessary to maintain independent living and self-direction/self-directed services:
 - Identifying areas of support to promote success with self-direction/self-directed services;
 - Community Mapping to identify informal networks within the community;
 - Developing, expanding, and facilitating a circle of support;
 - Locating and securing a place to live (apartment, condo, etc.).

17.20.5.1 Need for Service and Process for Choice of Provider

The need for Supports Brokerage services will typically be identified in the person-centered planning process documented in the Person-Centered Planning Tool (PCPT). It should be clearly indicated in a person’s individualized service plan that the person will be self-directing some or all of their services. Once this need is identified, an outcome related to the result(s) expected through the participation in Supports Brokerage services will be included in the Individual Service Plan (ISP) and the Supports Brokerage provider will develop strategies with the person, family/guardian, and identified planning team members as needed in reaching the desired outcome(s).

The Supports Brokerage service provider can require/request referral information that will assist the provider in offering quality services. Once the Support Coordinator has informed the provider that the individual has selected them to provide Supports Brokerage services, the provider has five (5) working days to contact the individual and/or Support Coordinator to express interest in delivering services.

The agency identified to provide this service along with details regarding the extent of the service hours, duration, frequency, etc. will be noted in the ISP providing prior authorization for the identified service provider to perform this service. Service hours, duration, and frequency will be determined through discussion and planning that takes place with the person, family/guardian, and planning team as needed to determine the supports provided by the Supports Broker. A copy of the approved ISP and Service Detail Report will be provided to the identified service provider.

17.20.5.2 Minimum Staff Qualifications

The service provider shall meet the minimum staff qualifications and training set forth in this manual. Qualifications and training shall be documented either in the employment application, resume, reference check, or other personnel document(s).

- Minimum 18 years of age; – AND –
- Complete State/Federal Criminal Background checks and Central Registry checks; – AND –
- Valid driver’s license and abstract (not to exceed 5 points) if driving is required; – AND –
- Two years of demonstrated experience working with individuals with ID/DD in a planning and/or coordination role.

17.20.5.3 Mandated Staff Training & Professional Development

The service provider shall comply with any relevant licensing and/or certification standards. Agency Trainers must have a minimum of 1 year experience in the field or 1 year experience in training. All staff providing Supports Brokerage services shall successfully complete the training outlined in Appendix E: Quick Reference Guide to Mandated Staff Training and comply with professional training requirements.

17.20.5.4 Documentation and Reporting

Demonstration of completion of all mandated staff training must be documented through certificates of attendance/completion; sign-in sheets from the training entity, provider, or trainer; information maintained through the College of Direct Support, etc. and made available upon request of the Division.

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, number of units of the delivered service, details of the service that was provided for each individual, signature, and must align with the prior authorization received for the provision of services. Documentation should include the scope of work as identified by the individual and additional support(s) provided. Documentation should include tasks, actions, and resolutions that have been completed to address overall support need(s). Tasks can include calling Medicaid with the individual, finding community resources, posting on job-search sites, etc.

17.20.5.5 Medication Standards

If the provider is distributing medications while delivering this service, the “Medication” standards described under Day Habilitation Section 17.7.5.8 or Prevocational Training Section 17.15.5.7 (these standards are the same for both services) shall be followed.

7.20.5.6 Quality Assurance/Monitoring

The Division will conduct quality assurance and monitoring of Supports Brokerage providers in accordance with the requirements of the Supports Program Quality Plan.

17.21 Transportation

Procedure Codes	Units	Additional Descriptor	Budget Component
A0090HI22	Mile	Multiple Passenger Rate	Either
A0090HI	Mile	Single Passenger Rate	Either
A0090HI52	15 minutes	Self-Directed Employee	Either

Please refer to Appendix H for current rates.

17.21.1 Description

Service offered in order to enable participants to gain access to services, activities and resources, as specified by the Service Plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State Plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

17.21.2 Service Limits

Reimbursement for transportation is limited to distances not to exceed 150 miles one way and cannot be used for services where transportation is built into the rate (e.g. Individual Supports/Daily Rate and/or Day Habilitation within assigned catchment area).

When one or more individuals is being transported, **the service rendered and claimed for is Transportation** (either Multiple Passenger, Single Passenger, or Self-Directed Employee). Transportation typically cannot be delivered concurrently (during the same period of time) as another service. A listing of services that can be provided at the same time as Transportation can be found in Appendix K: Quick Reference Guide to Overlapping Claims for SP Services. As with all SP services, the need for the overlapping service must be a documented medical or behavioral need of the individual, memorialized in the ISP, prior authorized and related to an ISP outcome.

17.21.3 Provider Qualifications

Multiple passenger rate providers and Self-Directed Employee transportation providers must comply with the standards set forth in this manual. In addition, Transportation providers shall complete State/Federal Criminal Background checks and Central Registry checks for all staff, drug tests as applicable under Stephen Komminos' Law, and ensure that all staff successfully completes the Division mandated training, are a minimum of 18 years of age, and possess a valid driver's license and abstract (not to exceed 5 points).

17.21.4 Transportation Options

Transportation services can be provided by Medicaid/DDD approved transportation providers, generic transportation services/vendors used by the general public, and/or Self-Directed Employees.

17.21.4.1 Multiple Passenger Rate

The Multiple Passenger Rate is utilized when a Medicaid/DDD approved provider is transporting more than one individual using their individualized budget to fund Division services. The multiple passenger rate is utilized for the entire trip for each individual receiving the service – even at the point when there is only one passenger in the vehicle because they are the first passenger picked up and/or the last passenger dropped off.

When Multiple Passenger Transportation is provided and more than one passenger has a documented medical or behavioral need for the overlapping service to be provided at the same time as Transportation to ensure their safety, a separate one-to-one support staff (in addition to the driver who is providing the transportation service) must be in the vehicle for each passenger receiving the overlapping service. See 17.21.2 Service Limits.

17.21.4.2 Single Passenger Rate

Due to the reasonable & customary rate, requests for this service must be submitted to the Division for review and approval prior to their use. This rate is utilized in the following circumstances:

- A community vendor or Medicaid/DDD approved provider is transporting one individual for the entire trip. **OR**
- A community vendor whose sole or primary business is transportation (and who does not provide other Division services) is transporting one or more individuals receiving DDD-funded transportation services.

17.21.4.3 Self-Directed Employee Rate

This rate is utilized when a Self-Directed Employee is being hired by the individual to provide transportation for them. All of the standards for the SDE hiring and payment process apply.

For information on determining the Reasonable and Customary Wage for an SDE please review section **8.3.2.0.2 – Establishing a Self-Directed Employee (SDE) Hourly Wage Where the Direct Support Professional Service Does Not Apply**.

17.21.4.3 Additional Flat Rate, Boarding Rate, etc.

If a generic transportation service has an additional flat or boarding fee, the request to cover that additional cost must go through Goods & Services. The process to request Goods & Services is described in Section 17.10.5.1.

17.21.5 Transportation Policies/Standards

In addition to the standards set forth in this manual, the service provider and staff must comply with relevant licensing and/or certification standards.

All vehicles utilized by the Transportation provider to transport individuals receiving services shall:

- Comply with all applicable safety and licensing regulations of the State of New Jersey Motor Vehicle Commission regulations;
- Be maintained in safe operating condition;
- Contain seating that does not exceed maximum capacity as determined by the number of available seatbelts and wheelchair securing devices;
- Be wheelchair accessible by design and equipped with lifts and wheelchair-securing devices which are maintained in safe operating condition when transporting individuals using wheelchairs; and
- Be equipped with the following:
 - 10:BC dry chemical fire extinguisher;
 - First Aid kit;
 - At least 3 portable red reflector warning devices;
 - Snow tires, all weather use tires, or chains when weather conditions dictate.

17.21.5.1 Need for Service and Process for Choice of Provider

The need for Transportation will be identified through the NJ Comprehensive Assessment Tool (NJ CAT) and the person-centered planning process documented in the Person-Centered Planning Tool (PCPT). Once this need is identified, an outcome related to the result(s) expected through the use of Transportation will be included in the Individual Service Plan (ISP).

17.21.5.1.1 Accessing Transportation Services

Once the transportation provider has been identified, the Support Coordinator will include details regarding the service, provider, mileage, etc. into the ISP.

17.21.5.1.1.1 Multiple Passenger

The Support Coordinator will indicate the chosen provider, mileage, dates of service, etc. in the ISP. The identified multiple passenger transportation provider will receive prior authorization upon ISP approval and will claim to Medicaid (through Gainwell Technologies) for reimbursement of services delivered.

17.21.5.1.1.2 Single Passenger

The Support Coordinator will add the transportation service to the ISP using the A0090HI (single passenger rate) procedure code. Upon selecting this procedure code, iRecord will provide a box to “Upload Service Request” where the Support Coordinator will upload the completed “Single Passenger Transportation Request” document review. As long as the requested transportation is within a reasonable & customary rate, approval will be provided by the Division. At the point at which the service is approved, the ISP will be able to be approved and prior authorization will be provided to the Fiscal Intermediary. The transportation provider will submit an invoice to the Fiscal Intermediary for payment.

17.21.5.1.2 Exclusions

- Medical transportation (see Section 17.21.1)
- Transportation provided as part of the Day Habilitation service (pick up and drop off within the service provider’s catchment area), and
- Transportation to community activities if the provider has decided to provide Day Habilitation services while traveling to and from the community site and claim for Day Habilitation rather than Transportation as described in Section 17.7.5.9.

17.21.5.2 Minimum Staff Qualifications

The service provider shall meet the minimum staff qualifications and training set forth in this manual. Qualifications and training shall be documented either in the employment application, resume, reference check, or other personnel document(s).

- Minimum 18 years of age; – AND –
- Complete State/Federal Criminal Background checks and Central Registry checks; and
- Valid driver’s license and abstract (not to exceed 5 points).

17.21.5.3 Mandated Training & Professional Development

The service provider shall comply with any relevant licensing and/or certification standards. Agency Trainers must have a minimum of 1 year experience in the field or 1 year experience in training.

17.21.5.4 Medication Standards

If the provider is distributing medications while delivering this service, the “Medication” standards described under Day Habilitation Section 17.7.5.8 or Prevocational Training Section 17.15.5.7 (these standards are the same for both services) shall be followed.

17.21.5.5 Documentation and Reporting

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, pick up and drop off addresses, and mileage of the delivered service for each individual and must align with the prior authorization received for the provision of services.

17.22 Vehicle Modifications

Procedure Codes	Units	Additional Descriptor	Budget Component
T2039HI	Single	NA	Individual/Family Supports

Please refer to Appendix H for current rates.

17.22.1 Description

Assessments, adaptations, or alterations to an automobile or van that is the participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the Service Plan, are necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.

17.22.2 Service Limits

All Vehicle Modifications are subject to prior approval on an individual basis by DDD. The following are specifically excluded: (1) Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; (2) Purchase or lease of a vehicle; and (3) Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

17.22.3 Provider Qualifications

All providers of Vehicle Modification services must comply with the standards set forth in this manual.

In addition, Vehicle Modifications providers must meet the following:

- Accredited by the National Mobility Equipment Dealers Association (NMEDA) recognized Quality Assurance Program, or its equivalent -and-
- Compliance with NJ State motor vehicle codes

17.22.4 Examples of Vehicle Modifications

*Please note that examples are not all inclusive of everything that can be funded through this service

- Vehicle steering/brake controls
- Vehicle lift
- Vehicle ramp
- Raising/lowering vehicle roof/floor

17.22.5 Vehicle Modifications Policies/Standards

In addition to the standards set forth in this manual, the service provider and staff must comply with relevant licensing and/or certification standards.

17.22.5.1 Need for Service and Process for Choice of Provider

The need for a Vehicle Modification will be identified through the NJ Comprehensive Assessment Tool (NJ CAT) and the person-centered planning process documented in the Person-Centered Planning Tool (PCPT). In addition, the following steps must be completed in order to access Vehicle Modifications:

- The Support Coordinator will assist the individual in identifying a business that offers this service and gather an estimate and supporting documentation;
- The Support Coordinator will complete and submit the "Vehicle Modification Request" form as well as upload the estimate/bid and any supporting documents to iRecord and notify the Division at DDD.ServiceApprovalHelpdesk@dhs.nj.gov for review. All estimates/bids must include the following:
 - The requested item needed, including name, model number, and any other identifying specifications (all measurements must be taken by a professional to ensure the specifications are correct);
 - Unit cost and quantity, if applicable, and total quoted price;
 - Clear itemization of cost of material, labor, and shipping/freight if applicable;

- Name and address of vendor on company letterhead;
- Vendor's Federal ID number;
- Vendor representative's name, phone number, and email address.
- The Division will review the estimate/bid and supporting documentation and provide a determination regarding the requested Vehicle Modifications;
- Upon Division approval, the Support Coordinator will add needed Vehicle Modifications and follow the ISP approval process;
- The Vehicle Modifications provider will render services as prior authorized by the approved ISP and claim through the FI.

If the available/remaining Individual/Family Supports budget does not cover the entire cost of the Vehicle Modification, the individual/family may pay for the difference, divide the cost between plan years/terms or request to use funding from a budget component other than Individual/Family Supports (assuming available funding in the alternate budget component) in order to get the work completed.

17.22.5.2 Documentation and Reporting

Documentation of the delivery of service must be maintained to substantiate claims. This documentation should include the date, start and end times, and number of units of the delivered service for each individual and must align with the prior authorization received for the provision of services.

18 HOUSING SUPPORTS FOR INDIVIDUALS IN THE SUPPORTS PROGRAM

Individuals enrolled in the Supports Program cannot reside in licensed settings, but the Division has developed mechanisms for individuals in the Supports Program, on an individual-by-individual basis, to access housing assistance based on availability. Information regarding accessing this assistance and the standards related to it are described in this section.

18.1 Funding Support for Residential Services and Housing

18.1.1 Community Based Supports

The services provided within the home to assist the individual in daily living. See Section 17.5 for complete description of this service. Providers must be prior authorized and follow the standards described in Section 17.5 in order to provide these services and receive payment through Medicaid/DDD.

18.1.2 Housing Voucher through the Supportive Housing Connection (SHC)

The Division has partnered with the New Jersey Housing Mortgage Finance Association (NJHMFA) to provide housing subsidies to eligible individuals through the Supportive Housing Connection (SHC).

The SHC is meant to be a bridge program for housing assistance to be used until an individual can access a resource through a federal, state or local housing assistance program (i.e.: Housing Choice Voucher – formerly known as Section 8) or other outlet. Subsidies through the SHC are not an entitlement and distribution of available subsidies are based on funding availability in a given State Fiscal Year and criteria set forth by the Division.

18.1.2.1 Accessing a SHC Voucher

18.2.2.1.1 Individuals in the Supports Program

Individuals enrolled in the Supports Program may have access to a subsidy based on the availability of subsidies within the State Fiscal Year and criteria set forth by the Division. Individuals interested in receiving a housing subsidy should notify their Support Coordinator and ask that they submit a housing Subsidy Request to the Division on their behalf.

18.1.2.2 Role of the Supportive Housing Connection

- Administer rental subsidies for the Division;
- Provide landlord outreach and training;
- Administer rental and other housing assistance;
- Provide unit inspections (for licensed settings);
- Perform resident inquiry services for participants.

18.1.2.3 Supportive Housing Connection Guidelines

18.1.2.3.1 Rental Units

Individuals awarded an SHC subsidy are subject to the standards set forth in Section 18.1.2.4. Published Rent Standards (PRS) are applied as found at <https://nj.gov/humanservices/ddd/individuals/housing/>.

Individuals residing in units within PRS must agree to monitor federal, state, or local housing assistance program (i.e. Housing Choice Voucher – formerly known as Section 8) waiting lists for when they accept new names. At the time in which these programs are accepting new names, the individual must apply. When an individual is selected to receive housing assistance through another resource, they must move from the SHC subsidy to that other resource. This use of other resources will allow the individual to maintain their housing assistance and permit the Division to redistribute the SHC subsidy to other individuals receiving Division services that are not yet receiving a subsidy.

18.1.2.4 General Standards

SHC subsidy recipients must adhere to the following standards at all times:

- a. An initial rental unit must be located and secured within 90 days of an individual receiving their Welcome Package from the SHC.
- b. Individual must not have been deemed ineligible to receive federal, state or local housing assistance (Ex. Housing Choice Voucher – formerly known as Section 8) in the past. For example, an individual previously received a voucher through another source and lost that voucher due to activity making him/her ineligible to receive it again in the future.
- c. SHC subsidies are only available to Division eligible individuals who reside within New Jersey. SHC subsidies may not be used outside of the State of New Jersey.
- d. Individuals must maintain eligibility for Division services in order to receive/maintain an SHC rental subsidy. This includes Medicaid eligibility and cooperation with all relevant monitoring requirements for the Supports Program or Community Care Program (depending on which one they are enrolled in).
- e. Residents receiving an SHC subsidy must notify their Support Coordinator or Case Manager (Ex. Support Coordinator) and SHC when moving to a unit or renewing a lease or if there is any change in income or in the number of people residing in the residence. A change in the number of people residing in the household will be considered to occur when the tenant has a guest stay for more than four consecutive weeks or a timeframe established within their lease, whichever is less. Addition to the number of individuals residing in a unit could result in termination of rental subsidy.
- f. Resident must pay their portion of the rent directly to the landlord in a timely fashion and maintain all utilities. Individuals may receive support from utility assistance programs. Resident must pay 30% of their income, as established through the application process, directly to their landlord each month. The remaining rental cost, up to Published Rate Standards (PRS) as published at <https://nj.gov/humanservices/ddd/individuals/housing/>, will be paid directly to the landlord by the SHC. *Individuals residing in Rental Units that were previously funded by the Division as described in Section 18.2.2.2.1.2 are exempt from this standard.*
- g. Resident is required to apply for federal, state or local housing assistance programs (Ex. Housing Choice Voucher – formerly known as Section 8) when available. This can be done by monitoring the New Jersey Department of Community Affairs website, local housing authority websites and local newspapers. Failure to apply for and accept a resource from an alternate housing assistance program will result in loss of SHC subsidy. Upon approval for rental assistance through another source, the resident must comply with the coordinating program's approved living arrangement guidelines and tenant portion responsibility guidelines. *Individuals residing in Rental Units that were previously funded by the Division as described in Section 18.2.2.3.1.2 or residing in State or Agency Owned properties using the SRO reimbursement model described in Section 18.2.2.2.3.1 are exempt from this standard.*
- h. Applicants must remain in the residence and be in compliance with their lease for each lease term in order to remain eligible for the SHC subsidy. Lease terms are typically one year. A minimum of 30-days written notice must be provided and sent to the Division and SHC if the resident intends to move out of the unit at the end of their lease term.
- i. Rent and SHC subsidy may continue to be paid for up to six months during periods of hospitalization. Consideration may be given to shorten this timeframe if the resident so desires (Ex. Lease is set to expire).
- j. In instances where an individual no longer resides in a location and it is not due to hospitalization, no additional months' rent will be paid.
- k. Rental units in unlicensed settings must meet the Department of Housing and Urban Development (HUD) Quality Standards and will not be subject to the standards set forth in N.J.A.C. 10:44A – Standards for Community Residences for Individuals with Developmental Disabilities. Residents must allow SHC staff to inspect the unit prior to occupancy and re-inspect up to 90 days before the end of each lease year to ensure these standards continue to be met. (30-days-notice will be allowed for corrections; 24-hours for life threatening issues).
- l. Rental units in non-DDD licensed settings will receive housing inspections completed by SHC staff to ensure compliance with HUD Quality Standards.
- m. Resident must not commit any serious or repeated violation(s) of the lease.
- n. Resident cannot engage in drug related criminal activity, violent or any other criminal activity.
- o. Resident cannot receive SHC Rental Subsidy assistance while receiving another housing subsidy.
- p. Resident must comply with providing documentation required, including proof of total household income, information on other residents living in the home and copy of annual lease.

- q. Resident receiving an SHC subsidy is assigned a subsidy for a one-bedroom unit. If living in a location with multiple individuals served by the Division, a request can be made for more than one bedroom but explicit permission from the Division must be received. Requests for settings with additional bedrooms where only one individual served by the Division will reside are not generally approved. Resident must receive prior authorization before adding household members and bedrooms. Gross Annual Income is based on all residents in household, requiring proof of income for each household member.
- r. Any circumstances where an individual requests a live-in aide shall be deferred to the New Jersey Department of Community Affairs (DCA). The Division shall not approve or administer any subsidies related to live-in aides. Standards for live-in aides will be those established by DCA and determination of approval will be made solely by that entity. If approved, DCA will administer the subsidy and all of their established program rules shall apply. Any requests for live-in aide(s) denied by DCA shall not be approved by the Division.
- s. Subsidized units may not be used for commercial activities. Units must remain residential in use as defined by HUD and IRS guidelines.
- t. SHC subsidies cannot be used to subsidize bedrooms or units utilized as staff offices.
- u. Security deposits paid by SHC may be used by the individual for one-time purpose only, if there are no other means of obtaining a security deposit. If the individual relocates with the subsidy, returned deposits shall be supplied as part of the new deposit required. Individuals shall be required to pay the difference. If the security deposit is lost due to eviction, damage, etc. the individual shall pay the entire deposit on any new unit.
- v. Rental subsidies cannot be used in Division of Mental Health and Addiction Services (DMHAS) Level A+, A, B, or C Programs, Boarding Homes, Residential Healthcare Facilities, or Rooming Houses.
- w. Additional “fees” for having pets in the unit will not be provided/reimbursed. If the pet is a service animal, the individual would need to address directly with the landlord.
- x. SHC subsidies cannot be used in circumstances where the owner of the property is related to the individual (i.e. parent, child, grandparent, grandchild, sister, or brother). Any Division-funded arrangements that pre-date this policy shall be reviewed on a case-by-case basis as to how to best implement moving forward.
- y. SHC subsidies cannot be used if a unit is occupied by its owner or by any person with interest in the unit.
- z. SHC subsidies may be authorized, on a case-by-case basis, in shared living arrangements. In these circumstances, the PRS will be divided by the number of bedrooms in the unit so the individual receiving the subsidy pays an equal share of the rent. (For example, PRS is \$1200 per month for a two bedroom. One individual receives a subsidy and the other does not. The individual receiving a subsidy would have rent calculated at \$600 per month.) The individual will be expected to pay 30% of their income to the landlord for their portion of the rent with the SHC making up the remainder. Persons living in the unit not receiving an SHC subsidy would be responsible for their equal share of rent.
- aa. In circumstances where it is known that an individual requesting an SHC subsidy or a person with which an individual wishes to reside has a history of eviction for non-payment of rent, an SHC subsidy may not be provided.
- bb. No accommodations to SHC guidelines will be provided that would have the potential to not be honored by a federal, state, or local housing assistance program (i.e. Housing Choice Voucher – formerly known as Section 8) when it becomes available or are determined to not be in the best interest of the Division. Additionally, should federal, state, or local housing assistance program (i.e.: Housing Choice Voucher – formerly known as Section 8) guidelines be adjusted or changed in the future those changes will be reviewed and made applicable to existing SHC subsidies as necessary. Allocation of SHC subsidies are solely at the discretion of the Division.

18.2.2.5 Denial or Termination of Rental Subsidy

- If the resident violates any obligation under the NJ DDD Rental Subsidy Agreement.
- If the resident engages in criminal activity including drug related or violent activity.
- If the resident commits fraud, bribery, or any other corrupt or criminal act in connection with the NJ DDD Rental Subsidy Program.
- If the resident allows other individuals to live in the rental unit that have not been reported to the Division and received prior approval.

- If the resident refuses to pay their portion of the rent for damage to the unit or other amounts owed by the resident under the lease to the landlord.
- If the resident refuses to allow home inspection or comply with HUD Quality Standards.
- If the resident refuses to comply with providing documents required (for example, a copy of the annual lease or proof of income from any household member).
- If the resident is or becomes ineligible for Division services or does not comply with waiver monitoring requirements.

APPENDIX A – GLOSSARY OF TERMS

Acuity Factor – modifier added to the tier for individuals with high clinical support needs based on medical and/or behavioral concerns, notated by “a” next to the tier assignment. The acuity factor can also impact the rate and/or unit of a service base rate for services where that may be applicable.

Bump-Up – a short-term increase in an individual’s budget if he/she experiences changes in life circumstances that result in a need for additional temporary services that exceed his/her budget. A bump-up is capped at \$5,000 per individual, will be effective for up to one year, and can only be provided once every three years.

Centers for Medicare and Medicaid Services (CMS) – the federal agency within the U.S. Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children’s Health Insurance Program (SCHIP), and health insurance portability standards.

Children’s System of Care (CSOC) – the Division within the New Jersey Department of Children and Families that serves children (under 21) with emotional and behavioral health care challenges and their families and children (under 21) with developmental and intellectual disabilities and their families. Services include community-based services, in-home services, out-of-home residential services, and family support services.

College of Direct Support (CDS) – a collection of web-based courses designed for direct support staff, people with disabilities, their families and others who support people with disabilities. The course work connects learners with a nationally recognized curriculum that empowers people to lead more independent and self-directed lives.

Commission for the Blind and Visually Impaired (CBVI) – the Division within the New Jersey Department of Human Services that provides specialized services to persons who are blind or visually impaired and provides education in the community to reduce the incidence of vision loss.

Community Care Program (CCP) – a Division of Developmental Disabilities initiative included in the Comprehensive Medicaid Waiver (CMW) that funds community-based services and supports for adults (age 21 and older) with intellectual and developmental disabilities who have been assessed to meet the specified level of care (LOC) for Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) – i.e., an institutional level of care. Formerly known as the Community Care Waiver (CCW).

Comprehensive Medicaid Waiver (CMW) – the New Jersey Department of Human Services’ Medicaid waiver that is a collection of reform initiatives designed to sustain the program long-term as a safety-net for eligible populations, rebalance resources to reflect the changing healthcare landscape and prepare the state to implement provisions of the federal Affordable Care Act in 2014. The Supports Program is the Division of Developmental Disabilities’ initiative within this waiver.

Department of Children & Families (DCF) – the state agency that works to ensure the safety, well-being and success of children, youth, families and communities.

Department of Education (DOE) – the Department in state government that oversees the programs and services provided in all public and nonpublic primary and secondary schools in New Jersey; administers state and federal aid to schools and school districts; and establishes and regulates New Jersey’s educational policies.

Department of Human Services (DHS) – the Department of state government that serves seniors, individuals and families with low incomes; people with mental illnesses, addictions, developmental disabilities, or late-onset disabilities; people who are blind, visually impaired, deaf, hard of hearing, or deaf-blind; parents needing child care services, child support and/or healthcare for their children; and families facing catastrophic medical expenses for their children. DHS and its eight divisions provide programs and services designed to give eligible individuals and

families the help they need to find permanent solutions to a myriad of life challenges.

Department of Labor and Workforce Development (LWD) – the Department of state government that provides workforce development, family leave insurance, analyzes labor market information, health and safety guidelines, social security disability programs, temporary disability, unemployment benefits, worker’s compensation and resources for employers. The Department of LWD also provides services and support to individuals with disabilities in the workforce through the Division of Vocational Rehabilitation Services.

Division Circulars – documents issued by the Assistant Commissioner of the Division of Developmental Disabilities which set policy for the various agencies within the Division. Division Circulars can be found on the Division of Developmental Disabilities’ website at <https://nj.gov/humanservices/ddd/providers/staterequirements/circulars/>.

Division of Developmental Disabilities (Division or DDD) – the Division within the New Jersey Department of Human Services that coordinates funding for services and supports that assist adults age 21 and older with intellectual and developmental disabilities to live as independently as possible. An overview of DDD is outlined in section 1.2 in this manual.

Division of Vocational Rehabilitation Services (DVRS) – the Division within the New Jersey Department of Labor and Workforce Development that provides services to assist individuals with disabilities to prepare for, obtain, and/or maintain competitive employment consistent with their strengths, priorities, needs and abilities.

Employment/Day Budget Component – the portion of the individual budget that can be used to purchase services that are categorized as supporting an individual with their employment and day support needs. An indication of the budget component in which each service is categorized is available within the table provided for each service in Section 17 of this manual.

Fair Hearing – an administrative proceeding to resolve an appeal of a Medicaid waiver-funded service when the service has been denied, or will be reduced, suspended or terminated.

Fiscal Intermediary (FI) / Financial Management Service (FMS) – the entity that manages the financial aspects of the Supports Program on behalf of an individual choosing to direct some or all of their services through a Self-Directed Employee. In addition, the FI acts as a conduit for an organization or enterprising entity that is not a Medicaid provider but engages in commercial, industrial, or professional activities that are offered to the general public and will be available to individuals enrolled in the Supports Program. More information about the responsibilities of the FI can be found in section 10 of this manual.

Health Information and Portability and Accountability Act (HIPAA) – the federal law passed by Congress in 1996 that protects the privacy of protected health information (PHI) and personally identifiable information (PII) and establishes national standards for its written, oral, and electronic security.

Home and Community-Based Services (HCBS) – Medicaid-funded services and supports that are provided to individuals in their own home or community. HCBS programs serve a variety of targeted populations groups, including individuals experiencing chronic illness or individuals with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities.

Individual/Participant – an adult age 21 or older who has been determined to be eligible to receive services funded by the Division of Developmental Disabilities.

Individual Budget – an up-to amount of funding allocated to an eligible individual based on their tier assignment in order to provide services and supports. Each Individual Budget is made up of an Employment/Day budget component and an Individual/Family Supports budget component.

Individual/Family Supports Budget Component – the portion of the individual budget that can be used to purchase services that are categorized as providing support to the individual and/or family in addition to their employment/day services. An indication of the budget component in which each service is categorized is available within the table provided for each service in Section 17 of this manual.

Individualized Service Plan (ISP) – the standardized Division of Developmental Disabilities’ service planning document, developed based on assessed needs identified through the NJ Comprehensive Assessment Tool (NJCAT); the Person-Centered Planning Tool (PCPT); and additional documents as needed, that identifies an individual’s outcomes and describes the services needed to assist the individual in attaining the outcomes identified in the plan. An approved ISP authorizes the provision of services and supports.

iRecord – DDD’s secure, web-based electronic health record application.

Level of Care – the assessed level of assistance an individual requires in order to meet their health and safety needs and accomplish activities of daily living. Eligibility for certain Medicaid-funded long-term services and supports is tied to an individual’s Level of Care designation.

Managed Care Organizations (MCO) – organizations, also known as HMOs or health plans, that contract with state agencies to provide a health care delivery system that manages cost, utilization and quality of Medicaid health benefits and additional Medicaid services.

Managed Long Term Services & Supports (MLTSS) – the program that ensures the delivery of long-term services and supports through New Jersey Medicaid's NJ FamilyCare managed care program. MLTSS is designed to expand home and community-based services, promote community inclusion and ensure quality and efficiency. MLTSS provides comprehensive services and supports, whether at home, in an assisted living facility, in community residential services, or in a nursing home.

Medicaid – a federal and state jointly funded program that provides health insurance to parents/caretakers and dependent children, pregnant women, and people who are aged, blind or disabled. These programs pay for hospital services, doctor visits, prescriptions, nursing home care and other healthcare needs, depending on what program a person is eligible for.

National Core Indicators (NCI) – standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety. NCI is a voluntary effort by public developmental disabilities agencies to measure and track their own performance.

NJ Comprehensive Assessment Tool (NJ CAT) – the mandatory needs-based assessment used by the Division of Developmental Disabilities as part of the process of determining an individual's **eligibility** to receive Division-funded services and assessing an individual’s support needs in three main areas: self-care, behavioral, and medical.

Person-Centered Planning Tool (PCPT) – a mandatory discovery tool used to guide the person-centered planning process and to assist in the development of an individual’s service plan.

Planning for Adult Life Project – a statewide project funded by the NJ Division of Developmental Disabilities (DDD) to assist students (ages 16-21) with developmental disabilities and their families in charting a life course for adulthood. This project facilitates student and parent groups and offers informational sessions, webinars, and resource materials that address core areas that include but are not limited to employment, postsecondary education, housing, legal/financial planning, self-direction, health/behavioral health, and planning/visioning a life course.

Planning Team – a team of people, with a valuable connection to the individual, that participate in planning meetings and contribute to the development of the PCPT and ISP. At a minimum, the planning team includes the individual and Support Coordinator. Parents, family members, friends, service providers, coworkers, etc. are also often included in the planning team as established by the individual.

Prior Authorization – the approval – obtained prior to service delivery – that details start/end dates, number of units, and procedure codes authorized in order for the identified provider(s) to receive payment for services once they have been rendered.

Provider Database – a searchable database of Medicaid/DDD-approved service providers.

Self-Directed Employee (SDE) – a person paid through a DDD -approved fiscal intermediary who is recruited and offered employment directly by the individual or the individual’s authorized representative to perform waiver services for which SDEs are qualified.

Service Provider – the entity or individual who will provide the waiver service(s) indicated in the ISP. Service providers must meet the qualifications and standards related to the service(s) being offered.

Support Coordination Agency (SCA) – an organization approved by the Medicaid and the Division of Developmental Disabilities to provide services that assist participants in gaining access to needed program and state plan services, as well as needed medical, social, educational, and other services.

Support Coordination Supervisor (SCS) – the professional within a Support Coordination Agency that provides oversight and management of the Support Coordinators and approves ISPs.

Support Coordinator (SC) – the professional responsible for developing and maintaining the Individualized Service Plan with the participant, their family, and other team members; linking the individual to needed services; and monitoring the provision of services included in the Individualized Service Plan.

Supported Employment Budget Component – an additional component of the individual budget that can be accessed in situations when the individual budget does not sustain the level of Supported Employment – Individual Employment Support needed in order for the individual to find or keep a competitive job in the general workforce.

Supports Program – the Division of Developmental Disabilities initiative included in the Comprehensive Medicaid Waiver (CMW) that provides needed supports and services for individuals eligible for DDD who are not in the Community Care Program (CCP).

Tier – an assigned descriptor, based on support needs determined through the NJ CAT, that determines the individual budget and reimbursement rate a provider will receive for that individual for particular services.

APPENDIX B – HELPFUL LINKS TO THE DIVISION

Division of Developmental Disabilities - www.nj.gov/humanservices/ddd/home/

- Applying for Services - <https://www.nj.gov/humanservices/ddd/individuals/applyservices/>
- Becoming a Provider - <https://www.nj.gov/humanservices/ddd/providers/apply/>
- Contact Information - <https://www.nj.gov/humanservices/ddd/about/contactus/communityservices/>
- Division Circulars - <https://www.nj.gov/humanservices/ddd/providers/staterequirements/circulars/>
- Medicaid Eligibility and DDD - <https://www.nj.gov/humanservices/ddd/individuals/applyservices/medicaid/>
- News and Announcements - <https://www.nj.gov/humanservices/ddd/news/updates/>
- NJ CAT Resource Page - <https://www.nj.gov/humanservices/ddd/individuals/applyservices/assessment/>
- Provider Search - <https://irecord.dhs.state.nj.us/providersearch>
- Support Coordination - <https://www.nj.gov/humanservices/ddd/individuals/community/care/>
- Supports Program (SP) - <https://www.nj.gov/humanservices/ddd/assets/documents/supports-program-policy-manual.pdf>

APPENDIX C – DIVISION HELP DESKS

Topic/Subject Area	Help Desk
Communications / Division Update	DDD.Communications@dhs.nj.gov
Community Care Program Waiting List	DDD.CCPWaitlistRequests@dhs.nj.gov
Employment	DDD.EmploymentHelpdesk@dhs.nj.gov
Fee-for-Service	DDD.FeeForService@dhs.nj.gov
HCBS Helpdesk (i.e., HCBS Settings Rule Questions of Compliance Issues)	DDD.HCBSHelpdesk@dhs.nj.gov
Human Rights Committee	DDD.HRC@dhs.nj.gov
IT Requests	DDD.ITRequests@dhs.nj.gov
Medicaid Eligibility	DDD.MediEligHelpdesk@dhs.nj.gov
NJCAT	DDD.DDPIAssessmentRequests@dhs.nj.gov
Office of Education on Self-Directed Services	DDD.OESDS@dhs.nj.gov
Provider	DDD.Providerhelpdesk@dhs.nj.gov
Support Coordination	DDD.SCHelpdesk@dhs.nj.gov

APPENDIX D – DOCUMENTS

Referenced documents are available on the Division’s website at <https://www.nj.gov/humanservices/ddd/providers/support/>. Links are also provided for most documents below.

Service Delivery Documents

Please note that the documents are available by clicking on the name of the document below:

- [Community Based / Individual Supports Log](#)
- [Community Inclusion Services – Individualized Goals](#)
- [Community Inclusion Services – Activities Log](#)
- [Community Inclusion Services – Annual Update](#)
- [Day Habilitation – Individualized Goals](#)
- [Day Habilitation – Activities Log](#)
- [Day Habilitation – Annual Update](#)
- [Natural Supports Training Log](#)
- [Prevocational Training – Individualized Goals](#)
- [Prevocational Training – Activities Log](#)
- [Prevocational Training – Annual Update](#)
- [Supported Employment Services – Pre-Employment Service Log](#)
- [Supported Employment Services – Intervention Plan & Service Log](#)

Planning Documents

- Person-Centered Planning Tool (PCPT)
- Individualized Service Plan (ISP)

Other Documentation and Forms (in alphabetical order)

- [Addressing Enhanced Needs Form](#)
- [Assistive Technology/Environmental Modification Evaluation Request Form](#)
- [AT/EM/VM Purchase Request Form](#)
- [Community Transitions Unit Case Transfer Form](#)
- [Continuation of Prevocational Training Justification Form](#)
- [DDD 1115 NJ FamilyCare Comprehensive Demonstration Participant Enrollment Agreement \(English\)](#)
- [DDD 1115 NJ FamilyCare Comprehensive Demonstration Participant Enrollment Agreement \(Spanish\)](#)
- [Early Retirement Form](#)
- [Employment Determination Form - \(F3\)](#)
- [Employment Non-Referral Form to DVRS or CBVI – \(F6\)](#)
- [Employment Forms Instruction Guide – F3 & F6](#)
- [Good and Services Request Form](#)
- [Human Rights Committee Referral Form](#)
- [Individual Supports Request Form](#)
- [ISP Review Checklist for Support Coordination Supervisors](#)
- [Participant Statement of Rights & Responsibilities \(English\)](#)
- [Participant Statement of Rights & Responsibilities \(Spanish\)](#)
- [Single Passenger Rate Transportation Request Form](#)
- [Support Coordination Agency Change Form](#)
- [Support Coordinator Monitoring Tool – Monthly](#)
- [Support Coordinator Monitoring Tool - Quarterly and Annual](#)
- [Support Coordinator Monitoring Tool – Work Instructions](#)
- [Supported Employment Funding Request Form](#)
- [Supported Employment Funding Request Form](#)
- [Voluntary Discharge from Division Services](#)

QUICK REFERENCE GUIDE TO SERVICE DELIVERY DOCUMENTATION

The following documentation requirements must be utilized for individuals enrolled in the Supports Program and can be applied to all other individuals (including those individuals on the CCP) **effective immediately**. They must be utilized for anyone who isn't enrolled in the Supports Program once they become enrolled and for anyone on the CCP once they are moved to the Fee-for-Service system. Support Coordination documentation is already in use and will continue for anyone enrolled in the Supports Program or in the interim system.

Please Note: In addition to the documentation requirements specific to service delivery that are documented below and described further in Section 17 of the Supports Program Policies & Procedures Manual, service providers must comply with documentation requirements related to service certification/licensing, staff training, facilities, medications, emergencies, individual records, etc. as described in this manual.

Providers using an electronic health record (EHR) or billing system that cannot duplicate these standardized documents will remain in compliance if all the information required on these documents is captured somewhere and can be shown/reviewed during an audit.

Services	Required Documents
All Services	<ul style="list-style-type: none"> Documentation of the delivery of all services must be maintained to substantiate claims. This documentation should include the date, start and end times, and number of units of the delivered service for each individual and must align with the prior authorization received for the provision of services and the individual's ISP.
Career Planning	<ul style="list-style-type: none"> Career Plan – developed by the Career Planning provider but must include, at a minimum, indication of the individual's career goal, a detailed description/outline of how the individual is going to achieve that goal, and identification of areas where employment support may be needed.
Community Based Supports Self-Directed Employees (SDE)	<ul style="list-style-type: none"> Community Based / Individual Supports Activity Log
Community Inclusion Supports	<ul style="list-style-type: none"> Community Inclusion Services – Individualized Goals Community Inclusion Services – Activities Log Community Inclusion Services – Annual Update
Day Habilitation	<ul style="list-style-type: none"> Day Habilitation – Individualized Goals Day Habilitation Activities Log Day Habilitation Services – Annual Update
Natural Supports Training	<ul style="list-style-type: none"> Natural Supports Training Log
Prevocational Training	<ul style="list-style-type: none"> Prevocational Training – Individualized Goals Prevocational Training – Activities Log Prevocational Training – Annual Update
Support Coordination	<ul style="list-style-type: none"> Person-Centered Planning Tool (PCPT) Individualized Service Plan (ISP) Support Coordinator Monitoring Tool For all documents visit: Division of Developmental Disabilities Support Coordinator Information (nj.gov)
Supported Employment – Individual Employment Support Supported Employment – Small Group Employment Support	<ul style="list-style-type: none"> Supported Employment Services – Pre-Employment Service Log Supported Employment Services – Intervention Plan and Service Log

APPENDIX E – QUICK REFERENCE GUIDE TO MANDATED STAFF TRAINING

The following training requirements are in effect for staff supporting individuals in the Supports Program. See the Supports Program Manual, Section 17, for requirements associated with licensing/certifications for specific services.

Timeline	All Agency Staff	Trainer	Applicable Services
Prior to working with individuals	DDD System Mandatory Training Bundle: DDD Life Threatening Emergencies (Danielle’s Law) DDD Stephen Komninos Law Training	College of Direct Support	<ul style="list-style-type: none"> • Behavioral Supports • Career Planning • Community Based Supports • Community Inclusion Services • Day Habilitation • Prevocational Training • Respite • Support Coordination • Supported Employment – Individual Employment Support • Supported Employment – Small Group Employment Support • Supports Brokerage
	Provider Developed Orientation: Incident Reporting	Service Provider	
	Orientation to Supports Brokerage	Boggs Center on Developmental Disabilities	<ul style="list-style-type: none"> • Supports Brokerage
Within 90 days of hire	DDD System Mandatory Training Bundle: DDD Shifting Expectations - Changes in Perception, Life Experience & Services Prevention of Abuse, Neglect & Exploitation: Modules 1, 3, 4, 5, and 7	College of Direct Support	<ul style="list-style-type: none"> • Behavioral Supports • Career Planning • Community Based Supports • Community Inclusion Services • Day Habilitation • Prevocational Training • Respite • Support Coordination • Supported Employment – Individual Employment Support • Supported Employment – Small Group Employment Support • Supports Brokerage
	Prevention of Abuse, Neglect & Exploitation Practicum (on-site competency assessment after completing Prevention of Abuse, Neglect & Exploitation modules listed above)	Service Provider	

	<p>Provider Developed Orientation <i>Includes but is not limited to:</i></p> <ul style="list-style-type: none"> ✓ Overview of the Agency ✓ Mission, philosophy, goals, services and practices ✓ Personnel policies ✓ Safety ✓ Supporting Healthy Lives ✓ Individualized Service Plan Process and Documentation ✓ Individual Support Plans, Progress and Personal Goals ✓ Cultural Competence ✓ Individual Rights ✓ Working with Families ✓ Documentation & recordkeeping 	<p>Service Provider</p> <p>AND/OR</p> <p>College of Direct Support</p>	<ul style="list-style-type: none"> • Career Planning • Community Based Supports • Community Inclusion Services • Day Habilitation • Prevocational Training • Respite • Support Coordination • Supported Employment – Individual Employment Support • Supported Employment – Small Group Employment Support • Supports Brokerage
<p>Annually, 12 hours per calendar year for full time staff (30 or more hours per week.</p> <p>Annually, 6 hours per calendar year for part time staff (less than 30 hours per week).</p>	<p>Professional Development: Mandated Trainings, Orientation, Seminars, Webinars, In-service, College of Direct Support, and Conferences all count</p> <p>Prorated at 1 hour per month for full time staff hired after January.</p> <p>Prorated to 1 hour every two months per-year for part-time staff (less than 30 hours a week).</p>	<p>Various Trainers</p>	

Timeline	Service Provider Staff	Trainer	Applicable Services
<p>Prior to assuming sole responsibility for one or more individuals, within 90 days of hire and as needed</p>	<p>Specialized Staff Training Including but not limited to:</p> <ul style="list-style-type: none"> ✓ Special diets/mealtime needs ✓ Mobility procedures & devices ✓ Seizure management & support ✓ Assistance, care & support for physical or medical conditions, mental health and/or behavioral needs 	<p>Service Provider</p>	<ul style="list-style-type: none"> • Community Based Supports • Community Inclusion Services • Day Habilitation • Prevocational Training • Respite
	<p>Employment Specialist Foundations: Basic Knowledge & Skills</p> <ul style="list-style-type: none"> ✓ Overview, Assessment/Discovery ✓ Marketing & Job Development ✓ Instruction & Data Collection ✓ Retention & Long Term Follow Along <p>OR</p> <p>Alternate training entity preapproved by the Division: DDD.TransitionHelpdesk@dhs.nj.gov</p>	<p>Boggs Center on Developmental Disabilities OR Division preapproved training entity</p>	<ul style="list-style-type: none"> • Supported Employment – Individual Employment Support • Supported Employment – Small Group Employment Support • Career Planning (within 1st year of hire)
<p>Within 90 days and annually</p>	<p>Fire Evacuation & Emergency Procedures</p>	<p>Service Provider</p>	<ul style="list-style-type: none"> • Day Habilitation • Prevocational Training (when service is facility based)
	<p>Universal Precautions</p>		
<p>Prior to assuming sole responsibility of an individual & every 2 years</p>	<p>CPR Certification Recertification every two years</p>	<p>Nationally Certified Training Programs</p>	<ul style="list-style-type: none"> • Community Based Supports • Community Inclusion Services • Day Habilitation
	<p>Standard First Aid Certification Recertification every two years</p>		
<p>Prior to administering medication</p>	<p>Medication</p> <ul style="list-style-type: none"> ✓ Overview of Direct Support Roles ✓ Medication Basics ✓ Working with Medications ✓ Administration of Medications & Treatment ✓ Follow-up, Communication and Documentation of Medications 	<p>College of Direct Support</p>	<ul style="list-style-type: none"> • Prevocational Training • Respite
<p>Prior to administering medication & annually</p>	<p>Medication Practicum (on-site annual competency assessment after completing medication training above)</p>	<p>Service Provider</p>	

Timeline	Service Provider Staff	Trainer	Applicable Services
<p>Prior to implementing a behavior supports plan</p>	<p>For <u>staff overview</u> training: Positive Behavior Supports Overview Introduction to Positive Behavior Supports OR Alternate training preapproved by the Provider Performance and Monitoring Unit at DDD.BehavioralServices@dhjs.nj.gov</p> <p>OR</p>	<p>Boggs Center on Developmental Disabilities</p> <p>OR</p> <p>Division preapproved alternate training</p>	<ul style="list-style-type: none"> Behavioral Supports Community Based Supports Community Inclusion Services Day Habilitation Prevocational Training Respite
<p>Prior to conducting behavioral assessment or developing, training, supervising or monitoring a behavior support plan</p>	<p>For <u>credentialed staff advanced</u> training: Applied Positive Behavior Supports Functional Behavior Assessment & Development of Support Plans OR Alternate training preapproved by the Provider Performance and Monitoring Unit at DDD.BehavioralServices@dhjs.nj.gov</p>		<ul style="list-style-type: none"> Behavioral Supports
Timeline	Support Coordination Staff	Trainer	Applicable Services
<p>Prior to delivering services</p>	<p>Support Coordination Orientation ✓ Prerequisite Orientation Lessons ✓ Person Centered Planning & Connection to Community Supports</p>	<p>College of Direct Support AND Boggs Center on Developmental Disabilities</p>	<ul style="list-style-type: none"> Support Coordination
<p>Within 90 days of hire</p>	<p>Medicaid Training for NJ Support Coordinators</p>	<p>Provider Developed</p> <p>AND/OR</p> <p>College of Direct Support</p>	
	<p>NJISP Related: New Jersey Comprehensive Assessment Tool (NJCAT) and Person-Centered Planning Tool (PCPT) Overview</p>		
	<p>NJISP Related: Employment Expectations and Overview</p>		
	<p>NJISP Related: Service Entry and iRecord Overview</p>		
	<p>Support Coordinator’s Guide to Navigating the Employment Service System</p>		
	<p>Cultural Competence</p>		

Timeline	Self-Directed Employees	Trainer	Services
Within 6 months of hire	<p>DDD System Mandatory Training Bundle: DDD Life Threatening Emergencies (Danielle’s Law)</p> <p>DDD Shifting Expectations: Changes in Perception, Life Experience & Services</p> <p>Prevention of Abuse, Neglect & Exploitation: Modules 1, 3, 4, 5, and 7</p> <p>DDD Stephen Komninos Law Training</p> <p>Prevention of Abuse, Neglect & Exploitation Practicum (on-site competency assessment after completing Prevention of Abuse, Neglect & Exploitation modules listed above)</p> <p>Individual/Family Developed Orientation Length & content determined by the Individual/Family</p>	<p>College of Direct Support</p> <p>OR</p> <p>non-online version available</p> <p>Individual/Family</p> <p>Individual/Family</p>	<ul style="list-style-type: none"> Self-Directed Employees (SDEs)
If applicable, prior to administering	<p>Medication</p> <ul style="list-style-type: none"> ✓ Medication Basics ✓ Working with Medications ✓ Administration of Medications & Treatment ✓ Follow-up, Communication and Documentation of Medications 	<p>College of Direct Support</p> <p>OR</p> <p>non-online version available</p>	
If applicable, prior to administering	<p>Medication Practicum (on-site competency assessment after completing training listed above)</p>	<p>Individual/Family</p>	
Within 6 months of hire & every 2 years	<p>CPR Certification Recertification every two years</p> <p>Standard First Aid Certification Recertification every two years</p>	<p>Nationally Certified Training Programs</p>	
If applicable, within 6 months of hire	<p>Specialized Training As determined by caregivers</p>	<p>Individual/Family</p>	
If applicable, within 6 months of hire	<p>Behavior Supports Plan Overview</p>	<p>Author of the Behavior Plan</p>	

APPENDIX F – QUICK REFERENCE GUIDE TO SERVICE APPROVALS

While most CCP services can be accessed by identifying the need for that service through the NJ CAT and/or person-centered planning process documented in the PCPT and including the service and related outcome in the approved ISP, some services require additional steps or Division approval in order to access them. The following processes must be followed in order to access those services for someone enrolled in the CCP:

Service	Process for Approval/Access
Assistive Technology	<ul style="list-style-type: none"> • The Support Coordinator will assist the individual in identifying an approved Assistive Technology provider to conduct an evaluation • The Support Coordinator will submit a request to conduct the Assistive Technology evaluation through iRecord for Division review and approval • If an AT evaluation has already been conducted (through school, for example), the Support Coordinator should include that information within the details of the submitted request and upload the evaluation into the “Documents” tab • The Division will review the evaluation request and provide a determination. This determination may be to skip the evaluation if needed information is already available (through a previous evaluation, for example). • If “approved,” by the Division, the Support Coordinator will add Assistive Technology to the ISP and utilize the Assistive Technology Evaluation procedure code (T2028HI) • Upon approval of the ISP, the Assistive Technology provider conducts the evaluation as prior authorized and submits the completed evaluation and supporting documents to the Support Coordinator • Once the evaluation has been completed (or if the evaluation step has been skipped as approved by the Division), the Support Coordinator will submit a request for the Division to review and approve the Assistive Technology itself • Once the Assistive Technology is approved, the Support Coordinator will add Assistive Technology to the ISP using procedure code T2028HI • The Assistive Technology provider will render services as prior authorized by the approved ISP and claim to Medicaid (if a Medicaid provider) or submit an invoice to the Fiscal Intermediary (if not a Medicaid provider) • Questions or concerns that are related to this process can be directed to the Service Approval Help Desk at DDD.ServiceApprovalHelpdesk@dhs.nj.gov.
Community Transition Services	<ul style="list-style-type: none"> • The SC will assist the individual in identifying entities from which they can access the needed Community Transition Services • The SC will complete and submit the Community Transition Services Request Form to DDD.ServiceApprovalHelpdesk@dhs.nj.gov for approval • The Division will review the request to ensure it meets Community Transition Services criteria, ask for supporting documentation or additional information as needed, and provide a determination • Upon Division approval, the SC will add Community Transition Services to the ISP and follow the ISP approval process • The Community Transition Services provider will render services as prior authorized by the approved ISP and claim through the FI
Goods & Services	<ul style="list-style-type: none"> • The Support Coordinator will assist the individual in identifying entities from which they can access the needed Goods & Services • The Support Coordinator will add Goods & Services to the ISP prompting submission of the request for Goods & Services which will be submitted and reviewed by the Division • The Division will review the request to ensure it meets Goods & Services criteria, ask for supporting documentation or additional information as needed, and provide a determination • Upon Division approval, the SCA will follow the process to approve the ISP • Once the ISP is approved, the prior authorization will be automatically sent to the Fiscal Intermediary • The Support Coordinator should send the Service Detail Report (and ISP if appropriate and agreed upon by the individual) to the entity that will be providing the approved Goods & Services • The Goods & Services provider will render services as prior authorized by the approved ISP and submit an invoice through the FI for payment

<p>Supported Employment – Individual or Group</p> <p>Career Planning</p> <p>Prevocational Training</p>	<ul style="list-style-type: none"> • The individual must seek employment services, if needed, from the Division of Vocational Rehabilitation Services (DVRS) or Commission for the Blind and Visually Impaired (CBVI) • DVRS/CBVI determines eligibility and completes the Employment Determination Form - (F3) and submits it to the SC • The SC uploads the Employment Determination Form - (F3) in iRecord • Individual accesses services available through DVRS/CBVI as indicated on the Employment Determination Form - (F3) • Individual accesses services not available through DVRS/CBVI through DDD – as written in the approved ISP (DDD will always provide employment services if they are not available through DVRS)
<p>Environmental Modifications</p>	<ul style="list-style-type: none"> • The Support Coordinator will assist the individual in identifying an approved Assistive Technology provider to conduct an evaluation in order to ensure the Environmental Modification will benefit the individual and is completed correctly for the individual’s needs • The Support Coordinator will submit a request to conduct the Assistive Technology evaluation through iRecord for Division review and approval • The Division will review the evaluation request and provide a determination. This determination may be to skip the evaluation if necessary information is already available (through a previous evaluation, for example). • If “approved,” by the Division, the Support Coordinator will add Assistive Technology to the ISP and utilize the Assistive Technology Evaluation procedure code (T2028HI) • Upon approval of the ISP, the Assistive Technology provider conducts the evaluation as prior authorized and submits the completed evaluation and supporting documents to the Support Coordinator • Once the evaluation has been completed (or if the evaluation step has been skipped as approved by the Division), the Support Coordinator will submit a request and additional details for the Division to review and approve the Environmental Modification itself • Once the Environmental Modification is approved, the Support Coordinator will add Environmental Modification to the ISP • The Environmental Modification provider will render services as prior authorized by the approved ISP and claim to Medicaid (if they are a Medicaid provider) or submit an invoice to the Fiscal Intermediary (if not a Medicaid provider) • Questions or concerns that are related to this process can be directed to the Service Approval Help Desk at DDD.ServiceApprovalHelpdesk@dhs.nj.gov.
<p>Physical Therapy</p> <p>Occupational Therapy</p> <p>Speech, Language, and Hearing Therapy</p>	<p>Therapy is for Habilitation</p> <ul style="list-style-type: none"> • The Support Coordinator will review the NJ CAT to identify an indication that the Occupational Therapy is needed • The Support Coordinator uploads a copy of the medical prescription and documentation that the Occupational Therapy is necessary for habilitation provided by an appropriate health care professional to iRecord – this information may be provided through two separate documents or all within the prescription • The Support Coordinator will include Occupational Therapy in the ISP as is done for other services • Occupational Therapy is prior authorized, delivered, and claimed <p>Therapy is for Rehabilitation</p> <ul style="list-style-type: none"> • The Support Coordinator will review the NJ CAT to identify an indication that the Occupational Therapy is needed • The Support Coordinator uploads a copy of the medical prescription provided by an appropriate health care professional to iRecord • The individual/family reaches out to the primary insurance carrier/MCO to request Occupational Therapy • If the primary insurance carrier/MCO approves the Occupational Therapy, the individual will access this therapy through their primary insurer and follow the process required by that insurer • If the primary insurer/MCO denies the Occupational Therapy, the individual will receive (or must request) an Explanation of Benefits (EOB) • The individual will submit the primary insurer/MCO’s EOB to the Support Coordinator

	<ul style="list-style-type: none"> • The Support Coordinator will upload the EOB to iRecord and assist the individual in identifying providers of Occupational Therapy • The Support Coordinator will include Occupational Therapy in the ISP as is done for other services • When the ISP is approved, the prior authorization will be emailed to the provider and the Support Coordinator will submit the EOB from the primary carrier/MCO to the service provider that has been identified in the ISP to provide Occupational Therapy • The prior authorized service provider (identified in the ISP) will request the “Bypass Letter Request Form” from OSC.tplunit@osc.nj.gov • The service provider completes the Bypass Letter Request Form, attaches the explanation of benefits (EOB) for the denied service (either for exhausted benefits or non-coverage), and submits the documents to the OSC • Staff at the OSC will review the information and issue a Bypass Letter if appropriate • The service provider will submit claims for rendered services along with the Bypass Letter to Gainwell Technologies for payment
<p>Vehicle Modifications</p>	<ul style="list-style-type: none"> • The SC will assist the individual in identifying a business that offers this service and gather an estimate and supporting documentation • The SC will upload the estimate/bid and any supporting documents to iRecord and notify the Division at DDD.ServiceApprovalHelpdesk@dhs.nj.gov for review. All estimates/bids must include the following: <ul style="list-style-type: none"> ○ The requested item needed, including name, model number, and any other identifying Specifications (all measurements must be taken by a professional to ensure the Specifications are correct) ○ Unit cost and quantity, if applicable, and total quoted price <ul style="list-style-type: none"> ○ Clear itemization of cost of material, labor, and shipping/freight if applicable ○ Name and address of vendor on company letterhead ○ Vendor’s Federal ID number ○ Vendor representative’s name, phone number, and email address • The Division will review the estimate/bid and supporting documentation and provide a determination regarding the requested Vehicle Modifications • Upon Division approval, the SC will add needed Vehicle Modifications and follow the ISP approval process • The Vehicle Modifications provider will render services as prior authorized by the approved ISP and claim through the FI

APPENDIX G - PROVIDING SERVICES WITHIN A SOCIAL ENTERPRISE SETTING

A social enterprise is a provider-owned business utilized primarily to provide learning and work experiences to (and occasionally to employ) individuals with disabilities. Funding for services provided within social enterprise settings may be provided by the Division of Developmental Disabilities (Division) in circumstances where the following criteria are met in addition to the standards that apply specifically to the service(s) being provided (this funding is based on the specific waiver service(s) that is being provided and has been prior authorized through an approved Individualized Service Plan):

- The business is owned by the provider (and is different from and not considered self-employment for an individual)
- The business is located in an area typical of this type of business/industry and utilized by the general public
- It is expected that the decision to open and operate the business will be based on market research and demand, and that professionals who have sufficient expertise in the type of business will support the business
- The business is focused on one industry and meets the standards typical and/or required of that particular industry (not commingled with other industries/businesses in the same building/location)
- The type of business/industry is one that people without disabilities engage in, run, etc. in the general workforce (participation in labor markets that are generally available to the entire workforce rather than those specifically for individuals with disabilities)
- The business is conducted in settings typical of that industry/business and utilizes equipment typical of that industry/business
- The opportunity for interaction with the general public is in line with the extent to which others would interact typically in this business/industry
- This business, and experience within in it, provides the individual with the opportunity for advancement within the business itself and the opportunity to become competitively employed in the general workforce, but participation in this business is not a required steppingstone in accessing competitive employment opportunities
- Efforts will be made to transition individuals out of the social enterprise into the general workforce in a non-agency owned business
- Individuals receive regular performance evaluations and have the opportunity to advance in their positions and increase their salaries based on performance, experience, etc.
- Focus on job training and time-limited engagement to support financial independence and healthy/safe lifestyles for the individual participants. Employment of individuals by the social enterprise is generally time limited.
- Social enterprise must be able to function as a commercial activity as well
- Social enterprise must look and feel like any comparable business. How a social enterprise is branded, how it is represented to the community and the value it brings to the community as a business will all impact how the business is viewed and the extent to which it becomes part of the general labor market.
- Supplement to primary efforts focused on employer-paid individual jobs integrated within the general workforce

In addition to the above criteria and standards described in the Supports Program Policies & Procedures manual specific to the service that is being provided, the following standards must be implemented when an individual is employed by a social enterprise:

- A plan to competitive employment in the general workforce must be developed, followed, and updated as needed
- The individual is provided with every opportunity for integration and activities/schedules are in compliance with the Centers for Medicare & Medicaid Services (CMS) regulations governing Home and Community-Based Settings (HCBS)
- It is expected that potential employees will experience a typical hiring process – application, interview, etc.
- When employed by the business, the individual must be compensated at or above minimum wage

- Participating in services provided through the social enterprise is not considered pursuing employment or being employed unless the individual is employed by the social enterprise and receiving a competitive salary
- It is expected that individuals employed by the social enterprise will work side-by-side, take breaks, eat lunch, etc. with individuals without disabilities and not become a separate group
- It is expected that individuals employed by the social enterprise will experience the same work routines; personnel policies; opportunities for advancement; performance standards, evaluations, and disciplinary actions; compensation policies – including both wages and benefits; hiring/firing procedures; and orientation/training practices as those individuals without disabilities
- If the individual employed by the business is in need of Supported Employment services, those services must be provided by a different provider than the one that owns the social enterprise and is the individual's employer

In addition to the above criteria and standards described in the Supports Program Policies & Procedures manual specific to the service that is being provided, the following standards must be implemented when an individual is receiving an assessment or training through the social enterprise and/or within the social enterprise setting:

- The Department of Labor's regulations on unpaid training and assessment must be followed
- There is a clear structure in place that differentiates between training and assessment vs. employment
- The decision to utilize the social enterprise for training and/or assessment is based on the individual's specific interests/preferences and needs
- Time limits on how long individuals can be in training and assessment will be established
- Documentation of progress on training and assessment will be maintained

General considerations for using social enterprises as time limited opportunities for job exploration, situational assessments, and/or skill development are as follows:

- Use as a situational assessment site: Ideally, such assessments would be conducted in typical workplaces in the general public, but a social enterprise could be utilized as a site for assessing an individual's strengths, skills, interests, preferences, and support needs as long as the social enterprise is not the only site utilized in the assessment and the individual has expressed an interest in the type of business in which the social enterprise engages.
- Use for training: Social enterprises can be utilized in part for training purposes when the business is aligned with the individual's interests and keeping in mind that optimal learning is often obtained on the job where someone can not only learn job specific tasks but the unique manner in which they are performed in a particular business and the impact that the environment has on learning and retention.

APPENDIX H - SUPPORTS PROGRAM SERVICES QUICK REFERENCE GUIDE

**R&C = Reasonable & Customary Budget Components - E/D = Employment/Day, I/FS = Individual/Family Supports, DSP = Direct Support Professional Service & accounts for wage increases*

Supports Program Service	Service Description / Tier	Standard Rate per Unit	Billing Unit	Procedure Code	Budget Component
Assistive Technology	Evaluation	*R&C	Single	T2028HI	I/FS
	Purchase/Customize/Repair/Replace	R&C	Single	T2028HI22	I/FS
	Remote Monitoring	R&C	Single	T2029HI	I/FS
Behavioral Supports	Assessment / Plan Development	\$22.05	15 Minutes	H0004HI22	Either
	Monitoring	\$8.26	15 Minutes	H0004HI	Either
Career Planning	Base	\$19.15	15 Minutes	H2014HI	Either (DSP service applies)
Cognitive Rehabilitation	Base	\$37.69	15 Minutes	97532HI	I/FS
Community Based Supports	Base	\$9.53	15 Minutes	H2021HI	Either (DSP service applies)
	Acuity Differentiated	\$14.71	15 Minutes	H2021HI22	Either (DSP service applies)
	Self-Directed Employee (SDE)	R&C	15 Minutes	H2021HI52	Either (DSP service applies)
Community Inclusion Services	Tier A	\$3.57	15 Minutes	H2015HIU1	Either (DSP service applies)
	Tier B	\$4.55	15 Minutes	H2015HIU2	Either (DSP service applies)
	Tier C	\$5.63	15 Minutes	H2015HIU3	Either (DSP service applies)
	Tier D	\$8.35	15 Minutes	H2015HIU4	Either (DSP service applies)
	Tier E	\$11.08	15 Minutes	H2015HIU5	Either (DSP service applies)
Day Habilitation	Tier A (Factors in a 5% absentee rate)	\$3.57	15 Minutes	T2021HIUS	E/D (DSP service applies)
	Tier A / Acuity Differentiated (Factors in a 5% absentee rate)	\$4.97	15 Minutes	T2021HIU1	E/D (DSP service applies)
	Tier B (Factors in a 5% absentee rate)	\$4.55	15 Minutes	T2021HIUR	E/D (DSP service applies)
	Tier B / Acuity Differentiated (Factors in a 5% absentee rate)	\$6.34	15 Minutes	T2021HIU2	E/D (DSP service applies)
	Tier C (Factors in a 5% absentee rate)	\$5.63	15 Minutes	T2021HIUQ	E/D (DSP service applies)
	Tier C / Acuity Differentiated (Factors in a 5% absentee rate)	\$7.84	15 Minutes	T2021HIU3	E/D (DSP service applies)
	Tier D (Factors in a 5% absentee rate)	\$8.35	15 Minutes	T2021HIUP	E/D (DSP service applies)
	Tier D / Acuity Differentiated (Factors in a 5% absentee rate)	\$11.62	15 Minutes	T2021HIU4	E/D (DSP service applies)
	Tier E (Factors in a 5% absentee rate)	\$11.08	15 Minutes	T2021HIUN	E/D (DSP service applies)
	Tier E / Acuity Differentiated (Factors in a 5% absentee rate)	\$15.42	15 Minutes	T2021HIU5	E/D (DSP service applies)
Environmental Modifications		R&C	Single	S5165HI	I/FS
Goods & Services		R&C	Single	T1999HI22	Either
Interpreter Services	American Sign Language (ASL)	\$16.78	15 Minutes	T1013HI22	I/FS
	Other - Non-ASL	\$6.29	15 Minutes	T1013HI	I/FS
	Self-Directed Employee	R&C	15 Minutes	T1013HI52	I/FS

Supports Program Service	Service Description / Tier	Standard Rate per Unit	Billing Unit	Procedure Code	Budget Component
Natural Supports Training		R&C	15 Minutes	S5110HI	I/FS
Occupational Therapy	Individual	\$27.48	15 Minutes	97535HI	I/FS
	Group – Blended	\$7.85	15 Minutes	97535HIUN	I/FS
PERS	Purchase / Installation / Testing	R&C	Single	S5160HI	I/FS
	Response Center Monitoring	R&C	Month	S5161HI	I/FS
Physical Therapy	Individual	\$28.48	15 Minutes	S8990HI	I/FS
	Group – Blended	\$8.14	15 Minutes	S8990HIUN	I/FS
Prevocational Training	Individual	\$18.57	15 Minutes	T2015HI22	E/D (DSP service applies)
	Tier A - Group of 2-8	\$3.99	15 Minutes	T2015HIUS	E/D (DSP service applies)
	Tier B - Group of 2-8	\$5.09	15 Minutes	T2015HIUR	E/D (DSP service applies)
	Tier C - Group of 2-8	\$6.29	15 Minutes	T2015HIUQ	E/D (DSP service applies)
	Tier D - Group of 2-8	\$9.33	15 Minutes	T2015HIUP	E/D (DSP service applies)
	Tier E - Group of 2-8	\$12.38	15 Minutes	T2015HIUN	E/D (DSP service applies)
Respite	Base	\$7.16	15 Minutes	T1005HI	I/FS (DSP service applies)
	Out of Home Overnight – Tier A	\$80.74	Daily	T1005HI52	I/FS (DSP service applies)
	Out of Home Overnight – Tier Aa	\$142.57	Daily	T1005HI52	I/FS (DSP service applies)
	Out of Home Overnight – Tier B	\$161.49	Daily	T1005HIU1	I/FS (DSP service applies)
	Out of Home Overnight – Tier Ba	\$285.16	Daily	T1005HIUS	I/FS (DSP service applies)
	Out of Home Overnight – Tier C	\$269.14	Daily	T1005HIU2	I/FS (DSP service applies)
	Out of Home Overnight – Tier Ca	\$475.27	Daily	T1005HIUR	I/FS (DSP service applies)
	Out of Home Overnight – Tier D	\$376.80	Daily	T1005HIU3	I/FS (DSP service applies)
	Out of Home Overnight – Tier Da	\$665.36	Daily	T1005HIUQ	I/FS (DSP service applies)
	Out of Home Overnight – Tier E	\$484.47	Daily	T1005HIU4	I/FS (DSP service applies)
	Out of Home Overnight – Tier Ea	\$855.49	Daily	T1005HIUP	I/FS (DSP service applies)
	Day Camp Only (up to 6 hrs/day)	\$161.49	Daily	T2036HI22	I/FS (DSP service applies)
	Overnight Camp (day + overnight)	\$322.64	Daily	T2036HI	I/FS (DSP service applies)
	In-Home (CCR Only)	\$198.54	Daily	S9125HI	I/FS (DSP service applies)
	Self-Directed Employee	R&C	Single	T1005HI52	I/FS (DSP service applies)
	Speech, Language, and Hearing Therapy	Individual	\$26.84	15 Minutes	92507HI
Group – Blended		\$7.67	15 Minutes	92507HIUN	I/FS
Support Coordination	Per Person / Per Month	\$374.68	Month	T2024HI	N/A
	Per Person / Per Day (partial month)	\$12.50	Daily	T2024HI52	N/A
Supported Employment	Individual	\$21.01	15 Minutes	T2019HI	Either (& SE as needed) (DSP service applies)
	Tier A - Group of 2-8	\$4.52	15 Minutes	T2019HIUS	Either (DSP service applies)
	Tier B - Group of 2-8	\$5.75	15 Minutes	T2019HIUR	Either (DSP service applies)
	Tier C - Group of 2-8	\$7.12	15 Minutes	T2019HIUQ	Either (DSP service applies)
	Tier D - Group of 2-8	\$10.56	15 Minutes	T2019HIUP	Either (DSP service applies)
	Tier E - Group of 2-8	\$14.00	15 Minutes	T2019HIUN	Either (DSP service applies)
Supports Brokerage	Base	\$10.00	15 Minutes	T2041HI22	I/FS
	Self-Directed Employee	R&C	15 Minutes	T2041HIU7	I/FS

Supports Program Service	Service Description / Tier	Standard Rate per Unit	Billing Unit	Procedure Code	Budget Component
Transportation	Multiple Passenger Rate	\$0.76	Mile	A0090HI22	Either
	Single Passenger Rate	R&C	Mile	A0090HI	Either
	Self-Directed Employee	R&C	15 Minutes	A0090HI52	Either
Vehicle Modification		R&C	Single	T2039HI	I/FS



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

Volume 33 No. 02

January 2023 (REVISED April 2023)

TO: All Providers - **For Action**
Managed Care Organizations (MCOs) – **For Action**

SUBJECT: Excluded, Unlicensed or Uncertified Individuals or Entities

This Newsletter Updates Newsletter Volume 26, Number 14, dated September 2016

PURPOSE: To remind providers and MCOs of their responsibility to determine if an individual or entity that they employ or contract with is excluded, unlicensed or uncertified.

NOTE: This revised version of the newsletter corrects a phone number on the last page. All other information in this newsletter remains the same.

BACKGROUND: Providers and MCOs are responsible for ensuring that any payments received from the State of New Jersey are not for items or services that are directly or indirectly furnished, ordered, directed, managed or prescribed in whole or in part by an excluded, unlicensed or uncertified individual or entity. Excluded individuals or entities are those identified by the State or federal government as not being allowed to participate in State or federally-funded health benefit programs, such as Medicaid, NJ FamilyCare, or Pharmaceutical Assistance to the Aged and Disabled (PAAD).

ACTION: Providers and MCOs are required to verify that any current or prospective employees (regular or temporary), contractors or subcontractors, who directly or indirectly will be furnishing, ordering, directing, managing or prescribing items or services in whole or in part are not excluded, unlicensed or uncertified by searching the following databases on a monthly basis:

- State of New Jersey debarment list (mandatory): https://nj.gov/comptroller/doc/nj_debarment_list.pdf
- Federal exclusions database (mandatory): <https://exclusions.oig.hhs.gov/>
- N.J. Treasurer's exclusions database (mandatory): <http://www.state.nj.us/treasury/revenue/debarment/debsearch.shtml>
- N.J. Division of Consumer Affairs licensure databases, including all licensed healthcare professionals (mandatory, if applicable): <http://www.njconsumeraffairs.gov/Pages/verification.aspx>

- N.J. Department of Health licensure and certification database, including: Nursing Home Administrators, Certified Assisted Living Administrators, Certified Nurse Aides/Personal Care Assistants, and Certified Medication Aides (mandatory, if applicable):
<https://njna.psiexams.com/>.
- Federal exclusions and licensure database (optional and fee-based):
<https://www.npdb.hrsa.gov/hcorg/pds.jsp>. Please note that only certain provider types may access this database.
See www.npdb.hrsa.gov/hcorg/register.jsp for more information.

Background checks utilizing these databases shall be included in a provider's or MCO's written policies and procedures for preventing and detecting fraud, waste and abuse. The aforementioned requirements shall be mandatory for compliance with Section 6032 of the Federal Deficit Reduction Act, 42 U.S.C. §1396a(a)(68). The State reserves the right either to deny, void or to seek recovery for any services that are directly or indirectly furnished, ordered, directed, managed or prescribed in whole or in part by an excluded, unlicensed or uncertified individual or entity. Further, interest and civil penalties may be assessed in any such recovery. Finally, providers and MCOs discovering any excluded, unlicensed or uncertified individual or entity employed by, or contracting with the provider or MCO must send written notification to the Office of the State Comptroller, Medicaid Fraud Division, P.O. Box 025, Trenton, NJ 08625-0025.

Additionally, if any provider or person discovers fraud and/or abuse occurring in any State or federally-funded health benefit program, they should report it to the Office of State Comptroller, Medicaid Fraud Division hotline at 1-888-937-2835 or web site at <https://www.nj.gov/comptroller/about/work/medicaid/complaint.shtml>.

If you have any questions concerning this Newsletter, please call the Office of the State Comptroller, Medicaid Fraud Division hotline at 1-888-937-2835.

RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE

APPENDIX J – DVRS/CBVI/DDD MEMORANDUM OF UNDERSTANDING

MEMORANDUM OF UNDERSTANDING

BETWEEN

THE DEPARTMENT OF HUMAN SERVICES
COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

AND

THE NEW JERSEY OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES

AND

THE NEW JERSEY DEPARTMENT OF LABOR AND WORKFORCE
DEVELOPMENT
DIVISION OF VOCATIONAL REHABILITATION SERVICES

FOR

COORDINATION OF SERVICES TO ASSIST INDIVIDUALS WITH INTELLECTUAL
AND DEVELOPMENTAL DISABILITIES GAIN COMPETITIVE INTEGRATED
EMPLOYMENT

THIS MEMORANDUM OF UNDERSTANDING (this “MOU” or “Agreement”) is made by and between the New Jersey Department of Human Services (“DHS”), Commission for the Blind and Visually Impaired (“CBVI”), DHS, Division of Developmental Disabilities (“DDD”), and the New Jersey Department of Labor and Workforce Development (“LWD”), Division of Vocational Rehabilitation Services (“DVRS”) (collectively referred to as the “Parties” and individually referred to as the “Party”);

WHEREAS, CBVI serves youth and adults who are blind, deaf-blind, or visually impaired and works with them to pursue independent living and employment goals in order to obtain their fullest measure of self-reliance and improved quality of life;

WHEREAS, DDD assures the opportunity for individuals with developmental disabilities to receive quality services and support, participate meaningfully in their communities, and exercise their right to make choices;

WHEREAS, DVRS enables eligible individuals with disabilities to achieve an employment outcome consistent with their strengths, priorities, needs, abilities, and capabilities;

WHEREAS, CBVI, DDD, and DVRS will collaborate on an ongoing basis regarding the development and modification of all documents, policies, and processes related to competitive integrated employment services and supports for shared individuals;

WHEREAS, the Parties will each designate a liaison to meet regularly to share concerns, address issues, brainstorm ideas to assist individuals in becoming competitively employed, and ensure, to the extent possible, consistency in messaging between agencies;

NOW, THEREFORE, the Parties, agree as follows:

I. OBLIGATIONS OF CBVI/DVRS

- A. CBVI/DVRS shall provide services to individuals with disabilities who seek and are eligible for services from CBVI/DVRS. Those services will include:
- (i) Determining if an individual is eligible and requires vocational rehabilitation (“VR”) services to prepare him/her/them for, secure, retain, or regain competitive-integrated employment;
 - (ii) Development of an Individualized Plan for Employment (“IPE”);
 - (iii) Review of the IPE, at least annually, to assess the individual’s progress in achieving the identified competitive integrated employment outcome;
 - (iv) Amending the IPE, including agreeing to and signing an amendment to an individual’s IPE in order for it to take effect; and
 - (v) Determining that an individual’s competitive-integrated employment outcome is satisfactory and that the individual is performing well on the job before the individual can be considered to have achieved a successful competitive integrated employment outcome and the individual’s case may be closed.
- B. CBVI/DVRS shall presume eligibility for individuals who receive Social Security supplemental security income (“SSI”) or supplemental security disability insurance (“SSDI”). This presumption means that an individual receiving SSI or SSDI can benefit in terms of a competitive-integrated employment outcome from VR services unless DVRS/CBVI can demonstrate by clear and convincing evidence that such individual is incapable of benefiting in terms of an integrated competitive employment outcome from VR services due to the severity of the disability of the individual.
- C. CBVI/DVRS shall inform individuals, through the application process for VR services, whom receive services under the program that they must intend to achieve a competitive integrated employment outcome (34 C.F.R. 361.41(b)(2)).
- D. CBVI/DVRS shall complete the agency appropriate Determination Form for Individuals Eligible for DDD (F3 Form) related to individuals eligible for DDD and submit it by email to the Support Coordinator/DDD Case Manager identified on the form.

- E. CBVI and DVRS shall each designate a liaison to meet with DDD’s representative regarding integrated competitive employment issues.
- F. A CBVI/DVRS counselor will inform the Support Coordinator in the event an individual receiving services is moving to Long-Term Follow Along (“LTFA”) and/or competitive integrated employment services/supports become unavailable through the CBVI/DVRS so these supported employment services can be funded by DDD and incorporated into the Individual Service Plan.
- G. The chart below outlines the processes involved in determining an individual’s path to any appropriate integrated competitive employment services:

Individual is Determined Eligible for DVRS/CBVI	DVRS/CBVI is not sure of Eligibility	Individual would not benefit from DVRS/CBVI Services
Development of Individual Plan for Employment (IPE)	Trial Work Experience (TWE) will be conducted	DVRS/CBVI Counselor submits F3 to the Support Coordinator/DDD Case Manager to inform DDD that the individual is not eligible at this time
DVRS/CBVI Counselor submits the “DVRS/CBVI Determination Form for Individuals Eligible for DDD form” (F3 Form) to the Support Coordinator/DDD Case Manager to inform DDD of eligibility determination and availability of DVRS/CBVI services	Eligibility determination will be made (see applicable column for next steps)	DDD will fund competitive-integrated employment services (Supported Employment and/or Career Planning) to explore/address reasons for non-employment and/or assist individual in finding competitive-integrated employment
Referral to DVRS/CBVI and DDD approved provider(s) for eligible services		Referral to DVRS/CBVI for competitive-integrated employment services
Once employed, DVRS/CBVI will provide 1:1 job coaching, if needed, for a period of time. When the individual is stabilized on the job, Supported Employment funding shifts to DDD for Long-Term Follow-Along (LTFA)		DVRS/CBVI makes eligibility determination <ul style="list-style-type: none"> • If eligible, follow “Individual is Determined Eligible for DVRS/CBVI” column • If not eligible, DDD will continue to fund competitive-integrated employment services

II. OBLIGATIONS OF DDD

- A. DDD shall provide all individuals eligible for DDD services the opportunity for competitive integrated employment and information about services available to assist in gaining and maintaining competitive integrated employment in the general workforce.
- B. DDD shall refer all individuals within the DDD system who express an immediate interest in integrated competitive employment to DVRS or CBVI as appropriate.
 - (i) If it is anticipated that an individual will need a higher level of services/supports through CBVI/DVRS and/or has complex barriers to competitive integrated employment, the Support Coordinator/DDD Case Manager will work with the individual to access DDD-funded supported employment services to conduct the discovery process in order to assist the individual in finding out who they are, what they want to do, and what they have to offer by collecting information about the individual's interests, skills, environmental preferences, integrated competitive employment goals, and other topics related to the competitive-integrated employment search.
 - (ii) The discovery process will be utilized to create a blueprint for integrated competitive employment ("Blueprint") (for example, a customized or negotiated job, self-employment, or an existing traditional wage job). Once the Blueprint has been developed, the individual will be referred to DVRS/CBVI for an eligibility determination as discussed in Article II, Section G.
 - (iii) Non-employment services administered by DDD, including but not limited to Community Based Supports, Individual Supports, Community Inclusion Services, Prevocational Training, and Day Habilitation, can be provided by DDD while DVRS/CBVI eligibility is being determined and can continue thereafter.
- C. DDD shall complete, through the Support Coordinator/DDD Case Manager, a "Non-Referral to VR" (F6 Form) for individuals eligible for DDD services who will not be accessing competitive integrated employment services.
- D. DDD shall provide LTFA to individuals who are in need of this service and are eligible for DDD services.
- E. DDD shall fund competitive integrated employment services/supports for individuals eligible for DDD services in need of these supports in the event that funding for such services from DVRS or CBVI becomes unavailable.

III. GENERAL PROVISIONS

- A. The Parties agree that they are not relying upon any promises, understanding, warranties, circumstances, conduct, negotiations, expectations, representations, or agreements, oral or written, express or implied, other than those expressly set forth herein; that this Agreement is a complete integration and constitutes the entire agreement of the Parties with respect to the subject matter hereof; that this entire Agreement has been bargained for and negotiated; and the Parties have read, understood and approved this Agreement in its entirety.
- B. This Agreement may be amended, modified, or supplemented only by a written agreement executed by both Parties.
- C. The Parties agree that electronic communication via email is the preferred method for the exchange of correspondence, deliverables, invoices, etc., for this Agreement unless stated otherwise herein.
- D. The Parties agree to comply with all applicable federal, State and local laws, rules and regulations (collectively, "laws"), including but not limited to the following: State and local laws relating to licensure; federal and State laws relating to safeguarding of confidential information, including HIPAA, 42 C.F.R. Part 2, N.J.S.A. 30:4-24.3, and N.J.S.A. 26:5C-1 et seq.; the federal Civil Rights Act of 1964 (as amended); P.L. 1975, Chapter 127, of the State of New Jersey (N.J.S.A. 10:5-31 et seq.) and associated executive orders pertaining to affirmative action and nondiscrimination in public contracts; the federal Equal Employment Opportunity Act; Section 504 of the federal Rehabilitation Act of 1973 pertaining to non-discrimination on the basis of handicap, and regulations thereunder; the Americans With Disabilities Act (ADA), 42 U.S.C. 12101 et seq. Failure to comply with the laws, rules and regulations referenced above shall be grounds for termination for cause.

If any provision of this Agreement conflicts with any federal or State law(s) or has the effect of causing the State to be ineligible for federal financial participation in payment for services, the specific provision shall be considered amended or nullified to conform to such law(s). All other Agreement provisions shall remain unchanged and shall continue in full force and effect.

- E. In the event that a dispute between the Parties as to the rights and obligations under the Agreement, the Party alleging the dispute shall provide written notice to the other. Upon receipt of the notice, the Parties shall meet and confer for a period of thirty (30) calendar days in a good faith effort to resolve the matter. The 30-day period may be extended upon the agreement of both Parties. The exercise of this dispute resolution process shall not relieve either Party of its obligations and/or rights to file notice or actions in accordance with the law.

- F. Except as specifically provided in this Agreement, the Parties hereto may not assign their rights, duties or obligations under this Agreement, either in whole or in part, without receiving the prior written consent of the other Party. Any assignment made without consent of the other Party shall be void and the non-assigning Party shall not recognize any such assignment.
- G. The laws of the State of New Jersey shall govern this Agreement.
- H. In the event DVRS is functioning as CBVI's and/or DDD's business associate, as that term is defined in the HIPAA Privacy Rule, 45 C.F.R. 160.103, and/or as a qualified service organization, as defined at 42 C.F.R. 2.12(c)(4), in providing the services and deliverables under the Agreement, then the Parties shall execute DHS/CBVI/DDD's standard Business Associate (BA)/Qualified Service Organization (QSO) Agreement. A copy of the executed BA/QSO Agreement shall be attached hereto and it shall be made a part of this Agreement, as though fully set forth herein.
- I. Each Party, subject to the provisions of the New Jersey Tort Claims Act and availability of appropriated funds, shall be responsible for, and shall at its own expense, defend itself against any and all suits, claims, losses, demands or damages of whatsoever kind or nature, arising out of or in connection with any act of omission of its employees, agents or contractors, in the performance of the obligations assumed by the party pursuant to this Agreement. Both Parties are subject to the New Jersey Contractual Liability Act. Each Party is hereby released from any and all liabilities, claims, losses, costs, expenses and demands of any kind or nature whatsoever, arising under State of Federal law, solely out of or in connection with the other Party's performance of the obligations assumed pursuant to this Agreement.
- J. Any and all publicity and/or public announcements relating to this Agreement or the work products of this Agreement shall be reviewed and approved in writing by both Parties prior to release or distribution. Both Parties must be in agreement prior to any release or distribution unless required as part of a legal proceeding.
- K. All data, technical information, materials gathered, originated, developed, prepared, used or obtained in the performance of the requested services, including but not limited to, all papers, reports, surveys, plans, charts, records, analyses or publications produced for, or as a result of, this Agreement (hereinafter "Work Product") shall bear an acknowledgement of each CBVI's and DDD's support and shall be the Property of the Parties. No Work Product produced utilizing funds or data obtained under this Agreement shall be released to the public without the prior written consent of the Parties. The Parties shall each have the right to edit said Work Product and shall further have the right to add co-authorship or disclaimers as they each, in their own discretion, deem appropriate.

- L. The Parties each reserve a royalty-free, non-exclusive and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, the Work Products developed pursuant to this Agreement.
- M. Each Party is an independent entity and no Party shall hold itself out as an agent or representative of any other.
- N. Each Party certifies that it shall not violate the federal anti-kickback statute, set forth at 42 U.S.C. §1320a-7b (b) ("Anti-Kickback Statute"), or the federal prohibition against physician self-referrals, set forth at 42 U.S.C. § 1395nn ("Stark Law"), with respect to the performance of its obligations under this Agreement.
- O. Counterparts and Electronic Signatures. This Agreement may be executed in counterparts and by any electronic means, each of which shall be deemed an original but all of which together shall constitute the Agreement.

IV. COMMENCEMENT AND TERMINATION

- A. This MOU shall be effective upon its execution until further notice.
- B. Termination of this Agreement by the Parties shall require the mutual consent of the Parties with 30 days' notice. Notice of termination shall be delivered via U.S. Postal Service, return receipt requested. Notice must be sent to the Parties identified herein.

V. PRINCIPAL CONTACTS

NJ Department of Human Services, Commission for the Blind and Visually Impaired:

Signatory: Dr. Bernice Davis, Executive Director
 NJ Commission for the Blind & Visually Impaired
 NJ Department of Human Services
 153 Halsey Street, 6th Floor
 Newark, NJ 07101
 Telephone: 973-648-2324
 Email: Bernice.Davis@dhs.nj.gov

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Amanda Gerson
NJ Commission for the Blind & Visually Impaired
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Fiscal Contact: Edward Szajdecki
NJ Commission for the Blind & Visually Impaired
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NJ Department of Human Services, Division of Developmental Disabilities:

Signatory: Jonathan Seifried, Assistant Commissioner
Division of Developmental Disabilities
NJ Department of Human Services
222 S. Warren Street
P.O. Box 726
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Program Contact: Nkechi Okoli
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Fiscal Contact: Patrick Boyle
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NJ Department of Labor and Workforce Development, Division of Vocational Rehabilitation Services:

Signatory: Dr. Charyl Yarbrough
Assistant Commissioner
NJ Department of Labor and Workforce Development
Employment Accessibility Services
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Email: Charyl.Yarbrough@dol.nj.gov

Program Contact: Karen Carroll, Director
Division of Vocational Rehabilitation Services
NJ Department of Labor and Workforce Development
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Fiscal Contact: Gordon V. Horvath, Jr.
Assistant Commissioner/CFO
NJ Department of Labor & Workforce Development
Office of Finance & Accounting
PO Box 955
Trenton, NJ 08625
Telephone: 609-292-9772
Email: Gordon.Horvath@dol.nj.gov

We, the undersigned, consent to the contents of this Agreement:

Signature:

Date:

Bernice Davis

11/28/22

Dr. Bernice Davis, Executive Director
Commission for the Blind & Visually Impaired
NJ Department of Human Services

Jonathan S. Seifried

11/23/2022

Jonathan Seifried, Assistant Commissioner
Division of Developmental Disabilities
NJ Department of Human Services

Charyl Yarbrough

12/05/2022

Dr. Charyl Yarbrough, Assistant Commissioner
Employment Accessibility Services
Division of Vocational Rehabilitation Services
NJ Department of Labor and Workforce Development

APPENDIX K – QUICK REFERENCE GUIDE TO OVERLAPPING CLAIMS FOR SUPPORTS PROGRAM SERVICES

Service	Allowable Claims for Simultaneous Services	Special Details
Assistive Technology	<ul style="list-style-type: none"> • Interpreter Services (to provide assistance with the evaluation if needed) 	While AT is utilized in a variety of settings during a multitude of activities throughout the day, there are no claims for use of AT.
Behavioral Supports	<ul style="list-style-type: none"> • Career Planning • Community Based Supports • Community Inclusion Services • Day Habilitation • Goods & Services (classes, for example) • Interpreter Services • Prevocational Training • Respite • Supported Employment (individual and/or small group) • Transportation 	<p>If the individual is assigned the acuity differentiated factor, Behavioral Supports cannot be claimed separately while providing the following services unless the criteria in Section 3.4.1 are met:</p> <ul style="list-style-type: none"> • Community Based Supports • Day Habilitation • Out of Home Overnight Respite
Career Planning	<ul style="list-style-type: none"> • Interpreter Services 	
Cognitive Rehabilitation	<ul style="list-style-type: none"> • Interpreter Services 	
Community Based Supports	<ul style="list-style-type: none"> • Behavioral Supports • Goods & Services (classes, activity fees, for example) • Interpreter Services • Transportation 	<ul style="list-style-type: none"> • If the individual is assigned the acuity differentiated factor Behavioral Supports cannot be claimed separately unless the criteria in Section 3.4.1 are met • Community Based Supports can only be provided at the same time as Transportation if the individual is in need of one-to-one supports for safety purposes. There must be separate staff providing Community Based Supports and Transportation (one ensuring safety and one driving).
Community Inclusion Services	<ul style="list-style-type: none"> • Behavioral Supports • Goods & Services (activity fees only) • Interpreter Services 	

Day Habilitation	<ul style="list-style-type: none"> • Behavioral Supports • Goods & Services (activity fees only) • Interpreter Services 	If the individual is assigned the acuity differentiated factor Behavioral Supports cannot be claimed unless the criteria in Section 3.4.1 are met.
Environmental Modifications	<ul style="list-style-type: none"> • Interpreter Services 	
Goods & Services	<ul style="list-style-type: none"> • Behavioral Supports (classes) • Community Based Supports (support at classes, activity fees, for example) • Community Inclusion Services (activity fees only) • Day Habilitation (activity fees only) • Interpreter Services • Prevocational Training (activity fees only) • Supported Employment (individual or small group) – fees for work related needs 	
Interpreter Services	All services if needed	
Natural Supports	<ul style="list-style-type: none"> • Interpreter Services 	
Occupational Therapy	<ul style="list-style-type: none"> • Interpreter Services 	
PERS	<ul style="list-style-type: none"> • Interpreter Services (during set up, purchase) 	While PERS can be utilized in a variety of settings during a multitude of activities throughout the day, there are no claims for use of PERS in that way.
Physical Therapy	<ul style="list-style-type: none"> • Interpreter Services 	
Prevocational Training	<ul style="list-style-type: none"> • Behavioral Supports • Goods & Services (activity fees only) • Interpreter Services 	
Respite	<ul style="list-style-type: none"> • Behavioral Supports • Goods & Services (activity fees only) • Interpreter Services 	If the individual is assigned the acuity differentiated factor Behavioral Supports are already covered for out-of-home overnight Respite through the rate and cannot be claimed separately.
Speech, Language, Hearing Therapy	<ul style="list-style-type: none"> • Interpreter Services 	
Supported Employment – Individual Employment Supports	<ul style="list-style-type: none"> • Behavioral Supports • Goods & Services • Interpreter Services 	Goods & Services may be used to fund the purchase of items necessary for employment – fingerprinting, drug testing, uniform, for example

Supported Employment – Small Group Employment Supports	<ul style="list-style-type: none"> • Behavioral Supports • Goods & Services • Interpreter Services 	Goods & Services may be used to fund the purchase of items necessary for employment – fingerprinting, drug testing, uniform, for example
Supports Brokerage	<ul style="list-style-type: none"> • Interpreter Services 	
Transportation	<ul style="list-style-type: none"> • Community Based Supports 	Community Based Supports can only be claimed for at the same time as Transportation if there is both a driver providing Transportation services and a second support staff providing one-to-one Community Based Supports, and it has been documented in the ISP that the individual has a medical or behavioral need that requires the provision of Community Based Supports to ensure the health and safety of the individual.
Vehicle Modifications	<ul style="list-style-type: none"> • Interpreter Services 	



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

Volume 28 No. 01

February 2018

TO: All Providers – **For Action**
Health Maintenance Organizations – **For Information Only**

SUBJECT: Rounding of Service Units

EFFECTIVE: Immediately

PURPOSE: To provide clarification concerning the time component of billing codes and what constitutes a “unit” for billing purposes.

BACKGROUND: The electronic submission of billing codes requires the use of Health Insurance Portability and Accountability Act (HIPAA)-compliant codes. Multiple codes include time in their definitions and several providers have expressed questions on what these times actually mean and when “rounding” of time is allowable for NJ FamilyCare (NJFC) billing.

ACTION: NJFC requires HIPAA-compliant coding for electronic submission of claims. Multiple HIPAA-compliant codes have a required time value. In order to ensure consistency among providers, for those codes that do have a required time value, NJFC requires that only full units of service be provided and billed for face-to-face encounters and no “rounding up” is allowed. Face-to-face time, for coding purposes, is defined as only that time spent face-to-face with the client and/or family. Work spent performing such tasks as reviewing records and tests and communicating with other professionals via written reports or telephone contact is considered non-face-to-face. Non-face-to-face time is not directly reimbursable but is accounted for in the base rate.

Evaluation and Management (E/M): E/M codes have a time component included in their Current Procedural Terminology (CPT) definition. However, it should be noted that the inclusion of time in the definitions of E/M codes was added to assist in selecting the most appropriate level of E/M services and that the times expressed in the descriptions are averages. The actual times may be higher or lower depending on clinical circumstances.

Psychiatric and Psychotherapy Diagnostic Procedure Codes: NJ FamilyCare utilizes codes described in the Current Procedural Terminology (CPT) and Health Care Procedure Coding System (HCPCS). Psychiatric diagnostic procedure codes 90791 and 90792 do not have a time component in their description. They are used for the diagnostic assessment or reassessment of psychotherapeutic services. Psychotherapy

codes 90832-90838 do have times listed as descriptors and NJFC requires the full face-to-face time for billing purposes. If the procedure code descriptor states it is a 50 minute session, the provider must provide and bill for 50 minutes. Certain codes such as 90853 do not have a time descriptor in their definition but do have times listed in regulations that address the provider type. Any code with a specific time listed in regulation shall take precedence and the full amount of face-to-face time listed shall be required for billing purposes.

Home Care: Home care has explicit time requirements listed in N.J.A.C. 10:60. If a unit of service is defined as a 15 minute interval of face-to-face service, the provider must provide the required 15 minutes and rounding up is not allowed. For example, one unit of service shall be billed for services provided from the first minute through 29 minutes. The second unit of service shall be billed for services provided from 30 minutes through 44 minutes. The third unit of service shall be billed for services provided from 45 minutes to 59 minutes, etc.

Supports Program/Community Care Program: Due to the nature of their services, the Division of Developmental Disabilities (DDD) allows their community providers to add non-continuous units of billable sessions together. This requires careful documentation supporting the time the individual sessions were provided. These times may not be estimated. The provider may then add non-continuous units together to reach a total. Since units are 15 minutes in length, the initial unit of service less than 15 minutes may be billed as one unit. Beyond the initial unit, service times less than half of the unit shall be rounded down while service time equal to or greater than half shall be rounded up. For example, 53 minutes would consist of 3 full fifteen minute units and a partial unit of 8 minutes. Eight minutes is greater than half. This total may be rounded up to 4 full units. A total of 52 minutes would consist of 3 full fifteen minute units and a partial unit of 7 minutes. Seven minutes is less than half of the unit. This total would be rounded down to 3 full units. The total used for rounding may only include services provided that calendar day.

The Division of Medical Assistance and Health Services anticipates proposing regulations to address these issues.

If there are any questions regarding the information listed in this newsletter, please contact The Office of Customer Service 609-631-4642.

RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE

APPENDIX M – EXTENSION TO COME INTO COMPLIANCE WITH BEHAVIORAL SUPPORTS QUALIFICATIONS



STATE OF NEW JERSEY

DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES

PO BOX 726
TRENTON, NJ 08625-0726
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www.nj.gov/humanservices/ddd

PHILIP D. MURPHY
Governor

Sheila Y. Oliver
Lt. Governor

Carole Johnson
Acting Commissioner

Jonathan S. Seifried
Acting Assistant Commissioner

TO: Approved Medicaid/DDD Behavioral Supports Providers

FROM: Jonathan S. Seifried, Acting Assistant Commissioner
Division of Developmental Disabilities

DATE: August 15, 2018

SUBJECT: Extension to come into compliance with Behavioral Supports qualifications

As you are aware, the qualifications to provide Behavioral Supports were updated in Section 17.2.3 Behavioral Supports Provider Qualifications of the Supports Program and Community Care Program Policies & Procedures Manuals released in May of 2018. This update added the need for someone conducting assessments, developing behavior support plans, and evaluating their effectiveness with a Master's/Bachelor's degree in applied behavioral analysis, psychology, special education, social work, public health counseling, or a similar degree to be supervised by a BCBA-D or BCBA.

In order to give providers time to hire/engage a BCBA level staff member or consultant, the Division is extending the deadline for which providers must come into compliance with the Behavioral Supports qualifications described in the Supports Program and CCP Policies & Procedures Manuals to February 28, 2019. Providers can continue to follow the staffing qualifications as described in Division Circular #34 until that date.

**APPENDIX N – INTERAGENCY AGREEMENT BETWEEN WAGE & HOUR IN THE U.S.
DEPARTMENT OF LABOR, DVRS, CBVI, AND DDD**

**INTERAGENCY AGREEMENT BETWEEN
WAGE AND HOUR DIVISION
IN THE U.S. DEPARTMENT OF LABOR
AND
THE DIVISION OF VOCATIONAL REHABILITATION
SERVICES IN THE
NEW JERSEY DEPARTMENT OF LABOR
AND
THE COMMISSION FOR THE BLIND AND VISUALLY
IMPAIRED
AND
THE DIVISION OF DEVELOPMENTAL DISABILITIES
IN THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES**

The Division of Vocational Rehabilitation Services, the Commission for the Blind and Visually Impaired, the Division of Developmental Disabilities, and the United States Department of Labor, Wage and Hour Division in conjunction with community-based rehabilitation programs are committed to the continued development and implementation of individual vocational rehabilitation programs that will facilitate the employment of persons with disabilities into employment within their communities. This must take place under conditions that will not jeopardize the protections afforded by the Fair Labor Standards Act to program participants, employees, employers or other programs providing rehabilitation services to individuals with disabilities.

Where ALL of the following criteria are met, the U.S. Department of Labor will NOT assert an employment relationship for purposes of the Fair Labor Standards Act.

- o Participants will be individuals with physical and/or mental disabilities for whom competitive employment at or above the minimum wage level is not immediately obtainable and who, because of their disability, will need intensive ongoing support to perform in a work setting.
- o Participation will be for vocational exploration or assessment in an integrated community-based work site under the general supervision of rehabilitation organization personnel.
- o Community-based placements will be clearly defined components of individual rehabilitation programs developed and designed for the benefit of each individual. The statement of needed services established for the exploration and assessment components will be included in the person's Vocational Assessment Plan (VAP), Individualized Plan of Employment (IPE), or Individual Habilitation Plan(IHP).
- o Information contained in the VAP/IPE/IHP will not have to be made available, however, documentation as to the individual's enrollment in the community-based placement program and the identification of the employer(s) participating will be made available to the U.S. Department of Labor. The individual and, when appropriate, the parent or guardian of each individual must be fully informed of the VAP/IPE/IHP and the community-based placement component and have indicated voluntary participation with the understanding that participation in such a component does not entitle the participant to wages.

- o The activities of the individuals at the community-based placement site do not result in an immediate advantage to the business. The U.S. Department of Labor will look at several factors.
 - 1) There has been no displacement of employees; vacant positions have not been filled; employees have not been relieved of assigned duties; and the individuals are not performing services that, although not ordinarily performed by employees, clearly benefit the business.
 - 2) The individuals are under continued and direct supervision by either representatives of the rehabilitation program or by employees of the business.
 - 3) Such placements are made according to the requirements of the individual's VAP/IPE/IHP and not to meet the labor needs of the business.
 - 4) The periods of time spent by the individuals at any one site or in any clearly distinguishable job classification are specifically limited by the VAP/IPE/IHP.

- o While the existence of an employment relationship will not be determined exclusively on the basis of the number of hours, as a general rule, each component will not exceed the following limitations:

Vocational exploration	5 hours per job experience
Vocational assessment	90 hours per job experience
Vocational training	120 hours per job experience

- o Individuals are not entitled to employment at the business at the conclusion of their VAP/IPE/IHP, however, once an individual becomes an employee, the person cannot be considered a trainee at that particular community-based placement unless in a clearly distinguishable occupation.

An employment relationship will exist unless all of the criteria described in the policy are met. If an employment relationship is found to exist, the business will be held responsible for full compliance with the applicable sections of the Fair Labor Standards

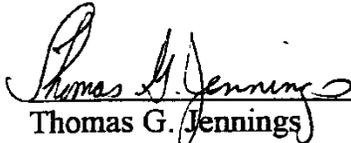
Act, including those relating to child labor.

Businesses and rehabilitation organizations may, at any time, consider participants to be employees and may structure the program so that the participants are compensated in accordance with the requirements of the Fair Labor Standards Act

The Division of Vocational Rehabilitation Services, the Division of Developmental Disabilities, and the Commission for the Blind and Visually Impaired will be responsible for informing the U.S. Department of Labor of the businesses participating in this program. The Divisions and the Commission will also maintain a list of clients involved in the program so that the U.S. Department of Labor may be alerted to the special circumstances when reviewing a site.

For the Division of Vocational
Rehabilitation Services

For the Wage and Hour Division
of the U.S. Department of Labor

 8/30/01

Thomas G. Jennings Date
Director

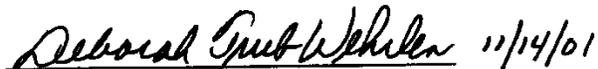
 10/23/01

Corlis L. Sellers Date
Regional Administrator

For the Commission for the Blind
and Visually Impaired

For Division of Developmental Disabilities

Jamie C. Hilton Date
Director

 11/14/01

Deborah Trub Wehrlen Date
Director

APPENDIX O – PER-MEMBER, PER-MONTH FEE FOR AGENCY WITH CHOICE FI MODEL

For every individual participating in one of the Division’s two self-directed service models (Agency with Choice or Vendor Fiscal/Employer Agent), a monthly fee must be paid to the fiscal intermediary for each model to cover the cost of the administrative and payroll services they provide. This monthly amount is referred to as the per-member, per-month (PMPM) fee.

The state pays an amount toward every individual’s PMPM fee. Currently, the state payment covers the monthly cost to participate in the Vendor Fiscal/Employer Agent model, but does not cover the cost to participate in the Agency with Choice model. The remaining cost to participate in the Agency with Choice model is deducted each month from the individual’s budget. Below is the PMPM cost to an individual’s budget when they choose to participate in the Agency with Choice model. The PMPM is based on the number of self-directed employees an individual has and whether or not their employee(s) elect employer-sponsored health benefits through the fiscal intermediary.

	PMPM 1	PMPM 2	PMPM 3	PMPM 4
	One or more SDEs working 0-40 hrs. per week for you or the employer of record (Easterseals) and NOT electing health benefits	One SDE working less than 30 hrs. per week for you but 30+ hrs. per week for the employer of record (Easterseals) AND electing health benefits	One SDE working 30+ hrs. per week for you AND electing health benefits; --OR-- Two or more SDEs working less than 30 hrs. per week for you but 30+ hrs. per week for the employer of record (Easterseals) AND electing health benefits	Two or more SDEs working 30+ hrs. per week for you AND electing health benefits
MONTHLY Cost to Individual Budget*:	\$193.97	\$340.15	\$442.48	\$736.19
ANNUAL Cost to Individual Budget*:	\$2,327.64	\$4,081.80	\$5,309.76	\$8,834.28

*Includes state allowance toward cost

PLEASE NOTE: This table is for guidance purposes only. Your support coordinator will need to work with Easterseals directly to determine which PMPM will be applied.



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services
Division of Developmental Disabilities

NEWSLETTER

Volume 30 No. 19

August 2020

TO: Providers of Community Care Program or Supports Program
Services – **For Action**
Managed Care Organizations – **For Information Only**

SUBJECT: Temporary Employment Agencies

EFFECTIVE: Immediately

PURPOSE: To notify providers of a policy decision related to contracting with a temporary employment agency to supplement staffing needs for the Community Care Program (CCP) or the Supports Programs.

BACKGROUND: The NJ FamilyCare (NJFC) Medicaid Fee-For-Service Program explicitly precludes the use of sub-contracting by a New Jersey Division of Developmental Disabilities (DDD)/NJFC Medicaid approved provider. This policy is not subject to change. However, DDD brought to the Division's attention an important need for DDD providers to contract with a qualified temporary employment agency for temporary staff to ensure their compliance with DDD staffing requirements. An example of this is could be a DDD/Medicaid approved provider of Individual Supports needing temporary staffing to ensure compliance with required staffing ratios.

DDD conducted a review of current services that would benefit from accessing qualified temporary employment agency staffing. For both CCP and Supports, these services would include behavioral supports, day habilitation, interpreter services, occupational therapy, physical therapy, and speech, language, and hearing therapy. For CCP, an additional service would include individual supports and for Supports Program, an additional service would include community based supports.

ACTION: Effective Immediately, a qualified temporary employment agency that will provide one or more of the identified services to a DDD/NJFC approved provider must submit the combined DDD/NJFC Medicaid provider application to the State's Fiscal Agent, currently DXC Technology, for approval by the New Jersey Division of Medical Assistance and Health Services (DMAHS). The temporary employment agency shall be screened and assigned a NJFC Medicaid Provider ID Number by DXC Technology.

Any DDD/NJFC Medicaid-approved agency providing temporary employees (acting as a subcontractor) shall maintain a vendor contract with the DDD/NJFC Medicaid enrolled

provider that has requested the temporary staffing services (acting as a contractor). This contract shall outline that the contractor shall complete the DXC billing in exchange for the required services from the subcontractor. The contract shall also outline reimbursement rates, contain a description of needed staff profiles and attestation to assure continuous vetting of current employees to ensure minimum requirements continue to be met. At no time shall that contract violate DDD/NJFC Medicaid requirements. The contract shall be subject to review by DDD and DMAHS.

The subcontractor is responsible for ensuring that any individuals under contract and temporarily employed for staffing purposes fully satisfy all applicable State, federal, and any other licensure and certification requirements, including those regulations incorporated within the DDD/NJFC Medicaid combined application. Failure to assure that all such requirements are met, which are consistent with N.J.A.C. 10:49-9.8(d), may result in either or both actions listed below:

1. DMAHS may recover from the enrolled contractor the NJFC Medicaid reimbursement paid by the Program to the provider for any service rendered by an employee not meeting such requirements; and/or
2. The contractor or subcontractor may be subject to any applicable civil or criminal sanctions and/or penalties.

If a DDD provider has any questions concerning this Newsletter, please contact DDD at 609-633-1482. For questions related to provider enrollment, please contact the DXC Technology Provider Enrollment Unit at 609-588-6036.

RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE

APPENDIX Q – NEWSLETTER VOLUME 31 NO.23 – October 2021



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services
Division of Developmental Disabilities

NEWSLETTER

Volume 31 No. 23

October 2021

TO: Division of Developmental Disabilities (DDD) Providers – **For Action**
Managed Care Organizations – **For Information Only**

SUBJECT: **Provider Enrollment Requirements for Address Changes**

EFFECTIVE: **Immediately**

PURPOSE: To notify Medicaid/NJ FamilyCare Fee-for-Service (FFS) providers regarding provider application requirements for providers changing primary and/or secondary location addresses.

BACKGROUND: The New Jersey Division of Medical Assistance (DMAHS) and the New Jersey Division of Developmental Disabilities (DDD) have received inquiries regarding provider application requirements for a provider changing to a new provider address.

ACTION: Effective immediately, Gainwell Technologies, the State's Fiscal Agent, is changing the DDD Supports Program and Community Care Program (CCP) provider application to:

- (1) allow providers to indicate when their application is being submitted for a change in a provider's primary location; and
- (2) report a change in a provider's secondary location. **Providers must continue to submit fully completed applications.**

When changing a provider's primary location, the provider must respond "Yes" to the question: **"Is this a change in the primary physical location?"** found in the "Primary Physical Location" section of the application. For a secondary location address change, only the **"Secondary Location Change"** section needs to be completed. This new section (see below) requests information related to the secondary location address change. When there is a secondary location address change, **the provider is not required to report information related to all other secondary locations in their provider network.** Payment of an application fee is not a requirement for DDD providers.

18. Secondary Location Change

A. Name: _____

1). Prior Address:

Street: _____

City: _____

State: _____ Zip: _____ County: _____

2) New Address:

Street: _____

City: _____

State: _____ Zip: _____ County: _____

Existing Medicaid Provider # (if you have one): _____ NPI # (if different) _____

3). List the name, birth date, social security #s of, agent(s), administrator(s) and managing employees:
(use separate sheet of paper if needed)

a. _____

b. _____

c. _____

d. _____

If you have any questions concerning this Newsletter, please contact the Gainwell Technologies Provider Enrollment Unit at (609) 588-6036.

RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE

APPENDIX R – RESERVED

APPENDIX S - Quick Guide to Required Content Areas for Provider Policy and Procedure Manuals

For providers required to have an agency Policy & Procedure Manual, the following content areas are required to be included in that manual (based on services approved to provide). Agencies approved for multiple services must ensure their Policy & Procedure Manual includes the required areas for any approved services. This DOES NOT mean having multiples of the same content area, but rather ensuring that each of the required content areas of any service you are approved to provide is included in the manual.

Service	Required P&P Content Areas
Assistive Technology Environmental Modification Goods & Services PERS Vehicle Modification	N/A
Behavioral Supports	<ul style="list-style-type: none"> • Organizational Governance • Personnel • Admission, Suspension, Discharge • Reporting Incidents • Complaint/Grievance Resolution or Appeals Process • Complaint Investigation • HIPAA & Protected Health Information • Emergency Procedure • Medication Administration • Reporting Medicaid Fraud/Waste/Abuse • Human Rights • Financial Management & Billing • Quality Management Plan • Behavior Policy
Career Planning Community Inclusion Services Prevocational Training Supported Employment – Individual and Small Group	<ul style="list-style-type: none"> • Organizational Governance • Personnel • Admission, Suspension, Discharge • Reporting Incidents • Complaint/Grievance Resolution or Appeals Process • Complaint Investigation • HIPAA & Protected Health Information • Emergency Procedure • Medication Administration • Reporting Medicaid Fraud/Waste/Abuse • Human Rights • Financial Management & Billing • Quality Management Plan
Cognitive Rehabilitation Interpreter Services Natural Supports Training Occupational Therapy Physical Therapy Speech, Language, & Hearing Transportation	<ul style="list-style-type: none"> • Reporting Incidents • Complaint Investigation • HIPAA & Protected Health Information • Reporting Medicaid Fraud/Waste/Abuse

<p>Community Based Supports Day Habilitation Individual Supports (Daily Rate) Individual Supports (Hourly Rate) Respite</p>	<ul style="list-style-type: none"> • Organizational Governance • Personnel • Admission, Suspension, Discharge • Reporting Incidents • Complaint/Grievance Resolution or Appeals Process • Complaint Investigation • HIPAA & Protected Health Information • Emergency Procedure • Medication Administration • Reporting Medicaid Fraud/Waste/Abuse • Human Rights • Financial Management & Billing • Quality Management Plan • Behavior Policy
<p>Support Coordination</p>	<ul style="list-style-type: none"> • Organizational Governance • Personnel • Admission, Suspension, Discharge • Reporting Incidents • Complaint/Grievance Resolution or Appeals Process • Complaint Investigation • HIPAA & Protected Health Information • Emergency Procedure • Reporting Medicaid Fraud/Waste/Abuse • Human Rights • Financial Management & Billing • Quality Management Plan
<p>Supports Brokerage</p>	<ul style="list-style-type: none"> • Organizational Governance • Personnel • Admission, Suspension, Discharge • Reporting Incidents • Complaint/Grievance Resolution or Appeals Process • Complaint Investigation • HIPAA & Protected Health Information • Emergency Procedure • Reporting Medicaid Fraud/Waste/Abuse • Human Rights • Financial Management & Billing • Quality Management Plan
<p>Transportation</p>	<ul style="list-style-type: none"> • Personnel • Reporting Incidents • Complaint Investigation • HIPAA & Protected Health Information • Reporting Medicaid Fraud/Waste/Abuse