

SUPPORTS PROGRAM PARTICIPANT ENROLLMENT AGREEMENT

By signing this Participant Enrollment Agreement, the Participant, Guardian (as applicable), and Family (as applicable) accept and agree to the following terms and conditions of the Supports Program:

1. The provisions herein shall apply to participation in the Supports Program as operated by the NJ Division of Developmental Disabilities (DDD) and approved by the federal Centers for Medicare and Medicaid Services (CMS).
2. Participant understands that accessing services from the DDD is voluntary and that he/she may utilize any willing service provider who meets the State's Provider Qualifications and has been identified in the Individualized Service Plan (ISP), subject to the terms of #4 of this document.
3. Participant shall comply with all policies and procedures established by the State governing participation in the program as outlined in the Supports Program Policies and Procedures Manual.
4. Participant may receive the types of services required to meet his/her assessed needs at the rates set forth in and prior authorized by the approved Individualized Service Plan (ISP).
5. Approved providers/self-directed employees (SDE) will be paid for all prior authorized services rendered, on behalf of Participant and as authorized in the ISP. The Participant shall not receive any direct payments.
6. The State may disenroll Participant from the program and/or discontinue all payment, as applicable, to a provider/SDE, 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, fraud or abuse related to the provision of services under this Participant Enrollment Agreement;
 - (c) The Participant consistently seeks payment for unauthorized or inappropriate charges;
 - (d) The Participant refuses to allow, or does not participate in, monthly, quarterly, and annual contacts/visits conducted by the Support Coordinator in accordance with guidelines provided in the Supports Program Policies & Procedures Manual;
 - (e) The Participant fails to submit on a timely basis documents and records required in relation to the provision of services under this Participant Enrollment Agreement;
 - (f) The Participant fails to report changes in care needs and financial circumstances that may affect eligibility;
 - (g) The Participant is no longer Medicaid eligible;
 - (h) The Participant has moved out of the State;
 - (i) The Participant no longer meets the Level of Care for the Supports Program;
 - (j) The Participant has enrolled in another HCBS or MLTSS program (including the Community Care Waiver – CCW);
 - (k) The Participant has failed to abide by any terms of this Participant Enrollment Agreement;
 - (l) The Participant chooses to no longer receive services from the Division/Supports Program; or
 - (m) The Participant is not accessing Supports Program services other than Support Coordination for greater than 90 days.

In the event of disenrollment or discontinuation of payment, Participant shall be solely liable for the cost of all services received after notification from the State pursuant to #7 of this document.

7. The State shall provide 30 days notice to the Participant in the event of disenrollment or discontinuation of payment pursuant to 6(a), 6(d), or 6(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 disenrolled. If the issue(s) has been addressed within those 30 days, his/her waiver status will be reinstated.
8. Individuals subject to removal from the Supports Program are entitled to the opportunity to request a Fair Hearing. The Participant must request a Fair Hearing within 20 days of the date of notification of disenrollment.
9. If the Participant finds the provider or SDE to be unsatisfactory or suspects misrepresentation; fraud; abuse; or violation of the law in rendering services, Participant should terminate the relationship and must report the termination and reasons therefore to the Support Coordinator. Participant must report to the Support Coordinator or the State any suspected exploitation, misrepresentation, fraud, or abuse related to the provision of services under this Participant Enrollment Agreement.
10. Participant shall provide to the State or agent/representative of the State all documents and records related to participation in the program, on a timely basis. The State or agent/representative of the State shall also be allowed access to all such documents and records for audit purposes.
11. Participant is subject to all applicable statutes, regulations, and laws governing non-discrimination.
12. The Supports Program maintains provisions for Participant to exercise choice and control in managing Waiver services and other supports in accordance with their needs and personal preferences.
13. This Participant Enrollment Agreement is effective as of the date last signed and shall remain in full force and effect until such time as Participant is no longer enrolled in the Supports Program.

I, as a Supports Program Participant, understand and agree that enrollment in the Supports Program is subject to the terms and conditions explained in this Participant Enrollment Agreement.

Participant Name	Signature	Date
Guardian Name, if applicable	Signature	Date
Family Member, if applicable	Signature	Date