

**DIVISION CIRCULAR #35**

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

**EFFECTIVE DATE:** March 1, 2006

**DATE ISSUED:** March 1, 2006

**(Rescinds Division Circular #35, "Individual Habilitation Plan", issued January 21, 2001).**

**I. TITLE: SERVICE PLAN**

**II. PURPOSE:** To establish policies which assure that each individual who is eligible for and receives services from the Division of Developmental Disabilities (DDD) participates in the development and completion of an annual Division approved Service Plan. The Service Plan is a tool for the planning and implementation of generic and specialized services designed to achieve personal outcomes that are appropriate to the individual's interests, strengths, needs and preferences.

**III. SCOPE:** This circular applies to all components of the Division and agencies and entities under contract with the Division or regulated by the Department, who provide services to Division eligible individuals.

**IV. GENERAL STANDARDS:**

A. Definitions - for the purpose of this circular, the following terms shall have the meaning defined herein.

1. "Assessment" means the process of identifying the strengths, needs, and preferences of an individual served, barriers to and recommendations for the provision of services.
2. "Behavioral Objective" means one in a series of short-range steps developmentally sequenced and directed toward the

achievement of an established goal. Each behavioral objective specifies a single, learned response to be exhibited by the individual and the criterion against which progress is to be measured.

3. “Case Manager” means the Division or a contracted agency employee who coordinates the implementation of programs, supports and/or services to facilitate the achievement of the outcomes, goals and/or objectives identified in the Service Plan. A case manager provides assistance to the individual in gaining access to needed state plan services, medical, social, educational and other services, regardless of the funding source for the services. Activities of the case manager may include assessment, service/support planning, arranging for services, coordinating service providers, and/or monitoring and overseeing the provision of services.
4. “Consensus” means a general verbal or written agreement regarding a plan of action. It does not mean unanimity.
5. “Goal” means a written statement of attainable, measurable, behavioral or service objectives with an outcome which is expected to be achieved partially or completely within the year the service plan is in effect. Goals must be related to the personal outcomes desired by the individual.
6. “Guardian” means an individual or agency appointed by a court of competent jurisdiction or who is otherwise legally authorized and responsible to act on behalf of a minor or incompetent adult to assure provision for the health, safety, and welfare of the individual and to protect his or her rights consistent with N.J.S.A. 3B 2-57 and N.J.S.A. 30:165.1 et seq.
7. “Habilitation” means services designed to assist individuals with developmental disabilities in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to function successfully in residential, day program, and other community based settings. Habilitation services are long term supports usually provided to persons with a developmental disability that are distinguished from rehabilitation services in terms of length of treatment, goals of treatment, and recipient of treatment. Rehabilitation services are short term medical or remedial services recommended by a physician for restoration of a recipient to his or her best

possible functional level after an acute episode of physical or mental disability or long term mental illness.

8. "Habilitation Plan Coordinator (HPC) " means a Division employee who may be utilized as the case manager or team leader for the development of the Service Plan.
9. "Interdisciplinary Team" (IDT) means a group that shall minimally consist of the individual receiving services, the plan coordinator, the legal guardian, and/or the Division case manager. The IDT may include the parents or family member at the preference of the person served or guardian. In addition, members may include: advocates and friends, those persons who work most directly with the individual served, and professionals and representatives of service areas who are relevant to the identification of the individual's needs and preferences and the design and evaluation of programs to meet them.
10. "Level of Care for the DDD Community Care Waiver(s)" means "Eligibility for Intermediate Care Facility /Mental Retardation (ICF/MR) services". Eligibility for ICF/MR Services means the recipient has been determined eligible for Division services in accordance with N.J.A.C. 10:46 and has substantial functional limitations in self-care which require care and/or treatment in an ICF/MR or, alternatively, in a community program under the DDD Community Care Waiver.
11. "Level of Care for ICF/MR facility" means "Eligibility for ICF/MR services". The recipient has been determined eligible for Division services in accordance with N.J.A.C. 10:46 and has substantial functional limitations in self-care, communication, learning, mobility, self-direction, socialization, capacity for independent living or economic self-sufficiency, which require a range of professional services or interventions and care and/or treatment in an ICF/MR facility.
12. "Limited guardian" means someone who is appointed by a court of competent jurisdiction to make only those personal decisions for which an incapacitated person has been adjudicated to lack capacity.
13. "Measurable" means a characteristic of objectives which can be assessed and quantified in a manner in which achievement of that objective can be determined.

14. "Medicaid Home and Community Based Services – HCBS DDD Medicaid Waiver" means the Community Care Waiver(s), which is/are Medicaid program(s) that allow(s) the State of New Jersey to waive certain Federal Medicaid eligibility criteria for individuals who meet eligibility for DDD services, reside in the community and require an ICF/MR level of care.
15. "Outcomes" means the achievement of goals and objectives as developed by the individual and the interdisciplinary team and outlined in the Service Plan.
16. "Plan Coordinator" means a person designated to coordinate the development of each individual's Service Plan.
17. "Plenary guardian" means someone who is appointed by a court of competent jurisdiction to make all personal decisions in a person's life. A private plenary guardian may make decisions about a person's property. A state guardianship worker is unable to make decisions about a person's property.
18. "QMRP" means "Qualified Mental Retardation Professional" in accordance with 42 CFR-483.430 who is a person who has at least one year of experience in working with persons with developmental disabilities and is one of the following:
  1. A doctor of medicine or osteopathy;
  2. A registered nurse;
  3. A professional program staff person who is licensed, certified or registered, as applicable. If the professional program staff do not fall under the jurisdiction of State licensure, certification or registration requirements, he or she shall meet the following qualifications:
    - i. To be designated as an occupational therapist, an individual shall be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body;
    - ii. To be eligible as an occupational therapy assistant, an individual shall be eligible for certification as a certified occupational therapy

- assistant by the American Occupational Therapy Association or other comparable body;
- iii. To be eligible as a physical therapist, the individual shall be eligible for certification as a physical therapist by the American Physical Therapy Association or other comparable body;
  - iv. To be eligible as a physical therapy assistant, an individual shall be eligible for registration by the American Physical Therapy Association or be a graduate of a two-year college level program approved by the American Physical Therapy Association or other comparable body;
  - v. To be designated as a psychologist, an individual shall have at least a master's degree in psychology from an accredited school;
  - vi. To be designated as a social worker, an individual shall:
    - (1) Hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; or
    - (2) Hold a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body;
  - vii. To be designated as a speech language pathologist or audiologist, an individual shall:
    - (1) Be eligible for a certificate of clinical competence in speech language pathology or audio logy granted by the American Speech Language Hearing Association or other comparable body; or
    - (2) Meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification;
  - viii. To be designated as a professional recreation staff, an individual shall have a bachelor degree in recreation or in a specialty area such as art, dance, music or physical education;
  - ix. To be designated as a professional dietitian or nutritionist, an individual shall be eligible for registration by the American Dietetics Association;
  - x. To be designated as a human services professional, an individual shall have at least a

bachelor degree in a human services field, including, but not limited to, sociology, special education, rehabilitation, counseling or psychology.

19. "Self-Direction Process" means a service delivery system which allows an individual with developmental disabilities, in conjunction with his or her legal guardian, family and selected friends to identify appropriate services and supports and determine how an individual budget, along with personal, family and community resources can be used to develop a service plan.
20. "Services" or "Services for people with developmental disabilities" means specialized services or specialized adaptations of generic services as defined in N.J.S.A. 30:6D-25f.
21. "Service Plan" means a written, individualized habilitation plan, consistent with the requirements of N.J.S.A. 30:6D-10 through 12, developed with the individual, and/or his or her legal guardian, and the IDT. It is an outcome-based planning tool that, at a minimum, identifies each individualized program, support and/or service requested by and provided to the individual, for which the individual demonstrates a need. It identifies the person and/or agency responsible for its implementation. The complexity of the Service Plan will vary according to the individual's interests, preferences, and needs. The Service Plan format must be Division approved but can be chosen from various types of Plans, as determined by the requirements of the specific program, service, or support, and can include, but is not limited to, the following types of plans: Individual Habilitation Plan (IHP) Appendix #1, Essential Lifestyle Plan (ELP) Appendix #2, Self-Determination Plan (Appendix #3) and Individual Service Plan (ISP) (Appendix #4).
22. "Transfer" means a change in residence due to a change in the needs or preferences of the person with a developmental disability based upon the recommendation of the Interdisciplinary Team, with the following exception; it is not a placement from the waiting list for residential placement.

**V. SERVICE PLAN: MEETING STANDARDS:**

- A. A plan coordinator shall be assigned and is responsible to coordinate the development of the individual's Service Plan. The person designated as plan coordinator may vary according to the type of plan utilized.
- B. In order that all participants understand the Service Plan process, the Service Plan meeting shall be conducted with an emphasis on plain language.
- C. At the meeting, an individual receiving supports and services shall be encouraged to exercise the highest level of personal autonomy that is consistent with his or her capacity to understand the risks and consequences of his or her choices.
- D. The role of the IDT is to provide support, facilitate informed decision-making and complement, not supplant, the role of the individual and/or legal guardian.
- E. Whenever possible, decision-making shall be by consensus reached by the IDT regarding a specific course of action.
- F. At the annual Service Plan meeting, the plan coordinator shall review the individual's health and safety, rights and responsibilities, and the risks and benefits involved.
- G. The annual Service Plan meeting shall address the recommendation of the need for a legal guardian to make decisions on behalf of an individual. Recommendations to consider include, but are not limited to:
  - 1. Current decisions being made by an individual;
  - 2. Goals to develop decision-making skills; and
  - 3. Where an individual has a legal guardian recommendations to change level of guardianship from plenary to limited, limited to plenary or restore capacity.
- H. At the annual Service Plan meeting, the individual's status on the Waiting List(s) will be reviewed.
- I. A review of the representative payee status shall be made at the Service Plan meeting. If the IDT has concerns about how the benefits are handled by a representative payee, the assigned

Business Manager in a developmental center or the Fiscal Coordinator in the community shall be available to assist the IDT in referring the matter to the Social Security Administration for review.

- J. Where no funeral arrangements exist on record with the Division, and the individual served and/or his or her legal guardian is in agreement, information regarding the individual's burial arrangements, including, but not limited to, prepaid burial arrangements, type of funeral service preferred and specific details regarding the funeral, shall be reviewed and documented. Where the burial plan has been established, changes shall be discussed. There can only be one established burial plan.

**VI. SERVICE PLAN: REPORT STANDARDS:**

- A. The Service Plan shall be based upon an assessment that identifies the individual's interests, preferences and needs in the following areas, as determined appropriate by the individual, legal guardian and/or IDT: his or her plan for the future, physical and emotional well being, nutrition, personal care needs, adaptive and independent living abilities, vocational skills, cognitive and educational abilities, recreation and leisure time, community participation, communication, religion and culture, social and personal relationships and any other areas important to the individual.
- B. Each person receiving Division services shall have a Service Plan delineating the individual programs, supports and/or services identified by the person, his or her legal guardian and/or the Interdisciplinary Team (IDT) to attain personal goals and to maximize his or her quality of life. All Service Plans shall address that which is *important to* the person as well as that which is *important for* the person and reflect his or her desired outcomes, goals and/or service objectives.
- C. In all cases, a QMRP must approve the Service Plan developed by the IDT. For persons funded through the Medicaid DDD Waiver(s), in accordance with the development of the Service Plan, the designated QMRP shall complete the re-certification component, by making the determination consistent with the requirements of the Medicaid DDD Waiver, as to whether the individual receiving service requires an ICF/MR level of care.
  - 1. Where the Division case manager is not the plan coordinator, the designated QMRP shall review the Service Plan for compliance with the requirements of the Medicaid DDD Waiver; and



2. In accordance with N.J.A.C. 10:46D, update the DDD Annual Income Form, which is subsequently returned to the Division's Central Office.
- D. The Division of Developmental Disabilities shall ensure the development of a Service Plan that includes the services, supports, or individual programs funded by the Division (DDD) or funded by another resource.
- E. The plan coordinator shall conduct a periodic review of the Service Plan in order to, at a minimum, ensure the delivery of services and/or programs identified in the plan and the continuous progress toward stated goals. The individual or his legal guardian may request an IDT review of the Service Plan at any time.
- F. Service Plans developed for children, who are receiving educational services either residentially or while he or she is residing in their own home, shall include goals related to transition to adult roles when educational entitlement ends.
1. The necessary services to achieve the outcome of community inclusion and participation in adult roles, may or may not be funded by the DDD, but shall be planned in collaboration with the Local Education Authority (LEA) preferably beginning at age 14, the age in which the Federal Law, the Individuals with Disabilities Education Act (IDEA) and Federal Administrative Code require LEA to identify transition needs.
  2. Transition services must be provided by the LEA by age 16.
  3. Beginning three years prior to the expiration of their educational entitlement, for children who are residentially placed by their LEA, the Service Plans developed by DDD in collaboration with the LEA, shall focus on transitioning the individual into appropriate adult services which may include DDD funded services.
- G. The Service Plan will identify the preferences of the individual receiving services for specific programs, supports, and/or services.
1. The implementation of a Service Plan that reflects the individual's preferences may range from the provision of a single program, support or service to the development of a comprehensive plan, or result in a list of barriers that prohibit

access to that preferred program, support or service and the means to address those barriers.

2. When the individual's preferences cannot be met, alternate services acceptable to the individual shall be delineated in the Service Plan.
  3. If an individual is unable to verbally express his or her preferences, the IDT shall seek to understand the preferences of the individual through observation, alternate means of communication and by obtaining the input of the legal guardian, members of the individual's family, and other interested persons, who have pertinent information regarding the individual's interests, preferences and needs
- H. Every program, support and/or service outlined in the Service Plan shall operate in accordance with generally accepted professional standards in a setting that is least restrictive of personal liberty. When an individual's rights are restricted, each restriction and the justification for the restriction shall be documented in the Service Plan. The Service Plan shall also indicate when restrictions may be lessened or eliminated. The restriction shall be reviewed in accordance with Division Circular #5 "Human Rights". The individual or legal guardian shall be advised of their right to appeal any restriction of rights.
- I. After receiving input from the individual served and/or the legal guardian and other members of the IDT, the plan coordinator shall be responsible to complete the Service Plan. Any disagreement between members of the IDT regarding the individual programs, supports and services contained in the Service Plan shall be documented within the plan. Disagreements shall not delay the completion of the Service Plan.
- J. The Service Plan is part of the client record and is subject to confidentiality provisions defined in N.J.A.C. 10:41, Division Circular #30. Release of the Service Plan shall be made in accordance with Division Circulars #53, #53A and #53B, "Health Insurance Portability and Accountability Act (HIPAA)."
- K. The Service Plan shall be reviewed and revised, when appropriate, and at least every 365 days, in accordance with N.J.S.A. 30:10 through 12. Modifications to the Service Plan shall be completed when major changes occur at any point in the Service Plan cycle relative to the achievement or lack of achievement of goals, objectives, availability of services, programs, or supports, changes

in the individual's physical condition, cognitive functioning, needs, or preferences.

- L. The Service Plan shall specify that when an individual is residing in a residential placement funded by DDD the person is required to contribute to the cost of his or her care and maintenance per the requirements of N.J.A.C. 10:46D "Contribution to Care and Maintenance".
- M. The Service Plan developed for persons served who reside in facilities licensed as Community Residences, shall comply with the requirements of N.J.A.C. 10:44A, 10:44B or 10:44C which outline specific criteria and information that must be included in the Service Plans used in that setting.
- N. The Service Plan may be appealed in accordance with N.J.A.C. 10:48-
  - 1. Division Circular #37 "Appeal Procedure" or N.J.A.C. 10:49-9.14 "Provisions for appeals; fair hearings", a Medicaid rule that would apply to waiver services.
- O. Except in emergency situations in accordance with N.J.A.C. 10:46B-3.3, a Service Plan shall be developed 30 days prior to admission to a residential placement or transfer between services.
  - 1. The Service Plan shall be reviewed, and modified if necessary in no cases beyond 30 days after admission or transfer to another service.
  - 2. The individual and/or his or her legal guardian may request an IDT review of the Service Plan at any time.
- P. A copy of the Service Plan shall be provided to the individual (upon request), the legal guardian and DDD. Each developmental center, agency and/or individual providing services to the person shall receive, at a minimum, a copy of the portion of the Service Plan delineating the service the agency or individual is to render.

## **VII: Service Plan: Administrative Procedures**

- A. Assignment/Designation of Plan Coordinator
  - 1. When individuals are not self-directing a budget for services, the plan coordinator shall be assigned in accordance with Division Circular #52, "Community Services System of Case Management."

2. For individuals residing in developmental centers operated by the Division, the HPC is the plan coordinator.
  3. For individuals self-directing a budget for services, the individual served and/or his or her guardian designates a plan coordinator.
- B. For individuals residentially placed by the Division or individuals attending day programs funded by the Division and managed by a contracting agency, the designated case manager is responsible to attend all Service Plan meetings for individuals on their caseload. The only exception to this are individuals participating in self-directed programs.
1. When the assigned case manager/HPC is unable to attend, the HPC/case manager's supervisor is responsible to designate an alternate case manager/HPC to attend the Service Plan meeting.
  2. In the event of an emergency that does not allow sufficient time for the case manager's supervisor to designate an alternate case manager, the agency plan coordinator, with DDD approval, may choose to conduct the Service Plan meeting, providing that the individual and his or her legal guardian are in attendance.
  3. When an HPC in a developmental center is unable to attend, an alternate HPC shall be assigned.
- C. Date of the Annual Plan of Care Meeting
1. Each Service Plan shall have a single annual date by which it is to be revised and updated as necessary. IDT meetings held between annual Service Plan meetings to address changes in an individual's circumstances (e.g., medical or medication issues, behavioral issues, change in living arrangement, achievement or lack of progress in an objective) may modify the Service Plan; however, they do not alter the date that the annual Service Plan meeting is due. This annual date can be changed under certain conditions outlined in VII-C. 2 below.
  2. A change from a non-waiver to waiver program will change the Service Plan date.

- a. A new annual Service Plan date can be changed only under the conditions outlined below:
  - b. Upon initiation of Medicaid DDD Community Care Waiver services (e.g. lives at home and begins day program); For example, change from Medical to Adult Training Services Day Program.
  - c. Upon transfer from developmental center to developmental center;
  - d. Upon transfer from developmental center to community based living arrangement;
  - e. Upon transfer from community-based living arrangement to developmental center
  - f. Upon transfer from LEA funded program to community-based living arrangement;
  - g. Upon transfer from an out-of-state placement to a NJ residential placement, and
  - h. For extraordinary circumstances as outlined in 3(d).
3. Notification of the Annual Service Plan Meeting
- a. The Service Plan meeting shall accommodate the schedules of all parties, including but not limited to the individual, his or her legal guardian, and the IDT members, to the extent possible, while complying with regulatory requirements for the annual date.
  - b. A plan coordinator or designee is responsible to send written notification to all individuals invited to participate in the Service Plan meeting indicating the date, time and location of the meeting, no less than 14 calendar days before the meeting.
  - c. The plan coordinator shall attempt to honor requests to reschedule the Service Plan meeting, but in no case shall the Service Plan meeting be delayed beyond 30 days from the originally scheduled date, in accordance with the Medicaid DDD Waiver, except as under the conditions of VII-C.2. However, for individuals who reside in developmental centers, the annual Service

Plan meeting shall be held within 365 days of the implementation of the previous annual Service Plan.

- d. For extraordinary circumstances, as necessary e.g., the guardian is out of country for six months, the plan coordinator may hold the meeting on an earlier date than the annual date to remain in compliance with the Medicaid DDD Waiver Service Plan date. The new annual date shall be consistent with the date the meeting was held as necessary to remain in compliance with the Medicaid DDD Waiver.

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Carol Grant  
Director

## **APPENDIX #1: Individual Habilitation Plan**

1. “Individual Habilitation Plan” (IHP) is a type of Service Plan which is utilized in settings where the budget for programs, supports, and services are not self-directed. The IHP is a written document that serves as an agreement among the service recipient, service provider and other members of the IDT, as to the type and frequency of services, the goals of the services, and how the progress will be monitored. An IHP may include plans from programs, services, or supports that are funded from another agency. An IHP is used in settings in which the funding source requires compliance with ICF/MR standards; such as developmental centers; or compliance with Medicaid Waiver standards, such as community residences licensed under 10:44A, “Standards for Community Residences for Individuals with Developmental Disabilities” 1044B, “Standards for Community Residences for the Developmentally Disabled: Community Care Residences” 1044C, “Standards for Community Residences for Persons with Head Injuries” and 1047”Standards for Private Licensed Facilities for Persons with Developmental Disabilities”. An IHP is also required in day programs contracted by the Division of Developmental Disabilities.
  - a. The IHP shall include at least the following elements:
    - i. Cover page;
    - ii. Evaluation summaries;
    - iii. Summary of progress toward previous IHP goals and objectives
    - iv. Goals;
    - v. Behaviorally stated, measurable, sequential objectives;
    - vi. Clearly stated method of achieving each objective;
    - vii. Identification of IDT members and persons responsible for ensuring the delivery of services and/or programs described in the plan;
    - viii. A list of all current and planned programs, supports and/or services, their dates of initiation, anticipated duration and frequency;
    - ix. The waiting list status, if appropriate;
    - x. Barriers to meeting the individual's needs and desires, if any;
    - xi. A review of guardianship status;
    - xii. Meeting summary and any addendums, if modified;
    - xi. Sign-off section. This section indicates attendance only. Disagreement with any part of the plan may be indicated in the meeting summary.
    - xii. Community Care Waiver Certification where needed.
  - b. Individualized Habilitation Plan (IHP) Modification(s)
    - i. Major proposed modifications to an IHP shall be recommended in writing to the plan coordinator.

Except in an emergency, the proposed modification shall be discussed with the individual and/or his or her legal guardian before the modification is implemented.

- ii. Where the plan coordinator concludes that a proposed modification to the IHP results in a significant difference from the original intent of the IDT, he or she shall reconvene the IDT for discussion of the proposed modification.
  - iii. Where there is consensus, the modification to the IHP shall be documented and communicated to the appropriate team members by the plan coordinator for implementation.
  - iv. If, after receipt of the written IHP, there is a disagreement by any member of the IDT, the IDT shall reconvene within 30 days to discuss the content. The issue(s) under dispute shall not delay the implementation of agreed upon portions of the IHP.  
The designated QMRP shall review any modification to the IHP for compliance with the requirements of the ICF/MR or Medicaid Home and Community Based Services Waiver(s).
- c. Monitoring the Individualized Habilitation Plan (IHP) in a Developmental Center
- i. The HPC shall conduct, at a minimum, a quarterly review of each individual's plan to ensure the delivery of services and/or programs identified in the plan and the continuous progress towards goals.
  - ii. Where progress is not achieved, the IDT shall reconvene to consider revisions to the plan.
- d. Monitoring of an IHP in a Community-based living arrangement
- i. The designated case manager shall monitor the IHP in accordance with the requirements of Division Circular #52, "Community Services System of Case Management."
  - ii. Where progress is not achieved, the IDT shall reconvene to consider revisions to the plan.



## **APPENDIX #2: Essential Lifestyle Plan**

1. “Essential Lifestyle Plan (ELP)” is a type of Service Plan utilized by individuals who self-direct a budget of state and/or federal dollars for programs, services, and/or supports. Essential Lifestyle Planning is a method of prioritizing individual needs, creating an individualized budget for his/her choice and types of services, and selecting providers that may facilitate the achievement of the individual’s preferred lifestyle.
  - a. The Essential Lifestyle Plan should include but is not limited to the following elements:
    - i. Cover page;
    - ii. The introduction, which describes what people like and admire about the person;
    - iii. What the plan is to accomplish and what needs to be learned to accomplish it;
    - iv. What is important to the person in everyday life;
    - v. What is important for the person with regard to health and safety;
    - vi. What makes sense in the person’s life and what needs to stay the same;
    - vii. What doesn’t make sense in the person’s life and what needs to change;
    - viii. What others need to know or do to support the person;
    - ix. Identified outcomes;
    - x. An action plan to attain outcomes;
    - xi. Dates for reaching outcomes;
    - xii. Individual budget;
    - xiii. Sign-off section;
    - xiv. Community Care Waiver Certification

### **APPENDIX #3: Self-Determination Plan**

1. Self-Determination Plan is a type of service plan which allows an individual with developmental disabilities, in conjunction with his or her legal guardian, if any, family and selected friends to identify appropriate services and supports. It determines how an individual budget, as well as personal, family and community resources, can be used to develop a service plan. For individuals participating in Self-determination, the plan shall be considered the Service Plan as required by N.J.S.A. 30:6D 10 through 12.
2. Self-Determination was offered to individuals with urgent status on the Community Services Waiting List from July 1997 until February 2003. It is limited to the participants who had approved plans prior to February 20, 2003 and those individuals who had completed a written application for participation in Self-Determination prior to February 20, 2003.
3. A Self-Determination Plan shall be utilized, modified and monitored in accordance with Division Circular #33, "Self-Determination Process."
  - a. The Self-Determination Plan should include, but is not limited to the following documents:
    - i. Outcome forms
    - ii. Plan signature page
    - iii. Resource form
    - iv. Full financial disclosure
    - v. Line item budget
    - vi. Budget narrative and budget justification
    - vii. Budget sign off sheet
    - viii. New Support Broker contract
    - ix. Community Care Waiver Certification

## **APPENDIX #4: Individual Service Plan**

1. "Individual Service Plan"(ISP) is a type of Service Plan for an individual who participates only in a community-based, non-waiver program. It addresses only the services that the individual has requested from the Division. An ISP may be appropriate for services that include, but are not limited to, extended employment funded through the Department of Labor, family care provided in a community care residence, family support, respite for which the Division does not receive Medicaid DDD Waiver(s) funding, and services funded through educational entitlements.
  - a. A comprehensive IHP document can be utilized in lieu of the ISP if requested by the individual and/or parent of a minor child or legal guardian receiving only those services determined to be non-eligible under the Medicaid DDD Waiver(s).
  - b. The Individual Service Plan shall include at least the following elements:
    - i. Cover page;
    - ii. Services requested by the individual, and/or legal guardian;
    - iii. Evaluation summaries, where appropriate;
    - iv. Identification of IDT members and persons responsible for ensuring the delivery of services described in the Individual Service Plan;
    - v. Service objectives;
    - vi. Method of monitoring the Individual Service Plan
    - vii. A review of guardianship status;
    - viii. Meeting summary and, any addendums; if modified
    - ix. Sign-off section.
  - c. The plan coordinator shall forward the completed Individual Service Plan to the individual served and/or legal guardian for signature, which indicates agreement with the Individual Service Plan.
    - i. Where the individual served and/or legal guardian is not in agreement with the Individual Service Plan, they may make written changes directly on the plan and return it to the plan coordinator for revision.
    - ii. When revised, the plan coordinator shall forward the Individual Service Plan to the individual and/or parent of minor child, legal guardian for signature, which indicates agreement.
    - iii. Once signed, the Individual Service Plan shall be returned to the plan coordinator for signature and to be copied, and forwarded to the individual, parent of minor child and/or legal guardian, if appropriate.