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

Community Care Program Policies & Procedures Manual

PLEASE NOTE: This manual is only applicable to services, policies, procedures, and standards related to individuals enrolled on the CCP who have been shifted into the Fee-for-Service system.

Community Care Program Policies & Procedures Manual, Version 2.0 – May 2018

Section	Description of Changes
Overall Manual	• General grammatical, typo, etc. corrections, updated services to reflect move into the Comprehensive Medicaid Waiver
3	• Revised name of "Addressing Identified Clinical Needs Form" to "Addressing Enhanced Needs Form" • Added clarification regarding use of Behavioral Supports when an individual is assigned the acuity differentiated factor
5	• Provided clarification that an individual can disenroll from another HCBS or MLTSS program in order to enroll in the Supports Program • Added need to review the NJ CAT as part of the LOC annual review process • Aligned practice of completing a NJ CAT reassessment when enrolling into services if the most recent completion of the NJ CAT was done more than 1 year prior to enrollment • Added statement regarding entitlement to Fair Hearing as governed by Medicaid regulations if an individual is not voluntarily disenrolled from the Supports Program
6	• Added information regarding the new feature of emailing the individual or designee when his/her SCA has been assigned if email address is provided within the SCA Selection Form • Added language to further explain the need for SCs to become aware of provider documentation needs prior to serving an individual and ensure they are provided prior to service delivery • Provided further clarification that the monthly rate for Support Coordination includes responsibilities beyond the deliverables
7	• Added recommendation to include the identified providers within the planning team unless the individual has indicated that he/she does not wish to include the provider • Added language to clarify that the provider must be included on the planning team if providing residential services (Individual Supports – Daily Rate) • Added a separate section to identify responsibilities of the service provider as planning team member when included • Added "Path 4: Unemployed – Not Pursuing" to the Pathway to Employment to align with information provided in iRecord • Provided clarification regarding the Employment First Initiative and how various services (including Day Habilitation) can provide support toward reaching employment outcomes • Added information regarding services in need of approval by the Division
8	• Added information regarding the importance of the collaboration between the Support Coordinator and service provider during the referral process – included statement regarding need for SC to identify items/documentation needed by the service provider prior to serving the individual and ensuring those items are made available prior to start of services • Provided statement to confirm that Self-Directed Employees cannot be the individual's spouse, parent, or guardian • Added information related to Worker's Compensation for Self-Directed Employees • Provided an explanation of rounding units for billing purposes • Expanded the information provided regarding retirement from employment and/or from employment/day services and how to initiate the retirement process • Provided information on how retirement is reflected as it relates to the Individual Supports (supports provided residentially) component of the budget for someone on the CCP
12	• Added information regarding the process for a service provider to discontinue services
14	• Provided updated and clarified information regarding financial reporting requirements
15	• Updated office phone numbers for applicable UIR Units
17	• Provided statement referring to a new guide available in the Appendix to explain services for which claims can overlap

	• Included requirement for drug testing as applicable under Stephen Komninos' Law • Updated information regarding accessing Assistive Technology to align with new features in iRecord • Revised credentialing requirements to provide Behavioral Supports in response to stakeholder feedback and align with Division Circulars • Added examples of Behavioral Supports • Added statement addressing the need for a Division approved Behavior Supports Policy and Procedure prior to provision of Behavioral Supports per Division Circular #34 • Revised service delivery documentation requirements from the Quarterly Update to an Annual Update for Community Inclusion Services, Day Habilitation, Prevocational Training • Added Community Inclusion Services • Provided missing criteria for Day Habilitation staff • Added language to clarify that services providing education and training to acquire skills and experience that will assist an individual in moving toward his/her employment outcomes can be provided through Day Habilitation • Provided a more detailed explanation of transportation services as they relate to Day Habilitation • Updated process for accessing Environmental Modifications to reflect new iRecord features • Added Goods & Services • Added language to further explain Goods & Services criteria as it relates to businesses/providers • Updated process for accessing Goods & Services to reflect new iRecord features • Indicated that the budget component used to fund 15 minute unit versions of Individual Supports can also include the Individual Supports (supports provided residentially) component of the budget • Added language regarding the use of the "hourly rate" of Individual Supports as well as the "daily rate" • Added Interpreter Services • Added Natural Supports Training • Updated processes for accessing Occupational, Physical, or Speech, Language, and Hearing Therapies to reflect differences between habilitative and rehabilitative therapies and based on changes that have been made to simplify the process • Extended timeframe in which the need for Prevocational Training needs to be reassessed and approved by the Division from 1 year and every 6 months thereafter to 2 years and every year thereafter • Added information about the daily rate for Support Coordination (rate & procedure code) • Provided additional clarification for providing Supported Employment services when a provider is employing an individual or a group of individuals • Added Supports Brokerage • Added new procedure codes and rates for Transportation to reflect the need for additional options
Appendix	• Added completion of the Stephen Komninos Law training prior to working with individuals (must be completed within 60 days of availability for staff already employed) • Updated service approval processes for Assistive Technology, Goods & Services, Environmental Modifications to reflect new features in iRecord • Updated processes for accessing Physical, Occupational, and Speech, Language, and Hearing Therapies to reflect differences between habilitative and rehabilitative therapies and based on changes that have been made to simplify the process • Added new transportation codes and rates to the "Services Quick Reference Guide" • Added "Quick Reference Guide to Overlapping Claims for Services" • Added Appendix L to provide clarification on rounding for claiming process • Added Appendix M to provide clarification on when claims can be made for the daily rate Individual Supports

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1 INTRODUCTION

1.1 Community Care Program Policies & Procedures Manual

The purpose of the New Jersey Division of Developmental Disabilities (Division) Community Care Program Policies & Procedures Manual is to provide additional clarity on practices governing the Community Care Program (CCP) within the approved Comprehensive Medicaid Waiver (CMW).

This manual contains the current policies and practices governing all aspects of the Community Care Program including but not limited to eligibility, care management, service delivery and standards, housing assistance, and quality assurance. These policies apply to all individuals enrolled in the Community Care 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 Community Care Program policies as needed.

Questions or requests for manual revisions should be directed to the Division's Community Care Program Help Desk at DDD.CCWHelpdesk@dhs.state.nj.us.

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: http://www.nj.gov/humanservices/ddd/news/publications/divisioncirculars.html.

It is important to note that the State is currently waiting for approval from the federal Centers for Medicare and Medicaid Services (CMS) on its Statewide Transition Plan to come into compliance with CMS's regulations governing Home and Community-Based Settings (HCBS). Revisions may have to be made based upon additional CMS guidance and stakeholder input in subsequent phases of implementation. Adjustments may need to be made to the policies set forth in this manual in order to ensure compliance with the Statewide Transition Plan.

Upon inclusion of the CCP into the Comprehensive Medicaid Waiver on November 1, 2017, the Division continues shifting the system within which the CCP operates into a Medicaid-based, Fee-for-Service model. This manual applies to policies and procedures utilized by individuals who elect self-direction and providers with individuals who have shifted 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 referenced 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 be afforded 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 First

In April 2012, New Jersey became the fourteenth state to adopt an Employment First initiative meaning that "competitive employment in the general workforce is the **first and preferred** post education outcome for people with any type of disability." As a result of this initiative, Division personnel, Support Coordinators, planning team members, etc. must begin with the presumption that everyone receiving Division-funded supports and services will work in the general workforce. 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 (SCA) 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 disenroll individuals from the CCP; 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 his/her future by ascertaining his/her vision for life as an adult and assisting him/her 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.planningforadultlife.org. The Division also disseminates information targeted to "aging out" youth each year and begins the process of support coordination selection as early as April of the year where a young person is aging out of the school system to allow a seamless transition into adult services once he/she graduates. 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 DDD 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 his or her 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.

3.2 Intake/Application Process

In order 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 of this manual.

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 http://www.nj.gov/humanservices/ddd/services/apply/application.html. Upon request, the intake worker can provide assistance in completing the application.

3.2.1 Application

The following application forms must 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 and Portability and Accountability Act (HIPAA)** information;
    - **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 his or her 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 his/her 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 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.

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 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 and the Division has been found that functional criteria are met, 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 he/she does 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 domains: self-care, behavior, and medical. This resulting score establishes the "tier" in which each individual is assigned based on his/her 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 include: 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 his/her 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. The service provider must 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. Copies of the completed form will be uploaded to iRecord by the Support Coordinator, kept in the individual file maintained by the service provider, and revised as necessary.

When an individual is assigned the acuity differentiated factor, it is presumed that medical and/or behavioral staff will need to be provided during service delivery. Therefore, when acuity is factored into the rate for a service (i.e. Community Based Supports, Day Habilitation, Individual Supports, and Respite), the needed behavioral support services, including those described as "Behavioral Supports" under Section 17.2 must be provided and cannot be claimed for separately/concurrently during the time in which Community Based Supports, Day Habilitation, Individual Supports, or Respite is being provided. Needed behavioral supports are to be available to be additionally clamed for in accordance with Section 17.2 during these services for individuals who are not assigned the acuity factor. Regardless of whether or not someone is assigned the acuity factor, the qualifications of staff and/or service providers responsible for the services described under 17.2 shall meet the qualifications listed in Section 17.2.3.

In order to ensure that changes in need are identified and individuals remain in the appropriate tier, individuals eligible for Division services will be reassessed via the NJ CAT every 5 years or sooner if warranted.

3.5 Individual Budgets

Individual budgets, based on tiering, for participants enrolled in the CCP include the following components: Employment/Day Supports, Individual/Family Supports, Individual Supports (supports provided residentially), 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 on the CCP 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	Individual Supports (supports provided residentially)	Supported Employment	Total Individual Budget
A	$14,000.00	$5,000.00	$25,740.00	Available as needed	$44,740.00
Aa	$20,000.00	$5,000.00	$54,692.00	Available as needed	$79,692.00
B	$18,000.00	$10,000.00	$51,480.00	Available as needed	$79,480.00
Ba	$26,000.00	$10,000.00	$109,383.00	Available as needed	$145,383.00

C	$22,000.00	$10,000.00	$85,801.00	Available as needed	$117,801.00
Ca	$32,000.00	$10,000.00	$182,303.00	Available as needed	$224,303.00
D	$33,000.00	$15,000.00	$120,122.00	Available as needed	$168,122.00
Da	$47,000.00	$15,000.00	$255,226.00	Available as needed	$317,226.00
E	$43,000.00	$15,000.00	$154,442.00	Available as needed	$212,442.00
Ea	$63,000.00	$15,000.00	$328,150.00	Available as needed	$406,150.00

Information about which services can be purchased through which budget component is included for each service described in Section 17. Support Coordination services and Fiscal 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 his/her 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). 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.

3.6 Requesting NJ CAT Reassessment

An individual may experience changes in his/her self-care, behavior, or medical needs that result in the need for a NJ CAT reassessment. The process for submitting a request to be reassessed is as follows:

1. The individual requests a copy of the most recently completed NJ CAT from his/her Support Coordinator
2. The individual reviews the NJ CAT and notes any changes directly on the assessment
3. The individual completes the "Request for Reassessment Form" found on the Division's website under "FFS Information/Resources" at http://www.nj.gov/humanservices/ddd/programs/ffs_implementation.html.
4. The individual submits the completed "Request for Reassessment Form," NJ CAT changes, and any supporting documents to the assessment request email address at DDD.DDPIAssessmentRequests@dhs.state.nj.us 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 gather information about the change(s) that has led to the request and reach out to the designated "informant" within 3 business days from the initial contact.
6. The Division designee will submit the gathered information to the Division's Intake Director or designee for review to determine if a reassessment will be conducted. Re-assessments are conducted if the changes noted on the NJCAT would have the result of changing the tier assigned to the individual.
7. The Division designee assigned to the mailbox will be notified whether the request for reassessment has been approved or denied and will inform the individual of the decision within 3 weeks of Director or designee review.
8. If the reassessment request is approved, details to conduct the reassessment will be provided to the informant.
9. If the reassessment request is denied, the requester will be informed that a reassessment is not warranted at this time via confidential email or written correspondence.

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:

- He/she no longer meets the functional criteria necessary to be eligible for the Division,
- He/she chooses to no longer receive services from the Division,
- He/she does not maintain Medicaid eligibility,
- He/she no longer resides in the State of New Jersey, or
- He/she does 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.

4 OVERVIEW OF THE COMMUNITY CARE PROGRAM (CCP)

The CCP is a 1115 Medicaid Home and Community Based Services (HCBS) waiver program that permits New Jersey to receive a federal match on an array of approved waiver services and supports to Medicaid beneficiaries to live in the community and avoid institutionalization.

The CCP is a critical component of the Division's ability to provide services in the community to individuals with developmental disabilities. Without the CCP, New Jersey could only use Medicaid funding to help provide services to these individuals if they resided in an institution. The federal government allows states to create waivers, including the CCP, as a way to help individuals with specific service needs avoid institutionalization and return to or remain in the community.

In order to enroll on the CCP, individuals must be eligible for Division services; must meet the specified clinical level of care for Intermediate Care Facility of Individuals with Intellectual Disabilities (ICF/ID) and must meet specific Medicaid requirements regarding income and resources

The CCP provides needed supports and services for adult individuals, 21 and older who reside in a variety of living arrangements – with their families, in licensed residential settings, or in a variety of other unlicensed settings.

The CCP will provide all enrolled participants with choice amongst approved waiver services and providers. Individuals and their families will have the flexibility to choose the options and opportunities for 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.

Individuals enrolled on the CCP cannot be enrolled in another Home & Community Based Setting (HCBS) or Managed Long Term Services & Supports (MLTSS) program (including the Supports Program).

5 CCP ELIGIBILITY AND INDIVIDUAL ENROLLMENT

5.1 Eligibility Criteria for the CCP

In addition to meeting the requirements for Division eligibility (as described in Section 3.1), individuals' eligible for the CCP 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;
- Meets ICF/ID clinical level of care (LOC);
- Comes to the top of the waiting list or is deemed an emergency as described in Sections 5.1.3 and 5.1.2;
- Is not currently enrolled in another HCBS or MLTSS program (including the Supports Program) or, if enrolled in another program, agrees to dis-enroll in order to enroll in the CCP.

5.1.1 Allowable Types of Medicaid for the CCP

- Supplemental Security Income Medicaid;
- Workability Medicaid;
- NJ Care;
- CCP Medicaid Only.

5.1.1.1 Accessing CCP 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, the individual will need to apply for CCP Medicaid Only. The process for accessing CCP Medicaid Only is as follows:

- The CCP Unit will send the appropriate individual the CCP Medicaid Only application;
- Once the CCP Medicaid Only application form is returned to the CCP Unit they will review the application and supporting documents for accuracy ensuring it is completed in its entirety and that all required supporting documents are present;
- The CCP Unit staff submits the completed application and supporting documents to the Institutional Support Services (ISS) staff at Medicaid;
- The ISS staff are responsible to determine if the individual meets the financial requirements for the Community Care Program Medicaid program;
- By regulation the ISS staff has 90 days to make a financial determination;
- Once the financial determination is made the individual and Division are notified, in writing, of the determination by the ISS Office;
- If an individual meets the financial requirements and is eligible for the CCP, the individual is added to the CCP immediately and a letter of determination is mailed to the individual and the Division is notified;
- If an individual does not meet the financial requirements, ISS sends a letter to the individual and Division indicating that they do not meet the financial requirements and includes information regarding fair hearing rights;
- The Division notifies the Support Coordination agency of the determination.

Additional information about Medicaid eligibility and the Division can be found on the Division's website at http://www.nj.gov/humanservices/ddd/services/medicaideligibility.html.

5.1.2 ICF/ID Level of Care (LOC)

ICF/ID Level of Care (LOC) means that the individual would need to live in an institution without the home and community based services/supports provided through the CCP. The following factors are included in making a determination regarding LOC:

- Review of the individual's NJ CAT;
- Review of additional documentation;
- Division clinical review.

5.1.2.1 LOC Appeal Rights

Individuals for whom LOC has not been determined to be met may appeal the decision in accordance with the provisions of Division Circular #37 "Appeals Procedure" (N.J.A.C. 10:48). An initial appeal shall be made in writing to:

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

5.1.2.2 LOC Annual Review

During the annual service planning process, the Support Coordinator will conduct a review for LOC by identifying, through conversation with planning team members, observation, and review of the NJ CAT, if there has been any noted change in the individual's functional level that warrants a change in supports. Results of this review are indicated in iRecord.

5.1.3 CCP Waiting List

The Division maintains a CCP Waiting List. In accordance with N.J.A.C. 10:46C, individuals are eligible to apply for enrollment onto the CCP when they are reached on the waiting list. When an individual is reached, the Division will notify the individual or his or her guardian in writing. The Division will then contact the individual or guardian to discuss services and program eligibility based upon the individual's assessed needs. Individuals may also access the CCP when they are in need of CCP services due to emergent circumstances. To be enrolled on the CCP, individuals must meet the level of care for the CCP. The process for review of emergent circumstance and subsequent level of care can be initiated by the Support Coordinator alerting their assigned Division Mentor.

5.2 Individual Enrollment onto the CCP

The following steps will be taken to enroll an individual who meets CCP eligibility criteria as described in Section 5.1 onto the CCP:

- 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 1 year prior to enrollment into the CCP, a reassessment may be conducted;
- The individual will submit the Support Coordination Agency Selection Form accessed on the Support Coordination page – http://www.nj.gov/humanservices/ddd/services/support_coordination.html – the Division's website; or through contacting the Division Regional Community Services Office;
- 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 CCP Policy Manual and will explain the Participant Enrollment Agreement and obtain a signed copy from the individual/guardian;
- The Support Coordinator obtains the signed Participant Enrollment Agreement; the Support Coordinator will follow procedures described in this manual to assist the individual in accessing services.
- Division staff will submit the following completed forms to the CCP Unit:
    - Notice of Expected Admission to Waiver Services;
    - Clinical Determination that CCP Level of Care is met;
    - Freedom of Choice Form between institutional and community services.

5.3 Individual Responsibilities

In addition to following the terms and conditions of the CCP 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 CCP 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 Community Care 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, 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 CCP Policy 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 CCP;
(j) The participant has enrolled in another HCBS Waiver (e.g.: Supports Program, MLTSS).
(k) The participant has failed to abide by any terms of the Participant Enrollment Agreement;

(l) The participant is not accessing CCP waiver services other than Support Coordination for greater than 90 days[1]; or
(m) The participant chooses to voluntarily disenroll from the Division and/or the CCP.

5.4.1 Individual Disenrollment Process

In the event that a participant chooses to voluntarily disenroll from Division services, he/she will provide signed documentation stating his/her intention to disenroll from all Division services, including waiver services, by submitting the "Move to Discharge" 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 he/she is being dis-enrolled. If the issue(s) has been resolved within those 30 days, his/her waiver status may not be terminated.

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

- When an ISP is developed without CCP services, the Support Coordinator will explain to the individual that he/she will be dis-enrolled if CCP services are not accessed within 90 days.
- During monthly monitoring the Support Coordinator will verify that the CCP services identified in the ISP are being accessed. If services are not being accessed the Support Coordinator will document the reason (i.e.: barrier to service delivery, choosing not to access the service, etc.) If there is not a barrier to service delivery the Support Coordinator will remind the individual of their requirement to disenroll if the individual continues not to access CCP services.
- At 60 days without a CCP 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 CCP services and the disenrollment process will begin at 90 days if the individual continues not to access CCP services.
- At 90 days without a CCP 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 he/she will be disenrolled from the CCP if he/she is not in need of CCP 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 disenroll the individual from the CCP, indicate the reason for disenrollment in iRecord notes, and notify the Support Coordination Agency.
- Individuals who do not voluntarily disenroll from the CCP 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 CCP, 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

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

providers will automatically be updated with an ISP that has been approved to "inactive" and services will be ended as of that date.

6 CASE MANAGEMENT

Case management for CCP services is provided through Medicaid/Division approved Support Coordination Agencies[2]. 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 Community Care Program must have a Support Coordinator[2].

6.1.1 Choosing a Support Coordination Agency

The individual has the opportunity to choose his/her 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. The individual will indicate his/her preferred Support Coordination Agency on the Support Coordination Agency Selection Form. 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 17.19.4, 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.

The Support Coordination Agency Selection Form can be accessed on the Division website at http://www.nj.gov/humanservices/ddd/programs/supports_program.html.

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 "Medicaid Approved" box under the "Medicaid Approved" dropdown menu
- Check the county in which the individual resides under the "County Served" dropdown menu
- 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:

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

- The individual receives a copy of the Support Coordination Agency Selection Form from the Division's website or by contacting the Division Community Services Office;
- The individual/guardian/family completes and submits the Support Coordination Agency Selection Form as directed on the form. 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 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 his/her 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 him/herself and begin the planning process.

6.1.3 Changing Support Coordination Agencies

If the individual wishes to change Support Coordinators, he/she 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, he/she must indicate that request on the Support Coordination Agency Selection 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. Once the form is received, 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 Support Coordination Agency has not uploaded documentation to iRecord, a hard copy of all current documents must be distributed to the newly assigned Support Coordination Agency within 3 business days.

In the event that a Support Coordination Agency closes, is suspended or terminated, etc. the Division will notify the individual of the need to reassign his/her 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.

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 17.19.

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, 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; 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.
- 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.
- 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, 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.
- 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 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.
- Reporting data to the Division as required and upon request.
- At the direction of Division staff, completion of surveys that may be required.
- Including the Individual Supports – Daily Rate service provider in the planning process.
- Ensuring involved service provider(s) have received notification to begin services.

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 17.14.

- 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 (and annually thereafter).

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 notify the assigned Division Support Coordination Quality Assurance Specialist and he/she shall 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 disenrollment from Division services and/or the CCP. 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.

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.state.nj.us.

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 90 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 90 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 this form to the Division assigned QAS for the Support Coordination Agency for review.
    - The QAS 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.

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 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

6.5.3 Transitions from Hospitalization to Community Settings

When an individual already utilizing Support Coordination services is placed in an institutional setting 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 he/she will no longer be eligible for CCP service. 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.
- On the 30th day of any institutional placement the Support Coordinator must notify CCP staff of the placement because, depending upon the situation, the CCP staff may need to terminate the CCP status in order for the institutional setting to be paid.
- 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 including, if applicable, re-enrollment onto the CCP. 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 7.9.

Individuals eligible for Division services who reside in an SNF long term but elect to move to a community setting supported by the Division should contact the Division's Intake Unit as outlined in section 3.2.

7 SERVICE PLAN

It is a requirement that each person who has been determined eligible to receive services from the Division must have 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 he/she does not wish to include the provider. If providing residential services (Individual Supports – Daily Rate), the provider must be included on the planning team. This plan, 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, identifies 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 his/her 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.

7.2 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;
- The Individual Supports provider ;
- 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 his/her 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:

- 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 him/herself;

- 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).

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 he/she 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 providers of service 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 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 reassessment;
- 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 which may cause the need for changes to the ISP or effect the provision of services.

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 enrollment onto the CCP[3]. 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 to ensure that outcomes and services included in the ISP are warranted by assessed need.

[3] When individuals are already on the CCP and shifting into Fee-for-Service, the ISP must be developed and approved within 30 days from the point of SCA assignment.

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 his/her 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. While the PCPT is not written annually, the Support Coordinator must review it on an annual basis to identify changes and inform the annual ISP.

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 he/she likes about him/herself and others like about him/her, 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 his/her free time, hobbies, and things the individual misses when not around or available.

7.4.1.1.2.1.4 Hopes

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 him/herself having fun in the future, what he/she sees him/herself doing, where he/she wants to be living, etc. would be included here.

7.4.1.1.2.1.5 Caregiving Need/Supporter Quality

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.

7.4.1.1.2.1.6 Community Experiences

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.

7.4.1.1.2.1.7 Additional Communication Information

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 his/her 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 his/her 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 his/her current job and establish outcomes and service needs related to maintaining his/her 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 him/her 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 he/she is 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 his/her 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 his/her 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. The Division expects that all individuals receive annual physicals and recommends dental examinations as well as best practice preventative care based on gender and age. Support Coordinators are reminded to discuss the importance of annual medical and dental exams on the SC planning/monitoring tool.

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;
- Review and completion of the ICF/ID level of care certification;
- 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 (i.e.: increase due to a parent retiring, etc).

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 his/her desire to facilitate his/her own planning meetings. Every opportunity will be provided for the individual to facilitate his/her planning meetings if he/she so desires. 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 CCP 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 his/her 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 CCP if it is determined, upon further review by the Division, that CCP 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 the 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 Procedure

The procedure is the service that will be provided

7.5.2.4 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 CCP Services Quick Reference Guide available in Appendix H.

7.5.2.5 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.

7.5.2.6 Claims

The payment source for the provider (Medicaid, FI, DVRS, 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.

7.5.2.7 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.

7.5.2.8 Location

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

7.5.2.9 Start & End Dates

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

7.5.2.10 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.

7.5.2.11 Frequency

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

7.5.2.12 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 CCP Services Quick Reference Guide in Appendix H.

7.5.2.13 Total Units

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

7.5.2.14 Total Cost

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

7.5.3 Employment First Implementation

As an Employment First state, "competitive employment in the general workforce is the first and preferred post education outcome for people with any type of disability." Every ISP must contain at least one employment outcome even if the individual is not directly 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 his/her 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 Nutrition and Health 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 and Support 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 and guardian/legal representative (if 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 his/her rights and Responsibilities as documented in the "Participants Statement of Rights & Responsibilities" and indicated through the list of items with which the individual's signature attests to agreement. The ISP 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.

7.6 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 his or her point of view has not received a complete hearing during a team meeting, he/she is encouraged to discuss his/her concerns privately with the Support Coordinator, who may subsequently reconvene the planning team to readdress the issue.

The individual will indicate his/her 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 Quality Review Checklist 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 his/her 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 out of the reasonable & customary range);
- 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 him/her 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 the 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 CCP 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 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 require 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 his/her 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 care[4].

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 DVRS/CBVI Determination Form for Individuals Eligible for DDD form (also known as the F3 form) and providing it to the Support Coordinator. Employment services that are not available through DVRS/CBVI and are provided by the CCP will be provided by the Division. If an individual is not seeking employment services, the Support Coordinator will complete the Non-Referral to DVRS/CBVI Form (also known as the 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 CCP are as follows:

- Assistive Technology
- Behavioral Supports
- Career Planning
- Case Management*
- Community Inclusion Services
- Community Transition Services
- Day Habilitation
- Environmental Modifications
- Goods & Services
- Individual Supports
- Interpreter Services
- Natural Supports Training
- Occupational Therapy
- Personal Emergency Response System (PERS)
- Physical Therapy
- Prevocational Training Services
- 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 – Services that are marked with an asterisk 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 16.

8.3.1 Utilizing a Service Provider

The individual selects each service provider he/she prefers to provide the services included in the ISP. The Division encourages the individual to research service providers through phone calls, interviews, provider fairs,

[4] Does not preclude the individual/family from contacting the MCO Care Manager

site visits, word of mouth, marketing materials, etc. prior to selecting the service provider. To assist in this effort, the Division maintains a database of approved service providers. This provider database can be utilized to locate service providers in the individual's catchment area and is available 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, he/she 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 his/her 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 his/her needs and providing services that will help him/her progress toward his/her 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 his/her 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 at the date in 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 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 CCP Services section of this manual (Section 17). The SDE cannot be the individual's spouse, parent, or guardian.

The individual is the managing employer and is responsible for creating the position description, setting the hours of employment, managing the SDE, and determining the continuation or termination of employment.

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 the 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 FI through a manual, handbook, enrollment packet, and website.

8.3.2.1 Selecting SDE Service Delivery

If the individual is in need of one of the services that is available through a SDE (Individual Supports, Respite, or Transportation), the Support Coordinator will present the options of utilizing a SDE or a provider agency and explain the SDE process, as outlined in the documentation developed and maintained by the FI.

If the individual elects to use a SDE, 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. Upon

notification from the Support Coordinator, the FI will initiate the enrollment process and register the individual and any authorized representatives in the FI developed orientation process. 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 enrollment packet. This packet will contain the forms necessary for the individual to register as an employer and appoint the FI as the agent for employment-related matters. The FI will assist the individual in completing these forms and 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. Support Coordinators, other individuals, the FI, and the provider database can be resources used to access a list of potential SDE candidates for recruitment.

8.3.2.2 Wages and Benefits

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. The FI will verify that hourly wages are in compliance with federal and NJ Department of Labor and Workforce Development (NJ LWD) rules and compute standard payroll deductions that will be applied to the SDEs paycheck. The established Fee-for-Service rate (hourly wage) indicated in the ISP does not include a component for payment of employee health benefits since it is unlikely that the individual will be required to provide health benefits given that he/she will typically only employ a few SDEs during the course of a year. The individual can, however, choose to include this rate component within the wage so the SDE can 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 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.

Individuals who are receiving services from a Self-Directed Employee (SDE) must pay an annual rate to maintain a Workers Compensation policy. This annual rate (made by the NJ Compensation Rating and Inspection Bureau) is deducted from the individual's 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.

8.3.2.3 SDE Hiring

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 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 and professional development applicable to the service(s) being delivered (as explained for each Specific service in Section 16 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. The Support Coordinator will enter the SDE information into the ISP and a prior authorization will be generated and emailed to the FI upon the ISP 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.

8.3.2.4 Mandated SDE Training

The SDE shall comply with any relevant licensing and/or certification standards required for the service he/she is 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:

8.3.2.4.1 DDD System Mandatory Training Bundle – Within 90 days 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)

8.3.2.4.2 Individual/Family Developed Orientation – Within 30 days 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.

8.3.2.4.3 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.

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

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

8.3.2.4.5 Cardio Pulmonary Resuscitation (CPR) and Standard First Aid – Prior to assuming sole responsibility of an individual receiving services

Staff shall not assume sole responsibility for an individual served until he/she has current certification from a nationally certified training program for CPR and for Standard First Aid following the guidelines provided in Section 11.4.2.

8.3.2.4.6 CPR and Standard First Aid Recertification – In accordance with time frames established by the certified training program

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.

8.3.2.4.7 Specialized Staff Training – Within 90 days 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)

8.3.2.4.8 Behavior Plan (if applicable because the SDE is working with individual(s) who have a behavior plan) – Prior to implementation of the behavior plan

8.3.2.5 SDE Termination

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. As the employer, it is the responsibility of the individual 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 LWD Reason for Separation Notice within ten (10) calendar days, 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, including retirement of the individual's employer identification number, process and deposit final tax payments, and terminate the workers' compensation policy.

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, and FI and the SC or Division will revise the ISP as necessary to end prior authorization as appropriate.

8.3.2.6 Payroll Processing

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 electronic deposit. 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 authorization. FI services are procured by the State for use by participants for processing and record keeping 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 Support Coordinator, the Division, and the individual within one (1) day of receiving the timesheet and the Support Coordinator will notify the individual and employee that the timesheet requires adjustment. 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.

8.3.3 Accessing/Continuing Needed Services upon 21st Birthday

Services and supports are primarily covered through the school district until the individual exhausts his/her educational entitlement upon graduation ***after*** his/her 21st birthday. However, some additional services that are not provided by school districts (respite, for example) are sometimes provided through the Department of Children & Families (DCF) Children's System of Care (CSOC) until the individual's 21st birthday. At that time, the Division can continue the services provided through CSOC 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 he/she is 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 his/her 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 his/her 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

In order to ensure that 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 business 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 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.

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 1/21/2017 through 1/27/2017, 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 providing no labor laws are violated.

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 his/her schedule or account for an unexpected change in service needs from week to week. For example, someone attending a program that provides Career Planning, Prevocational Training Services, and Day Habilitation may need flexibility to account for his/her preferences in activities from day to day. This individual may include a few additional units for each of these services so he/she can use carry over units of Prevocational Training (i.e. to switch from one service to another when he/she is not interested in participating 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 he/she is 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.

8.4.2 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 when 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 when an individual is accessing these duplicative services, the percentage of time – based on a 30 hour week – he/she is CCP ending 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 his/her budget will be deducted. The remaining budget can be utilized to fund additional services as needed.

8.7 Retirement

An individual enrolled in the CCP can retire at the age of 65 if he/she chooses. There are 2 potential areas of retirement. Individuals who are competitively employed in the general workforce may choose to retire from work but continue participating in his/her other day services/activities (such as Day Habilitation, Community Inclusion Services, 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 he/she remains eligible for DDD services.

8.7.1 Retirement from Employment

If the 65+ year old individual 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" 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 65+ year old individual 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. This will increase the Individual Supports (supports provided residentially) budget to the budget linked to the next tier (unless the individual is already assigned to tier E or Ea), and the Employment/Day budget will no longer be available. The individual can continue to access his/her Individual/Family Supports budget component fully to provide funding for alternative services and supports. Rates for services for which the tier assignment has an impact will move up as well.

For example, if the individual is in tier C, his/her Individual Supports (supports provided residentially) budget will increase from $85,801.00 (tier C Individual Supports budget) to $120,122.00 (tier D Individual Supports budget). The daily rate for Individual Supports will increase from the rate of $235.07/day associated with tier C to the tier D rate of $329.10/day. However, the individual will continue to be assigned to tier C within all documentation showing his/her tier. The table below provides further explanation.

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 provide details regarding the reason for retirement to the Division for review and approval

Tier	Initial Budget			Budget Upon Retirement		
	Employment & Day	**Individual & Family Supports**	**Individual Supports (supports provided residentially)**	**Employment & Day**	**Individual & Family Supports**	**Individual Supports (supports provided residentially)**
A	$14,000.00	$5,000.00	$25,740.00	None	$5,000.00	$51,480.00
Aa	$20,000.00	$5,000.00	$54,692.00	None	$5,000.00	$109,383.00
B	$18,000.00	$10,000.00	$51,480.00	None	$10,000.00	$85,801.00
Ba	$26,000.00	$10,000.00	$109,383.00	None	$10,000.00	$182,303.00
C	$22,000.00	$10,000.00	$85,801.00	None	$10,000.00	$120,122.00
Ca	$32,000.00	$10,000.00	$182,303.00	None	$10,000.00	$255,226.00
D	$33,000.00	$15,000.00	$120,122.00	None	$15,000.00	$154,442.00
Da	$47,000.00	$15,000.00	$255,226.00	None	$15,000.00	$328,150.00
E	$43,000.00	$15,000.00	$154,442.00	None	$15,000.00	$154,442.00
Ea	$63,000.00	$15,000.00	$328,150.00	None	$15,000.00	$328,150.00

9 PROVIDER ENROLLMENT

The CCP is implemented using a Medicaid based, Fee-for-Service model. Acceptance of applications to become an approved provider for CCP services is ongoing and open. In order to deliver services available through the CCP, 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

- **Review the CCP Service Descriptions, Limitations, and Qualifications** available in Section 17 CCP 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 CCP Policies & Procedures Manual**
  Approved service providers must assure Medicaid and the Division that they will follow the policies and procedures governing the CCP as described in this manual. In addition, provision of services within the CCP must meet any Division standards Specific to a particular service as described in Section 17 of this manual.
- **Review additional informational materials and resources**
  Webinars on a variety of topics related to the Division, including becoming a provider, are available on the Webinars page of the Division's website at http://www.nj.gov/humanservices/ddd/resources/webinars.html and the steps to becoming a provider are included on the Provider Portal page of the Division's website at http://www.nj.gov/humanservices/ddd/programs/CCWpp.html .

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) is available on the Fee-for-Service Provider Portal page of the Division's website at http://www.nj.gov/humanservices/ddd/programs/ffs_provider_portal.html. The process for becoming an approved service provider is also described on this website.

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. Accessing the NPI 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 provider portal of the Division's website at http://www.state.nj.us/humanservices/ddd/programs/CCWpp.html. 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 Molina Medicaid Solutions Provider Enrollment Unit at P.O. Box 4804, Trenton, NJ 08650-4804.
- Retain a copy of the original completed Combined Application for ease of processing of service or location additions/addendums.

An application packet consists of the following information:

- Application Cover Letter - (DDD-CCP-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-CCP-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-CCP-SOI 03-25-2013) form including an accurate verification code from the Division's website http://www.state.nj.us/humanservices/ddd/programs/CCWpp.html;
- 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.

9.3 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 he/she has received education and/or licensing, as appropriate, will receive payment for services 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)

The Fiscal Intermediary (FI) for the CCP serves two main functions. The FI manages the financial aspects of the CCP on behalf of an individual choosing to direct their services through a 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 CCP.

Responsibilities of the FI include, but are not limited to, the following:

- Billing for participant-directed services rendered;
- Functioning as a fiscal conduit making non-routine, non-payroll purchase transactions;
- Enrolling the individual/representatives, as appropriate, as the common law employer of the individual's SDE employees, including assistance with the completion and maintenance of all employer-related paperwork. This function includes assuring that all SDEs complete and pass all background checks and meet all the qualification criteria before delivering services;
- Managing SDE's payroll including the filing and paying of federal and state employment-related taxes;
- Facilitating the receipt of worker's compensation insurance policies and the payment of premiums for employers and their workers;
- Preparing and distributing reports to participants, their representatives and designated state agencies, as required;
- Claiming for services provided by organizations or enterprising entities that are not Medicaid providers but offer services to individuals enrolled in the CCP.

The current Fiscal Intermediary for the Department of Human Services is Public Partnerships LLC (PPL).

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 CCP and Community Care Program (CCP) Policy & Procedures Manuals and applicable Division Circulars. Policies and procedures related to reporting Medicaid waste/fraud/abuse; Protected Health Information (PHI) - HIPAA; human rights; emergencies (and how they will be dealt with); reporting unusual incidents; personnel; and admission, suspension, and discharge should be addressed.

11.2 Organizational Governance Policy

All approved service providers must maintain and be able to produce for the Division's review at any time, (1) 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) a requirement that all Board members/stock holders, names, affiliations, and any potential conflicts of interest be disclosed and made publicly available if requested (this must include the requirement that, at a minimum, all board members/stock holders names be made publically available on the organization's website), (3) must 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, 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 record keeping, 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.

Approved service providers must have a CDS Agency Administrator. It is strongly recommended that each agency 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 CPR and/or First Aid training is mandatory, providers may choose a training entity, which 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. The guidelines represent a consensus reached by the International Liaison Committee on Resuscitation (ILCOR) whose membership includes seven international resuscitation organizations and are available through the American Heart Association at: http://guidelines.ecc.org/index.html.

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;
- Successful completion of a skills test/practicum;
- Successful completion of a competency assessment.

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.

12 SERVICE PROVISION

12.1 Service Provider Responsibilities

- Maintain and follow standards, qualifications, regulations, policies, procedures, etc.
- Develop strategies in collaboration with the individual receiving services to assist the individual in reaching his/her outcomes.
- Complete and maintain documentation as required.
- Claim for services according to Medicaid (Molina) 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 when identified in that role by the individual.
- Complete, maintain, and submit reporting documents as required.
- Comply with monitoring, auditing, quality assurance measures conducted by the Division and/or Medicaid/Molina.
- Comply with policies, standards, and procedures 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 in order to submit a claim for a Medicaid service:

- The delivery of service must be properly documented 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 must have 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,

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 Molina Health Care. Molina provider services can be reached by calling 800-776-6334 or on the NJMMIS website through the option "Contact Provider Services".

12.4 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 he/she finds a new service provider and can coordinate services beginning with that new provider.

12.4.1 Discontinuing Individual Supports in Residential Settings

In addition to the steps outlined in Section 12.4, the provider must also follow the policies outlined in Division Circular #36. These policies include but are not limited to the following:

- Notifying the Division by telephone and in writing regarding the intent to end services along with substantive evidence as to why the individual can no longer be served by the provider.
- The Division will review the request and determine whether the standards that would necessitate a discharge as set forth in DC#36 exist.
- The Division will communicate the outcome to the individual and guardian, if applicable.
- If the request is approved, the service provider will continue to support the individual until he/she finds a new service provider, place to live, and can coordinate the move. In this circumstance, the Division, Support Coordinator, guardian, and individual will make all reasonable efforts to expedite a move.
- The individual and guardian will be given at least 60 days-notice but can move sooner if agreed to.
- The individual and guardian have the right to appeal based on the policies outlined in DC#36.
- The service provider and Support Coordinator will notify the Division's Housing Subsidy Unit at 732-968-4222 of the date the individual will move from his/her current residence and the date he/she will move into the new residence so rental payments can be adjusted in a timely fashion.

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 he/she and/or his family or caregiver has not received contact from his/her Support Coordinator monthly or had the opportunity to meet with his/her Support Coordinator.

13.1 Mandatory Monitoring

As an enrolled participant in the CCP, 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, parents, or agency staff are not always available, a designee familiar with the individual and his/her services can fill this role. The Support Coordinator is responsible for conducting ongoing monitoring of all individuals on his/her 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 at this time 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 upd. 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. 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 Home Visit** – must be conducted any time within 1 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. 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.
- Discuss new or previously identified risks and the prevention of those risks.
- Discuss with the 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 which 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 will collect information and data in order to measure a provider agency's fiscal sustainability. Analysis of this information and data will inform policy decisions at both a systems and provider agency level. At a systems level, the Division is responsible for ensuring network adequacy as well as program quality. Analysis will be performed to identify trends around a variety of factors that impact service availability and delivery, including program expenses and revenues, geographic locations, and correlations with other systemic quality metrics.

The Division is also responsible for ensuring that each provider agency is in compliance with the terms and conditions of program participation. Financial measurements will 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 is addressed in other auditing and reporting requirements.

Reports referenced below should be submitted to: DDDWaiverFinancialReports@dhs.state.nj.us

Rate Component Reports and Fiscal Sustainability Criteria must be submitted for provider agency fiscal years ending on or after June 30, 2019, at which point the Division's shift to fee-for-service will be substantially complete. This deadline is meant to give provider agencies ample time to adjust from a program-based cost reporting structure to financial measurement based on waiver service components.

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 subrecipient 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 cost reimbursement contract continue to be governed 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.

All provider agencies that claim less than $100,000 in combined reimbursement for Community Care Program and Supports Program services 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 and state partners or oversight agencies.

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.

Rate Component Report
The rate component report will be submitted to the Division once each year, and is due within 120 days after the close of the provider agency's fiscal year. The report will detail the rate component values for each waiver service operated during the fiscal year.

14.2 Notifications

The Provider Agency shall notify the Division within 5 business days of receiving a draft or final audit report that contains a qualified option 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 5 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 5 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 5 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 5 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

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

<u>Operations</u>
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 less than "1.5" indicates that the business may have difficulty servicing 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 human services agencies and service providers 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 Individual Supports or vendors providing Assistive Technology, the FI will be responsible for checking all applicable federal and State databases.

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 in the required time frames and cooperate in 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 UIR 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 his/her 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 unusual incidents. In any case, Support Coordinators are required to write a case note summarizing the incident in iRecord and categorizing it as a UIR 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 it to the Unusual Incident Reporting (UIR) unit that corresponds to the county where the individual resides. There are two means by which an incident report can be conveyed to a UIR unit:

- UPDOC – a web based application that is the preferred means for sending an incident report to the appropriate UIR 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 UIR Unit, as follows:
    - **Trenton UIR Unit (Hunterdon, Mercer, Middlesex, Monmouth, Ocean and counties): 609-341-2343.**
    - **Flanders UIR Unit (Bergen, Hudson, Morris, Passaic, Sussex, and Warren counties): 609-341-2341.**
    - **Mays Landing UIR Unit (Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, and Salem counties): 609-341-2340.**
    - **Upper Central UIR Unit (Essex, Somerset, and Union counties): 609-341-2342**.

In addition to reporting to the UIR 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 and 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 as that is the responsibility of the service provider. However, Support Coordinators are required to notify the applicable UIR unit of such incidents so the UIR unit ensures that the service provider reports the incident as required.

15.2.1.3 Service Provider

Service Providers are required to report incidents to an applicable UIR 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 UIR 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.

Any incident of abuse, neglect, or exploitation that occurs in connection with the delivery of services by a service provider must be investigated by the service provider unless otherwise advised by the Office of Investigation or the Critical Incident Management Unit. The UIR unit to which the incident of abuse, neglect, or exploitation was reported will advise the service provider 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 UIR 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 Support Coordinator accordingly.

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 UIR unit, as soon as they become aware. The UIR 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 UIR unit that corresponds to the county in which the individual lives.

15.2.3 Assistance with Unusual Incident Reporting

UIR 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). UIR Coordinators review all available information and determine if 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 a UIR Coordinator.

County of Residence	UIR 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 in-person 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. The current set of NCI performance indicators includes 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 stated 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. In addition, summary information from NCI data in NJ will be released to Division stakeholders to begin analyzing baseline data and areas for growth.

15.3.3 Customer Satisfaction Measures

Service providers will be 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
http://www.nasddds.org/uploads/documents/HCBSQualityFramework%28rev06-05%29.pdf

Support Coordination Agencies may utilize the "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 unusual incident reports should be collected and a trend analysis conducted on at least an annual basis. Additional areas for data collection and reporting in regards to the agency's Quality Management Plan will continue to be reviewed and added to over the initial year of the CCP and Fee-for-Service implementation. Opportunity for feedback and input from stakeholders will be available as additional areas are developed.

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 effecting 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 service recipients;
- 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.

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 either via 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 (i.e.: 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: http://www.state.nj.us/humanservices/ool/licensing/

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

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: http://nj.gov/comptroller/divisions/medicaid/index.html
- Provider Compliance Program information: http://nj.gov/comptroller/divisions/medicaid/compliance/

15.6 Technical Assistance

The Division is committed to providing quality services to individuals with developmental disabilities and as such, 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 disenroll any provider in its entirety or any one or more 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 disenroll 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 disenroll 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 disenrolling 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. For agencies serving more than 50 individuals, a longer timeframe may be required 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.
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 time frames.
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 they are actively being assisted with the transition to a new provider.

a. If the agency to close is a Support Coordination (SC) agency, the SC agency must provide the individual/family with the SC 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 moved to disenrollment due to lack of claiming activity for 18 or more months. 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** disenrolled 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

A. 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.
B. 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.

C. 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 Quality Improvement (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.

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; 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 time frames 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 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, 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 COMMUNITY CARE PROGRAM SERVICES

The services available through the CCP are as follows:

- Assistive Technology
- Behavioral Supports
- Career Planning
- Case Management*
- Community Inclusion Services
- Community Transition Services
- Day Habilitation
- Environmental Modifications
- Goods & Services
- Individual Supports
- 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 and Case Management 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 are generally delivered one at a time, but there are circumstances in which multiple services can be delivered simultaneously and the provider(s) delivering the services can be reimbursed for delivery of multiple services. Information regarding the provision of multiple services at the same time is available in the "Quick Reference Guide to Overlapping Claims for CCP Services" provided in Appendix K.

17.1 Assistive Technology

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

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. 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 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.state.nj.us.

17.1.5.2 Documentation & Record Keeping

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	Rates	Units	Additional Descriptor	Budget Component
H0004HI22	$19.60	15 minutes	Assessment/Plan Development	Either
H0004HI	$7.34	15 minutes	Monitoring	Either

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. 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 and Central Registry checks for all staff, drug tests as applicable under Stephen Komninos' 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 <u>or be under the supervision of</u> 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

17.2.5 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.state.nj.us 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 Quality Assurance/Monitoring

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

17.3 Career Planning

Procedure Codes	Rates	Units	Additional Descriptor	Budget Component
H2014HI	$13.25	15 minutes	NA	Either

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 his or her chosen career.

17.3.2 Service Limits

This service is available to participants in accordance with the DDD Community Care 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 and 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 he/she wants to pursue and develop a plan to assist him/her 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 he/she 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 but are not limited to the following:

- 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 his/her career direction in circumstances where the individual is unsatisfied with his/her 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 he/she already knows 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 his/her needs;
- Finding a new approach to the individual's career path; and
- 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 F3 Form "DVRS or CBVI Determination Form for Individuals Eligible for DDD" (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 his/her 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 Quality Assurance and Monitoring

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

17.4 Community Transition Services

Procedure Codes	Rates	Units	Additional Descriptor	Budget Component
H0004HI22	Reasonable & Customary	Single	n/a	Individual/Family Supports

17.4.1 Description

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another group living arrangement to a less restrictive living arrangement or a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure needed resources.

17.4.2 Service Limits

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

The maximum expenditure for Community Transition Services for the benefit of an individual Medicaid beneficiary may not exceed $10,000. If an individual requires an expenditure which exceeds the maximum expenditure amount, NJDDD may consider an increase of $10,000 for issues of health and safety (for total of $20,000) based upon a secondary level review requiring approval by the NJDDD Assistant Commissioner, or designee. Items covered by the Medicaid state plan cannot be purchased through this benefit. This is not a stand-alone service and the participant requesting this service, in addition to case management/support coordination, must also require ongoing waiver services. Community Transition Services are a one-time benefit per eligible individual.

17.4.3 Provider Qualifications

- As applicable, license, certification, registration, or authorization from the New Jersey Department of Consumer Affairs (NJDCA) or any other endorsing entity and Liability Insurance.
- As applicable, meets the qualifications of state, county and local municipality.
- For NJ State Approved Vendors-Be an established place of business as a medical supplier, assistive technology supplier, or other business related to approved items for community transition in New Jersey or be an out-of-state for the same who is an approved Medicaid provider in their state of residence.

17.4.4 Community Transition Services Polices/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.

In addition there must be agreement to permit properly identified representatives of the New Jersey Medicaid and/or DDD to:

- Inspect the original prescription or the documentation of necessity for the community transition service items on file;
- Audit records pertaining to costs of community transition supplies, equipment, services, etc. provided to CCP participants; and
- Inspect private sector records, where deemed necessary, to comply with Federal regulations to determine a provider's usual and customary charge to the public.

17.4.4.1 Need for Service and Process for Choice of Provider

The need for Community Transition 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 Community Transition Services require Division approval in order for prior authorization to be provided for the purchase of the Community Transition Services.** The following steps must be completed in order to access Community Transition Services:

- The Support Coordinator will assist the individual in identifying entities from which he/she can access the needed Community Transition Services;
- The Support Coordinator will complete and submit the Community Transition Services Request Form to the Division for approval (at this time, Community Transition Services Request Forms must be submitted to the Service Approval Help Desk at DDD.ServiceApprovalHelpDesk@dhs.state.nj.us) ;
- 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 Support Coordinator 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.

17.4.4.2 Documentation and Reporting

Documentation of the delivery of service must be maintained to substantiate claims. This documentation would generally consist of a receipt(s) and 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 Community Inclusion Services

Procedure Codes	Rates	Units	Additional Descriptor	Budget Component
H2015HIU1	$2.36	15 minutes	Tier A	Either
H2015HIU2	$2.99	15 minutes	Tier B	Either
H2015HIU3	$3.73	15 minutes	Tier C	Either
H2015HIU4	$5.60	15 minutes	Tier D	Either
H2015HIU5	$7.46	15 minutes	Tier E	Either

17.5.1 Description

Services provided outside of a participant's home that support and assist participants in educational, enrichment or recreational activities as outlined in his/her 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.

17.5.2 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.

17.5.3 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 Komninos' 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)

17.5.4 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

17.5.5 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.

17.5.5.1 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 his/her needs.

The Community Inclusion Servicesprovider 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.

17.5.5.2 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 Inclusion Services 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.

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.

17.5.5.4.1 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.

17.5.5.4.2 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.

17.5.5.4.3 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.

17.5.5.5 Quality Assurance/Monitoring

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

17.6 Day Habilitation

Procedure Codes	Rates	Units	Additional Descriptor	Budget Component
T2021HIUS	$2.36	15 minutes	Tier A	Employment/Day
T2021HIU1	$3.43	15 minutes	Tier A/Acuity Differentiated	Employment/Day
T2021HIUR	$2.99	15 minutes	Tier B	Employment/Day
T2021HIU2	$4.35	15 minutes	Tier B/Acuity Differentiated	Employment/Day
T2021HIUQ	$3.73	15 minutes	Tier C	Employment/Day
T2021HIU3	$5.43	15 minutes	Tier C/Acuity Differentiated	Employment/Day
T2021HIUP	$5.60	15 minutes	Tier D	Employment/Day
T2021HIU4	$8.15	15 minutes	Tier D/Acuity Differentiated	Employment/Day
T2021HIUN	$7.46	15 minutes	Tier E	Employment/Day
T2021HIU5	$10.87	15 minutes	Tier E/Acuity Differentiated	Employment/Day

17.6.1. 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.

17.6.2 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.

17.6.3 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 Komninos' 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.

17.6.3.1 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.

17.6.3.1.1 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.

17.6.3.1.2 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. Certification type will be issued as follows:

- **3 Year Certification** – awarded for compliance scores of 86% and above in both critical and significant standards
- **1 Year Certification** – awarded when compliance scores fall between 85% and 70% in critical and/or significant standards
- **Conditional Certification** – awarded when compliance scores are 69% or below in critical and/or significant standards

17.6.4 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.

17.6.4.1 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.**

17.6.4.1.1 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.

17.6.4.1.1.1 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

17.6.4.1.1.2 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, film-making
    - 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

17.6.5 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.

17.6.5.1Need for Service and Process for Choice of Provider

The need for Day Habilitations 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 his/her 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.

17.6.5.2 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).

17.6.5.2.1 All Staff

- 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.

17.6.5.2.2 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.

17.6.5.2.3 Program Management Staff/Supervisors

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

17.6.5.2.4 Direct Service Staff

- High school diploma or equivalent.

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

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

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 Day

Habilitation 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 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.

17.6.5.4.1 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 the Centers for Medicare and 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.

17.6.5.4.2 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.

17.6.5.4.3 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.

17.6.5.5 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.

17.6.5.6 Medical/Behavioral

17.6.5.6.1 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.

17.6.5.6.2 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.

17.6.5.7 Emergencies

17.6.5.7.1 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.

17.6.5.7.2 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."

17.6.5.7.3 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.

17.6.5.7.4 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.

17.6.5.7.5 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.

17.6.5.7.6 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.

17.6.5.7.7 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.

17.6.5.8 Medication

The service provider shall comply with the Division-approved Medication Module

17.6.5.8.1 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; and
- Definition and reporting of errors, emergency medication for life threatening conditions and staff training requirements.

17.6.5.8.2 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.

17.6.5.8.3 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.

17.6.5.8.3.1 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.

17.6.5.8.3.2 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.

17.6.5.8.3.3 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.

17.6.5.8.4 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.

17.6.5.8.4.1 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.

17.6.5.8.4.2 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.

17.6.5.8.5 PRN Over the Counter (OTC) Medication

17.6.5.8.5.1 Administration of PRN – OTC

- Can only been 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.

17.6.5.8.5.2 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

17.6.5.8.6 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

17.6.5.8.6.1 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.

17.6.5.8.5.2 Storage

- Medication shall be kept in an area that provides for the safety of others, if necessary.
- Each individual who administers his or her own medication shall receive training and monitoring by the service provider regarding the safekeeping of medications for the protection of others, as necessary.

17.6.5.9 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 individuals 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).

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.

17.6.5.9.1 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 devises 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.

17.6.5.9.1.1 Maintenance

The day habilitation provider shall develop a preventative maintenance system and conduct monthly, at a minimum, review of the condition of vehicles.

17.6.5.9.2 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.

17.6.5.10 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.

17.6.5.11 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.

17.6.5.11.1 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…;
- Criteria for acceptance – diagnosis/disability type, tier…;
- Appeal process;
- Admission process – determining start date, submission of referral packet…;
- Waiting list; and
- Program rules and expectations, rights and responsibilities.

17.6.5.11.2 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.

17.6.5.12 Day Habilitation Suspension/Discharge

17.6.5.12.1 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;
- Appeal process.

17.6.5.12.2 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.

17.7 Environmental Modifications

Procedure Codes	Rates	Units	Additional Descriptor	Budget Component
S5165HI	Reasonable & Customary	Single	NA	Individual/Family Supports

17.7.1 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.

17.7.2 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, and are not of direct medical or remedial benefit to the participant. 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).

17.7.3 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.

17.7.4 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
- Air filters/humidifiers
- Stair lifts
- Ceiling track systems for transfers

17.7.5 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.

17.7.5.1 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 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; and
- 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).

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 in order to get the work completed.

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

17.7.5.2 Documentation & Record Keeping

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.

17.8 Goods & Services

Procedure Codes	Rates	Units	Additional Descriptor	Budget Component
T1999HI22	Reasonable & Customary	Single	NA	Either

17.8.1 Description

Goods and Services are services, equipment or supplies, not otherwise provided through generic resources, the Community Care 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.

17.8.2 Service Limits

Experimental or prohibited treatments are excluded. Goods and Services must be based on assessed need and specifically documented in the Service Plan.

17.8.3 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 and complete State/Federal Criminal Background checks and Central Registry checks for all staff and drug tests as applicable under Stephen Komninos' Law. In addition, staff providing Goods & Services must meet the qualifications/standards mandated by the relevant industry from which the specific service is being provided.

17.8.4 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 to home
- Microwave oven to assist someone in cooking his/her own meals
- Classes within the general public
- Durable medical equipment prescribed by a physician but not otherwise covered
- Activity Fees
- Flat rate/boarding rate associated with transportation services
- Security Deposit

17.8.5 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.

17.8.5.1 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 he/she 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.

17.8.5.1.1 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;
- Fully integrated;
- Employment-related;
- Does not benefit someone other than the individual; and
- Available to the general public and not specifically designed for people with disabilities.

17.8.5.1.2 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; and/or
- Experimental or prohibited treatments.

7.8.5.1.3 Criteria to Utilize Goods & Services to Fund Classes[5]

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.

Funding for classes can be provided through Goods & Services when the following criteria are met:

- The class is attended by the general public – OR –
- The class is provided by a business entity that offers comparable classes to the general public and does not primarily serve individuals with disabilities. These classes are limited to no more than 12 individuals with intellectual and developmental disabilities attending the class at the same time. Individuals can attend the class for up to 3 hours per day and 10 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. 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.

17.8.5.1.4 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 – such as admission fees to a museum – 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. There is a $1,000.00 cap per year on activity fees used for the individual and/or for someone providing support to assist the individual in participating in the activity through Community Base Supports.

17.8.5.2 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.

[5] 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.

17.8.5.3 Mandated Staff Training & Professional Development

The goods & services provider shall comply with any relevant industry standards and licensing and/or certification standards.

17.8.5.4 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.

17.8.5.5 Quality Assurance/Monitoring

The Division will conduct quality assurance and monitoring of Goods & Services in accordance with the requirements of the Community Care Program Quality Plan.

17.9 Individual Supports

Procedure Codes	Rates	Units	Additional Descriptor	Budget Component
H2016HI	$7.01	15 minutes	Base	Employment/Day or Individual/Family Supports or Individual Supports (supports provided residentially)
H2016HI22	$11.89	15 minutes	Base with Acuity	Employment/Day or Individual/Family Supports or Individual Supports (supports provided residentially)
H2016HIU8	Reasonable & Customary	15 minutes	Self-Directed Employee	Employment/Day or Individual/Family Supports or Individual Supports (supports provided residentially)
H2016HI52	$70.52	Daily	Tier A Licensed OR Unlicensed with shared staff for 3+ hours/day	Individual Supports (supports provided residentially)
H2016HIU1	$149.84	Daily	Tier Aa Licensed OR Unlicensed with shared staff for 3+ hours/day	Individual Supports (supports provided residentially)
H2016HIUS	$141.04	Daily	Tier B Licensed OR Unlicensed with shared staff for 3+ hours/day	Individual Supports (supports provided residentially)
H2016HIU2	$299.68	Daily	Tier Ba Licensed OR Unlicensed with shared staff for 3+ hours/day	Individual Supports (supports provided residentially)
H2016HIUR	$235.07	Daily	Tier C Licensed OR Unlicensed with shared staff for 3+ hours/day	Individual Supports (supports provided residentially)
H2016HIU3	$499.46	Daily	Tier Ca Licensed OR Unlicensed with shared staff	Individual Supports (supports provided residentially)

			for 3+ hours/day	
H2016HIUQ	$329.10	Daily	Tier D Licensed OR Unlicensed with shared staff for 3+ hours/day	Individual Supports (supports provided residentially)
H2016HIU4	$699.25	Daily	Tier Da Licensed OR Unlicensed with shared staff for 3+ hours/day	Individual Supports (supports provided residentially)
H2016HIUP	$423.13	Daily	Tier E Licensed OR Unlicensed with shared staff for 3+ hours/day	Individual Supports (supports provided residentially)
H2016HIU5	$899.04	Daily	Tier Ea Licensed OR Unlicensed with shared staff for 3+ hours/day	Individual Supports (supports provided residentially)

17.9.1 Description

Individual Supports are 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 his/her Service Plan. Individual Supports may include but are not limited to: 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.

17.9.2 Service Limits

For individuals residing in the same home as a family member:

Providers of Individual Support Services may be members of the participant's family except for spouse, parent or guardian, provided that the family member has met the same standards as providers who are unrelated to the individual.

Family members who provide Individual Support services must meet the same standards as providers who are unrelated to the individual.

17.9.3 Unit Distinctions for Individual Supports

17.9.3.1 "Hourly Rate" – Base and Base with Acuity (15 minute unit)

These Individual Supports can be provided in or out of the home for an individual who resides in an unlicensed setting (own or family home). If more than one individual receiving Division services resides within the unlicensed home and is sharing staff to provide Individual Supports, that staff must be utilized for under 3

hours/day in order to continue utilizing the "Base" or "Base with Acuity" rate. The unit for this type of Individual Supports is 15 minutes.

This type is also utilized when Self-Directed Employees are providing the Individual Supports.

The "hourly rate" version of Individual Supports can be provided to individuals accessing the "daily rate" version of Individual Supports as long as the hourly Individual Supports is needed, identified in the ISP, prior authorized, and covering services outside of those that are expected to be covered within the daily rate (for example, services provided during evening or weekend hours). If the entity offering both the hourly and daily rate versions of Individual Supports is the same provider, the Support Coordinator will submit a request to the Division for review to ensure that the hourly Individual Supports should not already be covered.

An example of using the "hourly rate" in addition to the "daily rate" for Individual Supports would be when someone living in a group home has a competitive job in the general workforce. The individual's Supported Employment provider checks in with the individual every week to assist in learning new work tasks, address issues that have come up with the supervisor, ensure the supervisor remains satisfied with the individual's work, etc., but the individual needs constant one-on-one support on the job site to ensure he/she does not vacate the building without supervision. An Individual Support at the "hourly rate" can be utilized to provide that one-on-one support to make sure the individual remains in the building. The funding for this would come from the individual's day/employment section of their budget.

17.9.3.2 "Daily Rate" – Licensed Settings or Unlicensed with Shared Staff for 3 or More Hours/Day (Daily unit)

These Individual Supports can be provided in or out of the home for an individual who resides in a licensed residential settings or an unlicensed setting in which more than one individual receiving Division services are residing in the same dwelling and sharing staff for 3 or more hours/day. The unit for this type of Individual Supports is daily.

The "hourly rate" version of Individual Supports can be provided to individuals accessing the "daily rate" version of Individual Supports as long as the hourly Individual Supports is needed, identified in the ISP, prior authorized, and covering services outside of those that are expected to be covered within the daily rate (services provided during evening or weekend hours, for example). If the entity offering both the hourly and daily rate versions of Individual Supports is the same provider, the Support Coordinator will submit a request to the Division for review to ensure that the hourly Individual Supports should not already be covered see example provided under Section 17.7.3.1 for additional information).

17.9.3.2.1 Reimbursement for Use of the Daily Rate for Residential Setting Services

Providers utilizing the daily rate for Individual Supports must comply with Newsletter Volume 28 No. 02 released in February 2018 and found in Appendix M of this manual. When billing for residential setting services provided under the CCP, the following guidelines shall apply:

Daily Rate: Providers shall seek reimbursement only for those dates the individual was:

- Documented as being under the care of the facility; and
- Physically present during any part of the 24 hour period starting at 12:00 AM and ending at 11:59 PM; and
- Received some level of service required of the residential provider.

Admission Date: The admission date is the initial date where residential services begin and the beneficiary is expected to continue to receive services until discharged. This shall include initial referrals as well as transfers received from another residential setting. Billing is allowed for all dates of admission where the individual meets the requirements listed under "Daily Rate" above.

Discharge Date: The beneficiary's discharge date shall be the date the beneficiary is expected to permanently leave the residence. The beneficiary's discharge date does not include dates the beneficiary leaves, but is expected to return, including, but not limited to, absences due to vacations, visits with family and temporary hospitalizations. The actual date of discharge is not billable. In the event of a transfer to another residential setting, the beneficiary is not expected to return. Therefore, the sending provider may not bill for the date of transfer to another residential facility.

Hospitalizations: When a CCP residential beneficiary receives some level of service in the residential facility prior to being admitted to a hospital setting, the CCP provider may bill for this date of service as long as the beneficiary is anticipated to return to the residential facility and as long as the criteria listed under "Daily Rate" above are met. The date the beneficiary is discharged from the hospital setting and returns to the residential facility shall also be billable as long as the criteria listed under "Daily Rate" above are met. Full dates where the beneficiary is hospitalized and did not receive any services within their residential setting shall not be reimbursed to the CCP provider

17.9.4 Provider Qualifications

All providers of Individual Supports must comply with the standards set forth in this manual. In addition, Individual Supports 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. Self-Directed Employees (SDEs) cannot be the individual's spouse, parent, or guardian. In addition, Providers must meet one of the below criteria:

17.9.4.1 Attestation for Individual Supports Providers

All providers applying to become Medicaid/DDD approved to provide Individual Supports must complete, sign, and submit the Attestation for Individual Supports Provider document in order to indicate the provider's intent to operate a licensed setting or not. This attestation must be completed and submitted along with the Combined Application. Both documents are available at http://www.nj.gov/humanservices/ddd/programs/sppp.html.

If an agency initially indicated that they were not going to operate a licensed setting, but later concludes that they will, they are required to inform the Division's Provider Enrollment Unit by emailing DDD.ProviderEnrollment@dhs.state.nj.us and submit a new Attestation Form.

17.9.4.2 Unlicensed Settings

All providers of Individual Supports in unlicensed settings must comply with the standards set forth in this manual. In addition, Individual Supports providers shall complete State/Federal Criminal Background checks and Central Registry checks for all staff 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 Individual 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).

17.9.4.3 Licensed Settings

All providers of Individual Supports in licensed settings must comply with the standards set forth in this manual. In addition, Individual Supports providers shall complete State/Federal Criminal Background checks and Central Registry checks for all staff 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.

In addition, Individual Supports providers in licensed settings must meet the following license requirements:

- Licensed per N.J.A.C. 10:44A or 10:44C; -OR-
- Licensed per N.J.A.C. 10:44C; -OR-
- Licensed under 10:44B (Community Care Residence Provider).

17.7.9.3.1 Need for Licensure

The following factors inform the determination that a setting must be licensed under the provisions set forth in N.J.A.C. 10:44A – Standards for Community Residences for Individuals with Developmental Disabilities:

- Individuals residing in the setting are on the CCP; – AND –
- The setting is provider managed (see definition in Section 18.1); – AND –
- The individual residing in the setting, as documented in the ISP, requires personal guidance as defined in Section 18.1.

Recognizing an individual's right to choose, the Division will review requests made by individuals to have a location licensed or un-licensed on a case by case basis. The Division reserves the right to license a setting if it is determined to be in its best interest to do so.

Failure to license settings meeting the above factors will result in negative action(s) including but not limited to denial of claims submitted for Individual Support Services rendered in the setting.

17.9.4.3.2 The Licensing Process

17.9.4.3.2.2 Assignment of a Program Developer

Agencies submitting the Attestation Form and indicating their intent to provide Individual Supports in licensed settings on the Combined Application will be assigned a program developer who will assist them with the licensing process.

17.9.4.3.3 Procedural Manual

Providers operating a licensed setting must develop and maintain a Policy and Procedure Manual that has been approved by the Department of Human Services (DHS) Office of Licensing (OOL) and is in compliance with N.J.A.C 10:44A-2.2. This manual can be separate from the one required as described in Section 11 or can be the same manual as long as it is in compliance with licensing standards as approved by the OOL. No development of a licensed site can occur until the Policy and Procedure Manual is approved by the OOL.

17.9.4.3.4 Compliance with Division Circulars

A service provider of Individual Supports must be in compliance with all Division Circulars. All Division Circulars are available on the Division's website at http://www.state.nj.us/humanservices/ddd/news/publications/divisioncirculars.html.

In order to provide Individual Supports to individuals with behavioral involvement, compliance with Division Circular 19 – Defensive Techniques and Person Control Techniques and Division Circular 34 – Behavior Modification Programming is required.

The assigned program developer will refer the service provider to Division staff designated to oversee the process and provide any needed technical assistance. Upon completion, Division staff will provide official notification to the service provider. It is recommended that these compliance activities take place concurrently with the development of the Policy and Procedure Manual referenced in the previous section. A service provider cannot serve individuals with behavioral involvement in licensed settings until this requirement is satisfied.

17.9.4.3.5 Service Provider Site Selection

Individuals and service providers will consider several factors when selecting a service location. These factors include but are not limited to the behavioral and/or medical needs of the individual(s), individual preferences on geographic location, accessibility needs, finances, etc. All individuals who aren't residing in their own/family home, regardless of the setting, are required to have tenant rights in the form of a lease or residential agreement upon moving into a property.

17.9.4.3.6 Funding Support

Information regarding housing subsidies is provided in Section 18 of this manual.

If a rental property that was not previously funded by the Division prior to the shift to Fee-for-Service is selected, the monthly cost of the property cannot exceed the Published Rent Standards (PRS) for the county in which it is located. Rental units that were funded by the Division prior to the shift to Fee-for-Service will continue to be funded at the rental cost for that property, regardless of PRS. Provisions set forth in Section 18.2 shall apply.

If a service provider intends on purchasing a site, they will need to secure all needed financing. The service provider should discuss other funding opportunities that may be available from the Division with their program developer. Rental costs will be based on the provisions set forth in Section 18.2.

17.9.4.3.7 Site Search

Once a service provider identifies a potential site, whether it is a rental or purchase, they shall contact the assigned program developer and provide the proposed site address along with any other pertinent data that may be available (MLS listing, lot and block information, etc.) prior to entering into a lease or sales agreement.

The program developer will initiate a site search completed by the Office of Housing staff. This search ensures that approved locations are not located in geographic areas that are saturated with other residential or vocational service locations operated by the Division, Department, or other State funded entities. The program developer will relay the outcome of the site search to the service provider.

17.9.4.3.8 Division Architect Review

Once the Office of Housing has completed the site search and deemed a service location to be acceptable in terms of the site search, the program developer will coordinate with the service provider to arrange for the Division Architect to complete a physical review of the site. This is required whether a site is to be rented or purchased

and is completed at no expense to the service provider. The Division architect review will inform on the suitability of the site for licensure and identify potential issues related to construction, renovation, accessibility modifications, etc. before a service provider commits to the site. The architect will generally provide a verbal indication as to the sites appropriateness during this review. A subsequent written report will be provided to the service provider outlining areas that need to be addressed before occupation. An inspection by the architect is not required if the service provider is not receiving any Division capital funding for the program. If the service provider is not receiving Division funding but would still like the architect to inspect the property, a request for the inspection should be made through the Program Developer.

17.9.4.3.9 Site Acquisition

After a property has been approved via a site search and reviewed by the Division architect, the service provider may move forward with securing the service location. This process can be accomplished through finalizing any rental agreements or completing the purchase process. The property will be assigned a Group Home or Supervised Apartment identifier at this time. Definitions of the settings are available in Section 18.1.

If the Division architect has concluded that no construction or renovation work is needed for the site, the process of licensure can continue. If a site does require construction or renovation, the service provider is required to inform their program developer when the progress of the work reaches 50% and 100% completion. If the service provider is receiving Division capital funding for the project, the Division architect is required to complete additional inspections at those benchmarks in order to ensure that all work being completed will meet licensing standards.

17.9.4.4 Fire Suppression Systems

In consultation with the Department of Community Affairs, the Division will continue to implement the following policy regarding the requirement for sprinkler systems: *"Fire suppression systems are required in all new stand-alone DDD licensed homes and DDD homes that require a change in use group. Fire suppressions systems are not required in multi-family dwellings (condominium, townhouse or apartment) when the service recipient can evacuate without physical assistance. Verbal prompts, verbal cues and physical prompts can be provided to assist in the evacuation. Fire suppression systems are required in multi-family dwellings when the service recipient requires physical assistance for prompt emergency evacuation."*

The Division will fund the installation of fire suppression systems in licensed settings in some cases. The service provider should contact their program developer for more information.

17.9.4.4.1 Identification of Residents

Concurrent to other elements of the site development process, a service provider must identify the specific individuals who are targeted to reside in the service location. Once 75% of these individuals have been identified, the service provider will summarize the needs of these residents on a cover sheet submitted with the Program Description referenced in Appendix D of this manual.

17.9.4.4.2 Submission of Documentation – Program Description

Once 75% of the individuals targeted to reside in the service location have been identified, the service provider must complete and submit a Program Description to their program developer. A blank copy of this document can be found on the Division's website as linked in Appendix D. Within the program description is a Program Description Statement of Attestation that must be signed by an authorized agent of the service provider.

Once completed, the service provider will submit the program description to their assigned program developer. The program developer will review the documents to ensure that they are complete and forward them to the OOL.

17.9.4.4.3 Licensure of the Site

The service providers assigned program developer will provide the agency with a Pre-Opening Inspection Checklist. At the point in which all the elements within the checklist are completed, the program developer shall be notified by the service provider. The program developer will then submit a request to inspect the property to the OOL. OOL will schedule and complete the inspection. Once the site is licensed, individuals can move in to their residence.

17.9.4.4.4 Admission of Residents

The service provider should collaborate with Support Coordinators to identify individuals who can potentially reside at the site based on who the individual chooses to reside with, where he/she wants to live, support needs, etc. It is recommended that service providers offer HIPAA compliant lists (i.e., Listing that does not include the physical street address or personal identifiable information related to current residents) of locations in need of residents to Support Coordination Agencies, self-advocacy groups, family groups, etc. in order to access interested individuals. When interest in a home and service provider is expressed by an individual, the Support Coordinator, service provider, and individual will begin the process to determine whether the home is a good match for everyone involved. The Support Coordinator will assist the individual in providing any documentation/information required by the provider, setting up meetings, arranging visits at potential settings, etc.

17.9.5 Examples of Individual Supports Activities

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

- 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.
- Support from staff to assist in activities of daily living in their residence – dressing, personal care, eating, etc.
- Support from staff to enable an individual to attend an event, take a class, etc.
- Support on a job site to assist in basic self-care, social skills, and activities of daily living.
    - **Please note that Individual Supports can be used in addition to <u>but cannot replace</u> Supported Employment services (such as job coaching). Supported Employment services must be provided in accordance with the standards described in this manual by professionals who have completed the Employment Specialist/Job Coach series of trainings. For example, Individual 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 his/her supervisor in learning work tasks, setting up accommodations to complete work tasks, or the training associated with learning new aspects of his/her job duties. Those activities must be conducted by an appropriately qualified and approved Supported Employment provider.*

17.9.6 Individual 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.

17.9.6.1 Need for Service and Process for Choice of Provider

The need for Individual 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 Individual Supports will be included in the Individual Service Plan (ISP) and the Individual Supports provider will develop strategies to assist the individual in reaching the desired outcome(s). Individuals and families are encouraged to

include the Individual Supports 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 his/her needs.

The Individual 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 Individual 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 will be provided to the identified service provider.

17.9.6.2 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

17.9.6.3 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 Individual Supports services shall successfully complete the training outlined in Appendix E: Quick Reference Guide to Mandated Staff Training.

17.9.6.4 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.

17.9.6.4.1 "Hourly Rate"

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.

The provider of Individual Supports, in collaboration with the individual, must indicate the strategies the Individual Supports Provider will be using to assist the individual in reaching his/her personally defined outcome(s) indicated in the ISP. These strategies must be indicated on the Community Based/Individual Supports Activity Log.

17.9.6.4.2 "Daily Rate"

Documentation of the delivery of service must be maintained to substantiate claims and must align with the prior authorization received for the provision of services. This documentation must include the date in which the service was delivered and a case note describing the services for that day for each individual.

In addition, the provider must meet all documentation requirements per licensing standards reflected in N.J.A.C 10:44A. The provider may need to create their own forms of documentation to address areas beyond what is covered in the Individualized Service Plan.

17.9.6.5 Settings

17.9.6.5.1 Non-Provider Managed Settings

Individual Supports provided in these settings (typically owned, rented, or leased by the individual/family) are not subject to the site specific standards detailed in Section 17.9.6.5.2 because they are specific to site development for Provider Managed settings.

17.9.6.5.2 Settings Owned, Rented, Leased by Service Provider (Provider Managed)

17.9.6.5.2.1 Addressing Vacancies

In situations when a vacancy has become available at a particular location, it is recommended that the service provider reach out to Support Coordination Agencies serving that county to inform them of these vacancies and provide HIPAA compliant information about the setting(s), characteristics/support needs generally found in individuals residing in that location, etc. When interest in a home and service provider is expressed by an individual, the Support Coordinator, service provider, and individual will begin the process to determine whether the home is a good match for everyone involved.

17.9.6.6 Quality Assurance/Monitoring

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

17.10 Interpreter Services

Procedure Codes	Rates	Units	Additional Descriptor	Budget Component
T1013HI22	$16.25	15 minutes	American Sign Language	Individual/Family Supports
T1013HI	$6.09	15 minutes	Other Spoken Language	Individual/Family Supports
T1013HI52	Reasonable & Customary	15 minutes	Self-Directed Employee	Individual/Family Supports

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 the State Plan service for language line interpretation is not available or not feasible or 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 Komninos' 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. Self-Directed Employees cannot be the individual's spouse, parent, or guardian.

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 his/her 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.

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 Quality Assurance/Monitoring

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

17.11 Natural Supports Training

Procedure Codes	Rates	Units	Additional Descriptor	Budget Component
S5110HI	Reasonable & Customary	15 minutes	NA	Individual/Family Supports

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 hoyer 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 his/her 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 Quality Assurance/Monitoring

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

17.12 Occupational Therapy

Procedure Codes	Rates	Units	Additional Descriptor	Budget Component
97535HIUN	$7.60	15 minutes	Group – Blended	Individual/Family Supports
97535HI	$26.61	15 minutes	Individual	Individual/Family Supports

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 services 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 Komninos' 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 Molina for payment.

17.12.5.2 Documentation & Record Keeping

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.

17.13 Personal Emergency Response System (PERS)

Procedure Codes	Rates	Units	Additional Descriptor	Budget Component
S5160HI	Reasonable & Customary	Single	Purchase/Installation/Testing	Individual/Family Supports
S5161HI	Reasonable & Customary	Month	Response Center Monitoring	Individual/Family Supports

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	Rates	Units	Additional Descriptor	Budget Component
S8990HIUN	$7.88	15 minutes	Group – Blended	Individual/Family Supports
S8990HI	$27.58	15 minutes	Individual	Individual/Family Supports

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 Molina for payment.

17.14.5.2 Documentation & Record Keeping

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.

17.15 Prevocational Training

Procedure Codes	Rates	Units	Additional Descriptor	Budget Component
T2015HI22	$12.73	15 minutes	Individual	Employment/Day
T2015HIUS	$2.68	15 minutes	Tier A*	Employment/Day
T2015HIUR	$3.40	15 minutes	Tier B*	Employment/Day
T2015HIUQ	$4.24	15 minutes	Tier C*	Employment/Day
T2015HIUP	$6.37	15 minutes	Tier D*	Employment/Day
T2015HIUN	$8.49	15 minutes	Tier E*	Employment/Day

*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 demonstration participants in accordance with the DDD Community Care 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 Komninos' 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*)

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.ServiceApprovalHelpDesk@dhs.state.nj.us 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 F3 Form "DVRS or CBVI Determination Form for Individuals Eligible for DDD" 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 F3 Form 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 his/her 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 in tact.
- 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, 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;
  - 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 been 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 his or her 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 Community Care Program Quality Plan.

17.16 Respite

Procedure Codes	Rates	Units	Additional Descriptor	Budget Component
T1005HI	$4.78	15 minutes	Base	Individual/Family Supports
T1005HI52	$57.36	Daily	Out of Home Overnight Tier A	Individual/Family Supports
T1005HIU1	$114.72	Daily	Out of Home Overnight Tier Aa	Individual/Family Supports
T1005HIUS	$114.72	Daily	Out of Home Overnight Tier B	Individual/Family Supports
T1005HIU2	$229.44	Daily	Out of Home Overnight Tier Ba	Individual/Family Supports
T1005HIUR	$191.20	Daily	Out of Home Overnight Tier C	Individual/Family Supports
T1005HIU3	$382.40	Daily	Out of Home Overnight Tier Ca	Individual/Family Supports
T1005HIUQ	$267.68	Daily	Out of Home Overnight Tier D	Individual/Family Supports
T1005HIU4	$535.35	Daily	Out of Home Overnight Tier Da	Individual/Family Supports
T1005HIUP	$344.16	Daily	Out of Home Overnight Tier E	Individual/Family Supports
T1005HIU5	$688.32	Daily	Out of Home Overnight Tier Ea	Individual/Family Supports
T2036HI22	$114.72	Daily	Day Camp Only (up to 6 hrs/day)	Individual/Family Supports
T2036HI	$229.20	Daily	Overnight Camp (covers day + overnight camp)	Individual/Family Supports
S9125HI	$141.04	Daily	In-Home CCR Only	Individual/Family Supports
T1005HIU8	Reasonable & Customary	15 minutes	Self-Directed Employee	Individual/Family Supports

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 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. Hotel Respite shall not exceed two consecutive weeks and 30 days per year.

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 Komninos' Law, and ensure that all staff successfully completes the Division mandated training. Self-Directed Employees (SDEs) cannot be the individual's spouse, parent, or guardian.

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 Community Care 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 Community Care Program when the services provided meet those service descriptions instead. For example, a program that has traditionally been referred 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

Base Respite is provided in or out of the individual's home.

17.16.4.2 Out of Home Overnight Respite

Out of Home 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.

Out of Home 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.

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 10:44C.

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.

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 his/her 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.

17.16.5.2Minimum 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 Quality Assurance/Monitoring

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

17.17 Speech, Language, and Hearing Therapy

Procedure Codes	Rates	Units	Additional Descriptor	Budget Component
92507HIUN	$7.43	15 minutes	Group – Blended	Individual/Family Supports
92507HI	$25.99	15 minutes	Individual	Individual/Family Supports

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 Komninos' 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 Molina for payment.

17.17.5.2 Documentation & Record Keeping

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.

17.18 Support Coordination

Procedure Codes	Rates	Units	Additional Descriptor	Budget Component
T2024HI	$239.81	Monthly	Month	NA
T2024HI52	$8.00	Daily	Daily Rate is used when an individual within the following categories is assigned to a SCA on any day other than the 1st of the month and Support Coordination services have been provided within that partial month: • Individual is brand new to DDD services • Individual has switched SCAs • Individual has moved from the Supports Program to CCP or vice versa	NA

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 Community Care Program participants receive monthly contact with their Support Coordinator. The Supports Coordinator cannot be legal guardians of the participant, or other individuals who reside with the participant.

17.18.3 Provider Qualifications

All providers of Support Coordination must comply with the standards set forth in this manual. In addition, Support Coordination Agencies shall ensure all staff meets the following qualifications:

- Bachelor's Degree or higher in any field - and-
- 1 year of experience working with adult (18 or older) individuals with developmental disabilities
    - The experience must be the equivalent of a year of full-time documented experience working with adults (18 or older) with intellectual/developmental disabilities;
    - This experience can include paid employment, volunteer experience, and/or being a family caregiver of an adult with a developmental disability;
    - If you have previously provided care coordination to a different population and some percentage of the individuals you served had developmental disabilities, you may be able to demonstrate the equivalence of a year of experience working with adults with developmental disabilities (a waiver

request along with the resume detailing experience and a justification for hiring the potential Support Coordinator may be submitted to the Division's Assistant Director to demonstrate the experience requirement has been met); - 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 who's plan they will supervise or sign off on; - and-
- State, Federal Criminal Background checks and Central Registry check at the time of hire; - and-
- Successfully complete trainings required by the Division before rendering services.

17.18.4 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.

17.18.4.1 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.

17.18.4.2 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.

17.18.4.3 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 must make a clear distinction between acting as a resource and providing advocacy on behalf of the individual/family. The Support Coordinator provides information, supports individuals in advocating for themselves, and links individuals to advocacy resources but does not serve as the advocate for the individual/family.

The Support Coordinator's role can be divided into the following 4 general functions: individual discovery, plan development, coordination of services, and monitoring.

17.18.4.3.1 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."

17.18.4.3.2 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.

17.18.4.3.3 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.

17.18.4.3.4 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.

17.18.4.4 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 services funded by the Division will be considered only when the following conditions are met:
    - 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.
- 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, if appropriate, the family; 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; writing 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;
- 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;
- 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, and other supporting documents uploaded to the iRecord for each individual served;
- Ensuring individuals served are free from abuse and neglect, 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;
- 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;
- Notifying the individual regarding any pertinent expenditure issues; and
- Conducting monthly contacts, quarterly face-to-face visits, and an annual home visit that includes review of the ISP and is documented on the Support Coordinator Monitoring Tool.

17.18.4.5 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 home visit documented on the Support Coordinator Monitoring Tool.
- Completed PCPT & approved ISP by 30 days from date the individual was enrolled into the Community Care Program and annually thereafter.
- Signed and uploaded Participant Enrollment Agreement
- Notes/reports as needed.
- Reporting data to the Division upon request.

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 notify the designated Division SC Quality Assurance Specialist and he/she shall 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.

17.18.4.6 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.

17.18.4.7 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; care managers do not establish the levels of funding for individuals; and anyone who is conducting evaluations, assessments, and the plan of care cannot be related by blood or by marriage to the individual or any of their paid caregivers.

The full policy is available on the Division's website at:
http://www.nj.gov/humanservices/ddd/documents/Documents%20for%20Web/Conflict%20Free%20Policy%20Revised.pdf

17.18.4.8 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 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.

A Support Coordination Agency must provide services in at least one county and for a minimum of 60 individuals. Support Coordination Agencies providing services in this interim phase are given the opportunity to build their capacity to meet this requirement. Once the Community Care Program is operationalized and individuals begin to be enrolled, Support Coordination Agencies will be expected to serve the minimum of 60 individuals.

17.18.4.9 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.

17.18.4.10 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.

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 him/her 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.

17.18.4.11 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.

17.18.4.12 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 service such as services provided by unqualified staff or incorrect dates of service;
- Billing for duplicate services;
- Serious record keeping 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.

17.18.4.12.1 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.

17.18.4.12.2 Required Support Coordination Documents

- Support Coordinator Monitoring Tool;
- Person-Centered Planning Tool (PCPT);
- Individualized Service Plan (ISP);
- Participants Statement of Rights & Responsibilities;
- ISP Quality Review Checklist;
- F3 Form – DVRS or CBVI Determination Form for Individuals Eligible for DDD;
- F6 Form - Non-Referral to DVRS or CBVI Form.

17.18.4.12.3 Other Related Documents

- Support Coordination Agency Selection Form;
- NJ Comprehensive Assessment Tool (NJ CAT);
- Optional Individual Discovery Tools;
- Participant Enrollment Agreement;
- Public Partnerships LLC (PPL) SDE Enrollment Packet;
- Unusual Incident Report;
- Division Circulars – found at: http://www.nj.gov/humanservices/ddd/news/publications/divisioncirculars.html
- Satisfaction Surveys - to be developed.

17.18.5 Resources/Technical Assistance

Additional information and guidance related to Support Coordination can be accessed through the following resources:

17.18.5.1 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.

17.18.5.2 Unusual Incident Reporting (UIR)

UIR 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 Unusual Incident Reporting."

17.18.5.3 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.state.nj.us. 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.

17.18.5.4 General Resources, Information, & Clarification

- Support Coordination Resource Page- http://rwjms.rutgers.edu/boggscenter/projects/njisp.html;
- Support Coordination Help Desk – DDD.SCHelpdesk@dhs.state.nj.us;
- iRecord Help Desk – DDD.ITRequests@dhs.state.nj.us;
- iRecord Tutorials – http://rwjms.rutgers.edu/boggscenter/projects/njisp.html;
- Designated Division SC Quality Assurance Specialist – as assigned per agency;
- Medicaid Eligibility Help Desk – DDD.MediElighelpdesk@dhs.state.nj.us;
- Person-Centered Planning/Thinking;
    - www.inclusion.com;
    - www.learningcommunity.us;
    - www.capacityworks2.com;
    - The Boggs Center on Developmental Disabilities http://rwjms.rutgers.edu/boggscenter/training/person_centered.html.

17.18.5.5 Supervisory Resources, Information, & Clarification

- Support Coordination Resource Page- http://rwjms.rutgers.edu/boggscenter/projects/njisp.html
- Support Coordination Help Desk – DDD.SCHelpdesk@dhs.state.nj.us
- SC Supervisor Help Desk – DDD.SCSupervisorSupport@dhs.state.nj.us

17.18.6 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.state.nj.us
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 (previously known as a Mentor) 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 Unit.

17.19 Supported Employment – Individual & Small Group Employment Support

Procedure Codes	Rates	Units	Additional Descriptor	Budget Component
T2019HI	$13.25	15 minutes	Individual	Either AND SE Component as needed
T2019HIUS	$2.79	15 minutes	Tier A*	Either
T2019HIUR	$3.53	15 minutes	Tier B*	Either
T2019HIUQ	$4.42	15 minutes	Tier C*	Either
T2019HIUP	$6.62	15 minutes	Tier D*	Either
T2019HIUN	$8.83	15 minutes	Tier E*	Either

*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 his or her employer. Services are individualized and may include but are not limited to: job development, discovery, 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 but are not limited to: 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 Community Care 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 Community Care 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 Komninos' 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 individuals 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 his/her 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 his/her 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 his/her 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 his/her 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 his/her 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 F3 Form "DVRS or CBVI Determination Form for Individuals Eligible for DDD." 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 when an individual is receiving Division funding during the LTFA phase of Supported Employment loses his/her job and needs employment services to provide assistance in finding a new job, he/she must go to DVRS/CBVI to determine eligibility (even if he/she was 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 his/her 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 him/her in maintaining employment with a Supported Employment provider will need to access those Supported Employment – Individual Employment Support services from a Supported Employment provider separate from the one that is employing him/her.

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 his/her 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 his/her 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 Quality Assurance and Monitoring

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

17.20 Supports Brokerage

Procedure Codes	Rates	Units	Additional Descriptor	Budget Component
T2041HI22	$6.09	15 minutes		Individual/Family Supports
T2041HIU7	Reasonable & Customary	15 minutes	Self-Directed Employee	Individual/Family Supports

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 personal 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 family 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.

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 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, 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 experience working with individuals with ID/DD. Self-Directed Employees (SDEs) providing Supports Brokerage cannot be the individual's spouse, parent, or guardian.

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).

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
- Developing advertisements, flyers, and other recruiting materials as needed for hiring staff

- Completing applicant screenings
- Providing assistance to complete and submit employment paper work to fiscal agent.
- Support in managing workers
- 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.

17.20.5.1 Need for Service and Process for Choice of Provider

The need for Supports Brokerage 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 Supports Brokerage services will be included in the Individual Service Plan (ISP) and the Supports Brokerage provider will develop strategies to assist the individual in reaching the desired outcome(s). Individuals and families are encouraged to include the Supports Brokerage service provider in the planning process to assist in identifying and developing applicable outcomes.

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. 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 experience working with individuals with ID/DD.

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.

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, and details of the service that was provided for each individual and must align with the prior authorization received for the provision of services.

7.20.5.5 Quality Assurance/Monitoring

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

17.21 Transportation

Procedure Codes	Rates	Units	Additional Descriptor	Budget Component
A0090HI22	$0.74	Mile	Multiple Passenger Rate (not for use by SDEs)	Either
A0090HI	Reasonable & Customary	Mile	Single Passenger Rate (not for use by SDEs)	Either
A0090HI52	Reasonable & Customary	15 minutes	Self-Directed Employee	Either

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.

17.21.3 Provider Qualifications

Multiple passenger rate 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 Komninos' 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). Self-Directed Employees (SDEs) cannot be the individual's spouse, parent, or guardian.

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.

*The Division is in the process of establishing prepaid debit cards to be used with transportation providers that cannot enroll with the Fiscal Intermediary in order to receive payment through their invoices. These options such as public transportation (NJ Transit and Access Link) and rideshare services (such as Uber or Lyft) will be available once these payment mechanisms are worked out.

17.21.4.1 Multiple Passenger Rate

This rate of $0.74/mile per passenger is utilized when the transportation provider, typically a Medicaid/DDD approved provider in this case, is transporting more than one individual using his/her 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 he/she is the first passenger picked up and/or the last passenger dropped off.

17.21.4.2 Single Passenger Rate

This rate is utilized when the transportation provider, typically a generic transportation service available to the general public in this case, is transporting one individual for the entire trip. Due to the reasonable & customary rate, requests for this service must be submitted to the Division for review and approval.

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 him/her. All of the standards for the SDE hiring and payment process 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 devises 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 Molina) for reimbursement of services delivered.

17.21.5.1.1.2 Single Passenger

The Support Coordinator will complete and submit the "Single Passenger Transportation Request" document to DDD.ServiceApprovalHelpDesk@dhs.state.nj.us for review. As long as the requested transportation is within a reasonable & customary rate, approval will be provided by the Division. At the point in which the service is approved, the Support Coordinator will indicate the chosen provider, mileage, dates of service, etc. in the ISP and prior authorization will be provided to the Fiscal Intermediary upon ISP approval. 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 as part of Day Habilitation services).

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 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, 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	Rates	Units	Additional Descriptor	Budget Component
T2039HI	Reasonable & Customary	Single	NA	Individual/Family Supports

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 the Division. 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 Modifications Request" form as well as upload the estimate/bid and any supporting documents to iRecord and notify the Division at

DDD.ServiceApprovalHelpdesk@dhs.state.nj.us 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.

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 ON THE CCP

In addition to the services available through the CCP – as outlined in Section 17 – the Division has developed mechanisms for individuals to receive support in accessing a variety of housing options. Information regarding accessing these options and the standards related to them are described in this section.

18.1 Definitions

Group Home – living arrangements operated in residences leased or owned by the licensee, regardless of any underlying residency agreement with the individual(s) served, which provide the opportunity for individuals with developmental disabilities to live together in a home, sharing in chores and the overall management of the residence. Staff in a group home provide supervision, training, and/or assistance in a variety of forms and intensity as required to assist the individuals as they move toward independence.

Individual/Family Owned, Rented, Leased – a setting the individual or his/her family directly owns, rents, or leases.

Personal Guidance – the assistance provided to an individual with intellectual/developmental disabilities on a daily basis in activities of daily living because he or she requires help completing such activities of daily living and/or cannot direct someone to complete such activities when physical disabilities prevent self-completion; or there is a documented health or mental health problem requiring supervision of the person for the protection of the individual or others. In the absence of a court determination, the Planning Team determines the need for personal guidance for each individual, in accordance with N.J.A.C. 10:44A-4.3(c)

Provider Managed – a setting owned, rented, or leased by the licensee, regardless of any underlying residency agreement with the individual(s) served, in which services and supports are coordinated by a singular service provider that manages all aspects of residential services for one or more individual residing in that location.

Self-Direction – a setting in which an individual (or his/her authorized representative) elects to manage all aspects of service provision through the utilization of Self-Directed Employees (SDE), multiple Medicaid/DDD approved service providers, or any combination thereof.

Supervised Apartment – apartments leased or owned by the licensee, regardless of any underlying residency agreement with the individual(s) served, that are occupied by individuals with intellectual/developmental disabilities. Staff provide supervision, guidance, and training as needed in activities of daily living as defined by the individual's needs and targeted future goals, in accordance with N.J.A.C 10:44A.

18.2 Funding Support for Residential Services and Housing

18.2.1 Individual Supports

The services provided within the home to assist the individual in daily living. See Section 17.9.1 for complete description of this service. Providers must by prior authorized and follow the standards described in Section 17.9 in order to provide these services and receive payment through Medicaid/DDD.

18.2.2 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. Vouchers through the SHC are not an entitlement and distribution of available vouchers are based on funding availability in a given State Fiscal Year and criteria set forth by the Division.

18.2.2.1 Accessing a SHC Voucher

18.2.2.1.1 Individuals on the CCP

Individuals on the CCP will generally be approved for a subsidy (barring extenuating circumstances). To start the evaluation process, they should notify their Support Coordinator or Case Manager and ask that they submit a Housing Subsidy Request to the Division on their behalf[6].

18.2.2.2 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.

18.2.2.3 Supportive Housing Connection Guidelines

18.2.2.3.1 Rental Units – Maintenance Included in Rent (Generally Third Party Rentals)

18.2.2.3.1.1 Units Not Previously Funded by the Division

Individuals awarded an SHC voucher in units that have not previously been funded by the Division are subject to the standards set forth in Section 18.2.2.4. Published Rent Standards (PRS) are applied as found at http://www.nj.gov/humanservices/ddd/documents/fair_market_rents.pdf.

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, he/she must move from the SHC voucher 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 voucher to other individuals receiving Division services that are not yet receiving a voucher.

18.2.2.3.1.2 Units Funded by the Division – prior to the Shift to FFS

If the rental unit chosen by an individual was funded by the Division prior to the shift into Fee-for-Service the Division will pay the current rental cost of the unit – even if it exceeds the PRS.

In these limited cases, the provisions set forth in Section 18.2.2.4 apply, but the resident does not need to apply for other forms of rental assistance as described in Section 18.2.2.4g and the rental cost can exceed the PRS as described in Section 18.2.2.4f.

[6] While individuals already served through the CCW are switching into the Fee-for-Service system, the Division or provider will initiate the SHC voucher process.

Should an individual elect at any time to move to a unit that was not previously funded by the Division, Section 18.2.2.3.1.1 "Units Not Previously Funded by the Division" applies and the standards described in Section 18.2.2.4 must be followed.

18.2.2.3.2 State or Agency Owned Properties

SHC guidelines described in Section 18.2.2.4 apply for vouchers provided for these settings with the following exceptions:

- Single Room Occupancy (SRO) rates will be paid for these settings unless the PRS is used because the provider agency has an existing rental arrangement with a landlord where PRS is already being paid and maintenance costs are included.
- Individuals residing in properties utilizing the SRO reimbursement model do not need to apply for other forms of rental assistance unless they are planning to move to a rental unit in the future.

18.2.2.3.2.1 Single Room Occupancy (SRO)

The Single Room Occupancy is calculated at 75% of the 0 bedroom rate for the county in which the home is located (See http://www.nj.gov/humanservices/ddd/documents/fair_market_rents.pdf.)

- To determine the total monthly **unit rent**, multiply the SRO rate by the number of bedrooms in the unit that are occupied by individuals served by the Division. There is a maximum of 5 bedrooms included in the count and shared bedrooms count as 1 bedroom.
- To determine the monthly **individual rent**, divide the total rent by the total number of individuals living in the unit.
- Each individual is provided an individual lease or residential agreement.
- Each individual contributes 30% of his/her gross annual income (SSI benefit employment wages, etc.) on a monthly basis to the landlord/provider and the SHC pays the remainder of each individual's rent to the landlord/provider.

Settings where the SRO reimbursement model is utilized are not provided additional maintenance costs for things like snow removal, grass cutting, repairs, etc.

Security deposits will not be permitted in circumstances where the SRO model is being used.

Division-funded arrangements exceeding PRS that pre-date the Housing Assistance Policy will be reviewed on a case-by-case basis.

18.2.2.4 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 Vouchers are only available to Division eligible individuals who reside within New Jersey. SHC vouchers 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 voucher 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 http://www.nj.gov/humanservices/ddd/documents/fair_market_rents.pdf, 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).
a. Rental units in licensed settings will receive housing inspections completed by the Office of Licensing and adhere to the standards set forth in N.J.A.C. 10:44A – Standards for Community Residences for Individuals with Developmental Disabilities rather than only HUD Quality Standards.
l. Resident must not commit any serious or repeated violation(s) of the lease.
m. Resident cannot engage in drug related criminal activity, violent or any other criminal activity.
n. Resident cannot receive SHC Rental Subsidy assistance while receiving another housing subsidy.
o. 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.
p. Resident receiving an SHC subsidy is assigned a voucher 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.

q. 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 vouchers 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.
r. Subsidized units may not be used for commercial activities. Units must remain residential in use as defined by HUD and IRS guidelines.
s. SHC subsidies cannot be used to subsidize bedrooms or units utilized as staff offices.
t. 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.
u. 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.
v. 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.
w. 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.
x. SHC subsidies cannot be used if a unit is occupied by its owner or by any person with interest in the unit.
y. 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 his/her income to the landlord for his/her portion of the rent with the SHC making up the remainder. Person's living in the unit not receiving an SHC subsidy would be responsible for their equal share of rent.
z. 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.
aa. 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 vouchers as necessary. Allocation of SHC vouchers 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 his/her 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.

18.2.4 Individual Contribution

In addition to the 30% contribution of the individual's gross annual income that is mentioned in Section 18.2.2.3.2.1 to go toward the rent, a provider can establish policies to require an additional "contribution to care" from the remainder of the individual's income to cover items such as food and utilities.

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 CCP 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 http://www.nj.gov/humanservices/ddd/news/publications/divisioncirculars.html

Division of Developmental Disabilities (Division of 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 based. 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) – the entity that manages the financial aspects of the CCP on behalf of an individual choosing to direct 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 CCP. 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 chronical 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 his/her 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 his/her 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 approved service providers.

Self-Directed Employee (SDE) – a person 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 – a 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 on the 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 - www.nj.gov/humanservices/ddd/services/apply/index.html
- Becoming a Provider - www.nj.gov/humanservices/ddd/programs/CCWpp.html
- Community Care Program (CCP) - www.nj.gov/humanservices/ddd/services/ccw/index.html
- Contact Information - www.nj.gov/humanservices/ddd/staff/
- Division Circulars - www.nj.gov/humanservices/ddd/news/publications/divisioncirculars.html
- Fee-for-Service Implementation - www.nj.gov/humanservices/ddd/programs/ffs_implementation.html
- Medicaid Eligibility and DDD - www.nj.gov/humanservices/ddd/services/medicaideligibility.html
- News and Announcements - www.nj.gov/humanservices/ddd/news/news/index.html
- NJ CAT Resource Page - www.nj.gov/humanservices/ddd/resources/njcat.html
- Provider Database – Coming Soon!
- Support Coordination - www.nj.gov/humanservices/ddd/services/support_coordination.html
- CCP - www.nj.gov/humanservices/ddd/programs/supports_program.html
- Webinars - www.nj.gov/humanservices/ddd/resources/webinars.html

APPENDIX C – DIVISION HELP DESKS

Topic/Subject Area	Help Desk
Communications / Division Update	DDD.Communications@dhs.state.nj.us
Fee-for-Service	DDD.FeeForService@dhs.state.nj.us
IT Requests	DDD.ITRequests@dhs.state.nj.us
Medicaid Eligibility	DDD.MediEligHelpdesk@dhs.state.nj.us
Provider Database	DDD.ProviderDatabaseHelpdesk@dhs.state.nj.us
Provider Enrollment Unit	DDD.ProviderEnrollmentHelpdesk@dhs.state.nj.us
CCP	DDD.SuppProgHelpdesk@dhs.state.nj.us
Support Coordination	DDD.SCHelpdesk@dhs.state.nj.us
Support Coordination Supervisors Support	DDD.SCSupervisorSupport@dhs.state.nj.us

APPENDIX D – DOCUMENTS

Referenced documents are available on the Division's website. Links are provided with the names of each document below.

Quick Reference Guide to Service Delivery Documentation Requirements

Service Delivery Documents

Please note that the fillable versions of these documents are available by clicking on the name of the document below or at www.nj.gov/humanservices/ddd/programs/supports_program.htm.

- Community Based / Individual Supports Activity 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
- 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
- Community Transitions Unit Case Transfer Form
- Continuation of Prevocational Training Justification Form
- DDD 1115 NJ FamilyCare Comprehensive Demonstration Participant Enrollment Agreement
- DVRS/CBVI Determination Form (F3 Form)
- Goods & Services Request Form
- Individual Supports Request Form
- Interest in Retirement Form
- ISP Quality Review Checklist
- Move to Discharge Form
- Non-Referral to DVRS/CBVI Form (F6 Form)
- Participant Statement of Rights & Responsibilities
- Program Description of a Licensed Community Residence for Persons with Developmental Disabilities
- Purchase Request for Assistive Technology, Environmental Modification, or Vehicle Modification
- Self-Directed Employee Request
- Single Passenger Rate Transportation Request Form
- Support Coordination Agency Selection Form
- Support Coordination Monitoring Tool
- Supported Employment Funding Request Form

QUICK REFERENCE GUIDE TO SERVICE DELIVERY DOCUMENTATION

The following documentation requirements must be utilized for individuals enrolled in the CCP 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 CCP 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 CCP 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 CCP 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	• 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	• **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 Inclusion Supports	• **Community Inclusion Services – Individualized Goals** • **Community Inclusion Services – Activities Log** • **Community Inclusion Services – Annual Update**
Day Habilitation	• **Day Habilitation –Individualized Goals** • **Day Habilitation Activities Log** • **Day Habilitation Services – Annual Update**
Individual Supports (hourly rate) **Self-Directed Employees (SDE)**	• **Community Based / Individual Supports Activity Log**
Natural Supports Training	• **Natural Supports Training Log**
Prevocational Training	• **Prevocational Training – Individualized Goals** • **Prevocational Training – Activities Log** • **Prevocational Training – Annual Update**
Support Coordination	• **Person-Centered Planning Tool (PCPT)** • **Individualized Service Plan (ISP)** • **Support Coordinator Monitoring Tool** • **For all documents visit:** **http://rwjms.rutgers.edu/boggscenter/projects/njISP.html**
Supported Employment – Individual Employment Support **Supported Employment – Small Group Employment Support**	• **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 Community Care Program (CCP). See the CCP 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** *(must be completed within 60 days of availability for already employed staff)*	College of Direct Support	• Behavioral Supports • Career Planning • Community Inclusion Services • Day Habilitation • Individual Supports • 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	
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	
	Prevention of Abuse, Neglect & Exploitation Practicum (on-site competency assessment after completing Prevention of Abuse, Neglect & Exploitation modules listed above)	Service Provider	
	Provider Developed Orientation *Includes but is not limited to:* ✓ Overview of the Agency ✓ Mission, philosophy, goals, services and practices ✓ Personnel policies ✓ Training in Health & Safety ✓ Understanding Service Plans & Individualizing services ✓ Cultural Competence ✓ Individual Rights ✓ Working with Families ✓ Documentation & record keeping	Service Provider AND/OR College of Direct Support	• Career Planning • Community Inclusion Services • Day Habilitation • Individual Supports • Prevocational Training • Respite • Support Coordination • Supported Employment – Individual Employment Support • Supported Employment – Small Group Employment Support • Supports Brokerage
Annually, 12 hours per calendar year	**Professional Development:** Mandated Trainings, Orientation, Seminars, Webinars, In-service, College of Direct Support**,** and Conferences all count Prorated at 1 hour per month for **full time staff** hired after January 1. Prorated to 6 hours per-year for **part-time staff** (less than 30 hours a week).	Various Trainers	

Timeline	Service Provider Staff	Trainer	Applicable Services
Within 90 days of hire and as needed	**Specialized Staff Training** Including but not limited to: ✓ Special diets/mealtime needs ✓ Mobility procedures & devices ✓ Seizure management & support ✓ Assistance, care & support for physical or medical conditions, mental health and/or behavioral needs	Service Provider	• Community Inclusion Services • Day Habilitation • Individual Supports • Prevocational Training • Respite
	Employment Specialist Foundations: Basic Knowledge & Skills ✓ Overview, Assessment/Discovery ✓ Marketing & Job Development ✓ Instruction & Data Collection ✓ Retention & Long Term Follow Along OR Alternate training entity preapproved by the Director, Supports Program & Employment Services: Jennifer.Joyce@dhs.state.nj.us	Boggs Center on Developmental Disabilities OR Division preapproved training entity	• Supported Employment – Individual Employment Support • Supported Employment – Small Group Employment Support • Career Planning (within 1st year of hire)
Within 90 days and annually	**Fire Evacuation & Emergency Procedures** **Universal Precautions**	Service Provider	• Day Habilitation • Individual Supports • Prevocational Training (when service is facility based)
Prior to assuming responsibility of an individual & every 2 years	**CPR Certification** Recertification every two years **Standard First Aid Certification** Recertification every two years	Nationally Certified Training Programs	• Community Inclusion Services • Day Habilitation • Individual Supports • Prevocational Training • Respite
Prior to administering medication	**Medication** ✓Introduction ✓Overview of Direct Support Roles ✓Medication Basics ✓Working with Medications ✓Administration of Medications & Treatment ✓Follow-up, Communication and Documentation of Medications	College of Direct Support	
Prior to administering medication & annually	**Medication Practicum** (on-site annual competency assessment after completing medication training above)	Service Provider	

Timeline	Service Provider Staff	Trainer	Applicable Services
Prior to implementing behavior supports	**For <u>staff overview</u> training:** **Positive Behavior Supports Overview** Introduction to Positive Behavior Supports OR Alternate training preapproved by the Assistant Director of Behavioral Supports at DDD.BehavioralServices@dhs.state.nj.us **OR** **For <u>credentialed staff</u> advanced training:** **Applied Positive Behavior Supports** Functional Behavior Assessment & Development of Support Plans OR Alternate training preapproved by the Assistant Director of Behavioral Supports at DDD.BehavioralServices@dhs.state.nj.us	Boggs Center on Developmental Disabilities OR Division preapproved alternate training	• Behavioral Supports • Community Inclusion Services • Day Habilitation • Individual Supports • Prevocational Training • Respite
Prior to conducting behavioral assessment or developing, training, supervising or monitoring a behavior support plan			• Behavioral Supports
Timeline	**Support Coordination Staff**	**Trainer**	**Applicable Services**
Prior to delivering services	**Support Coordination Orientation** ✓Prerequisite Orientation Lessons ✓Person Centered Planning & Connection to Community Supports	College of Direct Support AND Boggs Center on Developmental Disabilities	• Support Coordination
Within 90 days of hire	**Medicaid Training for NJ Support Coordinators**	College of Direct Support	
	Support Coordination Modules		
	Support Coordinator's Guide to Navigating the Employment Service System		
	Cultural Competence		

Timeline	Self-Directed Employees	Trainer	Services
Within 6 months of hire	**DDD System Mandatory Training Bundle:** **DDD Life Threatening Emergencies** (Danielle's Law) **DDD Stephen Komninos Law Training** *(must be completed within 60 days of availability for already employed staff)* **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 OR non-online version available	• Self-Directed Employees (SDEs)
	Prevention of Abuse, Neglect & Exploitation Practicum (on-site competency assessment after completing Prevention of Abuse, Neglect & Exploitation modules listed above)	Individual/Family	
	Individual/Family Developed Orientation Length & content determined by the Individual/Family	Individual/Family	
If applicable, prior to administering	**Medication** ✓ Medication Basics ✓ Working with Medications ✓ Administration of Medications & Treatment ✓ Follow-up, Communication and Documentation of Medications	College of Direct Support OR non-online version available	
If applicable, within 6 months of hire	**Medication Practicum** (on-site competency assessment after completing training listed above)	Individual/Family	
Within 6 months of hire & every 2 years	**CPR Certification** Recertification every two years **Standard First Aid Certification** Recertification every two years	Nationally Certified Training Programs	
If applicable, within 6 months of hire	**Specialized Training** As determined by caregivers	Individual/Family	
If applicable, within 6 months of hire	**Behavior Supports Plan Overview**	Author of the Behavior Plan	

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	• 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 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 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.state.nj.us.
Community Transition Services	• The SC will assist the individual in identifying entities from which he/she can access the needed Community Transition Services • The SC will complete and submit the Community Transition Services Request Form to DDD.ServiceApprovalHelpdesk@dhs.state.nj.us 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	• The Support Coordinator will assist the individual in identifying entities from which he/she 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
	•
Supported Employment – Individual or Group **Career Planning** **Prevocational Training**	• 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 DVRS/CBVI Determination Form (F3) and submits it to the SC • The SC uploads the F3 in iRecord • Individual accesses services available through DVRS/CBVI as indicated on the 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)
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 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.state.nj.us.
Physical Therapy **Occupational Therapy** **Speech, Language, and Hearing Therapy**	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 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 Molina for payment

Vehicle Modifications	• 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.state.nj.us 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 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 the 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 "stepping stone" 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 CCP 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 CCP 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: CCP SERVICES QUICK REFERENCE GUIDE

R&C = Reasonable & Customary
Budget Components - E/D = Employment/Day, I/FS = Individual/Family Supports, IS = Individual Supports (supports provided residentially)

CCP 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	$19.60	15 Minutes	H0004HI22	E/D or I/FS
	Monitoring	$7.34	15 Minutes	H0004HI	E/D or I/FS
Career Planning	Base	$13.25	15 Minutes	H2014HI	E/D or I/FS
Community Inclusion Services	Tier A	$2.36	15 Minutes	H2015HIU1	Either
	Tier B	$2.99	15 Minutes	H2015HIU2	Either
	Tier C	$3.73	15 Minutes	H2015HIU3	Either
	Tier D	$5.60	15 Minutes	H2015HIU4	Either
	Tier E	$7.46	15 Minutes	H2015HIU5	Either
Community Transition Services		R&C	Single	H0004HI22	I/FS
Day Habilitation	Tier A	$2.36	15 Minutes	T2021HIUS	E/D
	Tier A / Acuity Differentiated	$3.43	15 Minutes	T2021HIU1	E/D
	Tier B	$2.99	15 Minutes	T2021HIUR	E/D
	Tier B / Acuity Differentiated	$4.35	15 Minutes	T2021HIU2	E/D
	Tier C	$3.73	15 Minutes	T2021HIUQ	E/D
	Tier C / Acuity Differentiated	$5.43	15 Minutes	T2021HIU3	E/D
	Tier D	$5.60	15 Minutes	T2021HIUP	E/D
	Tier D / Acuity Differentiated	$8.15	15 Minutes	T2021HIU4	E/D
	Tier E	$7.46	15 Minutes	T2021HIUN	E/D
	Tier E / Acuity Differentiated	$10.87	15 Minutes	T2021HIU5	E/D
Environmental Modifications		R&C	Single	S5165HI	I/FS
Goods & Services		R&C	Single	T1999HI22	Either
Individual Supports	Base (hourly rate)	$7.01	15 Minutes	H2016HI	E/D, I/FS, or IS
	Base with Acuity (hourly rate)	$11.89	15 Minutes	H2016HI22	E/D, I/FS, or IS
	SDE (hourly rate)	R&C	15 Minutes	H2016HIU8	E/D, I/FS, or IS
	Tier A Licensed or Unlicensed with shared staff for 3+ hours (daily rate)	$70.52	Daily	H2016HI52	IS
	Tier Aa Licensed or Unlicensed with shared staff for 3+ hours (daily rate)	$149.84	Daily	H2016HIU1	IS

	Tier B Licensed or Unlicensed with shared staff for 3+ hours (daily rate)	$141.04	Daily	H2016HIUS	IS
	Tier Ba Licensed or Unlicensed with shared staff for 3+ hours (daily rate)	$299.68	Daily	H2016HIU2	IS
	Tier C Licensed or Unlicensed with shared staff for 3+ hours (daily rate)	$235.07	Daily	H2016HIUR	IS
	Tier Ca Licensed or Unlicensed with shared staff for 3+ hours (daily rate)	$499.46	Daily	H2016HIU3	IS
	Tier D Licensed or Unlicensed with shared staff for 3+ hours (daily rate)	$329.10	Daily	H2016HIUQ	IS
	Tier Da Licensed or Unlicensed with shared staff for 3+ hours (daily rate)	$699.25	Daily	H2016HIU4	IS
	Tier E Licensed or Unlicensed with shared staff for 3+ hours (daily rate)	$423.13	Daily	H2016HIUP	IS
	Tier Ea Licensed or Unlicensed with shared staff for 3+ hours (daily rate)	$899.04	Daily	H2016HIU5	IS
Interpreter Services	American Sign Language (ASL)	$16.25	15 Minutes	T1013HI22	Indiv/Family Supports
	Other - Non-ASL	$6.09	15 Minutes	T1013HI	Indiv/Family Supports
	Self-Directed Employee	R&C	15 Minutes	T1013HI52	Indiv/Family Supports
Natural Supports Training		R&C	15 Minutes	S5110HI	Indiv/Family Supports
Occupational Therapy	Individual	$26.61	15 Minutes	97535HI	I/FS
	Group – Blended	$7.60	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	$27.58	15 Minutes	S8990HI	I/FS
	Group – Blended	$7.88	15 Minutes	S8990HIUN	I/FS
Prevocational Training	Individual	$12.73	15 Minutes	T2015HI22	E/D
	Tier A – Group of 2-8	$2.68	15 Minutes	T2015HIUS	E/D
	Tier B – Group of 2-8	$3.40	15 Minutes	T2015HIUR	E/D
	Tier C – Group of 2-8	$4.24	15 Minutes	T2015HIUQ	E/D
	Tier D – Group of 2-8	$6.37	15 Minutes	T2015HIUP	E/D
	Tier E – Group of 2-8	$8.49	15 Minutes	T2015HIUN	E/D
Respite	Base	$4.78	15 Minutes	T1005HI	I/FS
	Out of Home Overnight – Tier A	$57.36	Daily	T1005HI52	I/FS
	Out of Home Overnight – Tier Aa	$114.72	Daily	T1005HIU1	I/FS
	Out of Home Overnight – Tier B	$114.72	Daily	T1005HIUS	I/FS
	Out of Home Overnight – Tier Ba	$229.44	Daily	T1005HIU2	I/FS
	Out of Home Overnight – Tier C	$191.20	Daily	T1005HIUR	I/FS
	Out of Home Overnight – Tier Ca	$382.40	Daily	T1005HIU3	I/FS
	Out of Home Overnight – Tier D	$267.68	Daily	T1005HIUQ	I/FS

	Out of Home Overnight – Tier Da	$535.35	Daily	T1005HIU4	I/FS
	Out of Home Overnight – Tier E	$344.16	Daily	T1005HIUP	I/FS
	Out of Home Overnight – Tier Ea	$688.32	Daily	T1005HIU5	I/FS
	Day Camp Only (up to 6 hrs/day)	$114.72	Daily	T2036HI22	I/FS
	Overnight Camp (day + overnight)	$229.20	Daily	T2036HI	I/FS
	In-Home CCR Only	$141.04	Daily	S9125HI	I/FS
	Self-Directed Employee	R&C	15 Minutes	T1005HIU8	I/FS
Speech, Language, and Hearing Therapy	Individual	$25.99	15 Minutes	92507HI	I/FS
	Group – Blended	$7.43	15 Minutes	92507HIUN	I/FS
Support Coordination	Per Person / Per Month	$239.81	Month	T2024HI	N/A
	Per Person / Per Day (partial month)	$8.00	Daily	T2024HI52	N/A
Supported Employment	Individual	$13.25	15 Minutes	T2019HI	E/D or I/FS (& SE as needed)
	Tier A - Group of 2-8	$2.79	15 Minutes	T2019HIUS	E/D or I/FS
	Tier B - Group of 2-8	$3.53	15 Minutes	T2019HIUR	E/D or I/FS
	Tier C - Group of 2-8	$4.42	15 Minutes	T2019HIUQ	E/D or I/FS
	Tier D - Group of 2-8	$6.62	15 Minutes	T2019HIUP	E/D or I/FS
	Tier E - Group of 2-8	$8.83	15 Minutes	T2019HIUN	E/D or I/FS
Transportation	Multiple Passenger Rate	$0.74	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

APPENDIX I – NEWSLETTER VOLUME 20 NUMBER 22 – OCTOBER 2010

Newsletter

Published by the
N.J. Dept. of Human Services,
Div. of Medical Assistance & Health Services;
the N.J. Dept. of Health & Senior Services,
Div. of Senior Benefits and Utilization Management; and
Office of the State Comptroller, Medicaid Fraud Division

Volume 20 No. 22 **October 2010**

TO: **All Providers - For Action**
Health Maintenance Organizations (HMOs) – For Action

SUBJECT: **Excluded, Unlicensed or Uncertified Individuals or Entities**

PURPOSE: To remind providers and HMOs of their responsibility to determine if an individual or entity that they employ or contract with is excluded, unlicensed or uncertified.

BACKGROUND: Providers and HMOs 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 Assistant to the Aged and Disabled (PAAD).

ACTION: Providers and HMOs are responsible for verifying 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**:

1. Federal exclusions database (mandatory):
   http://oig.hhs.gov/fraud/exclusions.asp
2. N.J. Treasurer's exclusions database (mandatory):
   www.state.nj.us/treasury/debarred/
3. N.J. Division of Consumer Affairs licensure databases (mandatory):
   https://newjersey.mylicense.com/verification/
   http://12.150.185.184/dca/
4. N.J. Department of Health and Senior Services licensure database (mandatory):
   http://www.state.nj.us/health/healthfacilities/search.shtml
5. Certified nurse aide and personal care assistant registry (mandatory, if applicable):
   http://njna.psiexams.com/search.jsp

6. Federal exclusions and licensure database (optional and fee-based): http://www.npdb-hipdb.hrsa.gov/pds.html. Please note that only certain provider types may access this database. See http://www.npdb-hipdb.hrsa.gov/entity.html for more information.

We strongly recommend that background checks utilizing these databases be included in a provider's or HMO's written policies and procedures for preventing and detecting fraud, waste and abuse. 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 HMOs discovering any excluded, unlicensed or uncertified individual or entity employed by, or contracting with the provider or HMO 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 http://nj.gov/comptroller/divisions/medicaid .

If you have any questions concerning this Newsletter, please call Michael McCoy, Manager, Office of the State Comptroller, Medicaid Fraud Division, General Recovery, Auditing and Data Mining Units, at 609-826-4808.

RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE

APPENDIX J – DVRS/CBVI/DDD MEMORANDUM OF UNDERSTANDING

MEMORANDUM OF UNDERSTANDING
BETWEEN
THE NEW JERSEY DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF VOCATIONAL REHABILITATION SERVICES
AND
THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES
COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED
AND
DIVISION OF DEVELOPMENTAL DISABILITIES

JULY 1, 2015 THROUGH JUNE 30, 2020

This Memorandum of Understanding (MOU) made by and between the New Jersey Department of Labor and Workforce Development (LWD) Division of Vocational Rehabilitation Services (DVRS) and the Department of Human Services (DHS) Commission for the Blind and Visually Impaired (CBVI) and the Division of Developmental Disabilities (DDD) is being entered into to set forth the understanding of the parties with respect to the Governor's Employment First Initiative and applies to individuals with developmental disabilities eligible for employment services through the DVRS/CBVI and the DDD. This MOU identifies the roles and responsibilities of the State agencies primarily involved in assisting adults with disabilities in finding and maintaining competitive integrated employment and will assist the State agencies to operate in an efficient and successful manner to improve employment outcomes for individuals with developmental disabilities by operating consistently across agencies ensuring quality service provision.

WHEREAS, Governor Chris Christie proclaimed New Jersey to be the 14th Employment First State on April 19, 2012; and

WHEREAS, competitive integrated employment in the general workforce is the first and preferred post-education outcome for people with any type of disability; and

WHEREAS, the LWD DVRS, the DHS CBVI, and the DHS DDD have a mutual interest in coordinating services that result in individuals with disabilities meeting this outcome;

NOW, THEREFORE, through this MOU, the LWD DVRS and the DHS CBVI and DDD agree on the following terms and conditions to govern the funding, administration, implementation and oversight of the Employment First Initiative for New Jersey.

Responsibilities/Assurances

The New Jersey LWD DVRS and DHS CBVI shall:

1. Provide services to individuals with disabilities, including the most significant disabilities, to individuals who seek and who are eligible for, services from the DVRS/CBVI including:
    - Determination of eligibility to decide if an individual requires vocational rehabilitation (VR) services to prepare for, secure, retain or regain employment;
    - Development of the Individualized Plan for Employment (IPE);
    - Review of the IPE, at least annually to assess the individual's progress in achieving the identified employment outcome;
    - Amendment of the IPE including agreeing to and signing an amendment to an individual's IPE in order for it to take effect; and
    - Determination that an individual's 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 employment outcome and the individual's case can be closed.

2. 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 an employment outcome from vocational rehabilitation services unless the DVRS/CBVI can demonstrate by clear and convincing evidence that such individual is incapable of benefiting in terms of an employment outcome from vocational rehabilitation services due to the severity of the disability of the individual.
3. Inform individuals, through its application process for vocational rehabilitation services, that individuals who receive services under the program must intend to achieve an employment outcome (34 CFR 361.41(h)(2).
4. Complete the F-3 Determination Form for individuals eligible for the DDD and submit it to the Support Coordinator/DDD Case Manager identified via email on the form.
5. Designate an Employment First subject matter expert who will provide technical assistance to the DVRS/CBVI local offices as requested and who will liaison with the DDD regarding Employment First issues.
6. Inform the DDD in the event that employment services/supports become unavailable through the DVRS/CBVI.

The New Jersey DHS DDD shall:

1. Provide all individuals eligible for DDD with the option of employment prior to other services/supports and information about services available to assist in gaining and maintaining competitive integrated employment in the general workforce.
2. Refer all individuals within the DDD system who express an immediate interest in achieving competitive employment to the DVRS or the CBVI as appropriate.

APPENDIX K – QUICK REFERENCE GUIDE TO OVERLAPPING CLAIMS FOR CCP SERVICES

Service	Allowable Claims for Simultaneous Services	Special Details
Assistive Technology	• 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	• Career Planning • Community Inclusion Services • Day Habilitation • Goods & Services (classes, for example) • Individual Supports • Interpreter Services • Prevocational Training • Respite • Supported Employment (individual and/or small group) • Transportation	If the individual is assigned the acuity differentiated factor, Behavioral Supports cannot be claimed while providing the following services because those supports are already included within the rate: • Individual Supports • Day Habilitation • Out of Home Overnight Respite
Career Planning	• Interpreter Services	
Community Inclusion Services	• Behavioral Supports • Goods & Services (activity fees only) • Interpreter Services	
Community Transition Services	None	
Day Habilitation	• Behavioral Supports • Goods & Services (activity fees only) • Interpreter Services	If the individual is assigned the acuity differentiated factor Behavioral Supports are already covered through the rate and cannot be claimed separately.
Environmental Modifications	• Interpreter Services	
Goods & Services	• Behavioral Supports (classes) • Individual 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)	
Individual Supports – daily rate	All services can be provided and separately claimed when the daily rate	• The 15 minute unit rate for Individual Supports can only be delivered when it is covering

	is being used	services that are not covered through the daily rate. For example, services that take place during evenings or weekend hours are expected to be covered by the daily rate so the 15 minute unit rate would not be available during those times. • If the entity delivering the 15 minute unit rate and daily rate is the same provider, the SC must submit a request for Division approval to ensure that the services are not already covered through the daily rate.
Individual Supports – 15 minute units	• Behavioral Supports • Goods & Services (classes, activity fees, for example) • Individual Supports – Daily • Interpreter Services • Transportation	• If the individual is assigned the acuity differentiated factor Behavioral Supports are already covered through the rate. • The 15 minute unit rate for Individual Supports can only be delivered when it is covering services that are not covered through the daily rate. For example, services that take place during evenings or weekend hours are expected to be covered by the daily rate so the 15 minute unit rate would not be available during those times. • If the entity delivering the 15 minute unit rate and daily rate is the same provider, the SC must submit a request for Division approval to ensure that the services are not already covered through the daily rate. • Individual 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 Individual Supports and Transportation (one ensuring safety and one driving).
Interpreter Services	All services but Community Transition Services if needed	
Natural Supports	• Interpreter Services	
Occupational Therapy	• Interpreter Services	
PERS	• 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	• Interpreter Services	
Prevocational Training	• Behavioral Supports • Goods & Services (activity fees only)	

	• Interpreter Services	
Respite	• 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	• Interpreter Services	
Supported Employment – Individual Employment Supports	• 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	• 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	• Interpreter Services	
Transportation	• Individual Supports	Individual 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 Individual Supports and Transportation (one ensuring safety and one driving).
Vehicle Modifications	• Interpreter Services	

APPENDIX L – NEWSLETTER VOLUME 28 NO. 01 – FEBRUARY 2018

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

Published by the
N.J. Dept. of Human Services,
Div. of Medical Assistance & Health Services
& the Division of Developmental Disabilities

Newsletter

Volume 28 No. 02 February 2018

TO: Providers of Community Care Program or Supports Program Services – **For Action**
Health Maintenance Organizations **– For Information Only**

SUBJECT: NJ FamilyCare (NJFC) Coverage and Reimbursement for Residential Setting Services under the Community Care Program (CCP)

EFFECTIVE: Immediately

PURPOSE: To provide clarification of billing requirements for residential services (individual supports) provided to beneficiaries enrolled in the CCP. The New Jersey Division of Medical Assistance and Health Services (DMAHS) and the New Jersey Division of Developmental Disabilities (DDD) are providing these guidelines for NJ FamilyCare (NJFC) fee-for-service (FFS) providers submitting claims for residential services.

BACKGROUND: Effective November 1, 2017, the DDD Community Care Waiver (CCW) was incorporated into New Jersey's Comprehensive Demonstration Waiver. As a result, the CCW has been re-named and now referred to as the Community Care Program (CCP). This change had no impact on services.

CCP residential providers receive per diem reimbursement for residential setting services. Questions have arisen concerning how long a client must reside in a facility/residence and what services must be provided on any given day to allow billing for that date of service.

ACTION: When billing for residential setting services provided under the CCP, the following guidelines shall apply:

Daily Rate: Providers shall seek reimbursement only for those dates the beneficiary was:

- documented as being under the care of the facility, and
- physically present during any part of the 24 hour period starting at 12:00 AM and ending at 11:59 PM; and
- received some level of service required of the residential provider.

Admission Date: The admission date is the initial date where residential services begin and the beneficiary is expected to continue to receive services until discharged. This shall include initial referrals as well as transfers received from another residential setting. Billing is allowed for all dates of admission where the individual meets the requirements listed under "Daily Rate" above.

Discharge Date: The beneficiary's discharge date shall be the date the beneficiary is expected to permanently leave the residence. The beneficiary's discharge date does not include dates the beneficiary leaves, but is expected to return, including, but not limited to, absences due to vacations, visits with family and temporary hospitalizations. The actual date of discharge is not billable. In the event of a transfer to another residential setting, the beneficiary is not expected to return. Therefore, the sending provider may not bill for the date of transfer to another residential facility.

Hospitalizations: When a CCP residential beneficiary receives some level of service in the residential facility prior to being admitted to a hospital setting, the CCP provider may bill for this date of service as long as the beneficiary is anticipated to return to the residential facility and as long as the criteria listed under "Daily Rate" above are met. The date the beneficiary is discharged from the hospital setting and returns to the residential facility shall also be billable as long as the criteria listed under "Daily Rate" above are met. Full dates where the beneficiary is hospitalized and did not receive any services within their residential setting shall not be reimbursed to the CCP provider

If there are any questions regarding the submission of FFS claims, please contact Molina Medicaid Solutions Provider Services at 1-800-776-6334.

RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE

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