Children's Specialized Hospital®

Improving lives. Changing futures.

Resources:

Ages 17 to 21+

Children's Specialized Hospital (CSH)
Special Needs Pediatric Primary Practice
The Autism Medical Home Transition Collaborative:
Partnering Pediatric and Adult Care

Transition Reference Sheet: Ages 17-21

Transitioning from Pediatric To Adult Care

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Tips to Transition

The Home Stretch

- Are you ready? Complete a readiness tool to assess you/your child's health care independence skill
  - Please refer to the Got Transition Sample Readiness Tool for Youth or Parents/Caregivers
- Remember: Celebrate your final transition appointment in a special way!
- Complete a Healthcare passport and finalize your care plan and goals
- Continue to talk with your doctor about what is important to you/your child with an adult provider
- Work with your doctor to identify an adult provider to ensure that your transition is smooth and the first appointment is a success
  - Please refer to the provider list for patients transitioning from pediatric to adult care
- Continue to participate in community recreation activities to support independent living and social skills

From School To Adult System Of Care

- Students are entitled to special education services through age 21 or until they graduate
  - Please refer to the NJ Department of Education Sample Activities/Strategies for Statements of Transition Services and Sample IEP Measurable Goals
- Students may apply for DVRS services up to two years prior to graduation
  - Please refer to the Step by Step Guide for Transitioning Students and the DVRS list of office contacts for your local office
- Prior to graduation, ensure that you are eligible for DDD, ensure that you are eligible for Medicaid, and complete the NJ CAT. You will not be eligible for the DDD Supports Program if you do not maintain Medicaid eligibility
  - Please refer to the Steps to Accessing Services/Supports from DDD for Graduates Aging out of the School System
  - Please refer to the Supports Program Quick Guide for families and the DDD Community Service Location list for your local office
  - Please review the Sample NJ CAT for more information prior to completing the live assessment

Important Topics

- Guardianship - Understand what the options are for your family and begin the process early so that you are prepared to file by your child's 18th birthday
  - Please refer to the The Arc Family Institute Guide to Guardianship & Alternative Options or the Bureau of Guardianship Services resources for additional information
- Social Security Benefits and Medicaid - Apply for Social Security Benefits prior to your 18th birthday; once you are eligible for SSI, you will automatically receive Medicaid benefit
  - Please refer to the SSI Factsheet for eligibility and application information
- Other Insurance Options and Medicaid - If you are over income for SSI benefits, you can still apply for Medicaid through the NJ Special Care or Workability program
  - Please refer to the Medicaid Eligibility for the Supports Program Fact Sheet

Related Topics To Consider & Resources That Can Help

- Safety & Elopement - If your adolescent is at risk to wander or get lost, contact your local sheriff office to access services available through Project Lifesaver
  - Please refer to the Autism NJ Q&A sheet on Project Lifesaver for more information and your county sheriff's office

- Hygiene & Sexuality - Puberty can be a stressful and confusing time for adolescents and young adults
  - Please refer to The Vanderbilt Kennedy Center Healthy Bodies Toolkit or the Autism Speaks Puberty and Adolescence Guide for additional resources and tools to help support your child through this process
- Housing - Consider independent living options or identify what supportive housing options may be available in your community
  - Please refer to the Supportive Housing Association's Journey to Community Housing with Supports Guide or contact your local the Center for Independent Living for additional information and referrals
- Transportation - Become familiar with your options for accessible transportation through Logisticare and NJ Transit (Community Paratransit and Accesslink)
  - Please refer to the Logisticare Services brochure for additional non-emergency medical transportation
  - Please contact Accesslink at 1-800 -955-ADA1 (2321) or refer to the list of Community Paratransit County contact list for more information

ADDITIONAL RESOURCES

- Special Child Health Case Management Unit
  - Contact your local county office for additional resources and support
  - http://www.nj.gov/health/fhs/sch/sccase.shtml
- Got Transition
  - Please refer to the Got Transition website for more information on health care transitions
  - http://www.gottransition.org
- SPAN
  - Please refer to SPAN's Transition from School to Adult Life Project for additional information and technical assistance
  - http://www.spanadvocacy.org/content/transition-school-adult-life
- Planning for Adult Life
  - Please refer to the Planning for Adult Life website for assistance with a variety of transition topics
  - http://planningforadultlife.org
- The Arc of New Jersey
  - Please refer to The Arc of New Jersey Family Institute for more information on accessing adult services
  - http://www.thearcfamilyinstitute.org/resources/helpful-guides.html
- Autism Speaks
  - Please refer to the Autism Speaks Transition Tool Kit for additional assistance on the journey from adolescence to adulthood
- Please contact your doctor or patient care coordinator for additional resources

Sample Transition Readiness Assessment for Youth

Six Core Elements of Health Care Transition 2.0

Please fill out this form to help us see what you already know about your health and how to use health care and the areas that you need to learn more about. If you need help completing this form, please ask your parent/caregiver.

Date:

Name: Date of Birth:

Transition Importance and Confidence

On a scale of 0 to 10, please circle the number that best describes how you feel right now.

How important is it to you to prepare for/change to an adult doctor before age 22?

0 (not)	1	2	3	4	5	6	7	8	9	10 (very)

How confident do you feel about your ability to prepare for/change to an adult doctor?

0 (not)	1	2	3	4	5	6	7	8	9	10 (very)

My Health — *Please check the box that applies to you right now.*	*Yes, I know this*	*I need to learn*	*Someone needs to do this… Who?*
I know my medical needs.	☐	☐	☐
I can explain my medical needs to others.	☐	☐	☐
I know my symptoms including ones that I quickly need to see a doctor for.	☐	☐	☐
I know what to do in case I have a medical emergency.	☐	☐	☐
I know my own medicines, what they are for, and when I need to take them.	☐	☐	☐
I know my allergies to medicines and medicines I should not take.	☐	☐	☐
I carry important health information with me every day (e.g. insurance card, allergies, medications, emergency contact information, medical summary).	☐	☐	☐
I understand how health care privacy changes at age 18 when legally an adult.	☐	☐	☐
I can explain to others how my customs and beliefs affect my health care decisions and medical treatment.	☐	☐	☐
Using Health Care			
I know or I can find my doctor's phone number.	☐	☐	☐
I make my own doctor appointments.	☐	☐	☐
Before a visit, I think about questions to ask.	☐	☐	☐
I have a way to get to my doctor's office.	☐	☐	☐
I know to show up 15 minutes before the visit to check in.	☐	☐	☐
I know where to go to get medical care when the doctor's office is closed.	☐	☐	☐
I have a file at home for my medical information.	☐	☐	☐
I have a copy of my current plan of care.	☐	☐	☐
I know how to fill out medical forms.	☐	☐	☐
I know how to get referrals to other providers.	☐	☐	☐
I know where my pharmacy is and how to refill my medicines.	☐	☐	☐
I know where to get blood work or x-rays if my doctor orders them.	☐	☐	☐
I have a plan so I can keep my health insurance after 18 or older.	☐	☐	☐
My family and I have discussed my ability to make my own health care decisions at age 18.	☐	☐	☐

Ejemplo de la evaluación del nivel de preparación para la transición
Para el joven
Los seis elementos esenciales para la transición de los cuidados médicos del paciente 2.0

Por favor, sírvase llenar este formulario para ayudarnos a entender lo que usted sabe sobre su salud y sobre cómo utilizar la atención médica, así como los aspectos sobre los cuales debe aprender más. Si necesita ayuda para llenar el formulario, por favor, solicite la ayuda de los padres/guardián.

Fecha: Nombre: Fecha de nacimiento:

Importancia y confianza con respecto a la transición — *En una escala de 0 a 10, sírvase marcar con un círculo el número que describa mejor cómo se siente usted en este momento.*

¿Qué tan importante es para usted prepararse para cambiar a un médico de adultos antes de los 22 años de edad?

0 (no es)	1	2	3	4	5	6	7	8	9	10 (muy)

¿Qué tan seguro se siente usted en cuanto a su capacidad de prepararse/cambiar a un médico de adultos?

0 (no)	1	2	3	4	5	6	7	8	9	10 (muy)

Mi salud — *Sírvase marcar el recuadro que se aplica a usted en este momento*	*Sí, lo sé*	*Debo aprender*	*Alguien tiene que hacerlo… ¿quién?*
Conozco mis necesidades médicas	☐	☐	☐
Puedo explicar mis necesidades médicas a otras personas	☐	☐	☐
Conozco mis síntomas, incluso aquéllos que requieren atención médica inmediata	☐	☐	☐
Sé qué hacer en caso de una emergencia médica	☐	☐	☐
Conozco mis medicamentos, sé para qué son y cuándo debo tomarlos	☐	☐	☐
Conozco mis alergias a medicamentos y sé cuáles medicamentos no debo tomar	☐	☐	☐
Llevo conmigo la información importante relacionada con mi salud en todo momento (por ejemplo, tarjeta de seguro médico, información sobre alergias, medicamentos, información sobre contactos de emergencia, resumen médico)	☐	☐	☐
Entiendo cómo la confidencialidad médica cambia a los 18 años cuando soy legalmente un adulto	☐	☐	☐
Puedo explicar cómo mis costumbres y creencias afectan las decisiones sobre mi salud y mis tratamientos médicos.	☐	☐	☐
Uso de servicios médicos			
Conozco el número de teléfono de mi médico o lo puedo encontrar.	☐	☐	☐
Hago mis propias citas médicas.	☐	☐	☐
Antes de la cita médica, pienso en las preguntas que voy a hacer.	☐	☐	☐
Tengo una forma para llegar a la oficina de mi médico	☐	☐	☐
Sé que debo presentarme 15 minutos antes de la cita para registrarme.	☐	☐	☐
Sé dónde ir para recibir atención médica cuando el consultorio médico está cerrado.	☐	☐	☐
En mi casa tengo una carpeta con mi información médica.	☐	☐	☐
Tengo una copia de mi plan médico actualizado.	☐	☐	☐
Sé cómo llenar los formularios médicos.	☐	☐	☐
Sé cómo obtener recomendaciones para otros médicos.	☐	☐	☐
Sé dónde está mi farmacia y cómo pedir la repetición de mis medicamentos.	☐	☐	☐
Sé dónde puedo hacerme análisis de sangre o radiografías si el médico lo solicita.	☐	☐	☐
Tengo un plan para mantener mi seguro médico después de los 18 años y en adelante.	☐	☐	☐
Mi familia y yo hemos hablado sobre mi capacidad de tomar mis propias decisiones sobre salud a los 18 años de edad.	☐	☐	☐

Sample Transition Readiness Assessment
for Parents/Caregivers
Six Core Elements of Health Care Transition 2.0

Please fill out this form to help us see what your child already knows about his or her health and the areas that you think he/she needs to learn more about. After you complete the form, compare your answers with the form your child has complete. Your answers may be different. We will help you work on some steps to increase your child's health care skills.

Date:

Name: Date of Birth:

Transition Importance and Confidence *On a scale of 0 to 10, please circle the number that best describes how you feel right now.*

How important is it for your child to prepare for/change to an adult doctor before age 22?

0 (not)	1	2	3	4	5	6	7	8	9	10 (very)

How confident do you feel about your child's ability to prepare for/change to an adult doctor?

0 (not)	1	2	3	4	5	6	7	8	9	10 (very)

My Health *Please check the box that applies to your child right now.*	*Yes, he/she knows this*	*He/she needs to learn*	*Someone needs to do this… Who?*
My child knows his/her medical needs.	☐	☐	☐
My child can explain his/her medical needs to others.	☐	☐	☐
My child knows his/her symptoms including ones that he/she quickly needs to see a doctor for.	☐	☐	☐
My child knows what to do in case he/she has a medical emergency.	☐	☐	☐
My child knows his/her own medicines, what they are for, and when he/she needs to take them.	☐	☐	☐
My child knows his/her allergies to medicines and medicines he/she should not take.	☐	☐	☐
My child carries important health information with him/her every day (e.g. insurance card, allergies, medications, emergency contact information, medical summary).	☐	☐	☐
My child knows he/she can see a doctor alone as I wait in the waiting room.	☐	☐	☐
My child understands how health care privacy changes at age 18.	☐	☐	☐
My child can explain to others how his/her customs and beliefs affect health care decisions and medical treatment.	☐	☐	☐
Using Health Care			
My child knows or can find his/her doctor's phone number.	☐	☐	☐
My child makes his/her own doctor appointments.	☐	☐	☐
Before a visit, my child thinks about questions to ask.	☐	☐	☐
My child has a way to get to his/her doctor's office.	☐	☐	☐
My child knows to show up 15 minutes before the visit to check in.	☐	☐	☐
My child knows where to go to get medical care when the doctor's office is closed.	☐	☐	☐
My child has a file at home for his/her medical information.	☐	☐	☐
My child has a copy of his/her current plan of care.	☐	☐	☐
My child knows how to fill out medical forms.	☐	☐	☐
My child knows how to get referrals to other providers.	☐	☐	☐
My child knows where his/her pharmacy is and how to refill his/her medicines.	☐	☐	☐
My child knows where to get blood work or x-rays if his/her doctor orders them.	☐	☐	☐
My child has a plan to keep his/her health insurance after ages 18 or older.	☐	☐	☐
My child and I have discussed his/her ability to make his/her own health care decisions at age 18.	☐	☐	☐
My child and I have discussed a plan for supported decision-making, if needed.	☐	☐	☐

Ejemplo de la evaluación del nivel de preparación para la transición
Para los padres/guardianes
Los seis elementos esenciales para la transición de los cuidados médicos del paciente 2.0

Por favor, sírvase llenar este formulario para ayudarnos a entender lo que su hijo/a sabe sobre su salud y los aspectos en los cuales usted considera que él/ella necesita aprender más. Después de llenar este formulario, compare sus respuestas con el formulario que respondió su hijo/a. Sus respuestas pueden ser diferentes. Los ayudaremos a encontrar maneras de mejorar las habilidades de su hijo/a con respecto al cuidado propio de su salud.

Fecha: **Nombre:** **Fecha de nacimiento:**

Importancia y confianza respecto a la transición	*En una escala de 0 a 10, sírvase marcar con un círculo el número que describa mejor cómo se siente usted en este momento.*									
¿Qué tan importante es para su hijo/a prepararse/cambiar a un médico de adultos antes de los 22 años de edad?										
0 (no es)	1	2	3	4	5	6	7	8	9	10 (muy)
¿Qué tan seguro se siente usted sobre la capacidad de su hijo/a de prepararse/cambiar para un médico de adultos?										
0 (no)	1	2	3	4	5	6	7	8	9	10 (muy)

La salud de mi hijo/a — *Sírvase marcar el recuadro que se aplica a usted en este momento*	*Sí, él/ella lo sabe*	*Él/ella debe aprender*	*Alguien debe hacerlo… ¿Quién?*
Mi hijo/a conoce sus necesidades médicas.	☐	☐	☐
Mi hijo/a puede explicar sus necesidades médicas a otras personas.	☐	☐	☐
Mi hijo/a conoce sus síntomas, incluidos aquéllos que requieren atención médica inmediata.	☐	☐	☐
Mi hijo/a sabe qué hacer en caso de que él/ella tenga una emergencia médica.	☐	☐	☐
Mi hijo/a conoce sus medicamentos, para qué son y cuándo él/ella debe tomarlos.	☐	☐	☐
Mi hijo/a conoce sus alergias a medicamentos y los medicamentos que él/ella no debe tomar.	☐	☐	☐
Mi hijo/a lleva la información de salud consigo en todo momento (por ejemplo, tarjeta de seguro, alergias, medicamentos, información sobre contactos de emergencia, resumen médico).	☐	☐	☐
Mi hijo sabe que él/ella puede ver a un médico sólo/a mientras yo espero en la sala de espera.	☐	☐	☐
Mi hijo/a entiende cómo la confidencialidad en la atención médica cambia a los 18 años de edad.	☐	☐	☐
Mi hijo/a puede explicar cómo sus costumbres y creencias afectan las decisiones sobre los cuidados de salud y los tratamientos médicos	☐	☐	☐
Uso de los servicios médicos			
Mi hijo/a sabe o puede encontrar el número de teléfono de su médico.	☐	☐	☐
Mi hijo/a hace sus propias citas médicas.	☐	☐	☐
Antes de una cita, mi hijo/a piensa en preguntas para hacer.	☐	☐	☐
Mi hijo/a tiene una forma de llegar al consultorio pediátrico.	☐	☐	☐
Mi hijo/a sabe que debe estar 15 minutos antes de la visita médica para registrarse	☐	☐	☐
Mi hijo/a sabe dónde ir para obtener atención médica cuando el consultorio pediátrico está cerrado.	☐	☐	☐
Mi hijo/a tiene una carpeta con su información médica en la casa.	☐	☐	☐
Mi hijo/a tiene una copia de su plan de atención médica actualizado.	☐	☐	☐
Mi hijo/a sabe cómo llenar formularios médicos.	☐	☐	☐
Mi hijo/a sabe cómo obtener recomendaciones para otros médicos.	☐	☐	☐
Mi hijo/a sabe dónde está su farmacia y cómo pedir la repetición de sus medicamentos.	☐	☐	☐
Mi hijo/a sabe dónde hacerse exámenes de sangre o radiografías si el médico lo solicita.	☐	☐	☐
Mi hijo/a tiene un plan para mantener su seguro médico a partir de los 18 años de edad y en adelante.	☐	☐	☐
Mi hijo/a y yo hemos hablado sobre su capacidad de decidir acerca de su salud a los 18 años de edad	☐	☐	☐
Mi hijo/a y yo hemos hablado sobre un plan para tomar decisiones con apoyo, si fuera necesario.	☐	☐	☐

My Health Passport

If you are a *health care professional* who will be helping me,

PLEASE READ THIS

***before* you try to help me with my care or treatment.**

My full name is: _____

I like to be called: _____

Date of birth: ___/___/_____

My primary care physician: _____

Physician's phone number: _____

Attach your picture here!

This passport has important information so you can better support me when I visit/stay in your hospital or clinic.

Please keep this with my other notes, and where it may be easily referenced.

My signature: _____ Date completed: ___/___/_____

You can talk to this person about my health: _____

Phone number: _____ Relationship: _____

I communicate using: (e.g. speech, preferred language, sign language, communication devices or aids, non-verbal sounds, also state if extra time/ support is needed)

_____

_____

_____

_____

My brief medical history: (include other conditions (e.g. visual impairment, hearing impairment, diabetes, epilepsy) past operations, illnesses, and other medical issues)

My current medications are:

-
-
-
-
-
-

When I take my medication, I prefer to take it: (e.g. with water, with food)

I am allergic to: (list medications or foods, e.g. penicillin, peanuts)

If I am in pain, I show it by: (also note if I have a low/high pain tolerance)

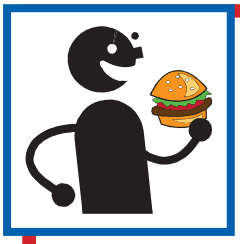
If I get upset or distressed, the best way you can help is by: (e.g. play my favorite music)

How I cope with medical procedures: (e.g. how I usually react to injections, IV's, physical examinations, x-rays, oxygen therapy—also note procedures never experienced before or in recent years)

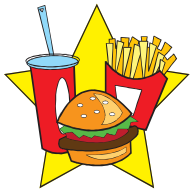
My mobility needs are: (e.g. whether I can transfer independently, devices I use, pressure relief needed)

When getting washed and dressed, you may assist me by:

When drinking, you may assist me by:



When eating, you may assist me by:



My favorite foods and drinks are:

I do not like to eat or drink the following:

I am very sensitive to: (specific sights, sounds, odors, textures/fabric, etc. that I really dislike, e.g. fluorescent lights, thunderstorms, bleach, air freshener)

Things I like to do that will help pass the time:

How to make future/follow-up appointments easier for me:

(e.g. give me the first/last appointment of the day, allow extra time for the appointment, let me visit before my appointment, give information to my caregiver, etc.)

USF UNIVERSITY OF SOUTH FLORIDA
COLLEGE OF BEHAVIORAL & COMMUNITY SCIENCES

FCIC Florida Center for Inclusive Communities

Please Cite this Document as: Perkins, E.A. (2011). *My Health Passport for Hospital/Clinic Visits*. Florida Center for Inclusive Communities, http://flfcic.fmhi.usf.edu/docs/FCIC_Health_Passport_Form_Typeable_English.pdf.

Development of this material was supported by the Administration on Developmental Disabilities (#90-DD-0668, Fox and Kincaid). For more information visit www.flcic.org

For further information contact Dr. Elizabeth Perkins at eperkins@usf.edu.

treat me right!
www.supportforliving.org.uk

This passport was adapted with permission from the "*About Me—My Hospital Passport*" from the Treat Me Right campaign.

Mi Pasaporte de Salud

Si usted es el *profesional médico* que me estará ayudando,
POR FAVOR LEA ESTO
antes **de ayudarme con mi cuidado o tratamiento.**

Mi nombre es: _____

Me gusta que me llamen: _____

Fecha de nacimiento: ____/____/_____

Mi medico de cabecera es: _____

Número de teléfono de mi doctor: _____

¡Apegue su foto aquí!

Este pasaporte tiene información muy importante para que me pueda brindar mejor apoyo durante mi estadía en su hospital o clínica.

Por favor mantenga este documento con mis otras notas médicas, y donde sea fácil de referenciar.

Mi firma: _____ Fecha: ____/____/_____

Puedes hablar con esta persona sobre mi salud: _____

Número de teléfono: _____ Relación: _____

Yo me comunico usando: (ej.: el habla, idioma preferido, lenguaje de seña, aparatos o asistentes de comunicación, sonidos no verbales. También exprese si tiempo o apoyo adicional es necesitado.)

_____

_____

_____

_____

Mi breve historial médico: (incluya otras condiciones (ej.: discapacidad visual o auditiva, diabetes, epilepsia), operaciones, enfermedades, y otros problemas médicos)

Mis medicamentos actuales son:

Cuando tomo mi medicamento, prefiero tomarlo:
(ej.: con agua, con comida)

Soy alérgico(a) a: (liste medicamentos o comidas, (ej.: penicilina, maní))

Si algo me duele, lo muestro: (también anote si tiene una alta o baja tolerancia al dolor)

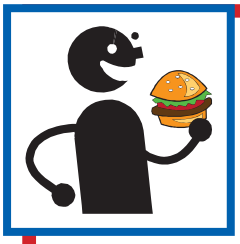
Si estoy molesto o angustiado, la mejor forma de ayudarme es:
(ej.: tocando mi música favorita)

Como enfrento a los procedimientos médicos: (ej.: como reacciono a inyecciones, inyección intravenosa (IV), exámenes físicos, radiografías, terapia de oxigeno. También anote procedimientos que no ha tenido en recientemente)

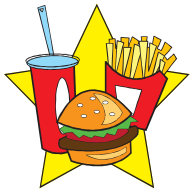
Mis necesidades de movilidad son: (ej.: si puedo moverme independientemente, aparatos que uso, alivio de presión necesario)

Cuando me baño y me visto, me puede ayudar así:

Cuando estoy bebiendo, me puede ayudar así:



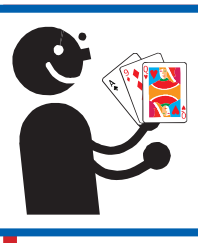
Cuando estoy comiendo, me puede ayudar así:



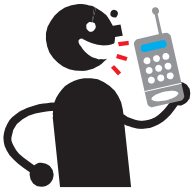
Mis comidas y bebidas favoritas son:

No me gusta comer o beber lo siguiente:

Tengo sensitividad a: (imágenes especificas, sonidos, olores, texturas o telas, que no me gusten. ej.: luces florecientes, tormentas, blanqueador, odorizantes)



Cosas que me gustan hacer para ayudar pasar el tiempo:



Como hacer citas futuras/de seguimiento más fáciles para mí:

(ej.: deme la primera o última cita del día, dedique más tiempo para la cita, déjeme visitar el local antes de mi cita, provea información a mi proveedor de cuidado)

USF UNIVERSITY OF SOUTH FLORIDA
COLLEGE OF BEHAVIORAL & COMMUNITY SCIENCES

FCIC Florida Center for Inclusive Communities

Por favor, citar este documento como: Perkins, E.A. (2011). *Mi Pasaporte de Salud para Hospitales/Visitas Clínicas.* Florida Center for Inclusive Communities, http://flfcic.fmhi.usf.edu/docs/FCIC_Health_Passport_Form_Typeable_Spanish.pdf.

Desarrollo de este material fue apoyado por la Administración de Discapacidades del Desarrollo (#90-DD-0668, Fox y Kincaid). Para más información visite: www.flcic.org.

Para mayor información contactar a la Dra. Elizabeth Perkins por correo electrónico a eperkins@usf.edu.

treat me right!
www.supportforliving.org.uk

Este pasaporte se ha adaptado con el permiso de "Acerca de Mi—Mi Pasaporte Hospital" de la campaña Treat Me Right.

Primary Care for Patients and Families Transitioning from Pediatric To Adult Care
North Jersey Region
(*Including Warren, Morris, Sussex, Passaic, Bergen, Hudson, Essex counties*)

This is a comprehensive list of adult providers throughout the state, to assist you in your decision of who will best meet your needs or the needs of your child and family. We would suggest that you contact the provider directly to see which practice will be best for you or your child as you transition to an adult care provider. Please discuss this with your pediatrician, who can assist you as you make your decision.

Practice	Contact Information	Insurance Accepted	Accepting New Patients (Y/N)	Special Accommodations	Access to Public Transportation *For assistance contact Access Link (1-800-955-2321) or Logisticare (1-866-527-9933)
Developmental Disabilities Center	At Morristown Medical Center 100 Madison Avenue, Box 60 Anderson Building, Lower G Morristown, NJ 07960 Morris County 973-971-4095 – medical 973-971-5302 – mental health	Medicaid - United Health Care Community Plan - Horizon NJ Health - Well Care (Union only) Medicare Private insurance plans	N (Mental Health only)	Any adult with a developmental disability is eligible for services Treats adults with autism and able to make for sensory needs Comprehensive medical and behavioral health services offered Wheelchair accessible	Limited access to public transportation
Hackensack University Medical Group	HackensackUMG 321 Summit 321 Summit Avenue Hackensack, NJ 07601 Bergen County 201-343-2434 Mountainside Medical Group 123 Highland Avenue – Suite 203 Glen Ridge, NJ 07028 Essex County 973-748-0678 HackensackUMG Forest Healthcare 277 Forest Avenue				

	Paramus, NJ 07652 Bergen County 201-986-1881 HackensackUMG 20 Prospect Avenue 20 Prospect Ave, Suite 715 Hackensack, NJ 07601 Bergen County 201-342-1877 HackensackUMG 150 Overlook 150 Overlook Avenue Hackensack, NJ 07601 Bergen County 201-489-5999 HackenackUMG 200 The Plaza 200 The Plaza Teaneck, NJ 07666 Bergen County 201-833-8840 HackensackUMG 301 Beech 301 Beech Street Hackensack, NJ 07601 Bergen County 201-342-5350 HackensackUMG 116 Terrace 116 Terrace Avenue Lodi, NJ 07644 Bergen County 973-473-3896 HackensackUMG Pascack Valley 125 Washington Avenue				

	Dumont, NJ 07628 Bergen County 201-374-2722 HackensackUMG 480 Market 480 Market Street Saddle Brook, NJ 07663 Bergen County 201-845-4048 HackensackUMG 6-20 Plaza 6-20 Plaza Road Fair Lawn, NJ 07410 Bergen County 201-797-2003 HackensackUMG 413 Boulevard 413 Boulevard Hasbrouck Heights, NJ 07604 Bergen County 201-288-6335				
Internal Medicine Faculty Practice at St. Barnabas	101 Old Short Hills Road - Suite 106 West Orange, NJ 07052 Essex County 973-322-6256	Medicare Medicaid - United Health Care Community Plan - Horizon NJ Health	Y	Medical home recognition with care coordination Teaching practice (assigned resident/attending) Accepts patients with special health care needs	Bus stop across the street from hospital
Maplewood Family Medicine	111 Dunnell Road, Suite 200 Maplewood, NJ 07040 Essex County 908-598-6690	Medicaid	Y	Two physician practice Willing to make accommodations for sensory needs	Locally accessible by bus Out of town accessible by train or bus

Summit Medical Group	Family Medicine Locations: 6 Brighton Road Clifton, NJ 07012 Passaic County 973-777-7911 230 Sherman Avenue Glen Ridge, NJ 07028 Essex County 973-743-2321 75 E Northfield Road Livingston, NJ 07039 Essex County 973-436-1465 48-50 Fairfield Street Montclair, NJ 07042 Essex County 973-744-8511 405 Northfield Avenue - Suite 205 West Orange, NJ 07052 Essex County 973-669-2820 Internal Medicine Locations: 140 Park Avenue (Enter The Green at Florham Park across from the Wyndham Hotel) Florham Park, New Jersey 07932 Morris County 973-404-7880 75 E Northfield Road Livingston, NJ 07039 Essex County 973-436-1460 85 Woodland Road	*Does not accept Medicaid	Y	Accepts all patients regardless of diagnosis Provides care coordination services Willing to make accommodations for sensory needs *Share needs prior visit	Some locations accessible to public transportation and Access Link

	Short Hills, NJ 07078 Essex County 973-379-4496				

Primary Care for Patients and Families Transitioning from Pediatric To Adult Care
Central New Jersey Region
(Including Hunterdon, Somerset, Union, Middlesex, Mercer, Monmouth, Ocean counties)

This is a comprehensive list of adult providers throughout the state, to assist you in your decision of who will best meet your needs or the needs of your child and family. We would suggest that you contact the provider directly to see which practice will be best for you or your child as you transition to an adult care provider. Please discuss this with your pediatrician, who can assist you as you make your decision.

Practice	Contact Information	Insurance Accepted	Accepting New Patients (Y/N)	Special Accommodations	Access to Public Transportation *For assistance contact Access Link (1-800-955-2321) or Logisticare (1-866-527-9933)
The Arc Mercer Healthcare Center	3131 Princeton Pike Building 5, Suite 109 Lawrenceville, NJ 08648 Mercer County 609-989-9211 For new patient intake, contact Angela	Medicare Medicaid - United Health Care Community Plan - Horizon NJ Health Horizon Blue Cross/Blue Shield Private insurance and DDD for therapy services	Y (Primary care and Therapy only) N (Psychiatry)	Primary care and mental health services for individuals with developmental disabilities ages 18 and up Treats adults with autism and able to make accommodations for sensory needs Extended appointments/Limited wait times Wheelchair accessible On site lab work, EKG, Ob/Gyn services	Bus Stop close to corner of Princeton Pike and Franklin Corner Road
Developmental Disabilities Center	At Overlook Medical Center Union Campus 1000 Galloping Hill Road Union, NJ 07083 Union County 908-598-6655 – medical/mental health	Medicaid - United Health Care Community Plan - Horizon NJ Health - Well Care (Union only) Medicare Private insurance plans	Y	Any adult with a developmental disability is eligible for services Treats adults with autism and able to make for sensory needs Comprehensive medical and behavioral health services offered Wheelchair accessible	Limited access to public transportation

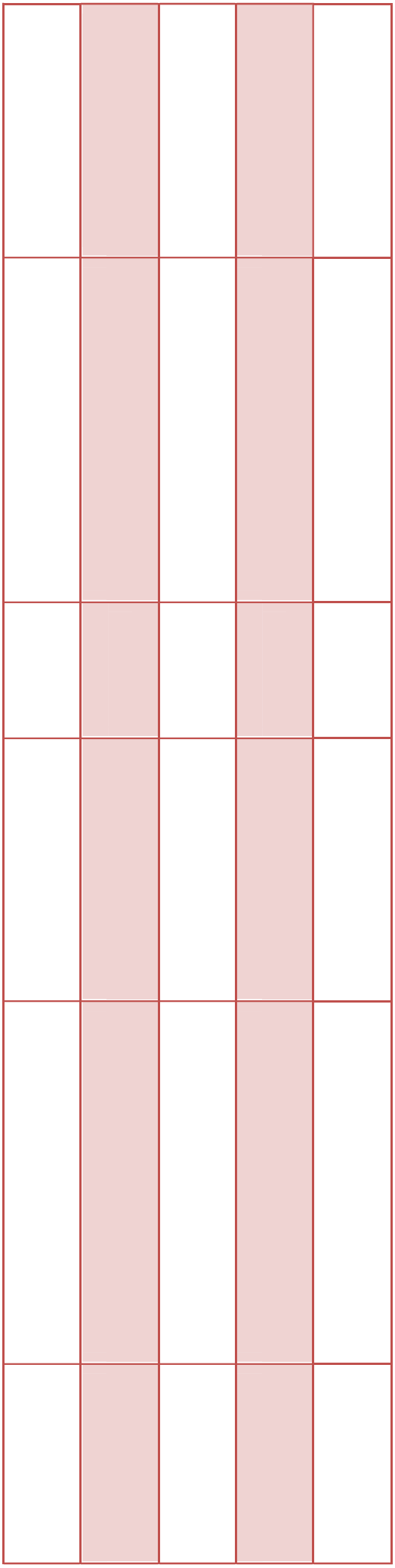
Hunterdon Family Medicine at Phillips-Barber	72 Alexander Avenue Lambertville, NJ 08530 Hunterdon County 609-397-3535 *Request appointment with Melissa Burgos, MD	Medicare Medicaid - United Health Care Community Plan - Horizon NJ Health Private insurance	Y	Physician with special interest in individuals with special health care needs Request extended intake for first office visit Wheelchair accessible	Close to Main Street Accessible for Access Link transportation
Jersey Shore Family Health Center	1828 West Lake Avenue Neptune, NJ 07753 Monmouth County 732-776-4209	Medicaid - United Health Care Community Plan - Horizon NJ Health	Y	Accepts adult patients with autism and able to make accommodations for sensory needs	Bus stop 3 blocks away Train Station (Asbury Park) 5 blocks away
Monmouth Family Health Center	270 Broadway, Long Branch, NJ 07740 Monmouth County 732-923-7100 732-413-2030 (patient appointments)	Medicaid Offers sliding scale payment option	Y	Accepts adult patients with autism and able to make accommodations for sensory needs	Bus stop outside of facility
Robert Wood Johnson Family & Internal Medicine Dr. Santhanam	1950 Brunswick Ave Lawrenceville, NJ 08648 Mercer County 609-392-6366	*Does not accept Medicaid	Y	Family centered/Patient focused practice	May utilize Access Link transportation
Robert Wood Johnson Family & Internal Medicine	569 Abbington Drive, Suite 4 East Windsor, NJ 08520 Mercer County 609-448-7465	*Does not accept Medicaid	Y		No access to public transportation May be accessible for Access Link
Robert Wood Johnson University Hospital Hamilton	1 Hamilton Health Place Hamilton, NJ 08670 Mercer County 609-586-7900	Medicaid	Y	Hospital based practice Willing to make accommodations for sensory needs	Not easily accessible to public transportation or Access Link

Rutgers Robert Wood Johnson Medical Group Department of Family Medicine and Community Health	Family Medicine at Monument Square 317 George Street New Brunswick, NJ 08901 Middlesex County 732-235-8993 Family Medicine at Monroe 18 Centre Drive Monroe Township, NJ 08831 Middlesex County 609-655-5178	Medicaid	Y	Teaching practice Willing to make accommodations for sensory needs	Accessible to public transportation in New Brunswick Accessible for Access Link or Logisticare in Monroe
Summit Medical Group	Family Medicine Locations: 465 Union Avenue Suite B Bridgewater, NJ 08807 Somerset County 908-864-4820 1 Diamond Hill Road Berkeley Heights, NJ 07922 Union County 908-277-8878 67 Walnut Street Suite 202 Clark, NJ 07061 Union County 732-388-7300 202 Elmer Street Westfield, NJ 07090 Union County 908-228-3675 563 Westfield Avenue Westfield, NJ 07090 Union County 908-232-5858 Internal Medicine Locations:	*Does not accept Medicaid	Y	Accepts all patients regardless of diagnosis Provides care coordination services Willing to make accommodations for sensory needs *Share needs prior visit	Some locations accessible to public transportation and Access Link

	1 Diamond Hill Road Lawrence Pavilion 1st Floor Berkeley Heights, NJ 07922 Union County 908-273-4300 67 Walnut Street Suite 202 Clark, NJ 07061 Union County 732-388-7300 34 Mountain Blvd. Building C 2nd Floor (above the bank) Warren, NJ 07059 Somerset County 908-561-8600 202 Elmer Street Westfield, NJ 07090 Union County 908-228-3675 560 Springfield Avenue Westfield, NJ 07090 Union County 908-228-3600 563 Westfield Avenue Westfield, New Jersey 07090 Union County 908-228-3600				

Primary Care for Patients and Families Transitioning from Pediatric To Adult Care
South Jersey Region
(Including Burlington, Camden, Gloucester, Salem, Cumberland, Cape May, Atlantic counties)

Practice	Contact Information	Insurance Accepted	Accepting New Patients (Y/N)	Special Accommodations	Access to Public Transportation *For assistance contact Access Link (1-800-955-2321) or Logisticare (1-866-527-9933)



Transition Services: Helping Students Move From School to Adult Life

The Arc of New Jersey Family Institute
Advocacy • Empowerment
Resources • Education

What is transition? Transition is the formal process of long range cooperative planning that will assist students with disabilities to successfully move from school into the adult world. Transition planning is a process mandated by the Individuals With Disabilities Education Act (IDEA).

What are transition services? Transition services are activities that prepare students with disabilities to move from school to post-school life. The activities must be based on the student's needs, preferences, and interests, and shall include needed activities in the following areas including:

- Instruction
- Related Services
- Community Experiences
- Employment (Post-Secondary Education)
- Daily Living Skills
- Functional Vocational Evaluation

Community-Based Instruction

Community Based Instruction (CBI) is educational **instruction** in naturally occurring **community** environments providing students "real life experiences". The goal is to provide a variety of hands on learning opportunities at all age levels to help students acquire the needed skills to live in the world today.

When does transition planning begin?

Planning for transition services should begin at 14 and **must** be included in the IEP when the student reaches age 16. States don't require that transition be discussed in the IEP meeting until 14, 15 or 16, but it is permissible and encouraged that transition services be discussed at any age.

***The school district is responsible for providing transition services and there is no provision for a waiver of this requirement.**

Please read: bit.ly/2aL76pN

Type all links exactly as seen including any capital and lowercase letters, and numbers.

Who develops the transition services?

Parents and students are key players in the transition planning process. Both parties can share plans and ideas they have discussed concerning the student's future.

The team should include:

- Students
- Parents
- Teachers
- Guidance counselor
- Transition coordinator
- Vocational counselor
- Job coach
- Employer
- Adult service representative (DDD)
- Anyone who knows the student well (friends, family members)

Read: bit.ly/2avJdBF

What is the transition team's job?

The transition plan must be individualized and be based on the student's strengths, preferences and interests. The plan should include opportunities to develop functional skills for work and community life.
The team must:

- Identify the student's vision for his/her life
- Discuss what the student's strengths and weaknesses are
- Identify age-appropriate, measurable goals
- Establish services designed to build on strengths
- Identify needed accommodations
- Define each transition activity in the IEP and who is responsible for the activity
- Schedule when each activity will begin and end

How can students best prepare?

Quality transition planning is student centered and student driven.
The school should teach the student:

- The purpose and benefits of an IEP
- What an IEP meeting looks like (who is there and why)
- The purpose of transition planning
- The importance of the student's input
- How to describe their own strengths and weaknesses

*One of the most important skills needed by students who have intellectual and developmental disabilities is **Self-Advocacy**. Students need to be responsible for communicating their needs and desires in a straightforward manner to the transition team.

IEP Goals for Self-Advocacy and Transition

Self-Advocacy:

Student will identify by name his/her disability

Student will conduct research on his/her disability and be able to explain it

Student will respond with personal information such as name, address, parent's and primary doctor's names and contact information

Student will schedule doctor/therapy appointments independently

Student will advocate for sensory accommodations while out within the community

Student will know who and how to contact in case of emergency

Student will name, identify by sight, and know proper dosages of medications taken

Student will order refill for medication from pharmacy

Transition:

Student will participate in testing to determine vocational matches

Student will complete necessary skills to prepare him/her to transition to competitive or supported employment

Student will acquire the skills to successfully transition to a two-year or four-year college/university

Student will acquire the necessary daily living skills to allow for independent functioning in a variety of environments (home, vocational and community)

IEP: Parent Input Form

This sheet was created to help parents be at ease and able to participate as a team member during their child's IEP meeting. By having your thoughts, ideas, questions, and concerns organized and in one place you can effectively advocate for your child's needs.

Input regarding academic performance/needs for (Math, Reading, Science)

Input regarding language and communication

Input regarding social interactions and relationships

Input regarding behavioral concerns

Input regarding daily living skills

Input regarding medical issues

Input regarding community skills

Input regarding vocational programming

Input regarding “life after school”

Other Concerns/issues/thoughts

The New Jersey Department of Education
Office of Special Education Programs

Sample Activities/Strategies for Statements of Transition Services

The term "transition services" means a coordinated set of activities for a child with a disability that—
(A) is designed to be within a results-oriented process, that is focused on improving the academic and functional achievement of the child with a disability to facilitate the child's movement from school to post-school activities, including post-secondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation; (B) is based on the individual child's needs, taking into account the child's strengths, preferences, and interests; and (C) includes instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and, when appropriate, acquisition of daily living skills and functional vocational evaluation. 20 U.S.C. §1401(34)

"Beginning at Age 14" Transition Statement

Beginning with the IEP in place for the school year when the student will turn age **14**, or younger if determined appropriate by the IEP team, one of the components that must be included in the IEP are **strategies and/or activities** that are consistent with the student's strengths, interests, and preferences, and are intended to assist the student in developing or attaining postsecondary goals. The following pages of this document contain examples of activities/strategies that can be used to assist students who are unsure of their future plans to further identify and clarify their preferences and interests for the development of postsecondary goals. These sample activities /strategies are identified by an asterisk (*).

Another component of the IEP that must be included in the "beginning at age 14" transition statement is a statement of any needed interagency linkages and responsibilities. Sample interagency linkages are included at the end of this document.

Beginning with the IEP in place for the school year when the student will turn age 14, or younger if determined appropriate by the IEP team, and updated annually: i. A statement of the student's strengths, interests and preferences; ii. Identification of a course of study and ***related strategies and/or activities*** *that: (1) Are consistent with the student's strengths, interests, and preferences; and (2)* ***Are intended to assist the student in developing or attaining postsecondary goals*** *related to training, education, employment and, if appropriate, independent living; …….. iv. As appropriate, a* ***statement of any needed interagency linkages and responsibilities****; N.J.A.C. 6A:14-3.7(e)11i, ii, and iv.*

"Beginning at Age 16" Statement of Transition Services

Beginning with the IEP in place for the school year when the student will turn age **16**, or younger if determined appropriate by the IEP team, the IEP must include a statement of transition services. The statement of transition services includes a multi-year plan of **strategies/activities** that will assist the student to prepare for post-secondary activities such as post-secondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, and community participation. The "beginning at age 16" statement of transition services does not replace the "beginning at age 14" transition statement, but rather builds upon it to form a complete plan for the future.

For each activity/strategy specified in the "beginning at age 16" statement of transition services, IEP teams should specify the expected date of implementation, (i.e. Spring 2016, Fall 2017). The dates of implementation can be from the date of the IEP meeting to any date prior to the student's expected date of high school graduation. The person or agency responsible for arranging, providing and/or implementing each activity/strategy should also be specified, and responsibilities should be shared among IEP meeting participants (student, parent, school staff, etc.).

The following pages contain examples of activities/strategies that can be used to assist students to prepare for their desired post-school goals. The activities/strategies are organized by the seven areas contained in the "age 16" statement of transition services; instruction, related services, community experiences, employment, post-school adult living, daily living skills, and functional vocational evaluation. **Whenever spaces are included in a sample activity, provide information needed to individualize the activity to the needs of the student.**

Sample Transition Activities/Strategies

INSTRUCTION

1. Use the following tools/methods to gather information regarding (the student's) desired post-secondary educational involvement: _____*
2. Visit the following college campuses and meet with student support services: _____*
3. Enroll in career awareness course entitled _____ in the __ grade*
4. Enroll in adult living course entitled _____in the __ grade*
5. Tour post-school occupational training programs*
6. Obtain, complete, and submit applications to the following colleges: _____
7. Obtain, complete, and submit applications for tuition assistance
8. Learn about Section 504 of the Rehabilitation Act
9. Explore admission requirements for enrollment at Vocational/Technical School
10. Learn about the process for accessing apartments for rent
11. Obtain information on continuing and adult education opportunities
12. Learn about the Americans with Disabilities Act by attending a workshop at _____
13. Learn about students' rights under IDEA and N.J.A.C. 6A:14
14. Enroll in Self-Advocacy/Self-Awareness Studies in the __ grade
15. Enroll in Internship/Apprenticeship program in the __ grade
16. Participate in the following extra curricular activities: _____
17. Enroll in the following Adult/Continuing Education courses:_____
18. Enroll in the following Community College Courses: _____
19. Enroll in “parenting” classes in the __ grade
20. Learn about time management strategies
21. Enroll in SAT prep course in the __ grade
22. Learn about community agencies that provide services and support to people with disabilities by _____
23.
24.

RELATED SERVICES

1. Use existing information and gather new information to determine if (the student) is likely to need transportation assistance, a type of therapy, or other related service after graduating high school*
2. Obtain a driving evaluation from _____
3. Explore county transportation options on the web at: http://www.njtransit.com/tm/tm_servlet.srv?hdnPageAction=ParaTransitTo
4. Obtain information about NJ Transit's programs for people with disabilities on the web at http://www.njtransit.com/tm/tm_servlet.srv?hdnPageAction=AccessibleServicesTo
5. Obtain sources of support for coping with difficult life situations by contacting _____
6. Visit the community mental health agency _____ located at _____
7. Identify potential post-school providers of recreation therapy
8. Identify potential post-school providers of occupational therapy and potential funding sources
9. Visit potential post-school providers of physical therapy
10. Learn about potential post-school providers of speech therapy
11. (If student is receiving SSI) Write a Plan for Achieving Self-Support (PASS) and submit to SSA to set aside income and/or resources for transportation to and from a job
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COMMUNITY EXPERIENCES

1. Use the following tools/methods to collect information regarding (the student)'s desired post-secondary community involvement:_____*
2. Investigate participation in social/recreation events sponsored by _____ *
3. Learn about and visit potential places in the community to shop for food, clothes, etc.*
4. Investigate participation on the community sports team for _____*
5. Tour apartments for rent*
6. Investigate participation in community civic organization (Lions Club, Rotary, etc.)*
7. Investigate opportunities for socialization training in the community
8. Visit and investigate the youth volunteer program at the library
9. Visit and learn about youth volunteer program at the hospital
10. Visit the community theater group to learn about participating
11. Visit and learn about the community symphonic organization
12. Investigate participation in the community arts council
13. Visit and learn about the community horticultural club
14. Visit and learn about the community historical preservation society
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EMPLOYMENT

1. Use the following tools/methods to collect information regarding (the student)'s desired employment and career interests for adult life beyond college and/or post-secondary vocational training: _____ *
2. Participate in the high school career fair to learn about careers*
3. Participate in career awareness program in the __ grade*
4. Enroll in the CTE program for _____
5. Enroll in the CTE Program of Study for _____
6. Enroll in the entry-level career program for _____
7. Enroll in the community-based career exploration program in the __ grade*
8. Work towards obtaining a license to become a _____
9. Explore possible summer employment through the county One-Stop Career Center located at: _____
10. Meet with the following Supported Employment agencies to evaluate their services: _____
11. Obtain a part-time job (volunteer or paid) in a career field of interest through participation in a Structured Learning Experience
12. Learn about the County One-Stop Career Center http://careerconnections.nj.gov/careerconnections/plan/support/njccsites/one_stop_career_centers.shtml
13. Enroll in the youth apprenticeship program for _____
14. (If student is receiving SSI) Learn about social security work incentives at www.ssa.gov/redbook/index.html
15. (If student is receiving SSI) Learn about and write a Plan for Achieving Self-Support (PASS) and submit to Social Security to set aside income and/or resources for a job coach and/or for starting a business (www.ssa.gov/online/ssa-545.html)
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POST SCHOOL ADULT LIVING

1. Use the following tools/methods to collect information regarding (the student)'s desired residential life beyond high school and a residential post-secondary educational setting: _____ *
2. Learn about a person centered planning*
3. Join and participate in the following community recreation/health center: _____ *
4. Prepare for tests that are required for obtaining a driver's license
5. Register to vote and learn about the election process
6. Register for the draft and learn about public service obligations/opportunities
7. Obtain assistance to complete tax return from _____
8. Explore insurance issues/needs by meeting with _____
9. Explore guardianship issues and estate planning by attending a presentation sponsored by _____
10. Learn about managing/maintaining/performing simple repairs on a home and obtaining modifications/accommodations
11. Contact the Center for Independent Living for information/training on self-advocacy http://www.njsilc.org/
12. Learn about ways to purchase/lease a car and maintain a vehicle/obtain modifications
13. Open a bank account and manage finances/budget/bills
14. Apply for credit/debit cards and manage personal debt
15. Learn about expectations for eating in restaurants
16. Obtain information on managing personal health
17. Meet with social worker to discuss interpersonal skill development
18. Plan for a vacation/leisure activities
19. Learn about consumer skills/rights and responsibilities
20. Obtain information about financial planning and investing
21. Contact the NJ Commission for the Blind and Visually Impaired to obtain training on independent living
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DAILY LIVING SKILLS

1. Meet with and interview adults with disabilities and their families who are receiving residential supports*
2. Visit and tour a variety of adult housing options with supports*
3. Visit community agencies that provide daily living skills training to adults
4. Obtain a list of agencies that provide residential supports in this county
5. Contact DDD case manager to be placed on the residential services waiting list
6. Develop a network of informal supports (friends, neighbors, etc.)
7. Explore the possible use of technology and adaptive assistance
8. Develop emergency procedures for use at home
9. Manage daily time schedule
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FUNCTIONAL VOCATIONAL EVALUATION

1. Use the following tools/methods to collect functional information regarding (the student)'s vocational interests and abilities: _____*
2. Use existing functional information about (the student) to develop functional assessments*
3. Participate in community-based situational vocational assessment program*
4. Develop a vocational profile based on functional information*
5. Provide opportunities for job sampling in the community in the __ grade*
6. Contact agencies that provide functional vocational assessments in the community*
7. Meet with employers to develop a situational vocational assessment site in the community related to (the student)'s interest in the field of _____*
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Sample Interagency Linkages

1. Contact the NJ Division of Disability Services for information and referral assistance at 1-888-285-3036 or on the web at www.state.nj.us/humanservices/dds
2. Obtain, complete, and submit applications to gain admittance to specialized disability support programs offered by the following colleges or universities: _____
3. Obtain and complete a referral form for the NJ Division of Vocational Rehabilitation Services (DVRS), and submit the completed form to the local DVRS office located at _____
4. After submitting the referral form, follow up with the local DVRS office to schedule an intake appointment for (the student) to meet with a DVRS counselor to complete the written application for services
5. After (the student) has been determined eligible for DVRS services and is ready to consider specific services to be provided upon graduation, schedule an appointment for (the student) to meet with a DVRS counselor to develop an Individualized Plan for Employment (IPE)
6. Contact the Center for Independent Living (CIL) to establish eligibility and develop an independent living plan. The phone number is _____
   (Call 732-571-3703 or visit www.njsilc.org to locate the nearest CIL)
7. Obtain, complete, and submit an application for eligibility with New Jersey Transit Access Link Program 1-800-955-2321 or on the web at: http://www.njtransit.com/tm/tm_servlet.srv?hdnPageAction=AccessLinkTo
8. Obtain, complete, and submit an application for eligibility with the County Paratransit System. The phone number is _____ To determine area provider, visit http://www.njtransit.com/tm/tm_servlet.srv?hdnPageAction=ParaTransitTo
9. Access behavioral health or developmental disability services from the Children's System of Care by calling 1-877-652-7624 or visiting http://www.nj.gov/dcf/families/csc/index.html
10. Obtain, complete, and submit an application for eligibility with the New Jersey Division of Developmental Disabilities (DDD). The phone number is _____
    (To determine area provider, call 1-800-832-9173 or visit http://www.state.nj.us/humanservices/ddd/staff/cso/index.html
11. Apply for Supplemental Security Income (SSI) from the Social Security Administration. To learn more about applying for benefits for children under 18 years old, visit www.socialsecurity.gov/applyfordisability/child.htm
12. Contact the NJ Commission for the Blind and Visually Impaired to obtain complete, and submit an application for eligibility. The phone number is 973-648-3333. (Visit www.state.nj.us/humanservices/cbvi for more information)

Measurable Postsecondary Goals

Beginning with the IEP in place for the school year when the student will turn age 16, or younger if deemed appropriate by the IEP team, [the IEP shall include] a statement consisting of ……**appropriate measurable postsecondary goals** based upon age-appropriate transition assessments related to training, education, employment and, if appropriate, independent living…..

N.J.A.C. 6A:14-3.7(e)12

Postsecondary goals are "generally understood to refer to those goals that a child hopes to achieve after leaving secondary school (i.e., high school)" (IDEA 2004 Part B Regulations, §300.320(b), discussion of Final Rule p. 46,668)

Postsecondary goals in the areas of training, education, employment, and independent living are based upon the results of age-appropriate transition assessments.

Examples

Training

After graduating high school, _____ will enroll in a driver training program.

_____ is planning on enrolling in a part time emergency medical technician training program after graduating high school.

After graduating high school, _____ is planning to pursue a 3-month training course for computer repair.

After graduating high school, _____ plans to attend Job Corps to receive training in the construction trades.

After completing the district's 18 to 21 year old program, _____ will attend a DDD-funded special needs program to receive training on daily living skills and social/community integration skills.

After high school, _____ will receive on-the-job training from coworkers and job coaches as a supported employee.

Education

After graduating high school, _____ will enroll full time in _____Technical Institute to prepare for a career as an electronic systems technician.

After graduating high school, _____ will enroll in _____ University to prepare for the health sciences field.

After high school, _____ will attend the Career and Community Studies Program at the College of New Jersey.

_____ is planning on enrolling full time at the county community college to obtain an associate's degree in the horticulture field.

Employment

_____ will obtain a full time job in retail fashion sales after graduating high school.

_____ is planning to obtain a part time job as a clerical assistant in an office setting after graduating high school.

After graduating high school, _____ will work part time in the campus cafeteria while attending college.

_____ is planning to pursue a full time job in retail fashion sales after graduating high school.

After graduating high school, _____ will seek to work part time as a volunteer at the community hospital while pursuing classes to prepare for a career in the medical field.

After graduating high school, _____ will obtain part time work in supported employment.

Independent Living

_____ is planning to pursue obtaining a drivers license after graduating high school.

After high school, _____ will live in a college dorm at _____ College or share an off-campus apartment with friends.

After graduating high school, _____ is planning to participate in a community tennis league.

Immediately after graduating high school at age 21, _____ will live in a DDD-funded group home.

The Arc. of New Jersey

Understanding The New Jersey Division of Vocational Rehabilitation Services (DVRS) For People with Developmental Disabilities

What is DVRS	The New Jersey Division of Vocational Rehabilitation Services (DVRS) provides services that enable individuals with disabilities to find jobs or keep their existing jobs. If you or a loved one has a disability that is preventing employment, or is endangering present employment, you can submit a referral for services (*see "Timeline" below for referral links*).
Who is Eligible	Any individual with a physical or mental impairment that wants to be employed at a competitive wage may qualify for individual or vocational rehabilitation services.
What Services Does DVRS Offer People with Developmental Disabilities?	The consumer and DVRS counselor will work together to develop an Individualized Plan for Employment (IPE). The plan may include: Vocational Counseling & Guidance, Job Placement Services, Job Seeking Skills, Supported Employment, Time Limited Placement and Coaching, Job Accommodations, Skills Training, **College Training*, Physical and/or Emotional Restoration (Equipment or therapies which improve physical or cognitive functioning so that a person is able to work), Mobility Equipment, *Driver Training*, or Vehicle and/or Home Modification. For more information visit: bit.ly/njdvrs

Read

- **NJ DVRS Home Page:** bit.ly/njdvrs
- **DVRS Frequently Ask Questions:** bit.ly/dvrsfaq
- **Students With Disabilities:** bit.ly/dvrsstudentswithdisabilities
- **DVRS Myths and Facts:** bit.ly/mythsandfactsdvrs

Client Assistance Program
www.drnj.org/capprogram
609.292.9742
Assists individuals with disabilities in securing and understanding rehabilitation services.

New Jersey Work Incentives Network Support
www.njwins.org
Assists SSI and SSDI beneficiaries to start, continue or increase work efforts while maintaining benefits.

Timeline

14-21: Beginning at age 14, DVRS counselors can provide consultation to transition students, parents/ guardians, and school personnel when deemed appropriate. Some local DVRS school representatives may be able to attend a student's IEP meeting.

18-21: Transition students may apply to DVRS up to two years prior to exiting from school. However, an individual will not receive service until 21 or older.

21+: At any time school personnel, a caregiver or individual can contact DVRS for services.

- **Online Referral Form:** bit.ly/dvrsonlinereferralform
- **Print Referral Form:** bit.ly/printreferralformdvrs

Contact Local DVRS Office: bit.ly/dvrsofficelocations

DVRS Partners

The New Jersey Statewide Independent Living Council (NJ SILC): www.njsilc.org

The Commission for the Blind and Visually Impaired: bit.ly/commissionfortheblind

The Division of the Deaf and Hard of Hearing: bit.ly/2ajesom

Community Rehabilitation Programs: bit.ly/crprograms

One-Stop Career Centers: bit.ly/onestopcareercenters

Centers for Independent Living: bit.ly/centersfoindependentliving

The Division of Developmental Disabilities (DDD): bit.ly/ddd_homepage

Get Connected

As changes take place within the service delivery systems, it is vital for families to stay connected with an organization that can provide the most recent and important information.

The Arc of New Jersey Family Institute keeps you informed, educated and up-to-date on all the latest changes that affect your loved one with an intellectual or developmental disability.

Sign up today for free!

bit.ly/familyinstitutenewslettersignup

*Remember to discuss college options when meeting with the DVRS counselor.

Type all links exactly as seen including any capital or lowercase letters, and numbers.

The New Jersey Division of Vocational Rehabilitation Services (DVRS) works with students with disabilities including those with an IEP (Individualized Education Program), who will need help in planning for, getting and keeping a job.

The goal of DVRS is to make your transition (next steps) from school to work an easy one. DVRS can help you by giving you the services you need to find the right job!

STEPS IN THE DVRS PROCESS

- **1. Referral:** As a student, you may be referred to DVRS up to two years before leaving high school. It is usually a staff person from your school like a teacher or someone on your child study team who will refer you to DVRS, but your parent or another adult can as well. You may also refer yourself.

- **2. Application and Intake Appointment:** After you have been referred to DVRS, the next step will be for you to come to one of the local DVRS offices for an Intake Appointment. This is called a **"Survey Interview."** At this interview you will meet in person with a DVRS counselor. The DVRS counselor will talk to you about DVRS and explain the services that you may need to get the right job and be successful!

- Services: A "service" means the different kinds of help you may need with getting and keeping a job. This will include "vocational counseling and guidance." This is when the DVRS counselor helps you decide what job skills you have, what type of job you want to do, and then helps you find the right job when you graduate.

  Some people working with DVRS may need other kinds of "services" such as having a person called a "job coach" who can come to your workplace to help you learn your job. Services could also mean some kind of training or schooling that will help you learn how to do your job or prepare for your career.

- What to know before coming to the Survey Interview: You may have a parent or another adult that knows you well come with you to this appointment, but may choose to talk with the counselor by yourself at least for part of the appointment time. It is important for you to know that what is talked about in this interview is private and that you (if you are 18 or over) or your parent or guardian will need to give written permission to the DVRS counselor to share your information with others, including your school.

    - The DVRS counselor may also request that you bring personal information with you to the Survey Interview such as your Social Security Card, your student ID, paperwork from your doctor and school records that may have not already been sent to DVRS.

    - During this interview you will be asked questions about yourself. Examples of questions that the DVRS counselor may ask you can be found in the next section called the "SURVEY INTERVIEW GUIDE." You may also be asked to add to what is listed or may decide that there is more information that you want to share with your counselor.

SURVEY INTERVIEW GUIDE

1. **Personal information**: What is your name, date of birth, Social Security number, phone number and address? With whom do you live? Are you a U.S. Citizen? What language(s) do you speak? In what languages do you read and write and how well?
2. **Disability History**: Who is the name of your doctor(s) or clinic? Are you being treated for any medical or mental health conditions? (This could include special education classifications listed on your IEP.) Do you take any medications? (If you answered yes, do you know the name of your medicine(s) and how it helps you?)
3. **Education:** What grade have you completed? Do you have an IEP or a 504 plan? If Yes, what services do you receive at school and why? (This could mean things like getting extra time when you take a test, or having a tutor who gives you extra help with your school work.) Do you have any difficulties with your classes? If yes, which classes? What are your favorite classes and why?
4. **Employment:** Do you have a work history? If so, what types of jobs have you had and when? Do you have any volunteer experience? Do you have a vocational goal? What type of career would you like when you leave school?
5. **Program Expectations**: A) What kind of assistance or services would you like to get from DVRS? B) How do you see your disability as interfering with your ability to work?

    - **Deciding to Apply for Services:** DVRS is a voluntary service. This means that the DVRS counselor will ask you at the end of the Survey interview if you would like to take the next step in working with DVRS. If you do then you will sign the application form. Then, the next step will be for the DVRS counselor to decide if you are eligible to receive DVRS services.

- **3. Eligibility Determination:** Your DVRS counselor will review your school and medical records and with your permission may talk to your school, doctor or other adults in order to figure out if you would be eligible for DVRS. This information is also needed to know what supports and services you will need for a job. If you are eligible for DVRS this means that you will need some type of service to help you with getting and keeping a job. You will get a letter in the mail letting you know if you are eligible and asking you to make an appointment with your DVRS counselor.
- **4. IPE (Individualized Plan for Employment):** Once you have been "determined eligible" for DVRS the next step is to work with your DVRS counselor in developing your IPE. Your IPE includes your vocational goal (the type of work you will be doing) and the services you will receive in order to meet this goal.

- ✓ You and your DVRS counselor will decide together what your vocational goal will be and what services will be provided to you. This is your plan to help you get the job you want. It is also about getting a job that is the best match for your interests, skills and abilities.

- **5. Case Closure:** You will keep working with DVRS until the services you have gotten have ended and you have been employed for at least 90 days. You case is then "closed" with DVRS.
  - ✓ You can always come back and apply to DVRS again if your job situation changes.

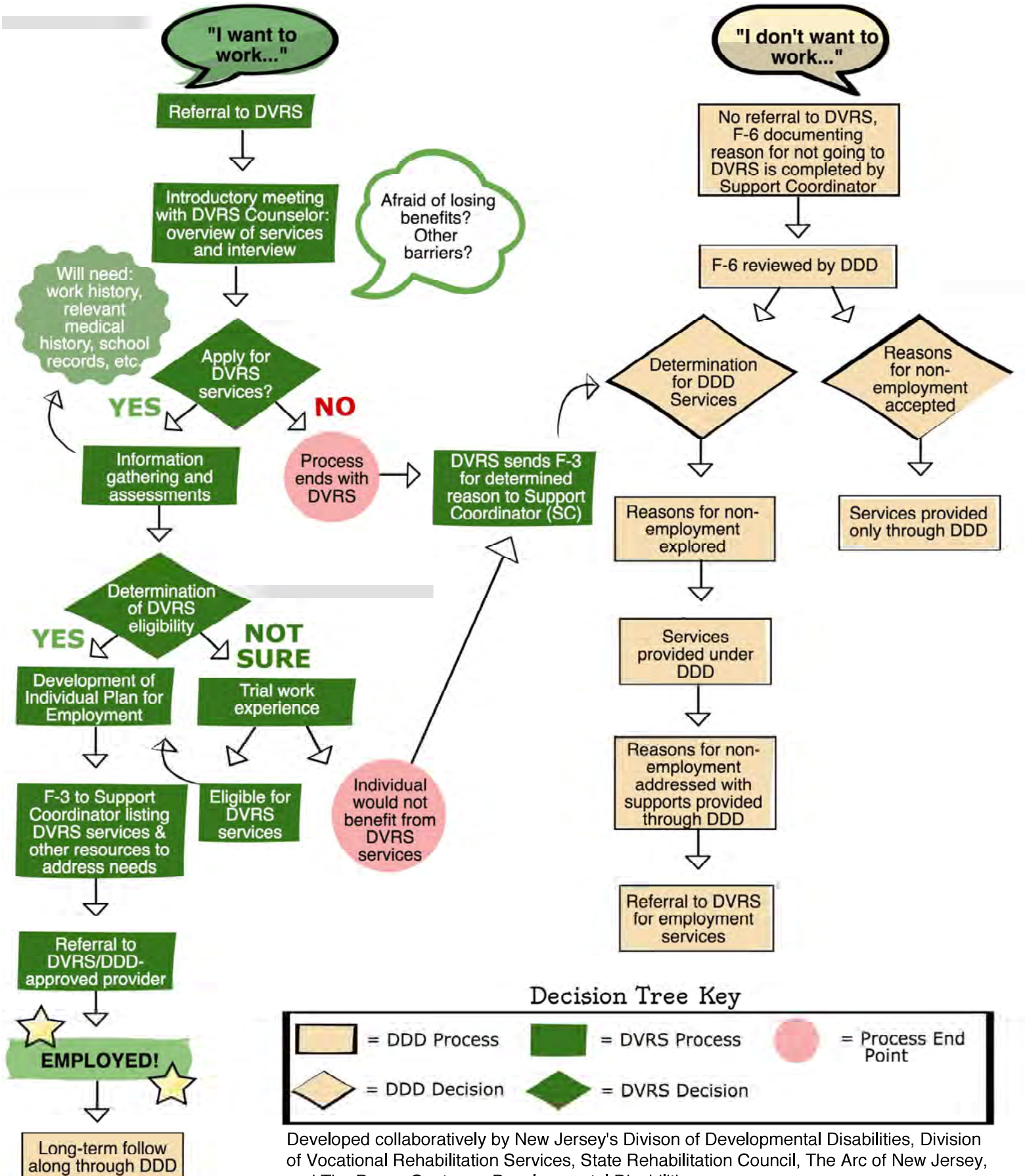
DVRS FIELD OFFICE CONTACT LIST

TRENTON (Central) John Fitch Plaza – 12th Floor P.O. Box 398, 08625-0398 **ALICE HUNNICUTT, Director** 609-292-5987, 609-292-8347/FAX, 292-4033/AH FAX 609-292-2919/TTY, 609-498-6221/VP dvradmin@dol.state.nj.us http://lwd.dol.state.nj.us/labor/dvrsDVRIndex.html	**NEPTUNE** (Monmouth) 60 Taylor Avenue, 07753-4844 **SUSAN RAKOCI-ANDERSON, Manager** **KATHY SPACE, Supervisor** 732-775-1799, 732-775-1666/FAX DVR.Neptune@dol.state.nj.us NJ Transit Contact: Donna Smith/ Cheryl Neal	**THOROFARE** (Gloucester) Gloucester Regional Service Ctr. 215 Crown Point Rd., Suite 200, 08086-2153 **STACEY SMITH, Manager** **VITO PALO, Supervisor** 856-384-3730, 856-384-3777/FAX DVR.Thorofare@dol.state.nj.us NJ Transit Contact: Teresa Baus
BRIDGETON (Cumberland, Salem) 40 E. Broad Street, Suite 204, 08302-2881 **KEANE ZIMMERMAN, Manager** **MARVA FERGUSON, Supervisor** 856-453-3888, 856-453-3909/FAX 856-497-0075/VP DVR.Bridgeton@dol.state.nj.us NJ Transit Contact: Nicole LaTourette	**NEW BRUNSWICK** (Middlesex) 550 Jersey Avenue, P.O. Box 2672, 08901 **JANICE FISHBEIN, Manager** **VACANT, Supervisor** 732-937-6300, 732-937-6358/FAX 732-393-8056/VP DVR.NewBrunswick@dol.state.nj.us NJ Transit Contact: Richard Rodd	**TOMS RIVER** (Ocean) 1027 Hooper Ave., Bldg. 6, 3rd Floor Suite 1, 08753-2225 **CHERYL DEGRAFF-SHANKLE, Manager** **TADD MAFFUCCI, Supervisor** 732-505-2310, 732-505-2317/FAX DVR.TomsRiver@dol.state.nj.us NJ Transit Contact: Patrick Murphy
CAMDEN (Camden) 2600 Mt. Ephraim Ave., Suite 103 08104-3290 **JEFFERY DEITZ, Manager** **JENNIFER VENEZIANI, Supervisor** **JEFFREY CLARK, Supervisor** 856-614-2500, 856-614-2538/FAX 856-831-7599/VP DVR.Camden@dol.state.nj.us NJ Transit Contact: Charlotte Bagley	**NEWARK** (Essex) 990 Broad Street, 2nd Floor, 07101 **ELIZABETH A. DAVIS, Manager** **CARREL COREUS, Supervisor** **WILLIAM SCHULZ, Supervisor** 973-648-3494, 973-648-3902/FAX 862-772-7166/VP DVR.Newark@dol.state.nj.us NJ Transit Contact: Carol Tucker	**TRENTON** (Mercer) Labor Station Plaza, P.O. Box 959 28 Yard Avenue, 08625-0959 **HAIRONG (HELEN) LIU, Manager** **CHERI THOMPSON, Supervisor** 609-292-2940, 609-984-3553/FAX 609-498-7011/TTY & VP DVR.Trenton@dol.state.nj.us NJ Transit Contact: Miledy Diaz
ELIZABETH (Union) 921 Elizabeth Ave., 3rd Floor 07201 **MYRNA PINCKNEY, Manager** **PAT WILLIAMS, Supervisor** 908-965-3940, 908-965-2976/FAX 908-965-3995/VP DVR.Elizabeth@dol.state.nj.us NJ Transit Contact: Carol Serrano/Vanessa Harris	**PATERSON** (Passaic) 200 Memorial Drive, 1st Floor, 07505 **ROSEMARY PETRIZZO, Manager** **DEBRALU HAGERMAN, Supervisor** 973-742-9226/Option 3 or 973-340-3400, 973-279-5895/FAX 973-968-6556/VP DVR.Paterson@dol.state.nj.us NJ Transit Contact: Karen Brown	**WESTAMPTON** (Burlington) 795 Woodlane Road, Suite 201 08060 **STACEY SMITH, Manager** **FERNE ALLEN, Supervisor** 609-518-3948, 609-518-3956/FAX DVR.Westampton@dol.state.nj.us NJ Transit Contact: Claudia Rivera
HACKENSACK (Bergen) 60 State Street, 2nd Floor, 07601-5471 **VACANT, Manager** **MAXINE BECKER, Supervisor** 201-996-8970, 201-996-8880/FAX DVR.Hackensack@dol.state.nj.us NJ Transit Contact: Donalette Miller	**PLEASANTVILLE** (Atlantic) 2 South Main St., 1st Fl. Suite 2, 08232 **CANDACE TITANSKI, Manager** **J. MICHAEL MARGRAF, Supervisor** 609-813-3933, 609-813-3959/FAX 608-813-3958/TTY, 609-241-7064/VP DVR.Pleasantville@dol.state.nj.us NJ Transit Contact: Leslie Heyer	**WILDWOOD** (Cape May) 3810 New Jersey Avenue, 08260 **CANDACE TITANSKI, Manager** **VACANT, Supervisor** 609-523-0330, 609-523-0212/FAX 609-224-1218/VP DVR.Wildwood@dol.state.nj.us NJ Transit Contact: Karen Sandora
HACKETTSTOWN (Sussex, Warren) 223 Stiger Street, Suite A, 07840-1217 **ANTONEY SMITH, Manager** **SCOTT MCGILL, Supervisor** 908-852-4110, 908-813-9745/FAX DVR.Hackettstown@dol.state.nj.us	**RANDOLPH** (Morris) 13 Emery Avenue, 2nd Floor, 07869 **ANTONEY SMITH, Manager** **JOAN WLAZLOWSKI, Supervisor** 862-397-5600 (3), 973-895-6420/FAX 862-242-5412/VP DVR.Randolph@dol.state.nj.us NJ Transit Contact: Beverly Halgren	
JERSEY CITY (Hudson) 438 Summit Avenue, 6th Floor, 07306-3187 **ANAND SUMAITHANGI, Manager** **JORGE DELGADO, Supervisor** 201-217-7180, 201-217-7287/FAX 201-942-0085/VP DVR.JerseyCity@dol.state.nj.us NJ Transit Contact: Madeline Ribarte	**SOMERVILLE** (Somerset, Hunterdon) 75 Veterans Memorial Dr., Suite 101 08876-2952 **JANICE FISHBEIN, Manager** **ELIZABETH CONTE, Supervisor** 908-704-3030, 908-704-3476/FAX 866-954-1190/VP DVR.Somerville@dol.state.nj.us NJ Transit Contact: Danielle Kwan	

REV. 5/15

Employment Decision Tree for DDD-Eligible Individuals

This decision tree displays the path to employment services for individuals that are eligible for DDD. If determined eligible for DDD services, supports can be provided by DDD throughout the employment decision process.



Developed collaboratively by New Jersey's Divison of Developmental Disabilities, Division of Vocational Rehabilitation Services, State Rehabilitation Council, The Arc of New Jersey, and The Boggs Center on Developmental Disabilities.

The Arc of New Jersey

Achieve with us.

Robert Hage, President
Thomas Baffuto, Executive Director
985 Livingston Avenue
North Brunswick, NJ 08902
T 732.246.2525
F 732.214.1834
www.arcnj.org

Accessing DDD services that were previously provided through the DCF Children's System of Care (CSOC) when an individual turns 21

Background information

Once an individual with an intellectual and developmental disability (I/DD) reaches his or her 21st birthday, services (such as respite, summer camp, behavioral supports) previously provided by the New Jersey Department of Children and Families' Children's System of Care (CSOC) and coordinated through PerformCare are no longer available through this avenue.

How do I access services that had been provided through PerformCare, when my child turns 21?

A 21-year-old individual with an intellectual and/or developmental disability who meets the following criteria can request to continue certain services (e.g., respite, summer camp, behavioral supports) from the New Jersey Division of Developmental Disabilities (DDD) prior to leaving school:

- ✓ Individual has turned 21 years old
- ✓ Individual is still receiving special education and related services through his/her local school district
- ✓ Individual has been determined eligible for services by DDD which includes completion of the mandatory NJ CAT assessment and Medicaid eligibility*)

Below are the steps to follow when requesting access to certain services from DDD **at age 21 and before leaving school**. Be prepared to access all available services from DDD **at age 21 and after leaving school**.

1. At age 18 (or older), apply for Supplemental Security Income (SSI). An individual who is enrolled on SSI is automatically Medicaid eligible, which is a requirement for DDD eligibility.*
2. Also at age 18 (or older), contact your DDD Community Services Office to complete the DDD Intake Application process, including completion of the mandatory NJ CAT assessment.
3. Stay in contact with your **DDD Intake Worker** to be sure the intake process is proceeding smoothly.
4. Two months before the individual's 21st birthday, contact your DDD Intake Worker to discuss any **specific services needed when the individual turns 21**. The DDD Intake Worker will complete a request for certain available services.

   * **Please Note**: Employment/Day services cannot be provided by DDD while the individual is receiving special education and related services through the local school district.

5. Request confirmation from the DDD Intake Worker that the service(s) requested is available and will begin on a specific date.
6. In spring of the year the individual will graduate from special education services, contact DDD to complete the final transition steps for service planning. See the 2016 Graduates Timeline for details:

   http://www.nj.gov/humanservices/ddd/documents/2016_graduates_aging_out_of_school_system.pdf

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*A small number of school-age individuals with intellectual and developmental disabilities may not be eligible to receive SSI or Medicaid because a parent retired from employment, became disabled, or died before the individual's 18th birthday. There is a special process for these situations. For more information, contact The Arc of New Jersey at 732-246-2567.

Understanding the Division of Developmental Disabilities Eligibility Process (21 years or older)

What is the Division of Developmental Disabilities?
The Division of Developmental Disabilities (DDD), within the Department of Human Services, is the New Jersey state agency that can provide supports and services to individuals 21 years of age or older with an intellectual or developmental disability (I/DD). In order to receive services an individual must file an application with the Division. **You can obtain an application by contacting your regional DDD office (see reverse side) or by downloading the application from DDD's website at bit.ly/applyfordddservices.**

What is DDD looking for when making a determination of eligibility decision?

1. Does the individual have a **documented intellectual or developmental disability (I/DD)**?
2. Does the individual **meet the Functional Criteria**?
3. Does the individual **meet the Medicaid Eligibility requirement**?

Initial Application

You must provide DDD with all requested documentation listed in the application packet along with the application, before DDD will review the application. Below are some examples of required documents.

Documentation of an intellectual or developmental disability (I/DD)

- ❑ Psychological Evaluation
- ❑ Neurological Evaluations
- ❑ Individual Education Plan (IEP)

Legal documentation of age and citizenship

- ❑ Birth Certificate
- ❑ Social Security Card or Green Card

Functional Criteria

After a completed application is reviewed, the Division determines if the individual meets the functional criteria (bit.ly/dddeligibility). This is done through a questionnaire called the NJ Comprehensive Assessment Tool, also referred to as the NJ CAT (bit.ly/dddnjcat).

The NJ CAT assesses a person's strengths and weaknesses. It identifies areas in which a person will need support and assistance. It is important to give a clear and accurate picture of the person with the disability.

Note: The assessment is usually completed online. A letter with a link to the assessment will be mailed by the New Jersey Institute of Technology (NJIT), *not DDD*. If the individual does not have computer access, the assessment can be conducted over the phone.

****Type all links exactly as seen including any capital and lowercase letter, or numbers.****

Medicaid Eligibility

An individual applying for DDD services must become Medicaid eligible*. The process to apply for Medicaid may take some time and should start as soon as possible. If an individual receives health insurance through a family member they can remain on that insurance, but must still become Medicaid eligible. There are several ways to become Medicaid eligible.

- The best way to have Medicaid is to apply for Supplemental Security Income (SSI) starting at 18. A person automatically receives Medicaid if found eligible for SSI (bit.ly/understandingssdiandssi).
- Apply for NJ Workability (bit.ly/ddsNJWorkAbility).
- Apply through your local County Board of Social Services (bit.ly/countysocialservices)

*There is an exception to the Medicaid Eligibility requirement for a very small group of people. Visit bit.ly/whatisadac for further information.

Note: DDD established a Medicaid Help Desk on its website (bit.ly/dddmedicaid). Contact the help desk at DDD.MediElighelpdesk@dhs.state.nj.us or call your DDD Regional Community Services Office (see below).

Determination

Once DDD reviews all materials the individual (or guardian) will receive a letter in the mail with DDD's decision.

Note: You can appeal any decision by DDD if you believe it to be incorrect. The determination letter you receive will explain how to file an appeal or you can refer to Division Circular #37 (bit.ly/dddappealsprocess).

DDD's Regional Community Services Offices

Flanders Office: Morris, Sussex, Warren
(973) 927-2600

Paterson Office: **Bergen, Hudson, Passaic**
(973) 977-4004

Newark Office: Essex
(973) 693-5080

Plainfield Office: Union, Somerset
(908) 226-7800

Freehold Office: Ocean, Monmouth
(732) 863-4500

Trenton Office: Hunterdon, Mercer, Middlesex
(609) 292-1922

Mays Landing Office: Atlantic, Cape May, Cumberland, Salem
(609) 476-5200

Voorhees Office: Burlington, Camden, Gloucester
(856) 770-5900

****Type all links exactly as seen including any capital and lowercase letter, or numbers.****

Comprendiendo el Proceso de Elegibilidad para la División de Discapacidades del Desarrollo (mayores de 21 años)

¿Qué es la División de Discapacidades del Desarrollo?
La División de discapacidades del Desarrollo (DDD, por sus siglas en Ingles) es una agencia del estado de Nueva Jersey, la cual provee servicios de apoyo a individuos mayores de 21 años, los cuales tienen discapacidades intelectuales o de desarrollo (I/DD, por sus siglas en Ingles). Para poder recibir estos servicios usted debe llenar una aplicación con la División. Dicha aplicación se puede obtener contactando su oficina regional de DDD (vea el lado reverso) o cargándola de la página web de DDD, la cual es: bit.ly/applyfordddservices.

¿Qué es lo que DDD está buscando al determinar una decisión de elegibilidad?

1. ¿Tiene el individuo discapacidad intelectual o de desarrollo documentada **(I/DD por sus siglas en Ingles)**?
2. ¿El individuo cumple con **los criterios de funcionalidad**?
3. ¿El individuo **cumple con los requisitos de elegibilidad de Medicaid?**

Aplicación Inicial

Usted debe entregar a DDD todos los documentos solicitados junto con la aplicación. A continuación encontrara ejemplos de los documentos requeridos. Refiérase a la aplicación original para que reciba mayor información sobre los documentos a entregar. DDD *no revisara* una aplicación hasta que todos los documentos sean recibidos.

Documentación de discapacidad intelectual o de desarrollo (I/DD)

- ❑ Evaluación Psicológica (Resultados del coeficiente de inteligencia, IQ por sus siglas en Ingles)
- ❑ Plan de Educación Individualizada (IEP por sus siglas en Ingles)

Documentos legales sobre la edad y ciudanía

- ❑ Certificado de nacimiento
- ❑ Tarjeta de seguro social o Tarjeta Verde

Criterios de Funcionalidad

Después que la aplicación ha sido analizada, el próximo paso es determinar si el individuo cumple con los criterios de funcionalidad (bit.ly/dddeligibility). Esto se realiza a través de un cuestionario conocido como Herramienta de Evaluación Integral de Nueva Jersey (NJ CAT por sus siglas en Ingles) bit.ly/dddnjcat.

El NJ CAT evalúa las fortalezas y debilidades del individuo e identifica las áreas en las cuales va a necesitar apoyo y servicio. *Es importante que se presente una imagen clara y precisa del individuo con la discapacidad*.

Nota: Usualmente este proceso es completado en línea. Una carta con un enlace a la evaluación será enviada por correo al individuo y esta es proporcionada por el Instituto de Tecnología de New Jersey (NJIT, por sus siglas en Ingles), *no por DDD*. Si el individuo no tiene acceso a una computadora, la evaluación se puede realizar por teléfono. Un representante de NJIT se pondrá en contacto con el individuo para que complete la evaluación.

*****Escriba los enlaces exactamente como aparecen incluyendo letras mayúsculas, minúsculas o números. *****

Elegibilidad de Medicaid

Es un requisito ser elegible para Medicaid si desea aplicar para DDD. El proceso de aplicación para Medicaid puede tomar tiempo y debe realizarse tan pronto sea posible. Si el individuo tiene seguro médico a través de un miembro de la familia, puede continuar en el seguro, pero debe de ser elegible para Medicaid. Existen muchas formas para ser elegible para Medicaid. Las tres más comunes son:

- La forma más fácil de obtener Medicaid es aplicando al Seguro Complementario (SSI por sus siglas en ingles). Esto se debe realizar una vez el individuo cumpla 18 años. Se es automáticamente elegigle para Medicaid, si la persona es elegible para SSI. (bit.ly/understandingssdiandssi).
- Aplique para NJ Workability (en Ingles) ((bit.ly/ddsNJWorkAbility)
- Aplique través de la oficina local de la junta de Servicios Sociales de su condado. (bit.ly/countysocialservices)

✶ Existe una excepción a los criterios de Elegibilidad de Medicaid para un pequeño grupo. Para mayor información visite la página web: http://bit.ly/whatisadac

Nota: DDD estableció una línea de ayuda para Medicaid en su página de web: (bit.ly/dddmedicaid) Usted también puede contactarlos por medio de correo electrónico: DDD.MediElighelpdesk@dhs.state.nj.us.

Determinación

Una vez DDD haya revisado toda la información, el individuo o tutor recibirá una carta por correo con la decisión de DDD.

Nota: Usted puede apelar si está en desacuerdo con la decisión tomada por DDD. La Carta de Determinación que usted reciba le explicara los pasos a seguir para apelar la decisión, o se puede referir al Circular # 37 de la División: (bit.ly/dddappealsprocess).

Oficina en Flanders: Morris, Sussex, Warren
(973) 927-2600

Oficina en Paterson: Bergen, Hudson, Passaic
(973) 977-4004

Oficina en Newark: Essex
(973) 693-5080

Oficina en Plainfield: Union, Somerset

(908) 226-7800

Oficina en Freehold: Ocean, Monmouth
(732) 863-4500

Oficina en Trenton: Hunterdon, Mercer, Middlesex
(609) 292-1922

Oficina en Mays Landing: Atlantic, Cape May, Cumberland, Salem
(609) 476-5200

Oficina en Voorhees: Burlington, Camden, Gloucester
(856) 770-5900

*****Escriba los enlaces exactamente como aparecen incluyendo letras mayúsculas, minúsculas o números. *****

The New Jersey Comprehensive Assessment tool (NJ CAT): A Guide for Caregivers

For individuals seeking support from the Division of Developmental Disabilities

The Arc of New Jersey Family Institute
Advocacy • Empowerment
Resources • Education

What is the NJ CAT?

The New Jersey Comprehensive Assessment Tool (NJ CAT) is 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. The NJ CAT assesses an individual's support needs in three main areas: Self-care, Behavioral and Medical. The NJ CAT ensures that all individuals seeking Division-funded services have their support needs assessed through a single, standardized format.

The Developmental Disabilities Planning Institute (DDPI) of Rutgers University conducts the NJ CAT assessment on behalf of DDD. It is completed in **only** one of two ways:

1. Online via a password protected link that is sent from DDIP to the person completing the assessment
2. Over the telephone with a representative from DDPI

The NJ CAT cannot be submitted by postal mail or fax.

To ensure that your information is up to date for completion of the NJ CAT, visit bit.ly/ddpiassessment or you can contact DDPI by phone at 732.640.0730.

Assessment Tools (Old)	Assessment Tools (New)
Developmental Disabilities Resource Tool (DDRT)	New Jersey Comprehensive Assessment Tool (NJ CAT)
No Longer Used	The DDRT questions are now part of the NJ CAT

When is the NJ CAT completed?

- **Individuals 18 and older applying for DDD services for the first time.** The NJ CAT is completed as part of the DDD Intake Application Process. (Division-funded services are not available until 21 or older) bit.ly/applyfordddservices
- **Students who are turning 21 and transitioning out of school** can complete the NJ CAT in the fall/winter of their last year of school. (students are entitled to remain in school through 21, and are encouraged to do so as the Division only funds services for individuals who are 21 and older).
- During the DDD's transition to a fee-for-service system, individuals who already receive services must be reassessed through the NJ CAT.

Who Completes the NJ CAT?

- The NJ CAT is completed by the individual, family member or other responsible person. It should be completed by someone who spends a significant amount of time with the individual and is the primary person responsible for assisting with the individual's daily support needs.
- In some cases, the service provider may complete the NJ CAT.

***Important Note:** Once you submit the assessment, you cannot go back and make changes.

****Type all links exactly as seen including any capital and lowercase letters, and numbers.**

Why does the NJ CAT need to be completed?

- In the fee-for-service system, results of the NJ CAT establish the tier into which an individual is assigned. The tier is associated with a corresponding individualized budget.
- All individuals must be assessed by the NJ CAT, even if the person is currently receiving DDD services. A person cannot be placed in DDD's Supports Program unless the NJ CAT is completed.
- If you wish to receive the individual's tier assignment and corresponding budget information from DDD, you **must** complete the Tier Assignment Request Form. bit.ly/dddrequesttier

Resources

NJ CAT Sample Assessment Tool:
bit.ly/dddnjcatsample

Webinar: Completing the NJ CAT:
bit.ly/dddnjcatwebinar

DDD NJ CAT FAQ:
bit.ly/dddnjcat

DDD Fee for Service Help Desk– For questions contact:
DDD.FeeForService@dhs.state.nj.us

The Arc of New Jersey Family Institute – If needed, Family Institute staff can provide support to a family who may need help completing the NJCAT.
732.246.2525 x38 or 24
thefamilyinstitute@arcnj.org
www.thearcfamilyinstitute.org

Preparing for the New Jersey Comprehensive Assessment Tool (NJ CAT)

- ☐ Make sure you are **Medicaid eligible**.
  - DDD's fact sheet on Supplemental Security Income (SSI): bit.ly/dddssifactsheet
  - DDD's webpage on Medicaid eligibility: bit.ly/dddmedicaid
  - For more information on Medicaid eligibility visit: www.mainstreamingmedicalcare.org
- ☐ Call your local county DDD intake office or click the link below to **request or print the intake package (DDD eligibility application)**. bit.ly/applyfordddservices
- ☐ After submitting the intake package to DDD and the individual has been assigned a DDD ID#, contact your local county DDD intake office and **request to complete the NJ CAT.** The NJ CAT can be completed online or the phone.
- ☐ Once you receive the link, **complete the NJ CAT**. View a sample of the NJ CAT here: bit.ly/dddnjcatsample.
- ☐ **Request the individual's tier assignment:** bit.ly/dddrequesttier.
- ☐ An individual may experience changes that result in the need for a NJ CAT reassessment. **To request a reassessment**, contact your local DDD Intake Office. bit.ly/dddcommunityserviceoffices

For more information visit www.thearcfamilyinstitute.org or call 732.246.2525 x38 or x24

****Type all links exactly as seen including any capital and lowercase letters, and numbers.****

WARNING

This site contains protected health information (PHI). In accordance with the Health Insurance Portability and Accountability Act (HIPAA), unauthorized access is forbidden and may result in civil and criminal penalties.

IMPORTANT

Please take your time and consider your answers to the following questions *carefully*. You will be able to use the "previous page" button to return to a question during the survey if you wish to change a response. However, once you have completed this assessment and submitted your responses, *you will be unable to make any further changes*.

State Of New Jersey
Division Of Developmental Disabilities
New Jersey Comprehensive Assessment Tool (NJ CAT)

Conducted by Rutgers University
Developmental Disabilities Planning Institute (DDPI)

Version 1.3 April 27, 2015

DDPI has been asked by the New Jersey Division of Developmental Disabilities (DDD) to obtain information on [name], who is applying for services. Security measures have been taken to safeguard the confidentiality of the information provided.

Instructions for completing the survey:

1. ***The person who knows [name] best* should be the respondent.**
2. **You must answer *ALL* questions on each page in order to proceed to the next page.**
3. **Questions should be answered based on the consumer's status *NOW*, not at some point in the past or future.**
4. **This survey will take approximately 30-40 minutes to complete.**
5. **If you have any questions about how to respond to a question, please contact us *before* submitting the completed survey.**

Thank you for your time and assistance with this important endeavor.

CONSUMER DETAILS

The consumer is the person who is or may receive DDD services.

MIS_D) **MIS/Serial: (pre-populated field)**

CLName_D) **Consumer's First Name: (pre-populated field)**
Consumer's Last Name: (pre-populated field)

This survey is for **[Consumer's First Name (pre-populated field) / Consumer's Last Name (pre-populated field) / DDD ID # (pre-populated field)].** If this is not the correct person, please exit this survey now.

1. Please review the following information and correct any misspellings.

Again, if this is not the correct person, please exit this survey now

Consumer's First Name: (pre-populated field)
Consumer's Last Name: (pre-populated field)

1_Cons) Please provide [firstname lastname]'s current address and date of birth in the boxes below:

1_Cons _1. Permanent Street Address: _____
1_Cons _2. City: _____
1_Cons _3. State: _____
1_Cons _4. Zip Code: _____
1_Cons _5. Date of Birth (*Please use mm/dd/yyyy format*.): _____

[Only ask VerifyDOB if the answer to 1_Cons_5 does not match file data]

VerifyDOB) On the previous page you indicated that [firstname lastname]'s date of birth is *mm/dd/yyyy*. If this is not correct, please enter the correct information below.
_____

RESPONDENT DETAILS

The respondent is the person who is completing this assessment on behalf of the consumer.

1a. Who will be filling out the information in this survey?

1. Respondent on the behalf of the consumer
2. Consumer ➔ ***Go To Question 3b***

1_Resp) Please provide the following information about the respondent:

1_Resp _1. Your First Name: _____
1_Resp _2. Your Last Name: _____
1_Resp _3. Your Phone Number (*Please use xxx-xxx-xxxx format*): _____
1_Resp _4. Your Cell/Alternate Phone Number (*Please use xxx-xxx-xxxx format*): _____
1_Resp _5. Your Email Address (e.g. abcdef@ghij.com): _____
1_Resp _6. Your Street Address: _____
1_Resp _7. Your City: _____
1_Resp _8. Your State: _____
1_Resp _9. Your Zip Code: _____

2. Are you the primary caregiver for [name]? The primary caregiver is the person who is principally responsible for the care and well-being of [name].

(*Note: If you equally share caretaking with a spouse or other person, please answer "Yes."*)

0. No
1. Yes

3a. Does [name] currently live with you?

0. No
1. Yes

3b. What best describes [names]'s current living arrangement?

1. At home alone
2. In a home with family or friend(s)
3. In a group home facility or supervised apartment
4. In a nursing home setting
98. Some other setting (please specify) _____

[Only Ask 4 and 5 if the answer to 1a is "Respondent on the behalf of the consumer"]

4. What is your relationship to [name]?

   1. Mother or father
   2. Grandmother or grandfather
   3. Sister or brother
   4. Son or daughter
   5. Other relative
   6. Friend of the family
   7. Agency or group home staff (Clinical)
   8. Agency or group home staff (Non-clinical)
   98. Other (please specify) _____

5. Respondent's (your) gender:

   1. Male
   2. Female

6. Who is [name]'s guardian for medical and legal decisions at this time?

   1. [name] is his/her own guardian
   2. I am (Please select this option even if you are a co-guardian with someone else)
   3. Another family member
   4. A family friend
   5. BGS (Bureau of Guardianship Services)/State guardianship
   6. Applying for guardianship/Guardianship in process
   7. Someone else/Other (Please specify relationship)_____

7. Who is likely to be [name]'s guardian for medical and legal decisions 5 years from now?

   1. [name] will be his/her own guardian
   2. I will (Please select this option even if you will be a co-guardian with someone else)
   3. Another family member
   4. A family friend
   5. BGS (Bureau of Guardianship Services)/State guardianship
   6. Someone else/Other (Please specify relationship)_____

CONSUMER CHARACTERISTICS

8. How old is [name]?

Please select from the drop down list below.
[Drop down list values = "17 years old or younger" to "97 or older"]

_____

9a. What is [name]'s gender?

1. Male
2. Female

9b. Which of the following best represents [name]'s racial or ethnic heritage?

Please select all that apply.

1. Hispanic, Latino, or Spanish Origin
2. Black or African-American
3. White
4. Asian
5. American Indian or Alaska Native
6. Native Hawaiian or Pacific Islander
98. Some other group (Please specify) _____

9c. Does [name] have a valid drivers license?

0. No ➔ ***Go To Question 10***
1. Yes

9d. Does [name] have access to a motor vehicle and drive himself/herself as a means of regular transportation?

0. No
1. Yes

10) Please tell us whether [name] has any of the following:

		No	Yes
10_1.	Autism spectrum disorder	0	1
10_2.	Cerebral palsy	0	1
10_3.	Spina bifida	0	1
10_4.	Down's syndrome	0	1
10_5.	An intellectual or cognitive disability (formerly known as mental retardation)	0	1
10_6.	Prader-Willi syndrome	0	1
10_7.	Any physical disabilities (including, but not limited to, any physical disability on this list)	0	1
10_8.	A mental health problem with a psychiatric diagnosis (*other than an intellectual or cognitive disability, pervasive developmental disorder, or autism spectrum disorder*)	0	1
10_9.	Traumatic brain injury including acquired non-degenerative brain injury	0	1
10_10.	Epilepsy or a seizure disorder	0	1

[Only Ask 10_1a if the answer to 10_1 is "Yes"]

10_1a. Would you describe [name]'s autism or autism spectrum disorder as mild, moderate, or severe?

1. Mild
2. Moderate
3. Severe

[Only Ask 10_8a if the answer to 10_8 is "Yes"]

10_8a. You indicated that [name] has a mental health problem with a psychiatric diagnosis. Please specify the diagnosis in the space below.

_____

[Only Ask 10_10a and 10_10b if the answer to 10_10 is "Yes"]

10_10a. You indicated that [name] has epilepsy or a seizure disorder. When was the last time that [name] had a seizure?

1. In the last 3 months
2. In the last 4-6 months
3. In the last 7-12 months
4. More than a year ago

10_10b. Does [name] currently require CONSTANT SUPERVISION at all times during waking and/or sleeping hours in order to prevent injury due to an uncontrolled seizure disorder?

0. No
1. Yes

CONSUMER CHARACTERISTICS: SENSORY/MOTOR

11. Does [name] experience any hearing loss that cannot be corrected by hearing aids?

    0. No, hearing is in normal range or normal with aids ➔ ***Go to Question 13***
    1. Yes, has hearing loss

12. Which answer best describes [name]'s hearing in the last month?

    (Note: If [name] uses a corrective device, such as a hearing aid, please select the response that best describes (name's) hearing while using the hearing aid.)

    1. Mild loss: [name] often finds it difficult to hear normal speech
    2. Moderate loss: [name] has to turn up the TV or speak loudly to hear, deaf in one ear, etc.
    3. Severe loss: [name] can hear only if someone is shouting
    4. Profound loss: [name] is deaf

13. Does [name] experience any visual problems that cannot be corrected with glasses or contacts?

    0. No, vision is in normal range with or without correction ➔ ***Go to Question 15***
    1. Yes, has visual impairment that cannot be corrected

14. Which answer best describes [name]'s vision in the last month?

    (Note: If [name] uses a corrective device, such as glasses, which answer best describes [name]'s vision using glasses?)

    1. Mild impairment: [name] is color blind or has trouble seeing small objects
    2. Moderate impairment: [name] sees more than light or shadows, has trouble with depth perception, seeing curbs, or recognizing people by sight, or is blind in one eye, etc.
    3. Severe impairment: [name] sees only light or shadows
    4. Profound impairment: [name] is totally blind

15) Please indicate whether [name] was not able to, needed help with, or independently could do each of the following in the last month:

		Not able	Needed help	Could do Independently
15_1.	Rolling from back to stomach	0	1	2
15_2.	Pulling himself/herself to standing from a sitting position	0	1	2
15_3.	Going up stairs in any house or building (*Note: If uses hand rail on his/her own, please answer "Independently."*)	0	1	2
15_4.	Going down stairs in any house or building (*Note: If uses hand rail on his/her own, please answer "Independently."*)	0	1	2
15_5.	Picking up small objects, such as a Cheerio	0	1	2
15_6.	Transferring an object from hand to hand	0	1	2
15_7.	Crawling, creeping, or scooting, such as getting something from under a bed or chair	0	1	2
15_8.	Sitting without support for at least 5 minutes, such as on a piano bench or stool without a back	0	1	2

16. Does [name] walk independently without difficulty, without using a corrective device, and/or without receiving assistance?

0. No
1. Yes ➔ ***Go to Question 22A***

17. Which best describes [name]'s typical level of walking mobility?

0. Cannot walk by self with a corrective device or with assistance
1. Walks only with assistance from another person
2. Walks independently with a corrective device (e.g., walker, crutches, brace)
3. Walks independently, but with difficulty (no corrective device)

18. Does [name] use a wheelchair or electric scooter?

(Note: If [name] is temporarily using a wheelchair due to a recent injury or acute condition, please answer "No.")

0. No, does not use ➔ ***Go to Question 22A***
1. Yes, uses at all times
2. Yes, uses for long trips or as needed

19) Please indicate which of the following is currently being used by [name].

(Note: *If prescribed, but not used by [name], please answer "No."*)

		No	Yes
19a.	Non-motorized wheelchair	0	1
19b.	Motorized wheelchair	0	1
19c.	Electric scooter	0	1

20. Which best describes [name]'s ability to transfer himself/herself in or out of the wheelchair or scooter?

0. Regularly requires the use of a Hoyer or other lift and/or more than one other person when transferring
1. Needs a lot of physical assistance from one other person when transferring
2. Needs only minimal assistance from one other person when transferring
3. Can transfer independently without assistance

21. Which best describes [name]'s ability to move a wheelchair from place to place?

(*Note: Response categories apply to use of both motorized and non-motorized wheelchairs*.)

0. Has no independent wheelchair mobility – needs someone to push him/her from place to place
1. Can move wheelchair back and forth with hands or feet, but requires pushing to move from place to place for any real distance
2. Can move wheelchair independently from place to place without assistance, but requires pushing for long distances
3. Can move wheelchair independently from place to place without assistance and requires no assistance even for longer trips

CONSUMER CHARACTERISTICS: COGNITIVE ABILITIES

22A) Below are some questions about [name]'s cognitive, or mental, abilities. Please indicate whether [name] has done each of the following <u>in the last month</u>.

22A) Associating Time with Events and Actions

		No	Yes
22A_1.	Remembers events that happened a month or more ago (*Note: Would [name] remember someone he/she hasn't seen in a month or since a special occasion?*)	0	1
22A_2.	Knows daily routine, such as what occurs in the morning, afternoon, and evening	0	1
22A_3.	Associates events with time in past, present, or future, such as knowing the difference between yesterday, today, and tomorrow	0	1

[Only Ask 22A_2a if the answer to 22A_2 is "Yes"]

22A_2a. Associates regular events with a specific hour, such as knowing 6:00 PM is time for dinner

0. No
1. Yes

[Only Ask 22A_3a if the answer to 22A_3 is "Yes"]

22A_3a. Tells time to nearest five minutes, such as knowing the difference between 5 minutes to 6:00 PM and 5 minutes after 6:00 PM, or understands the difference between 5 minutes and 10 minutes from now

0. No
1. Yes

22B) Spatial/Perceptual Abilities

		No	Yes
22B_1.	Knows difference between red, blue, green, and yellow	0	1
22B_2.	Knows difference between big and small	0	1
22B_3.	Knows difference between a circle, square, and triangle	0	1
22B_4.	Finds way around the home by himself/herself (*Note: If mobility issues prevent moving from room to room by himself/herself, but he/she knows where different rooms are located, please answer "Yes."*)	0	1

22C) Number Awareness

		No	Yes
22C_1.	Uses numbers, even if inaccurately (*Note: Please answer "Yes" whether [name] uses numbers accurately or inaccurately.*)	0	1
22C_2.	Counts to 10 without help	0	1

[Only Ask 22C_2a if the answer to 22C_2 is "Yes"]

22C_2a. Does simple addition without use of a calculator or computer

0. No ➔ ***Go to Question 22D_1***
1. Yes

22C_2b. Does simple subtraction without use of a calculator or computer

0. No
1. Yes

22D) Writing Skills (Include Braille or Typing)

		No	Yes
22D_1.	Prints or writes single letters without a model or tracing	0	1

[Only Ask 22D_1a and 22D_1b if the answer to 22D_1 is "Yes"]

22D_1a. Prints or writes own first name without a model or tracing

0. No
1. Yes

22D_1b. Prints or writes single words, other than his/her name, without a model or tracing

0. No
1. Yes

[Only Ask 22D_1ba if the answer to 22D_1b is "Yes"]

22D_1ba. Prints or writes simple sentences without a model or tracing

0. No
1. Yes

22E) Reading and Sign Skills

		No	Yes
22E_1.	Recognizes his/her own first and last name when it is written	0	1
22E_2.	Reads and understands simple words	0	1

[Only Ask 22E_2a if the answer to 22E_2 is "Yes"]

22E_2a. Reads and understands simple sentences

0. No
1. Yes

[Only Ask 22E_2aa if the answer to 22E_2a is "Yes"]

22E_2aa. Reads and understands a simple story

0. No
1. Yes

CONSUMER CHARACTERISTICS: COMMUNICATION

23) Please think about [name]'s ability to communicate. Please indicate whether [name] has done the following <u>in the last month</u>.

23A) Expressive Verbal Communication

		No	Yes
23A_1.	Uses at least a few simple words, signs, or picture symbols	0	1

[Only Ask 23A_1a if the answer to 23A_1 is "Yes"]

23A_1a. Uses 10 or more simple words or signs in his/her entire vocabulary

0. No
1. Yes

[Only Ask 23A_1aa – 23A_1ac if the answer to 23A_1a is "Yes"]

		No	Yes
23A_1aa.	Asks simple questions using words or signs	0	1
23A_1ab.	Uses complete sentences when carrying on a conversation	0	1
23A_1ac.	Tells a simple story, such as about a television show	0	1

23B) Clarity of Speech

		No	Yes
23B_1.	Clearly says "Yes" or "No" to a simple question	0	1
23B_2.	Speech is readily understood by strangers	0	1

[Only Ask 23B_1a if the answer to 23B_1 is "Yes"]

23B_1a. Is English [name]'s primary language?

0. No
1. Yes

[Only Ask 23B_1aa if the answer to 23B_1a is "No"]

23B_1aa. What is [name]'s primary language? (*Please specify in the box below.*)

_____

[Only Ask 23B_2a if the answer to 23B_2 is "No"]

23B_2a. Speech is understood by those who know [name] well

0. No
1. Yes

23C) Receptive Verbal Communication

		No	Yes
23C_1.	Does [name] respond to his/her name when it is spoken or signed?	0	1
23C_2.	Does [name] understand the meaning of "Yes" and "No"?	0	1

[Only Ask 23C_2a if the answer to 23C_2 is "Yes"]

23C_2a. Does [name] understand a one-step direction, such as "Look at me"?

0. No
1. Yes

[Only Ask 23C_2aa and 23C_2ab if the answer to 23C_2a is "Yes"]

23C_2aa. Does [name] understand a two-step direction, such as "Turn your head and look at me"?

0. No
1. Yes

23C_2ab. Does [name] understand a joke or story?

0. No
1. Yes

CONSUMER CHARACTERISTICS: SOCIAL INTERACTION

24. The following questions concern [name]'s ways of acting (or behaving) in different social situations -- with family members and others -- in the last month. Please tell us, based on your own knowledge, about [name]'s behavior in the following situations.

24a. Does [name] make direct eye contact when you or others are talking to him/her -- or does he/she tend to look away?

1. Makes eye contact
2. Looks away

24b. Can you tell by [name]'s facial expression how he/she is feeling -- or is it difficult to tell what he/she is feeling?

1. Can tell
2. Cannot tell

24c. Does [name] primarily prefer spending time with other people -- or would he/she rather be alone?

1. With others
2. Alone

24d. Is [name] comfortable being part of a group -- or does he/she find it uncomfortable to be a part of a group?

1. Comfortable
2. Uncomfortable

24e. Does [name] show enjoyment/sadness about what he/she is doing -- or does [name] keep feelings of enjoyment/sadness to himself/herself (i.e., you can't tell if he/she is happy or sad)?

1. Shows enjoyment/sadness
2. Keeps enjoyment/sadness to self

24f. Does [name] like to do things with others -- or would he/she rather do things alone?

1. With others
2. Alone

24g. Does [name] easily take turns -- or is taking turns difficult for him/her?

1. Takes turns easily
2. Has difficulty taking turns

24h. Does [name] notice when others are upset or feeling bad -- or is it difficult for him/her to tell if others are upset or feeling bad?

1. Notices when others are upset or feeling bad
2. Has difficulty telling when others are upset or feeling bad

24i. Does [name] tend to use the same words or sounds over and over -- or does his/her use of different words or sounds vary by subject matter?

1. Varies by subject
2. Uses same words or sounds

24j. Does [name] like to do one activity over and over -- or does he/she like a variety of activities?

1. Varies activities
2. Repeats activities

24k. Does [name] have special rituals or repetitive behaviors that have to be expressed a number of times -- or does he/she not have special rituals or repetitive behaviors?

1. Does not use repetition or special rituals
2. Uses repetition or rituals

CONSUMER CHARACTERISTICS: SELF DIRECTION

25) The following questions concern to what extent [name] makes decisions about his/her everyday activities. Please indicate whether [name] decides, others decide, or both decide the following.

(Note: These items are about decision making, so please do not answer based on physical assistance [name] may need. Please base your responses on [name]'s current everyday decision making.)

25) Everyday Activities

		Others Decide	Both Decide	[name] Decides
25_1.	How to spend time during weekdays	0	1	2
25_2.	How to spend time on weekends	0	1	2
25_3.	How to spend his/her own money	0	1	2
25_4.	When to spend time with friends or others (other than family)	0	1	2
25_5.	When to go out of or leave the house for leisure	0	1	2
25_6.	Whether to have someone over to the home	0	1	2
25_7.	Whether to go for a visit to someone's home with or without someone else	0	1	2
25_8.	Whether to go to the movies with or without someone else	0	1	2
25_9.	Whether to go to a library, museum, or other public building with or without someone else	0	1	2
25_10.	Whether to go to a beach or park with or without someone else	0	1	2

CONSUMER CHARACTERISTICS: SELF-CARE/INDEPENDENT LIVING SKILLS

26) Please take a moment to think about [name]'s ability to do self-care tasks. Please indicate how independently [name] typically performed each task in the last month: Whether he/she was not able or has had no opportunity; required hands on assistance; required mainly supervision; or was independent in completing each task in the last month.

26A) Basic Self-Care Needs

		Has Not Done (Had no opportunity or is not able)	Lots of Assistance (Requires lots of hands on)	Mainly Supervision (Requires mainly verbal prompts)	Independent (Starts and finishes without prompt or help)
26A_1.	Feeding himself/herself	0	1	2	3
26A_2.	Drinking from a glass or cup (*Note: Can be using a sippy cup or with a straw.*)	0	1	2	3
26A_3.	Chewing and swallowing bite-size food	0	1	2	3
26A_4.	Toileting with regards to bladder	0	1	2	3
26A_5.	Toileting with regards to bowels	0	1	2	3
26A_6.	Physically dressing himself/herself (*Note: Do not include picking out clothing.*)	0	1	2	3
26A_7.	Moving around in familiar settings, such as home	0	1	2	3
26A_8.	Washing hands	0	1	2	3
26A_9	Washing face	0	1	2	3
26A_10.	Brushing or combing hair	0	1	2	3
26A_11.	Wiping or blowing nose with tissue	0	1	2	3
26A_12.	Adjusting water temperature for washing hands or bathing	0	1	2	3
26A_13.	Tying laces or fastening Velcro on own shoes	0	1	2	3
26A_14.	Drying entire body after bathing	0	1	2	3

26B) Being Independent

		Has Not Done (Had no opportunity or is not able)	Lots of Assistance (Requires lots of hands on)	Mainly Supervision (Requires mainly verbal prompts)	Independent (Starts and finishes without prompt or help)
26B_1.	Making his/her bed	0	1	2	3
26B_2.	Cleaning his/her room	0	1	2	3
26B_3.	Doing his/her laundry	0	1	2	3
26B_4.	Caring for his/her own clothes, such as folding them or putting them away	0	1	2	3

26C) Household Activities

		Has Not Done (Had no opportunity or is not able)	Lots of Assistance (Requires lots of hands on)	Mainly Supervision (Requires mainly verbal prompts)	Independent (Starts and finishes without prompt or help)
26C_1.	Using public transportation for a simple direct trip other than ACCESS link or other medical transports	0	1	2	3
26C_2.	Choosing food when shopping for a simple meal	0	1	2	3
26C_3.	Preparing foods that do not require cooking, such as making a sandwich or bowl of cereal	0	1	2	3
26C_4.	Using the stove	0	1	2	3
26C_5.	Using the microwave	0	1	2	3
26C_6.	Washing dishes or using a dishwasher	0	1	2	3
26C_7.	Ordering food in public	0	1	2	3
26C_8.	Choosing items he/she wants to buy	0	1	2	3
26C_9.	Using money, such as handing it to a cashier	0	1	2	3

[Only Ask 26C_9a and 26C_9b if the answer to 26C_9 is "Lots of Assistance", "Mainly Supervision", or "Independent"]

		Has Not Done (Had no opportunity or is not able)	Lots of Assistance (Requires lots of hands on)	Mainly Supervision (Requires mainly verbal prompts)	Independent (Starts and finishes without prompt or help)
26C_9a.	Making small routine purchases	0	1	2	3
26C_9b.	Making or counting change	0	1	2	3

CONSUMER CHARACTERISTICS: SPECIAL BEHAVIORS

27) Please tell us whether [name] has engaged in any of the following special behaviors in the last 6 months.

27A) Behaviors Dangerous to Self

		No	Yes
27A_1.	Runs away or wanders off without you knowing	0	1
27A_2.	Repeatedly gets out of bed at night other than for going to the bathroom	0	1
27A_3.	Eats or mouths inedible objects	0	1
27A_4.	Scratches own body to the point of causing harm	0	1
27A_5.	Hits his/her own body	0	1
27A_6.	Hits his/her own face or head	0	1
27A_7.	Bangs his/her head	0	1
27A_8.	Bites self	0	1

[Only Ask 27A_3a to 27A_3c if the answer to 27A_3 is "Yes"]

27A_3a. How often does [name] eat or mouth inedible objects?

1. Once a day or more
2. Several times per week
3. Once a week
4. Once a month
5. Less than once a month

		No	Yes
27A_3b.	Has [name] ever been hospitalized due to this behavior?	0	1
27A_3c.	Did this behavior occur while [name] was being supervised?	0	1

[Only Ask 27A_8a to 27A_8c if the answer to 27A_8 is "Yes"]

27A_8a. How often does [name] bite himself/herself?

1. Once a day or more
2. Several times per week
3. Once a week
4. Once a month
5. Less than once a month

		No	Yes
27A_8b.	Has [name] ever been hospitalized due to this behavior?	0	1
27A_8c.	Did this behavior occur while [name] was being supervised?	0	1

27B) Behaviors Dangerous to Others

		No	Yes
27B_1.	Verbally threatens others	0	1
27B_2.	Physically threatens others	0	1
27B_3.	Hits or punches others	0	1
27B_4.	Kicks others	0	1
27B_5.	Uses objects to harm others	0	1
27B_6.	Bites others	0	1
27B_7.	Grabs or scratches others	0	1
27B_8.	Head-butts others	0	1
27B_9.	Pulls hair of others	0	1
27B_10.	Chokes or attempts to choke others	0	1
27B_11.	Aggression toward personal property (*i.e., breaks or harms objects*)	0	1

[Only Ask 27B_5a to 27B_5c if the answer to 27B_5 is "Yes"]

27B_5a. How often does [name] use objects to harm others?

1. Once a day or more
2. Several times per week
3. Once a week
4. Once a month
5. Less than once a month

		No	Yes
27B_5b.	Has [name] ever been hospitalized due to this behavior?	0	1
27B_5c.	Did this behavior occur while [name] was being supervised?	0	1

[Only Ask 27B_6a to 27B_6c if the answer to 27B_6 is "Yes"]

27B_6a. How often does [name] bite others?

1. Once a day or more
2. Several times per week
3. Once a week
4. Once a month
5. Less than once a month

		No	Yes
27B_6b.	Has [name] ever been hospitalized due to this behavior?	0	1
27B_6c.	Did this behavior occur while [name] was being supervised?	0	1

[Only Ask 27B_8a to 27B_8c if the answer to 27B_8 is "Yes"]

27B_8a. How often does [name] head-butt others?

1. Once a day or more
2. Several times per week
3. Once a week
4. Once a month
5. Less than once a month

		No	Yes
27B_8b.	Has [name] ever been hospitalized due to this behavior?	0	1
27B_8c.	Did this behavior occur while [name] was being supervised?	0	1

[Only Ask 27B_10a to 27B_10c if the answer to 27B10 is "Yes"]

27B_10a. How often does [name] choke or attempt to choke others?

1. Once a day or more
2. Several times per week
3. Once a week
4. Once a month
5. Less than once a month

		No	Yes
27B_10b.	Has [name] ever been hospitalized due to this behavior?	0	1
27B_10c.	Did this behavior occur while [name] was being supervised?	0	1

27C) Inappropriate or Rule-Violating Behaviors

		No	Yes
27C_1.	Has tantrums or outbursts	0	1
27C_2.	Displays repetitive behavior, such as body rocking or hand flapping	0	1
27C_3.	Smears feces	0	1
27C_4.	Makes noises, curses, or other inappropriate vocalizations	0	1
27C_5.	Disrupts activities of others	0	1
27C_6.	Defies known directions or rules	0	1
27C_7.	Takes off clothes in public	0	1
27C_8.	Masturbates in public	0	1
27C_9.	Sexually touches others without their consent	0	1
27C_10.	Displays sexually predatory behavior (*For example, forcing himself/herself on others in a sexual manner.*)	0	1

27D) Other Special Behaviors

		No	Yes
27D_1.	Has [name] been a target or victim of inappropriate behavior by others?	0	1

27E.	Please indicate which of the following have occurred as a result of any behavior problem with [name] <u>in the last 6 months</u>.	No	Yes
[Only Ask 27E_1 if respondent answers "Yes" to any of these questions 27A_1, 27A_3-27A_8, 27B_1 to 27B_10, 27C_3, or 27C_7 to 27C_10]			
27E_1.	Has it required one-on-one supervision due to behavioral issues?	0	1
[Only Ask 27E_2 to 27E_6 if respondent answers "Yes" to any of these questions 27A_1 to 27A_8, 27B_1 to 27B_10, or 27C_1 to 27C_10]			
27E_2.	Have any specific behavioral modification/support procedures <u>actually</u> been used?	0	1
27E_3.	Has [name]'s environment been carefully structured due to behaviors?	0	1
27E_4.	Has physical intervention sometimes been required?	0	1
27E_5.	Was a supervised time-out needed to an area within or outside the room?	0	1
27E_6.	Were any medications increased or used as needed (prn) to reduce/control behaviors?	0	1

HEALTH

28) Please indicate whether [name] currently has any of the following diagnosed conditions or illnesses.

		No	Yes
28_1.	Respiratory or Breathing Conditions, such as asthma, emphysema, or cystic fibrosis	0	1
28_2.	Heart or Circulatory Conditions, such as heart disease, high blood pressure, anemia, or other blood disorders	0	1
28_3.	Digestive Conditions, such as ulcers, colitis, liver/bowel disorders, or tube feeding	0	1
28_4.	Swallowing Conditions, such as difficulty swallowing, gastric reflux, or aspiration	0	1
28_5.	Bladder or Kidney Conditions	0	1
28_6.	Conditions of the Nervous System, such as multiple sclerosis, organic brain syndrome, Parkinson's disease, or seizures	0	1
28_7.	Hormone or Endocrine Conditions, such as diabetes, thyroid problems, or hormone replacement therapy	0	1
28_8.	Chronic Conditions related to Skin, Hair, or Nails, such as thick toenails, eczema, psoriasis, or dermatitis	0	1
28_9.	Musculoskeletal Conditions, such as muscular difficulties with the arms and/or legs, arthritis, osteoporosis, or cerebral palsy	0	1
28_10.	Allergies, such as those to foods, medications, or seasonal	0	1
28_11.	Other Conditions (Please specify) _____	0	1

29) Please indicate whether [name] has been to or utilized any of the following health services in the last 3 months in any setting for routine or non-routine care.

		No	Yes
29_1.	Been to an emergency clinic or emergency room in a hospital	0	1
29_2.	Stayed overnight in a hospital	0	1
29_3.	Seen a podiatrist (*i.e., a specialist for the feet*)	0	1
29_4.	Seen a psychiatrist	0	1
29_5.	Seen a psychologist for counseling or behavior management	0	1
29_6.	Seen any other behavior specialist (*such as a behavioral analyst*)	0	1
29_7.	Received physical therapy	0	1
29_8.	Received speech therapy	0	1
29_9.	Received occupational therapy	0	1

30) Please indicate whether any of the following special medical treatments or services have been received by [name] in this home or residence in the last 3 months.

		No	Yes
30_1.	Use of special bowel equipment or enemas	0	1
30_2.	Catheterization	0	1
30_3.	Suctioning at least once a day to remove internal fluids	0	1
30_4.	Special breathing or respiratory care, such as the use of an inhaler or nebulizer	0	1
30_5.	Turning or positioning to protect skin integrity	0	1
30_6.	Dressing and wound care	0	1
30_7.	Dialysis or use of a kidney machine	0	1
30_8.	Any medication via injection by others or intravenously at home **other than insulin via an auto-injector** (which is similar to an epi pen or flex pen)	0	1
30_8a.	Insulin administered with an auto-injector (which is similar to a flex pen or epi pen)	0	1
30_9.	Is [name] tube fed?	0	1

[Only Ask 30_9a if the answer to 30_9 is "Yes".]

		No	Yes
30_9a.	Does [name] eat any food by mouth?	0	1

[Go to 30_11 if the answer to 30_9a is "No"]

[Only Ask 30_10a – 30_10e if the answer to 30_9 is "No" or if the answer to 30_9a is "Yes"]

		No	Yes
30_10a.	Has [name] used adaptive eating equipment, such as a plate guard and special utensils (not a feeding tube)?	0	1
30_10b.	Has [name] required assistance due to choking incident(s), such as requiring food to be cleared from the mouth with hand or the Heimlich Maneuver?	0	1
30_10c.	Is [name] physically fed by others?	0	1
30_10d.	Does [name] require special food preparation, such as pureed or chopped?	0	1
30_10e.	Does [name] have any special dietary foods or restrictions, such as low salt?	0	1
30_11.	Were any increases in fluids required?	0	1

31) Please indicate whether any of the following <u>adaptive or special equipment</u> has been used by [name] at any time <u>in the last 3 months</u>.

(*Note: If prescribed, but not used in the last 3 months, answer "No."*)

		No	Yes
31_1.	Glasses or other visual aids	0	1
31_2.	Walker	0	1
31_3.	Crutches or cane	0	1
31_4.	Brace or splint	0	1
31_5.	Hearing aid	0	1
31_6.	Picture symbols or any other communication device	0	1
31_7.	A helmet not used for biking or horseback riding	0	1
31_8.	Prescribed orthotics or orthopedic shoes	0	1
31_9.	Special bed or bed modifications, such as side rails, special mattress, elevated bed, or hospital bed	0	1
31_10.	Other (Please specify)_____	0	1

SCHOOL EXPERIENCE

32. Did [name] ever attend any type of public or private school, including a special school for persons with disabilities?

0. No ➔ ***Go To Question 37***
1. Yes
98. Don't know ➔ ***Go To Question 37***

33. Is [name] currently enrolled in a high school or some other special school for persons with disabilities?

(*Note: Please answer "No" if [name] is attending college or a post-high school technical program*.)

0. No ➔ ***Go To Question 37***
1. Yes

34. Is [name] participating in any school-sponsored work activities like a work-study job, internships, or a school-based business?

0. No ➔ ***Go To Question 36***
1. Yes
98. Don't know ➔ ***Go To Question 36***

35. Is [name] paid for this work?

1. Yes, for all
2. Yes, for some
3. No, for all
98. Don't know

36) What do you think [name] will do during the day after leaving school?

		No	Yes
36_1.	Get a job for pay (making at least minimum wage)	0	1
36_2.	College or junior college	0	1
36_3.	Vocational training or technical school	0	1
36_4.	Day program	0	1
36_5.	Other (Please specify) _____	0	1

CURRENT EMPLOYMENT

37. Does [name] currently have a paid job?

0. No ➔ ***Go To Question 41***
1. Yes
98. Don't know ➔ ***Go To Question 41***

38. About how many hours per week did [name] work at this paid job in the past 2 weeks?

Please select from the drop down list below.

_____ hours
[Drop down list values = 1 hour or less to 40 or more, Don't know = 98]

39. About how much per hour was [name] paid? *(If you are unsure of the exact amount, please enter your best estimate.)*

(*Please provide approximate amount in US dollars only. Do not include a dollar sign ($).*)

$_____

40. Does [name] have a job coach or someone special from an agency who helps him/her at this paid job?

0. Yes, usually ➔ ***Go To Question 48***
1. Sometimes ➔ ***Go To Question 48***
2. Occasionally ➔ ***Go To Question 48***
3. No, does not need one ➔ ***Go To Question 48***

PAST EMPLOYMENT

41. Has [name] had a paid job in the past 2 years?

    0. No ➔ ***Go To Question 45***
    1. Yes
    98. Don't know ➔ ***Go To Question 45***

42. About how many hours per week on average did [name] work for pay?

    Please select from the drop down list below.

    _____ hours

    [Drop down list values = 1 hour or less to 40 or more, Don't know = 98]

43. About how much per hour was [name] paid? *(If you are unsure of the exact amount, please enter your best estimate.)*

    (*Please provide approximate amount in US dollars only. Do not include a dollar sign ($).*)

    Approximate amount paid per hour $_____

44. Did [name] have a job coach or someone special from an agency who helped him/her on this paid job?

    0. Yes, usually
    1. Sometimes
    2. Occasionally
    3. No, does not need one

FUTURE EMPLOYMENT

45. Was [name] actively looking and trying to get a paid job in the past 2 weeks?

    0. No
    1. Yes

46. How likely do you think it is that [name] will have a paid job next year?

    0. Definitely will not ➔ ***Go To Question 48***
    1. Probably will not
    2. Probably will
    3. Definitely will

47. If [name] had a paid job next year, about how much do you think [name] would make per hour?

    (*Please provide your best estimate. Please provide approximate amount in US dollars only. Do not include a dollar sign ($).*)

    $_____

CONTACT WITH DIVISION OF VOCATIONAL REHABILITATION (DVR)

48. Have you had any contact with anyone who works for the Division of Vocational Rehabilitation (DVR) within the last two years?

    0. No ➔ ***Go To Question 50***
    1. Yes

49. How helpful were the services or information provided by DVR?

    1. Very helpful
    2. Somewhat helpful
    3. Not very helpful
    4. Not at all helpful
    98. Don't know

CAREGIVER CHARACTERISTICS

Please Note: The following questions apply to the primary caregiver of [name]. If you are not [name]'s primary caregiver (Question 2 is "No" or Question 4 is "Agency or group home staff (Clinical)" or (Non-clinical), Go To Question 60.

As the Division of Developmental Disabilities is concerned about the experiences of the whole family, including those providing support, we now want to find out more about YOU. Please note that these questions are asked for record keeping purposes only and to learn more about who we are serving.

50. How many years of schooling have you had a chance to complete?

1. No formal schooling
2. 1st through 8th grade
3. Attended high school, but did NOT graduate
4. Graduated from high school/obtained GED
5. Trade, technical, or vocational school after high school
6. Some college (Have not yet earned degree)
10. Completed a 2-year Associates Degree (AA, AS, or AAS) or a 3-year RN degree
7. Completed a 4-year degree (BA, BS, Bachelors)
8. Currently working on post-graduate work or post-graduate degree (e.g., Doctorate or Master's Degree)
9. Completed post-graduate work or post-graduate degree (e.g., Doctorate or Master's Degree)

51. Are you currently employed?

0. No ➔ ***Go To Question 54***
1. Yes

52. Is this employment inside or outside of your home?

1. Inside the house
2. Outside the house
3. Both inside and outside the house

53. On average, how many hours per week do you work for <u>pay</u>?

(*Include lunch, but not travel time to and from your job*.)

Please select from the drop down list below.

_____

[Drop down list values = 1 hour or less to 40 or more, Don't know = 98]

54. In total, how many persons under 18 currently live in your home?

(Enter 0 if there are none.)

Please select from the drop down list below.

_____
[Drop down list values = 0 to 10 or more]

55. In total, how many persons 18 or older currently live in your home, including you and [name]?

Please select from the drop down list below.

_____
[Drop down list values = 1 to 10 or more]

56. Besides caring for [name], are you currently the primary caregiver for anyone else inside or outside of your home who needs special care, such as a disabled child, elderly parent, disabled spouse, etc.?

0. No ➔ ***Go To Question 58***
1. Yes

57. Does this individual live with you?

0. No
1. Yes

58. Which of the following best represents your racial or ethnic heritage?

Please select all that apply.

1. Hispanic, Latino, or Spanish Origin
2. Black or African-American
3. White
4. Asian
5. American Indian or Alaska Native
6. Native Hawaiian or Pacific Islander
98. Some other group (Please specify) _____

59. How old were you on your last birthday?

Please select from the drop down list below.

_____
[Drop down list values = 18 to 97 or older, Prefer not to say = 3]

60. Is [name] or are you on [name]'s behalf currently receiving any of the following?

		No	Yes
60_1.	SSI (Supplemental Security Income)	0	1
60_2.	Medicaid or New Jersey Family Care	0	1
60_3.	Social Security Benefits (Retirement, Disability, or Survivor)	0	1
60_4.	Medicare	0	1
60_5.	Food Stamps	0	1
60_6.	Unemployment	0	1
60_7.	Any other form of state or local public assistance, other than those mentioned above (Please specify) _____	0	1

[Only Ask Question 61 if the answer to 1a is "Respondent on the behalf of the consumer", and if Q4 equals 7, 8 or 98]

61. From which of the following sources have you obtained information to complete this evaluation?

		No	Yes
61_1.	Medical records/ISP (Individualized Service Plan)	0	1
61_2.	Legal guardian	0	1
61_3.	Family member	0	1
61_4.	[name]	0	1
61_5.	Other professionals	0	1
61_6.	Own knowledge of [name]	0	1
61_7.	Other (Please specify) _____	0	1

IMPORTANT: The survey is almost complete. If you wish to verify your answers or make any corrections, *please do so now*.

Once you have completed this assessment and submitted your responses, *you will be unable to make any further changes*.

Initials) Are you a DDPI staff member?

1. Yes (If "Yes") Please enter your intitials in the box below _____.
2. No

[Only Ask Intervw_As_1 and Intervw_As_2 if the answer to Initials is "No"]

Intervw_As_1) Did anyone assist you in completing this survey?

1. Yes
2. No ➔ ***Go To End***

Intervw_As_2) Please provide the name of the person who assisted you, and his or her agency, in the boxes below.

Name _____

Agency _____

When you have finished, please press the submit button in the lower right corner to submit your responses.

Thank you very much for completing this survey.

***Your responses have been recorded and submitted*.**

The NJ DDD will be contacting you in the near future in regard to the next steps in this process.

Estado de Nueva Jersey
DEPARTAMENTO DE SERVICIOS HUMANOS
DIVISIÓN DE DISCAPACIDADES DEL DESARROLLO

ADVERTENCIA

Este sitio web contiene información médica protegida (PHI, por sus siglas en inglés). De acuerdo con la Ley Federal de Portabilidad y Responsabilidad de los Seguros de Salud (HIPAA, por sus siglas en inglés), el acceso no autorizado está prohibido y puede resultar en sanciones civiles y penales.

IMPORTANTE

Por favor, tómese su tiempo y considere sus respuestas a las siguientes preguntas cuidadosamente. Usted será capaz de utilizar el botón "página anterior" para volver a una pregunta durante la encuesta si desea cambiar una respuesta. Sin embargo, una vez que haya completado esta evaluación y sometido sus respuestas, usted no será capaz de hacer más cambios.

Estado de New Jersey
División de Discapacidades del Desarrollo
Herramienta de Evaluación Completa de New Jersey (NJ CAT, por sus siglas en inglés)

Realizado por la Universidad de Rutgers
Instituto para Planificación de Discapacidades del Desarrollo (DDPI, por sus siglas en inglés)

30 de octubre 2014
Versión 1.3 del 27 de abril 2015

DDPI ha sido preguntado por la División de Discapacidades del Desarrollo (DDD) para obtener información sobre [nombre], que está aplicando para servicios. Se han tomado medidas de seguridad para salvaguardar la confidencialidad de la información proporcionada.

Instrucciones para completar la encuesta:

1. ***La persona que conoce mejor a [nombre]* debe de ser el respondedor.**
2. **Debe de responder a *TODAS* las preguntas en cada página para poder proceder a la próxima página.**
3. **Preguntas deben de ser respondidas basadas en el estatus del consumidor *ACTUAL*, no en un momento pasado o futuro.**
4. **La encuesta tomará aproximadamente 30-40 minutos para completar.**
5. **Si tiene algunas preguntas sobre cómo responder a una pregunta, por favor póngase en contacto con nosotros *antes* de enviar su encuesta completada. Puede salirse de la encuesta y regresar a otra hora para completarlo al punto que lo dejó.**

Gracias por su tiempo y asistencia con este importante esfuerzo.

DETALLES DEL CONSUMIDOR

El consumidor es la persona que recibe o puede que reciba servicios de la DDD.

MIS_D) **MIS/Serial: (campo rellenado automáticamente)**

CLName_D) **Primer nombre del consumidor: (campo rellenado automáticamente)**
Apellido del Consumidor: (campo rellenado automáticamente)

Esta encuesta es para [Primer nombre del consumidor (campo rellenado automáticamente) / Apellido del Consumidor (campo rellenado automáticamente) / DDD ID # (campo rellenado automáticamente)]. Si esta no es la persona correcta, por favor salga de esta página ahora.

1. Por favor repase la siguiente información y corrija cualquier mal deletreo.

Otra vez, si esta no es la persona correcta, por favor salga de esta página ahora.

Primer nombre del consumidor: (campo rellenado automáticamente)
Apellido del Consumidor: (campo rellenado automáticamente)

1_Cons) Por favor proporcione la dirección actual y la fecha de nacimiento de [primernombre apellido] en los cuadros abajo:

1_Cons _1. Dirección postal permanente, pre-admisión: _____
1_Cons _2. Ciudad: _____
1_Cons _3. Estado: _____
1_Cons _4. Código postal: _____
1_Cons _5. Fecha de nacimiento (Por favor use el formato mm/dd/aaaa.):_____

[Solo Pregunte VerifyDOB si la respuesta a 1_Cons_5 no coincida con los datos de archivos]

VerifyDOB) En la página anterior usted indicó que la fecha de nacimiento de [nombre apellido] es *mm/dd/aaaa*. Si esto no es correcto, por favor provea la información correcta abajo.
_____

DETALLES DEL RESPONDEDOR

El respondedor es la persona que está completando la evaluación en nombre del consumidor.

1a. ¿Quién va a rellenar la información para esta evaluación?

1. Respondedor de parte del consumidor
2. Consumidor ➔ ***Pase a la pregunta 3b***

1_Resp) Por favor proporcione la siguiente información sobre el respondedor:

1_Resp _1. Su primer nombre: _____
1_Resp _2. Su apellido: _____
1_Resp _3. Su número de teléfono
(Por favor use el formato xxx-xxx-xxxx): _____
1_Resp _4. Su celular/número de teléfono alternativo
(Por favor use el formato xxx-xxx-xxxx)): _____
1_Resp _5. Su correo electrónico (p. ej. abcdef@ghij.com): _____
1_Resp _6. Dirección postal: _____
1_Resp _7. Su ciudad: _____
1_Resp _8. Su estado: _____
1_Resp _9. Su código postal: _____

2. ¿Es usted el cuidador principal de [nombre]? El cuidador principal es el responsable primario del cuidado y bienestar de [nombre].

(Nota: Si usted comparte igualmente el cuidado con su esposo(a) u otra persona, responda "Sí".)

0. No
1. Sí

3a. ¿Vive [nombre] con usted actualmente?

0. No
1. Sí

3b. ¿Cuál describe mejor el arreglo de vivienda actual de [nombre]?

1. En el hogar solo
2. En un hogar con la familia o amigo(s)
3. En una instalación casa hogar o apartamento supervisado
4. En un ambiente de casa de reposo
98. En algún otro ambiente (por favor especifique) _____

[Solo Pregunte 4 and 5 si la respuesta a 1a es "Respondedor de parte del consumidor"]

4. ¿Cuál es su relación con [nombre]?

    1. Madre o padre
    2. Abuela o abuelo
    3. Hermana o hermano
    4. Hijo o hija
    5. Otro pariente
    6. Amigo de la familia
    7. Agencia o personal de una casa hogar (Clínico)
    8. Agencia o personal de una casa hogar (No-clínico)
    98. Otro (por favor, especifique) _____

5. Género del respondedor (usted):

    1. Masculino
    2. Femenino

6. ¿Quién es el guardián de [nombre] para las decisiones legales y médicas en este momento?

    1. [Nombre] es su propio guardián
    2. Yo soy (Por favor seleccione esta opción si usted es el guardián con otra persona)
    3. Otro miembro de la familia
    4. Un amigo de la familia
    5. Oficina de Servicios de Tutela (conocido en inglés como Bureau of Guardianship Services)/Tutela del Estado
    6. Solicitando Tutela/Tutela en proceso
    7. Alguien más/Otro (Por favor especifique la relación)_____

7. ¿Quién es probable que sea el guardián de [nombre] para tomar decisiones médicas y legales dentro de 5 años?

    1. [Nombre] será su propio guardián
    2. Yo seré (Por favor seleccione esta opción si usted es el guardián con otra persona)
    3. Otro miembro de la familia
    4. Un amigo de la familia
    5. Oficina de Servicios de Tutela (conocido en inglés como Bureau of Guardianship Services)/Tutela del Estado
    6. Alguien más/Otro (Por favor especifique la relación)_____

CARACTERÍSTICAS DEL CONSUMIDOR

8. ¿Cuántos años tiene [nombre]?

Por favor seleccione del menú desplegable abajo.

[Valores del menú desplegable = "17 años de edad o menos" a "97 o más"]

_____

9a. ¿Cuál es el género de [nombre]?

1. Masculino
2. Femenino

9b. ¿Cuál de lo siguiente mejor representa la herencia racial o étnica de [nombre]?

Por favor seleccione todas las que correspondan.

1. Hispano, latino, u origen español
2. Negro o afroamericano
3. Blanco
4. Asiático
5. Aborigen de América del Norte o nativo de Alaska
6. Nativo Hawaiano o nativo de la Polinesia
98. Algún otro grupo (Por favor, especifique) _____

9c. ¿Tiene [nombre] una licencia de conducir válida?

0. No ➔ ***Pase a la pregunta 10***
1. Sí

9d. ¿Tiene [nombre] acceso a un vehículo y maneja por si solo de una manera de transportación regular?

0. No
1. Sí

10) Por favor díganos si [nombre] tiene cualquier de los siguientes:

		No	Sí
10_1.	Trastorno del espectro autista	0	1
10_2.	Parálisis cerebral	0	1
10_3.	Espina bífida	0	1
10_4.	Síndrome de Down	0	1
10_5.	Una discapacidad intelectual o cognitiva (anteriormente conocido como retraso mental)	0	1
10_6.	Síndrome de Prader-Willi	0	1
10_7.	Cualquier discapacidad física *(Incluyendo , pero no limitado a cualquier discapacidad física en esta lista)*	0	1
10_8.	Un problema de salud mental con un diagnóstico psiquiátrico *(además de una discapacidad intelectual o cognitiva, o trastorno del espectro autista)*	0	1
10_9.	Traumatismo cerebral incluyendo una lesión cerebral adquirida que no es degenerativa	0	1
10_10.	Epilepsia o un trastorno de convulsiones	0	1

[Solo Pregunte 10_1a si la respuesta a 10_1 es "Sí"]

10_1a. ¿Describiera el autismo o el trastorno del espectro autista de [nombre] como leve, moderado, o severo?

1. Leve
2. Moderado
3. Severo

[Solo Pregunte 10_8a si la respuesta a 10_8 es "Sí"]

10_8a. Usted indicó que [nombre] tiene un problema de salud mental con un diagnóstico psiquiátrico. Por favor especifique el diagnóstico en el espacio abajo.

_____

[Solo Pregunte 10_10a y 10_10b si la respuesta a 10_10 es "Sí"]

10_10a. Usted indicó que [nombre] tiene epilepsia o un trastorno de convulsiones. ¿Cuándo fue la última vez que [nombre] tuvo una convulsión?

1. En los últimos 3 meses
2. En los últimos 4-6 meses
3. En los últimos 7-12 meses
4. Hace más de un año

10_10b. ¿Requiere [nombre] actualmente SUPERVISION CONSTANTE en todo momento durante las horas que está despierto/a y/o durante las horas de dormir para evitar lesiones debido a un trastorno de convulsiones incontrolado?

0. No
1. Sí

CARACTERÍSTICAS DEL CONSUMIDOR: SENSORIAL/MOTORAS

11. ¿Sufre [nombre] una pérdida de audición que no puede ser corregida con audífonos?

    0. No, audición está en una gama normal o normal con los audífonos➔***Pase a la pregunta 13***
    1. Sí, sufre de pérdida de audición

12. ¿Cuál respuesta describe mejor la audición de [nombre] en el último mes?

    (Nota: Si [nombre] usa aparatos correctivos, como audífonos, por favor seleccione la respuesta que mejor describe la audición de [nombre] mientras usa audífonos.)

    1. Pérdida leve: [nombre] frecuentemente encuentra dificultad cuando escucha el habla normal
    2. Pérdida moderada: [nombre] tiene que darle volumen a la televisión o hablar duro para escuchar, sordo en un oído, etc.
    3. Pérdida severa: [nombre] solo puede escuchar si alguien está gritando
    4. Pérdida profunda: [nombre] es sordo

13. ¿Tiene [nombre] cualquier problema de la vista que no se puede corregir con lentes o lentes de contacto?

    0. No, visión está en gama normal con o sin corrección➔***Pase a la pregunta 15***
    1. Sí, tiene impedimento de la vista que no puede ser corregida

14. ¿Cuál respuesta describe mejor la visión de [nombre] en el último mes?

    (Nota: Si [nombre] usa un aparato correctivo, como lentes, ¿cuál respuesta describe mejor la visión de [nombre] cuando está usando los lentes?)

    1. Impedimento leve: [nombre] tiene daltonismo o tiene problemas para ver objetos pequeños
    2. Impedimento moderado: [nombre] ve más que luz o sombras, tiene problemas con la percepción de profundidad, para ver el borde de la acera, o para reconocer personas a la vista, o está siego de un ojo, etc.
    3. Impedimento severo: [nombre] ve solo luz y sombras.
    4. Impedimento profundo: [nombre] es totalmente siego.

15) Por favor, indique si [nombre] no era capaz de hacerlo, necesitaba ayuda con, o independientemente podía hacer cada uno de los siguientes en el último mes:

		No capaz	Necesitaba ayuda	Podía hacerlo independientemente
15_1.	Rodar de boca arriba a boca abajo	0	1	2
15_2.	Jalarse a sí mismo/a de una posición sentada a una posición parada	0	1	2
15_3.	Subir las escaleras en cualquier casa o edificio. *(Nota: Si usa pasamanos por sí solo/a, por favor responda "Independientemente")*	0	1	2
15_4.	Bajar las escaleras en cualquier casa o edificio. *(Nota: Si usa pasamanos por sí solo/a, por favor responda "Independientemente")*	0	1	2
15_5.	Recoger objetos pequeños, como un Cheerio	0	1	2
15_6.	Transferir un objeto de mano a mano	0	1	2
15_7.	Gatear, trepar, o deslizarse, como conseguir algo debajo de una cama o silla	0	1	2
15_8.	Sentarse sin apoyo por lo menos 5 minutos, por ejemplo en un banco de piano o banco sin respaldo.	0	1	2

16. ¿Camina [nombre] independientemente sin dificultad, sin usar un aparato correctivo, y/o sin asistencia?

0. No
1. Sí ➔ ***Pase a la pregunta 22A***

17. ¿Cuál describe mejor el nivel típico de la movilidad de [nombre] de caminar?

0. No puede caminar por sí solo con un aparato correctivo o con asistencia
1. Camina solo con asistencia de otra persona
2. Camina independientemente con aparato correctivo (p. ej. andador ortopédico, muletas, o aparato ortopédico)
3. Camina independientemente, pero con dificultad (sin aparato correctivo)

18. ¿Usa [nombre] una silla de ruedas o un scooter eléctrico?

(Nota: Si [nombre] está utilizando temporalmente una silla de ruedas debido a una reciente lesión o condición aguda, por favor responda "No.")

0. No, no la usa ➔ ***Pase a la pregunta 22A***
1. Sí, la usa todo el tiempo
2. Sí, la usa para viajes largos o cuando sea necesario

19) Por favor, indique cuál de las siguientes está utilizando [nombre] actualmente.

(Nota: Si fue recetado, pero no usado por [nombre], por favor responda "No.")

		No	Sí
19a.	Silla de ruedas no motorizada	0	1
19b.	Silla de ruedas motorizada	0	1
19c.	Un scooter eléctrico	0	1

20. ¿Cuál describe mejor la capacidad de [nombre] de transferirse a sí mismo dentro o fuera de la silla de ruedas o scooter eléctrico?

0. Regularmente requiere el uso de un Hoyer u otra grúa médica y/o más de una persona al transferir
1. Necesita mucha asistencia física de otra persona al transferir
2. Solo necesita asistencia mínima de otra persona al transferir
3. Se puede transferir independientemente sin asistencia

21. ¿Cuál describe mejor la capacidad de [nombre] de mover una silla de ruedas de un lugar a otro?

(Nota: Las categorías de respuestas se aplican ambos al uso de sillas de ruedas motorizadas y a las no motorizadas.)

0. No tiene movilidad de silla de ruedas independiente---necesita que alguien lo/la empuje de un lugar a otro
1. Puede mover la silla de ruedas hacia atrás y adelante con las manos y los pies, pero tiene que ser empujado para moverse de un lugar a otro para cualquier distancia real
2. Puede mover la silla de ruedas de forma independiente desde un lugar a otro sin asistencia, pero requiere ser empujado para largas distancias
3. Puede mover la silla de ruedas de forma independiente desde un lugar a otro sin asistencia y no requiere asistencia incluso para viajes más largos

CARACTERÍSTICAS DEL CONSUMIDOR: HABILIDADES COGNITIVAS

22A) Abajo se presentan algunas preguntas acerca de las capacidades cognitivas o mentales de [nombre]. Por favor, indique si [nombre] ha hecho cada uno de los siguientes en el último mes.

22A) Asociar el tiempo con eventos y acciones

		No	Sí
22A_1.	Recuerda eventos que sucedieron hace un mes o más *(Nota: ¿Recordaría [nombre] a alguien que vio hace un mes o desde una ocasión especial?)*	0	1
22A_2.	Conoce la rutina diaria, como lo que ocurre en la mañana, tarde y noche.	0	1
22A_3.	Asocia eventos con el tiempo pasado, presente, o futuro, por ejemplo, saber la diferencia entre ayer, hoy, y mañana.	0	1

[Solo Pregunte 22A_2a si la respuesta a 22A_2 es "Sí"]

22A_2a. Asocia eventos regulares con una hora específica, como saber que 6:00 pm es la hora de cenar

0. No
1. Sí

[Solo Pregunte 22A_3a si la respuesta a 22A_3 es "Sí"]

22A_3a Dice la hora a los 5 minutos más cercanos, como saber la diferencia entre 5 minutos para las 6:00 pm y 5 minutos después de las 6:00 pm, o entiende la diferencia entre 5 minutos y 10 minutos de ahora

0. No
1. Sí

22B) Habilidades espaciales/perceptivos

		No	Sí
22B_1.	Sabe la diferencia entre rojo, azul, verde y amarillo	0	1
22B_2.	Sabe la diferencia entre grande y pequeño	0	1
22B_3.	Sabe la diferencia entre un círculo, cuadrado, y un triángulo	0	1
22B_4.	Encuentra su camino alrededor de la casa por sí mismo. *(Nota: Si los problemas de movilidad impiden moverse de una habitación a otra, pero sabe dónde se encuentran diferentes cuartos, por favor responda "Sí.")*	0	1

22C) Conocimiento numérico

		No	Sí
22C_1.	Usa números, aunque sea incorrectamente. *(Nota: Por favor responda "Sí" si [nombre] utiliza números correctamente o incorrectamente.)*	0	1
22C_2.	Cuenta hasta 10 sin ayuda	0	1

[Solo Pregunte 22C_2a si la respuesta a 22C_2 es "Sí"]

22C_2a. Hace sumas simples sin el uso de calculadora o computadora

0. No ➔ ***Pase a la pregunta 22D_1***
1. Sí

22C_2b. Hace restas simples sin el uso de calculadora o computadora

0. No
1. Sí

22D) Habilidades de escritura (Incluya Braille o teclear)

		No	Sí
22D_1.	Imprime o escribe letras individuales sin un modelo o sin trazar	0	1

[Solo Pregunte 22D_1a and 22D_1b si la respuesta a 22D_1 es "Sí"]

22D_1a. Imprime o escribe su propio nombre sin un modelo o sin trazar

0. No
1. Sí

22D_1b. Imprime o escribe palabras individuales, además de su propio nombre, sin un modelo o sin trazar

0. No
1. Sí

[Solo Pregunte 22D_1ba si la respuesta a 22D_1b es "Sí"]

22D_1ba. Imprime o escribe oraciones simples sin un modelo o sin trazar

0. No
1. Sí

22E) Habilidades de lectura y señales

		No	Sí
22E_1.	Reconoce su propio nombre y apellido cuando está escrito	0	1
22E_2.	Lee y entiende palabras simples	0	1

[Solo Pregunte 22E_2a si la respuesta a 22E_2 es "Sí"]

22E_2a. Lee y entiende oraciones simples

0. No
1. Sí

[Solo Pregunte 22E_2aa si la respuesta a 22E_2a es "Sí"]

22E_2aa. Lee y entiende una historia simple

0. No
1. Sí

CARACTERÍSTICAS DEL CONSUMIDOR: COMUNICACIÓN

23) Por favor piense en la habilidad de [nombre] de comunicarse. Por favor indique si [nombre] ha hecho lo siguiente en el último mes.

23A) Comunicación verbal expresiva

		No	Sí
23A_1.	Usa por lo menos algunas palabras, signos, o imágenes de símbolos simples	0	1

[Solo Pregunte 23A_1a si la respuesta a 23A_1 es "Sí"]

23A_1a. Usa 10 o más palabras o señales simples en su vocabulario entero

0. No
1. Sí

[Solo Pregunte 23A_1aa – 23A_1ac si la respuesta a 23A_1a es "Sí"]

		No	Sí
23A_1aa.	Hace preguntas simples usando palabras o señales	0	1
23A_1ab.	Usa oraciones completas en una conversación	0	1
23A_1ac.	Cuenta una historia simple, tal como de un programa de televisión	0	1

23B) Claridad del habla

		No	Sí
23B_1.	Claramente dice "Sí" o "No" a una pregunta simple	0	1
23B_2.	El habla es fácilmente entendida por extraños	0	1

[Solo Pregunte 23B_1a si la respuesta a 23B_1 es "Sí"]

23B_1a. ¿Es inglés el idioma principal de [nombre]?

0. No
1. Sí

[Solo Pregunte 23B_1aa si la respuesta a 23B_1a es "No"]

23B_1aa. ¿Cuál es el idioma principal de [nombre]? (*Por favor especifique en el cuadro abajo.*)

_____

[Solo Pregunte 23B_2a si la respuesta a 23B_2 es "No"]

23B_2a. El habla es entendida por aquellos que conocen bien a [nombre]

0. No
1. Sí

23C) Comunicación verbal receptiva

		No	Sí
23C_1.	¿Responde [nombre] a su nombre cuando es hablado o señalado?	0	1
23C_2.	¿Comprende [nombre] el significado de "Sí" y "No"?	0	1

[Solo Pregunte 23C_2a si la respuesta a 23C_2 es "Sí"]

23C_2a. ¿Entiende [nombre] una orden de un solo paso, como "Mírame"?

0. No
1. Sí

[Solo Pregunte 23C_2aa and 23C_2ab si la respuesta a 23C_2a es "Sí"]

23C_2aa. ¿Entiende [nombre] una orden de dos pasos, como "Voltea la cabeza y mírame"?

0. No
1. Sí

23C_2ab. ¿Entiende [nombre] un chiste o una historia?

0. No
1. Sí

CARACTERÍSTICAS DEL CONSUMIDOR: INTERACCIÓN SOCIAL

24. Las siguientes preguntas son acerca de cómo actúa [nombre] en diferentes situaciones sociales — con miembros de la familia y otros — en el último mes. Por favor díganos, basado en su propio conocimiento, acerca del comportamiento de [nombre] en las siguientes situaciones.

24a. ¿Hace [nombre] contacto visual directo cuando usted u otras personas hablan con él/ella—o es propenso/a a mirar hacia otro lado?

1. Hace contacto visual (mira a los ojos)
2. Mira hacia otro lado

24b. ¿Puede notar por las expresiones faciales de [nombre] como se siente él/ella—o es difícil de notar como se siente él/ella?

1. Se puede notar
2. No se puede notar

24c. ¿Prefiere [nombre] primariamente pasar tiempo con otras personas—o prefiere estar solo/a?

1. Con otros
2. Solo/a

24d. ¿Se siente [nombre] cómodo/a siendo parte de un grupo—o se siente él/ella incómodo/a siendo parte de un grupo?

1. Cómodo/a
2. Incomodo/a

24e. ¿Demuestra [nombre] gozo/tristeza sobre lo que él/ella está haciendo—o guarda los sentimientos de gozo/tristeza para sí mismo/a (p. ej., no se puede notar si él/ella está contento/a o triste)?

1. Demuestra gozo/tristeza
2. Mantiene su gozo/tristeza por sí mismo

24f. ¿Le gusta a [nombre] hacer cosas con otros---o prefiere hacer cosas solo/a?

1. Con otros
2. Solo/a

24g. ¿Es fácil para [nombre] tomar turnos—o es difícil para él/ella tomar turnos?

1. Toma turnos fácilmente
2. Tiene dificultad tomando turnos

24h. ¿Nota [nombre] si otros están molestos o se sienten mal—o es difícil para él/ella notar si otros están molestos o se sienten mal?

1. Nota cuando otros están molestos o se sienten mal
2. Tiene dificultad notando si otros están molestos o se sienten mal

24i. ¿Es [nombre] propenso/a a usar las mismas palabras o sonidos una y otra vez—o el uso de palabras o sonidos diferentes varean dependiendo en el tema?

1. Varea por tema
2. Usa las mismas palabras o sonidos

24j. ¿Le gusta a [nombre] hacer una actividad una y otra vez—o le gusta a él/ella una variedad de actividades?

1. Varea actividades
2. Repite actividades

24k. ¿Tiene [nombre] rituales especiales o comportamiento repetitivo que tiene que ser expresado un número de veces—o no tiene rituales especiales o comportamiento repetitivo?

1. No usa repetición o rituales especiales
2. Usa repetición o rituales

CARACTERÍSTICAS DEL CONSUMIDOR: AUTO DIRECCIÓN

25) Las siguientes preguntas son acerca de hasta qué medida [nombre] hace decisiones sobre sus actividades diarias. Por favor indique si [nombre] decide, otros deciden, o ambos deciden sobre lo siguiente.

(Nota: Estos artículos son acerca de tomar decisiones, por favor no responda basado en la asistencia física que pueda necesitar. Por favor, base su respuesta en la toma de decisiones diarias.)

25) Actividades diarias

		Otros deciden	Ambos deciden	[nombre] decide
25_1.	Como pasar el tiempo durante los días entre semana	0	1	2
25_2.	Como pasar el tiempo los fines de semana	0	1	2
25_3.	Como gastar su propio dinero	0	1	2
25_4.	Cuando pasar tiempo con amigos u otros (otros aparte de familiares)	0	1	2
25_5.	Cuando salir de o dejar la casa para tiempo libre	0	1	2
25_6.	Si debe tener invitados a la casa	0	1	2
25_7.	Si debe ir de visita al hogar de alguien con o sin alguien más	0	1	2
25_8.	Si debe salir al cine con y sin alguien más	0	1	2
25_9.	Si debe ir a la biblioteca, museo, u otros edificios públicos con o sin alguien más	0	1	2
25_10.	Si debe ir a la playa o parque con o sin alguien más	0	1	2

CARACTERÍSTICAS DEL CONSUMIDOR: CUIDADO PERSONAL/ HABILIDADES DE VIDA INDEPENDIENTE

26) Por favor, tome un momento para pensar en la capacidad de [nombre] de hacer tareas de cuidado personal. Por favor, indique cuán independiente [nombre] realizó cada tarea en el último mes: Si él/ella no fue capaz o no ha tenido la oportunidad; requirió asistencia directa; principalmente requirió supervisión; o fue independiente en completar cada tarea en el último mes.

26A) Necesidades de cuidado personal básicas

		No Ha Hecho (No ha tenido la oportunidad o no es capaz)	Mucha Ayuda (Requiere mucha ayuda)	Principalmente Supervisión (Principalmente requiere pistas verbales)	Independiente (Empieza y termina sin pistas ni ayuda)
26A_1.	Alimentarse por sí solo/a	0	1	2	3
26A_2.	Beber de un vaso o una tasa *(Nota: Puede ser con un vaso de aprendizaje o con una paja.)*	0	1	2	3
26A_3.	Masticar y tragar comida en partes pequeñas	0	1	2	3
26A_4.	Usar el baño en relación con orinar	0	1	2	3
26A_5.	Usar el baño en relación con defecar	0	1	2	3
26A_6.	Vestirse físicamente *(Nota: No incluya seleccionando la ropa.)*	0	1	2	3
26A_7.	Moverse en un ambiente familiar, tal como su hogar	0	1	2	3
26A_8.	Lavarse las manos	0	1	2	3
26A_9	Lavarse la cara	0	1	2	3
26A_10.	Peinarse o cepillarse el pelo	0	1	2	3
26A_11.	Sonarse o limpiarse la nariz con un pañuelo de papel	0	1	2	3
26A_12.	Ajustar la temperatura de agua para lavar las manos o bañarse	0	1	2	3
26A_13.	Atarse los cordones o cerrar los ajustes de Velcro de sus zapatos	0	1	2	3
26A_14.	Secarse el cuerpo entero después de bañarse	0	1	2	3

26B) Ser independiente

		No Ha Hecho (No ha tenido la oportunidad o no es capaz)	Mucha Ayuda (Requiere mucha ayuda)	Principalmente Supervisión (Principalmente requiere pistas verbales)	Independiente (Empieza y termina sin pistas ni ayuda)
26B_1.	Hacer su cama	0	1	2	3
26B_2.	Limpiar su cuarto	0	1	2	3
26B_3.	Lavar su ropa	0	1	2	3
26B_4.	Cuidar su propia ropa, tal como doblarla o guardarla	0	1	2	3

26C) Actividades del hogar

		No Ha Hecho (No ha tenido la oportunidad o no es capaz)	Mucha Ayuda (Requiere mucha ayuda)	Principalmente Supervisión (Principalmente requiere pistas verbales)	Independiente (Empieza y termina sin pistas ni ayuda)
26C_1.	Usar transporte públicos para un simple viaje directo además de Access link u otras transportes médicos	0	1	2	3
26C_2.	Seleccionar comestibles cuando hace compras para una comida simple	0	1	2	3
26C_3.	Preparar comidas que no requieren cocinar, tal como hacer un sándwich, o una taza de cereal	0	1	2	3
26C_4.	Usar la estufa	0	1	2	3
26C_5.	Usar el microondas	0	1	2	3
26C_6.	Lavar los platos o usar un lavaplatos	0	1	2	3
26C_7.	Ordenar comida en público	0	1	2	3
26C_8.	Seleccionar artículos que quiere comprar	0	1	2	3
26C_9.	Usar dinero, tal como dándolo al cajero	0	1	2	3

[Solo Pregunte 26C_9a and 26C_9b si la respuesta a 26C_9 es "Mucha Ayuda", "Principalmente Supervisión", o "Independiente"]

		No Ha Hecho (No ha tenido la oportunidad o no es capaz)	Mucha Ayuda (Requiere mucha ayuda)	Principalmente Supervisión (Principalmente requiere pistas verbales)	Independiente (Empieza y termina sin pistas ni ayuda)
26C_9a.	Hacer compras pequeñas de rutina	0	1	2	3
26C_9b.	Dar o contar cambio	0	1	2	3

CARACTERÍSTICAS DEL CONSUMIDOR: COMPORTAMIENTO ESPECIAL

27) Por favor díganos si [nombre] ha hecho algunos de los siguientes comportamientos especiales en los últimos 6 meses.

27A) Comportamientos peligrosos a sí mismo/a

		No	Sí
27A_1.	Huye o pasea sin que usted lo sepa	0	1
27A_2.	Repetidamente sale de la cama durante la noche además de ir al baño.	0	1
27A_3.	Come o se pone objetos no comestibles en la boca.	0	1
27A_4.	Se rasca su propio cuerpo hasta que causa daño	0	1
27A_5.	Se pega su propio cuerpo	0	1
27A_6.	Se pega su propia cara o cabeza	0	1
27A_7.	Se golpea la cabeza	0	1
27A_8.	Se muerde a sí mismo/a	0	1

[Solo Pregunte 27A_3a to 27A_3c si la respuesta a 27A_3 es "Sí"]

27A_3a. ¿Con qué frecuencia come o se pone [nombre] objetos no comestibles en la boca?

1. Una vez al día o más
2. Varias veces a la semana
3. Una vez a la semana
4. Una vez al mes
5. Menos de una vez al mes

		No	Sí
27A_3b.	¿Alguna vez ha sido [nombre] hospitalizado a causa de este comportamiento?	0	1
27A_3c.	¿Ocurrió este comportamiento mientras [nombre] estaba siendo supervisado?	0	1

[Solo Pregunte 27A_8a to 27A_8c si la respuesta a 27A_8 es "Sí"]

27A_8a. ¿Con qué frecuencia se muerde [nombre] a sí mismo/a?

1. Una vez al día o más
2. Varias veces a la semana
3. Una vez a la semana
4. Una vez al mes
5. Menos de una vez al mes

		No	Sí
27A_8b.	¿Alguna vez ha sido [nombre] hospitalizado a causa de este comportamiento?	0	1
27A_8c.	¿Ocurrió este comportamiento mientras [nombre] estaba siendo supervisado?	0	1

27B) Comportamientos peligrosos a otros

		No	Sí
27B_1.	Amenaza a otros verbalmente	0	1
27B_2.	Amenaza a otros físicamente	0	1
27B_3.	Golpea o da puñetazos a otros	0	1
27B_4.	Patea a otros	0	1
27B_5.	Usa objetos para hacer daño a otros	0	1
27B_6.	Muerde a otros	0	1
27B_7.	Agarra o rasca a otros	0	1
27B_8.	Da cabezazos a otros	0	1
27B_9.	Jala el pelo de otros	0	1
27B_10.	Estrangula o trata de estrangular a otros	0	1
27B_11.	Agresión a la propiedad privada *(p. ej. Rompe o hace daño a objetos)*	0	1

[Solo Pregunte 27B_5a to 27B_5c si la respuesta a 27B_5 es "Sí"]

27B_5a. ¿Con qué frecuencia usa [nombre] objetos para hacer daño a otros?

1. Una vez al día o más
2. Varias veces a la semana
3. Una vez a la semana
4. Una vez al mes
5. Menos de una vez al mes

		No	Sí
27B_5b.	¿Alguna vez ha sido [nombre] hospitalizado a causa de este comportamiento?	0	1
27B_5c.	¿Ocurrió este comportamiento mientras [nombre] estaba siendo supervisado?	0	1

[Solo Pregunte 27B_6a to 27B_6c si la respuesta a 27B_6 es "Sí"]

27B_6a. ¿Con qué frecuencia muerde [nombre] a otros?

1. Una vez al día o más
2. Varias veces a la semana
3. Una vez a la semana
4. Una vez al mes
5. Menos de una vez al mes

		No	Sí
27B_6b.	¿Alguna vez ha sido [nombre] hospitalizado a causa de este comportamiento?	0	1
27B_6c.	¿Ocurrió este comportamiento mientras [nombre] estaba siendo supervisado?	0	1

[Solo Pregunte 27B_8a to 27B_8c si la respuesta a 27B_8 es "Sí"]

27B_8a. ¿Con qué frecuencia da [nombre] cabezazos a otros?

1. Una vez al día o más
2. Varias veces a la semana
3. Una vez a la semana
4. Una vez al mes
5. Menos de una vez al mes

		No	Sí
27B_8b.	¿Alguna vez ha sido [nombre] hospitalizado a causa de este comportamiento?	0	1
27B_8c.	¿Ocurrió este comportamiento mientras [nombre] estaba siendo supervisado?	0	1

[Solo Pregunte 27B_10a to 27B_10c si la respuesta a 27B10 es "Sí"]

27B_10a. ¿Con qué frecuencia estrangula o trata [nombre] de estrangular a otros?

1. Una vez al día o más
2. Varias veces a la semana
3. Una vez a la semana
4. Una vez al mes
5. Menos de una vez al mes

		No	Sí
27B_10b.	¿Alguna vez ha sido [nombre] hospitalizado a causa de este comportamiento?	0	1
27B_10c.	¿Ocurrió este comportamiento mientras [nombre] estaba siendo supervisado/a?	0	1

27C) Comportamientos inapropiados o que violan las reglas

		No	Sí
27C_1.	Hace berrinches o tiene rabietas	0	1
27C_2.	Muestra comportamiento repetido, tal como mecer el cuerpo o aletear con las manos	0	1
27C_3.	Embadurna las heces	0	1
27C_4.	Hace ruidos, dice groserías, u otras vocalizaciones inapropiadas	0	1
27C_5.	Interrumpe actividades de otros	0	1
27C_6.	Desafía direcciones o reglas conocidas	0	1
27C_7.	Se desviste en público	0	1
27C_8.	Se masturba en público	0	1
27C_9.	Acaricia a otros sexualmente sin consentimiento de ellos	0	1
27C_10.	Muestra comportamiento sexual predatorio *(p. ej., forzarse a otros en una manera sexual)*	0	1

27D) Otros comportamientos especiales

		No	Sí
27D_1.	¿Ha sido [nombre] objetivo o víctima de comportamiento inapropiada de otros?	0	1

27E.	Por favor indique cuál de las siguientes han ocurrido debido a un problema de comportamiento con [nombre] en los últimos 6 meses.	No	Sí
[Solo Pregunte 27E_1 si el respondedor contesta "Sí" a alguna de estas preguntas 27A_1, 27A_3-27A_8, 27B_1 to 27B_10, 27C_3, o 27C_7 to 27C_10]			
27E_1.	¿Ha requerido supervisión individual a causa de problemas de comportamiento?	0	1
[Solo Pregunte 27E_2 to 27E_6 si el respondedor contesta "Sí" a alguna de estas preguntas 27A_1 to 27A_8, 27B_1 to 27B_10, o 27C_1 to 27C_10]			
27E_2.	¿Se ha <u>realmente</u> utilizado cualquier modificación/apoyo de comportamiento específico?	0	1
27E_3.	¿Ha sido el ambiente de [nombre] estructurado cuidadosamente debido a comportamientos?	0	1
27E_4.	¿Ha sido requerido a veces una intervención física?	0	1
27E_5.	¿Fue necesario un tiempo fuera supervisado a un área dentro o fuera de la habitación?	0	1
27E_6.	¿Fue algún medicamento incrementado o usado según sea necesario (prn) para reducir/controlar los comportamientos?	0	1

SALUD

28) Por favor indique si [nombre] tiene alguna de las siguientes enfermedades o condiciones diagnosticadas actualmente.

		No	Sí
28_1.	Condiciones respiratorias o de respiración, tal como asma, enfisema, o fibrosis quística	0	1
28_2.	Condiciones del corazón o circulatorios, tal como cardiopatía, la presión arterial alta, anemia, u otros trastornos de sangre	0	1
28_3.	Condiciones digestivas, tal como úlceras, colitis, trastornos del hígado/intestino, o alimentación por sonda	0	1
28_4.	Condiciones de tragar, tales como dificultad para tragar , reflujo gástrico, o aspiración	0	1
28_5.	Condiciones de la vejiga o del riñón	0	1
28_6.	Condiciones del sistema nervioso tal como esclerosis múltiple, síndrome orgánico cerebral, enfermedad de Parkinson, o convulsiones	0	1
28_7.	Condiciones de hormona o endocrino, tal como diabetes, problemas con la glándula tiroides, o terapia de reemplazo hormonal	0	1
28_8.	Condiciones crónicas relacionadas con la piel, el cabello, o las uñas, tal como las uñas de los pies gruesas, eczema, psoriasis, o dermatitis	0	1
28_9.	Condiciones musculoesqueléticas, tal como dificultades de los músculos con los brazos y/o las piernas, artritis, osteoporosis, o parálisis cerebral	0	1
28_10.	Alergias, tal como aquellos a la comida, medicamentos, o alergias estacionales	0	1
28_11.	Otras condiciones (Por favor, especifique) _____	0	1

29) Por favor indique si [nombre] ha ido a o utilizado algunos de los siguientes servicios de salud en los últimos 3 meses en cualquier ambiente para cuidado de rutina o no de rutina.

		No	Sí
29_1.	Ha ido a una clínica de emergencia o una sala de emergencia en un hospital.	0	1
29_2.	Pasó la noche en un hospital	0	1
29_3.	Vio a un podólogo (p. ej. un especialista para los pies)	0	1
29_4.	Vio a un psiquiatra	0	1
29_5.	Vio a un psicólogo para terapia o manejo de comportamiento	0	1
29_6.	Vio a cualquier otro especialista de comportamiento *(tal como un analista del comportamiento)*	0	1
29_7.	Recibió fisioterapia	0	1
29_8.	Recibió la terapia del habla y del lenguaje	0	1
29_9.	Recibió terapia ocupacional	0	1

30) Por favor indique si [nombre] recibió algunos de los siguientes servicios o tratamientos médicos especiales en su hogar o residencia en los últimos 3 meses.

		No	Sí
30_1.	El uso de enemas o equipo de intestino especial	0	1
30_2.	Cateterismo	0	1
30_3.	Succionando por lo menos una vez al día para remover líquidos internos	0	1
30_4.	Cuidado especial de respiración o respiratorio, tal como el uso del inhalador o nebulizador	0	1
30_5.	Girarse o posicionarse para proteger la integridad de la piel	0	1
30_6.	Vendar y cuidado de herida	0	1
30_7.	Diálisis o el uso de un aparato para los riñones	0	1
30_8.	Cualquier medicamento por vía inyección por otras personas o por vía intravenosa en casa **además de la insulina por vía auto-inyector** (que es similar a un EpiPen o FlexPen)	0	1
30_8a.	La insulina administrado con un auto-inyector (que es similar a un EpiPen o FlexPen)	0	1
30_9.	¿Es [nombre] alimentado por sonda¿	0	1

[Solo Pregunte 30_9a si la respuesta a 30_9 es "Sí".]

		No	Sí
30_9a.	¿Come [nombre] cualquier comida por la boca?	0	1

[Pase a 30_11 si la respuesta a 30_9a es "No"]

[Solo Pregunte 30_10a – 30_10e si la respuesta a 30_9 es "No" o si la respuesta a30_9a es "Sí"]

		No	Sí
30_10a.	¿Ha usado [nombre] equipo adaptable para comer, tal como un reborde para platos, cubiertos especiales (que no sea una sonda)?	0	1
30_10b.	¿Ha requerido [nombre] asistencia debido a un(os) incidente(s) de asfixia, tal como requerir que la comida sea desobstruida de la boca con la mano o la maniobra de Heimlich?	0	1
30_10c.	¿Es [nombre] físicamente alimentado/a por otros?	0	1
30_10d.	¿Requiere [nombre] preparación de comida especial, tal como comida hecha en puré o picada?	0	1
30_10e.	¿Tiene [nombre] necesidades de dieta especiales, tal como una dieta baja en sal?	0	1
30_11.	¿Requirió algunos aumentos en líquidos?	0	1

31) Por favor indique si alguno del siguiente <u>equipamiento adaptable o especial</u> ha sido usado por [nombre] en algún momento <u>en los últimos 3 meses.</u>

(Nota: Si es recetado, pero no usado en los últimos 3 meses, conteste "No.")

		No	Sí
31_1.	Lentes u otras ayudas visuales	0	1
31_2.	Un andador ortopédico	0	1
31_3.	Muletas o bastón	0	1
31_4.	Un aparato ortopédico o férula	0	1
31_5.	Audífonos	0	1
31_6.	Imágenes de símbolos o cualquier otro aparato de comunicación	0	1
31_7.	Un casco que no se usa para montar en bicicleta o montar a caballo	0	1
31_8.	Un aparato ortopédico recetada o zapatos ortopédicos	0	1
31_9.	Una cama especial o modificaciones de cama tal como barandillas de cama, un colchón especial, una cama elevado, una cama de hospital	0	1
31_10.	Otro (Por favor, especifique)_____	0	1

EXPERIENCIA ESCOLAR

32. ¿Alguna vez asistió [nombre] a cualquier tipo de escuela pública o privada, incluyendo una escuela especial para discapacitados?

0. No ➔ ***Pase a la pregunta 37***
1. Sí
98. No sé ➔ ***Pase a la pregunta 37***

33. ¿Está [nombre] actualmente inscrito/a en una escuela secundaria u otra tipo de escuela especial para discapacitados?

(Nota: Por favor conteste "No" si [nombre] asiste a una universidad o una escuela técnica posterior a la escuela secundaria.)

0. No ➔ ***Pase a la pregunta 37***
1. Sí

34. ¿Está [nombre] participando en algunas actividades de trabajo patrocinado por la escuela, como un trabajo por estudio, pasantías, u otro negocio basado en la escuela?

0. No ➔ ***Pase a la pregunta 36***
1. Sí
98. No sé ➔ ***Pase a la pregunta 36***

35. ¿Es [nombre] pagado por este trabajo?

1. Sí, por todo
2. Sí, por parte
3. No, por todo
4. No sé

36) ¿Qué piensa que va a hacer [nombre] después de salir de la escuela?

		No	Sí
36_1.	Conseguir un trabajo a sueldo (ganando por los menos el salario mínimo)	0	1
36_2.	Una universidad o escuela de iniciación	0	1
36_3.	Clases prácticas (del instituto de formación profesional) o escuela técnica	0	1
36_4.	Un programa de día	0	1
36_5.	Otro (Por favor, especifique)_____	0	1

EMPLEO ACTUAL

37. ¿Tiene [nombre] un trabajo a sueldo?

0. No ➔ ***Pase a la pregunta 41***
1. Sí
98. No sé ➔ ***Pase a la pregunta 41***

38. ¿Aproximadamente cuantas horas por semana trabajó [nombre] en este trabajo a sueldo en las últimas dos semanas?

Por favor seleccione del menú desplegable abajo.

_____ horas
[Valores del menú desplegable = 1 hora o menos hasta 40 o más, No sé = 98]

39. ¿Aproximadamente cuánto se le pagó a [nombre] por hora? *(Si no está seguro de la cantidad exacta, por favor introduzca su mejor estimación.)*

(Por favor provee la cantidad aproximada sólo en dólares estadounidenses. No incluye el símbolo del dólar ($).)

$_____

40. ¿Tiene [nombre] un entrenador de trabajo o alguien especial de una agencia quien le ayuda en este trabajo a sueldo?

0. Sí, normalmente ➔ ***Pase a la pregunta 48***
1. A veces ➔ ***Pase a la pregunta 48***
2. De vez en cuando ➔ ***Pase a la pregunta 48***
3. No, no lo necesita ➔ ***Pase a la pregunta 48***

EMPLEO ANTERIOR

41. ¿Ha tenido [nombre] un trabajo a sueldo en las últimas dos años?

0. No ➔ ***Pase a la pregunta 45***
1. Sí
98. No sé ➔ ***Pase a la pregunta 45***

42. ¿Aproximadamente cuantas horas por semana en promedio tenía que trabajar [nombre] por sueldo?

Por favor seleccione del menú desplegable abajo.

_____ horas

[Valores del menú desplegable = 1 hora o menos hasta 40 o más, No sé = 98]

43. ¿Aproximadamente cuánto se le pagaba a [nombre] por hora? *(Si no está seguro de la cantidad exacta, por favor introduzca su mejor estimación)*

(Por favor provee la cantidad aproximada sólo en dólares estadounidenses. No incluye el símbolo del dólar ($).)

Cantidad aproximada pagado por hora $_____

44. ¿Tuvo [nombre] un entrenador de trabajo o alguien especial de una agencia a quien le ayudaba en este trabajo al sueldo?

0. Sí, normalmente
1. A veces
2. De vez en cuando
3. No, no lo necesita

EMPLEO DEL FUTURO

45. ¿Estaba [nombre] activamente buscando y tratando de conseguir un trabajo a sueldo en las últimas dos semanas?

    0. No
    1. Sí

46. ¿Cuán probable piensa que [nombre] tendrá un trabajo a sueldo el próximo año?

    0. Definitivamente no lo tendrá➔ ***Pase a la pregunta 48***
    1. Probablemente no lo tendrá
    2. Probablemente lo tendrá
    3. Definitivamente lo tendrá

47. Si [nombre] tuviera un trabajo a sueldo el próximo año, ¿cuánto piensa que ganaría [nombre] por hora?

    (Por favor provee la cantidad aproximada sólo en dólares estadounidenses. No incluye el símbolo del dólar ($).)

    $_____

CONTACTO CON LA DIVISIÓN DE REHABILITACIÓN VOCACIONAL (DVR POR SUS SIGLAS EN INGLÉS)

48. ¿Ha tenido usted contacto con alguien que trabaja para la División de Rehabilitación Vocacional (DVR) en los últimos dos años?

    0. No ➔ ***Pase a la pregunta 50***
    1. Sí

49. ¿Cuán útil fueron estos servicios o información provista por la División de Rehabilitación Vocacional?

    1. Muy útil
    2. Algo útil
    3. No muy útil
    4. No útil para nada
    98. No sé

CARACTERÍSTICAS DEL CUIDADOR

Por favor anote: Las siguientes preguntas se aplican a la cuidadora al cuidador principal de [nombre]. Si usted no es el cuidador principal de [nombre] [Pregunta 2 es "No" o Pregunta 4 es "Agencia o personal de una casa hogar (Clínico)" o (No-clínico)], pase a la pregunta 60.

Dado que la División de Discapacidades del Desarrollo está preocupada por las experiencias de toda la familia, incluyendo a los que prestan apoyo, ahora queremos saber más acerca de USTED. Por favor tenga en cuenta que estas preguntas se hacen solo con fines de mantenimiento de registros y para aprender más acerca de quien estamos sirviendo.

50. ¿Cuántos años de estudios ha tenido la oportunidad de completar?

1. Ninguna educación formal
2. 1° grado hasta 8° grado
3. Asistió a la escuela secundaria, pero NO se graduó
4. Se graduó de la escuela secundaria /obtuvo el certificado estadounidense del Desarrollo Educacional General (GED)
5. Un instituto profesional, o escuela técnica, o vocacional después de la escuela secundaria
6. Hasta algún grado de la universidad (pero todavía no ha obtenido so título)
10. Recibió un título asociado de un programa de 2 años (Asociado en Artes [AA], Asociado en Ciencias [AS], o Asociado en Ciencias Aplicadas [AAS]) o un título de enfermera registrada (RN) de 3 años
7. Recibió un título de 4 años (Licenciatura en Artes (BA), Licenciatura en Ciencias (BS), Licenciatura)
8. Está trabajando actualmente en tarea de postgrado o para recibir su título postgrado. (p. ej., un Doctorado o Máster)
9. Cumplió la tarea de postgrado y recibió un título de postgrado (p. ej., un Doctorado o Máster)

51. ¿Está usted empleado/a actualmente?

0. No ➔ ***Pase a la pregunta 54***
1. Sí

52. ¿Está este empleo dentro o fuera de su casa?

1. Dentro de la casa
2. Fuera de la casa
3. Ambos dentro y fuera de la casa

53. En promedio, ¿cuántas horas por semana trabaja a <u>sueldo</u>?

(Incluya la hora de almorzar, pero no el tiempo de viaje para ir y venir de su trabajo.)

Por favor seleccione del menú desplegable abajo.

_____

[Valores del menú desplegable = 1 hora o menos hasta 40 o más, No sé = 98]

54. En total, ¿cuántas personas de menos de 18 años actualmente viven en su hogar?

(Seleccione 0 si no hay ninguno.)

Por favor seleccione del menú desplegable abajo.

_____

[Valores del menú desplegable= 0 a 10 o más]

55. En total, ¿cuántas personas de 18 años o más actualmente viven en su hogar, incluyéndose usted y [nombre]?

Por favor seleccione del menú desplegable abajo.

_____

[Valores del menú desplegable= 0 a 10 o más]

56. Además de cuidar a [nombre], ¿es usted actualmente el cuidador principal para cualquier otra persona dentro o fuera de su hogar que necesita cuidado especial, como un niño discapacitado, un padre anciano, cónyuge discapacitado, etc.?

0. No ➔ ***Pase a la pregunta 58***
1. Sí

57. ¿Vive esta persona con usted?

0. No
1. Sí

58. ¿Cuál de lo siguiente mejor representa su herencia racial o étnica?

Por favor seleccione todas las que correspondan.

1. Hispano, latino, u origen español
2. Negro o afroamericano
3. Blanco
4. Asiático
5. Aborigen de América del Norte o nativo de Alaska
6. Nativo Hawaiano o nativo de la Polinesia
98. Algún otro grupo (Por favor, especifique) _____

59. ¿Qué edad tenía en su último cumpleaños?

Por favor seleccione del menú desplegable abajo.

_____

[Valores del menú desplegable = 18 a 97 o mayor, Prefiero no decirlo = 3]

60. ¿Recibe [nombre] o está usted de parte de [nombre] actualmente recibiendo cualquiera de los siguientes?

		No	Sí
60_1.	Ingreso Suplementario de Seguridad (SSI, por sus siglas en inglés)	0	1
60_2.	Medicaid o New Jersey Family Care	0	1
60_3.	Beneficios del Seguro Social (de jubilación, de discapacidad, de familiares sobrevivientes)	0	1
60_4.	Medicare	0	1
60_5.	Estampillas para alimentos	0	1
60_6.	Prestaciones por desempleo	0	1
60_7.	Cualquier otra forma de asistencia estatal o local, además de aquellos mencionados (Por favor, especifique) _____	0	1

[Solo pregunte Pregunta 61 si la respuesta a 1a es "Respondedor de parte del consumidor", y si Pregunta 4 equivale 7, 8 o 98]

61. ¿De cuál de las siguientes fuentes ha obtenido información para completar esta evaluación?

		No	Sí
61_1.	Historia Médica/ Plan de Servicio Individual (ISP por sus siglas en inglés))	0	1
61_2.	Guardián legal	0	1
61_3.	Miembro de la familia	0	1
61_4.	[nombre]	0	1
61_5.	Otros profesionales	0	1
61_6.	Su propio conocimiento de [nombre]	0	1
61_7.	Otro (Por favor, especifique) _____	0	1

IMPORTANTE: Casi está completada la encuesta. Si desea verificar sus respuestas o hacer cualquier corrección, por favor hágalo ahora.

Una vez que haya completado esta evaluación y enviado sus respuestas, *no será capaz de hacer cualquier otro cambio*.

Initials) ¿Es usted un miembro del personal de DDPI?

1. Sí (Si contestó "Sí") Por favor, proporcione sus iniciales en el cuadro abajo _____.
2. No

[Solo Pregunte Intervw_As_1 e Intervw_As_2 si la respuesta a Initials es "No"]

Intervw_As_1) ¿Alguien le ayudó completar esta encuesta?

1. Sí
2. No ➔ ***Pase al final***

Intervsw_As_2) Por favor proporcione el nombre de la persona que le ha ayudado, y su agencia en el cuadro abajo.

Nombre _____

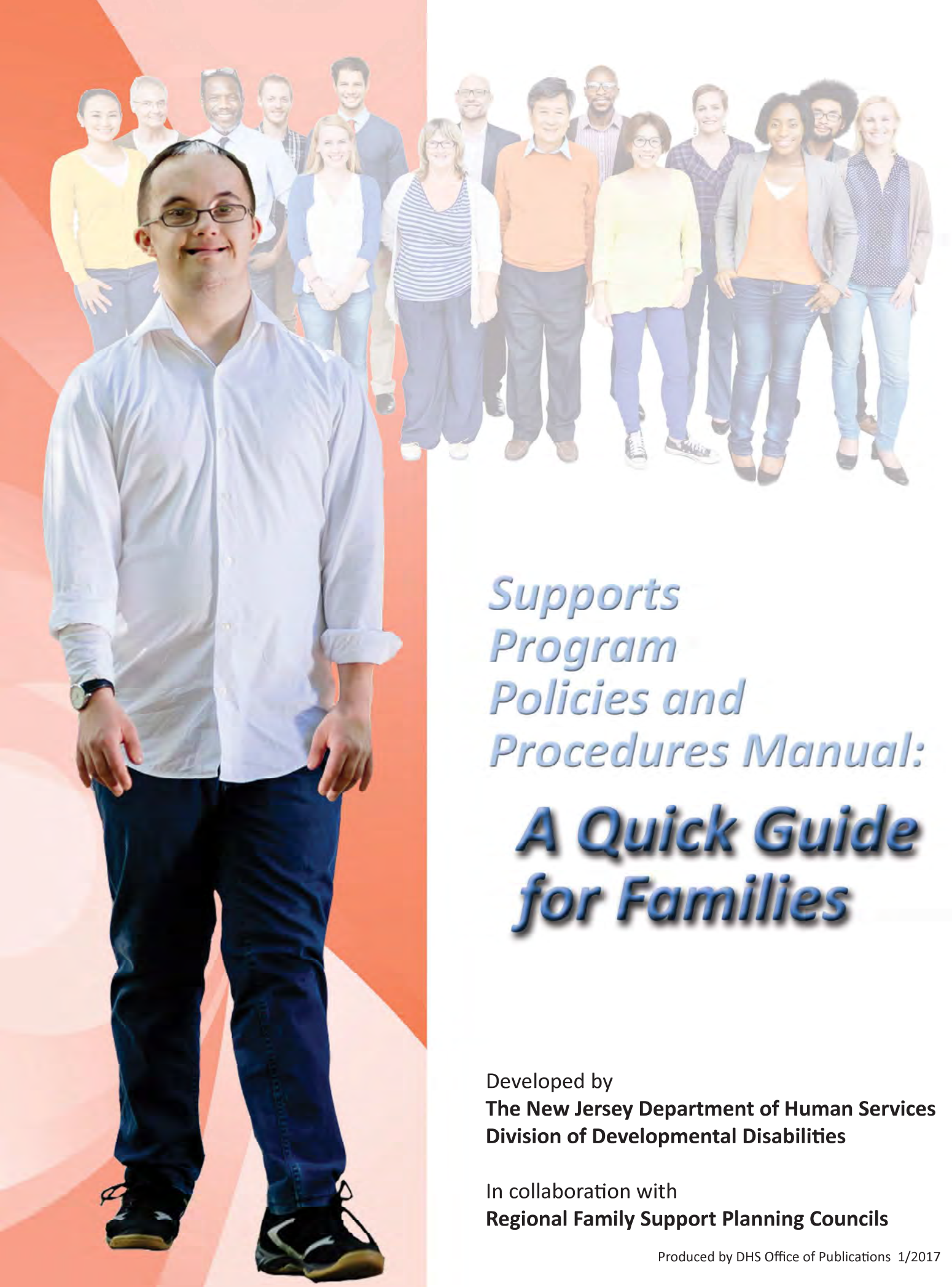
Agencia _____

Cuando haya terminado, pulse el botón "Enviar" en la esquina inferior derecha de la pantalla para finalizar la encuesta.

Muchas gracias por completar la encuesta.

Sus respuestas han sido registradas y enviadas.

La División de Discapacidades del Desarrollo (DDD) de New Jersey se pondrá en contacto con usted en un futuro próximo según los siguientes pasos del proceso.



Supports Program Policies and Procedures Manual:

A Quick Guide for Families

Developed by
The New Jersey Department of Human Services
Division of Developmental Disabilities

In collaboration with
Regional Family Support Planning Councils

Produced by DHS Office of Publications 1/2017

Introduction

The **Supports Program** was developed by the New Jersey Department of Human Services' Division of Developmental Disabilities (DDD), which provides public funding for certain services that assist eligible New Jersey adults with intellectual and developmental disabilities, age 21 and older, to live as independently as possible.

What is the Purpose of this Guide?

This guide summarizes the information in DDD's **Supports Program Policies and Procedures Manual – the rules that govern Supports Program eligibility and process –** in a comprehensive, yet uncomplicated format for families.

This guide is based on the information contained in DDD's Supports Program Policies and Procedures Manual. It is not intended to, nor does it replace the Supports Program Policies and Procedures Manual. The complete policy manual is available on the DDD website:

http://tinyurl.com/supportsprogrammanual

The Supports Program Policies and Procedures Manual is the final and definitive source for all policies and procedures related to DDD's Supports Program.

For questions, please contact:
DDD.SuppProgHelpdesk@dhs.state.nj.us
800.832.9173

Or visit:
NJ Division of Developmental Disabilities
www.nj.gov/humanservices/ddd

The Division of Developmental Disabilities would like to express appreciation to the **Regional Family Support Planning Councils** *for their assistance in the development of this guide, and to the families who provided valuable input and feedback.*

The Supports Program Policies and Procedures Manual:

A QUICK GUIDE FOR FAMILIES

Table of Contents

To be determined eligible for DDD services, an individual must:

- **Be a New Jersey resident**
- **Be Medicaid eligible**
- **Meet the functional criteria** of having a developmental disability, and must document that s/he has a chronic physical and/or intellectual impairment that
  - manifested in the developmental years, before age 22;
  - is lifelong; and
  - substantially limits the individual in at least three of the following life activities: self-care; learning; mobility; communication; self-direction; economic self-sufficiency; and the ability to live independently.

Medicaid Eligibility and the Supports Program

An applicant must be **Medicaid eligible** in order to access Supports Program services. (*To be "Medicaid eligible" means that an individual has applied and been approved for Medicaid and continues to meet the income and financial resources criteria for Medicaid.*)

Every New Jersey resident who qualifies for and receives federal SSI (Supplemental Security Income) automatically receives New Jersey Medicaid. Therefore, it is highly recommended and strongly encouraged that individuals with intellectual and developmental disabilities immediately apply for SSI when they turn 18.

To apply for SSI, contact the local Social Security office or call the **Social Security Administration** toll free at **1.800.772.1213** (TTY 1.800.325.0778). For help, contact DDD's **Medicaid Eligibility Help Desk**: **DDD.MediEligHelpdesk@dhs.state.nj.us.**

What if I'm not eligible for SSI?

If an individual's income and/or financial resources are above the limits for SSI eligibility, he or she can still apply for New Jersey Medicaid. (For example, s/he has money in a savings account, or receives a financial benefit due to a parent's death or because his/her parent has begun to collect social security benefits.) To apply for New Jersey Medicaid, contact the County Welfare Agency or Board of Social Services in the county where the individual resides.

To be determined DDD eligible, an individual must complete the **DDD Intake Application** and go through the **DDD Intake Process**.

The intake application, which must be mailed to DDD, is available on the DDD website or by contacting the **DDD Community Services Office** that serves the county where the individual resides.

Once the DDD Intake Application and all supporting documents have been received, DDD will conduct a preliminary eligibility review, and a **DDD Intake Worker** will create a case file for the individual.

After the preliminary review, the individual then will be referred to the Developmental Disabilities Planning Institute (DDPI) for completion of the **NJ CAT (New Jersey Comprehensive Assessment Tool**). A final review regarding the individual's eligibility for DDD services will be made when DDD receives the NJ CAT results. Once a determination regarding the individual's eligibility for DDD services has been made, a letter will be mailed to the individual/family.

*The **DDD Intake Worker** will be the individual's point of contact at DDD throughout the Intake Process. If there are questions or concerns during the intake process, the individual or his/her family should contact the individual's DDD Intake Worker.*

The **NJ CAT** **(New Jersey Comprehensive Assessment Tool**) is a tool that DDD uses to evaluate an individual's support needs in three main areas: **(1) Self-care, (2) Behavioral,** and **(3) Medical.** Completion of the NJ CAT is required for any individual who wishes to access Supports Program services.

The NJ CAT consists of two main components

Functional Criteria Assessment (FCA)

The FCA evaluates an individual's abilities in the following seven areas:

Ability to live independently
Communication
Economic self-sufficiency
Learning
Mobility
Self-care
Self-direction

Developmental Disabilities Resource Tool (DDRT)

The DDRT component of the NJ CAT evaluates the individual's abilities. It is a tool that makes sure that people with similar needs have access to similar levels of support.

There are no "right" or "wrong" answers on the NJ CAT.

Answers should reflect an individual's support needs and conditions at the time of the assessment.

The person who completes the NJ CAT is referred to as the **informant**. It is best for the NJ CAT informant to be someone who knows the individual well and spends a lot of time with him or her, both during the day and overnight. In many cases, a family member or guardian is the informant for the NJ CAT.

The NJ CAT is administered by the Rutgers University **Developmental Disabilities Planning Institute** (DDPI), on behalf of DDD, and is completed in one of two ways:

- **Online,** by receiving a password-protected link by email from DDPI 
- **Over the telephone**, with a professional from DDPI 

The NJ CAT assessment cannot be submitted by mail or fax.

A **sample NJ CAT assessment** can be found on the **NJ CAT** resource page of the DDD website.

Typically, the NJ CAT results are valid for five years. However, at the time of an individual's **initial enrollment** in the Supports Program the NJ CAT should not be older than one year (i.e., completed more than one year prior to the initial enrollment date). If the NJ CAT is older than one year, a new NJ CAT must be completed.

The NJ CAT results establish an individual's **tier**, which determines the individual's **annual budget amount**. The tier also determines the **provider reimbursement rate** for that individual for many Supports Program services.

Within two—four weeks of completion of the NJ CAT, eligible individuals will receive mailed notification of the tier. The assigned Support Coordinator can provide a copy of the completed NJ CAT, upon request, to the individual and/or the individual's guardian.

If an individual experiences changes in his/her level of care, behavioral, or medical needs, an NJ CAT reassessment may be needed. The process to request a reassessment is found in Section 3.6 of the Supports Program Policies and Procedures Manual.

What is the Supports Program?

Section 4, Supports Program Policies and Procedures Manual

The **Supports Program** is a Medicaid waiver program that provides certain services for eligible adults with intellectual and developmental disabilities, age 21 and older, living with their families or in other non-licensed settings.

The Supports Program

- is designed to help New Jersey better serve adults with intellectual and developmental disabilities, and to assist them to live in their communities
- provides opportunities for individuals with intellectual and developmental disabilities to make their own choices and direct their own services
- provides all enrollees with **Employment/Day Services** and **Individual/ Family Support Services**; individuals and their families are able to choose from a variety of services, based on the individual's assessed needs
- enables individuals who need both Private Duty Nursing (PDN) services and Supports Program services to enroll in Supports Program Plus Private Duty Nursing (SP+PDN)

Supports Program Eligibility

Section 5, Supports Program Policies and Procedures Manual

To enroll in and access services through the Supports Program, an individual first must be determined **DDD eligible** and **Medicaid eligible**. **All individuals who have been determined eligible for DDD services and who are Medicaid eligible can enroll in the Supports Program**, *except for individuals already enrolled on another Medicaid waiver program, such as the Community Care Waiver (CCW) or Managed Long Term Services and Supports (MLTSS*).

Supports Program Enrollment

Sections 5.2 and 5.3, Supports Program Policies and Procedures Manual

Once an individual is determined DDD eligible, the next steps to enroll in the Supports Program in order to begin services are:

1. Individual/family chooses (*or is auto-assigned to*) a **Support Coordination Agency**
2. Support Coordination Agency assigns a **Support Coordinator**
3. Support Coordinator explains the Supports Program Participant Enrollment Agreement
4. Individual signs the **Supports Program Participant Enrollment Agreement**

As indicated in the **Supports Program Participant Enrollment Agreement**, which the individual signs when enrolling in the Supports Program, it is very important to know what the individual needs to do (or not do!) to remain eligible for services through the Supports Program.

WHAT TO DO:

- ✓ **Submit all required information and documentation on time.**
- ✓ **Provide accurate and updated information.**
- ✓ **Participate in monthly, quarterly, and annual contacts/visits conducted by the Support Coordinator.**
- ✓ **Maintain Medicaid eligibility.**
- ✓ **Follow the rules explained in the Supports Program Participant Enrollment Agreement.**

If one or more of the following situations occurs, the individual may not be able to access Supports Program services:

- ➔ The individual loses his/her Medicaid eligibility.
- ➔ The individual has moved out of New Jersey.
- ➔ The individual has enrolled in another Medicaid waiver program.
- ➔ The individual does not access Supports Program services (other than Support Coordination) for more than 90 days due to lack of need of services rather than lack of availability of services.

For a complete list of requirements for maintaining Supports Program eligibility, see Section 5.4 of the Supports Program Policies and Procedures Manual.

Support Coordination (care management) services are provided by an independent Support Coordination Agency in the community that has been approved by Medicaid and DDD to provide this service. The Support Coordination Agency helps the individual and his or her family connect with appropriate Supports Program services and other services available through NJ Medicaid ("State Plan"), as well as other needed medical, social, and educational services.

How to Choose a Support Coordination Agency

- Using the Provider Search Database at **https://irecord.dhs.state.nj.us/ProviderSearch**, **identify approved Support Coordination Agencies** that serve the county where the individual resides:
    1. Under Filter, select "Service" and check "Support Coordination"
    2. Select "Medicaid Approved" and check the box
    3. Select "County Served" and select the county in which the individual resides
    4. Click the magnifying glass icon

- **Call and/or visit several potential Support Coordination Agencies**, and/or **ask for recommendations from individuals/families you know** who already are enrolled in the Supports Program and receiving services to make an informed choice about which agency is a good fit for the individual's needs.

- **Complete and submit the Support Coordination Agency Selection Form**. The **Support Coordination Agency Selection Form** is available on the Support Coordination page of the DDD website, or can be requested from the DDD Intake Worker or the DDD Community Services Office that serves the county where the individual resides. *(It is a good idea to include both your first and second choice on the SCA Selection Form, as this will increase the possibility of being assigned to an agency of your choosing.)*

FOR HELP CHOOSING A SUPPORT COORDINATION AGENCY

The Boggs Center on Developmental Disabilities has developed guide booklets to assist individuals and their families in choosing a Support Coordination Agency:

http://rwjms.rutgers.edu/boggscenter/products/SelectingandEvaluatingSupportCoordinationAgency.html

DDD's Assignment of a Support Coordination Agency

- Within 2-4 weeks after the Support Coordination Agency Selection Form is received (or beginning in April of the exit year for students who have turned or are turning 21 and will be exiting the school system), DDD will assign a Support Coordination Agency based on the indicated preference.
- If no preference is indicated, or if the preferred agency does not serve the county where the individual lives or does not have openings, DDD will auto-assign a Support Coordination Agency.

Changing a Support Coordination Agency

- **The individual has the right and ability to change the Support Coordination Agency.**
- If an individual would like to change his/her Support Coordination Agency, he/she can choose a different Support Coordination Agency (*section 6.1.3, Supports Program Policies and Procedures Manual*).
- To change the Support Coordination Agency, a new **Support Coordination Agency Selection Form** must be submitted (*the form is available on the DDD website or by calling the DDD Community Services Office that serves the county where the individual lives*).
- The Support Coordination Agency Selection Form can be submitted to DDD by email or mail. (Email and mail address are included on the form.)

I want to change my Support Coordination Agency but I don't want to start the process all over.

You don't have to start all over! When you change your Support Coordination Agency, all the information already gathered and developed —including contact and demographic information, planning documents such as the Person Centered Planning Tool (PCPT) and Individualized Service Plan (ISP), monitoring tools, etc. —is transferred to your new Support Coordination Agency.

The Role of the Support Coordinator

Sections 6.2 and 6.3, Supports program Policies and Procedures Manual

The Support Coordination Agency will assign a professional **Support Coordinator**, who will contact the individual/family to introduce him/herself and begin the planning process.

THE SUPPORT COORDINATOR:

- Is the primary point of contact—or "go-to" person—for the individual/family
- Helps connect the individual with services and other resources in the community
- Is available 24/7 for emergent situations, and can schedule other interactions with the individual/family at their convenience

THE SUPPORT COORDINATOR WILL:

- **Foster a good relationship** with the individual and his/her family and develop an understanding of the individual's level of need
- **Be knowledgeable** about services and other resources available in the communities he/she serves
- **Understand the information** contained in the Supports Program Policies and Procedures Manual, including all services available through the Supports Program
- **Understand the difference** between acting as a resource, which is part of the Support Coordinator's role, and speaking for the individual or family, which **is not** part of the Support Coordinator's role

THE SUPPORT COORDINATOR'S ROLE IS DIVIDED INTO FOUR AREAS:

- **Individual Discovery** – Assisting the individual in identifying hopes, dreams, and goals through completion of the Person Centered Planning Tool (PCPT)
- **Plan Development** – Developing the Individualized Service Plan (ISP) with input from the individual and other service planning team members
- **Coordination of Services** – Arranging for and coordinating DDD services; services not available through the Supports Program or funded by DDD; and other resources that meet the needs of the individual
- **Monitoring Progress –** Making sure that the individual is receiving quality services that are meeting his/her needs and helping him/her progress toward identified outcomes

CHANGING A SUPPORT COORDINATOR

If an individual wishes to change his/her **Support Coordinator**, he/she should talk with the agency's Support Coordination Supervisor. *(See page 10 for "Changing a Support Coordination Agency.")*

➔ STEP 1: Service Planning Team Meets

The members of the service planning team will work together to develop one integrated plan for the individual. Members of the planning team will vary depending upon the needs and wishes of the participant, and will include at a minimum:

- Individual
- Support Coordinator
- Individual's parent/family or legal guardian, as appropriate
- Any service provider and/or additional person(s), approved by the individual, whose participation is necessary to develop a complete and effective plan

➔ STEP 2: Support Coordinator completes the Person-Centered Planning Tool

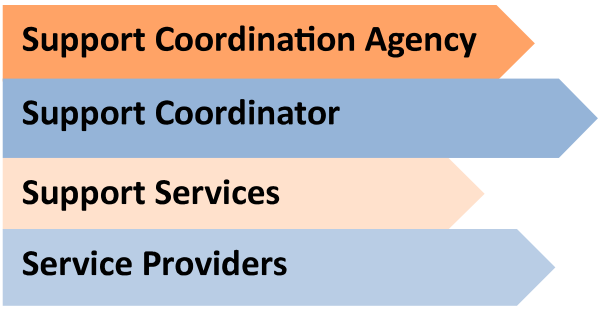
The **Person-Centered Planning Tool** (PCPT) assists the individual in identifying his/her hopes, dreams, and goals. The PCPT also includes the **Pathway to Employment**, which assists the individual in identifying employment-related outcomes for the service plan. The PCPT is written by the Support Coordinator in collaboration with the individual and his/her family, and other identified team members as needed. **The PCPT is completed before the Individualized Service Plan is developed** and must be used as part of the service planning process.

➔ STEP 3: Support Coordinator Develops the Individualized Service Plan

The **Individualized Service Plan** (ISP) is the document that directs and **prior authorizes** all Supports Program services and service providers. This means the individual's budget will only pay for services that are in the approved ISP. The Support Coordinator works with the individual and other planning team members to develop the ISP.

- The individual identifies his/her outcomes and, together with the Support Coordinator and planning team members, chooses appropriate services to reach those outcomes
- The individual's services, service providers, and service-related outcomes are documented in the ISP
- The ISP must be developed and approved within 30 days of Supports Program enrollment, and then renewed annually
- The ISP can be changed if an individual's needs or goals change
- Any changes in services or service providers must be documented and prior authorized through the ISP

The Supports Program gives individuals and families flexibility to choose and change any of the following:



Having the Freedom and ability to choose/change the individual's Support Coordination Agency, Support Coordinator, Support Services, and Service Providers is a basic, yet crucial part of the Supports Program.

All choices are made based on the individual's needs as identified in the Individualized Service Plan (ISP). The Individualized Service Plan (ISP) directs and prior authorizes all services and service providers, and any changes to services and/or service providers must be documented in the ISP. The Support Coordinator will work with the individual and his/her family to make sure that the individual's budget can accommodate the chosen services.

A list of available Supports Program services is included in this guide, on pages 16-17. The Support Coordinator will be familiar with professionals and agencies in his/her area that have been approved to provide Supports Program services. In addition, approved providers are listed in the web-based **Provider Search Database** and are searchable by a number of criteria, such as counties served, service type, etc.

It is important to know that individuals cannot receive services other than Support Coordination from their Support Coordination Agency, even if the agency is an approved provider of other services. This is a conflict of interest for the agency and is not allowed by DDD or Medicaid.

FOR HELP CHOOSING SERVICE PROVIDERS

The Boggs Center on Developmental Disabilities has developed guide booklets to assist individuals and their families in choosing service providers:
http://rwjms.rutgers.edu/boggscenter/SelectingaServiceProvider.html

For some services (*Community Based Supports, Interpreter Services, Respite, Supports Brokerage, and Transportation*), an individual and his/her family can choose to hire a Self-Directed Employee (SDE), sometimes called a "self-hire," as the provider. When hiring an SDE, the individual/family becomes the managing employer and the common law employer, and the individual/family is assisted in managing the SDE through the support of a Fiscal Intermediary (FI). The SDE and the service provided by the SDE must be prior authorized through the Individualized Service Plan (ISP) before services begin.

Important things to know when hiring a Self-Directed Employee:

SELF-DIRECTED EMPLOYEE	FISCAL INTERMEDIARY	INDIVIDUAL/FAMILY
Completes process to become approved to provide service	Ensures compliance with federal and state regulations and labor laws	Responsible for hiring, firing, and training of the Self-Directed Employee
Completes applicable mandated training	Manages payment to the Self-Directed Employee	Ensures compliance with Individualized Service Plan (ISP) – if an individual/family negotiates work outside of what is authorized through ISP, individual/family is responsible for payment

Entering the Supports Program: A Quick Overview

STEP 1	**INDIVIDUAL/FAMILY COMPLETES DDD INTAKE APPLICATION** ➔ DDD makes initial determination of DDD eligibility.
STEP 2	**INDIVIDUAL/FAMILY COMPLETES NJ CAT** *NJ CAT results establish the individual's tier, and tier determines the individual's budget.* ➔ **DDD** makes final determination of DDD eligibility. ➔ **DDD** provides written notification of DDD eligibility. ➔ **DDD** provides written notification of tier assignment to DDD eligible individuals.
STEP 3	**INDIVIDUAL/FAMILY SUBMITS SUPPORT COORDINATION AGENCY SELECTION FORM** *If the individual is still receiving school-based services, the Support Coordination Agency Selection Form is completed in February/March of the school year in which the individual turns 21 and will exit school-based services.* *If services are needed at age 21 and prior to exiting school-based services, the individual/family should contact DDD Intake.* ➔ **DDD** assigns Support Coordination Agency based on individual/family preference or through auto-assignment. ➔ **Support Coordination Agency** identifies a Support Coordinator to work with the individual/family. ➔ **Support Coordinator** contacts individual/family to introduce him/herself and schedule first Support Coordination meeting.
STEP 4	**INDIVIDUAL/FAMILY MEETS WITH SUPPORT COORDINATOR** ➔ **Individual** signs Supports Program Participant Enrollment Agreement. ➔ **Support Coordinator** completes Person-Centered Planning Tool (PCPT); helps identify and coordinates participation of service planning team; helps individual/family identify and connect with appropriate services and service providers; and develops Individualized Service Plan (ISP).
ONGOING	**SUPPORT COORDINATOR MAINTAINS MONTHLY CONTACT WITH INDIVIDUAL/FAMILY, OR MORE OFTEN IF NEEDED** ➔ Together with individual/family, Support Coordinator reviews progress and makes changes to services and service providers as needed and/or when individual/family requests a change.

Services Available in the Supports Program

Section 17, Supports Program Policies and Procedures Manual

Service	Section
ASSISTIVE TECHNOLOGY: *An item, piece of equipment, or product system used to increase, maintain, or improve an individual's functional capabilities*	**17.1**
BEHAVIORAL SUPPORTS: *Counseling, behavioral interventions, and/or diagnostic evaluations/ consultations to help an individual manage his/her behaviors and learn to interact with others*	**17.2**
CAREER PLANNING*: *Employment planning to help an individual get and keep a job*	**17.3**
COGNITIVE REHABILITATION: *Therapeutic cognitive activities to help an individual with a neurological impairment learn new and different ways to function*	**17.4**
COMMUNITY BASED SUPPORTS: *One-on-one direct support that promotes increased independence, productivity, enhanced family functioning, and inclusion in the community*	**17.5**
COMMUNITY INCLUSION SERVICES: *Direct support to assist a group of 2-6 individuals in educational, enrichment, or recreational activities*	**17.6**
DAY HABILITATION: *Education and training that assist an individual in gaining the skills needed to participate in the community (problem-solving skills, self-help skills, social skills, adaptive skills, daily living skills, and/or leisure skills)*	**17.7**
ENVIRONMENTAL MODIFICATIONS: *Physical adaptations to the private residence of an individual/family to ensure the health, welfare, and safety of the individual or to enable the individual to function with greater independence in his/her residence*	**17.8**
FISCAL MANAGEMENT SERVICES (An administrative service that does not come out of the individualized budget): *Assistance with disbursement of funds for Self-Directed Employees and fiscal accounting (referred to as Fiscal Intermediary, or FI)*	**17.9**
GOODS AND SERVICES: *Services, equipment, or supplies not provided through other Supports Program services, or other resources that address an identified need*	**17.10**
INTERPRETER SERVICES: *Face-to-face support to assist an individual to integrate more fully with community-based activities and employment*	**17.11**
NATURAL SUPPORTS TRAINING: *Training for caregivers who provide unpaid support, training, companionship, or supervision to an individual*	**17.12**
OCCUPATIONAL THERAPY: *Habilitative or rehabilitative, provided one-on-one or in a group (rehabilitative services available only after limits under the State Medicaid Plan are exhausted)*	**17.13**

Services Available in DDD's Supports Program

Section 17, Supports Program Policies and Procedures Manual

Service	Section
PERSONAL EMERGENCY RESPONSE SYSTEM (PERS): *Electronic device that gets help in an emergency*	**17.14**
PHYSICAL THERAPY: *Habilitative or rehabilitative, provided one-on-one or in a group (rehabilitative services available only after limits under the State Medicaid Plan are exhausted)*	**17.15**
PREVOCATIONAL TRAINING*: *Learning and work experiences that help an individual learn about jobs that he/she may be interested in, and learn skills to become more employable*	**17.16**
RESPITE: *Short-term care/support of an individual due to the absence or need for relief of the usual caregiver(s)*	**17.17**
SPEECH, LANGUAGE, AND HEARING THERAPY: *Habilitative or rehabilitative, provided one-on-one or in a group (rehabilitative services available only when the limits under State Medicaid plan are exhausted)*	**17.18**
SUPPORT COORDINATION (An administrative service that does not come out of the individualized budget): *Assists an individual to gain access to DDD program services, as well as needed medical, social, educational and other services*	**17.19**
SUPPORTED EMPLOYMENT – INDIVIDUAL*: *Assists an individual to get and/or keep a job in the general workforce at or above minimum wage*	**17.20**
SUPPORTED EMPLOYMENT – SMALL GROUP*: *Training activities in business, industry, and community settings for a group of 2-8 individuals*	**17.20**
SUPPORTS BROKERAGE: *Available to individuals using Self-Directed Employees for some or all services, to assist the individual in arranging for, directing, and managing these self-directed services (Intended to supplement, not duplicate, Support Coordination service)*	**17.21**
TRANSPORTATION: *Assists individual in gaining access to services, activities, and resources*	**17.22**
VEHICLE MODIFICATIONS: *Assessments, adaptations, or alterations to an automobile or van to accommodate an individual's needs*	**17. 23**

***Employment services (Career Planning, Prevocational Training, Supported Employment) must be initially accessed through the NJ Division of Vocational Rehabilitation Services (DVRS). If employment services are not available or have been exhausted through DVRS, Supports Program funding will be made available .**

DDD Community Services Offices for Intake

FLANDERS OFFICE	PATERSON OFFICE
Serving Morris, Sussex, Warren 1-B Laurel Drive, Flanders, NJ 07836 Phone: 973.927.2600	**Serving Bergen, Hudson, Passaic** 100 Hamilton Plaza, 7th Floor Paterson, NJ 07505 Phone: 973.977.4004
NEWARK OFFICE	**PLAINFIELD OFFICE**
Serving Essex 153 Halsey Street, 2nd Floor PO Box 47013 Newark, NJ 07101 Phone: 973.693.5080	**Serving Union, Somerset** 110 East 5th Street Plainfield, NJ 07060 Phone: 908.226.7800
FREEHOLD OFFICE	**TRENTON OFFICE**
Serving Ocean, Monmouth Juniper Plaza, Suite 1 - 11 3499 Route 9 North Freehold, NJ 07728 Phone: 732.863.4500	**Serving Hunterdon, Mercer, Middlesex** 120 South Stockton Street Trenton, NJ 08611 (Mail: PO Box 706, Trenton, NJ 08625-0706) Phone: 609.292.1922
MAYS LANDING OFFICE	**VOORHEES OFFICE**
Serving Atlantic, Cape May, Cumberland, Salem 5218 Atlantic Avenue, Suite 205 Mays Landing, NJ 08330 Phone: 609.476.5200	**Serving Burlington, Camden, Gloucester** 2 Echelon Plaza 221 Laurel Road, Suite 210 Voorhees, NJ 08043 Phone: 856.770.5900

QUESTIONS?

- Contact the Community Services Office that serves the county where the individual resides
- Contact the Supports Program Help Desk: **DDD.SuppProgHelpdesk@dhs.state.nj.us**
- Call DDD Toll-Free at **1.800.832.9173**

Additional Resources

APSE (Association for People Supporting Employment First)
www.apse.org (National chapter)
www.njapse.com (New Jersey chapter)

The Boggs Center on Developmental Disabilities
http://rwjms.rutgers.edu/boggscenter/

Community Health Law Project (CHLP)
http://chlp.org/

Disability Rights New Jersey (DRNJ)
www.drnj.org

Family Support Coalition of New Jersey
www.familysupportcoalition.org

Family Support Organizations (FSO)
www.nj.gov/dcf/families/support/support/

NJ Children's System of Care (CSOC)
http://performcarenj.com/

NJ Commission for the Blind and Visually Impaired (CBVI)
www.nj.gov/humanservices/cbvi/home/index.html

NJ Council on Developmental Disabilities (NJCDD)
www.njcdd.org

NJ Division of the Deaf and Hard of Hearing (DDHH)
www.nj.gov/humanservices/ddhh/home/index.html

NJ Division of Disability Services (DDS)
www.nj.gov/humanservices/dds/home/index.html
DDS annually publishes the comprehensive ***NJ Disability Resources Guide***

NJ Division of Vocational Rehabilitation Services (DVRS)
http://careerconnections.nj.gov/careerconnections/plan/foryou/disable/

NJ Statewide Independent Living Council
www.njsilc.org

Planning for Adult Life (PFAL) program
www.planningforadultlife.org

Regional Family Support Planning Councils (RFSPC)
www.njcdd.org/the-regional-family-support-planning-councils

Supportive Housing Association (SHA)
www.shanj.org

The New Jersey Department of Human Services (NJ DHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. NJ DHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The NJ DHS provides:

- free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters
- written information in other formats (large print, audio, accessible electronic formats, other formats)
- free language services to people whose primary language is not English, such as: Qualified interpreters
- information written in other languages

If you need these services, contact Bonny E. Fraser, Esq., or if you believe that the NJ DHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance:

NJ Department of Human Services
222 South Warren Street
PO Box 700
Trenton, NJ 08625-0700
Phone: 609.777.2026
Fax: 609.633.9610
Email: Bonny.Fraser@dhs.state.nj.us.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at www.hhs.gov/ocr/office/file/index.html

New Jersey

Department of Human Services

Division of Developmental Disabilities

In collaboration with

Regional Family Support Planning Councils

CHRIS CHRISTIE
GOVERNOR

KIM GUADAGNO
LT. GOVERNOR

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES
PO BOX 726
TRENTON, NJ 08625-0726
Visit us on the web at :
www.state.nj.us/humanservices/ddd

Elizabeth Connolly
Acting Commissioner

Elizabeth M. Shea
Assistant Commissioner

TEL. (609) 631-2200

Please mail the completed Intake Application Package to the Community Services Office serving the county in which the applicant resides. Address the envelope to the "Division of Developmental Disabilities, Intake Unit".

Flanders Office
Counties Served: Morris - Sussex - Warren
1-B Laurel Drive
Flanders, NJ 07836
Phone: (973) 927-2600

Paterson Office
Counties Served: Bergen - Hudson - Passaic
100 Hamilton Plaza, 7th Floor
Paterson, NJ 07505
Phone: (973) 977-4004

Newark Office
County Served: Essex
153 Halsey St., 2nd FL
P.O. Box 47013
Newark, NJ 07101
Phone: (973) 693-5080

Plainfield Office
Counties Served: Union - Somerset
110 East 5th Street
Plainfield, New Jersey 07060
Phone: (908) 226-7800

Freehold Office
Counties Served: Ocean - Monmouth
Juniper Plaza, Suite 1 - 11
3499 Route 9 North
Freehold, NJ 07728
Phone: (732) 863-4500

Trenton Office
Counties Served: Hunterdon - Mercer - Middlesex
120 South Stockton Street, Trenton, NJ 08611
Phone: (609) 292-1922
Mailing Address: P.O. Box 706, Trenton, NJ 08625-0706

Mays Landing Office
Counties Served: Atlantic - Cape May - Cumberland - Salem
5218 Atlantic Avenue
Suite 205
Mays Landing, NJ 08330
Phone: (609) 476-5200

Voorhees Office
Counties Served: Burlington - Camden - Gloucester
2 Echelon Plaza
221 Laurel Rd, Suite 210
Voorhees, NJ 08043
Phone: (856) 770-5900

In order to prevent any delay in processing your application, please insure that the Intake package is **not** addressed to PO BOX 726 Trenton, NJ.

Effective: 01/29/2014

CHRIS CHRISTIE
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Eligibility Documentation Checklist
Please complete the following forms as directed

Please Note: Individuals must be 18 years old to go through a functional evaluation for services. Individuals who meet functional criteria must also be 21 years old and Medicaid eligible before they can begin receiving services from the Division of Developmental Disabilities (DDD).

A. **DDD Eligibility Forms**:

- **Application for Eligibility.** The person completing the application must sign this form.
- **ICD Code Form.** This form must be completed by a Medical Professional.
- **Health Information and Portability and Accountability Act (HIPAA) information**
  - i. **Notice of Privacy Practices and Acknowledgement Form.** Please read the Department of Human Services *Notice of Privacy Practices* and sign and return the *Acknowledgement Form*.
  - ii. **Authorization for Disclosure of Health Information to Family and Involved Persons.** Gives DDD permission to talk with people the Applicant chooses about his or her health information. Complete, sign and return.
  - iii. **Authorization for the Release of Health Information.** Gives DDD permission to send copies of Applicant's health records to people or organizations chosen by the Applicant. Complete, sign and return.

Consent Form. For use with the documents in Section B

You must include as many of the available documents below that relate to your developmental disability. The more documentation you are able to provide, the easier it will be to process your application.

B. 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
_____Learning Evaluations/Social Summaries
_____Psychiatric Evaluation
_____Neurological Evaluation
_____Hospital Records/Discharge Summary
_____Physical Therapy Evaluation/Occupational Therapy Evaluation/Speech Therapy Evaluation

C. 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: 1) Voter Registration form 2) Pay Stub 3) W2 form 4) Real Estate Tax Bill or 5) Permanent Change of Station Orders to New Jersey (If individual's legal guardian is in the U.S. Military Service)

D. Other Necessary Documents:

_____Photocopy of Guardianship Order (if applicable)
_____Photocopy of Medicaid Card
_____Division of Vocational Rehabilitation Service (DVRS) Records/Evaluations (F3 form)
_____SSI annual award letter
_____Letter certifying Medicaid eligibility

E. NJ CAT Assessment: Will be administered by the Developmental Disabilities Planning Institute (DDPI) at a later date.

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PO BOX 726
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Elizabeth Connolly
Acting COMMISSIONER

Elizabeth M. Shea
Assistant Commissioner

Application for Eligibility

Please Note: Individuals must be 18 years old to go through a functional evaluation for services. Individuals who meet functional criteria must also be 21 years old and Medicaid eligible before they can begin receiving services from the Division of Developmental Disabilities (DDD).

In accordance with the Revised Statute, State of New Jersey, Section 30:4-25.2, application is being made to the Commissioner of the Department of Human Services for a determination of eligibility for services provided through DDD for:

Name: _____
First Middle Last

Date of Birth_____/_____/_____

By signing this application, I am declaring that:

1. This Application and all forms submitted along with it are completed as accurately as possible, and
2. I understand that I have the opportunity to appeal a determination of ineligibility in accordance with N.J.A.C. 10:48-1.1(j).

This application is being made under *R.S.* 30:4-25.2 by virtue of the relationship to the Applicant indicated above:

____Self

____Legal Guardian of the person _____Court of Competent Jurisdiction

Signature or Mark_____Date: _____

Signature of Witness (if mark) _____

Printed Name of Witness (if mark) _____

Title if Agency or Court representative _____

Do Not Write Below This Line – for DDD use only

_____Functional Criteria Met **_____Functional Criteria not met**

Eligible for Medicaid Yes_____No_____ **Closed due to insufficient information_____**

_____ _____ _____

DDD Representative Signature **Title/Discipline** **Date**

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Elizabeth Connolly
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Elizabeth M. Shea
Assistant Commissioner

Applicant Name _____

Date of Birth _____

Social Security # _____

Applicant's Primary Address _____

_____

Form Completed by _____

Relationship to Applicant _____

Phone Number _____ Email _____

Does Applicant have a Legal Guardian? ____No _____ Yes*

**If yes, please complete the below and provide a copy of the Guardianship Order with the application.*
Name_____Phone #:_____
Address _____
Relationship to individual _____

1. APPLICANT RESIDENCY AND OCCUPATION INFORMATION
Place of Birth (hospital, city, state or country if born outside U.S.)

_____
_____
If born outside U.S., is Applicant a U.S. citizen? ____ Yes ____ No
If No, is Applicant a permanent alien resident? ____ Yes ____ No
If Applicant has a legal guardian, is the legal guardian a permanent legal resident of New Jersey?
_____Yes _____No _____Has no legal guardian
Is Applicant currently receiving services from any agency in any state other than New Jersey?
_____Yes_____No If yes:

_____ _____ _____
Name of Agency Address Phone #

Is applicant currently receiving services from the NJ Department of Children and Families?
___Yes____No If yes, specify which services:

_____

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Does Applicant Reside in a Residential Program?_____Yes*_____No
**If yes, please complete*
Placement Type _____
Provider Name _____
Funding Source _____

Is Applicant Employed?_____Yes*_____No
**If yes, please complete*
Employer Name _____
Position _____

Does Applicant Attend a Day Program or School? _____Yes* _____No
**If yes, please complete*
Type of Program_____ Phone # _____
Name of Program/School _____
_____ Address _____
_____ Are you currently
~~Has DVR assisted you with employment or day services? _____Yes~~ ~~_____No~~
~~Has DVR assisted you with employment or day services? _____Yes _____No~~
Has DVR assisted you with employment or day services? _____Yes _____No

2. APPLICANT INSURANCE AND BENEFIT INFORMATION

Applicant's Medicaid Number_____
(Note: This is not the number on your Medicaid card. Please call N.J. Medicaid at 800-356-1561 to obtain your Medicaid number.)

Date of Medicaid Eligibility _____

If you do not have Medicaid, have you already applied for it?_____Yes_____No*

*If you do not have Medicaid, are you planning to apply for it?_____Yes_____No
(*Note: you will not be able to receive services without Medicaid.)*

Medicare? _____Yes_____No *If yes*, Medicare Number _____

Private Insurance?_____Yes_____No
If yes,
Policy Name Policy Number Telephone Number
_____ _____

Social Security Administration Death or Disability (SSA/SSDI) benefits? _____Yes ____ No
If yes: Claim # _____ Amount received per month: $ _____
If no: _____ Never applied _____ Application pending _____Ineligible

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Supplemental Security Income (SSI) benefits? _____Yes No
If yes, please complete
Claim #_____ Amount received per month: $ _____

If no, please complete
_____Never applied _____Application pending _____Ineligible

If Applicant receives SSA/SSDI or SSI, is there a Representative Payee?_____Yes* _____No
**If yes, please complete*

Benefit	**Name**	**Address**	**Phone**	**Relationship**
#1_____	_____	_____	_____	_____
#2_____	_____	_____	_____	_____

3. APPLICANT FAMILY AND HOUSEHOLD INFORMATION

Father:_____Living _____Deceased

If living, please complete the following
Name_____Date of Birth _____
Address, if different from Applicant_____
_____Phone (Home)
_____(Work)_____(Cell) _____
E-mail ___
Social Security #_____ Veteran? _____Yes _____No
Marital Status _____ Is Father an Emergency Contact?_____Yes___No

Mother:_____Living _____Deceased

If living, please complete the following
Name_____Date of Birth: _____
Address, if different from Applicant_____
Phone (Home)_____(Work)_____(Cell) _____
E-mail _____
Social Security #_____ Veteran?___Yes_____No_____
Marital Status _____
Marital Status/Maiden Name:_____Is Mother an Emergency Contact?_____Yes___No

Other Members of Applicants Household (Do not include parents if they are listed above)

Name _____ DOB_____Relationship _____
Name _____ DOB_____Relationship _____

NJ DEPT OF HUMAN SERVICES – DIVISION OF DEVELOPMENTAL DISABILITIES

This form MUST be completed by a Medical Professional (DC medical staff, private doctor, nurse, psychiatrist, psychologist, etc.).

IDENTIFYING INFORMATION (please print legibly)

Individual's Name: Birthdate:

DDD ID #: Last 4 Digits of Social Security #: Earliest Age of Onset:

CIRCLE APPLICABLE CODES

PRIMARY ICD-10 CODES	ICD-10 DIAGNOSTIC CODE	PRIMARY ICD-10 CODES	ICD-10 DIAGNOSTIC CODE
Abetalipoproteinemia	E78.6	Gonadal Dysgenesis (Turner's Syndrome)	Q96.9
Acrocephalosyndactyly (Apert's Syndrome)	Q87.0	Grand Mal Status	G40.409
Adrenaleukodystrophy	E71.529	Hallervorden-Spatz Syndrome	G23.0
Arginase Deficiency	E72.21	Head Injury, unspecified – Age of onset: _____	S09.90XA
Agenesis of the Corpus Callosum	Q04.3	Hemiplegia, unspecified	G81.90
Agenesis of Septum Pellucidum	Q04.3	Holoprosencephaly	Q04.2
Argyria/Pachygyria/Microgyria	Q04.3	Homocystinuria	E72.11
Aicardi Syndrome	G23.8	Huntington's Chorea	G10
Alcohol Embryo and Fetopathy	F84.5	Hurler's Syndrome	E76.01
Anencephaly	Q00.0	Hyperammonemia Syndrome	E72.4
Angelman Syndrome	Q93.5	I-Cell Disease	E77.0
Asperger Syndrome	F84.5	Idiopathic Torsion Dystonia	G24.1
Ataxia-Telangiectasia	G11.3	Incontinentia Pigmenti	Q82.3
Autistic Disorder (Childhood Autism, Infantile Psychosis, Kanner's Syndrome)	F84.0	Infantile Cerebral Palsy, unspecified	G80.9
Biotinidase Deficiency	D84.1	Intractable Seizure Disorder	G40.309
Canavan Disease	E75.29	Klinefelter's Syndrome	Q98.4
Carpenter Syndrome	Q87.0	Krabbe Disease	E75.23
Cerebral Palsy, unspecified	G80.9	Kugelberg-Welander Disease	G12.1
Cerebral Palsy, Hemiplegic, Congenital	G80.2	Larsen's Syndrome	Q74.8
Cerebral Palsy, Paraplegic, Congenital	G80.1	Leigh Disease	G31.82
Cerebral Palsy, Quadriplegic	G80.0	Lesch-Nyhan Syndrome	E79.1
Charcot Marie Tooth Disease	G60.0	Lissencephaly	Q04.3
CHARGE Association	Q89.8	Lowe (Terrey MacLachlan) Syndrome (Oculocerebrorenal Dystrophy)	E72.03
Cockayne Syndrome	Q89.8	Maple Syrup Urine Disease	E71.0
Coffin-Lowry Syndrome	Q89.8	Marfan Syndrome	Q87.40
Congenital Defects of Glycosylation	D80.3	Megalencephaly	Q04.5
Cornelia de Lange Syndrome	Q89.8	Menkes Disease (X-Linked)	E83.09
Cri-du-chat Syndrome	Q93.4	Metachromatic Leukodystrophy	E75.25
Crouzon Syndrome	Q75.1	Methylmalonic Aciduria (Acidemia)	E71.120
DiGeorge Syndrome	D82.1	Microencephaly	Q02
Down Syndrome	Q90.9	Mild Intellectual Disability	F70
Dubowitz Syndrome	Q07.8	Mixed Conductive and Sensorineural Hearing Loss	H90.8
Duchenne Muscular Dystrophy	G71.0	Moderate Intellectual Disability	F71
Dystonia Musculoram Deformans	G24.1	Moderate or Severe Impairment, Better Eye, Profound Impairment Lesser Eye	H54.10
Encephalopathy, not elsewhere classified	G93.40	Mucolipidosis Type IV	E75.11
Epilepsy, unspecified, not intractable, with status epilepticus	G40.901	Mucopolysaccharidosis (Hunter's Syndrome, Hurler's Syndrome, Scheie's Syndrome)	E76.01
Epilepsy, unspecified, not intractable, without status epilepticus	G40.909	Neuroaxonal Dystrophy	G23.0
Epilepsy, unspecified, intractable with status epilepticus	G40.911	Neurofibromatosis (von Recklinghausen's Disease)	Q85.01
Epilepsy, unspecified, intractable, without status epilepticus	G40.919	Neuronal Heterotopia	Q07.8
Fetal Alcohol Syndrome	Q86.0	Niemann-Pick Disease	E75.249
Fragile X Syndrome	Q99.2	Noonan Syndrome	Q87.1
Friedreich's Ataxia	G11.1	Other Cerebral Degeneration	G32.89 (non-specified)
Fucosidosis	E77.1	Other Chromosomal Abnormalities, not elsewhere classified	Q99.8
Gaucher's Disease	E75.22	Other Disorders of Purine and Pyrimidine Metabolism (Lesch-Nyhan Syndrome)	E79.1
Generalized Convulsive Epilepsy	G40.309	Other Specified Anomalies (Cornelia de Lange Syndrome, Seckel Syndrome)	Q87.1
Generalized Non-Convulsive Epilepsy	G40.401	Other Specified Anomalies of Nervous System (Familial Dysautonomia; Riley-Day Syndrome)	G90.1

	Circle Applicable Codes		Circle Applicable Codes
Other Specified Cerebral Degenerations in Childhood (Alper's Disease or Gray-Matter Degeneration; Infantile Necrotizing Encephalomyelopathy; Leigh's Disease; Subaute Necrotizing Encephalopathy or Encephamyelopathy, Rett's Syndrome)	G31.81	Spina Bifida, Cervical without hydrocephalus	Q05.5
Other Specified Pervasive Developmental Disorders (Asperger's Disorder, Atypical Childhood Psychosis; Borderline Psychosis of Childhood)	F84.5	Spina Bifida, Thoracic without hydrocephalus	Q05.6
Other Spinocerebellar Diseases (Ataxia-Telangiectasia [Louis-Bar Syndrome])	G11.3	Spina Bifida, Lumbar, without hydrocephalus	Q05.7
Paraplegia (Paralysis of Both Lower Limbs)	G82.20	Spina Bifida, Sacral without hydrocephalus	Q05.8
Partial Epilepsy, with Impairment of Consciousness (Psychomotor Epilepsy)	G40.201	Spina Bifida, unspecified	Q05.9
Patau's Syndrome	Q91.7	Spinal Cord Injury (Initial Encounter)	S14.109A
Pervasive Developmental Disorder- NOS	F84.9	Spinal Muscular Atrophy, Unspecified	G12.1
Pick's Disease	G31.01	Sturge-Weber Syndrome	Q85.8
Propionic Acidemia	E71.121	Symptomatic Torsion Dystonia (Athetoid Cerebral Palsy)	G80.3
Prader-Willi syndrome	Q87.1	Tay-Sachs Disease	E75.02
Profound Intellectual Disabilty	F73	Torch Syndrome	P00.2
Pyruvate Dehydrogenase Deficiency (lactic, pyruvic)	E74.4	Trisomy 13, nonmosaicism	Q91.4
Quadriplegia and Quadriparesis, unspeciified	G82.50	Trisomy 13, mosaicism	Q91.5
Quadriplegia C1-C4 complete	G82.51	Trisomy 13, translocation	Q91.6
Quadriplegia C1-C4, incomplete	G82.52	Trisomy 13, unspecified	Q91.7
Quadriplegia C5-C7, complete	G82.53	Trisomy 18 nonmasaicism	Q91.0
Quadriplegia C5-C7, incomplete	G82.54	Trisomy 18, mosaicism	Q91.1
Refsum's Disease	G60.1	Trisomy 18, traslocation	Q91.2
Rett's Syndrome	F84.2	Trisomy 18, unspecified	Q91.3
Rubinstien-Taybi Syndrome	Q87.2	Tuberous Sclerosis	Q85.1
Sandhoff Disease	E75.01	Unspecified (Traumatic Blindness NOS)	S04.019A
Sanfillippo Syndrome	E76.22	Unspecified Anomaly of Brain, Spinal Cord, and Nervous System	Q07.9
Schindler Disease Type 1	E77.1	Unspecified Cause of Encephalitis	G04.90
Schizencephaly	Q04.6	Unspecified Delay in Development (Developmental Disorder NOS)	F89
Seckel Syndrome	Q87.1	Unspecified Disease of Spinal Cord	G95.9
Septo-optic Dysplasia	Q04.4	Unspecified Intellectual Disability	F79
Severe Hypoxic Ischemis CNS Injury	P91.63	Unspecified Pervasive Developmental Disorder (Pervasive Developmental Disorder NOS)	F84.9
Severe Intellectual Disability	F72	Untreated Phenylketonuria	E70.0
Sjogren-Larsson Syndrome	Q80.9	Urea Cycle Defects	E72.20
Spastic Hemiplegia	G80.2	Usher Syndrome Type II	L10.4
Spielmeyer-Vogt Disease	E.75.4	Vater Association	Q87.2
Spina Bifida, Cervical, with hydrochephalus	Q05.0	Werdnig-Hoffman	G12.0
Spina Bifida, Thoracic, with hydrocephalus	Q05.1	Williams-Beauren Syndrome	Q87.8
Spina Bifida, Lumbar, with hydrocephalus	Q05.2	Wilson Disease	E83.01
Spina Bifida, Sacral, with hydrocephalus	Q05.3	Zellwager Syndrome	E71.510
Spina Bifida, Unspecified with hydrocephalus	Q05.4	Psychiatric Disorder or Problem	F99

Description of diagnosis (not listed on the previous pages) related to developmental disability):

_____

Code(s): _____

My signature of this document certifies that the diagnosis identified is based on medical evaluation and documentation and/or established medical evaluation and documentation. I understand that the information on this document and supporting documentation will be used by the Division of Developmental Disabilities (DDD) to certify Federal reimbursement for services rendered to the individual identified on this form. This form does not guarantee eligibility or services by DDD. My signature certifies that the information is accurate based on medical opinion supported by medical records.

Printed Name of Medical Professional

Signature of Medical Professional

Date

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
P O Box 700
Trenton, NJ 08625
609-777-2026

NOTICE OF PRIVACY PRACTICES
Effective date: September 23, 2013

Your Information. Your Rights. Our Responsibilities.

This notice applies to individuals, or legal guardians or parents of minor children receiving services from the Department of Human Services and describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

Although your health record is the physical property of the Department of Human Services, the information in your health record belongs to you. You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services

- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and may be used to determine your diagnosis or the course of treatment that should work best for you. A doctor or other health care professional may share your information with other healthcare professionals who are either part of the Department of Human Services or who are outside of the Department of Human Services to determine how to diagnose or treat you.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Business Associates

There are some services provided in our organization through contracts with business associates:

- Examples include our accountants, consultants and attorneys
- We may disclose your health information to them so that they can perform the job we've asked them to do
- However, we require that the business associates appropriately safeguard your information

Do research

We can use or share your information for health research when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
- Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date of this Notice: September 23, 2013

New Jersey Department of Human Services
Division of Developmental Disabilities

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

This form must be signed upon receipt of the Notice of Privacy Practices and returned to the New Jersey Division of Developmental Disabilities. If the Applicant is under 18, a Parent or the Legal Guardian must sign. If Applicant is 18 or older, Applicant or the Legal Guardian must sign.

I,_____(print or type name),

hereby acknowledge that I have received the Notice of Privacy Practices

on_____.

I am the (please check one):

_____ Applicant

_____ Parent (if applicant is under 18)

_____ Legal Guardian

_____ _____

Applicant, parent or legal guardian signature or mark* Date

If signed by someone other than Applicant:

_____

Applicant Name (please print)

If mark is provided:

_____

Witness signature

_____

Witness Name (please print)

DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO FAMILY AND INVOLVED PERSONS

I authorize the use/disclosure of health information about:

Individual's Name:_____

Date of Birth:_____

1. Person(s) authorized to use, disclose or receive information, include legal guardian, if applicable:

Primary Contact:	**Alternate Contact:**
Name:_____	Name:_____
Address:_____	Address:_____
_____	_____
Phone:_____	Phone:_____
Alt Phone:_____	Alt Phone:_____
Relationship:_____	Relationship:_____
Other Contact:	Other Contact:
Name:_____	Name:_____
Address:_____	Address:_____
_____	
Phone:_____	Phone:_____
Relationship:	Alt Phone:_____
	Relationship:_____

Attach additional sheets if needed.

2. I am authorizing DDD staff to contact the primary contact or alternate contact, via telephone, to advise of any illness, injury or incident that may need prompt attention or authorization

3. I am authorizing the DDD staff to provide the minimum necessary health information to the individuals listed above and/or other individuals who are permitted to visit.

4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect ability to obtain treatment or payment or my eligibility for benefits or services. I may inspect or copy any written information used/disclosed under this authorization.

5. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

6. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization. The request to revoke this authorization must be provided to the DDD Privacy Officer. The revocation will be effective on the date that the Privacy Officer receives the request.

7. The authorization expires on_____ or one year from the date of the individual's/legal guardian's signature.

8. A complete copy of this form will be maintained in the client record.

9. To Legal Guardians: If the individual receiving services is over the age of 18 and you have indicated that you are the Legal Guardian for this individual, you must attach a copy of Appointment of Guardianship to this form.

Signature (or mark) of
Individual or Legal Guardian:_____

Date of Signature:_____

Name of Legal Guardian* (if applicable):_____
*Copy of Valid Appointment of Guardianship must be attached.

If Mark is provided in place of signature, the mark must be witnessed:

Witness Signature (if applicable): _____

Witness Name/Title:_____

C: Case Manager - Original
Residential Program (if applicable)
Day Program (if applicable)

AUTHORIZATION FOR
THE DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)
TO RELEASE RECORDS CONTAINING INDIVIDUALHEALTH INFORMATION

I hereby authorize_____(facility/office) of the Division of Developmental Disabilities to disclose the individually identifiable health information as described below.

Name of Individual whose medical records are being requested:

_____

Name (Please print) Social Security Number Date of Birth

The medical records being requested were created between_____and_____. A specific description of these records is provided below:

_____

_____

Purpose for which records will be used:_____

_____

☐ The records will be reviewed at the facility/agency.

☐ The records are to be copied. They will be picked up at the facility/office.

☐ The records being requested should be copied and sent to the person or organization and address below:

Name & address of person requesting records:

_____

_____

_____

Name & address of person(s) or organization(s) to receive the records <u>if other than person making request</u>:

_____

_____

_____

Telephone #:_____

Fax #_____

<u>Legal Authority for this request:</u>

☐ These are my records, and I am a legally competent adult.
☐ I am the legal guardian of the individual whose records are being requested, and I have attached a valid appointment of guardianship to this authorization.
☐ I am a parent of the individual whose records are being requested, and who is under the age of 18.
☐ I have Power of Attorney for the individual, and the Power of Attorney authorizes me to be able to request the individual's medical records, and a copy of the Power of Attorney is attached.

Understandings and Agreements about this Authorization:

1. This authorization is voluntary and I understand that DDD cannot condition treatment based on the signing of this authorization, unless the authorization is: (a) for research-related treatment, or (b) solely for the purpose of creating health information for the use or disclosure to a third party.

2. This authorization will expire_____(date to be determined by person signing this form) from the date of my signature below.

3. I understand that I may revoke this authorization at any time by notifying DDD in writing, but if I do, it will not have any effect on any actions taken prior to the time DDD received the revocation.

4. I agree to waive all claims against the DDD facility/agency for the release of the requested information.

5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by DDD if the recipient of the information is not a health plan, health care provider, healthcare clearinghouse, or a business associate that has a contract with DDD.

6. I understand that if I request that records be copied and sent to me, DDD will make a good faith effort to send those records to me in reasonable amount of time.

7. I understand that if I wish to have copies made of the records, DDD may assess a fee for copying the records.

***Signature (or mark) of Individual, Parent of Minor Child, Legal Guardian or person with Power of Attorney who is making this Request (please circle correct role)**:

_____

Date of Signature: **Telephone Number:**

_____ _____

_____ (Printed name of person making request)

***If a mark is provided in place of a signature, above, the mark must be witnessed:**

Witness Signature (if applicable):_____

Witness Name:_____

Witness Title:_____

***If person making request is a guardian or Power of Attorney, a copy of Valid Appointment of Guardianship or Power of Attorney must be attached.**

Consent to Release Information
To the
Division of Developmental Disabilities

I,_____, do hereby grant permission for
(Individual, Parent of individual if under 18, Legal Guardian or Power of Attorney)

_____
(Name of individual, institution, agency or other holder of information to be released)

to release the report(s), evaluation(s), summaries or other information described below regarding_____'s application for eligibility for services provided through the N.J. Division of Developmental Disabilities.

Information to be released:

_____

_____

_____

_____

This information is to be released to:

_____, Intake Worker
N.J. Division of Developmental Disabilities
Address: _____
_____
_____

Signature or Mark:_____Date: _____

Signature of Witness (if mark): _____

Printed Name of Witness (if mark): _____

If other than Individual Named Above, Relationship: _____

Note: The information received through this release is subject to the confidentiality regulations of the Division and cannot be released outside the Division without written permission unless otherwise provided by N.J.A.C. 10:41 et seq.

ESTADO DE NEW JERSEY
DEPARTAMENTO DE SERVICIOS HUMANOS
DIVISIÓN DE DISPACIDADES DEL DESARROLLO
PO BOX 726
TRENTON, NJ 08625-0726
Visítenos en Internet en:
www.state.nj.us/humanservices/ddd

CHRIS CHRISTIE
GOBERNADOR

KIM GUADAGNO
VICE
GOBERNADORA

Elizabeth Connolly
Comisionada

Dawn Apgar
Comisionada Adjunta

Elizabeth M. Shea
Comisionada Asistente

TEL. (609) 631-2200

Envíe por correo el Paquete de solicitud de admisión completo a la Oficina de servicios comunitarios del condado en el que viva el solicitante. Envíe el sobre a la "Unidad de admisión de la División de Discapacidades del Desarrollo".

Oficina en Flanders
Condados que atiende: Morris - Sussex - Warren
1-B Laurel Drive
Flanders, NJ 07836
Teléfono: (973) 927-2600

Oficina en Paterson
Condados que atiende: Bergen - Hudson - Passaic
100 Hamilton Plaza, 7th Floor
Paterson, NJ 07505
Teléfono: (973) 977-4004

Oficina en Newark
Condado que atiende:
Essex
153 Halsey St., 2nd FL
P.O. Box 47013
Newark, NJ 07101
Teléfono: (973) 693-5080

Oficina en Plainfield
Condados que atiende: Union - Somerset
110 East 5th Street
Plainfield, New Jersey 07060
Teléfono: (908) 226-7800

Oficina en Freehold
Condados que atiende: Ocean - Monmouth
Juniper Plaza, Suite 1 - 11
3499 Route 9 North
Freehold, NJ 07728
Teléfono: (732) 863-4500

Oficina en Trenton
Condados que atiende: Hunterdon - Mercer - Middlesex
120 South Stockton Street, Trenton, NJ 08611
Teléfono: (609) 292-1922
Dirección postal: P.O. Box 706, Trenton, NJ 08625-0706

Oficina en Mays Landing
Condados que atiende: Atlantic - Cape May - Cumberland - Salem
5218 Atlantic Avenue
Suite 205
Mays Landing, NJ 08330
Teléfono: (609) 476-5200

Oficina en Voorhees
Condados que atiende: Burlington - Camden - Gloucester
2 Echelon Plaza
221 Laurel Rd, Suite 210
Voorhees, NJ 08043
Teléfono: (856) 770-5900

Para evitar cualquier demora en el procesamiento de su solicitud, asegúrese de que el paquete de admisión **no** esté dirigido a PO BOX 726 Trenton, NJ.

En vigencia: 01/29/2014

CHRIS CHRISTIE, GOBERNADOR

KIM GUADAGNO VICE GOBERNADORA

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Lista de verificación de documentación para elegibilidad

Complete los siguientes formularios según se indica

Tenga en cuenta: las personas deben tener 18 años para someterse a la evaluación funcional para los servicios. Las personas que cumplan con los criterios funcionales deben tener 21 años y deben ser elegibles para Medicaid antes de poder recibir los servicios de la División de Discapacidades del Desarrollo (DDD).

A. **Formularios de elegibilidad de la DDD**:
- **Solicitud para elegibilidad.** La persona que complete la solicitud debe firmar este formulario.
- **Formulario de códigos CIE.** Este formulario debe completarse por un profesional médico.
- **Información sobre la Ley de Portabilidad y Responsabilidad del Seguro de Salud (HIPAA)**
  i. **Aviso de prácticas de privacidad y formulario de acuse de recibo.** Lea el *Aviso de prácticas de privacidad* del Departamento de Servicios Humanos y firme y envíe el *Formulario de acuse de recibo (Acknowledgement Form)*.
  ii. **Autorización para la divulgación de información de salud a familiares y personas involucradas.** Le otorga permiso a la DDD para compartir la información de salud del solicitante con las personas que este elija. Complete, firme y envíe.
  iii. **Autorización para la divulgación de información de salud.** Le otorga permiso a la DDD para enviar copias de los registros de salud del solicitante a las personas u organizaciones elegidas por este. Complete, firme y envíe.

Formulario de consentimiento. Para usar con los documentos en la sección B.

Debe incluir tantos documentos como tenga disponible a continuación que estén relacionados con su discapacidad del desarrollo. Mientras más documentos proporcione, más fácil será procesar su solicitud.

B. Documentación de discapacidad del desarrollo

_____Documentación médica de la discapacidad
_____Declaración del médico
_____Evaluación psicológica más reciente (puntajes de cociente intelectual)
_____Todos los informes psicológicos disponibles
_____Informes escolares o equipo de estudio para niños más recientes
_____Resúmenes sociales/evaluaciones de aprendizaje
_____Evaluación psiquiátrica
_____Evaluación neurológica
_____Resumen de dada de alta/registros del hospital
_____Evaluación de fisioterapia/evaluación de terapia ocupacional/ evaluación de terapia del habla

C. Documentación legal de edad, ciudadanía de los EE. UU. y residencia en New Jersey

_____Fotocopia del certificado de nacimiento
_____Fotocopia de la tarjeta de Seguro Social *o* prueba de ciudadanía de los EE. UU. *o* tarjeta de residencia (*Green Card*)
_____Fotocopia de uno de los siguientes documentos: 1) formulario de registro para votar 2) comprobante de pago de salario/sueldo 3) formulario W2 4) factura de impuesto sobre los bienes raíces u 5) órdenes de traslado permanente a New Jersey (si el tutor legal de la persona forma parte del servicio militar de los EE. UU.)

D. Otros documentos necesarios:

_____Fotocopia del pedido de tutela (si corresponde)
_____Fotocopia de la tarjeta de Medicaid
_____Evaluaciones/registros de la División de Servicios de Rehabilitación Vocacional (DVRS) (formulario F3)
_____Carta de concesión anual del Ingreso Suplementario del Seguro Social (SSI)
_____Carta que certifique la elegibilidad para Medicaid

E. Evaluación de NJ CAT: será realizada por el Instituto de planificación de discapacidades del desarrollo (DDPI) en una fecha posterior.

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GOBERNADOR

KIM GUADAGNO
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COMISIONADA

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Solicitud para elegibilidad

Tenga en cuenta: las personas deben tener 18 años para someterse a la evaluación funcional para los servicios. Las personas que cumplan con los criterios funcionales deben tener 21 años y deben ser elegibles para Medicaid antes de poder recibir los servicios de la División de Discapacidades del Desarrollo (DDD).

De acuerdo con la sección 30:4-25.2 del estatuto revisado del Estado de New Jersey, la solicitud se realiza ante la Comisionada del Departamento de Servicios Humanos para la determinación de elegibilidad para servicios proporcionados a través de la DDD para la siguiente persona:

Nombre: _____
Primer nombre Segundo nombre Apellido

Fecha de nacimiento_____/_____/_____

Mediante la firma de esta solicitud, declaro que:

1. Esta solicitud y todos los formularios enviados con la solicitud se completaron de la forma más precisa posible.
2. Comprendo que tengo la oportunidad de apelar una determinación de falta de elegibilidad de acuerdo con el N.J.A.C. 10:48-1.1 (j).

Esta solicitud se realiza según *R.S.* 30:4-25.2 en virtud de la relación mencionada anteriormente con el solicitante:

____El propio titular

____Tutor legal de la persona _____Tribunal competente

Firma o marca_____Fecha:_____

Firma del testigo (si tiene marca)_____

Nombre del testigo en letra de imprenta (si tiene marca) _____

Cargo si es un representante del tribunal o de la agencia _____

No escriba debajo de esta línea; solo para uso de la DDD

_____Criterios funcionales cumplidos **_____Criterios funcionales no cumplidos**

Elegible para Medicaid Sí_____ No_____ **Cerrado por falta de información_____**

_____ _____ _____

_____ _____ _____

Firma del representante de la DDD **Cargo/disciplina** **Fecha**

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Nombre del solicitante _____

Fecha de nacimiento _____

N° de Seguro Social _____

Dirección principal del solicitante _____

_____

Formulario completado por _____

Relación con el solicitante _____

Número de teléfono _____ Correo electrónico_____

¿El solicitante tiene un tutor legal? ____No ____Sí*

**Si la respuesta es Sí, complete lo que sigue a continuación y proporcione una copia del Pedido de tutela junto con la solicitud.*

Nombre_____ N° de teléfono: _____
Dirección _____
Relación con la persona _____

1. <u>INFORMACIÓN SOBRE LA OCUPACIÓN Y LA RESIDENCIA DEL SOLICITANTE</u>

Lugar de nacimiento (hospital, ciudad, estado o condado si nació fuera de los EE. UU.)

_____

_____

Si nació fuera de los EE. UU., ¿el solicitante es ciudadano de los EE. UU.? ____ Sí ____ No

Si la respuesta es No, ¿el solicitante es un residente extranjero permanente? ____ Sí ____ No

Si el solicitante tiene un tutor legal, ¿el tutor legal es residente legal permanente de New Jersey?
_____Sí _____No _____No tiene tutor legal

¿El solicitante recibe actualmente servicios de alguna agencia en algún estado que no sea New Jersey?
_____Sí _____No _____Si la respuesta es Sí:

_____ _____ _____
Nombre de la agencia Dirección N° de teléfono

¿El solicitante recibe actualmente servicios del Departamento de Niños y Familias de New Jersey?
_____Sí _____No Si la respuesta es Sí, especificar los servicios:

_____

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¿El solicitante vive en un programa residencial? _____Sí* _____No
**Si la respuesta es Sí, complete*
Tipo de colocación _____
Nombre del proveedor _____
Fuente de financiamiento _____

¿El solicitante tiene empleo? _____Sí*_____No
**Si la respuesta es Sí, complete*
Nombre del empleador_____
Cargo _____

¿El solicitante asiste a una escuela o a un programa de día? _____Sí*_____No
**Si la respuesta es Sí, complete*
Tipo de programa_____ N° de teléfono _____
Nombre del programa/de la escuela _____
Dirección _____
¿Recibe servicios de la DVR? _____ Sí _____No
¿La DVR lo ayudó con servicios de día o empleo? _____Sí _____No
¿La DVR lo ayudó con servicios de día o empleo? _____Sí _____No

2. INFORMACIÓN SOBRE LOS BENEFICIOS Y EL SEGURO DEL SOLICITANTE

Número de Medicaid del solicitante _____
(Nota: no es el número de su tarjeta de Medicaid. Comuníquese con Medicaid de New Jersey al 800-356-1561 para obtener su número de Medicaid).

Fecha de elegibilidad para Medicaid _____

Si no tiene Medicaid, ¿ya lo solicitó? _____Sí _____No*

*Si no tiene Medicaid, ¿planea solicitarlo? _____Sí _____No
(*Nota: no podrá recibir servicios sin Medicaid).*

¿Tiene Medicare? _____Sí _____No *Si la respuesta es Sí*: Número de Medicare _____

¿Tiene un seguro privado? _____Sí _____No
Si la respuesta es Sí:

Nombre de póliza	Número de póliza	Número de teléfono
_____		_____

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¿Tiene beneficios de la Administración del Seguro Social por Muerte o Discapacidad (SSA/SSDI)?
_____Sí _____No
Si la respuesta es Sí: N° de reclamación_____ Cantidad recibida por mes: $_____
Si la respuesta es No: _____Nunca los solicitó _____Solicitud pendiente _____No es elegible

¿Tiene beneficios del Ingreso Suplementario del Seguro Social (SSI)? _____Sí _____No
Si la respuesta es Sí, complete
N° de reclamación _____ Cantidad recibida por mes: $ _____

Si la respuesta es No, complete
_____Nunca los solicitó _____Solicitud pendiente _____No es elegible

Si el solicitante recibe SSA/SSDI o SSI, ¿hay un beneficiario representante? Sí* No
**Si la respuesta es Sí, complete*

Beneficio	**Nombre**	**Dirección**	**Teléfono**	**Relación**
N. 1				
N. 2				

3. INFORMACIÓN SOBRE EL HOGAR Y LA FAMILIA DEL SOLICITANTE

Padre: _____Vive _____Fallecido

Si vive, complete lo siguiente
Nombre_____ Fecha de nacimiento _____
Dirección, si fuera distinta a la del solicitante _____ Teléfono (Hogar)
_____(Trabajo)_____(Móvil) _____
Correo electrónico _____
N. del Seguro Social_____ ¿Es veterano?_____Sí_____No
Estado civil _____ ¿Su padre es un contacto de emergencia?____Sí_____No

Madre:_____Vive_____Fallecida

Si vive, complete lo siguiente
Nombre_____Fecha de nacimiento:_____
Dirección, si fuera distinta a la del solicitante _____ Teléfono (Hogar)
_____(Trabajo)_____(Móvil) _____
Correo electrónico _____
N. del Seguro Social_____
Estado civil _____ ¿Es veterana?_____Sí_____No

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Estado civil/apellido de soltera:_____¿Su madre es un contacto de emergencia?_____Sí___No

Otros miembros del hogar del solicitante (no incluya padres si se los incluyó anteriormente)

Nombre _____ Fecha de nacimiento_____Relación_____
Nombre _____ Fecha de nacimiento_____Relación _____

DEPARTAMENTO DE SERVICIOS HUMANOS DE NEW JERSEY – DIVISIÓN DE DISCAPACIDADES DEL DESARROLLO

Este formulario DEBE ser completado por un profesional médico (personal médico de DC, médico privado, enfermero, psiquiatra, psicólogo, etc.).

INFORMACIÓN DE IDENTIFICACIÓN (con letra de imprenta clara)

Nombre de la persona: Fecha de nacimiento:

N° de DDD: Últimos 4 dígitos del N° del Seguro Social: Primera edad de aparición:

MARQUE CON UN CÍRCULO LOS CÓDIGOS CORRESPONDIENTES

PRINCIPALES CÓDIGOS CIE-9	CÓDIGO CIE-9	CIE-10 CÓDIGO DE DIAGNÓSTICO	PRINCIPALES CÓDIGOS CIE-9	CÓDIGO CIE-9	CIE-10 CÓDIGO DE DIAGNÓSTICO
Abetalipoproteinemia	272.5	E78.6	Síndrome de Hallervorden-Spatz	333.0	G23.0
Acrocefalosindactilia (síndrome de Apert)	755.55	Q87.0	Lesión en la cabeza, sin especificar – Edad de aparición: _	959.01	S09.90XA
Adrenoleucodistrofia	277.86	E71.529	Hemiplejia, sin especificar	342.9	G81.90
Deficiencia de arginasa	270.6	E72.21	Holoprosencefalia	742.2	Q04.2
Agenesia del cuerpo calloso	742.2	Q04.3	Homocistinuria	270.4	E72.11
Agenesia del Septum Pellucidum	742.2	Q04.3	Enfermedad de Huntington	333.4	G10
Argiria/Paquigiria/Microgiria	742.2 o 758.33	Q04.3	Síndrome de Hurler	277.5	E76.01
Síndrome de Aicardi	333	G23.8	Síndrome de hiperamonemia	270.6	E72.4
Embriopatía alcohólica y fetopatía	760.71	F84.5	Enfermedad de células-I	272.2	E77.0
Anencefalia	655.0	Q00.0	Distonía idiopática de torsión	333.6	G24.1
Síndrome de Angelman	759.89	Q93.5	Incontinencia pigmentaria	757.33	Q82.3
Síndrome de Asperger	299.8	F84.5	Parálisis cerebral infantil, sin especificar	343.9	G80.9
Ataxia-Telangiectasia	334.8	G11.3	Epilepsia intratable	345.1	G40.309
Autismo (autismo infantil, psicosis infantil, síndrome de Kanner)	299.0	F84.0	Síndrome de Klinefelter	758.7	Q98.4
Deficiencia de biotinidasa	277.6	D84.1	Enfermedad de Krabbe	333.0	E75.23
Enfermedad de Canavan	330.0	E75.29	Enfermedad de Kugelberg-Welander	335.11	G12.1
Síndrome de Carpenter	759.89	Q87.0	Síndrome de Larsen	755.8	Q74.8
Parálisis cerebral, sin especificar	343.69	G80.9	Síndrome de Leigh	330.8	G31.82
Parálisis cerebral, hemiplejia, congénita	343.1	G80.2	Síndrome de Lesch-Nyhan	277.2	E79.1
Parálisis cerebral, paraplejia, congénita	343	G80.1	Lisencefalia	742.2	Q04.3
Parálisis cerebral, cuadriplejia	343.2	G80.0	Síndrome de Lowe (Terrey MacLachlan - distrofia óculo-cerebro-renal)	270.8	E72.03
Enfermedad de Charcot-Marie-Tooth	356.1	G60.0	Síndrome de Marfan	759.82	Q87.40
Síndrome de CHARGE	759.89	Q89.8	Megalencefalia	742.4	Q04.5
Síndrome de Cockayne	759.89	Q89.8	Enfermedad de Menkes (ligada al cromosoma X)	275.1	E83.09
Síndrome de Coffin-Lowry	759.89	Q89.8	Leucodistrofia metacromática	330.0	E75.25
Defectos congénitos de la glicosilación	279.03	D80.3	Aciduria metilmalónica (acidemia)	270.3 o 270.7	E71.120
Síndrome de Cornelia de Lange	759.89	Q89.8	Microencefalia	742.1	Q02
Síndrome del maullido de gato	758.31	Q93.4	Discapacidad intelectual leve	317.0	F70
Síndrome de Crouzon	756.0	Q75.1	Pérdida auditiva neurosensorial y conductiva mixta	389.2	H90.8
Síndrome de DiGeorge	279.11	D82.1	Discapacidad intelectual moderada	318.0	F71
Síndrome de Down	758.0	Q90.9	Deterioro moderado o grave, en el ojo con mejor vista, deterioro profundo en el ojo con peor vista	369.1	H54.10
Síndrome de Dubowitz	742.8	Q07.8	Mucolipidosis tipo IV	330.1	E75.11
Distrofia muscular de Duchenne	359.1	G71.0	Mucopolisacaridosis (síndrome de Hunter, síndrome de Hurler, síndrome de Scheie)	277.5	E76.01
Distonía muscular deformante	333.6	G24.1	Distrofia neuroaxonal	333	G23.0
Encefalopatía; no se clasificó en otro lugar	348.3	G93.40	Neurofibromatosis (enfermedad de von Recklinghausen)	237.71	Q85.01
Epilepsia, sin especificar	345.9	G40.90	Heterotopia neuronal	742.8	Q07.8
Síndrome de alcoholismo fetal	760.71	Q86.0	Enfermedad Niemann-Pick	272.7	E75.249
Síndrome del cromosoma X frágil	759.83	Q99.2	Síndrome de Noonan	759.81	Q87.1
Ataxia de Friedreich	334.0	G11.1	Otra degeneración cerebral	331.8 o 349.89	G32.89 (sin especifica
Fucosidosis	271.8	E77.1	Otras anormalidades cromosómicas; no se clasificó en otro lugar	758.89	Q99.8
Enfermedad de Gaucher	272.7	E75.22	Otros trastornos del metabolismo de la purina y la pirimidina (Síndrome de Lesch-Nyhan)	277.2	E79.1
Epilepsia convulsiva generalizada	345.1	G40.309	Otras anomalías especificadas (síndrome de Cornelia de Lange, síndrome de Seckel)	759.9	Q87.1
Epilepsia no convulsiva generalizada	345.0	G40.401	Otras anomalías especificadas del sistema nervioso (disautonomía familiar, síndrome de Riley-Day)	742.8	G90.1
Disgenesia gonadal (síndrome de Turner)	758.6	Q96.9	Otras degeneraciones cerebrales especificadas durante la infancia (enfermedad de Alper o degeneración de materia gris, encefalomielopatía necrotizante infantil, enfermedad de Leigh, encefalopatía necrotizante	330.8	G31.81
Crisis convulsivas de gran mal	345.3	G40.409	Otros trastornos generalizados del desarrollo especificados (trastorno de Asperger, psicosis infantil atípica, cuasi psicosis	299.8	F84.5

MARQUE CON UN CÍRCULO LOS CÓDIGOS CORRESPONDIENTES					
Otras enfermedades espinocerebelares (Ataxia-Telangiectasia [síndrome de Louis-Bar])	334.8	G11.3	Espina bífida sin presencia de hidrocefalia	741.9	Q05.8
Paraplejia (parálisis de los miembros inferiores)	344.1	G82.20	Lesión de la médula espinal (inicial)	952.9	S14.109A
Epilepsia parcial, con deterioro de la conciencia (epilepsia psicomotora)	345.4	G40.201	Atrofia muscular espinal, sin especificar	335.1	G12.1
Síndrome de Patau	758.1	Q91.7	Síndrome de Sturge-Weber	759.6	Q85.8
Trastorno generalizado del desarrollo-sin especificación (NOS)	299.9	F84.9	Distonía de torsión sintomática (parálisis cerebral atetoide)	333.7	G80.3
Enfermedad de Pick	331.11	G31.01	Enfermedad de Tay-Sachs	330.1	E75.02
Acidemia propiónica	270.3	E71.121	Síndrome de Torch	760.02	P00.2
Síndrome de Prader-Willi	759.81	Q87.1	Trisomía 13	758.1	Q91.13
Discapacidad intelectual profunda	318.2	F73	Trisomía 18 (síndrome de Edwards)	758.2	Q91.3
Deficiencia de piruvato deshidrogenasa (láctico, pirúvico)	271.8	E74.4	Esclerosis tuberosa	759.5	Q85.1
Cuadriplejia y cuadriparesia	344.00	G82.5	Sin especificar (ceguera traumática NOS)	950.9	S04.019A
Enfermedad de Refsum	356.3	G60.1	Anomalía sin especificar del cerebro, la médula espinal y el sistema	742.9	Q07.9
Síndrome de Rett	330.8	F84.2	Causa sin especificar de la encefalitis	323.9	G04.90
Síndrome de Rubinstien-Taybi	759.89	Q87.2	Retraso sin especificar en el desarrollo (trastorno de desarrollo NOS)	315.9	F89
Enfermedad de Sandhoff	330.1	E75.01	Enfermedad sin especificar de la médula espinal	336.9	G95.9
Síndrome de Sanfillippo	277.5	E76.22	Discapacidad intelectual sin especificar	319	F79
Enfermedad de Schindler de tipo 1	271.8	E77.1	Trastorno generalizado del desarrollo sin especificar (trastorno generalizado del desarrollo NOS)	299.9	F84.9
Schizencefalia	742.4	Q04.6	Fenilcetonuria sin tratar	270.1	E70.0
Síndrome de Seckel	759.89	Q87.1	Defectos del ciclo de la urea	270.6	E72.20
Displasia septo-óptica	742.4	Q04.4	Síndrome de Usher de tipo II	694.4	L10.4
Lesión al sistema nervioso central hipóxica isquémica grave	768.73	P91.63	Síndrome de Vater	759.89	Q87.2
Discapacidad intelectual grave	318.1	F72	Síndrome de Werdnig-Hoffman	335.0	G12.0
Síndrome Sjogren-Larsson	757.1	Q80.9	Síndrome de Williams-Beauren	758.9	Q87.8
Hemiplejia espástica	342.1	G80.2	Enfermedad de Wilson	275.1	E83.01
Enfermedad de Spielmeyer-Vogt	330.1	E75.4	Síndrome de Zellwager	277.86	E71.510
Espina bífida	741	Q05	Problema o trastorno psiquiátrico		F99

Descripción del diagnóstico (que no se menciona en las páginas anteriores) relacionado con la discapacidad del desarrollo):

Código(s): _____

Mi firma en este documento certifica que el diagnóstico identificado se basa en documentación y evaluaciones médicas o documentación y evaluaciones médicas establecidas.

Comprendo que la información de este documento y de la documentación de apoyo será utilizada por la División de Discapacidades del Desarrollo (DDD) para certificar el reembolso federal por servicios brindados a la persona identificada en este formulario. Este formulario no garantiza la elegibilidad ni los servicios por parte de la DDD. Mi firma certifica que la información es precisa en función de la opinión médica respaldada por los registros médicos.

Nombre en letra de imprenta del profesional médico

Firma del profesional médico

Fecha
(Formulario CIE-10 revisado el 1/24/14)

DEPARTAMENTO DE SERVICIOS
HUMANOS DEL ESTADO DE NEW JERSEY
P O Box 700
Trenton, NJ 08625
609-777-2026

AVISO DE PRÁCTICAS DE PRIVACIDAD
En vigencia: 23 de septiembre de 2013

Su información. Sus derechos. Nuestras responsabilidades.

Este aviso aplica a personas, tutores legales o padres de niños menores que reciban servicios del Departamento de Servicios Humanos, y describe cómo puede utilizarse y divulgarse información médica sobre usted y cómo usted puede acceder a esa información. **Revise esta información detenidamente.**

Sus derechos

Si bien su registro médico es propiedad física del Departamento de Servicios Humanos, la información que se encuentra en dicho registro le pertenece a usted. Usted tiene el derecho a:

- Obtener una copia de sus registros médicos en papel o formato electrónico
- Corregir sus registros médicos en papel o formato electrónico
- Solicitar una comunicación confidencial
- Pedirnos que limitemos la información que compartimos
- Obtener una lista de las personas con las que compartimos su información
- Obtener una copia de este aviso de privacidad
- Elegir a una persona para que actúe en su nombre
- Presentar una queja si cree que se violaron sus derechos de privacidad

Sus opciones

Tiene algunas opciones sobre la manera en que usamos y compartimos la información cuando realizamos lo siguiente:

- Informamos a familiares y amigos sobre su afección
- Proporcionamos servicios de salud para situaciones de desastre
- Lo incluimos en un directorio de hospitales
- Proporcionamos atención de salud mental
- Comercializamos nuestros servicios y vendemos su información
- Recaudamos dinero

Nuestros usos y divulgaciones

Es posible que usemos y compartamos su información cuando realizamos lo siguiente:

- Nos hacemos cargo de su tratamiento
- Dirigimos nuestra organización
- Facturamos sus servicios

- Ayudamos con problemas de seguridad y salud pública
- Realizamos investigaciones
- Cumplimos con la ley
- Respondemos a solicitudes de donaciones de órganos y tejido
- Trabajamos con un director de funeraria o examinador médico
- Tratamos compensaciones al trabajador, el cumplimiento de la ley y otras solicitudes del gobierno
- Respondemos a acciones legales y demandas

Sus derechos

Cuando se trata de la información de su salud, usted tiene ciertos derechos. A modo de ayuda, esta sección le explica sus derechos y algunas de nuestras responsabilidades.

Obtener una copia de sus registros médicos en papel o formato electrónico

- Puede solicitar ver u obtener una copia en papel o formato electrónico de sus registros médicos y otra información de salud sobre usted. Consúltenos cómo hacerlo.
- Le proporcionaremos una copia o un resumen de su información de salud, por lo general en un plazo de 30 días a partir de su solicitud. Es posible que cobremos una tarifa razonable en función de los costos.

Solicitarnos que corrijamos su registro médico

- Puede solicitarnos que corrijamos su información de salud cuando crea que es incorrecta o está incompleta.
  Consúltenos cómo hacerlo.
- Es posible que rechacemos su solicitud, pero le indicaremos la causa por escrito en un plazo de 60 días.

Solicite comunicaciones confidenciales

- Puede solicitarnos que lo contactemos de un modo específico (por ejemplo, al teléfono del hogar o del trabajo) o que le enviemos correos a una dirección distinta.
- Aceptaremos todas las solicitudes razonables.

Solicitarnos que limitemos la información que usamos o compartimos

- Puede solicitarnos que no usemos ni compartamos cierta información de salud para tratamientos, pagos o nuestras operaciones. No estamos obligados a aceptar esta solicitud y podemos rechazarla si podría afectar su atención.
- Si paga un servicio o elemento de atención médica completamente de su bolsillo, puede solicitar que no compartamos esa información a fines de pago o de nuestras operaciones con su aseguradora. Aceptaremos la solicitud a menos que la ley nos obligue a compartir esa información.

Obtener una lista de las personas con las que compartimos información

- Puede solicitar una lista (un conteo) de las veces que hemos compartido su información de salud durante los seis años anteriores a la fecha de la solicitud, con quién la compartimos y por qué.
- Incluiremos todas las divulgaciones, excepto las relacionadas con las operaciones de atención médica, pago, tratamiento y algunas otras divulgaciones (como las que nos pueda solicitar que realicemos). Proporcionaremos un conteo por año sin cargo, pero le cobraremos una tarifa razonable, en función de los costos, si solicita otra antes del año.

Obtener una copia de este aviso de privacidad

Puede solicitar una copia en papel de este aviso en cualquier momento, incluso si aceptó recibirlo en formato electrónico. Le proporcionaremos la copia en papel inmediatamente.

Elegir a una persona para que actúe en su nombre

- Si le proporcionó poder notarial para asistencia médica a una persona o si alguien es su tutor legal, esa persona podrá ejercer sus derechos y tomar decisiones sobre su información de salud.
- Antes de tomar cualquier medida, nos aseguraremos de que esa persona tenga esa autoridad y pueda actuar en su nombre.

Presentar una queja si cree que se violaron sus derechos

- Si siente que hemos violado sus derechos, puede comunicarse con nosotros usando la información en la página 1 para presentar una queja.
- Puede presentar una queja a la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. enviando una carta a 200 Independence Avenue, S.W., Washington, D.C. 20201; llamando al 1- 877-696-6775; o visitando el sitio **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- No tomaremos represalias contra usted por haber presentado una queja.

Sus opciones

Para cierto tipo de información de salud, puede indicarnos sus opciones sobre lo que compartimos. Comuníquese con nosotros si tiene preferencias claras sobre el modo en que compartimos su información en las situaciones que se mencionan a continuación. Indíquenos qué hacer y cumpliremos con sus instrucciones.

En estos casos, tiene tanto el derecho como la opción de indicarnos lo siguiente:

- Que compartamos información con familiares, amigos cercanos u otras personas involucradas en su atención.
- Que compartamos información en situaciones de desastre que requieran servicios de salud.
- Que incluyamos su información en un directorio de hospitales.

Si no puede indicarnos sus preferencias, como en el caso de que esté inconsciente, procederemos a compartir su información si creemos que es lo mejor para usted. También es posible que compartamos su información cuando sea necesario para disminuir una amenaza grave e inminente a la salud o la seguridad.

En estos casos, nunca compartiremos su información a menos que nos proporcione permiso por escrito:

- Para fines de comercialización.
- Para vender su información.
- Para compartir notas de psicoterapia.

En el caso de la recaudación de fondos:

- Es posible que nos comuniquemos con usted para recaudar fondos, pero puede indicarnos que no lo contactemos nuevamente.

Nuestros usos y divulgaciones

¿Cómo solemos usar o compartir su información de salud?

Por lo general, usamos o compartimos su información de salud en las siguientes situaciones.

Lo tratamos

Podemos usar su información de salud y compartirla con otros profesionales que lo traten.

Ejemplo: en su registro se asentará toda la información que una enfermera, un médico u otro miembro del equipo de atención de la salud haya recopilado. Esta información puede utilizarse para determinar su diagnóstico o el tratamiento que mejor se adapte a su situación. Un médico u otro profesional de atención de la salud pueden compartir su información con otros profesionales de atención de la salud que pertenezcan o no al Departamento de Servicios Humanos para determinar su diagnóstico o tratamiento.

Dirigimos nuestra organización

Podemos usar y compartir su información de salud para realizar nuestras prácticas, mejorar su atención y comunicarnos con usted cuando sea necesario.

Ejemplo: los miembros del personal médico, el gerente de riesgo o de mejora de la calidad, o los miembros del equipo de mejora de la calidad pueden utilizar la información de sus expedientes médicos para evaluar la atención y los resultados de su caso, y asuntos similares.

Facturamos sus servicios

Podemos usar y compartir su información de salud para facturar y obtener un pago de planes de salud o de otras entidades.

Ejemplo: le podemos enviar la factura a usted o a un tercero a cargo del pago. La información que acompaña la factura puede incluir información personal que lo identifique, así como el diagnóstico, los procedimientos y los suministros utilizados.

¿De qué otro modo podemos usar o compartir su información de salud?

Contamos con el permiso o la obligación de compartir su información de otras maneras que, por lo general, contribuyen al bien público, como a la investigación y la salud pública. Debemos cumplir con diversas condiciones establecidas por la ley antes de poder compartir su información para esos fines. Para obtener más información consulte: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Ayudamos con problemas de seguridad y salud pública

Podemos compartir su información de salud en ciertas situaciones, tales como las siguientes:

- Prevención de enfermedades
- Colaboración con el retiro del mercado de un producto
- Informes de reacciones adversas a medicamentos
- Informes de violencia doméstica, negligencia o sospecha de abuso
- Prevención o disminución de una amenaza grave a la seguridad o la salud de cualquier persona

Socios comerciales

Nuestra organización brinda algunos servicios a través de contratos con socios comerciales:

- Entre estos socios se encuentran nuestros contadores, consultores y abogados.
- Es posible que divulguemos su información de salud a nuestros socios para que puedan realizar las tareas que les encarguemos.
- No obstante, solicitamos que los socios comerciales protejan su información adecuadamente.

Realizamos investigaciones

Podemos usar o compartir su información para investigaciones de salud, siempre que la investigación haya sido aprobada por una junta de revisión institucional que haya revisado la propuesta de investigación y haya establecido los protocolos para garantizar la privacidad de su información de salud.

Cumplimos con la ley

Compartiremos su información si las leyes estatales o federales lo requieren, incluso con el Departamento de Salud y Servicios Humanos, en el caso de que desee corroborar que estamos cumpliendo con la ley federal de privacidad.

Respondemos a solicitudes de donaciones de órganos y tejido

Podemos compartir su información de salud con organizaciones para la procuración de órganos.

Trabajamos con un director de funeraria o examinador médico

Podemos compartir la información de salud con un médico forense, un examinador médico o un director de funeraria cuando la persona muera.

Tratamos compensaciones al trabajador, el cumplimiento de la ley y otras solicitudes del gobierno

Podemos usar o compartir su información de salud en los siguientes casos:

- Para reclamos de compensación al trabajador
- A fines de cumplimiento de la ley o con un miembro de la fuerza pública
- Con agencias de supervisión de la salud para actividades autorizadas por la ley
- Para funciones gubernamentales especiales como servicios de protección presidencial, de seguridad nacional y militares
- En caso de que usted sea recluso de una institución correccional, podemos divulgar a la institución o a los agentes correspondientes toda la información de salud que sea necesaria para su salud, y para la salud y la seguridad de otras personas.

Respondemos a acciones legales y demandas

Podemos compartir su información de salud a modo de respuesta a una orden judicial o administrativa, o a una citación judicial.

Nuestras responsabilidades

- La ley nos obliga a mantener la privacidad y la seguridad de la información protegida de salud.
- Le haremos saber inmediatamente si se produce una violación que pueda comprometer la privacidad o seguridad de su información.
- Debemos cumplir con las prácticas de privacidad y los deberes descritos en este aviso y le proporcionaremos una copia.
- No usaremos ni compartiremos su información de otro modo que no sea el descrito, a menos que nos indique por escrito que lo hagamos. Si nos da su autorización, puede cambiar de idea en cualquier momento. Háganos saber por escrito si cambia de idea.

Para obtener más información, consulte:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Cambios en los términos de este aviso

Podemos cambiar los términos de este aviso y los cambios se aplicarán a toda la información que tengamos sobre usted. El nuevo aviso estará disponible a pedido, en nuestro sitio web, y le enviaremos una copia.

Fecha de entrada en vigencia de este aviso: 23 de septiembre de 2013

Departamento de Servicios Humanos de New Jersey,
División de Discapacidades del Desarrollo

ACUSE DE RECIBO DEL AVISO DE PRÁCTICAS DE PRIVACIDAD

Este formulario debe firmarse al recibir el Aviso de prácticas de privacidad y debe enviarse a la División de Discapacidades del Desarrollo de New Jersey. Si el solicitante es menor de 18 años, un padre o tutor legal deberá firmarlo. Si el solicitante es mayor de 18 años, el solicitante o tutor legal deberá firmarlo.

Yo,_____(nombre en letra de imprenta o a máquina), por el presente, reconozco haber recibido el Aviso de prácticas de privacidad el _____.

Soy (marque una opción):

_____ Solicitante

_____ Padre (si el solicitante es menor de 18 años)

_____ Tutor legal

_____ _____
Marca o firma del solicitante, padre o tutor legal* Fecha

Si fue firmado por otra persona que no sea el solicitante:

_____
Nombre el solicitante (en letra de imprenta)

Si se proporciona una marca:

_____
Firma del testigo

_____
Nombre del testigo (en letra de imprenta)

DEPARTAMENTO DE SERVICIOS HUMANOS
DIVISIÓN DE DISCAPACIDADES DEL DESARROLLO

AUTORIZACIÓN PARA LA DIVULGACIÓN DE INFORMACIÓN DE SALUD A FAMILIARES Y PERSONAS INVOLUCRADAS

Autorizo el uso/la divulgación de información de salud sobre:

Nombre de la persona:_____

Fecha de nacimiento:_____

1. Persona(s) autorizadas a usar, divulgar o recibir información, incluso el tutor legal, si corresponde:

Contacto principal:	**Contacto alternativo:**
Nombre: _____	Nombre: _____
Dirección: _____	Dirección: _____
_____	_____
Teléfono: _____	Teléfono: _____
Teléfono alternativo: _____	Teléfono alternativo: _____
Relación: _____	Relación: _____
Otro contacto:	Otro contacto:
Nombre: _____	Nombre: _____
Dirección: _____	Dirección: _____
_____	
Teléfono: _____	Teléfono: _____
Teléfono alternativo: _____	Teléfono alternativo: _____
Relación: _____	Relación: _____

Si es necesario, adjunte hojas adicionales.

2. Autorizo al personal de la DDD a comunicarse con el contacto principal o el contacto alternativo, por teléfono, para dar asesoramiento sobre cualquier enfermedad, lesión o incidente que pueda necesitar autorización o atención inmediata.

3. Autorizo al personal de la DDD a proporcionar la cantidad mínima necesaria de información de salud a las personas mencionadas anteriormente o las personas con permiso para realizar visitas.

4. Comprendo que puedo negarme a firmar esta autorización y que mi negación a firmar no afectará mi capacidad para obtener tratamiento, pago o elegibilidad para beneficios o servicios. Puedo revisar o copiar cualquier información escrita usada/divulgada conforme a esta autorización.

5. Comprendo que si la persona o entidad que recibe la información no es un proveedor de atención médica o no forma parte de un plan de salud cubierto por las reglamentaciones federales de privacidad, la información descrita anteriormente podrá volver a divulgarse y dejará de estar protegida por esas regulaciones. Sin embargo, es posible que el destinatario tenga prohibido divulgar información sobre abuso de sustancias conforme a los requisitos de las normas federales de confidencialidad de abuso de sustancias.

6. Comprendo que tengo el derecho a revocar esta autorización por escrito en cualquier momento, excepto por las acciones que pudieran haberse realizado conforme a dicha autorización. La solicitud para revocar esta autorización debe proporcionarse al funcionario de privacidad de la DDD. La revocación entrará en vigencia en la fecha en la que el funcionario de privacidad reciba la solicitud.

7. La autorización vence el_____ o un año después de la fecha de la firma de la persona o su tutor legal.

8. Se conservará una copia completa de este formulario en el registro del cliente.

9. Información para tutores legales: si la persona que recibe los servicios tiene más de 18 años y usted indicó que usted es tutor legal de esa persona, debe adjuntar al formulario una copia de la Designación de tutela.

Firma (o marca) de
la persona o el tutor legal:_____

Fecha de la firma:_____

Nombre del tutor legal* (si corresponde):_____
*Debe adjuntarse una copia de la Designación de tutela válida.

Si se proporciona una marca en lugar de una firma, la marca debe contar con un testigo:

Firma del testigo (si corresponde): _____

Nombre/cargo del testigo:_____

C: trabajador social - Programa
residencial original (si corresponde)
Programa de día (si corresponde)

AUTORIZACIÓN PARA QUE LA DIVISIÓN DE DISCAPACIDADES DEL DESARROLLO (DDD) DIVULGUE REGISTROS QUE CONTENGAN INFORMACIÓN DE LA SALUD DE LA PERSONA

Por la presente, autorizo a la_____(instalación/oficina) de la División de Discapacidades del Desarrollo para divulgar la información de salud individualmente identificable, como se describe a continuación.

Nombre de la persona a la que pertenecen los registros médicos que se solicitan:

_____

Nombre (en letra de imprenta) Número del Seguro Social Fecha de nacimiento

Los registros médicos que se solicitan se crearon entre el _____y el_____. A continuación se proporciona una descripción específica de los registros:

_____

_____

Propósito para el que se usarán los registros:_____

_____

☐ Los registros serán revisados en la instalación/agencia.

☐ Los registros se copiarán. Los registros se retirarán en la instalación/oficina.

☐ Los registros solicitados deben copiarse y enviarse a la persona u organización y a la dirección incluida a continuación:

Nombre y dirección de la persona que solicita los registros:

_____

_____

_____

Nombre y dirección de la(s) persona(s) u organización(es) que reciben los registros <u>si no es la persona que realiza la solicitud</u>:

_____

_____

_____

N. de teléfono:_____

N. de fax:_____

<u>Autoridad legal para esta solicitud:</u>

☐ Estos son mis registros y soy un adulto legalmente competente.
☐ Soy el tutor legal de la persona a quien pertenecen los registros que se solicitan y adjunté a la autorización una designación de tutela válida.
☐ Soy padre de la persona, menor de 18 años, a quien pertenecen los registros que se solicitan.
☐ Tengo un poder notarial, con copia adjunta, para la persona que me autoriza a solicitar los registros médicos de la persona.

Acuerdos sobre esta autorización:

1. Esta autorización es voluntaria y comprendo que la DDD no puede condicionar el tratamiento en función de la firma de esta autorización, a menos que la autorización sea para: (a) tratamientos relacionados con la investigación, o (b) únicamente para los fines de crear información de salud para el uso o la divulgación a un tercero.

2. Esta autorización vence_____(fecha que determinará la persona que firme este formulario), a partir de la fecha de mi firma a continuación.

3. Comprendo que tengo derecho a revocar esta autorización en cualquier momento por medio de la notificación a la DDD por escrito, pero, en caso de hacerlo, no tendrá ningún efecto sobre ninguna medida tomada antes del momento en que la DDD reciba la revocación.

4. Acepto anular todas las reclamaciones contra la agencia/instalación de la DDD por la divulgación de la información solicitada.

5. Comprendo que una vez que la información descrita en el presente se divulgue, es posible que deje de estar sujeta a protecciones de privacidad administradas por la DDD en el caso de que el destinatario de la información no sea un plan de salud, un proveedor de atención médica, un centro de intercambio de información ni un socio comercial con un contrato con la DDD.

6. Comprendo que si solicito que se copien los registros y me los envíen, la DDD hará un esfuerzo de buena fe para enviarme esos registros en una cantidad de tiempo razonable.

7. Comprendo que si deseo que se hagan copias de los registros, la DDD puede cobrar una tarifa por copiar los registros.

***Firma (o marca) de la persona, el padre del menor, el tutor legal o la persona con el poder notarial que realice esta solicitud (marque con un círculo la función correcta)**:

_____

Fecha de la firma: **Número de teléfono:**

_____ _____

_____ (Nombre en letra de imprenta de la persona que realiza la solicitud)

***Si se proporciona una marca en lugar de una firma, la marca debe contar con un testigo:**

Firma del testigo (si corresponde):_____

Nombre del testigo:_____

Cargo del testigo:_____

***Si la persona que realiza la solicitud es un tutor o tiene un poder notarial, debe adjuntarse una copia del poder notarial o de la designación de tutela válida.**

Consentimiento para divulgar información a la División de Discapacidades del Desarrollo

Yo,_____, otorgo permiso por la presente para que
(persona, padre del menor de 18 años, tutor legal o poder notarial)

_____
(Nombre de la persona, institución, agencia u otro titular de la información que se divulgará)

divulgue informes, evaluaciones, resúmenes u otra información descrita a continuación con respecto a la solicitud de _____ de elegibilidad para servicios proporcionados a través de la División de Discapacidades del Desarrollo de New Jersey.

Información que se divulgará:

_____

_____

_____

_____

Esta información se divulgará a:

_____, trabajador social encargado de la recepción División de Discapacidades del Desarrollo de New Jersey

Dirección: _____

_____

_____

Firma o marca:_____ **Fecha:** _____

Firma del testigo (si tiene marca): _____

Nombre del testigo en letra de imprenta (si tiene marca): _____

Si no es la persona nombrada anteriormente, relación: _____

Nota: la información recibida mediante esta divulgación está sujeta a las regulaciones de confidencialidad de la División y no puede divulgarse fuera de la División sin permiso escrito, a menos que así lo indique el N.J.A.C. 10:41 y siguientes.

DDD Community Services Offices

Flanders Office

Serves Morris, Sussex, and Warren counties
1-B Laurel Drive
Flanders, NJ
(973) 927-2600

Paterson Office

Serves Bergen, Hudson, and Passaic counties
100 Hamilton Plaza, 7th Floor
Paterson, NJ
(973) 977-4004

Newark Office

Serves Essex County
153 Halsey Street, 2nd Floor
PO Box 47013
Newark, NJ
(973) 693-5080

Plainfield Office
Serves Union and Somerset counties (intake **only**)
110 East 5th Street
Plainfield, NJ
(908) 226-7800

Somerset Office
Serves Somerset County (case management **only)**
275 Greenbrook Road, 2nd Floor
Green brook, NJ
(732) 424-3301

Freehold Office
Serves Ocean and Monmouth counties
Juniper Plaza, Suite 1-11
Freehold, NJ
(732) 863-4500

Trenton Office
Serves Hunterdon, Mercer, and Middlesex counties
120 South Stockton Street
Trenton, NJ
(609) 292-1922
Mailing address: PO Box 706, Trenton, NJ 08625

Mays Landing Office

Serves Atlantic, Cape May, Salem, Cumberland counties

5218 Atlantic Avenue

Suite 205

Mays Landing, NJ

(609) 476-5200

Voorhees Office

Serves Burlington, Camden, and Gloucester counties

2 Echelon Plaza

221 Laurel Road, Suite 210

Voorhees, NJ

(856) 770-5900

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

2017 Graduates Aging Out of the School System:

Steps to Accessing Services/Supports from the Division of Developmental Disabilities (DDD)

This timeline applies to students who have exhausted their educational entitlement by turning 21 years of age within the 2016/2017 school year

October 2016 – JANUARY 2017 Eligibility /Intake

√ Ensure you are eligible for DDD

- If you have not already been deemed eligible for DDD, contact the Intake Unit within your DDD Community Services Office. You can also start the application process through the DDD website at: www.nj.gov/humanservices/ddd/services/apply/index.html

√ Ensure you are eligible for Medicaid

- Information on Medicaid eligibility as it relates to DDD is available at: www.nj.gov/humanservices/ddd/services/medicaideligibility.html
- If you need assistance with applying for Medicaid or have not been able to become eligible, complete the Medicaid Eligibility Troubleshooting Form available on the website provided above and send it to: DDD.MediElighelpdesk@dhs.state.nj.us
- Questions can be directed to the DDD Medicaid eligibility help desk at: DDD.MediElighelpdesk@dhs.state.nj.us

√ Complete the NJ Comprehensive Assessment Tool (NJ CAT)

- Contact the Intake Unit within your **DDD Community Services Office** to request access to complete the NJ CAT through the online survey or via phone call.

DDD Community Service Offices

Flanders: (973) 927-2600
Paterson: (973) 977-4004
Newark: (973) 693-5080
Plainfield: (908) 226-7800
Somerset: (732) 424-3301
Freehold: (732) 863-4500
Trenton: (609) 292-1922
Mays Landing: (609) 476–5200
Voorhees: (856) 770-5900
www.nj.gov/humanservices/ddd/staff/cso

ONGOING: DECEMBER 2016 – JUNE 2017 Planning

√ Participate in activities offered through the *Planning for Adult Life* project

- Visit www.PlanningforAdultLife.org for details about training sessions, resource materials, webinars, student groups, and parent groups covering topics for students with intellectual and developmental disabilities between the ages of 16-21 and their families. Topics covered through this project include but are not limited to transition planning, guardianship, employment/post-secondary education, housing, self-direction, self-advocacy/awareness, legal/financial planning, health/behavioral health, guardianship, building/maintaining community ties, and friendships.

√ Identify the student's vision for work and life and what supports he/she may need through Person-Centered Planning

- You can use DDD's Person-Centered Planning Tool (PCPT) available at: www.nj.gov/humanservices/ddd/documents/person_centered_planning_tool.doc to help get you started.

√ Research Service Providers and Support Coordination Agencies

- Potential Support Coordination Agencies may be found through the **Provider Search Database** at https://irecord.dhs.state.nj.us/providersearch, using the following four steps: **(1)** under Filter, select "Service" and check Support Coordination; **(2)** select "Medicaid Approved" and check the box; **(3)** select "County Served" and select the county in which the individual resides; and **(4)** click the magnifying glass. If you do not have a preference, you can choose to have the Division auto-assign one to you.
- The Provider Search Database could also be used to identify potential providers in your area and the services they cover.

FEBRUARY/MARCH 2017 Selection

√ Complete and submit the *Support Coordination Agency Selection Form*

- This form will be provided through the Intake Unit within your DDD Community Services Office or is available on the Supports Coordination page at: www.nj.gov/humanservices/ddd/services/support_coordination.html
- The completed SCA Selection form should be submitted to DDD.SCAChoice@dhs.state.nj.us.
- DDD will process these forms to confirm (1) DDD eligibility (2) Medicaid eligibility (3) Completion of the NJCAT, but the Support Coordination Agency will not be assigned until April 2017.
  *Review the Research Service Providers and Support Coordination Agencies section above.

APRIL 2017 Assignment

√ DDD Assigns the Support Coordination Agency

- DDD will assign Support Coordination Agencies based on the completed selection form. To maximize the possibility of being assigned to an agency of your choice, DDD encourages that two agencies be identified on the form. If you do not have a preference, please indicate that on the Support Coordination Agency Selection Form and one will be auto assigned for you.

→ • **Once assigned, Support Coordination Agencies can receive DDD funding to attend exit IEP and/or transition related meetings at the school and begin developing the Individualized Service Plan (ISP).**

APRIL – JUNE 2017 Service Plan

√ Develop DDD's *Individualized Service Plan* (ISP)

- The Support Coordinator will be responsible for writing the ISP, with guidance from the planning team (individual, support coordinator, family, providers, etc.), through the Person-Centered Planning process and information gathered from the NJ CAT.****The ISP should be completed and approved prior to exiting the school system in order for services/supports to be available upon graduation****

Preparation CHECKLIST for Students and Their Families

☐Confirm Medicaid Eligibility
☐Confirm DDD Eligibility
☐Complete (NJ CAT)
☐Research Support Coordination Agencies and Service Providers
☐Complete and Submit the Support Coordination Agency Selection Form
☐Receive Support Coordinator
☐Begin Planning Process with Support Coordinator
☐Complete/Approve ISP
☐Access DDD Services upon Graduation

Information regarding Division of Developmental Disabilities (DDD)

- Eligibility/Application Process:
  http://www.state.nj.us/humanservices/ddd/services/apply/

- Where to apply for services:
  www.state.nj.us/humanservices/ddd/home/

- Timeline for graduates:
  http://www.nj.gov/humanservices/ddd/documents/2017_graduates_aging_out_of_school_system.pdf

- Selecting a Support Coordination Agency:
  http://rwjms.rutgers.edu/boggscenter/products/documents/ChoosingaSupportCoordinationAgencyfinalApril2014.pdf

- Selecting a Service Provider:
  http://rwjms.rutgers.edu/boggscenter/SelectingaServiceProvider.html

Preparing for a Fee For Service System: A Guide for Caregivers

For individuals 21 years of age and older and their caregivers

The New Jersey Division of Developmental Disabilities (DDD), which serves adults with intellectual and developmental disabilities (I/DD) 21 years of age and over, is transitioning from a contract system of care to a fee for service (FFS) system.

Contract System (Old)	Fee for Service System (New)
Annual contracts. Payment made by DDD to an agency before service is provided	Agency submits a bill to Medicaid after service is provided
Based on slots available in a program	Service is tied to the person
Multiple rates for similar services	Standard rates for similar services

What does this mean for caregivers?

- **Support Coordinator:** Individuals eligible for DDD services will no longer have a case manager. Instead individuals and their caregivers will choose a Support Coordinator to provide case management services.
- **Budget:** Individuals eligible for DDD services will be assigned a budget based on their level of need. The individual and their caregivers will work with a Support Coordinator to choose which agencies to "purchase" services from. The Support Coordinator is responsible for maintaining the budget and coordinating services.
- **Budget Determination:** All current and newly eligible individuals will be assessed using the New Jersey Comprehensive Assessment Tool (NJ CAT). This tool assesses a person's strengths and weaknesses and identifies areas in which a person will need support and assistance. ***It is important that an accurate picture of the person's strengths and weaknesses are recorded. The results of the NJ CAT determine an individual's budget.***

Medicaid Eligibility

Individuals found eligible for DDD services must become and maintain Medicaid eligibility.
Individuals with private health insurance may remain on it, but must also become Medicaid eligible.
Three Primary Methods:

- Beginning at age 18 apply for Social Security Income (SSI) and if eligible you will automatically receive Medicaid.
- New Jersey Workability allows a person with a disability to work and keep their Medicaid.
  Call for more information — 888-285-3036
- Apply for Medicaid at your County Board of Social Services.

Read

Become Familiar With the New Services and Service Definitions

- Supports Program http://bit.ly/supportsprogramservices
- Community Care Waiver (Draft) http://bit.ly/ccwdraft

Research Support Coordination Agencies
http://bit.ly/researchsupportcoordinators

Individualized Service Plan (ISP)
Support Coordinators are responsible for utilizing this person-centered planning tool to create goals. The ISP will serve as the authorization for services funded by DDD.
http://bit.ly/individualizedserviceplan

Timeline

Fee for Service Implementation Timeline Part II: January – July 2015
http://bit.ly/ffstimelinepart2

Support Coordination Ramp-Up Timeline: October 2014 - July 2015
http://bit.ly/supportcoordinationtimeline

Get Connected

As changes take place within the service delivery systems, it is vital for families to stay connected with an organization that can provide the most recent and important information. ***The Arc of New Jersey Family Institute and its Family Advocacy Program keep you informed, educated and up-to-date*** on all the latest changes that affect your loved one with an intellectual or developmental disability.

Sign up today for free!
Family Member/Guardian Sign Up:
http://bit.ly/caregiverfapregister
Professional in the Field Sign Up:
http://bit.ly/professionalfapregister

The Arc. of New Jersey **Family Institute**

Advocacy • Empowerment Resources • Education

A Guide to Guardianship & Alternative Options

At 18 years old all individuals, including those with intellectual and developmental disabilities, reach the legal age of majority. This means that parents can no longer make decisions legally on behalf of their children, regardless of the nature of their disability and regardless of whether or not they still live with their family. Some families may want to consider guardianship as an option for their family.

What is a Guardian?

A guardian is a person or agency appointed by a court to make personal decisions for an individual who is not capable of making some or any decisions independently.

Role of guardian?

A guardian makes decisions about the care and treatment of another person.

New Jersey law allows for ***limited guardianship.*** This means a guardian can make some decisions in some areas, but not all areas of an individual's life.

A guardian may make decisions about property and assets of the person under guardianship, unless the property is in trust or consists of SSI Benefits.

Who can be a guardian?

- Person over 18
- Parents
- Close relative
- Sibling over 18
- Person with a close
- relationship to the individual
- The court may appoint a public guardian (for persons over 60) or an attorney to serve as guardian.

Where do I begin?

All guardianship appointments require a Judgement rendered by a Superior Court Judge. **Families can pursue guardianship by:**

⇒ Representing themselves (pro se)
⇒ Through an attorney
⇒ With assistance of the Bureau of Guardianship Services (BGS)

Pro se: means "without a petitioning attorney". The proposed guardian represents himself or herself in court.

Through an attorney: Families can hire an attorney at their own expense to complete the entire process. *This is the **only** option if guardianship is to be of person and property.*

Assistance of Bureau of Guardianship Services (BGS): *This process is for guardianship of the person **only.*** BGS is only able to assist individuals who are eligible to receive services funded by the Division of Developmental Disabilities.

Note: There are approximately 4000 requests currently pending with BGS

What should I read?

Pro Se: forms and instructions can be found at: bit.ly/njproseselfhelpcenter

Note: The Pro Se packet states "DDD official will complete a form verifying that the individual is a current client of the Division of Developmental Disabilities (DDD) and is receiving services". However, DDD no longer offers such a letter. Disregard this section as it isn't needed to complete the document. The New Jersey Administrative Office of the Courts is in the process of amending this document to remove the above quoted language.

Visit:

- **Planned Lifetime Assistance Network of New Jersey (PLAN/NJ):** bit.ly/planNJ
- **Guardianship Association of New Jersey, Inc. (GANJI):** bit.ly/ganjiforms
- **Bureau of Guardianship Services (BGS):** FAQs, fact sheets, roles of a guardian, and family guides to the court process can be found at: http://bit.ly/1HGFUUB

What is the process?

1. **Identify a guardian or co-guardians**
2. **Complete a psychological or medical evaluation**
3. **Receive a court recommendation:** Based on the psychological evaluation, a recommendation is made as to whether legal guardianship is needed.
4. **File paperwork with the court:** After getting forms signed and notarized they will get filed with the Superior Court in the individual's county of Residence.
5. **Conduct a hearing (if necessary):** If the Public Advocate does not oppose appointing a guardian, the court reviews the paperwork and signs Judgement.
6. **Obtain a court judgement:** Once the court signs the judgement appointing a guardian, the individual and his/her family will receive a copy of it.

Processing time varies

Alternatives to guardianship

Conservatorship is a voluntary , judicially supervised arrangement for people who need assistance, but who are capable of giving informed consent.

Living wills and durable powers of Attorney are documents where the guardian names a person to make decisions for him/her when the guardian is unable to do so.
Ex: medical decisions.

Person-centered Planning involves a group of people, family and/or friends who focus on the individual and that individual's vision of what he/she would like to do in the future. It is an ongoing problem solving process.

Supported decision-making is a series of relationships, arrangements and agreements designed to assist an individual with a disability to make and communicate to others decisions about the individuals life.

****Type all links exactly as seen including any capital and lowercase letters, and numbers.****

DEPARTMENT OF HUMAN SERVICES
BUREAU OF GUARDIANSHIP SERVICES

Role of the Legally Appointed Guardian

A guardian is a person or agency appointed by a court to make personal decisions for an individual who is not capable of making some or any decisions independently.

1. **A personal guardian is responsible for:**
    - encouraging the individual to participate with the guardian in the decision-making process, to the maximum extent of the individual's ability, in order to encourage the individual to act on his or her own behalf whenever he or she is able to do so
    - encouraging the individual to develop or regain higher capacity to make decisions to the maximum extent possible in those areas in which he or she is in need of a guardian
    - making decisions and giving consents on behalf of the individual, but only to the extent of the court order
    - protecting the individual from harm
    - looking out for the individual's interests
    - safeguarding the individual's human and civil rights
    - ensuring that the individual's physical, emotional and developmental needs ,including education and training, are met.
    - acting consistently with a previously executed power of attorney for health care or advance directive
    - helping the individual to obtain all available and appropriate benefits and supportive services
    - visiting the individual not less than once every three months
    - initiating legal action on the individual's behalf
    - submitting reports to the court as specified by the court

2. A personal guardian is <u>NOT</u> responsible for:

- providing for the individual from his or her own funds
- any liability to another person for acts of the individual
- injury to the individual from the wrongful conduct of another person providing medical or other care
- taking the individual into the guardian's home to live

3. What kinds of decisions might a guardian be expected to make?

A guardian may be asked to give informed consent in matters such as:

- transfers or other major changes of program or treatment
- certain types of medical or dental procedures or for certain types of behavior modification plans
- right-to-privacy issues such as release of confidential records
- trips, vacations and overnight visits

4. What preparation does a guardian need to make these decisions?

The guardian should gather and review as much information as possible about the issue at hand before making a decision. The guardian should also involve the individual as much as possible in the decision making process by learning about his or her interests, preferences and choices. In addition, the guardian should participate in all important conferences regarding the individual's programs, particularly the annual meetings where his/her individual plan is developed and reviewed.

5. Are there limitations on guardianship?

Yes. A guardian cannot consent to shock treatment, psychosurgery, sterilization or medical, behavioral or pharmacological research. The guardian must petition the court for a guardian ad litem that can give specific consent for a particular request.

6. What authority does a guardian have regarding the individual's programming?

Program-related decisions are made by the Division's professional staff with input from the guardian. The guardian has the right and responsibility to be involved in developing and reviewing the individual's program plans and to either give or withhold consent for major program changes. A guardian also

may appeal a program decision and, if necessary, seek a hearing on the matter.

7. If the Bureau of Guardianship Services is appointed guardian, does the individual's family remain involved?

Yes. The Guardianship staff providing services to the individual maintains contact with families or other interested parties, keeping them informed and obtaining their input in decision making.

8. How are changes in guardianship made?

The court that initially appointed a guardian may be petitioned at any time to terminate or transfer guardianship. As part of the individual's annual plan, guardianship is reviewed each year. A court-appointed guardian may name a successor guardian in his/her will, subject to court approval after the guardian's death.

9. Do all individuals with developmental disabilities need guardianship?

No. Guardianship is necessary only for an individual who lacks the ability to make decisions in some or all areas. Many individuals are capable of making their own decisions, with appropriate support and advice, and do not need a guardian.

Revised 6/09

DEPARTMENT OF HUMAN SERVICES

Bureau of Guardianship Services

Family Guide to the Guardianship Court Process

This document describes the guardianship process followed by The Bureau of Guardianship Services (BGS), which is responsible for processing and tracking guardianship actions for people served by the Division of Developmental Disabilities (DDD) who have been evaluated according to state law and determined to require a guardian. BGS is only able to serve individuals who have been determined by DDD, through its application process, to be eligible for its services.

If your family member has been determined to need a guardian, working through BGS is only one of several options you have for pursuing guardianship. Most of these options are described in the DDD BGS Fact sheet entitled Guardianship Frequently Asked Questions.

Many families elect to pursue guardianship privately, either through an attorney or pro se (without an attorney) because these options tend to move faster than the BGS process.

BGS is only able to process guardianship of the person. If your family member has property such as a trust or other large assets, you need to pursue guardianship of person and property through a private attorney. This must be done at your expense or that of the estate.

If a family chooses to have BGS facilitate the court action, the process occurs as follows:

Step 1: Identifying a proposed guardian or co-guardians

BGS contacts the individual's family to determine if any family members are interested in becoming guardians. The law requires that the individual and his/her close relatives be notified of the court action. It is important that BGS receive names and addresses of any spouse, adult children, parents, stepparents, adult siblings and/or other interested relatives of the individual. You may consider having co-guardians appointed. This means more than one person may be appointed at the same time to act on behalf of the individual. The benefit of having two or more co-guardians appointed is the increased chance of a guardian being available to make decisions on the individual's behalf.

Step 2: Completing a psychological evaluation

After identifying potential guardians, BGS makes a referral to a psychologist, who contacts the individual to schedule an evaluation. The purpose is to verify the need for a guardian and the type of guardianship required. New Jersey has two types of guardianship of the person, general and limited. Under general guardianship, the guardian makes decisions and gives consents related to all areas of a person's life. Limited guardianship applies only to certain areas specified by the court; these areas could include residential, vocational, legal, medical or educational issues.

Step 3: Receiving a court recommendation

Based on the psychological evaluation, a recommendation is made as to whether legal guardianship is needed and, if so, whether it should be general or limited. BGS prepares the required paperwork, including a Certification and Acceptance of Guardianship forms, and sends it to the proposed guardian(s) for signature. The Acceptance of Guardianship form must be signed in the presence of a Notary. Most banks have a Notary available to customers; often this service is provided free of charge. It is important to sign and return all forms as soon as possible. If there is significant delay in returning the forms, the Bureau of Guardianship may be recommended to serve as guardian.

Step 4: Filing paperwork with the court

After receiving signed and notarized forms from the proposed guardian(s), BGS completes the court paperwork and files it with the Superior Court in the individual's county of residence. All interested parties (the individual, his/her proposed guardians and other family listed in the court documents) receive copies of the paperwork and the court date. The court will schedule the court date four to six months from the day the paperwork is filed.

The court then assigns the Department of the Public Advocate office to represent the individual in the court action. An investigator from this office contacts the person and schedules an interview, either directly or through the caregiver.

At least part of the interview must be conducted in private due to client-attorney confidentiality. The investigator also talks to the proposed guardian(s), either in person or by phone. The Public Advocate then writes a report for the court, either agreeing with or opposing the need for a legal guardian and the choice of proposed guardian(s), according to the individual's wishes.

Step 5: Conducting a hearing (if necessary)

If the Public Advocate does not oppose appointing a guardian, the court reviews the paperwork submitted and signs the judgment without a formal hearing. In this case, neither the individual with the developmental disability nor the proposed guardians need to appear in court.

If the Public Advocate opposes appointment of a guardian, the individual and proposed guardian(s) may have to attend a hearing, where a judge will listen to arguments before making a decision. A Deputy Attorney General will present the arguments in favor of guardianship. Often, a settlement is reached outside the court and a hearing is not needed. The Deputy Attorney General also may notify the parties involved that the hearing has been rescheduled. If you have questions about the need for a hearing, call the Deputy Attorney General listed in the correspondence you receive regarding the hearing.

Step 6: Obtaining a court judgment

Once the court signs the Judgment appointing a guardian, the individual and his/her family receive a copy of it along with Letters of Guardianship. The Surrogate's Court may contact you to sign an additional document before sending the letters of guardianship. These are the official papers identifying the guardian(s) of the individual and whether the guardianship is general or limited. If limited guardianship is determined by the court, the areas of guardianship will be identified in the Judgment and Letters of Guardianship.

New Jersey Department of Human Services
GUARDIANSHIP

A guardian is a person or agency that is legally authorized to act on behalf of a minor or an incapacitated adult to assure that the person's health, safety, and welfare needs are met and that his or her rights are protected. The duties of a guardian also include making decisions on behalf of the individual and giving informed consent in certain matters. However, the guardian is required to involve the person in decision-making to the extent that his or her abilities permit.

The Division of Developmental Disabilities is required to evaluate all persons who receive services as to their need for a guardian, either upon entry into the service system, or prior to their 18th birthday, if they are receiving services as minors. A decision that an individual needs a guardian is based on a sound clinical assessment of the individual's ability to make choices and decisions, capacity for independent living and understanding of guardianship.

Guardianship may be considered for an individual only when it is clearly necessary and only to the extent that it is required. Limited guardianship is appropriate for persons who have been found capable of making and expressing some, but not all, decisions. General guardianship is appropriate for persons who have been found incapable of making or expressing any decisions.

There are several options for processing guardianship:

- A relative or other interested party may choose to pursue appointment as guardian privately, at his or her own expense. This is the only option when guardianship of both person and property is sought.
- The Division of Developmental Disabilities can facilitate the court action at no charge for the legal costs. A family member or other interested party may be designated guardian of the person only, not of his or her property.
- A family member who is unable or unwilling to serve as guardian may propose another appointee.
- A family member who is unable or unwilling to serve as guardian may accept the appointment of the Division's Bureau of Guardianship Services as guardian of the person.

Unless there is a privately initiated action to apply for guardianship, the Bureau of Guardianship is responsible for preparing the documents necessary to petition the court for appointment of the guardian.

Guardianship of the person only, and not of his or her property, involves no financial obligation for the guardian. A guardian's only role related to financial matters is to sign applications for benefits or other entitlements for which the person with a disability may qualify.

The Division's Bureau of Guardianship Services' authority is limited to guardianship of the person only, not of his or her property. Also, the BGS staff may not consent to procedures such as shock treatment; psychosurgery; sterilization; or medical, behavioral or pharmacological research as experimentation. Those matters may be referred to a court of competent jurisdiction for the appointment of a guardian ad litem.

The Bureau of Guardianship Services may provide guardianship services to a minor under certain circumstances. This applies to a person under age 18 who is without parent or guardian or whose legal guardian has granted a power of attorney to BGS to make personal decisions.

Guardianship is not permanent. As part of the annual Individual Habilitation Plan process for each adult with a guardian or receiving guardianship services, staff shall review the individual's continuing need for guardianship. If an assessment supports termination or reduction of guardianship, staff must initiate necessary action to terminate or limit guardianship.

Bureau of Guardianship Services

PO Box 726,
Trenton, NJ 08625-0726
(609) 631-2213

Northern Regional Office
153 Halsey St.
PO Box 47009, Newark, NJ 07102
(973) 648-4638

Serving Bergen; Essex, Hudson, Passaic, Morris, Somerset, Sussex, Union, and Warren Counties of Community Services;
North Jersey and Woodbridge Developmental Centers and Green Brook Regional Center

Central Regional Office
PO Box 726,
Trenton, NJ 08625-0726
(609) 631-2213

Serving Hunterdon, Mercer, Middlesex, Monmouth and Ocean Counties of Community Services;
Hunterdon and New Lisbon Developmental Centers

Southern Regional Office
860 N. Orchard Road
P.O. Box 1513
Vineland, NJ 08362-1513
(856) 690-5260

Serving Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, and Salem Counties of Community Services;
Vineland and Woodbine Developmental Centers

2/09

Departamento de Servicios Humanos de New Jersey
División de Discapacidades del Desarrollo

TUTELA (CUSTODIA)

Un tutor (guardián) es la persona o agencia legalmente autorizada a actuar en nombre de un menor o de un adulto incapacitado para garantizar que se cumplan las necesidades de bienestar, seguridad y salud de dicha persona y que se protejan sus derechos. Entre los deberes de un tutor (guardián) se encuentran el tomar decisiones en nombre del individuo y prestar consentimiento informado respecto de ciertos asuntos. Sin embargo, el tutor (guardián) debe hacer que la persona participe en la toma de decisiones en la medida en que sus aptitudes lo permitan.

La División de Discapacidades del desarrollo (*Division of Developmental Disabilities*) está obligada a evaluar a todas las personas que reciben servicios para determinar si necesitan un tutor (guardián), ya sea al momento de ingresar al sistema de servicio, o antes de que cumplan los 18 años de edad, en caso de recibir servicios como menores. La decisión de que una persona necesita un tutor (guardián) debe basarse en una evaluación clínica de la capacidad del individuo para realizar elecciones y tomar decisiones, su capacidad para vivir independientemente y la comprensión de la tutela.

La tutela de un individuo puede considerarse únicamente cuando su necesidad sea clara y sólo en la medida en que sea requerido. La tutela limitada es adecuada para aquellas personas que sean capaces de tomar y expresar algunas, pero no todas, las decisiones. La tutela plena es adecuada para aquellas personas declaradas incapaces de tomar o expresar cualquier decisión.

Hay distintas opciones para procesar la tutela:

- Un familiar u otro tercero interesado puede solicitar que se le nombre tutor (guardián) en forma particular, por cuenta suya. Ésta es la única opción cuando se pretende la tutela tanto de la persona como de los bienes. En algunos casos, la División puede subsidiar al integrante de la familia por lo menos por una parte de los costos.
- La División de Discapacidades del desarrollo puede facilitar la acción judicial sin cargo para los costos legales. Se podrá nombrar a un integrante de la familia o a otro tercero interesado tutor (guardián) únicamente de la persona, y no de sus bienes.
- Un integrante de la familia que no esté capacitado o no esté dispuesto a actuar como tutor (guardián) puede proponer que se nombre a otra persona.
- Un integrante de la familia que no esté capacitado o no esté dispuesto a actuar como tutor (guardián) puede aceptar que se nombre tutor (guardián) de la persona a la Oficina de Servicios de Tutela (*Bureau of Guardianship Services*) de la División.

Excepto que exista una acción iniciada en forma particular para solicitar la tutela, la Oficina de Tutela (*Bureau of Guardianship)* estará a cargo de preparar los documentos necesarios para solicitar al tribunal el nombramiento del tutor (guardián).

La tutela únicamente de la persona, y no de sus bienes, no implica obligación financiera alguna para el tutor (guardián). La única función del tutor (guardián) relacionada con las cuestiones financieras es firmar solicitudes de beneficios y demás asignaciones para las cuales la persona incapaz puede calificar.

La autoridad de la Oficina de Servicios de Tutela de la División está limitada únicamente a la tutela de la persona, y no a sus bienes. Además, el persona de la Oficina de Servicios de Tutela (BGS) no puede prestar consentimiento para la realización de procedimientos tales como tratamientos de shock; psicocirugía; esterilización; o investigación médica, conductual o farmacológica como experimento. Dichas cuestiones pueden derivarse a un tribunal de jurisdicción competente para que se nombre un tutor (guardián) ad lítem.

La Oficina de Servicios de Tutela puede brindar servicios de tutela a un menor en determinadas circunstancias. Esto se aplica a las personas menores de 18 años que no tienen progenitores ni tutor (guardián) o cuyo tutor (guardián) legal ha otorgado un poder a BGS para que tome decisiones personales.

La tutela no es permanente. Como parte del proceso del Plan de Habilitación Individual anual para cada adulto al que se le ha asignado un tutor (guardián) o que reciba servicios de tutela, el personal deberá evaluar si la persona continúa necesitando un tutor (guardián). En caso de que la evaluación muestre que la tutela debe reducirse o extinguirse, el personal debe iniciar las acciones necesarias para extinguir o limitar la tutela.

Bureau of Guardianship Services

(Oficina de Servicios de Tutela)
(División de Discapacidades del Desarrollo)
PO Box 726, Trenton, NJ 08625-0726
(609) 631-2213

Northern Regional Office
153 Halsey St.
PO Box 47009, Newark, NJ 07102
(973) 648-4638

Atiende a los Servicios Comunitarios de los condados de Bergen Essex, Hudson, Passaic, Somerset, Morris, Sussex, Union, y Warren; Centros del Desarrollo de North Jersey y Woodbridge y el Centro Regional Green Brook

Central Regional Office
PO Box 726, Trenton, NJ 08625-0726
(609) 631-2213

Atiende a los Servicios Comunitarios de los condados de Ocean, Hunterdon, Mercer, Middlesex, y Monmouth
Centros del Desarrollo de Hunterdon y New Lisbon

Southern Regional Office
860 N. Orchard Road
P.O. Box 1513
Vineland, NJ 08362-1513
(856) 690-5260

Atiende a los Servicios Comunitarios de los condados de Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, y Salem
Centros del Desarrollo de Vineland y Woodbine

2/09

Programmed File Phases: Spanish

Limited – *(Limitado)*

Phrases for Limited – (*Frases para limitado*)

Limited – Functional Deficits (*Déficit Funcional - Limitado*)

- All areas except legal matters and medical decisions requiring informed consent.
- (*Todas las áreas excepto los asuntos legales y las decisiones médicas que requieren consentimiento informado*)

- All areas except medical decisions requiring informed consent, legal matters, residential placement decisions and vocational decisions.
- (*Todas las áreas excepto las decisiones médica que requieren consentimiento informado, los asuntos legales, las decisiones sobre el lugar de alojamiento y las decisiones vocacionales*)

Letter Abilities: (*Aptitudes para carta.*)

- Legal matters requiring informed consent
- (*Asuntos legales que requieren consentimiento informado*)

- medical decisions requiring informed consent
- *(decisiones médicas que requieren consentimiento informado)*

- residential placement decisions
- (*decisiones sobre el lugar de residencia*)

- vocational decisions
- (*decisiones vocacionales.*)

DEPARTMENT OF HUMAN SERVICES
BUREAU OF GUARDIANSHIP SERVICES

Frequently Asked Questions

Q. What is a guardian?

A**.** A guardian is a person or agency appointed by a court to act on behalf of an individual to assure provision for the health, safety and welfare of the individual and to protect his or her rights in accordance with the judgment of guardianship.

Q. What does guardianship mean?

A. Guardianship is the court appointment of a person or an agency to make personal decisions for an individual who is not capable of making decisions independently.

It is important to understand that guardianship removes an individual's fundamental right of self-determination. Therefore, it should only be a solution of last resort.

Q. Do I have decision-making authority on behalf of my son or daughter when he or she turns 18 years old?

A. No. Eighteen is the legal age of majority, and at that point, without an action by a court of law, parents' legal decision-making authority for their children ends. However, parents can continue to be involved in planning for their son or daughter. So, you may continue to attend planning meetings such as the IEP or IHP. You may still be involved in medical decisions, and you may be asked to give consent in a medical emergency as the next of kin.

Q. Does everyone with a developmental disability need a guardian when they turn 18?

A. No. This is a very individual question and would depend on individual circumstances. If your son or daughter still lives at home with you and has no serious chronic medical issues that involve frequent hospitalizations, there is no immediate need to pursue guardianship. However, if your son or daughter has legal issues that require an advocate to make sure he or she is represented, a guardian may be needed.

Q. Is there more than one type of guardianship?

A. Yes, there are two types of guardianship: guardianship of the person and guardianship of property. A guardian can be appointed guardian of the person, guardian of the property or guardian of the person and property. It is generally not necessary to be guardian of the property unless the individual has assets in his or her name.

The Bureau of Guardianship Services, which is located at the Department of Human Services, only assists individuals and families with guardianship of the person. If a family believes it needs to pursue guardianship of the property because a large amount of money or property is involved, they will need to seek advice from a private attorney.

In addition, guardianship of the person can be either General or Limited.

- General Guardianship is appropriate for people who have been found incapable of making or expressing any decisions. This is sometimes referred to as 'plenary' guardianship.

- Limited Guardianship is appropriate for people who have been found capable of making and expressing some, but not all, decisions. The law identifies six areas for Limited Guardianship: residential, educational, medical, legal, vocational and financial. Of the six areas, BGS does not pursue a limited guardianship of the person for financial matters.

Q. Are there alternatives to guardianship?

A. Yes. In New Jersey, an individual may appoint a Power of Attorney (POA) to make decisions on his or her behalf.

In order to appoint a POA, the individual with the disability must be able to understand on a basic level that he or she is appointing someone to make decisions on his or her behalf. In addition:

- A person must be able to give consent
- A POA can cover person and/or property
- A POA can be revoked and/or changed at any time, based on changing needs
- A POA is significantly less costly than guardianship
- It is best to work through an attorney to establish POA

For additional information about this option, please visit the website of the Guardianship Association of New Jersey (GANJI) at http://www.ganji.org;

Q. If I want to pursue guardianship for my family member, how do I begin?

All guardianship appointments require a Judgment rendered by a Superior Court judge. Families can pursue guardianship in three different ways: by representing themselves (*pro se*); through an attorney; or with the assistance of the Bureau of Guardianship Services (BGS) at the Department of Human Services.

Families can pursue guardianship *pro se*. This is a great choice for families who can complete the process on their own, especially if the individual is not already under DDD Services.

1. Pro se means "without a petitioning attorney." The proposed guardian represents himself or herself in court.
2. The forms and instructions can be found at www.judiciary.state.nj.us or by clicking here: http://www.judiciary.state.nj.us/prose/10558.pdf.
    a. Click on "Represent myself in court.
    b. Click on "How to file for guardianship of a developmentally disabled person."
    c. This process eliminates the cost to hire an attorney to file the petition.
3. Remaining costs include court fees, guardianship assessments by a psychologist or physician, and the required court-appointed attorney to represent the individual.

Families can hire an attorney, at their own expense, to complete the entire process.

1. A relative or other interested party may choose to pursue appointment as guardian privately, at his or her own expense.
2. This is the only option if guardianship is to be of person and property.

Families can request BGS to process a guardianship petition.

1. There are approximately 4000 requests currently pending.
2. This process is for guardianship of the person only.
3. BGS is only able to assist individuals who receive services funded by the Division of Developmental Disabilities. Individuals must apply to DDD to receive an eligibility determination.

Q. How will a judge know about my child's ability to make decisions?

A. All applications for guardianship require an up-to-date assessment from a psychologist, psychiatrist or medical doctor licensed in the State of New Jersey. The purpose of this assessment is to verify the need for a guardian and if so, whether General or Limited guardianship is required. Under general guardianship, the guardian makes decisions and gives consents related to all areas of a person's life. Limited guardianship applies only to certain areas specified by the court; these areas could include residential, vocational, legal, medical and educational. Additionally, financial decision making will be assessed if seeking guardianship of property.

Q. Who can be a guardian?

A. The guardian can be a family member, another interested person, or the Bureau of Guardianship Services, Department of Human Services.

Q. Can more than one person be appointed as guardian?

A. Yes. When more than one person is appointed as a guardian, it is called co-guardianship. Co-guardians:

- have equal decision-making authority
- must be involved together in all decisions or consents needed for the individual
- should be limited to a reasonable number, generally three or less, to make sure decisions can be made on a timely basis
- must, like any single guardian, be appointed by the Superior Court, which is also the only entity that can modify or change the guardianship order.

Q. After a guardian or co-guardians have been appointed, can additional guardians be added later?

A. Yes. However, adding additional guardians requires going back to the court and requesting the change. In order to do this, the guardian or family would need to seek advice from an attorney. Given limited resources, the Bureau of Guardianship Services cannot process this type of request.

Q. If a guardian is appointed, can a successor guardian be named in the guardian's will?

A. Yes. However, this is not automatic just because it is in the will. Once the guardian dies, the request for appointment of a successor guardian must still be processed through the court.

Q. What happens if the person named in the will does not want to serve as guardian?

A. If the person named in the guardian's will does not want to succeed in that role, it will be necessary to find another person or agency that is willing to act as guardian. For this reason, it is important for guardians to be sure individuals named in their wills to be successor guardians continue to be willing to assume that role.

Q. What happens if an appointed guardian passes away or is otherwise unable to continue as guardian?

A. At that point, a substitute or successor guardian must be sought. This request will have to be petitioned through the court. If the Bureau of Guardianship Services pursues this option, an assessment for a continued need for a guardian will be completed. The next of kin will be asked if he or she wishes to become substitute guardian.

Q. How long does it take to complete the guardianship process through the Bureau of Guardianship Services?

A. BGS maintains a waiting list of individuals who have requested assistance with guardianship. Currently, there are approximately 4,000 individuals on that list. The actual waiting list time is unavailable, but it is safe to say that it can be measured in years. Once an individual is reached and BGS begins working with him or her, the process takes approximately 8-12 months to complete. This includes receipt of the court Judgment.

Q. What is the process for pursuing guardianship?

1. Identify a proposed guardian or co-guardians
2. Complete a psychological evaluation
3. Receive a court recommendation
4. File paperwork with the court
5. Conduct a hearing (if necessary)
6. Obtain a court judgment

Q. If I pursue guardianship privately, can I receive any assistance from the Division of Developmental Disabilities?

- Individuals who reside in a residential setting funded by DDD are required to contribute financially to the cost of their care; this is known as "Contribution to Care." When the family of such an individual pursues guardianship, the amount of the individual's Contribution to Care may be

reduced by up to $2,000, on a one-time basis, and applied to costs associated with pursuing a guardianship application with the court.