New Jersey Division of Developmental Disabilities
Individualized Service Plan
Name:
Date:

A. Participant Information

Demographics -

DDD ID:
DOB:
Gender: Select
Primary Language: Select

County: Select
Status: Select
Waiver Program: Select
Waiver Status: Select
Waiver Enrollment Date:
Waiver Waiting List Date:
Support Coordinator:
Support Coordinating Supervisor (SCS):

Participant Contact Information -

Address:
Home Phone #:
Work Phone #:
Cell Phone #:
Email:

Emergency / Contact Information –

#1
Name:
Relationship
Address:

Home Phone #:
Work Phone #:
Cell Phone #:
Email:

#2
Name:
Relationship
Address:

Home Phone #:
Work Phone #:
Cell Phone #:

Guardianship/Co-Guardianship Information – (obtain documentation)

#1
Name:
Address:

Home Phone #:
Work Phone #:
Cell Phone #:
Date Approved by Court:
Email:

#2
Name:
Address:

Home Phone #:
Work Phone #:
Cell Phone #:
Date Approved by Court:

Healthcare Contact Information –

Managed Care Organization (MCO)
MCO Name:
MCO Care Manager:
Contact #:

Administrative Services Organization (ASO)
ASO Name:
ASO Care Manager:
Contact #:

Private Insurance:
Contact #:
Member Number:
Group Number:

Medical Contact Information –

Primary Care Physician Name:
Address:

Phone Number:

Preferred Hospital:
Address:

Phone Number:

ICD-9 Primary Diagnosis Code:

ICD-9 Secondary Diagnosis Code:

ICD-10 Primary Diagnosis Code:

ICD-10 Secondary Diagnosis Code:

B. Personally Defined Outcomes & Services (Outcome # of)

Personally Defined Outcome:

	Planning Goal	Service(s)	Procedure Code	Reference Assessment Tool (1)	No. of Units	Unit Type (2)	Rate	Frequency (3)	Duration (4)	Provider	Payment Source (5)
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select

***Reference Assessment Tool (1):**
1. PCPT
2. DDD Assessment Tool
3. Other
4. Other

Units (2):
15 min
30 min
Hour(s)
Day(s)
Month(s)
Service(s)
Trip(s)
Mile(s)

Frequency (3):
Singular
Daily
Weekly
Monthly
Yearly

Payment Source (5):
DDD Contract
FI (Agency)
Natural
Generic
Medicaid
DVRS

B. Personally Defined Outcomes & Services (Outcome # of))

Personally Defined Outcome:

Planning Goal		Service(s)	Procedure Code	Reference Assessment Tool (1)	No. of Units	Unit Type (2)	Rate	Frequency (3)	Duration (4)	Provider	Payment Source (5)
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select

***Reference Assessment Tool (1):**
1. PCPT
2. DDD Assessment Tool
3. Other
4. Other

Units (2):
15 min
30 min
Hour(s)
Day(s)
Month(s)
Service(s)
Trip(s)
Mile(s)

Frequency (3):
Singular
Daily
Weekly
Monthly
Yearly

Payment Source (5):
DDD Contract
FI (Agency)
Natural
Generic
Medicaid
DVRS

B. Personally Defined Outcomes & Services (Outcome # of)

Personally Defined Outcome:

Planning Goal	Service(s)	Procedure Code	Reference Assessment Tool (1)	No. of Units	Unit Type (2)	Rate	Frequency (3)	Duration (4)	Provider	Payment Source (5)
	Select	Select	Select		Select		Select	To		Select
	Select	Select	Select		Select		Select	To		Select
	Select	Select	Select		Select		Select	To		Select
	Select	Select	Select		Select		Select	To		Select
	Select	Select	Select		Select		Select	To		Select
	Select	Select	Select		Select		Select	To		Select
	Select	Select	Select		Select		Select	To		Select
	Select	Select	Select		Select		Select	To		Select

***Reference Assessment Tool (1):**
1. PCPT
2. DDD Assessment Tool
3. Other
4. Other

Units (2):
15 min
30 min
Hour(s)
Day(s)
Month(s)
Service(s)
Trip(s)
Mile(s)

Frequency (3):
Singular
Daily
Weekly
Monthly
Yearly

Payment Source (5):
DDD Contract
FI (Agency)
Natural
Generic
Medicaid
DVRS

B. Personally Defined Outcomes & Services (Outcome # of)

Personally Defined Outcome:

Planning Goal		Service(s)	Procedure Code	Reference Assessment Tool (1)	No. of Units	Unit Type (2)	Rate	Frequency (3)	Duration (4)	Provider	Payment Source (5)
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select

***Reference Assessment Tool (1):**
1. PCPT
2. DDD Assessment Tool
3. Other
4. Other

Units (2):
15 min
30 min
Hour(s)
Day(s)
Month(s)
Service(s)
Trip(s)
Mile(s)

Frequency (3):
Singular
Daily
Weekly
Monthly
Yearly

Payment Source (5):
DDD Contract
FI (Agency)
Natural
Generic
Medicaid
DVRS

B. Personally Defined Outcomes & Services (Outcome # of)

Personally Defined Outcome:

Planning Goal		Service(s)	Procedure Code	Reference Assessment Tool (1)	No. of Units	Unit Type (2)	Rate	Frequency (3)	Duration (4)	Provider	Payment Source (5)
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select

***Reference Assessment Tool (1):**
1. PCPT
2. DDD Assessment Tool
3. Other
4. Other

Units (2):
15 min
30 min
Hour(s)
Day(s)
Month(s)
Service(s)
Trip(s)
Mile(s)

Frequency (3):
Singular
Daily
Weekly
Monthly
Yearly

Payment Source (5):
DDD Contract
FI (Agency)
Natural
Generic
Medicaid
DVRS

B. Personally Defined Outcomes & Services (Outcome # of)

Personally Defined Outcome:

Planning Goal		Service(s)	Procedure Code	Reference Assessment Tool (1)	No. of Units	Unit Type (2)	Rate	Frequency (3)	Duration (4)	Provider	Payment Source (5)
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select

***Reference Assessment Tool (1):**
1. PCPT
2. DDD Assessment Tool
3. Other
4. Other

Units (2):
15 min
30 min
Hour(s)
Day(s)
Month(s)
Service(s)
Trip(s)
Mile(s)

Frequency (3):
Singular
Daily
Weekly
Monthly
Yearly

Payment Source (5):
DDD Contract
FI (Agency)
Natural
Generic
Medicaid
DVRS

B. Personally Defined Outcomes & Services (Outcome # of)

Personally Defined Outcome:

Planning Goal	Service(s)	Procedure Code	Reference Assessment Tool (1)	No. of Units	Unit Type (2)	Rate	Frequency (3)	Duration (4)	Provider	Payment Source (5)
	Select	Select	Select		Select		Select	To		Select
	Select	Select	Select		Select		Select	To		Select
	Select	Select	Select		Select		Select	To		Select
	Select	Select	Select		Select		Select	To		Select
	Select	Select	Select		Select		Select	To		Select
	Select	Select	Select		Select		Select	To		Select
	Select	Select	Select		Select		Select	To		Select
	Select	Select	Select		Select		Select	To		Select

***Reference Assessment Tool (1):**
1. PCPT
2. DDD Assessment Tool
3. Other
4. Other

Units (2):
15 min
30 min
Hour(s)
Day(s)
Month(s)
Service(s)
Trip(s)
Mile(s)

Frequency (3):
Singular
Daily
Weekly
Monthly
Yearly

Payment Source (5):
DDD Contract
FI (Agency)
Natural
Generic
Medicaid
DVRS

B. Personally Defined Outcomes & Services (Outcome # of)

Personally Defined Outcome:

Planning Goal		Service(s)	Procedure Code	Reference Assessment Tool (1)	No. of Units	Unit Type (2)	Rate	Frequency (3)	Duration (4)	Provider	Payment Source (5)
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select

***Reference Assessment Tool (1):**
1. PCPT
2. DDD Assessment Tool
3. Other
4. Other

Units (2):
15 min
30 min
Hour(s)
Day(s)
Month(s)
Service(s)
Trip(s)
Mile(s)

Frequency (3):
Singular
Daily
Weekly
Monthly
Yearly

Payment Source (5):
DDD Contract
FI (Agency)
Natural
Generic
Medicaid
DVRS

B. Personally Defined Outcomes & Services (Outcome # of)

Personally Defined Outcome:

Planning Goal		Service(s)	Procedure Code	Reference Assessment Tool (1)	No. of Units	Unit Type (2)	Rate	Frequency (3)	Duration (4)	Provider	Payment Source (5)
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select

***Reference Assessment Tool (1):**
1. PCPT
2. DDD Assessment Tool
3. Other
4. Other

Units (2):
15 min
30 min
Hour(s)
Day(s)
Month(s)
Service(s)
Trip(s)
Mile(s)

Frequency (3):
Singular
Daily
Weekly
Monthly
Yearly

Payment Source (5):
DDD Contract
FI (Agency)
Natural
Generic
Medicaid
DVRS

B. Personally Defined Outcomes & Services (Outcome # of)

Personally Defined Outcome:

Planning Goal		Service(s)	Procedure Code	Reference Assessment Tool (1)	No. of Units	Unit Type (2)	Rate	Frequency (3)	Duration (4)	Provider	Payment Source (5)
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select
		Select	Select	Select		Select		Select	To		Select

***Reference Assessment Tool (1):**
1. PCPT
2. DDD Assessment Tool
3. Other
4. Other

Units (2):
15 min
30 min
Hour(s)
Day(s)
Month(s)
Service(s)
Trip(s)
Mile(s)

Frequency (3):
Singular
Daily
Weekly
Monthly
Yearly

Payment Source (5):
DDD Contract
FI (Agency)
Natural
Generic
Medicaid
DVRS

C. Employment First Implementation

Please note that New Jersey is an Employment First State, meaning that: "*Competitive employment in the general workforce is the first and preferred post education outcome for people with any type of disability*." In conjunction with this policy, at least one outcome in Section B must be related to employment, the pursuit of employment, or the exploration of employment unless the individual is of retirement age. This outcome should be developed utilizing the **Pathways to Employment** section of the PCPT.

Documentation of Compliance with Employment First Policy:
Please provide the individual's current employment status:

- ○ The individual is currently employed.
- ○ The individual is unemployed or underemployed and is pursuing employment options.
- ○ The individual is not currently pursuing employment at this time.

Please document why employment is not currently being pursued and what needs to change to pursue employment?

D. Religious/Cultural Information

1. Are there any Religious or Cultural preferences that you would like to share with your caregiver/provider? ○ YES ○ NO
   If yes, please describe:

2. Are there any Religious or Cultural restrictions that you would like share with your caregiver/provider? ○ YES ○ NO
   If yes, please describe:

E. Health & Safety Information

1. What level of monitoring and support is necessary to reduce the risk of harm to self/others (regardless of the person's living environment)? This information comes directly from and matches information provided in the NJ CAT.

	None	Periodic Visual Checks	Within Constant Supervision (Eyesight and/or Hearing)	Within Constant Eyesight AND Physically Near
Inside the Home	☐ 0	☐ 1	☐ 2	☐ 3
When Eating	☐ 0	☐ 1	☐ 2	☐ 3
When Using the Bathroom	☐ 0	☐ 1	☐ 2	☐ 3
Outside in a Familiar Setting	☐ 0	☐ 1	☐ 2	☐ 3
Outside in an Unfamiliar Setting	☐ 0	☐ 1	☐ 2	☐ 3
Crossing a Street with Traffic	☐ 0	☐ 1	☐ 2	☐ 3
Inside a Store or Restaurant	☐ 0	☐ 1	☐ 2	☐ 3
Around Other People's Possessions	☐ 0	☐ 1	☐ 2	☐ 3
With Strangers	☐ 0	☐ 1	☐ 2	☐ 3
With Small Children	☐ 0	☐ 1	☐ 2	☐ 3
With People of the Opposite Sex	☐ 0	☐ 1	☐ 2	☐ 3
With People of the Same Sex	☐ 0	☐ 1	☐ 2	☐ 3
Around Household Pets (dogs, cats, etc.)	☐ 0	☐ 1	☐ 2	☐ 3
When Sleeping	☐ 0	☐ 1	☐ 2	☐ 3
In Group Leisure Activities	☐ 0	☐ 1	☐ 2	☐ 3
Other	☐ 0	☐ 1	☐ 2	☐ 3

2. Please indicate any/all medications that you are currently taking, including any over-the-counter medications, along with prescribed medications that caregivers/providers need to know about:

Name of Medication	Dosage	Frequency	Purpose	Things to note

3. Do you self-medicate? ○ YES ○ NO
   If NO, please describe assistance needed and/or method of administering medication

4. Do you have allergies (Please refer to the DDRT Question 19 j)? ○ YES ○ NO
   If yes, what do caregivers/providers need to know to look out for and/or how to treat an allergic reaction:

5. Do you have any special dietary needs/restrictions (Please refer to DDRT Questions 21 i-o)? ○ YES ○ NO
   If yes, what do caregivers/providers need to know about these special dietary needs/restrictions:

6. Do you use any adaptive equipment (Please refer to DDRT Question 22 a-i)? ○ YES ○ NO
   If yes, what do caregivers/providers need to know about the use of the adaptive equipment:

7. Please identify any additional important health and safety information that caregivers/providers need to know to keep you healthy and safe not included above (i.e. physical/mental health or behavioral issues, or others). Please include information about how the above noted level of monitoring and support will be provided for the individual as needed.

F. Emergency Back-Up Plan

The Emergency Back-Up Plan is only required to be completed if the Team deems necessary. The Emergency Back-up Plan must identify specific arrangements necessary to maintain the health and safety of an individual in the event of a breakdown in the routine plan of care. In the event of a life-threatening emergency, call 911. *Please identify the order/priority in which these individuals should be called if your Caregiver/Provider does not arrive and you need assistance.*

☐ **Check here if the individual lives in an agency-managed setting with 24-hour access to staff assistance.**
☐ **Check here if the individual uses PERS (Personal Emergency Response System).**

Order/Priority to be Called	Name	Relationship	Primary Contact Number	Backup Contact Number

Other Important Numbers

	Name/Contact Name	Phone Number
Home Care Agency		
Doctor		
Preferred Hospital		
Transportation		
Police		
Fire		
Human Services Helpline		#211
Emergency Response Registration Website		www.registerready.nj.gov
DDD Abuse Hotline		1-800-832-9173
Adult Protective Services (APS)		1-800-792-8820

Special Instructions - Please describe any equipment, environmental factors, service animals, medication, emergency preparedness or other supports that – if not available- would threaten health and safety:

G. Authorizations & Signatures

Team Members Present/Participating in developing the Individualized Service Plan

Name	Phone/email	Role/Relationship

Approval of Services Certification:

- ☐ **I helped develop this Service Plan.**
- ☐ **I agree with this Service Plan.**
- ☐ **Everyone I wanted to include in the planning process was invited to participate.**
- ☐ **I had the ability to choose the services in this Service Plan.**
- ☐ **I had the ability to choose the providers of my services based on available providers.**
- ☐ **I am aware of my rights & responsibilities as a participant of this program.**
- ☐ **You may share my Person Centered Planning Tool with *all* providers.**
- ☐ **You may share my Person Centered Planning Tool with all providers *except*:**

Approval is for content of the plan and services. The service dates may vary based on approval date. The final approved version will be distributed.

Participant Signature _____ Date

Signature_____ Date
Qualified Intellectual Disabilities Professional
(Support Coordinator)

Signature_____ Date
○ Guardian/ ○ Legal Representative