

THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES



Self-Directed Services (SDS) Policies & Procedures

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New Jersey Division of Developmental Disabilities
Self-Directed Services Policies & Procedures
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The following are the current policies and practices governing the delivery of “Self-Directed Services” (SDS) funded by the New Jersey Division of Developmental Disabilities (DDD). These policies apply to all individuals self-directing their services except for individuals in the *Self-Determination Program*¹. Some of these policies will change as ongoing DDD-wide reform efforts are implemented in the coming months. The current standards will remain in place in the interim.

All Division Circulars referenced in this guide can be accessed on DDD’s website at: <http://www.state.nj.us/humanservices/ddd/news/publications/divisioncirculars.html>.

A. Overview of Self-Directed Services (SDS)

Self-Direction is a service model for the delivery of services and supports to people with intellectual and other developmental disabilities. The purpose of the self-direction service model is to expand individual choice and control over the services and supports that people need to live in the community. Self-directed services is grounded in the principles of “person-centered planning,” which focuses on building a life plan around an individual’s preferences, strengths, and abilities and involving families, friends and professionals in both the planning and delivery of services as desired by the individual.

The delivery of self-directed services (SDS) is anchored in the following 5 principles of self-determination and self-direction:

- **Freedom:** The opportunity to choose where and with whom one lives as well as how one organizes all important aspects of one’s life with freely chosen assistance as needed.
- **Authority:** The ability to control some targeted amount of public dollars.
- **Support:** The ability to organize that support in ways that are unique to the individual.
- **Responsibility:** The obligation to use public dollars wisely and to contribute to one’s community.
- **Confirmation:** The recognition that individuals with disabilities themselves must be a major part of the redesign of the human service system of care.

Self-Direction is one of a variety of service models available through DDD. It is not mandatory for individuals to choose the self-direction route, and information about other avenues for supports and services can be found on the DDD website at <http://www.nj.gov/humanservices/ddd/services/>.

Individuals who are eligible for SDS and choose the SDS model will:

- Be assessed and assigned a budget based on their individual needs;

¹ The Self-Determination Program is one of DDD’s earliest efforts to allow individuals to self-direct their services. The program is closed to new participants. This program is in the process of being transitioned to be consistent with these policies.

- Be assigned a Support Coordinator (SC) to assist them;
- Identify members of their Team;
- Develop their own Service Plan;
- Work with a Fiscal Intermediary to manage their budget;
- Hire/fire and supervise their support staff; and
- Choose services and supports that are individualized to their needs.

B. SDS Eligibility

In order to be eligible to participate in SDS an individual must:

1. Meet all of the general eligibility criteria for DDD services as outlined in Division Circular #3 – Determination of Eligibility.
2. Meet all of the eligibility requirements for Medicaid.
3. Apply for all other benefits for which he or she may be eligible including but not limited to Social Security (SS), Supplemental Security Income (SSI), etc. and maintain eligibility for all benefits (including Medicaid) for which he or she is eligible.
4. Participate in information sessions geared to provide general information about the rights and responsibilities associated with the self-directed services model. Information sessions include but are not limited to a general overview of self-directed services, differences between self-direction and provider directed services, the types of services and supports available, the roles of the individual and the team, and the responsibilities of each member of the team.
5. Have the capacity and desire to self-direct or be willing and able to appoint a representative who can self-direct on behalf of or with him/her. Capacity will be assumed unless the individual's Team (which includes the individual and his/her family) determines that the individual does not have the capacity to self-direct, even with supports.

C. Appeal Rights:

Individuals in SDS have the right to appeal according to Division Circular #37 (N.J.A.C. 10:48). The purpose of the appeal process is to provide the steps to be taken when disagreements arise between individuals and DDD. The goal is to encourage and permit the early resolution of disputes and, where that is not possible, to identify the steps to be taken for review by the appropriate authority.

In addition to DDD's appeal process, individuals eligible for the Community Care Waiver (CCW) can also request a Medicaid Fair Hearing under 42 CFR Part 431, Subpart E if they:

1. Are not given the choice of home and community-based services as an alternative to institutional care;
2. Are denied the service(s) of their choice (including self-directed services) or the providers of their choice; or
3. Have their services denied, suspended, reduced or terminated.

DDD is responsible to provide notice of action as required in 42 CFR 431.210.

D. Prior to Receiving Services

Information sessions (including one-on-one orientations when needed) are provided to assist individuals and their representatives in understanding the responsibilities associated with the self-direction service model.

1. Medicaid

If the applicant has not already been determined Medicaid eligible, s/he shall apply for Medicaid. **Services cannot be provided during the determination process.** The receipt of DDD-funded services is predicated on Medicaid eligibility.

2. Community Care Waiver (CCW)

Before DDD offers services covered under CCW, the individual must apply *and* be found eligible for the CCW, and comply with all the requirements of eligibility for these benefits.

3. Other Benefits that include but are not limited to Social Security (SS) and Supplemental Security Income (SSI)

The applicant shall also apply for SSI, SS and all other benefits for which s/he may be eligible. DDD will not provide services when those services are available through other sources.

4. Naming a Representative

Individuals may choose to designate a representative with whom they share or designate authority to participate in self-direction. In circumstances where a designee will be given such authority, s/he should be clearly named in the individual's plan and be an active participant in the plan development from the beginning.

If an individual is deemed by the Team to lack the capacity to self-direct, a representative must be named in order for the individual to participate in SDS. Naming a representative does not transfer legal authority or responsibility over personal decision making. Being named an individual representative does not make you a legal guardian or grant you power of attorney.

5. Representative Responsibilities

- The representative must be able to demonstrate a strong commitment to the individual's well-being.
- The representative must be able to carry out the responsibilities and comply with the requirements of SDS.
- The representative must be free of any conflicts of interest.
- The representative cannot be an employee of an agency or hired by the individual to provide services.
- The representative cannot receive compensation for any duties related to being the SDS representative with one exception

Exception: Due to unexpected staff loss, for no more than 30 days on an annual basis, a representative (other than the legally responsible relative, i.e. guardian) may provide Individual Supports. The hours of support will be determined by the hours that the staff member who left employment was scheduled to work, but cannot exceed more than 40 hours per week.

E. Assessment & Individual Budget Determination

1. Developmental Disabilities Individualized Resource Tool (DDRT)

Individuals who are eligible to participate in SDS will be assessed using the Developmental Disabilities Individualized Resource Tool (DDRT). The DDRT assesses individual competencies in the areas of self-care, medical, and behavioral 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. It assists in determining who needs more support and ensures that those with like needs receive a similar level of support.

2. Determination of Individual Budget

The level of support need assigned through the DDRT corresponds with a specific budget amount. The individual uses this budget to choose his/her services and supports and who will provide them. If requested, individuals will be provided access to information about their assessed budget level prior to making a decision to self-direct. Prior to attending a self-directed orientation session, an individual/family may request their “up to” budget by contacting the DDD Regional Self-Directed Unit that covers the county in which they reside

3. Support Need Reassessment

If, at any time, an individual feels that s/he has experienced a change in his/her needs – or a change in his/her caregiver’s needs - that requires additional or fewer supports, s/he should contact his/her Support Coordinator (SC). The SC will assist the individual in navigating the process. All requests for reassessment must be made in writing to the DDD Regional Self-Directed Unit that covers the county in which the individual resides. The request will be reviewed by the Regional Self-Directed Unit to determine if a reassessment is warranted.

- Level Reassessment - If the situation is **chronic** and requires a long-term permanent intervention – such as a dramatic decline in cognitive functioning or mobility because of stroke, onset of dementia, paralysis, etc. – and requires long-term permanent intervention, the individual will be reassessed so that the budget can be increased as needed.
- Patch - If the need for increased supports is **temporary** due to an acute situation that changes the support needs of the individual – for example, the individual breaks a leg and requires additional support for 6-8 weeks while the leg heals, or hospitalization of a caregiver – a “patch” may be offered to improve the situation prior to an assessment. A patch is a short-term increase in the budget that is limited to \$10,000. This process will ensure that the assessment is valid for the individual over time, as opposed to a false reading due to a temporary situational stressor.

F. The Team

At a minimum, the members of the team must include the individual (and his/her representative), the Support Coordinator (SC), and the Case Manager or Regional Monitor, as appropriate. The individual and/or his/her representative have the right to identify additional team members – including service providers - to include in the planning process.

1. Individual, Family, and Friends

The individual along with his/her family and friends are the key members of the team. Family and friends may provide support and assistance as the individual selects the services that best meets his/her needs.

2. Support Coordinator (SC)

a. Role

The role of Support Coordination is to assist individuals through the process of self-direction and empower them to remain in charge of their plans. The Support Coordinator (SC) introduces the

individuals to the person-centered planning process, assists with accessing services and supports, and is responsible for providing information about the range of services and supports available both in advance of, and during, the planning meeting.

b. Responsibilities

The role of the SC is very broad and the responsibilities of SCs include, but are not limited to:

- Attending DDD information sessions where families learn about the person-centered planning process;
- Introducing themselves to the individual and his/her family to outline their role as an SC;
- Becoming and remaining familiar with all applicable services;
- Arranging follow up meetings, both group and individual, to facilitate development of the service plan;
- Assisting individuals and their families in the person-centered planning process;
- Working with individuals, their families, and mentors to identify outcomes and utilize their budgets to achieve those outcomes;
- Ensuring that the service plan addresses health and safety issues, including all assurances that are required by Medicaid;
- Assisting in identifying services and supports that will achieve the individual's stated outcomes and can be accessed from a provider who is appropriately qualified by DDD to provide those services;
- Drafting the service plan and making revisions to it, with the appropriate input from all members of the Team, as needed;
- Assisting individuals and their families in assuring that the services they have identified will meet their desired outcomes;
- Connecting individuals and families with generic resources and natural supports;
- Providing additional resources and tools to assist the individual in planning and accessing specific services, such as supported employment, housing, etc.; and
- Entering all data into the electronic record and sending it to the individual for approval.

c. Requesting a Change of SC

If an individual has made a request to the support coordination agency for a change in support coordinator and the issue has not been resolved to his/her satisfaction, s/he can request a change of SC and/or the support coordination agency at any time by contacting the Self-Directed Unit Director in his/her region.

3. Case Manager (CM) and/or Regional Monitor (RM)

The CM and/or RM may provide information and technical assistance to individuals, support coordinators and/or the fiscal intermediary.

4. Peer and/or Family Mentors

Individuals and families who have experience with self-direction can:

- Offer information from a personal perspective;
- Share experiences, knowledge, and resources;
- Assist in problem solving;
- Inform and encourage choices;
- Schedule, organize and facilitate peer and family network meetings;
- Attend information sessions about the person-centered planning process;
- Assist in the person-centered planning process;

- Assist with connections to service providers; and
- Connect individuals and families with generic resources and natural supports.

5. Fiscal Intermediary (FI)

DDD contracts with an agency that provides Fiscal Intermediary Services (FIS) to individuals who are self-directing their services. The FI has two main functions (1) payer of services and (2) employer of record.

6. Staff

Staff members are paid supporters who help individuals achieve identified outcomes in the Service Plan. Staff may be hired directly through the FI or the individual may choose a qualified agency to provide staff.

G. The Service Plan²

Once an individual has been assigned a level of need and corresponding budget, a Support Coordinator will be assigned to assist the individual in the development of his/her Service Plan. The Service Plan is developed through a **Person-Centered Planning Process** that includes assessment of the individual's needs, strengths and preferences; 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 desired or required by the individual. Development of the Service Plan drives the outcomes and services that will be put into place in order to ensure that meeting the best interest and needs of the individual is the primary focus.

1. **Process and Timelines:** For individuals utilizing the ELP, the SC has 90 days from the date they are assigned to an individual to complete the planning process and have the Service Plan submitted to the Regional Monitor (RM) for review. Once a plan is submitted, the RM has 10 business days to review the plan, ensuring that services fall within established guidelines and that any identified health and safety risks have been addressed, and respond to the SC with an approval or a request for changes. For individuals utilizing the ISP, the SCA has 30 days to complete the planning process and ensure an individual can access services.

The Fiscal Intermediary will, within 5 working days of the plan approval, provide the chosen service provider(s) with the Service Detail Report, billing instructions and necessary paper work for payment. Service plans are developed at least annually and are on a 12 month cycle. Prior to the end of the 12 month cycle, the SC will meet with the individual to review the current plan and make any necessary changes.

2. Changes to the Service Plan

Adjustments can easily be made to a Service Plan as an individual's needs and outcomes change. There are no limitations on the number of revisions that can be made to a service plan. At the request of the individual or representative, the SC will make a revision to the plan and submit it – within 5 working days – to the RM (or the SC Supervisor in the case of individuals utilizing the ISP) for review and approval. The RM (or SC Supervisor) has 5 working days to review and approve. The fiscal intermediary will, within 5 working days of the plan approval, provide the chosen service

² The Division is in the process of implementing a system-wide standardized Service Plan document – the Individualized Service Plan (ISP). Implementation began in June of 2013 and it will be phased-in over the coming year. Individuals who began to self-direct their services prior to June 2013 will continue to utilize the Essential Lifestyle Plan (ELP) until they are rolled into the new plan.

provider(s) with the Service Detail Report, billing instructions and needed paper work for payment. Each revision made to a Plan requires the individual's or his/her representative's signature.

Unless the changes are necessary to address health, safety or other urgent concerns, they will be effective 20 days from the submission for approval of the revised plan. However, if the provider has not received the Service Detail Report, services cannot be started. If they are necessary for health or safety, as determined by the Team, they will be effective immediately.

3. Service Plan Monitoring

The SC, CM, and RM monitor the implementation of the service plan, including the individual's health and welfare. The Team is required to review – on at least an annual basis – whether the frequency of monitoring visits needs to be increased or decreased.

For individuals utilizing the ISP: Support coordinators must conduct monthly monitoring (which can be via the phone), quarterly face-to-face, and annual home visits.

For individuals utilizing the ELP:

a. Self-Directed Day Services (Non CCW) - Face-to-Face Contact

- Annual face-to-face contact with the SC and the CM is required for individuals who are self-directing their day services only (SDDS) and who are not on the CCW. These visits may be combined with one another but must be conducted where the individual lives.
- If one of the core indicators, listed below, is present, the frequency of the face-to-face visits will increase as determined by the Team.
- Monitoring for individuals who are receiving SDDS and who are on the CCW is covered in part (b) “All Other SDS – Face to Face Contact” below.

b. All Other SDS - Face to Face Contact

- Quarterly face-to-face contact with the SC is required for individuals living with an unpaid caregiver, including family. At least one of these meetings each year must be conducted where the individual lives.
- Monthly face-to-face contact with the SC is required, during the first year, for an individual living on his/her own. After that year, there must be quarterly visits, unless one of the below core indicators is present, in which case monthly visits must be resumed. At least one of these meetings each year must be conducted where the individual lives.

CORE INDICATORS:

(1) Imminent threat to someone's health and safety due to significant, unpredicted changes in a person's medical or behavioral health;

Examples include, but are not limited to:

- (a) Clear evidence of a dangerous level of mental health/psychiatric symptoms requiring frequent use of screening centers or other psychiatric facilities;
- (b) Problems with judgment. The person's decisions are currently causing harm to himself/herself;

(c) There is active protective services involvement and there is a risk the person will be removed from the home.

(2) *Imminent threat to someone's health and safety due to a significant decline in the primary support's ability to provide the support they were previously providing.*

Examples include, but are not limited to:

- (a) Caregiver has medical, physical, mental health/addiction issues that make it impossible to fulfill their caregiving role
- (b) Caregiver is absent or requires considerable help to monitor the person. Caregiver requires immediate and continuing assistance. The person is at risk of harm due to absence of supervision.

- If any of the core indicators above are present, sufficient and appropriate steps must also be taken to address and alleviate any health or safety risks.

c. Review Conducted at Visits

- The SC documents issues/concerns and/or consumer satisfaction with service delivery. The issues reviewed include, but are not limited to:
 - (1) Do the services continue to meet the needs of the individual?
 - (2) Are there any changes or anticipated changes in the individual's health, welfare and safety?
 - (3) Are the outcomes identified in the Action Plan being met?
 - (4) Are modifications needed to the Service Plan?
 - (5) Are there any barriers to services and if so, how are the barriers being addressed?
 - (6) Is the individual satisfied with the service providers?
 - (7) What is the overall progress toward achieving the individual's outcomes?

d. Responding to Significant Issues Identified During a Visit

- If an issue arises during a quarterly visit that includes, but is not limited to, the health and welfare of the individual or an indication of a conflict with self-directed policy, the Team must be contacted immediately.
- The individual/representative, their primary unpaid support, the SC and the RM and/or CM must discuss the issue that arose at the visit and determine next steps. The SC is responsible for documenting this conversation.

e. Immediate steps must be taken if an individual is in danger:

- In a life threatening emergency, 9-1-1 must be called (see Division Circular #20A).
- In a medical emergency, arrangements must be made for medical care immediately.
- If the person has been subject to abuse or neglect or exploitation or if there are suspicions of such, the local county office of Adult Protective Services (APS) must be called and action must be taken when necessary to at least provide temporary protection (see Division Circular #14 and Title 52:27D-406 through 426: The Adult Protective Services Act).
- If an alleged crime has occurred, the local police must be called.
- For all of the above, the RM and/or CM must also be called and informed of the situation.

H. Service Options

Individuals choosing SDS have an array of services and supports available to them. There are some variations in what services are available based on the initiative or circumstances in which an individual was offered the opportunity to receive SDS. Specifically, individuals who are not on the Community Care Waiver and are receiving Self-Directed Day Services (SDDS) only, cannot access all of the same services as individuals who are on the CCW. Any questions about this should be directed to an individual's SC.

1. Key Supports for Every SDS Participant

a. Support Coordination

Assistance with the creation of a service plan utilizing a person-centered planning process.

b. Fiscal Management Services

Assistance in payment of the funds for services received as outlined in the service plan and as employer of record for staff recruited and selected by the individual/family.

c. Monitoring

Review and approval of all service plans, ensuring that services fall within established guidelines and that the plan addresses any identified health and safety risks. Monitoring also includes ongoing checks to make sure the individual is receiving services as outlined in his/her plan.

2. Overall Array of Services

Service limits are incorporated under each service option, as applicable. Be advised that individuals must utilize services available to them through other funding sources prior to utilizing their individual budget.

The State cannot provide funding for duplicative services so adjustments must be made to individual budgets in situations where funding is being provided for day services through other State Agencies. The hourly rate for the service multiplied by the number of hours for which this day service is received will be deducted from the individualized budget. The remaining budget can be utilized to fund additional services as needed. Budgets will remain intact if the funds are being utilized for Division funded employment services and supports.

These other services and funding sources include, but are not limited to, the following:

- Medicaid (including State Plan, Personal Care Attendant (PCA), Personal Preference Program (PPP) and Personal Assistance Service Program (PASP))
- Private Insurance
- Division of Vocational Rehabilitation Services
- Commission of the Blind and Visually Impaired
- School Districts/Educational Entitlement
- County Services

a. Supported Employment

Services, such as job development, pre-placement, job coaching and follow-along supports, designed to assist an individual to secure and/or maintain individual employment in the general workforce at competitive wages. New Jersey has been declared an "Employment First" state, which means that "competitive employment in the general workforce is the first and preferred post-education outcome for people with any type of disability."

Service Limits:

- The Division of Vocational Rehabilitation Services (DVRS) or Commission for the Blind and Visually Impaired (CBVI) provide the initial funding for supported employment services as per the Memorandum of Understanding (MOU) between DDD and these agencies.
- Individuals receiving supported employment services from DVRS or CBVI may also access a DDD self-directed day services (SDDS) budget, although that budget will be subject to some reduction based upon the number of hours of employment or employment activities in which the individual is engaged. The SC and RM can help an individual to navigate this process.
 - Budgets for individuals who are self-directing their day services may eventually be adjusted, but only once they are working at least 15 hours per week independently. As per the Memorandum of Understanding between DVRS, CBVI, and DDD, the Division will provide funding for long-term follow-along supports for DDD eligible individuals.
 - If an individual who is self-directing continues to need job coaching supports after DVRS supports have been exhausted, this support will come out of his/her SDS budget. These services include but are not limited to long term follow along and job coaching supports. If an individual who is self-directing his/her day services is working without supports for over 15 hours a week, his/her budget is adjusted by the amount of hours the individual works over the 15 hours divided by a 35 hour week.
- Supported Employment services shall only be provided by personnel who have completed the Employment Specialist/Job Coach series of trainings offered through the Elizabeth M. Boggs Center or Region 2 TACE (Technical Assistance & Continuing Education) Center or other DDD approved training provider.
- Activities that are of a volunteer or non-paid nature (for example, career development activities such as job sampling or situational assessments) and occurring in community businesses must follow the state Wage and Hour regulations and the Wage and Hour Interagency Agreement.

b. Habilitation

Habilitation services are designed to develop, maintain and/or maximize independence in self-care, physical and emotional growth, socialization, communication and vocational skills.

Service Limits:

- Habilitation Services are limited to a total of 25 hours per week.
- Habilitation does not include services, activities or training to which the individual may be entitled under federal or state programs of public elementary or secondary education, state plan services or federally aided vocational rehabilitation.
- Rates for habilitation are inclusive of all materials, supplies and other costs that a program may incur.
- Activities that are of a volunteer or non-paid nature (for example, career development activities such as job sampling or situational assessments) and occurring in community businesses must follow the state Wage and Hour regulations and the Wage and Hour Interagency Agreement.
- Activity costs - such as admission fees to a museum, theater/ concert tickets, etc. - are limited to \$40 per event for the individual (or up to \$80 if an additional fee is required for a staff member) and must be clearly linked to specific activities outlined in the individual's

plan. Limited exceptions to this limit may be made on an individual basis by the Regional Self Directed Unit Director.

c. Extended Employment

Extended employment is any work in a “non-integrated or sheltered setting for which compensation is in accordance with the Fair Labor Standards Act.” If an individual is performing work-related tasks in an environment where a majority of the other employees have a disability, or if the individual is being compensated at less than minimum wage under the Fair Labor Standards Act, it is considered to be extended employment.

Service Limits:

- Funding for this service shall be provided by DVRS.

d. Individual Support Services

Services that include self-care and habilitation related assistance provided in the individual’s home, family home, or other community-based settings. This service may include assistance to, as well as training and supervision of, individuals as they learn and perform various tasks that are included in basic self-care, activities of daily living and behavioral shaping.

Service Limits:

- Activity costs for support staff accompanying an individual to an activity in which the individual would not be able to attend without assistance (i.e. cost of entrance to museum, movie, cultural or sporting events, etc.) can be reimbursed, but cannot exceed \$40 per event. Limited exceptions to this limit may be made on an individual basis by the Regional Self Directed Unit Director.
- Season passes are not reimbursable.
- Expenses incurred by an individual related to a vacation - or by other person(s) accompanying the individual on the vacation (including staff or family members) - are not reimbursable. This includes, but is not limited to, activity costs, lodging, food and transportation. Individual support hours while an individual is on vacations are limited to 16 hours per day for up to 14 days per year.
- Individual support services may be provided in employment settings, but cannot replace job coaching or other supported employment services, which must be provided in accordance with the DDD Standards for Supported Employment Services by personnel who have completed the Employment Specialist/Job Coach series of trainings offered through the Elizabeth M. Boggs Center or Region 2 TACE (Technical Assistance & Continuing Education) Center or other Division approved training provider. For example, an individual support can be provided to assist with self-care needs or eating lunch 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.

e. Respite Care

Care and supervision provided due to the temporary absence or disability of a parent, guardian, or other immediate caregiver. Respite services may be provided hourly or daily/overnight and may be provided in a variety of community-based settings.

Service Limits:

- Daily/Overnight respite must be provided in the individual's home, a licensed residential setting (i.e. group home, supervised apartment, etc.), an approved camp, or a hotel that meets DDD standards.
- Out of home overnight respite is limited to 30 days in an individual's plan year.
- Hotel respite is limited to 7 overnights in an individual's plan year.

f. Home Modifications

These services include physical home adaptations which are necessary to ensure the health, welfare and safety of the individual or which enable the individual to function with greater independence in the home and community. Such adaptations may include, but are not limited to, installation of ramps and grab bars, widening of doorways, stair lifts, roll in showers, etc.

Service Limits:

- Service maintenance contracts are allowable.
- Home Modifications, Vehicle Adaptations (below), and Assistive Technology Devices (below) *combined* shall not exceed \$11,000 every three years. Exceptions may be made for issues of health and safety.
- Adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit (based on the disability) to the individual such as carpeting, roof repair, central air conditioning, etc. are not reimbursable.
- Adaptations which add to the total square footage of the home are not reimbursable.
- All services must be provided in accordance with applicable state or local building codes and permits are needed, if applicable.

g. Vehicle Adaptations

These services include vehicle adaptations which are necessary to ensure the health, welfare and safety of the individual or which enable the individual to function with greater independence in the community. Such adaptations may include, but are not limited to, wheelchair lifts and adaptations that allow an individual to operate a vehicle.

Service Limits:

- Service maintenance contracts are allowable.
- Vehicle Adaptations, Home Modifications (above), and Assistive Technology Devices (below) *combined* shall not exceed \$11,000 every three years. Exceptions may be made for issues of health and safety.
- Adaptations, upgrades, or general maintenance to the vehicle which are of general utility and are not of direct medical or remedial benefit to the individual such as oil changes, heated seats, sun roof, etc. are not reimbursable.

h. Assistive Technology Devices

These services – comprised of assessment for the service, loaned use of equipment, and purchase of, modification to, or creation of assistive technology items – are utilized to increase, maintain, or improve functional capabilities in order to perform everyday activities. Examples include adaptive switches, head pointers, adapted wheelchair trays, speech recognition accessible phones, etc.

Service Limits:

- Service maintenance contracts are allowable.

- Assistive technology devices must be ordered or prescribed by a physician and must not be available through the Medicaid State Plan or private insurance.
- Assistive Technology Devices, Home Modifications (above), and Vehicle Adaptations (above) combined shall not exceed \$11,000 every three years. Exceptions may be made for issues of health and safety.
- iPads/iPods and computers are not included in approved assistive technology devices.
- Specialized applications, which may be downloaded to a privately owned electronic device, will be reviewed and approved on an individual basis. Examples include communication applications such as Proloquo2Go, speech recognition and word prediction software.

i. Personal Emergency Response System (PERS)

This electronic device allows an individual, who lives alone or is alone for significant parts of the day, to secure help in an emergency. This may include a portable “help” button connected to a phone and programmed to signal a response center once the button is activated.

Service Limits:

- PERS services are only reimbursable for individuals who live alone, or who are alone for significant parts of the day and who would otherwise require extensive routine supervision.

j. Transportation

These services allow individuals access to/from waiver supports in the community. The selected service chosen must be the most cost effective means of transportation that the individual is able to access. This service also includes transportation to/from community-based, integrated employment and “employment-like” activities, such as volunteer or internship positions that may lead to employment.”

Service Limits:

- For transportation related to habilitation: Transportation for an individual is an allowable expense when it is (a) from his/her place of residence or other designated pick-up/drop-off site to the habilitation site; (b) within 38 miles and/or a total of one hour and 15 minutes one-way – whichever limit is reached first; and (c) not an available service through another source at no cost to the individual. The individual’s plan must specify the estimated mileage and travel time for a one-way trip to the individual’s habilitation site.
- Transportation costs are only reimbursable when transportation is not already included in the rate charged for the related contracted services. Additional transportation supports will not be available to residential or day support providers contracted to provide transportation to and from the individual’s residence to the site(s) of a day program when payment for transportation is included in the established rate paid to the contracted program that the individual is attending.
- The need for transportation services must be directly related to accessing the services and fulfilling the outcomes specified in the service plan.
- Medical transportation, transportation available through the Medicaid State Plan and transportation that is available at no charge – or as part of administrative expenditures – is not reimbursable.
- Mileage reimbursement will not exceed a distance of 150 miles one-way.

k. Out-of-Home Housing Costs

Housing costs are not Medicaid waiver services and thus, they are not reimbursable under the Community Care Waiver. The Division is evaluating how to address housing costs in the future. In

the meantime, any requests for assistance related to housing costs (rent, etc.) will be considered on a case-by-case basis. Requests should be submitted to:

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

I. Non-Reimbursable Services

Services that are not available for reimbursement include, but are not limited to:

- Services available through another funding source such as DVRS, financial aid, Medicaid State Plan, private insurance, etc.;
- Food;
- Clothing;
- Housing and associated costs with housing;
- Vacation costs;
- Recreation costs for the individual;
- Cash directly paid to the individual;
- Services provided by an unqualified provider;
- Services that are not approved in the Plan of Care;
- Club or organization dues or memberships;
- Season passes to sporting events or amusement parks; and
- Hotel or activity costs – for the individual or staff supporting the individual – overnight outside of the state of New Jersey.

I. Provision of Services

SDS services can be provided by providers (agencies or individuals) who become “qualified” by DDD, or alternatively, by individuals who are “self-hires”.

1. Qualified Providers

In order to provide SDS, a provider must first complete the process to become a “Qualified Provider.”

a. Qualifying Process

- Agencies, organizations, companies, and/or individuals express an interest in becoming qualified providers.
- Applicants are referred to the Coordinator of Agency Qualifications to learn more about self-direction and to obtain the documents needed for the application process.
- After reviewing the information provided via the Coordinator of Agency Qualifications, applicants submit applications (electronically, mailed, or faxed to DDD) appropriate for their services.
- Each applicant must submit a supportive documentation package containing the application (if not submitted electronically), liability insurance certificate, and signed Provider Agreement within ten (10) business days of the receipt of the application.
- Additional supportive documentation necessary based on the services for which the applicant is seeking qualification may include, but are not limited to, license(s), certification(s), accreditation(s), approval(s), two professional references, vehicle insurance certificate and/or CDL license.
- Once the application and supportive documentation package are received within the specified time frame, they will be reviewed for accuracy and completeness.
- If the application and supportive documentation package are accurate and complete, service standards have been met, and state and federal fingerprinting clearance has been obtained, the

applicant will be deemed qualified to provide supports. A letter will be sent, within 10 business days, to the applicant verifying the services they are qualified to provide.

b. Qualifying for Additional Services

- Qualified providers who wish to provide services in addition to those for which they were originally qualified must complete a Supplemental Application. This application can be accessed through the same process by which the original application was obtained.

c. Disqualification Process

- Providers will be disqualified from rendering supports and services to individuals participating in SDS in the event of, but not limited to, any of the following occurrences:
 - a. Failure to comply with the terms and conditions of the Provider Agreement;
 - b. Failure to act in accordance with the mission and core principles of DDD, including but not limited to the failure to act professionally and treat individuals with developmental disabilities and their families with respect;
 - c. Conduct or acts, including but not limited to, adjudged criminal activity on the part of the qualified provider agency, its officers, board members, or employees, which are detrimental to DDD or the individuals participating in SDS; and/or
 - d. Sanctions or financial actions taken by third parties against the qualified provider agency that jeopardize the intent or fulfillment of the Provider Agreement.
- DDD may take one or more of the following actions if the qualified provider agency has violated any of the occurrences above:
 - a. Disqualify the provider agency;
 - b. Temporarily withhold cash payments pending further attempts to re-establish compliance;
 - c. Disallow all or part of the cost of the activity or service not in compliance;
 - d. Prohibit the qualified provider agency from supporting any additional participants; and/or
 - e. Take any and all other remedies that may be legally available.

2. Self-Hires

a. Definition

People who are recruited and offered employment directly by the individual or designee. The individual or designee is the managing employer while the FI is the employer of record. Self-hires do not go through the Qualified Provider process.

b. Hiring Process

- The self-hire is identified by the individual or representative;
- The individual/representative writes the job description and establishes the rate of pay;
- The self-hire completes the application package provided by the FI;
- The self-hire adheres to the federal/state regulations related to employees of the FI;
- The self-hire meets Central Registry Compliance;
- The self-hire complies with Division Circular #40 – Background Checks; and
- The self-hire completes Danielle’s Law training.

3. Providing Services

a. Service Detail Report

- Developed from information contained in the service plan;
- Informs the qualified provider of the service parameters associated with the individual by indicating the services that have been approved;
- Must be received by the qualified provider from the FI prior to providing the services;
- The qualified provider can only be reimbursed for services included in the Service Detail Report.

b. Central Registry Compliance

- On October 27, 2010 the New Jersey Department of Human Services (DHS) implemented N.J.S.A. 30:6D-73, et seq. the Central Registry of Offenders Against Individuals with Developmental Disabilities. This law created a confidential registry of paid caregivers and volunteers determined by DHS to have abused, neglected or exploited an individual with a developmental disability. This registry is maintained by DHS.
- Persons placed on the Central Registry are prohibited from employment or volunteering with facilities or programs licensed, contracted or regulated by the Department, or from providing community-based services with indirect state funding to individuals with developmental disabilities. Once a determination has been made that a person's name is listed on the Central Registry, the current employer must immediately terminate the employee/volunteer.
- Qualified Providers who do not have a contract with DDD will be monitored by the FI for Central Registry compliance.

c. State and Federal Criminal Background Check

- N.J.S.A. 30:6D-63 to 72 requires that the Department shall not contract with any community agency for the provision of services unless it has first been determined that no criminal history record information exists on file in the Federal Bureau of Investigation Identification Division, or in the State Bureau of Identification in the Division of State Police, which would disqualify the community agency head or the community agency employee from such employment.
- It is the responsibility of the qualified provider, including self-hires and family members who provide respite services, to comply with Division Circular #40 Background Checks.

4. Billing for Services

a. Rates for Qualified Providers

- The rates to render services and supports are determined by DDD.
- By signing the Provider Agreement, a qualified provider agrees to the rates set forth by DDD.

b. Rates for Self Hires

- The rates are negotiated by the individual or his/her representative and the staff, but there is a \$15 per hour cap.

c. Service Detail Report

- Contains three (3) sections:
 - (a) Provider Information – contains the mailing address, provider contact information and employer identification number.
 - (b) Program Information – contains information on where the actual service is going to take place.
 - (c) Services – contains information about the service(s) that will be provided and for which the provider will be billing.

- Services billed must meet the criteria set forth on this report and can only be provided after receiving this report.

d. Provider Payment Voucher

- The *Provider Payment Voucher* is completed by the service provider, approved and signed by the individual or representative and sent to the FI for payment.
- This form is individualized for each individual, captures the information from the Service Detail Report and is used for Medicaid reimbursement.
- It is important to use the most current Service Detail Report (updated throughout the plan year) and Provider Payment Voucher (updated annually) when billing for services.
- It is required that the Provider Payment Voucher be completed and approved by the individual or representative on a monthly basis.

e. Backup Documentation

- Back up documentation is required since the Provider Payment Voucher is simply collecting the information necessary for Medicaid billing.
- The backup documentation supports the payment to your agency and is needed for auditing purposes.

f. Tracking Services

- It is the selected service provider's responsibility to ensure conformance with the billing information provided within the Service Detail Report.
- The service provider must keep records of the service units provided and check those service units against those they have been approved for.
- Due to the flexibility within the design of self-directed services, a provider may provide services that exceed the weekly amount as long as fewer service units are provided at another time in order to balance the service units out.
- The individual or representative must request a revision through his/her SC if they need additional services that exceed the annual amount. The service provider is not authorized to provide those services without a revised Service Detail Report.

g. Timelines

- Provider Payment Vouchers must be submitted within 60 calendar days from the date in which the service(s) was rendered.
- All Service Detail Reports include the end date of each service. It is essential to keep track of this date as the FI will not be able to pay for services that are provided after that date.
- DDD must have all billing information on a timely basis.

h. Payment Process

- On average, payments are processed within 10 business days of receipt at the FI.
- A partial payment may occur if the amount of the bill exceeds the budget amount for that particular service. It will also occur if the billing information does not match the information contained in the Service Detail Report or back up documentation is missing.

i. Non-Billable

Services that are not available for reimbursement include, but are not limited to:

- Services occurred before the start date;
- Services occurred after the end date;
- Billing rate is higher than the approved unit cost;

- Services have exceeded the budgeted total units;
- The Provider Payment Voucher is not filled out correctly;
- Original signatures are missing from the Provider Payment Voucher; and/or
- Back up documentation is missing.

5. Marketing Services

a. Share Marketing Tools with SCs

In order to advertise services and garner business, Qualified Providers are encouraged to share marketing tools with SCs to highlight their services and identify the locations they serve, attend or become vendors at community events, and/or advertise in their local newspaper or other publications throughout the areas they serve.

b. Satisfy the Customers

Those choosing the Self-Direction model often become part of a “self-direction community” that shares its experiences with one another. Some of the most successful Qualified Providers get their business through “word of mouth” referrals.

J. Fiscal Management

One of the key components of SDS is Fiscal Management. Fiscal Management is provided by a statewide fiscal intermediary (FI) – a non-governmental agency under contract with DDD. As the FI, this agency has two main functions: (1) payer of services and (2) employer of record.

1. Payer of Services

a. Payment to Selected Providers, Community Businesses, and/or Direct Support Professionals (DSP)

- The FI will render payment after receiving confirmation of service provision from either the individual or representative.
- The FI is only approved to pay a provider up to the dollar amount that is obligated for that particular service.
- The FI “locks” the budgets, not allowing payment for services rendered unless there are funds available in the individual’s budget.
- The FI posts expenditures directly into an individual’s electronic Service Plan once it has been determined that funds are available in the individual’s budget.

b. Reports of Expenditures

- Expenditures are sent monthly to the individual for review and tracking of expenses against his/her Service Plan.
- Expenditures are available for review by the RM and SC by both outcome and service.

c. Budget Monitoring

- An individual or his/her representative is responsible for monitoring his/her budget closely with the support of the FI.
- Additional monitoring is provided by the RM and SC.

d. Change in Service Needs

- Should an individual need additional or fewer services, s/he must communicate this change in need to his/her SC to make the necessary revisions.

2. Employer of Record

The FI also acts as the “employer of record” for any DSPs that the individual or their representative selects to hire who are not already affiliated with an agency.

a. FI Responsibilities as Employer of Record

- Hiring and Firing - The FI, as the actual employer of record, is the entity that legally employs and dismisses employees (at the request of the individual or representative).
- Pre-Employment Paperwork and Screenings – The FI is responsible for ensuring all pre-employment paperwork and pre-employment screenings are completed.
- The FI is also responsible for making a determination in cases where a potential staff member, who has been found to have a criminal background, would like to be considered “rehabilitated” as per Division Circular #40.

b. Individual or Representative

- Maintains the right to hire and fire staff.
- Determines the number of hours to be worked, the hourly rate and the daily job duties.

c. Division of Developmental Disabilities

- Reserves the right to terminate staff for the following circumstances:
 - a. Over-using the budget;
 - b. As a result of violations found through a UIR investigation(s);
 - c. Placement on the Central Registry; or
 - d. Failure to comply with Division Circular #40 Background Checks.

3. Issues Related to Payment for Services

a. Parent/Stepparent, Spouse, Guardian, or Relative Residing in the Individual’s Residence

- Payment will not be made for services furnished by the individual’s parent/stepparent, spouse, guardian, or relative residing in the service recipient’s residence
- Exception – For no more than 30 days within an individual’s plan year, a relative residing in the individual’s home – other than the legally responsible relative – may provide Individual Support Service during the transition or hiring of new staff.
 - (a) The reimbursable hours of support will be determined by the hours that the staff that left employment was scheduled to work, but cannot exceed more than 40 hours per week.
 - (b) The SC must verify that there is need for this service as other staff is not available to fill the need.
 - (c) The individual and/or another individual involved in the SDS process, other than the family member rendering the service, must verify the service was provided.

b. Retainer Payments

- For providers of Individual Support and Habilitation, except for members of the individual’s family, when the individual is hospitalized or absent from his/her home for a period of no more than 30 consecutive days in an individual plan year.
- The individual plan must reflect the hospital absences or related absences (e.g., rehabilitation time in a rehabilitation unit) and retainer payment to the agency and/or DSP.
- The state is not able to pay for supports to an individual while s/he is in the hospital or a rehabilitation unit. It is the responsibility of the hospital or rehabilitation facility to provide staffing support to the individual.

c. Overtime Payments

- Overtime must be **Pre-Authorized** within your service plan and may not exceed 40 hours per year.
- Overtime must not exceed your allotted budget amount.
- In an unplanned emergency in which overtime occurred, notification to your Support Coordinator and DDD Regional Monitor is required within 3 business days.
- In event an emergency situation arises, and the need to exceed the 40 allowed overtime hours, Central Office Self Directed Unit must be notified for approval within 3 business days.
- If a participant exceeds their allotted budget amount due to excessive unauthorized overtime, this may result in waiver services that is denied, reduced, suspended or terminated as per N.J.A.C. 10:48.6.2
- An initial appeal shall be made in writing to the;
Assistant Commissioner, Division of Developmental Disabilities,
P.O. Box 726, Trenton, NJ 08625-0726.

K. Transfer from SDS to Provider-Directed Services

1. Circumstances

A transfer from SDS to Provider-Directed Services will occur in the following circumstances:

- Individual Choice** – an individual chooses to change from SDS to provider-directed.
 - Individual/Representative Non-Compliance (unable or unwilling)**
 - An individual/representative does not comply with the requirements and responsibilities set forth in the Service Plan including, but not limited to:
 - (a) Not accessing outside resources first;
 - (b) Not submitting timesheets for staff;
 - (c) Not signing off on Provider Payment Vouchers;
 - (d) Utilizing services not approved in the service plan despite ongoing efforts to remediate the situation;
 - (e) Not agreeing to comply with regular monitoring of the service plan;
 - (f) Not maintaining waiver eligibility; or
 - (g) Exceeding their individual budget despite ongoing efforts to remediate the situation.
- If an Individual's Representative is non-compliant, the individual has the right to choose another Representative at any time.
- Risks to Health and/or Safety** – a risk to the individual's health and/or safety has been identified which would necessitate transfer, either temporary or permanent – to provider-directed services.
 - Conflict of Representative's Interests** – The representative has been found to be acting in his/her own interest rather than in the best interest of the individual and no other representative can be found.

2. Transfer Process

- Choosing to Shift from SDS to Provider-Directed Services**
 - A team meeting will be held to discuss/determine what is appropriate for the individual.
 - The RM will make the referral for provider-directed services.

- DDD staff will discuss the type of provider-directed services the individual is requesting and the availability of specific programs or services.
- The individual will continue in SDS until s/he is enrolled in the provider-directed program.
- The individual or representative no longer have the option to hire, fire and supervise staff.

b. Choosing to Shift from Provider-Directed Services to Self-Directed Day Services (SDDS)

- The Interdisciplinary Team will meet to discuss the individual's desire to switch to SDDS.
- The case manager will make a referral to the DDD Regional Day Program Coordinator to begin the SDDS process.
- The individual will continue in provider-directed services until SDDS have been arranged.

c. Involuntary Shift to Provider-Directed Services Due to Noncompliance

- All efforts will first be made to work with the individual/representative to comply with SDS requirements. DDD will make all reasonable efforts to provide support and training as needed to ensure that the individual can comply.
- The individual will be notified of his/her Right to a Fair Hearing and will be provided the information necessary to appeal the decision.
- The individual will continue to be eligible for provider-directed services unless s/he does not comply with the ongoing eligibility and service requirements for provider-directed services (including the maintenance of Medicaid eligibility).
- The transition process will follow that which is described under "Choosing to Shift to Provider-Directed Services".