May 2, 2007

New Jersey Department of Human Services
Division of Developmental Disabilities Olmstead Plan

Executive Summary

The New Jersey Department of Human Services' Division of Developmental Disabilities (DDD) is pleased to present the Olmstead Plan, "Path to Progress" (The Plan). This Plan outlines the process of transitioning individuals with developmental disabilities from developmental centers (DCs) to the community over the next 8 years (State FY 2008 through FY 2015). The Plan addresses the requirements of state legislation (S1090, PL 2006, Chapter 61) as well as the issues in the NJ P&A Olmstead lawsuit.

Four public hearings were held in January 2007 to obtain public input for the development of the plan. More than 260 people attended and 76 people provided testimony. After publishing a draft of the Path to Progress plan, the division received 31 comments from people with developmental disabilities, family members, organizations and agency representatives. Stakeholder involvement will continue through an Olmstead Implementation and Planning Advisory Council that will start meeting in June 2007. The council members will include people with developmental disabilities, family members, advocates, provider agency representatives and state agency representatives.

The most important aspects of the Plan however, are the system changes that relate directly to what the 1850 individuals with developmental disabilities and their families/guardians will experience as they transition from developmental centers over the next 8 years. This number includes the 1,005 people who, in addition to their families/guardians and teams, have selected community placement. The Division anticipates an additional number of people, who after receiving education and information, will request a move to the community. These changes reflect the belief that most people with the right services are able to live in the community and should be supported to direct their own services whenever possible. The Plan also includes the development of criteria for admission to and continuing stay in developmental centers.

The Developmental Disabilities Resource Tool (DDRT) is used to assess each individual. The information obtained from this assessment identifies support needs to be considered for community planning in a variety of areas including medical and behavioral needs. At each individual's annual Individual Habilitation Plan (IHP) meeting, the Inter-Disciplinary Team (IDT) discusses transitioning to the community with the individual and his or her family/guardian. The IDT determines readiness for community transition

and incorporates the recommendation into the IHP. Individuals and their families/guardians can then go to family forums where they will learn about the process. Peer and family mentors who have made the transition will be in attendance. DDD transition case managers work with the individual and the DC staff to develop the team that supports him or her during their transition.

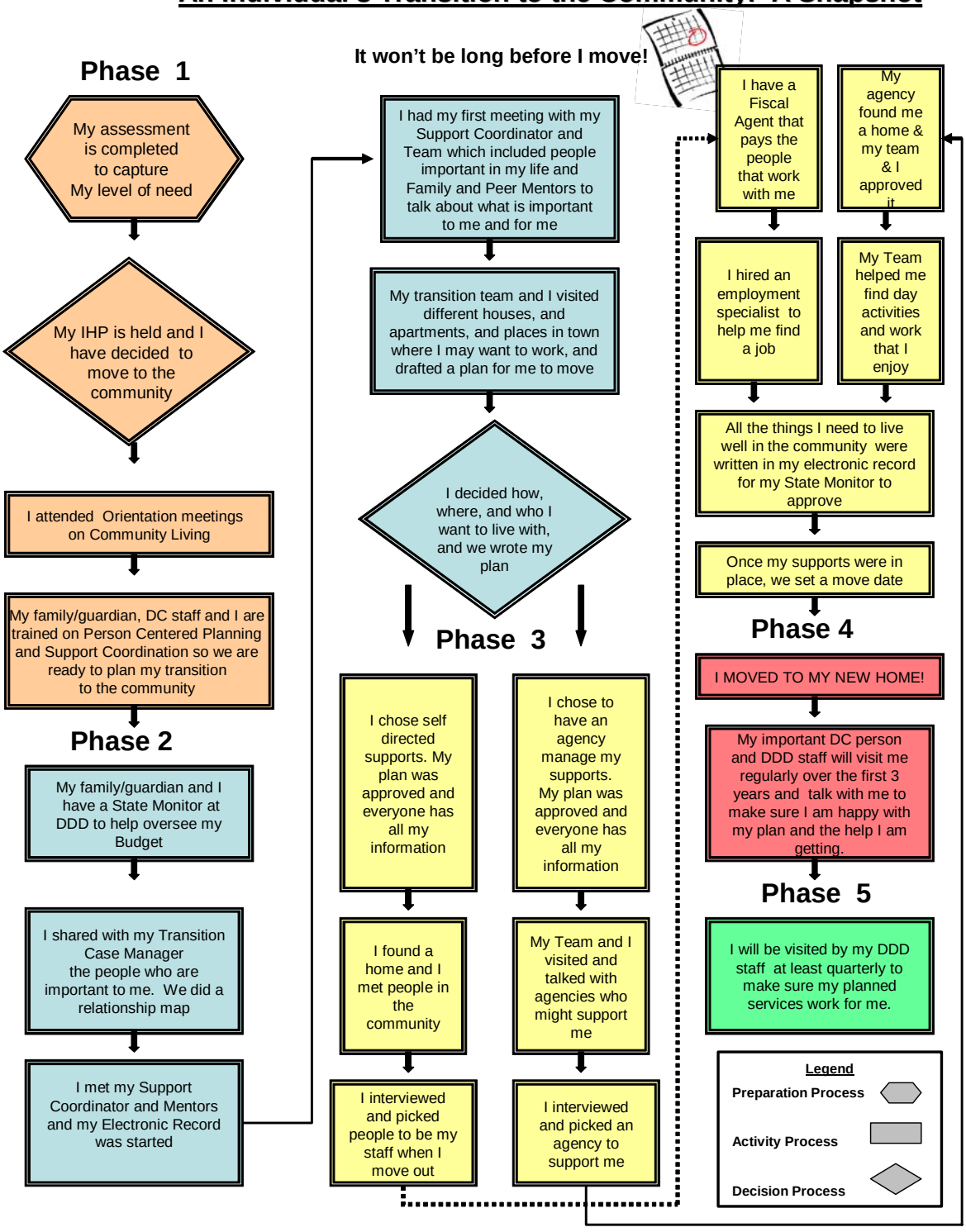
There will be an independent support coordinator to lead the team as they develop a plan with the individual for community living. Visits will be made to look at different types of living arrangements and day activities. Each person transitioning will have an individualized budget based on his or her needs. This will maximize an individual and his or her family/guardian's ability to directly control needed services and supports, including hiring support staff and establishing emergency back up services.

The individuals and their families/guardians will have many more options with different types of housing and new types of individual supports. The DDD has qualified over 100 agencies to provide residential, employment/day, housing, behavior and medical supports for persons with varying levels of behavior and medical needs. These agencies will be included on the qualified provider list. A new crisis response system and emergency residential capacity will also help individuals remain in the community. Developmental centers will evolve into smaller, more specialized, regional centers for people residing in the community. Specific services such as medical, dental, or respite will be some of the available resources. The Plan also addresses the continuous development of the direct care professional workforce to ensure that individuals will be served by staff that have the necessary experience and knowledge to meet their needs. The Division is also taking steps to redesign its community service operations, including how it provides case management. This Redesign will ultimately provide better support to individuals and their families/guardians as they transition to the community.

After an individual moves into the community, DDD will provide face-to-face visits to monitor the transition at 30, 60, 90 and 180 days and annually up to 3 years thereafter. The transition monitoring team will include community and DC staff who know the person well. After the transition monitoring period, monitoring will be through the existing DDD process. This emphasis on follow up and monitoring will ensure the health, safety and well-being of each person who transitions to the community from the Developmental Centers.

DDD has appointed a full-time Olmstead project manager and established a number of performance indicators to measure the state's progress. This administrative capacity together with the Implementation and Planning Advisory Council (which will include individuals with developmental disabilities and their families who are or have made the transition from DCs) will ensure the state continues to make progress toward the "Path to Progress" Plan goals.

An Individual's Transition to the Community: A Snapshot



Olmstead Plan
“Path to Progress”

New Jersey Division of Developmental Disabilities
Assistant Commissioner Kenneth W. Ritchey
May 2, 2007

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Olmstead Plan
"Path to Progress"

I. Introduction

A. Purpose of the Plan

"Path to Progress" is the New Jersey Department of Human Services' Division of Developmental Disabilities (DDD) action plan for systems change. The systems change will provide opportunities for residents of State Developmental Centers (DCs) who want to live in the community to do so over the next eight years. The Plan was developed in response to PL 2006, c.61 which requires DDD to:

- Establish benchmarks to ensure that within eight years of implementation, each resident in a State developmental center who expresses a desire to live in the community and whose individual habilitation plan so recommends, is able to live in a community-based setting;

- Review and establish objective criteria to identify those persons with developmental disabilities who are appropriate candidates for living in community based settings;

- Identify the resources needed to ensure that those persons can reside in the community and receive needed community-based services and supports in a manner that enables them to live as independently as possible;

- Set forth how the necessary funding, services and housing will be provided;

- Solicit public input in developing the plan by conducting four public hearings at or in close proximity to the State's developmental centers in each of the Division's four regional service areas. Public input must include the amount and type of supports and housing needed and how they are to be provided;

- Provide the plan and a report of its findings and recommendations to the Governor and, pursuant to section 2 of P.L. 1991, c.164 (C, 52:14-19.1), to the Senate Health, Human Services and Senior Citizens and Assembly Human Services committees no later than nine months (May 2, 2007) after the effective date of the act.

It is important to emphasize that although this plan is designed to meet the requirements of PL 2006, c.61, it also serves to strengthen the overall infrastructure of the Division resulting in benefits to all persons served by the Division.

B. Background

1. History of Community Services Development

For nearly three decades, DDD operations have been focused on expanding the development of services in community settings, while reducing the use of DCs. As a result, the number of individuals in Developmental Centers was reduced from 7,317 in 1980 to 3,027 by the beginning of 2007 while the number of DCs was reduced from eleven to seven. After the closure of North Princeton Developmental Center, 150 people who left the center were tracked for 27 months. The Division learned from those who made the transition that overall quality of life improved after moving to a community setting. Community Participation, Autonomy (including choice), Safety and Productivity were all enhanced when individuals moved from the center to a home in the community. Self Care ability improved for those who moved and mortality did not increase during the evaluation period as a result of moving to a community setting. Please visit http://www.ddpi.njit.edu/ddpi-publications-state-op.htm for more information regarding this report.

The challenge for the Division to continue this reduction has been the dramatic increase in the number of people eligible for division services. In 1986, there were 13,140 people on the caseload of the division. By 2007, that number had expanded to 37,359. There has been a 1400% increase in the number of people living in community residences from 471 in 1980 to nearly 7,200 by the beginning of 2007. The number of people on the community services caseload has increased from 6,720 in 1986 to 33,627. Now more than 92% of the people served by DDD live outside of the DCs. (See Appendix A). Over 24,000 people (73% of the community caseload) live in the family home, including over 800 who are using self directed service options, such as Self Determination and Real Life Choices. About 44% of the people on the community caseload are children under the age of 22 who receive few services from the Division.

The approach that DDD continues to employ, prior to moving people out of DCs, is to first prepare community supports and services. Additionally, the Division works to provide the necessary supports to people who have never entered DCs to continue living in communities and to reduce the potential risk of a DC placement. Building the level of services and supports available in community settings is the critical element to the reduction in reliance on the DCs.

In spite of DDD's efforts, a study conducted by Braddock, et al indicates studies show that New Jersey uses state DC placements for people with developmental disabilities at a rate of 36.3 people per 100,000 citizens of the general population.[1] There are only three

[1] "The State of the States in Developmental Disabilities: 2005," by Braddock, Hemp, Rizzo, Coulter, Haffer, and Thompson: AAMR, 2005. p. 48.

other States that use large public residential facilities at a higher rate then New Jersey. In order to achieve a further significant reduction in DC populations there is a need to expedite statewide community services expansion. Reinforcing existing community services and supports and expanding the types of available services will be necessary so that people with greater health, behavioral and mental health needs can move from DC settings to the community and those living with their families in their own communities can continue to do so.

2. Developing the Path to Progress Plan

The DDD recognizes that planning for needed services and supports requires stakeholder input and participation in order to be successful. Path to Progress draws on this stakeholder input, the operational experience of the division, and the experiences associated with closing four state-operated DCs for people with developmental disabilities between 1988 and 1998.

The plan will also require amendments to existing regulations and policies as well as the development of new ones. Specific decisions regarding these amendments will be deferred until the plan is further along into the implementation phase.

This Plan expands upon a number of stakeholder input processes including:

a. The Waiting List Plan 1998

The Waiting List Planning Workgroup developed a 10 point plan to eliminate the Waiting list for community Residential Services by 2008. The Workgroup's recommendations were offered with the hope of not only eliminating the Waiting List but also to enhance community resources and support services.

- Support and inform people with developmental disabilities and their families.
- Give people with developmental disabilities and their families more choices.
- Support people moving from developmental centers into the community and re-deploy resources currently tied to developmental centers.
- Commit adequate fiscal resources.
- Strengthen the community infrastructure.
- Enhance linkage services and support direct care workers.
- Simplify and streamline business practices and clarify decision making protocols.
- Enhance interagency collaboration.

- Engage in ongoing data collection, analysis and planning.

- Monitor and respond to changes in social policy.

b. New Jersey's "Governor's Stakeholder Task Force on the *Olmstead v. L.C.*

The New Jersey "Governor's Stakeholder Task Force on the *Olmstead v. L.C.* Decision" was convened in November 2001 to guide state efforts to shape a comprehensive plan that reflects a statewide vision for achieving community integration for people across all disability groups. In December 2002, the Department of Human Services issued the report: Achieving Community Integration for People with Disabilities in conjunction with The Governor's Stakeholder Task Force on Olmstead. The report contains the principles and desired outcomes, developed through the collaborative work of key stakeholder groups, whose interest is to make it possible for people with disabilities to live successfully in their communities, participate in making decisions about their lives and have the services and supports they require. The report contains 16 separate topics with a total of 62 recommendations. A number of these recommendations have been implemented by DDD. Path to Progress further incorporates these recommendations in the effort to move DC residents to community homes and reduce reliance on DCs.

c. PL 2006, c.61 Public Hearings

The most recent stakeholder input process was conducted as a result of PL 2006 c.61. The four hearings were held as follows:

- January 9, 2007 at Union County College;

- January 11, 2007 at New Lisbon Developmental Center;

- January 16, 2007 at Middlesex County College; and

- January 18, 2007 at North Jersey Developmental Center.

A total of 264 people attended the hearings with 76 people and organizations offering written and or verbal testimony. Although the Division did not restrict the scope of comments, those offering testimony were asked to address three key areas: 1) Services and supports needed to transition individuals from Developmental Centers; 2) Services and supports needed to successfully integrate and maintain individuals in the community; and 3) Concerns held regarding accessing and receiving services in the community. (See Action Step #16)

d. Comments on the Draft Plan

A draft of the Path to Progress was published on the Division's website in an effort to solicit further public input. Letters were sent to key stakeholders notifying them of its availability.

The Division received 31 comments from family members, organizations, and agencies many of which encompassed comments from large numbers of agency representatives. This information was reviewed by key staff and elements incorporated into the plan. The public input was very beneficial to the plan's development and has led to a stronger, more robust strategy.

3. The Context on Plan Implementation

a. Systems Transformation

Since 2002, the Division with its stakeholders has begun to address critical systems issues by working on creating a platform and an infrastructure that will make it possible to expand choice and service options to individuals with developmental disabilities. ("New and Expanded Options for Individuals with Developmental Disabilities and Their Families" published in September 2002.) Although the focus has been on individuals living with family or living independently with services and supports in the community to prevent DC placement, the systems transformation is also critical for transitioning individuals from Developmental Centers.

The DDD Vision**,** Mission, Values and Operating Principles will serve as a framework for the systems change required by this Action Plan. The elements presented here are contained in a draft document prepared by DDD for discussion purposes; they do not represent a finished product. Rather, they are a continuation of a dialogue that first resulted in the "New and Expanded Options Plan of 2002." These draft vision, mission, values and operating principles statements are based on the feedback and input we have received from our ongoing dialogue with individuals, their families, providers and Division staff. As a key member of a community committed to supporting individuals with developmental disabilities, the Division recognizes the need to develop consensus around the vision, mission, values, operating principles and strategies contained within this document.

Vision

Children and adults challenged by developmental disabilities will have opportunities to live their own lives, participating fully in their communities – to live as independently as possible; to work meaningfully; to have meaningful relationships with family and friends.

Mission

To partner with individuals who are challenged by developmental disabilities to establish across all settings, a system that maximizes each individual's ability to express his or her preferences and desires and their ability to self direct his or her services and supports to

the greatest extent possible. DDD will provide leadership for and effectively manage the design and equitable delivery of high quality, outcome based, culturally competent, person centered services and supports.

Values

The following set of values provides the context for the Division's policies, service design and operations. These values provide the framework for the DDD to assure that individuals with developmental disabilities and their families have access to needed community services, individualized supports, and other forms of assistance that promote self-direction, independence, productivity, and integration and inclusion in all facets of community life including work. We believe that individuals with developmental disabilities should:

- Direct their services whenever possible and be supported to make informed choices and decisions about their lives across all settings;
- Live in homes, communities and settings in which such individuals can exercise their full rights and responsibilities as citizens;
- Pursue meaningful and productive lives;
- Contribute to their families, communities, States, and the Nation;
- Have interdependent friendships and relationships with other persons;
- Be safe, living free of abuse, neglect, financial and sexual exploitation, and violations of their legal and human rights;
- Achieve full integration and inclusion in society through relationships and work, in an individualized manner, consistent with the unique strengths, resources, priorities, concerns, abilities, and capabilities of each individual; and
- Receive services and resources equitably, based on vulnerability and need.

Operating Principles:

Because we hold these values, the Division of Developmental Disabilities, its staff and leadership is committed to making fundamental system change so that:

- Individuals with developmental disabilities will be full participants in all aspects of the planning and delivery of services and supports so that they are empowered to exercise control over their own lives.
- The system will be person-centered with the needs of the individual dictating the types and variety of the available services and supports.
- Information about Division services as well as general community services will be readily available to assist individuals with developmental disabilities and to make the concept of choice and independence a reality.

- All individuals with developmental disabilities will have the option to use community-based services provided in the least restrictive setting appropriate to their needs.

- Individuals with developmental disabilities will have access to a comprehensive array of services that address their physical, emotional, social, educational and vocational needs.

- Services and supports will be flexible, habilitative, creative and innovative and delivered in a culturally sensitive manner whether provided by traditional provider agencies or natural supports.

- Individuals with DD will be provided with case management or care coordination to ensure that multiple services are delivered in a coordinated and habilitative way and to ensure that they can move through the system in accordance with their changing needs over the span of their lifetime.

- Children with developmental disabilities will be assured a coordinated transition to the adult service system.

- Services and supports should focus on people acquiring skills that are practical and useful and promote individual competence.

- The workforce serving individuals with developmental disabilities will have the necessary training to ensure they have the attitudes (including cultural sensitivity), knowledge and skills to be effective.

- The Division will advocate so that individuals with DD will have access to the same services and supports that are available to all.

- The Division's quality management strategy will address outcomes for people by developing structures that measure quality, provide feedback loops, and has the capacity to respond. These structures will emphasize that quality "is all our responsibility," promote best practice and continual improvement of services.

- Quality data from multiple sources will track performance including satisfaction, as well as improve services and remediate systemic problems.

- The Division's commitment to transparency through public reporting promotes trust and accountability among persons served, families, taxpayers who support the system, and the community within which the system operates.

C. The Transition Process

In order to provide a context for the document, the Division feels that it would be helpful to provide an outline of the Transition Process. This will provide the reader with information regarding what the various terms used throughout the plan mean in relation

to an actual person moving from a developmental center to a community setting. (See Action Step #20)

Phase 1 - Education and Decision Making

The Process of Transitioning from Developmental Centers begins when the Transition Case Managers at DC's begin to assist individuals with identifying the team, including family, friends, and those that know and care about the person.

- DDD identifies individuals to be transitioned to the community from those individuals who express a desire or do not oppose community placement and whose IDT so recommends.

- The Developmental Disabilities Resource Tool (DDRT) establishes the individual's Level of Need.

- The Level of Need determines the individual budget, and an up to amount is assigned.

- Individuals are assigned a Support Coordinator and an electronic record is developed.

- DDD ensures that the individual is added to the Community Care Waiver.

- Each individual, family and/or guardian has an information and education meeting to discuss person centered planning and the support coordination process with the DDD State Monitor.

- Orientation meetings are held with the IDT members of each of the individuals who have been identified to move. The goal of these meetings is to acknowledge the work of the DC, ensure receipt of the information that has been completed and review the Independent Support Coordination Team process. Information from the IHP and the Comprehensive Assessment will be given to the Independent Support Coordination Teams. These meetings will be the beginning of the process to identify DC staff who will be participating as members of the Independent Support Coordination Teams.

- Transition case managers will begin development of a "relationship map" to identify individuals who are important to and care about the person.

- Individuals and their team attend training to learn about writing person-centered descriptions and Essential Lifestyle Planning (ELP). The goal of this training is to assist the individual and their team to discuss what is important to the individual and what supports and services are important for the individual prior to developing a Service Plan.

Phase 2 - Plan Development

Support Coordinators begin work with individuals and their teams to develop a Service Plan.

- Independent Support Coordination team begins meeting with the person, and develops the person-centered description.

- Identified outcomes and specific actions needed to support the individual to better live and function within the community are established including the services and supports that are needed to achieve these identified outcomes.

- The first Service Plan is developed, based on how the individual wants to live, needed supports and the individual budget. Support Coordinator submits Service Plan to the State Monitor for review and approval.

- The State Monitor ensures health and safety issues are addressed throughout all aspects of the Plan.

- Selection of services and supports is initiated making sure that they are covered by the DDD Community Care Waiver (CCW).

Phase 3 - Plan is put into Action

Support Coordinator utilizing the Service Plan assists individuals and their teams to access services and supports.

- Individuals and their teams decide through the Service Plan the amount and kinds of services and supports they need based on the outcomes established in the ELP.

- Support Coordinator works with individuals and helps them to access services and supports using the computer database as a resource to learn about availability of services and supports, and qualified agencies that deliver services.

- Individuals, members of their teams, and/or their Support Coordinator contacts organizations to discuss potential services that would achieve the personal outcomes identified in the Service Plan.

- Support Coordinator ensures individuals and their teams make an informed choice. Opportunities for exposure to various service options and resources will occur. Among the options will be opportunities for individuals to meet and interview providers through provider fairs as well as more individualized visits which can include qualified providers with a more specialized support or service focus.

- The person, his or her family, and other members of the team make decisions about who will deliver services and supports described in their plan, where they are going to live, finalize the Plan and put supports in place.

- Once the person selects where they are going to live the process of beginning to establish community connections and visits to their new home, preferred day activity and community resources are initiated.

- A move date is identified, roles and responsibilities are communicated and resources prepared for transition. The Transition Case Manager ensures all activities related to the move are completed (necessary paperwork and arrangements for the move).

Phase 4 - Transition and Community Follow-up

- Information about the individuals and their service plan will be available and updated as changes are made on the electronic record. Information will be included from one or more of the following sources:

    - DDD

    - Support Coordinator

    - Fiscal Agent (This is through the electronic record, and will be organized to facilitate billing for the DDD Community Care Waiver).

- DC Staff provide transition services, including sharing knowledge of the individual and orienting community staff to that individual's support needs. For example, training in physical and nutrition plans, as well as environmental modification recommendations to the community residence. This is to ensure continuity of care between the Developmental Center and Community Services.

- Person moves to the community.

- If the individual has selected a provider managed method of procuring services, then the individual will be assigned a Community Services Case Manager when it is deemed by the team that the individual's plan is in place, services are being rendered, and those services are meeting the individual's outcomes. The identified Case Manager will become a member of the independent team.

- If the individual has selected a self directed method of procuring services, then that individual will continue working with the support coordinator and a State Monitor will be assigned to oversee the Plan.

- In addition to the monitoring of health and safety that occurs for all individuals in the community, a series of reviews will be conducted at 30, 60, 90 and 180 day intervals

and annually thereafter for a period totaling three years for those people who have transitioned to the community.

- The above mentioned face-to-face monitoring will be conducted by a team comprised of a developmental center staff person who knows the individual and the individual's assigned worker. The monitoring team will be responsible for ensuring that the individual's planned outcomes are being met and the transition continues to be successful.

Phase 5 - Long–term Follow-up and On-going Quality Assurances

Quality improvement and monitoring/review of the resource utilization identified through the Service Plan. The Service Plan is reviewed annually.

- Until the CCW is changed, the IHP must be the documented Service Plan for all people in the community although an ELP process will be used to develop the transition plan. The Division recognizes that this situation is not ideal and is working to resolve this discrepancy as soon as possible.

- If an individual chooses to change services and/or supports, the Support Coordinator or Community Services Case Manager will facilitate the requested changes.

- If the needs of an individual change, the Support Coordinator or the Community Services Case Manager will notify the Division and the DDRT will be utilized to revise the budget. Changes in Service Plan will occur based on an individual's changing needs.

- In the self directed option, the annual service plan review is facilitated by the Support Coordinator and the service plan is reviewed and approved by the DDD State Monitor. The DDD State Monitor will provide on-site oversight at least quarterly on health/safety. This includes, but is not limited to: review of medication administration records; review of personal needs allowance; review of annual medical and dental records; etc…

- In the provider managed option, the Community Services Case Manager will be responsible for the annual service plan. The Community Services Case Manager will provide on-site oversight on at least a quarterly basis on health/safety. This includes, but is not limited to: review of medication administration records; review of personal needs allowance; review of annual medical and dental records; etc…

- Quarterly follow-up is to be provided to DDD from Support Coordination teams regarding: (See Action Step #21)

    - Number of individuals served.

    - Phase of service for each individual.

- Follow-up status (in accordance with the waiver standards, the Support Coordinator is to document provision of the follow-up to ensure all supports are in place throughout the transition process and into the future).

- Support Coordination Agency to monitor for ongoing quality and needed improvements to assure:

    - Changes in the Service Plan are based on the individuals changing needs.

    - The DDRT is utilized to revise the budget.

    - Service and support changes are timely.

    - The Service Plan is reviewed/completed annually, facilitated by the Support Coordinator and reviewed/approved by DDD State Monitor.

- DDD Quality Assurances to be put into place include: (See Action Step #22)

    - Monitor Independent Support Coordination teams as people move out of DC's at 30, 60, and 90 days post movement.

    - Implementation of a Individual Satisfaction Survey, which will be linked to the National Core Indicators Project (NCI), to gather input from the individuals and their families regarding quality of life, choice and supports and services.

    - Evaluate the data collected through the NCI Project to identify areas needing improvements.

    - Provide evaluated data collection to the coordinated system of quality improvement committees, consisting of the Statewide Quality Management Steering Committee and Regional Continuous Quality Improvement Committees, to explore and pilot ways to improve service delivery and individual outcomes and satisfaction.

    - If funding allows, an independent group would conduct individual and family surveys.

    - Case manager or State Monitor oversees and monitors development, implementation, compliance and effectiveness of the Service Plan through the expanded IT capacity.

- Service monitoring and oversight, including provider agency compliance with policies and procedures, Division standards and performance reviews, and technical assistance for providers.

Appendix B can also be referenced to provide further clarity regarding an example of how a person's transition from the developmental center to the community might proceed.

D. Organization of the Planning Document

Path to Progress (the Plan) specifies the necessary activities to be accomplished, during the eight year implementation period of the Plan. Planning will of course evolve, based upon ongoing evaluation of the outcomes during initial implementation to include any needed adjustments that become evident. The Plan specifies the desired outcomes, the corresponding action steps and the target dates to achieve the outcomes. While specifics of the timeframes are contingent upon external factors, such as budget allocations and private service provider contracting, the intent is to use this plan as a framework to outline the necessary resources and track the progress toward achieving the desired outcomes.

The Plan is organized in three sections corresponding to the legislative requirements. The sections are:

- **Assessment** – This section will present the Division's review of criteria used by other states and describe the objective criteria used in New Jersey to identify people with developmental disabilities who are appropriate candidates for living in community-based settings.

- **Resource Needs** – This section will identify the resources needed to ensure that individuals with developmental disabilities who wish to transition to the community can reside in the community and receive needed community-based services and supports in a manner that enables them to live as independently as possible.

- **Implementation** – This section will set forth how the necessary funding, services and housing will be provided. It will describe the benchmarks, the actions steps necessary to achieve the benchmarks and the timeframes within which the benchmarks will be accomplished.

II. Assessment

This section will present the DDD's review of criteria used by other states and describe the objective criteria used in New Jersey to identify people with

developmental disabilities who are appropriate candidates for living in community-based settings. It will also describe the characteristics of individuals in developmental centers, the assessment tool and the assessment process.

A. Criteria Used By Other States

The Division queried the membership of the National Association of State Directors Developmental Disabilities Services (NADDDS) to review the criteria from other states. To date, DDD received responses from Wisconsin, North Carolina, Minnesota and Kentucky. Wisconsin passed legislation in 2005 that requires every individual's place of residence be in the most integrated setting (vs. least restrictive), and requires the preparation of an annual community plan, accompanied by a court order stipulating the plan's recommendations. The individual, as well as their guardian/family are part of a team that puts the plan together. Wisconsin assumes everybody should, wants, or is entitled to choose to live in smaller integrated settings.

In Wisconsin, any opposition to transitioning from the DC requires evidence that the guardian is 1) knowledgeable about community options, and 2) is actively involved in the person's life. The facility interdisciplinary team has virtually no say. Everyone who is eligible for the continued services of an Intermediate Care Facility (ICF), is also automatically eligible for HCB Waiver services.

Beyond guardian resistance, only cost-effectiveness would prevent movement: i.e. if services and supports in a community setting are more than the cost in the facility. There are also financial disincentives for counties (counties are fiscally responsible) to maintain individuals at Wisconsin Developmental Centers. They incur a daily charge if the person does not transition to the community (when knowledgeable guardians don't object, and the cost is not prohibitive.)

Kentucky, North Carolina and Minnesota's criteria are similar to New Jersey's as follows:

(a) The treatment professionals determine that a community living placement is appropriate for the individual; and

(b) The community living placement is not opposed by the individual or his or her legal representative.

B. Criteria for Community Placement from the Developmental Center

In New Jersey, the primary criteria presently used to identify individuals who can move from developmental centers to a community setting are:

- The person expresses a desire or does not oppose living in the community.
- The Interdisciplinary Team recommends a move to a community setting.

Because a large number of individuals living in the Developmental Centers meet this criteria it is necessary to prioritize the groups in the following manner:

- The family/guardian does not oppose the plan to transition the person to the community.

The Division recognizes the need for uniform criteria to be utilized in determining whether an individual should be recommended for community placement. The criteria will be as follows:

- The individual desires to move from the Developmental Center (DC) to a community setting.

- There is no court order prohibiting such a move.

- The IDT recommends an individual be placed in a community setting due to the absence of behavior that poses a significant risk to self/others and the level of intervention the persons requires does not exceed what can be provided in a community setting at the time of the recommendation.

Currently, admissions to the DCs are permitted only when an emergency exists as defined in Division regulations (N.J.A.C. 10:46B 3-3) and no community placement is available.

The Division recognizes the need for consistency between the criteria used for persons leaving the DC as well as persons going in. Therefore, it is investigating the adjustment of its admission criteria based upon stakeholder input. The new admission criteria will not only be further clarified, but will encompass a course of action that will include due process. An independent third party review process is being considered. The aim of this is to ensure that individual's civil rights are protected by providing the opportunity to live in the least restrictive environment.

C. Characteristics of Individuals in Developmental Centers

The Developmental Disabilities Planning Institute (DDPI) at the New Jersey Institute of Technology (NJIT) conducted an assessment of all individuals (over 3,000 people) living in New Jersey's seven developmental centers. (See Action Steps #1, 2 & 3). The original assessment instrument was first used in 1994 to assess about one third of the people living in developmental centers prior to the closure of the North Princeton Developmental Center. It was used again in 2000/2001 to assess a large sample of people living in the DCs. This instrument served as the starting point for the instrument used to assess all people living in the DCs. The tool was modified after consultation with key staff of the Division, including senior level and program staff from each DC. The core section of this assessment instrument has been refined over the years and has been shown to be statistically reliable and consistent over at least a 1.5 – 2 year period with individuals

living in developmental centers. Some medical and behavior conditions are less reliable due to their episodic nature and may need to be assessed at more frequent intervals.

Informants in eight programmatic areas at each DC, who knew each person well were trained in the use of the instrument and completed that module specific to their programmatic area. The programmatic areas were Social Work, Psychology, Physical Therapy, Occupational Therapy, Habilitation, Nursing, Nutrition, and Speech. Assessments were completed in late spring of 2006. The assessment instruments can be found in Appendix C of this document.

Some sections of the instrument are used as part of the assessment process for Real Life Choices (RLC). Two independent consultants were asked to review the instrument and methodology when the RLC application was being developed. One of these individuals is a statistical expert who was also on the development team for the Supports Intensity Scale (SIS). They were asked to evaluate whether or not the New Jersey instrument was a statistically valid tool for predicting relative support levels that could be tied to resource needs. After reviewing the statistical methodology and analyses used by the DDPI, each reviewer stated that the methodology was statistically sound and appropriate for use with resource allocation.

The assessment provides the Division with:

a. A standardized tool for use by all developmental center staff members to describe the unique abilities and needs of each resident;

b. A statewide database which includes information regarding the abilities, preferences and support needs of each resident of the developmental center; and;

c. The information necessary to identify specific obstacles which may influence the decision-making of staff members who determine, in the Individual Habilitation Plan (IHP), the potential for an individual's community placement.

1. Assessment Process Findings

a. Number of Targeted Individuals

A successful transition process includes a number of key steps. The first, and perhaps most critical, is for the individual, their guardian, and IDT to make an informed choice. There are 2,457 individuals who have a recommendation for community placement by his or her IDT. This is about 81% of the people living in the developmental centers. Of these 2,457 individuals, 2,303 individuals do not oppose community placement while 154 individuals have expressed a desire to remain in the DC. As such, the Division will be planning for placement of 2,303 individuals. This is about 75 % of people living in the developmental centers.

The Division's experience has been that transition to any type of community placement is most successful when the transition process is supported by the individual's family members. This is because a strong support system already exists for these individuals. It is for this reason that the Division has decided to transition those with support from family to the community first.

When family and/or guardian support is factored in the number of individuals ready to begin the transition process is reduced. Of the 2,303 individuals, the family/guardians opposed an individual leaving the center in 1,298 cases, even though the IDT and the person did not oppose moving. This leaves a total of 1,005 individuals whose family/guardians do not oppose such a move. It is important to note that from the legal point of view, it is unsettled in this State whether a guardian has the legal ability to keep an individual in a developmental center despite the individual's interest in community placement.

There are 1,005 individuals whose family/guardians do not oppose community placement currently residing in New Jersey Developmental Centers. Initially, the Division plans to focus on two of the state's seven Developmental Centers. These centers are New Lisbon Developmental Center and Woodbridge Developmental Center. The involvement of the Department of Justice (DOJ) determined the selection of the two DCs. The Division has a settlement agreement with the DOJ. This agreement expects the placement of individuals identified for community placement from these specific DCs. It is felt that through this structured approach the Division will achieve the most positive results for the persons it serves.

This initial pioneering phase will last for one year, ending July 1, 2008. After that time, all other Developmental Centers will be phased in to the process. Prioritization for placement will be based on those persons whom the center indicates are most ready to transition into the community. The volume of persons moved out of the centers will be based upon the figures in the Implementation Section of this document.

The success of a community placement can depend on the support and involvement of the person and the individual's family members. We know from speaking with families or guardians of individuals living in DCs that programs to inform families should have, as a minimum, the following goals:

- Factual knowledge of families must be maximized. This should include information about placement recommendations for their family member, the meaning of the Olmstead decision and state policy regarding Olmstead.

- Opportunities for families to visit community programs should be offered on a regular basis. We know that family members who visited community programs were likely to be favorably impressed with the programs.

- Involve individuals and/or family members of people who have moved from a DC to a community program in the past in discussions with families about their

relative moving to a community program. These individuals can be an important resource to help current DC families address concerns about health, safety and the general happiness of their relative who is recommended for community placement.

DDD has done considerable work in preparing families of people living in the DCs to evaluate community options. DDD contracted with the UMDNJ School of Public Health to assist in the preparation of families by providing information and relaying family concerns to DDD. UMDNJ's Developmental Disability Family Education Project will continue to provide support to all 2,457, including the 1,298 whose families/guardians do not support community placement at this time. This support and education will ensure they are provided opportunities to gain an understanding of the services and supports available in the community. This will provide families with the information they require to adequately support their family member through informed choice about transition. (See Action Step #14)

The Division has chosen to work first with the 1,005 people where the IDT, person, and family do not oppose moving from the center. This approach seems most feasible given the need to expand community infrastructure to accommodate this first group of people. The Division is committed to serving individuals in the least restrictive setting while providing safety and protection from harm. A reasonable pace of community placements from the developmental centers must be established, while ensuring that supports and services are available before moving forward. It is important that individuals who move to a community setting are able to participate fully in the communities where they live.

Facilitating the movement of 2,303 people from the developmental centers to a community setting without affecting services for people who are on the Division's waiting list for services or who require emergency placements out of the family home will be an important goal for DDD. For example, the Division is challenged to place about 340 people in emergency placements each year. During the four year interval from FY1997 through FY2000 the Division increased the number of people living in group homes and apartment programs by about 1,100. An additional one to two years was required to develop the supports and community infrastructure for these individuals before they moved. Thus, even during its most intense community development period in recent years, encompassing the closure of the North Princeton Developmental Center in 1998 and the funding of waiting list initiatives serving 500 people each year, the Division was only able to accommodate about 1,100 people in new community programs over an approximate six year period (including development time) or at a rate of about 183 individuals per year. This number is slightly more than the 1,005 people initially identified in developmental centers today where the IDT, person and family do not oppose moving from a center. Providing services to people on the Division's waiting list will require resources in addition to the funding for people leaving developmental centers.

For all of these reasons, the Division will transition 1,005 individuals to the community while continuing to educate and prepare the remaining 1,298 for community placement.

As families/guardians request a move to the community, individuals will be added to the 1,005 plan, bringing the total projected to move to 1,850 persons. The Division will continue the rate of placement in the five to six years beyond the span of the plan, or as long as it takes to move everyone who meets the placement criteria.

The Division has seen individuals and families change their minds about community placement when the transition is imminent. A community placement once seen as favorable can then be seen as not so desirable. It is expected through education, information and successful transitions that the number of community requests will increase over time to include many of the 1,298 individuals whose families/guardians currently oppose placement. A process will need to be developed to ensure that families/guardians receive numerous, varied and continuous opportunities for community experiences and exposure. The Division will be exploring the creation of a Mediation/Dispute Resolution process which incorporates a third party review in cases where an individual continues to desire or does not oppose community placement but their guardian, even after numerous education opportunities have been made available, still does not endorse such a move. The Division will take all the needed steps to ensure that individuals' rights are respected.

Additionally, community placement is discussed with all individuals annually at their IHP, and the DDRT assessment information will be updated and incorporated into the IHP. (See Action Step #3). It is anticipated that the numbers of individuals seeking community placement will be fluid throughout the years.

Annually the Division will track the number of individuals ready to begin the transition process because their families/guardians now support the individual's move to the community after participating in the informed choice education process with UMDNJ's Developmental Disability Family Education Project. This will allow the Division to plan for resources to meet their needs. These individuals will be included in transition planning. The Division will provide all individuals wishing to move to communities throughout New Jersey the opportunity to move. Adequate resources to support all people must be in place prior to initiating a transition.

Once this plan has been actualized, the Division will reassess our approach based on experience gained from this process. We will continue to provide community opportunities for individuals if they so desire.

b. Demographics and Use of the Assessment

Some of the basic demographic information, support needs and preferences of individuals from the assessment are provided in Appendices D thru H. All information obtained from the assessment process is not included here because of the sheer volume of data involved. However, Appendix C contains the assessments that were utilized during this process and will show the information that has been collected.

Findings from all people living in the DCs at the time the assessment was completed, the group of 1,005 where the IDT, individual, and family have no opposition to the person moving to a community setting, and the 1,298 individuals where the IDT and individual have no opposition to moving but the family is opposed are in the first three columns in the tables in Appendices D, E, F, G and H.

On average, the 1,005 individuals are about 50 years of age and more than half are males. Many are reported to have preferences about where and who they would like to live with and the general atmosphere of their home. Many will benefit from environmental modifications to the home due to difficulties with movement and coordination (e.g., cerebral palsy). Availability of medical, behavioral and nutritional supports, including psychiatrists and other medical specialties, for those who have medical conditions that require ongoing or episodic care will be important. Those who have autism (about 16%) may require access to specialized supports.

When compared with the 1,005 people, the 1,298 whose families are thought to oppose a move, have fewer with a psychiatric diagnosis, use psychotropic medication or use a behavior specialist. More of the 1,298 will use supports for self care activities and fewer individuals will need the most intensive levels of behavioral support. A higher proportion have epilepsy, where seizures have occurred within the last year, and use a wheelchair.

The Division is aware, based upon input from the Social Service Departments at the State's Developmental Centers and the public hearings, that there are some common themes as to why some families oppose community placement. These include, but are not limited to:

- The perception that their loved one is safer in the Developmental Center than in the community.

- The centers offer an array of on-site specialty services (eg. Podiatry, Occupational Therapy, Speech Therapy, Psychiatry, etc…).

- That, in many cases, their loved one has spent the majority of their life in the center and that is the only life they know. To remove them from that setting is perceived as an unnecessary adjustment the individual would need to make.

- The perception that, due to staffing issues in the community, their loved one would have less freedom than they have in the center. For example, individuals are free to walk the grounds of the center unaccompanied in some cases, due to the closed nature of the facilities grounds, whereas in the community the person would possibly need a staff person with them. This is perceived by families as problematic if there are staff shortages.

- The parents of the individual are elderly and express that they have peace of mind that their loved one is being cared for properly and do not want to have to worry that this could change.

It is important to provide information within this document about the 736 persons, about 25% of the current DC population, who are not identified for community placement at the present time (See right hand columns of Appendices D through H). There are two basic reasons for this:

- The informant completing the assessment who knew the person well felt that the individual would not want to move from the DC if given a choice (154 individuals) or;

- The IDT did not recommend that the individual move from the center (582 individuals).

When compared with the 1,005 individuals where no one opposed a move from the DC, the 154 people where the IDT recommended movement to a community program but the person was thought not to want to move if given a choice, are similar in many ways. However, there are some differences. As a group, the 154 people are older (in their mid 50's), are more likely to have a psychiatric diagnosis, be prescribed psychotropic medication, use physical therapy and have personal preferences about aspects of where they would like to live. The 154 individuals have a lower likelihood of using a behavior specialist and need proportionally fewer supports and assistance with activities related to self care.

The 582 people not recommended for movement from the DC by the IDT also appear to differ from the 1,005 individuals in a several areas. For example, as a group the 582 individuals have a greater likelihood of having a psychiatric diagnosis, having a prescription for psychotropic medication and using physical therapy. A greater proportion of these individuals have the highest level of behavioral support needs compared to the 1,005 individuals.

Some of the information from the assessment has been combined to give indices relating to the supports an individual may need to maintain a high quality of life after moving from a developmental center. The three indices include levels of Self Care Support Need, Medical Support and Behavioral Support.

2. Self Care Support Need. The four levels of Self Care Support Need are indicators of the amount of support an individual needs to maintain personal hygiene, complete household chores and participate in community activities. For those living in the developmental centers, the support needs vary from individuals who are independent in virtually all areas of self care activities, to those who need assistance with most activities. The majority of the people living in the developmental centers will need some degree of supports for self care activities. See Appendix E for a more detailed description of the self care levels and the proportion of people in each self care level.

3. Medical Support Levels. Having access to medical supports is very important for individuals when they move to a community home. Six levels of Medical Support were identified. These are based in part on whether the person can walk or use a wheel chair without assistance and on the degree of training required by those providing medical supports for the person. Individuals living at the centers vary from those who have no medical conditions or, if a condition is present, no unusual or specialized training is required by those supporting the person, to those who require a nurse be present or closely involved with providing supports to the person. The majority of individuals fall between these two extremes. They have medical conditions where it is important that people providing the medical supports have some specialized training (e.g., administering insulin), but a nurse does not have to be present. See Appendix F for a more detailed description of the Medical Support Levels and Appendix G for the proportion of people in the developmental centers in each medical support level.

4. Behavioral Support Levels. Four levels of Behavior Support were identified. These reflect the variety of behavioral supports that individuals may need to be full partners in the communities where they live. The levels are based on the behavioral supports individuals receive in a developmental center and could change when the person moves to a community home. They include individuals who have no or minimal behavioral disruptions not requiring any additional supports, people who require some formal behavioral supports provided by individuals with appropriate training, and individuals who require very intensive, high levels of behavioral support by specialized, highly trained staff. See Appendix F for a more detailed description of the Behavioral Support Levels and Appendix H for the proportion of people in the developmental centers in each behavioral support level.

The assessment is one of the first steps in the self directed planning process. These indices of support needs for Self Care, Medical and Behavioral areas provide an initial indication of the budget required as well as the degree and types of supports an individual may use when they move to a home in the community. However, the specific details of the person's self directed support plan will be completed after full involvement of the individual, family and the support team.

The IHP is the primary vehicle for assessing people on an ongoing basis. The Developmental Centers began using a revised IHP in September 2006 and it is projected that all individuals residing in the centers will be utilizing this updated version by September 2008. The DDRT assessment will be updated at the time the annual IHP is completed. The IHP was revised to include elements of the Essential Lifestyle Planning document. It is expected that the revised IHP, along with the assessment process, will allow for the creation of data-based reports, detailing the supports that would be necessary for each individual in the community.

III. Resource Needs

This section will identify the resources needed to ensure that individuals with developmental disabilities who wish to transition from the Developmental Centers can reside in the community and receive needed community-based services and supports in a manner that enables them to live as independently as possible. The resource needs identified are based upon the experiences of individuals who have made the transition from the DC to the community as well as the input from the public hearings conducted in January 2007. It is clear from the recommendations that the system serving people with developmental disabilities must increase the capacity of its infrastructure (both internal to the DDD as well as community capacity) to successfully transition individuals from the DCs. Planning is on an individual basis, therefore it is anticipated that community infrastructure will experience on-going expansion as the need for additional resources are identified. All supports and services identified will be available prior to the individual's transition.

A. Building Infrastructure

Infrastructure is the underlying base or foundation of an organization or system i.e. the basic structures and processes underlying operations; the basic services and supports needed for the system to function. The infrastructure serving people with developmental disabilities therefore must:

- Evolve in synch with changes in the system or organization's environment.
- Be based on technology's uses and user perceptions.
- Focus on quality of service; dependability and accountability.
- Promote simplicity and ease of operability and interoperability.
- Be managed to ensure its effectiveness.

Since 2002, the Division with its stakeholders has begun to address these issues and work on creating a platform for the future. To create this new platform the DDD recognizes the need to re-organize its many operational activities into interrelated components. These components form the underlying infrastructure that will support the Division in its efforts to meet the goals set forth in Path to Progress.

The community services infrastructure will be developed to accommodate each individual's specialized needs through recruitment of providers with the required expertise. This approach coupled with a flexible service planning process and an individual budget should meet the needs of individuals with very specialized disabilities, such as Autism, Prader-Willi Syndrome or Cerebral Palsy.

1. The Redesign of DDD Community Operations

In order to better address the needs of individuals currently living in the community, as well as to curtail future admissions to developmental centers, DDD is in the process of redesigning its community services system of case management. The goal of the redesign is two-fold. First, to ensure that a system of triage is in place so that individuals with a high level of vulnerability can receive the case management they need. Second, to explore the creation of a call center (Connections) that will enable families to receive information, support, and access to education and community services. Connections would also provide face-to-face information, training and support sessions for families allowing individuals and their families to receive the level of support commensurate with their needs.

The number of individuals on the community caseload has grown every year by approximately 1,500 people. The caseload as of December 2006 is 33,627. Approximately 80% of the individuals new to the caseload are under 22 and in school. The caseload was assessed using a uniform tool. Case management ratios were developed based on level of need. Individuals were identified who could benefit most from information, education and support. A triage system was developed to ensure that individuals with the highest levels of vulnerabilities be identified and plans put in place to meet their needs.

Families have asked for a service that can provide them with information and support throughout the life cycle of their family member with a developmental disability. Connections is a response to this request and once created will provide information, education and support for families and individuals with low vulnerabilities, most of whom are under 22 and in school. Connections would also provide information and education for individuals who request it whether or not they are currently eligible for DDD services. The intention is that Connections would be supported by a web-based information system with up to date information about community resources for individuals with developmental disabilities. Procedures would need to be developed to identify individuals who exhibit a change in their level of risk. Those cases would then quickly be transferred to Interim Case Management so more intensive services could be accessed.

Under Interim Case Management, a short term plan will be developed; services and supports will be arranged with referrals to the crisis system and clinical resource teams as needed. The goal of this process is to support the person where they currently live whenever possible. Interim Case Management will utilize the concept of person-centered planning, self-directed services and direct access to regional budgets to quickly access supports. Long term planning can include returning to Connections for information and education as needed, or transferring to on-going case management.
New caseload ratios will be put in place based on the level of vulnerability of the individual and/or where he or she lives. A triage system will ensure that individuals with risk factors receive the level of case management they need. They will receive the level of oversight and access to services that they need. The Centers for Medicare and

Medicaid Services (CMS) require that all individuals receiving waiver services receive case management.

The expected outcome of this redesign is better access to and equity of services, with support for individuals where they currently live. Multiple levels of care coordination will ensure changing needs are addressed. The new system works smarter and prioritizes those with the highest needs. The implementation of the System Redesign is highly dependent on adequate staffing resources and information technology capacity. The statewide hiring freeze and the reorganization of information technology units will slow the rate of implementation of these important system changes and may necessitate alternative measures to reach the expected outcomes.

2. Assessing Availability of Community Resources

Presence of sufficient community based infrastructure to insure that individuals who have significant self care, behavioral or medical support needs is critical to the success of this plan. No one will move to a community setting unless adequate supports are in place to meet their needs and preferences. Regardless, it is clear that a significant number of individuals living in the Division's centers will need medical/behavioral supports provided by trained staff to be full contributors to the communities where they will live.

As part of the early planning phase of this process the Division, with the DD Planning Institute at NJIT, is conducting an assessment of community resources in New Jersey. Structured interviews have been completed with staff very familiar with services available and needed in each county of New Jersey for adults and children receiving services from the Division. Focus Groups will be conducted with providers from different areas of the state. Services assessed are wide ranging and include supports to families such as respite and family support, medical/behavioral/mental health supports, both on going support and crisis/emergency care, services for individuals with mobility problems or multiple disabilities, varied ethnic or religious backgrounds, and day supports. (See Action step #10)

The areas and categories of support needs are presented in a manner consistent with the assessment of people living in the developmental centers, including the various self care, medical and behavioral groupings. This will help relate an individual's support needs or preferences with their availability in a particular area of New Jersey.

Other information obtained included whether services/supports are currently available, do the services/supports meet current demand, will simple expansion of existing resources be sufficient to meet needs of individuals living in a particular area or are new service types required. Additionally, respondents were asked to rate the quality of services and the waiting time to receive these services. Listings of providers of the supports/services was also requested. In addition to identifying specific providers of supports this will also facilitate access to services by individuals.

All interviews with staff were completed in March and the information is being compiled for use as the plan is implemented. The goal of this material is to provide a valuable guide to statewide support/service availability as well as highlight specific areas of need. This information can be easily linked with the support needs and preferences identified in the assessment of individuals and be useful during the planning process with individuals, families and support coordinators.

3. Community Residential and Support Options

The development of community residences for individuals with developmental disabilities is undergoing a major change in New Jersey. A transformation in the way that special-needs housing is developed has created a number of partnerships in which resources are leveraged to support individuals in integrated community settings. Individuals currently residing in developmental centers and moving into community settings will benefit from the new expanded residential options by offering individuals the opportunity to live in the least restrictive environments that promote growth, independence and choice.

Residential options can be characterized in two different ways: provider owned and operated or individual owned and self-directed. People moving from the developmental centers will have access to residences that fall under each of these two categories thereby providing more choices than in the past including the opportunity to live in supportive housing and self-direct their own services and supports. The needs of the individual, not the type of living arrangement chosen, will determine the level and type of services and supports. (See Appendix I)

The shift toward enhanced personal choice and control, and the move from a program-based approach to a person-centered approach has led to a separation of housing and supports options. During FY2007, the "Olmstead Individualized Community Supports and Services" Request for Proposals (RFP) was issued which introduced several new processes for transitioning people from developmental centers to communities. (See Action Step #8) A provider qualifying process is used to qualify agencies that have experience and expertise in specialized medical and behavioral supports and services leading to a network of agencies for individuals to choose from, even those with the highest levels of medical and behavioral support needs and those needing accessible housing. The planning process begins with an Independent Support Coordinator who will assist the individual and his/her family/guardian to choose the type of community living environment and supports based upon the person's Essential Lifestyle Plan. An individual budget is directly assigned to each person, allowing the flexibility to move or make modifications to his/her supports.

Prior to the Olmstead RFP, the Division of Developmental Disabilities implemented the Supportive Housing Moving-On Project during FY2006. This project included 50 people that were living in group homes. The project participants moved into their own residences, applied for a Section 8 rental-subsidy voucher, obtained leases in their own names and received supports separate from their housing costs. The resulting vacancies

in the group homes were then filled by people moving from developmental centers or by someone requiring an emergency placement thereby preventing placement in a developmental center.

The Moving-On project served three purposes: first, to allow more choice to individuals living in congregate settings, second; to shift control from the community agency to the individual, and third; to create vacancies in existing homes that are readily available to people moving from developmental centers. It is planned to continue the Moving-On project since agencies and staff have indicated that additional people currently living in group homes are interested in moving into supported living apartments thereby creating vacancies in existing homes. A targeted number of Moving-On opportunities will be identified each year.

The Moving On project has helped the division and the agencies learn about the benefits of supportive housing for people with developmental disabilities, including those moving from developmental centers, who will have the option to move into supportive housing residences with a full range of supports and services to meet their needs. The advantages of supportive housing as an option include increased choice, community integration and expedited development of the residence.

Another development within the State of New Jersey has been the increased focus from the Governor's Office on creating a capital funding stream in FY2005 of $200 million. These funds, referred to as the Special Needs Housing Trust Fund, are being utilized to develop 10,000 permanent supportive housing units and community residences for individuals with special needs. The Trust Fund was one of the outcomes of the New Jersey Governor's Task Force on Mental Health. The Trust Fund provides 50% to 80% of the capital financing of a project and requires that at least 50% to 20% of the project utilize other funding sources from local, county, state, federal and private sources.

The requirement for leveraging funds has mobilized various groups to work together to share resources and develop many innovative projects that include positive community assets such as developing housing in locations near jobs, transportation, community resources and services. Emphasis is also placed on utilizing high quality building and renovation materials as well as incorporating universal design, energy efficiency, low maintenance and durable features that add to the building's longevity. The Special Needs Housing Trust Fund is administered through the New Jersey Housing and Mortgage Finance Agency (NJHMFA) in conjunction with partnerships established with the Department of Community Affairs and the Department of Human Services. Technical assistance is provided by the State to private agencies developing projects with these funds. Additional technical assistance sessions will be scheduled routinely throughout the year in order to familiarize agencies with the various funding options available.

Over the past several years, agencies developing community residences for individuals with developmental disabilities have been more successful in applying for and being awarded funds from the U.S. Department of Housing and Urban Development (HUD) for

project-based funding. Agencies have also been successful in obtaining funding through the Community Development Block Grants. When agencies develop projects through these entities, the results are stronger relationships with Public Housing Authorities and local leadership in communities across the state. These relationships lead to more opportunities to develop creative housing options and increased units of accessible housing. Private for-profit construction companies are interested in receiving Council on Affordable Housing (COAH) tax credits to reduce large tax bills and are interested in working with agencies to build projects that meet the needs of special populations. When social service agencies work with housing developers the added benefit is that developers are educated about special needs housing. Developers are then able to design and create accessible housing units with specific needs in mind. Developers have the ability to leverage funds from a number of sources and the developmental disability community benefits from access to additional accessible housing. The result of these relationships with communities and builders is an increase in housing opportunities that will benefit individuals moving from developmental centers.

In 2003, the implementation of a new option in services entitled "Real Life Choices" became an option for individuals who are on the DDD waiting list for services and living at home with family members or guardians. This option provides a budget, based on an individual assessment, which determines one of four "levels of need." This option was created based upon the increased desire of individuals and families to continue to be fully integrated in the community and not separated or isolated in large congregate settings. Individuals and family members have raised awareness of their desire for residences to be accessible, smaller in size, more person-centered, allowing more privacy and individualization and include support accommodations to allow a person to age in place.

Over the years, DDD has developed a variety of housing options for people living in community settings including: group homes, supervised apartments, supportive housing, supported living, independent living, self-determination, rental subsidy and skill development homes. Additional residential support options are available from affordable housing opportunities offered by other government agencies including: Section 8 rental assistance, public housing and a home ownership program.

In the early stages of community residential development that began in the late 1970s, similar to most other states, New Jersey's efforts focused on the development of group homes. For many years, group homes were most frequently requested by family members since these homes offer round-the-clock care, supervision and community participation with the assistance of the staff members. While it will be necessary to add some group homes to the array of community residential options, it will be important to focus on developing the more recent options such as supportive housing and supervised apartments. Offering these newer housing options is the goal of the division in addition to including people currently residing in group homes the option to move to more independent settings with less people living together with the appropriate supports.
An additional focus of DDD will be to enhance existing living environments to ensure adequate supports are available to individuals living in the home and to those moving into a vacancy. A system-wide approach to evaluating the Division's community residences

is planned. A number of areas will be evaluated including accessibility of homes, fire suppression systems (sprinklers) installed, major maintenance needs, number of bedrooms in relation to number of people living in the home, etc. As the needs of the residents change, due to age or changes in their disabling condition, efforts may need to be included to add additional services or supports to existing residences including supports to skill sponsor homes. There will also be a need to explore the available options to make renovations to homes to provide increased physical accessibility. Maintaining and improving the existing community residences will lead to a better quality of life for all.

There are several challenges that confront housing development. Housing costs are at an all time high, making negotiations for existing homes and apartments more difficult and more costly. In low-income housing programs, such as Section 8 Housing, people with developmental disabilities compete with people with other disabilities for available space. There is an increasing demand for accessible housing for people who use wheelchairs or for people who are unsteady on their feet. One of the most cost-effective and least disruptive ways in which to deal with these needs and challenges is to properly maintain, repair and renovate new and existing homes.

In FY2007, funds have been designated to modify existing community residences to make them accessible for individuals transitioning from developmental centers who require ambulation supports. The funding is targeted for residences that have vacancies. Additional operating funds are also available for increased staff supports and accessible vehicles due to the anticipated higher level of needs displayed by the individuals filling the vacancies from the developmental centers. With the successful completion of this initiative, as funds will allow, it is planned to continue to modify a specified number of existing homes each fiscal year to make them accessible. This will result in increased choices for people moving from developmental centers that require accessible residences.

For people living in all of the various residential programs, there are a variety of services and supports necessary. The goal of the Division is to be able to provide flexible, individualized supports that meet the various needs and choices of people with developmental disabilities in community settings. While services are tailored to an individual's current needs and choices, ideally, these services and supports should be flexible, changing as a person's needs change. The goal is to provide what the individual needs to be fully integrated in the community, with an emphasis on individual empowerment, independence and self-sufficiency.

The Division has also developed resources to provide residential services to individuals who find themselves in emergency situations. This service, known as emergency capacity, can be provided in situations such as when a caretaker suddenly becomes unavailable for a period of time or a person becomes homeless due to challenging behaviors. At present, emergency capacity is available in all four DDD service regions. An RFP is currently being written to further expand this type of program.

Additionally, the developmental centers have the potential to be an important resource for people with developmental disabilities who live in community settings. As people move to homes in the community, developmental centers will become smaller and eventually evolve into more specialized, regional centers that provide additional support to people with developmental disabilities residing in the community. Specific services such as medical, behavioral, dental, or respite will be among the available resources. One benefit to this approach will be the increased availability of specialized supports that previously necessitated out of state placements.

In 2006, the Office of Quality Improvement completed research on how other states have retooled their developmental centers and have reduced the number of service recipients residing in them. The purpose of this research is to provide information on best practices as the Division plans for changes that will be consistent with the Olmstead decision. The Division is exploring some of the more noteworthy efforts revealed through this study.

Wherever people with developmental disabilities are served in their communities, they need to be able to get to work, to medical appointments, to shop, to recreational activities and to visit with family and friends. Often people need accessible and sometimes specialized transportation. Transportation for people living in traditional community options is arranged by the community provider agency. In other settings, the provider agency may assist with transportation or may support the person to use public transportation. The Division recognizes the difficulty with securing transportation services for all people. Several supports have been implemented to assist with this issue. Funds have been identified in the individual's budget to help with the cost. In addition to medical transportation services funded by Medicaid, non-medical transportation services will be available through the qualified provider process. The Division is exploring partnering with other departments who access transportation services in order to maximize resources. (See Action Steps 11 and 12)

4. Community Supports for People with Co-occurring Mental Illness and Developmental Disabilities

The DDD's strategy for providing community mental health services to people with developmental disabilities is to collaborate with the community mental health system building upon the existing mental health infrastructure of expertise and services. As a result DMHS and DDD have developed a 10-bed community inpatient program as well as step-down program capacity for people with developmental disabilities currently receiving treatment at Ancora Psychiatric Hospital to provide alternatives to a longer hospital admission for mental health reasons.

a) Crisis Response System

The DDD is also collaborating with the Division of Mental Health Services (DMHS) to develop a crisis response system that will provide a uniform response throughout the state to individuals in psychiatric or behavioral crises who are linked with the Division of Developmental Disabilities. The new system will also provide an opportunity to

proactively address psychiatric issues or escalating behavior. The DMHS Statewide Clinical Consultation and Training (SCCAT) contract includes clinical consultation over the telephone (4600 units) and face-to-face (520 units) for 1525 individuals with developmental disabilities. Clinical consultation is provided throughout the mental health system including community mental health programs, the designated screening centers (gatekeepers for psychiatric inpatient services), short-term care facilities (SCTF) (acute psychiatric inpatient units in general hospitals) and other community inpatient units, the state psychiatric hospitals and DDD community service programs. (See Action Step #10)

The DMHS contract also includes six regional training sessions targeting mental health and developmental disabilities service providers, care coordinators and case managers as well as 80 training sessions for individual agencies. The faculty includes experts in the area of dual diagnosis and autism from throughout the DD provider community.

DDD's expansion of this system will more than double the capacity to serve individuals directly referred from the DDD system (another 480 people). The expansion will double the number of phone consultations from 1200 to 2400 and more than triple the number of face-to-face assessments (from 175 to 655).

The crisis response system will be directly available to DDD, provider agencies and families through a 24/7 toll-free phone line. SCCAT clinicians will conduct a face-to-face assessment of the individual within the crisis setting(s) in order to develop a crisis management plan. SCCAT clinicians will provide on-site intervention in order to lessen the acuity of the crisis. This may include staff/family/sponsor training, environmental adaptations, helping the support staff to develop a crisis protocol and behavioral intervention. On the basis of the assessment and crisis intervention, recommendations will be generated regarding linkages to relevant longer term supports. The goal is to manage the crisis in place, equip support staff and families so that they can better manage the behavioral crisis and equip the individual to gain better behavioral control. Once the level of acuity is lessened, the individual will be ready for referral to agencies that can stabilize the individual to lessen the likelihood of crisis reoccurrence.

SCCAT Network Provider Relations staff will collect data regarding the stabilization resources needed. This information will be utilized to develop capacity for various services such as residential settings, emergency respite, day programs, and other behavioral support services. We will look to develop services from agencies with particular strengths that will promote stabilization and circumvent future crises.

The DDD Crisis Response system is committed to addressing the behavioral or mental health needs of individuals with developmental disabilities in order to maintain them in the community. The crisis response system is critical because expanding the capacity and availability uniformly across the state will help to reduce the number of referrals to developmental centers and will aid in supporting individuals who are moving from centers into community residences.

b) Other Services and Supports

Expanding the availability of behavioral support services is a key activity for ensuring that challenging behaviors can be addressed in community settings. Behavioral support service can be part of the DDD Crisis Response system or in stand alone agency programs. Behavioral support services include behaviorists and other professionals. These services can be used both to respond to crises, to develop individualized strategies in anticipation of potential behavioral difficulties and/or to address long-term challenging behaviors. Behavioral supports will be addressed in the following ways:

- The individual budgets have been constructed with dollars targeted to address the behavioral needs of individuals on an ongoing basis as well as on a transitional or short term basis.

- As a result of the Olmstead RFP, the DDD Qualified database now lists 57 providers of behavioral supports levels 1-4 (includes agencies qualified through the Olmstead RFP and the open enrollment process). These new providers will form a pool from which individuals can purchase specific behavioral supports. As people transition, DDD will continue to monitor the adequacy of the provider network and expand it to ensure quality and choice. Furthermore, the expertise of the Developmental Centers can be utilized as a resource to address behavioral issues.

- Originally contracted by DDD in July 1999, the Integrated Therapeutic Network, now known as Community Professional Support & Training (CPST), consists of time-limited habilitative therapies such as speech, physical and occupational therapy; as well as behavioral supports. Case managers, day program staff, caregivers and professional staff make referrals to the CPST through a regional coordinator to the Network Coordination and Management Agency (NCMA). The NCMA arranges for these services through approved private agencies. This referral service will be an important contributor to the success of future community placements and an expansion of this service will be needed to meet the needs of increasing numbers of people utilizing community services.

- An Integrated Service Delivery Team works with an individual and in concert with the individual's residential and vocational support team as well as with mental health practitioners to fashion an effective support plan that addresses the person's psychiatric needs. The team process requires direct observation of the individual and the individual's environment, training of support staff, and continuous round-the-clock availability of the team for crisis support. This model is particularly effective in supporting individuals recently discharged from formal treatment settings and those living in more independent supported living environments.

5. Quality Management

Supporting the transition to the community requires a quality management system that ensures a continued focus on quality of services and supports that result in chosen outcomes for people receiving services. The system is continually assessed, reviewed and improved to ensure that it is providing what is needed by all who are served by it. The quality management strategies designed to assess whether or not the system is meeting the needs of its customers relies on data that is generated by multiple sources including individuals, families, advocates, providers and other stakeholders. The Olmstead Plan creates an opportunity to strengthen the DDD quality management system and overall infrastructure of the Division and benefit all individuals served by the Division.

In recent years DDD has moved to enhance choice and simultaneously improve the quality of services and supports for people. In 2001 an Office of Quality Improvement (OQI) was established to survey, develop, monitor and improve service delivery and supports. The OQI is an arm of the Office of Quality Management and is uniquely positioned to build a culture of continuous quality improvement within all facets of the system. This office acts as the liaison between the Department's Office of Program Integrity and Accountability within which the Developmental Disabilities Licensing and Special Response Units conduct quality assurance activities. Quality assurance activities provide information on compliance with pre-established standards and are a source of useful information. DDD will continue to strengthen this partnership and build systems that address both quality assurance; such as the current inspections and investigations processes as well as quality improvement.

In anticipation of the continued growth in community living combined with the need to establish a coordinated, comprehensive structure to identify and manage risk, an Office of Risk Management was established in June 2006. With the increased numbers of individuals transitioning from Developmental Centers to the community it was vital for the Division to establish a structure to track and trend risk management data.

The DDD risk management system provides the structure that can measure key components of quality, provide feedback loops and has the capacity to respond. An early alert component of this system can provide DDD with information to assist in the timely identification of issues important for optimal service delivery as well as routine review and analysis of incidents of abuse, neglect and exploitation, follow up on investigations and promotion of best practices and continual improvement; all of which are indicators of quality of life and are important to individuals and their families.

Following a review of service delivery by major DDD stakeholder groups, in 2002, DDD announced a plan for system change that would provide: greater choice and equity in services, enhanced person-centered planning and introduced self directed models into the system. This system change was the beginning of the Real Life Choices option for people on the Division's waiting list who desire to live at home as long as possible. The Real Life Choices gives people the option to self-direct services.

A growing number of individuals are choosing to self direct their services. The development of more effective, non-intrusive methods of monitoring the effectiveness of self directed services and developing methods to evaluate natural supports is a challenge in most service delivery systems. The Division's quality management offices plan to seek guidance and input from stakeholders as we develop these systems.

In 2003, DDD began to develop its Information Technology system to allow data from a variety of monitoring sources to be brought together and analyzed using web-based technology. This system when fully implemented will enable the OQI to analyze data from multiple sources for patterns and trends and to recommend and implement actions to address them. The Regional Continuous Quality Improvement Committees, comprised of numerous stakeholders, will review aggregate data and survey reports generated from multiple sources and provide recommendations to the Quality Management Steering Committee that may result in system change/improvement/adjustments that will, in turn, improve the quality of life for individuals served by the system.

The Real Choice Systems Change grant, awarded in 2004, enabled DDD to establish the Quality Management Steering Committee that is comprised of families, individuals, advocates and other stakeholders. This Committee was created to advise, support and assist in the design and implementation of the DDD quality management system. After an extensive review, this committee has recommended the National Core Indicators as a benchmarking tool for NJ's DD community. The Core Indicators Program is a collaboration among participating National Association of State Directors of Developmental Disabilities Services (NASDDDS) member state agencies and Human Services Research Institute, with the goal of developing a systematic approach to performance and outcome measurement. Through the collaboration, participating states pool their resources and knowledge to create performance monitoring systems, identify common performance indicators, work out comparable data collection strategies, and share results.

The core indicators are the foundation for the program. The current set of performance indicators includes approximately 100 individual, family, systemic, cost, and health and safety outcomes - outcomes that are important to understanding the overall health of public developmental disabilities agencies. Associated with each indicator is a source from which the data is collected. Sources of information include individual survey (e.g., empowerment and choice issues) family surveys (e.g., satisfaction with supports), provider survey (e.g., staff turnover), and state systems data (e.g., expenditures, mortality, etc.). The core indicators can also provide information for many of the desired outcomes stated in the Home and Community Based Services Quality Framework. This framework is identified in our waiver and is the design endorsed by the Centers for Medicare and Medicaid Services.

The OQI is currently developing performance indicators for the transition of individuals out of the developmental centers. The independent support coordination team will be utilized to transition and provide support to people who choose to leave a developmental center and move to the community. Clearly, knowing and/or developing mechanisms for knowing "how" a person would like to live precedes where they "should" live. Person-

centered planning is one way to learn about what a person wants and discern the balance between what is important "to" and important "for" the person. With these tenets in mind, OQI will be working with the Teams in developing strategies for achieving positive outcomes for people leaving developmental centers. The OQI will seek input from the Quality Management Steering Committee and draw upon the expertise of the provider community and its capacity to impact positive outcomes for individuals and their families. The core indicator surveys for individuals and families can be designed to include questions related to satisfaction with pre and post transitions experiences. The Quality Management Steering Committee will assist the Division in designing these quality measures.

The importance of building and strengthening community infrastructure needed to under gird a system of supports cannot be overlooked. DDD has begun the Redesign of the Regional System, which includes case management services to improve the quality and the responsiveness of this service. Caseloads will be restructured and with IT developments that will utilize a uniform assessment, single monitoring tool which captures data and streamlines information, the case managers will be able to move from a caretaker role to a role of support that can identify systemic problems and provide the case manager with the ability to focus on the individual needs of the entire caseload.

Recommendations for the development of 4 regionally based community support units in the redesigned system are being considered. These Units are proposed to support the system through resource development, provision of technical assistance to licensed providers, providing much needed training to service providers (which include the community care providers), review and ongoing monitoring of day activities and programming in the community, development/review of continuous quality improvement systems with licensed providers, and implementing all aspects of quality improvement in the Region. While some more established providers would not need to utilize the resources of these Units; in the early stages of implementing this plan it seems prudent to consider the usefulness of building capacity for providers to address systemic issues.

6. Recruitment and Retention of Direct Service Staff Members

The recruitment and retention of direct service, paraprofessional and professional staff members with specialized training to provide community services has a vital role in reducing reliance on DCs. Compensation and training have been identified as the two most critical areas of concern.

Considerable research regarding compensation has been done nationally regarding the amount of wages paid to direct support professionals. One survey identifies New Jersey wages for direct service workers at an average of $13.25 in the public sector and $9.77 in the private sector, based on 2002 data.[2] While averages for both public and private sector

[2] "Policy Research Brief: Wages of Direct Support Professionals Serving People with Intellectual and Developmental Disabilities: A Survey of State Agencies and Private Residential Provider Trade Organizations: Published by the Research and Training Center on Community Living, Institute on

direct care wages in New Jersey are well above the national averages ($11.67 public and $8.68 private), wages of direct support professionals, as a proportion of the general state hourly average wages, were 63.1% for state direct support professionals and 46.5% for private sector direct support professionals.[3]

New Jersey has made efforts over the past several years to improve direct service worker salaries utilizing the Cost of Living Adjustment (COLA) to provide additional funds above the COLA to direct to the salaries of the direct service workers in the provider agencies.

While there have been some significant efforts in New Jersey to address the concern regarding the salary of direct service workers as a major contributing factor to the high turnover and difficulties for community provider agencies in the recruitment of direct service employees, there is still a gap between the current starting pay for direct service workers in the private sector versus the public sector. The current hourly wage is $10 for the direct service worker in the community agencies and the starting pay for state direct service workers is $13.51 an hour in the developmental centers. The recent history of compensation efforts is shown in the following chart:

Fiscal Year	**Increase**
2000	1.8% for all private direct service workers
2001	2% on direct care salaries 1.6% COLA to direct care salaries $1.00 per hour direct care salary bonus
2002	1.6% COLA $1.00 bonus
2003	2% COLA with stipulation that direct care salaries go up at least 2%
2004	None
2005	3.5% COLA with stipulation that if health care is paid, direct care salaries must receive at least 50% of the COLA. If no health care, they must receive 75%. .5% additional COLA later in year.
2006	1% COLA unrestricted
2007	1% COLA unrestricted
2008	Proposed 2% increase effective January 1, 2008

While wages are critically important to the recruitment and retention of direct service workers, studies show that there are other factors that deplete the numbers of direct service personnel, such as stress and the inability to take time off when needed. New Jersey and nine other states were recipients of "Real Choice" grants from the Federal Centers for Medicare and Medicaid Services (CMS) in SFY 2001 to utilize for initiatives

Community Integration, College of Education and Human Development, University of Minnesota, Vol. 14, Vol. 2 March 2003.

[3] "Policy Research Brief" pages 5-6.

that are intended to improve recruitment and retention of direct service staff. The grantees focused on recruitment efforts, extrinsic reward (wages and benefits), training and career ladders, changes in culture and systems administration and planning.

New Jersey's 2001 Real Choice Grant focus was to develop a Medicaid provider as a rapid response agency to provide a roster of part-time workers to provide direct service workers "on-call" in emergency situations or to replace workers with scheduled absences. This initiative led to an informal arrangement with a staffing agency that was willing to train temporary staff in DDD policies and procedures. That agency responds to requests for staffing by private providers around the state. A pool of trained temporary staff can help service provider agencies avoid mandatory overtime demands on their permanent staff, this is one significant strategy to reducing stress and improving retention.

7. Staff Members Competencies and Skill Acquisition

Professional, paraprofessional and direct service staff members are important contributors to the success of reducing reliance on developmental center placements. They need to be well-informed about the growth of community opportunities, the diversity of options, the process for building high-quality, person-centered IHPs, the transition process for people moving out of the centers and ways in which to support individuals and their families in making important life choices.

Some excellent work has already been done regarding building these worker skills by the Elizabeth M. Boggs Center on Developmental Disabilities UMDNJ – Robert Wood Johnson Medical School pertaining to building competencies and skills in these areas. The New Jersey Direct Support Professional Association is currently being coordinated from The Boggs Center at Robert Wood Johnson Medical School/UMDNJ. This group is designed to bring together Direct Support Professionals to allow for professional development, discussion of issues related to providing direct services, provide an avenue for Direct Support Professionals to network with one another and is a place to advocate and communicate their needs as professionals.

In collaboration with the Boggs Center, DDD co-chairs a Statewide Training Advisory Committee (STAC). The STAC reviews core training modules and updates them based on best-practice and national research. Statewide Clinical Consultation and Training (SCCAT) program through Trinitas Hospital provides an annual six session training series on mental health providers and developmental disabilities services providers, care coordinators and case managers on various mental health topics. The next step is to develop a process and establish a timeline for teaching these skills to staff members, and educating them in this plan. In addition, the Boggs Center is working closely with DDD to enhance staff skills in the provision of Positive Behavior Supports, through training and technical assistance. This is a priority in the continuing development of community infrastructure to support individuals transitioning to the community and also those living with their families or presently in community residential options.
In 2004, DDD was awarded a three-year "Real Choice Systems Change Grant" from CMS to help NJ build the infrastructure that will support people with developmental

disabilities in their communities and allow individuals to exercise meaningful choices. One goal of the grant is to develop an interactive training CD which will help facilitate a cultural shift to emphasize person-centered planning. In addition, this training CD will teach a continuous quality improvement model which is consistent with the CMS Home and Community Based Services Quality Framework and teaches business process redesign.

Direct support staff members need continuous training opportunities to assure they have the necessary skills and competencies to address both the day-to-day needs of the people they serve as well as the more challenging aspects of care. One resource available to and utilized by providers in several states outside of New Jersey is the College of Direct Support. This an on-line service developed at the University of Minnesota with courses that have been reviewed by national experts. DDD is working with the New Jersey provider community to explore the opportunities and benefits associated with the College of Direct Support.

The New Jersey Direct Support Professional Workforce Development Coalition and its Steering Committee is comprised of Direct Support Professionals, staff from The Boggs Center, staff from DDD, representatives from the three provider networks (ABCD, Arc of NJ, and NJACP), a representative from NJ Community Colleges and community agency executive staff. The primary purpose of this group is to further the development and implementation of a competency based Career Path (Career Ladder) for Direct Support Professionals. It is anticipated that this will lead to higher skill levels for staff and ensure better quality of care and therefore higher quality of life in the community for persons with developmental disabilities. A brief history includes:

- The formation of the Coalition followed a Workforce Development Summit held in 2002 which identified six areas for goals.

- In May 2006, a statewide Career Path Forum for Direct Support Professionals was held. From that forum, workgroups were formed to develop a framework for a career path for Direct Support Professionals in New Jersey. The Coalition applied for a Robert Wood Johnson Foundation grant in the summer of 2006, which, though not successful, has served as the blueprint for its ongoing work in developing a concrete career path lattice using DDD's Pre-service Training System and the College of Direct Support as the foundation.

- Research has also begun with provider networks to determine turnover rates and its cost to agencies. The Coalition Steering Committee is gathering and analyzing data from providers in NJ as to turnover rates and cost of turnover.

- In January 2007 the NJDSP Workforce Development Leadership Council (for the Coalition and the Career Path work) was formed as a forum of the leadership of the key partners in the Workforce Development Career Path work. The goal of the Council is ensuring that the leadership of DDD, the provider networks, the Council on DD, the Consortium on Workforce and

Economic Development of the NJ Council of Community Colleges, DDS, and NJ Medicaid are working collaboratively on policy issues related to the development of a career path.

- In February 2007, The Coalition was awarded a CMS Technical Assistance Grant for Workforce Development. The primary request for technical assistance was to figure out how to pay for training and employee benefits for a career path.

- The Coalition is currently reviewing the modules of the College of Direct Support for use in the NJ DDD system. The promise of the College is that it could be used by both staff in agencies and those working in self directed services and supports, as well as those working in DCs as deemed appropriate.

- The Coalition is seeking funding to implement a small scale pilot of the proposed career path lattice utilizing the College of Direct Support. (Appendix J)**.**

IV. Implementation

This section will set forth how the necessary funding, services and housing will be provided. It will describe the benchmarks, the action steps necessary to achieve the benchmarks and the timeframes within which the benchmarks will be accomplished.

A. Number Targeted for Transition

There are 1,005 people with developmental disabilities currently residing in New Jersey's Developmental Centers (DC's) who have expressed an interest or have not opposed transition into the community and whose families/guardians do not oppose community placement. DDD will begin to place these individuals immediately.

In addition, for the 1,298 people who also do not oppose and for whom community placement is recommended, but whose families/guardians oppose, as those situations are resolved placement efforts for those people will begin as well. DDD is committed to enabling these people to:

- Live in the most integrated community setting appropriate to their individual requirements and preferences,

- Exercise meaningful choices about their living environment, their providers of support and services, the types of supports they use, and the manner by which services are provided; and,

- Obtain the supports and services they want to enable them to achieve their desired results and outcomes, all of which will permit them to live as fully participating citizens of their communities.

The yearly transition benchmarks are outlined below. These benchmarks will be reviewed and adjusted annually to include new individuals who decide to make the transition from the Developmental Center. The Division recognizes its responsibility to take all action necessary to educate individuals, families and their guardians regarding the opportunity of placement in the community. Further, the Division's experience has been that more individuals choose community placement after it has been demonstrated that this move has been beneficial for people the individual, family, and/or guardian know personally. It is expected that as individuals move into the community and word of their success spreads, community placement will be seen as a more viable option. It is for this reason that the total number of individuals projected in the following table far exceeds the 1,005 currently identified.

The transition process will initially focus on individuals from Woodbridge and New Lisbon Developmental Centers in order to comply with the Division's Settlement Agreement with the US Department of Justice. Opportunities will also be provided for other individuals to transition.

Year	**Number**
SFY 2008	**100**
SFY 2009	**250**
SFY 2010	**250**
SFY 2011	**250**
SFY 2012	**250**
SFY 2013	**250**
SFY 2014	**250**
SFY 2015	**250**
SFY 2016 and Forward	**Placements will continue each year until all people identified have been offered the opportunity to move.**

B. The Elements of the Transition Process

This transition process will include the following elements:

1. Promoting Informed Choices by Individuals and their Families

Assisting individuals to make informed choices is also a key component of transitioning to a community home. Individuals living in developmental centers often lack sufficient information regarding the available options. Additionally, as a result of long term institutionalization, individuals may lack sufficient skills to weigh choices and may lack confidence in their own ability to both make choices and assert their desires. Prior DC closures within the State of New Jersey have demonstrated that a vigorous self advocacy movement supporting institutionalized individuals is the most effective intervention to promote making informed choices. The expertise and experience of the self advocacy groups in the community and developmental centers will be sought to support people transitioning from DCs. Various topics of interest will be available to individuals moving to the community. Additionally, peer mentors will support people through the process providing information that they have gained through their own experiences. Peer mentors as well as community connectors may also assist individuals in developing connections in the community. Therefore, an expansion of self advocacy supports will be an integral aspect of the Olmstead effort. (See Action Step #17)

In order to agree to the concept of moving to a community residential placement, the family needs to feel that their loved one will receive the needed services. Families have often heard stories about community placements that did not work out, or they may have personally experienced a community placement, that was made for their loved one in the past, that was not successful.

Supporting families to enable them to gain an understanding of available services, services under development and the evolution of services generally is an important responsibility. Families must be confident that health and safety issues are addressed and family members need to be included in the planning for people who will be transitioning from developmental centers to the community.

The Developmental Disabilities Planning Institute of the New Jersey Institute of Technology was engaged by the Division of Developmental Disabilities to do a study of the outcomes for the former residents of the North Princeton Developmental Center (NPDC) for 27 months after the people moved from NPDC. Their report, “Life After North Princeton Developmental Center: Final Outcomes,” published in November 2003 describes the experiences of people moving to community settings. The study concluded that “despite opposition to the closure of NPDC by some family members, there is now strong support of community living by a clear majority of NPDC family members.” The experience of other families plays an important role for those who are considering a community residence for their loved one and evaluating the options.

We know from speaking with families that those most likely to favor their family member moving to a community residence are those who believe the "general happiness" of their relative will improve and that the person's "personal safety" can be ensured in a community setting. To achieve this, families must be informed about the Olmstead decision and what it means for individuals with a developmental disability, the division's plan for Olmstead and how it relates to their relative, and expectations and recommendations for their family member about moving from the DC. In addition, opportunities will be offered on a regular basis for families and individuals to visit community programs, including meeting with individuals successfully using self directed options and families of people who have successfully moved from a DC to a community setting in the past.

DDD has done considerable work in preparing families of people in DCs to evaluate community options. DDD contracted with the UMDNJ School of Public Health to assist in the preparation of families by providing information to families and relaying family concerns to DDD. UMDNJ's Developmental Disability Family Education Project (DDFEP) has developed a workbook called "Moving On" that outlines the transition process for families. The workbook, which is based upon the experiences of New Jersey families, is undergoing revisions and has been renamed "New Beginnings in Community Living: A Workbook for Your Family Member's Transition from a Developmental Center to Community Living." These revisions will reflect the new person-centered approach as well as the support coordination model that is being utilized by DDD. When completed, by late August 2007, it will provide user-friendly, step-by-step modules that can support families going through the community placement process. One of the modules in the workbook will be a directory of qualified agencies. DDFEP also provides a quarterly newsletter "New Beginnings" which features articles and stories about community living and the process. The DDFEP conducts orientations for families of transitioning individuals to provide an overview of person-centered planning, support coordination, and the transition process. An appropriately modified orientation is also provided for DC staff identified as part of the person's transition process. Family forums that are open to all interested family members have been held to offer opportunities to hear from and ask questions of those who have experienced transition, agencies who provide community services, and to network with other families. Information is also disseminated by the mail and phone contact with the families. (See Action Step # 13)

The family forums will be offered, at a minimum, four times a year in different areas of the state and each will be followed by a series of smaller family orientation meetings. The family orientation meetings will also be scheduled in various locations throughout the state and on varying days and times, in order to accommodate the needs and schedules of as many families as possible. Information regarding the DDFEP, its resources and activities will be available for families in a designated area of each Developmental Center. A schedule of these forums and meetings will be posted on the DDFEP website, http://www.umdnj.edu/linkweb, as well as published in the quarterly newsletter. The DDFEP will continue to provide at least two training sessions a month at Woodbridge Developmental Center and New Lisbon Developmental Center, and will expand to other developmental centers beginning in January 2008. Additional training

related to Support Coordination and the transition process will be offered by the Division to both family members and staff. A yearly schedule of these trainings will be posted on the Division's website, the DDFEP website and quarterly newsletter, and disseminated to each developmental center.

2. Independent Support Coordination Team

The Independent Support Coordination Team will be the vehicle to assist people in exercising self-direction as they transition from developmental centers. It is an independent process that facilitates planning and coordinating services and supports. The Division has adopted this self-directed service delivery approach. This approach continues the evolution from program-based services to person-centered supports, applying those concepts on behalf of a larger number of people to increase the equity and choice in the system.

The vision is to contribute to an equitable system where individuals with developmental disabilities and their families are empowered to make choices about where they want to go and how best to utilize the supports necessary to get them there. The vision is to give individuals and families a voice and the power of choice. This shift of power from professionals to the individual and their families is at the core of national trends in quality service delivery.

Through a Request for Proposal process, the Division has contracted with two agencies to provide Independent Support Coordination. Contracts were finalized in April 2007 and the agencies will be operational by July 2007. (See Action Step #9)

Neighbours Incorporated has been providing Support Coordination in the community since 2005. This agency will be actively involved in the planning of independent support coordination services for individuals ready to move from Woodbridge and New Lisbon Developmental Centers beginning January 2007. Neighbours will be involved in the training of the new Independent Support Coordination agencies.

January through July 2007 the Division will solidify the procedures for the interface between the DCs and the Independent Support Coordination Teams. The Division is committed to a uniform process state-wide that focuses on the needs and wishes of the individuals moving from the Developmental Centers. The key element of planning utilizing Independent Support Coordination Teams is the ability of the individual to choose how and where they want to live and receive the services and supports to achieve that goal.

The Support Coordination Agency will function as part of a team that facilitates the process for the individual. The person is the center of the process and must take an active role as much as possible along with those who care about them. A "relationship map" will be developed to identify those who are important to the individual and have a close relationship with her or him. A transition case manager will initiate this process. They will play a key role throughout the planning. Transition case managers will be the

primary connection between the developmental center and the independent team. They will ensure that all the information from the person centered IHP developed at the DC and the assessment information is available to the team for inclusion in the plan. The person, their family and /or guardian, support coordinator, transition case manager, peer and family mentor and identified developmental center staff could be members of the team. This team will be the decision making body during the transition process. A person centered plan will be developed for each individual. An Essential Lifestyle Planning (ELP) process will be the critical vehicle for identifying supports and services. The ELP will be used as the transition plan to community living. All team members will be required to attend ELP trainings and demonstrate knowledge of the ELP model and the person-centered thinking philosophy.

The Support Coordination role within the team process includes the following:

- Attend information sessions where individuals learn about ELP.
- Make initial contact with the individuals and their teams to introduce their Support Coordination role.
- Arrange follow-up meetings, both group and individual, to continue development of the Service Plan.
- Assist individuals with the ELP process.
- Work with the individuals and their teams and the mentors in identifying Outcomes.
- Assure the service plan addresses health and safety issues.
- Assist in identifying, through the Qualifying Individuals and Agency Process, services and supports that would achieve the individual's stated outcomes.
- Ensure individuals, families, guardians and teams have significant experience and exposure to all types of available options and resources.
- Assist individuals in assuring that services they have identified will really meet outcomes.
- Mediate between individuals and providers to insure that individuals have been given supports and services based on identified outcomes, rather than those based on what program may be available.
- Assist in using the budget to achieve outcomes.

- Insure that supports and services identified are in the correct waiver category.

- Assist and facilitate Learning Communities.

- Enter all data into the electronic record, and send information to the individual and their team for approval.

(See Action Step #18)

3. Peer and Family Mentors

The Peer and Family Mentors currently play a critical support role within Real Life Choices and will play a critical support role in the transition process as well. The Mentor focuses on creating a strong support network around an individual and his/her family. Ultimately, the Family Mentor is responsible for forging relationships with the individual and his/her family, supporting them by sharing personal experience and helping to develop community connections. The Mentors participate in orientation and support coordination team meetings.

4. Service Plan Development through Essential Lifestyle Planning (ELP)

DDD will use the Essential Lifestyle Planning (ELP), a nationally and internationally recognized life-planning tool, for all individuals as they move from the developmental centers to the community. Individuals may choose a self directed or provider managed approach to securing supports and services. However, ELP will be the transition plan document. While it is true that like needs are directly linked to like supports and services, the types of services need to be very individualized. ELP starts with identifying how a person wants to live (important "to"), and balances that with any health and safety issues (important "for"). ELP is a guided process for learning how someone wants to live and for developing a plan to make it happen. The Essential Lifestyle Plan, developed through a process of asking and listening, provides a snapshot of how someone wants to live today, and serve as a blueprint for how to support them tomorrow.

Unlike any tool used in the past, the service plan that is developed through this ELP process, talks about the individual's strengths, not weaknesses. It allows individuals with disabilities and their families to discuss great things about the person. What are their mental, physical and spiritual strengths? What do others like about the person? What is important to the person? What are the characteristics of people who support the person best? What do others need to know or do to support the person? In this model, the individual is the focus, not the service or the program.

Individualized Support Coordination is a critical element in promoting self-direction for individuals transitioning from Developmental Centers. Support Coordination assists the individual and their team through the process and allows them to remain in control of their plan. This function is provided by individual Support Coordinators who work face-

to-face with the individuals and their team. Peer and Family Mentors also assist with the development and implementation of the plan by developing a relationship with the individual through the sharing of their own real life experiences.

A partnership is formed with all team members who are ultimately responsible for assisting individuals in the development and implementation of the Plans of Care. Decisions made by one individual or single agency do not offer the breadth of creativity that can come from a group process. A team of equal partners working together for the same goal can generate more comprehensive, successful outcomes. Not only does the team concept foster participation on the part of the individual, it brings the system partners to the table. The discussions and decisions can be made as a team, with an immediate feedback loop that does not require layers of agency approvals.

These teams, made up of the critical partners, generally meet during the initial stages of Service Plan development. As the process continues, a sub-team works face-to-face with the individuals on implementation and monitoring of their Plans of Care.

Payments for supports and services will be paid through existing contract payment methods or by fee for service via a fiscal agent. All supports and services will be provided by Qualified Providers; these could include housing, employment, residential and staff supports. Quality will be measured by the successful implementation of the desired outcomes of the individual. In order for the Support Coordination to succeed, ongoing technical assistance and training will be provided to each of the selected agencies.

5. Community Services and Supports through Qualified Individuals and Agencies

Individuals served under this person-centered, self-directed system may choose different providers for different supports as they transition to the community. An individual may choose one provider to supply personal care and assistance, another for employment/day supports and a third for housing; thus allowing the individual the opportunity to customize their supports. An individual may also choose one or two agencies to provide all services and supports.

Historically, services could only be accessed by providers under contract with DDD. This limited any choices for the individual with a developmental disability and their family. As part of the systems change to expand the ability for self-directed services and choice, DDD created a process for qualifying individuals and agencies. DDD-contracted providers are pre-qualified; and, non-contract providers, including individuals, can now apply for qualification and be approved to provide an array of services. Applications for qualification can be found online through the website of the Family Support Center of New Jersey [www.fscnj.org].

In addition, through the "Olmstead Individualized Community Supports and Services RFP", agencies were qualified to provide residential, employment/day, housing, behavior and medical supports for persons with varying levels of behavior and/or medical needs.

These agencies will also be included on the qualified provider list. This RFP is considered a success, with the following results:

- 55 agencies were qualified to provide housing.
- 73 agencies were qualified to provide residential supports.
- 63 agencies were qualified to provide employment/day supports.
- 38 agencies were qualified to provide medical supports.
- 47 agencies were qualified to provide behavior supports.
- 25 agencies were qualified in all categories.

In an attempt to build on the above success, the Division has initiated an Open Enrollment process that will foster the growth of the number of qualified agencies. Through this process, there are three opportunities each year that an agency can apply for qualification. Agencies wishing to be qualified under the Olmstead RFP can access an application through the DDD website http://www.state.nj.us/humanservices/ddd/index.html. A goal of the Division is to have one qualifying process for all supports and services. Qualifying allows DDD to include a provider in the database and facilitate an individual's awareness of the provider as an available resource.

The specific transition services that will be available include peer and family mentors, housing specialists/job specialists, community connector, staff connector, vehicle modification, appliances such as microwaves that would facilitate safety and independence, as well as one–time services such as security deposits, utility set-up and installation, furnishing and moving expenses. These transition services tie development activity and payment to an individual and his or her budget. There is a complete listing of the above mentioned services and their respective definitions in Appendix K.

6. Individualized Budgets

Once a level of need is determined, this information is used to develop an individualized budget. There is a strong correlation between individualized competencies and the amount of support time needed. Individuals with developmental disabilities with the lowest competencies need the most support time and have the highest need for services. The assessment and individual budget build equity into the system by determining who needs more support and by ensuring those with like needs receive like resources. More information on individual budgets can be found in Appendix L.

It is important to emphasize that if something fundamentally changes in an individual's life, the person can go through the assessment process again. As the assessment is utilized to determine the amount of funding a person is allocated, this will have a direct

impact on their budget. This will ensure as persons age or their needs change substantially, that the funding associated with the person changes accordingly.

7. Fiscal Management

The Division is committed to individual budgets for people. All dollars will follow the person. Funding will be associated with the person, rather than the program, allowing the individual the flexibility to move or make modifications in her or his supports. Presently the Division has hired a consultant to assess what would be involved in shifting from a cost reimbursement to a Fee for Service system. Stakeholders will be invited to participate in this process. It is recognized that support may be required in making this shift. We will work together to establish a plan to make portable individual budgets a reality.
Until this shift is operational, an individual who selects a provider managed option will have the supports and services paid through an existing contract payment method.

If an individual selects a self directed option then a fiscal agent is assigned. Since the state cannot give funds directly to individuals to pay for their services, DDD utilizes a fiscal agent to pay for the services and supports identified by people who are self-directing their services and supports. The major functions of the fiscal agent are to disburse the public funds allocated to individuals via payments to service providers and to act as employer of record for staff hired directly by the individuals. Easter Seals of New Jersey is the agency that is currently providing fiscal agent services on behalf of individuals who are self-directing their services transitioning from developmental centers and in Real Life Choices. An RFP is being developed and will be distributed to expand the capacity of the fiscal agent.

8. Management Information Systems (MIS)

The DDD is in the process of creating one integrated relational database for individual information. All data is entered through Internet browsers using a secure website. Division staff, Support Coordinators, and staff of the fiscal agent all have access and input information using a role-based system that authorizes level of access and protects privacy in compliance with the Health Insurance Portability and Accountability Act (HIPAA). This electronic record contains the Service Plan, which has been developed with input from Quality Improvement staff as well as families, participants, provider, and stakeholders.

Additionally, the assessment information will be incorporated into an integrated database available to DC staff who know each individual. The staff will be able to update assessment information at regular intervals and provide assessment information for individuals newly admitted to a developmental center. Having current information about each individual living in the developmental centers will be necessary to update and monitor those individuals who are recommended for community placement and who wish to move each year.

C. Managing and Ongoing Planning

The Path to Progress is intended to be a working plan, providing the framework that individuals will use to build meaningful lives in their communities. As the plan progresses over time and action steps reach their targeted outcomes, there will be a need for evaluation of that success and formulation of the next action step.

The Division of Developmental Disabilities' implementation of the Olmstead Plan calls for leadership and on-going support for ensuring that established goals and benchmarks are attained. Both internal and external key stakeholders will need to be active participants in measuring the State's progress in meeting the benchmarks.

To this end, the Division will organize an Implementation and Planning Advisory Council to work closely with the Division's leadership. The Advisory Council will consist of key stakeholders including self-advocates, family members of individuals with developmental disabilities, providers and state staff from DDD and other Department of Human Services Divisions, including the Division of Mental Health Services. It will provide on-going review and feedback from a wide spectrum of perspectives based upon reports the Division provides regarding the progression of the plan's benchmarks, as well as any difficulties that may arise during implementation. This will be the primary responsibility of the Council, to ensure that the needs of people with developmental disabilities are met. Through collaboration with the stakeholders, the action steps will be revised, modified or additional actions will be added.

The performance indicators to monitor the plans implementation include:

- Number of individuals identified for community placement.
- People transition from the DC to the community within an average of 6 months.
- Individual budgets sufficiently appropriated.
- Infrastructure provides the supports and services to achieve desired results and outcomes.
- Individuals choose living environment, providers of supports and services, types of supports they use and the manner by which services are provided.
- Resources from Developmental Centers are reallocated appropriately as individuals transition to the community.
- Individuals report a high level of satisfaction with the quality and appropriateness of services annually.
- The plan is implemented with transparency and stakeholders participate in ongoing planning and review of progress.

The implementation of Path to Progress necessitates the proper management of the action steps to be successful. To insure the success of this plan, DDD has appointed a full-time manager who is responsible to oversee the implementation, report on achievements and benchmarks as well as liaison with other state agencies as may be necessary. This manager assures that stakeholders are kept informed, that DDD operational efforts are in line with the timeframes and that questions and concerns are addressed. Access to upper management is transparent and facilitates removing barriers to progress as the plan moves forward.

Path to Progress is a plan to organize some of the most important activities necessary to transition people from Developmental Centers to communities throughout New Jersey. Its design is meant to be flexible in terms of planning and recognizes that the needs of the persons who will utilize it will be wide and varied. As planning develops for each individual, it is anticipated that new opportunities for collaboration will surface which must be fully explored in order to best meet the individual's outcomes.

There will be a continual need to develop resources for the individuals served through the plan. It is through individuals choosing the services they need and want that the person will become empowered to a level not previously seen. The shift is from the person fitting the resource to the resource fitting the person.

On a more individualized level, an individual's essential lifestyle plan is a true living document, being adjusted easily and quickly to meet the persons needs and outcomes. There will also be flexibility in the individual's budget that will provide ease is the purchase of supports and services.

The number of people living in the developmental centers will continue to decrease through the life of this plan. Consequently, it will be important that information from the assessment process be maintained and monitored on a regular basis to insure that projections for continued phase-in of the plan are based on the preferences and support needs of the individuals living in the centers who wish to move. (See Action Step #23)

D. Budget Considerations

This section contains specific information regarding the projected budget for the Olmstead Plan. Please see Appendix L for more detailed information.

1. Individual Budget Levels

The Path to Progress provides all individuals four distinct choices when developing their plans, each with its own unique budget. The budget assigned to the individual will follow the person. So if the person decides at some point to change their residential provider, day provider, or other support service they will have the ability to purchase an alternate support service. This is an extreme departure in scale from the previous methodology. In past initiatives, funding was assigned to an agency and not the

individual which limited that person's ability to completely tailor their services to their needs as their needs and wants changed.

The four choices, or paths, an individual can choose from are based on the type of living arrangement that best fits that person. These choices are to live at home with their family (parents, siblings, etc…); to live in housing that is in their own name (rented or purchased) and hire their own staff; to live in housing that is in their own name (rented or purchased) with an agency providing their supports; and finally to live in a traditional group home or supervised apartment where the agency provides both the housing and the supports.

In an effort to ensure that all individuals with like needs receive like supports, each person participating in the Path to Progress has a level of Self Care Support Need. This level has been determined through the utilization of the DDRT, which was described earlier in this document. These levels are one through four and on a continuum, with level one describing persons who have lower need for support in self care and level four describing persons who have a higher need for support in self care. It is important to note that as a person ages and the need for these supports change a reassessment will occur that will impact their budget if the change in their need is significant.

In addition to the level of support in self care an individual will need, factors such as behavioral and medical needs have been taken into account. If an individual has intense behavioral and/or medical needs as indicated by the assessment tool, a corresponding amount of funding is assigned to them. This funding can be used whenever the individual has a need for it as outlined in their service plan.

All individuals will receive a core budget that is based upon their level of need. In addition, depending on which path is selected by the person there are also other funds available to them which can be used in specific areas. These areas include:

- Day Activities.
- Financial assistance toward housing (Ex. Food, utility bills, etc…).
- Rental Assistance.
- Transportation.
- Development of the individuals housing plan.
- Assistance in connecting and coordinating services and supports.
- One time start up funding for furniture, security deposits, and activation of utilities.

- Additional funding available the first year of the plan in anticipation that an individual may require more supports during transition.

Please see Appendix L for more detailed information.

2. Agency Seed Money For Developing Housing Resources

The Division recognizes the need to ensure agencies receive seed money. Appendix L illustrates that funds have been identified for renovations, one time start-up costs such as furniture and vehicles. Funds will also be made available for start-up staffing and training.

3. Infrastructure Development

It is important to note that the ability to properly execute this plan is contingent upon the availability of appropriated funding over its lifetime. The Division received $50 million for Olmstead for FY 2007 through 2009. In FY 2007, $10 million over three years was directed to in-home services and family support for people living in the community. The Division is committed to reallocating resources from the Developmental Centers to the community so that money can follow the person. The Division has applied for a federal Money Follows the Person Grant application from the Centers for Medicaid and Medicare Services (CMS) and is expecting a CMS decision in April 2007.

The remaining $40 million over three years will be used to enhance and support continued development of infrastructure that would not only provide a bridge to the community for individuals transitioning from the Developmental Centers but would also benefit individuals living in the community to thrive. In subsequent years, community infrastructure will be further strengthened through the reallocation of the resources from the DCs to the community. This would be contingent upon the Division's capability to reallocate these resources. The specific activities funded through these dollars can be seen in Appendix L.

Independent Support Coordination Teams
Statewide Crisis Response System
Crisis Network Stabilization Services
Emergency Capacity Expansion
Individual and Family Education
Quality Improvement
Division Staffing
Capital for Accessibility
Reserve for Major Maintenance

Historical census data (1999-2006) was used in conjunction with the movement of individuals outlined in this Plan to project the Division's census for the next eight years. Between FY1999 and FY2006 there was a 36.9% increase in DDD Census. The Division is projecting a 35.18% increase in individuals served between June 30, 2007 and June 30,

2015. The chart below reflects the projected census on June 30th of each fiscal year (FY) based on this analysis.

	FY'07	FY'08	FY'09	FY'10	FY'11	FY'12	FY'13	FY'14	FY'15
Projected Community Census June 30 of FY	34,983	36,548	38,263	39,978	41,693	43,408	45,123	46,838	48,553
Projected DC Census June 30 of FY	3,020	2,920	2,670	2,420	2,170	1,920	1,670	1,420	1,170
Projected DDD Census June 30 of FY	38,003	39,468	40,933	42,398	43,863	45,328	46,793	48,258	49,723

The Case Management Redesign Plan focuses on addressing vulnerabilities that had been identified. It proposes ways to most efficiently utilize resources to meet the needs of our individuals. No additional resources were allocated to DDD for this endeavor; however forty (40) staffing resources (vacancies and check cut authority) were internally shifted from the developmental centers and central office to community services in FY'06. The Division, as a result of the state-wide hiring freeze (December 2005), has experienced a delay in its ability to fill these positions. In early April 2007, the Division received approval to fill the targeted positions and the Division will be able to implement the Case Management Redesign Plan.

In FY'08 a total of 122 positions, the forty (40) referenced above and eighty-two (82) additional positions are required to fully support the infrastructure needed to implement this Plan. Vacant positions and check cut target from the developmental centers will be utilized to create (reclassify) the needed positions and offset the salary expenses. In order to fully implement the Plan, a proportional number of staff must be added each year of the plan. Each year, vacant positions and check cut target from the developmental centers will be utilized to create (reclassify) the needed positions and offset the salary expenses. The chart below reflects the total numbers of staff that are needed each FY to implement the Plan.

	FY'07	FY'08	FY'09	FY'10	FY'11	FY'12	FY'13	FY'14	FY'15
Projected Community Census June 30 of FY	34,983	36,548	38,263	39,978	41,693	43,408	45,123	46,838	48,553
Division Staff Required to Initiate/ Implement Olmstead Plan by June 30 of FY	707	829	851	875	903	926	954	984	1016
Additional Staff Required to Initiate/Implement Olmstead		122	22	24	28	23	28	30	22

A total of 299 staff are required to fully implement this plan and to support DDD individuals living in the community between FY 2008 and FY 2015. The total salary cost for the additional staff will be approximately $26.2 million which will be phased in during the entire plan and will be more than offset by the resources moved, reclassified and eliminated from the developmental centers.

The Division is committed to ensuring that its individuals are provided all of the services and supports that they require. During the next eight years, the Plan outlines the movement of 1850 individuals from our developmental centers to the community. In addition, there will be no increase in census as admissions will be held at a zero (0) net

growth. The chart below reflects the projected Developmental Center census on June 30th of each FY based on this Plan. The Division is projecting a 61% decrease in individuals served between June 30, 2007 and June 30, 2015.

The current staffing level at our Developmental Centers is inadequate to meet the needs of the individuals without the utilization of overtime to supplement staffing and maintain adequate staffing levels. National statistics show that as of June 2004, New Jersey developmental centers were 17.83% below the national average for total staff. Insufficient staffing has been cited and has been a contributing factor to many of the deficiencies cited by the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Senior Services (DHSS) in annual surveys. Enhancing staff was also necessary to resolve issues identified by the Department of Justice (DOJ) as a concern at both Woodbridge Developmental Center and New Lisbon Developmental Center. The chart below outlines the staffing levels and overtime that will be required to meet the needs of our individuals as census decreases in our Developmental Centers.

	FY'07	FY'08	FY'09	FY'10	FY'11	FY'12	FY'13	FY'14	FY'15
Projected Developmental Center Census June 30 of FY	3020	2920	2670	2420	2170	1920	1670	1420	1170
Developmental Center Staff Required to Meet the Needs of Individuals & Maintain Operation at each DC June 30 of FY	8232	8055	7550	6930	6270	5596	4918	4237	3556
Staff Overtime (Mil. Hours) Required to Meet Individual Needs & Maintain Operation at each DC June 30 of FY	1.63	1.58	1.45	1.31	1.17	1.04	.91	.77	.63
Projected Salaries and Overtime ($ Mil.) with COLA Added	$460.61	$471.00	$472.10	$466.39	$459.39	$451.53	$443.53	$434.80	$425.02
Projected Salaries and Overtime ($ Mil.) with COLA Added – Without Implementing Olmstead Plan	$460.61	$476.73	$493.41	$510.68	$528.56	$547.06	$566.20	$586.02	$606.53

Note: Projected salaries do not include fringe benefits nor increments. COLAs are included in these projections. It is assumed that the salary appropriations at the developmental centers continue with mandated COLAs. Without being able to project the end date of employment of staff, total projected salary savings would not be realized until the following fiscal year.

The overall salary savings (with COLA) will be approximately $61.10 million over the length of the Plan. Without implementing the Plan the projected cumulative increase in salaries would be $145.92 million projected over 8 years. This is a total decrease of $207.02 million in salaries over the length of the plan.

Staffing levels will be reduced through attrition as DDD will not refill targeted positions as positions are vacated and census decreases at the developmental centers. A total of 4,676 positions will be eliminated through attrition at the developmental centers between FY 2008 and FY 2015.

An analysis of current staffing resources versus the staffing needs outlined in this Plan was conducted. Based on this analysis it was concluded that the Division does not

currently have the required vacant positions and titles necessary to initiate and implement this plan. An analysis of the positions/titles and job functions was conducted. It was concluded that most of the titles/positions that would be moved from the developmental centers to community services would have a low rate of transference. The Division will require reclassifications completed for the majority of positions/titles that will be moved to community services. It is assumed that the necessary positions, the funding for those positions, and the hiring authority will be granted to the Division in order to achieve the goals contained within the “Path to Progress”.

E. Action Steps

ASSESSMENT				
Action Steps	**Elements**	**Target Date**	**Date Completed**	**Outcomes**
1. Identify the Supports and Services that will be needed to serve individuals moving from Developmental Center living to Community living	• New Jersey Institute of Technology developed an assessment of all individuals currently residing in New Jersey's seven developmental centers which was completed by DC staff. • The information gathered was used to prepare a report which identifies the descriptive characteristics of the individuals and then analyzes the data to determine needed supports and services.		• 9/1/06 • Draft report received 2/6/07	NJIT report received
2. Interviews completed to gain clarification of assessment information.	• NJIT conducting interviews with individuals from the assessment who can participate and provide answers in an interview format. o Interviews completed during initial assessment as follows: ▪ 24 Individuals from Woodbridge interviewed - 2/6/07 ▪ 36 individuals from New Lisbon interviewed – 2/6/07	• 6/1/07		

Action Steps	Elements	Target Date	Date Completed	Outcomes
2. Interviews completed to gain clarification of assessment information, cont'.	o Interviews to be completed with individuals as follows: 10 at Greenbrook 14 at Hunterdon 9 at New Lisbon 39 at North Jersey 21 at Vineland 28 at Woodbine	• 6/1/07		
3. Incorporate completion or update of the assessment information into the annual IHP process	• Information gathered from the NJIT assessment will be shared with developmental centers. • NJIT assessment information will be incorporated into each individual's IHP beginning with 6/07 IHPs. • Annually, DC staff will update the NJIT assessment and incorporate changes into the IHP. • As NJIT assessments are updated the information will be incorporated into the database.	• 7/07 • 6/08 • Beginning 7/07 • Beginning 7/07	• Ongoing • Ongoing	

Action Steps	Elements	Target Date	Date Completed	Outcomes
4. Develop Guidelines for Admission Criteria to Developmental Centers	• Create uniform procedure for developmental center admissions. • Define course of action in terms of due process, including independent third party review. • Ensure collaboration with stakeholders. • Implement new admission criteria for DCs.	• 7/07 • 7/07 • Ongoing • TBD		
5. New Admissions to Developmental Centers will be assessed utilizing the DDRT.	• An initial assessment will be completed in conjunction with the individual's 30-day admission IHP. • Annually thereafter the assessment information will be reviewed and updated	• Ongoing • Ongoing		
6. Implement New Criteria for use in Determining who is referred for Community Placement	• Completed in conjunction with Annual IHP	• 7/07		

Action Steps	Elements	Target Date	Date Completed	Outcomes
7. Develop a System Wide Approach to Evaluate the Division's Community Residences	• Gather information regarding accessibility, fire suppressions systems, major maintenance needs, number of bedrooms, and number of people living in the home. • Develop a system to track modifications made to existing homes to make them accessible.	• 12/07 • 12/07		
RESOURCE NEEDS				
8. Expansion of Community Supports (RFP to expand agencies qualified to provide housing, residential, employment/day, medical, behavioral supports)	**Olmstead RFP** • RFP posted and Bidders' Conference information posted on DDD website. • Pre-qualify new agencies (develop review tool, complete reviews, notify agencies). • Conduct Bidders Conference for Olmstead RFP. • Interviews of Olmstead applicants conducted and completed. • Notifications of Qualification sent to Olmstead RFP applicants. • RFP for the statewide expansion of Emergency Capacity Services .	 • 9/19/06 • 9/22/06 • 10/3/06 • 12/06 • 1/12/07 • 6/07		**Olmstead RFP Outcomes** • 134 Agencies in attendance • 211 persons in attendance DDD Website updated to reflect outcome: • 101 applications received by 11/3/06 • 69 interviews conducted during 12/06 • 55 agencies qualified to provide housing • 73 agencies qualified to provide residential supports • 63 agencies qualified to provide employment/day supports

Action Steps	Elements	Target Date	Date Completed	Outcomes
8. Expansion of Community Supports cont'd	o Olmstead qualified providers included on the Family Support Center (FSCNJ) website.	• 4/1/07		• 38 agencies qualified to provide medical supports • 47 agencies qualified to provide behavior supports • 25 agencies qualified in all categories • Of those agencies qualified: o 15 do not currently have a contract with DDD o 7 new to NJ
9. Identification of Independent Support Coordination Agencies (RFP held to identify two Support Coordination Agencies)	**<u>Support Coordination RFP</u>** • RFP Posted and Bidder's Conference information posted on DDD website. • Mandatory Supports Coordination Bidders' Conference and Optional Technical Assistance Session. • Interviews of Independent Supports Coordination applicants completed. • Support Coordination contracts awarded.		• 10/16/06 • 11/2/06 • 12/14/06 • 12/22/06	**<u>Support Coordination RFP</u>** • 25 agencies in attendance • 40 people in attendance • 18 applications received and reviewed • 18 agencies interviewed • Support Coordination contracts awarded to 2 agencies: o Caregivers of New Jersey o Values into Action

Action Steps	Elements	Target Date	Date Completed	Outcomes
10. Increase and expand availability of Community Services and Supports	• Open enrollment process initiated.		• 1/07	• 5 additional agencies qualified for Housing • 6 additional agencies qualified for Employment/Day • 6 additional agencies qualified for Medical • 3 additional agencies qualified for Behavior • 5 additional agencies qualified for Residential
	• Draft of DDD Vacancy policy developed to ensure agencies are accountable for filling vacant beds.		• 3/13/07	
	• Contract & budget developed for expansion of Statewide Clinical Consultation & Training program to form a Crisis Response System to work primarily with DDD providers on behavioral issues & overlapping psychiatric problems.		• 3/31/07	• Budget approved and program implemented.
	• NJIT completing Community Resource Assessment. Interviews conducted 2/07 & 3/07 in all regions to determine availability of resources throughout the state.	• 6/30/07		• Community Resource Inventory published.

Action Steps	Elements	Target Date	Date Completed	Outcomes
11. Increase community residential options and capacity to ensure a variety of choices are available in self-directed and provider-managed residences.	• Community Development is underway to increase community capacity for people transitioning from developmental centers. A total of 80 people will move to the community by June 30, 2007.	• 6/30/07		
	• In order to divert people from entering the developmental centers, community capacity is also being developed for 40 people on the Community Services Waiting List, 11 aging out of educational residential entitlements, 80 emergencies due to sudden loss of care givers and 8 moving out of structured settings into their own apartments.	• 6/30/07		
	• A total of 30 people will be moving into supportive housing units in which the lease is in their name and a percentage of personal benefits pay for their own expenses.	• 6/30/07		
	• Depending upon available funds in FY 2008, the potential increased community capacity of projects with realistic plans totals 248.	• 6/30/08		

Action Steps	Elements	Target Date	Date Completed	Outcomes
11. Increase community residential options and capacity to ensure a variety of choices are available in self-directed and provider-managed residences con't.	• Of the 248 in increased capacity, approximately 100 units are affordable housing apartments developed through partnerships with community for-profit developers. • A portion of the apartments will be supportive housing units in which the lease will be in the individuals' names. • 6 homes are planned for people requiring specialized medical needs. • 5 of the 6 medical supports homes will have a maximum capacity of 4 residents. • 6 community residences will be designated for people currently in out of state Purchase of Care (POC) facilities in order to bring them back to their home state. This will enable DDD to include these individuals in the Residential CCW.	• 6/30/08 • 6/30/08 • 6/30/08 • 6/30/08 • 6/30/08		

Action Steps	Elements	Target Date	Date Completed	Outcomes
11. Increase community residential options and capacity to ensure a variety of choices are available in self-directed and provider-managed residences cont'd	• Develop better mechanisms for repair and maintenance of the existing housing stock. • Expand the pool of existing skill sponsor homes. • Evaluate transportation needs and include in support planning.	• 7/1/08 • 1/1/08 • 7/1/08	• Ongoing • Ongoing • Ongoing	

Action Steps	Elements	Target Date	Date Completed	Outcomes
12. Leverage funding to include multiple resources in order to maximize the number of projects funded with DDD state funding.	• Accessing alternate sources of funding for community projects has increased each fiscal year for the past several years as more and more agencies become educated in the funding options available.	• 6/30/07		
	• In FY 2007, 5 projects are funded by HUD, 6 projects receive COAH funds, 3 are financed by the Special Needs Housing Trust Fund, 2 are supportive housing projects with state rental assistance vouchers and 5 homes are agency purchased utilizing only DDD state funds for services and supports.	• 6/30/07		
	• Most of the residences designated to be developed during FY 2008 leverage one or more funding resources other than DDD state dollars.	• 6/30/08		
	• 18 projects are funded by COAH funds, 14 projects are funded with 50% to 80% capital funds from the Special Needs Housing Trust Fund, 12 projects are funded by HUD and several of the apartment projects have state rental assistance vouchers.	• 6/30/08		

Action Steps	Elements	Target Date	Date Completed	Outcomes
12. Leverage funding to include multiple resources in order to maximize the number of projects funded with DDD state funding. cont'd	• Five projects identified to be in the early planning stages and will not be available until FY 2009 or FY 2010. • One project with 18 apartments geared towards senior citizens requiring continuing care retirement community setting. Project is partially funded with COAH funds. • Another project is a cluster of community residences for people with autism on donated property. • Two projects are for people moving back from out of state POC facilities. • Another project is a joint partnership between a DDD contract agency & community developer for multiple apartment units to be funded by the Special Needs Housing Trust Fund.	• 6/30/10 • 6/30/10 • 6/30/10 • 6/30/09 • 6/30/09		

Action Steps	Elements	Target Date	Date Completed	Outcomes
13. Education and Information Sharing	• Community Service cross training on placement options for Woodbridge Staff in 8/06, 9/06 and 10/06. o 148 staff toured group homes. o 178 staff attended community placement training. • Schedule community services cross training including training on placement options for other DCs. • Effective 10/06, monthly updates regarding Olmstead shared with contracted providers. • Effective 10/06, dialogue with Division Director regarding Olmstead. • Effective 12/06, regular meetings with DC CEO's and regional staff to provide updates re: Olmstead progress. • Meetings with Division Staff and Court Monitor for Settlement Agreements with DOJ at the onset of each six month review.		• 10/06 • Ongoing • Ongoing • Ongoing • Ongoing • Ongoing	

Action Steps	Elements	Target Date	Date Completed	Outcomes
14. Education and Information Sharing cont'd.	• Weekly Olmstead Update meeting established.		• Ongoing	
	• UMDNJ DD Family Education & Information Project provided Family Forums on New Beginnings In Community Living. Four forums held annually.		• Ongoing	
	• UMDNJ DD Family Education & Information Program are updating training materials to reflect DDD's new approach to development of community services.	• 6/07		
	• Members of the Self Advocacy group from Woodbridge attended a presentation on community living at New Lisbon Developmental Centers Fall Conference.		• 10/06	
	• Meeting with NJ Self Advocacy Project.		• 2/07	• Met with 2 self advocates and 2 Project Advisors/Representatives. They will meet with their constituencies to determine how they want to partner with DDD throughout the transition process.
	• DDD & Self Advocacy Groups will hold regular meetings & provide information for residents at all of the State's DCs.	• 7/07		
	• Presentation to Family Associations regarding Independent Support Coordination.	• To be phased in		

Action Steps	Elements	Target Date	Date Completed	Outcomes
14. Education and Information Sharing cont'd.	• Provide families/guardians with: o Information on placement recommendations. o Information on meaning of the Olmstead Decision. o Information on State policy regarding Olmstead. o Opportunities to visit community programs on a regular basis. o Opportunities to meet with individuals/families of individuals who have moved to the community to ascertain their experience.	• Ongoing • Ongoing • Ongoing • Ongoing • Ongoing • Ongoing		
15. Receive and Implement Money Follows the Person Grant	• Meetings held to formulate proposal for DDD to participate in the Money Follows the Person Grant • Submitted Response to Request for Additional Information • Expand Fee for Service model.		• 10/27/06 • 2/26/07 • 3/07	

Action Steps	Elements	Target Date	Date Completed	Outcomes
15. Receive and Implement Money Follows the Person Grant con't.	o Contract awarded to assist in the development of a strategic plan			
16. Finalization of Path to Progress (DDD plan to move individuals from DC living to community living)	• Public Notice published in New Jersey Register, and on the DDD and DHS web sites announcing Public Hearings to be held in 1/07. • Letters sent to DC residents and families/guardians notifying them of the Public Hearings. • Public Hearings held as required by S1090 on the following dates: o 1/9/07 Union County College o 1/11/07 New Lisbon DC o 1/16/07 Middlesex County College o 1/18/07 North Jersey DC		• 12/18/06 • 12/22/06 • 1/18/07	**Public Hearings Outcomes:** • 246 people in attendance • 76 people and organizations offered written and/or verbal testimony.

Action Steps	Elements	Target Date	Date Completed	Outcomes
16. Finalization of Path to Progress cont'd	Testimony requested to address 3 areas: o Services/supports needed to transition from DCs o Services/supports needed to successfully integrate and maintain individuals in the community o Concerns re: accessing and receiving services in the community • Summary of testimony from public hearings posted on the Division's website. • Draft plan forwarded to Department of Human Services for comments. • Path to Progress finalized and submitted to Legislature	• 5/07	• 3/14/07 • 5/2/07	
17. Ensuring Informed Choice	• Information materials for families include o Newsletter "New Beginnings in Community Living" (ongoing) o Family Workbook on Community Living (revision SFY 2007) o Project website for information dissemination (ongoing)	• 6/30/07	• Ongoing • Ongoing	

Action Steps	Elements	Target Date	Date Completed	Outcomes
17. Ensuring Informed Choice cont'd	• Outreach to transitioning families/guardians o Family orientation sessions at the beginning of the transition process that gives an outline and overview of the DC transition process. o Family information forums focusing on community living and what that can actually look like for people today. o Individual family working sessions o Telephone and mail information outreach. • Feedback to DDD on the status of families and their concerns during the transition process. • Identification of family mentors from families whose family members have already moved to community living and peer mentors who have transitioned to the community. The mentors will be available to support current individuals and their families in the transition process (SFY 2007).		• Ongoing • Ongoing • Ongoing • Ongoing • Ongoing • 3/07	

Action Steps	Elements	Target Date	Date Completed	Outcomes
17. Ensuring Informed Choice cont'd	• DDFEP will provide orientations for staff identified as important to the person's successful transition. The orientations give an overview of person-centered planning and the support coordination process.		• Ongoing	
18. Implementation of Independent Support Coordination Teams for Transition	• Establish Olmstead Team with Project Manager to plan and review issues. • Woodbridge and New Lisbon Developmental Centers selected to pilot Independent Support Coordination for transitioning people to the community due to commitments regarding community placement in Settlement Agreements with DOJ. • Implement Independent Support Coordination Team approach to all developmental centers on a gradual basis. • Person-centered Thinking and Essential Lifestyle Planning, and Team Building training for members of support coordination teams.	• To be phased in	• 8/06 Ongoing • 12/06 • 12/18/06 12/19/06 1/13/07 ongoing	

Action Steps	Elements	Target Date	Date Completed	Outcomes
18. Implementation of Independent Support Coordination Teams for Transition cont'd	• Meetings initiated with two new Independent Support Coordination Agencies.		• Ongoing	
	• Briefing paper entitled "Implementing Independent Support Coordination to Facilitate the Olmstead Plan" developed to provide: o Background of Olmstead in NJ. o Role of developmental centers. o Creation of Independent Support Coordination (ISC) to move people from DCs. o Procedures for Implementing ISC o Next steps, Long and Short Term goals.		• 1/31/07	• Document sent out to Regional Administrators, developmental center CEOs, and Bureau of Guardianship Services.
	• Support Coordinators and Transition Case Managers are identified to begin working together for Woodbridge.		• 3/16/07	
	• Support Coordinators and Transition Case Managers are identified to begin working together for New Lisbon.		• 3/31/07	

Action Steps	Elements	Target Date	Date Completed	Outcomes
18. Implementation of Independent Support Coordination Teams for Transition cont'd	• UMDNJ provided training sessions for Woodbridge staff regarding Support Coordination. • UMDNJ provide training sessions for New Lisbon staff regarding Support Coordination. • UMDNJ provided training for Woodbridge families and guardians regarding Support Coordination. • UMDNJ to provide training for New Lisbon families and guardians regarding Support Coordination. • UMDNJ to provide training on Support Coordination for families and guardians at all other DCs. • Support Coordinators will work with DC Staff to identify peer and family mentors as individuals transition from DCs to community living arrangements.	• To be phased in	• 2/21/07 Ongoing • 3/8/07 Ongoing • 2/24/07 ongoing • 4/2/07 • Ongoing • Ongoing • Ongoing	3 training sessions held 2/07; 2 additional sessions scheduled for 3/07 2 training sessions held 3/07

Action Steps	Elements	Target Date	Date Completed	Outcomes
19. Implement procedures to guide transition from Developmental Centers	• Draft procedures to address the pre-placement IHP, what is to occur between pre-placement and the day of discharge and the 30 day IHP to be developed. • Procedures to address the pre-placement IHP, what is to occur between pre-placement and the day of discharge and the 30 day IHP to be developed finalized •	• 6/1/07	• 3/20/07	• Policies finalized and implemented
20. Timeframes for Individuals moving from Developmental Centers using Independent Support Coordination	**<u>Timeframes for Transitioning Individuals</u>** **Phase 1: Education and Decision Making** • People to move are identified and included on a published list. Informal conversations take place, assessment information is confirmed, and assessments are completed. Formal education is provided for the individual, family/guardian/staff. Relationship maps are started. • People confirm their choice to move forward, are assigned a Support Coordinator, an up to amount of budget is assigned and people are listed on the e-record.	To be completed within 1 month.		• Independent Support Coordination teams going out with and getting to know individuals. • People and their Support Coordinator are included on the e-record

Action Steps	Elements	Target Date	Date Completed	Outcomes
20. Timeframes for Individuals moving from Developmental Centers using Independent Support Coordination cont'd	**Phase 2: Plan Development** • The Independent Planning Team meets with the person and important people in the person's life and the Essential Lifestyle Plan is initiated during which: o The Independent Support Coordination team meets the person and gets to know them. o The Independent Support Coordination team develops the description and does some planning. o Person-centered description is completed. o The Independent Support Coordination team tests the information in the description by getting the person experience with parts of the plan in different places…so "vision of my life emerges."	To be completed within 90 days		• Activities of Independent Support Coordination team w/ each person available on the e-record. • Planning team meeting regularly – evidence on e-record • Plan is approved and placed on the e-record

Action Steps	Elements	Target Date	Date Completed	Outcomes
20. Timeframes for Individuals moving from Developmental Centers using Independent Support Coordination cont'd	○ Coordination of services begins. ○ All necessary supports are identified. ▪ Housing. ▪ Day program/activities. ▪ Transportation. ▪ Community supports/services/medical. ▪ Funding streams for supports and services. ▪ Fiscal intermediary identified. • The first plan is completed laying out the action plan/roadmap and it is placed on the live record.			• Transitional services are being utilized/expenditure of dollars

Action Steps	Elements	Target Date	Date Completed	Outcomes
20. Timeframes for Individuals moving from Developmental Centers using Independent Support Coordination cont'd	• An action plan/roadmap is laid out. o The selection of supports and services is initiated. (What you are hiring for/who you are hiring). o Plan is submitted to the State Monitor for review and approval. o State Monitor ensures health and safety issues are addressed throughout all aspects of the plan. **Phase 3: Plan is put into Action** • Person is connected to support or service. o Needed supports and services are selected and interviews conducted with businesses, qualified agencies and provided. • Support Coordinator ensures individuals and their teams make an informed choice. o Opportunities for exposure to various service options and resources occur.	To be completed within 60 days. **Total Transition = 6 months**		

Action Steps	Elements	Target Date	Date Completed	Outcomes
20. Timeframes for Individuals moving from Developmental Centers using Independent Support Coordination cont'd	• Person selects where they are going to live and put supports in place. o Community connections are established. o Person visits their new home, day activities and community resources. • Move date identified. o Roles & responsibilities are communicated to all parties. o Resources are prepared for transition. o Transition Case Manager prepares necessary paperwork and makes arrangements for each persons move.	• Ongoing		• Supports and services are in place 30 days prior to scheduled move. • Completed 30 days prior to actual move. • Address change is made on the e-record.

Action Steps	Elements	Target Date	Date Completed	Outcomes
20. Timeframes for Individuals moving from Developmental Centers using Independent Support Coordination cont'd	**Phase 4: Move and Initial Transition Follow-up** • Person moves into the community. • Information related to the individual & their service plan are available & updated as changes are made on the electronic record. • Follow-up meetings initiated to determine if what people wanted is working for them & that their outcomes are being met or addressed. • For the first three years following placement a knowledgeable employee of the DC from which the individual previously resided may be requested by the Support Coordinator or Community Service Case Manager to participate as a part of the team. • If a provider managed method of procuring services is chosen, a Community Services Case manager will be assigned. This Case Manager will be identified and become a member of the independent team.			• Revisions 30, 60, 90, 180 days for follow-up meeting/event. Then annually there after or as needed. NOTE: Independent Support Coordinator only stays involved past 90 days after move if a self-directed community placement is chosen by the individual. If a traditional community placement is chosen then a Community Services Case Manager will assume responsibility for continued follow-up with the individual.

Action Steps	Elements	Target Date	Date Completed	Outcomes
20. Timeframes for Individuals moving from Developmental Centers using Independent Support Coordination cont'd	• If a self directed method of procuring their services is selected, then the individual's case will remain with the Support Coordinator. They will also have a State Monitor located in the regional office. **Phase 5: Move and Long Term follow-up** • If an individual chooses to change services and/or supports, the Support Coordinator or Community Services Case Manager will facilitate the requested changes. • If the needs of an individual change, the Support Coordinator or the Community Services Case Manager will notify the Division & the DDRT will be utilized to revise the budget. Changes in Service Plan will occur based on changing needs. • In the self directed option, the annual Service Plan review is facilitated by Support Coordinator & then the Service Plan is reviewed & approved by the DDD State Monitor. In the provider managed option, the Community Services Case Manager will be responsible for the annual Service Plan.	• Ongoing • Ongoing • Ongoing		

Action Steps	Elements	Target Date	Date Completed	Outcomes
21. Support Coordination Agencies responsibilities for on-going follow-up/oversight.	• Quarterly follow-up provided to DDD from Support Coordination Agencies regarding: o Number of individuals served. o Phase of service for each person. o Follow-up status (In accordance with the waiver standards, Support Coordinator to document provision of follow-up to ensure all supports are in place throughout the transition process & into the future. • Support Coordination Agency to monitor for ongoing quality and needed improvements to assure: o Changes in the Service Plan are based on the individuals changing needs. o The DDRT is utilized to revise the budget. o Service & support changes are timely.			

Action Steps	Elements	Target Date	Date Completed	Outcomes
21. Support Coordination Agencies responsibilities for on-going follow-up/oversight, con't.	o Service Plan is reviewed/completed annually, facilitated by the Support Coordinator & reviewed/approved by DDD State Monitor.			
22. DDD Quality assurance system developed to ensure supports and services are delivered once someone moves to the community.	• Monitor Support Coordination as people move out of DC's at 30, 60, & 90 days post movement. • Implementation of a Indiividual Satisfaction Survey, which will be linked to the National Core Indicators Project (NCI), to gather input from the individual & their family regarding quality of life, choice & supports and services. • Evaluate the data collected through the NCI Project to identify areas needing improvements.			

Action Steps	Elements	Target Date	Date Completed	Outcomes
22. DDD Quality assurance system developed to ensure supports and services are delivered once someone moves to the community, cont'd.	• Provide evaluated data collection to the coordinated system of quality improvement committees, consisting of the Statewide Quality Management Steering Committee and Regional Continuous Quality Improvement Committees, to explore & pilot ways to improve service delivery & individual outcomes and satisfaction. • If funding allows, an independent group would conduct individual & family surveys. • Case manager oversees and monitors development, implementation, & effectiveness of Service Plan. • Management of Service Plan compliance through the expanded IT capacity. • Service monitoring and oversight, including provider agency compliance with policies and procedures, Division standards and performance reviews. • Technical Assistance for providers.			

Action Steps	Elements	Target Date	Date Completed	Outcomes
23. Managing Action Steps	• Develop Implementation and Planning Advisory Council. • Report on Performance Indicators to key stakeholders. • Adjust plan as necessary. • Establish or revise benchmarks as necessary. • Revise Division regulations and policies as needed.	• 7/07 • Every 6 Months • Ongoing • Ongoing • Ongoing		

Appendix A

Division of Developmental Disabilities (DDD)
Where Individuals of Services from the Division of Developmental Disabilities Live [1]
Fiscal Year

	1986	1988	1990	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	Dec 2006
Own Home [2]	3,435	4,296	7,032	8,905	9,493	10,421	11,567	12,448	8,335	14,132	15,331	16,431	17,891	19,124	20,510	21,908	23,095	24,044	24,519
Skill Development or Family Care	1,135	1,212	1,268	1,406	1,518	1,578	1,644	1,745	1,760	1,762	1,797	1,779	1,723	1,657	1,599	1,529	1,432	1,376	1,331
Group Home	987	1,236	1,379	1,587	1,782	1,854	1,952	2,156	2,314	2,751	2,926	3,079	3,206	3,428	3,697	3,902	4,073	4,120	4,213
Supervised Apartment	251	327	395	535	617	685	719	755	798	831	875	922	965	1,012	1,049	1,064	1,068	1,051	1,090
Supported Living	44	91	158	252	291	323	335	382	431	439	460	473	493	504	513	501	496	515	539
Unsupervised Apartment	124	100	100	110	112	123	140	139	156	181	188	189	188	188	184	177	179	169	152
Boarding Home or DCA Licensed Home	341	258	230	239	251	209	203	170	157	152	138	129	130	123	115	111	107	53	55
Other [3]	403	707	922	1,080	1,103	1,167	1,185	1,212	1,265	1,286	1,459	1,466	1,407	1,529	1,605	1,707	1,692	1,722	1,728
Subtotal - Community	6,720	8,227	11,484	14,114	15,167	16,360	17,745	19,007	15,216	21,534	23,174	24,468	26,003	27,565	29,272	30,899	32,142	33,050	33,627
Private Institutional Care	939	967	1,001	885	903	890	841	616	556	527	524	545	553	575	593	603	639	681	705
Developmental Centers [4]	5,481	5,235	5,110	4,737	4,407	4,363	4,286	4,241	4,056	3,672	3,596	3,514	3,433	3,296	3,169	3,121	3,070	3,051	3,027
Total Served by DDD	**13,140**	**14,429**	**17,595**	**19,736**	**20,477**	**21,613**	**22,872**	**23,864**	**19,828**	**25,733**	**27,294**	**28,527**	**29,989**	**31,436**	**33,034**	**34,623**	**35,851**	**36,782**	**37,359**

Notes

1. 1986 - 2006 are from June 30 of each Fiscal Year.
2. From 1990 forward Own Home includes people who received "only supported work" and "only home assistance".
3. Nursing Home, Psychiatric Hospital, etc.
4. The DC at Edison closed in 1988, the ER Johnstone Training and Research Center and the DC at Ancora closed in 1992, and the North Princeton Developmental Center closed in 1998.

Person's Perspective	**Action Steps**
At my IHP meeting my social worker asked if I would like to leave New Lisbon and live closer to my mom; I said yes. Then some people asked my staff and my mom a bunch of questions about what I can and can't do and what help I need.	• DD Planning Institute Assessment completed to establish level of need. • DC Team meets with individual, family, and guardian to discuss preference for community placement.
My Mom and I went to a meeting with other people from New Lisbon and their families. We got to ask questions, and think about possibilities for moving out of the developmental center	• Family forums are provided and training is provided to individual, family, and staff.
My mom and I met the people who were going to be with me as I moved; we also learned about how it was going to happen. I met Bob (peer mentor) who uses a wheelchair just like mine. He lives on his own, with the support of staff and friends. He answered questions about what it is like living in the community. My Mom met Ann (family mentor), who is the mom of someone who uses a lot of the supports I do. We learned about Support Coordinators; about what they do and how they would help me. After this meeting my mom and I were pretty sure that this was what we wanted to do, but we got so much information our heads were full; we knew we would have more questions later.	• Orientations with Individuals and Family • Introductions of Peer and Family Mentors.
My Mom wanted to know about budgets so she talked to Tricia, who I had already met. Tricia works at the DDD Central Office. My Mom asked about my budget and the planning process. She was reassured of how much DDD, support coordinators, family mentors, and peer mentors work together as a team.	• Follow up by DDD Central Office staff with families to verify their willingness to move forward and answer questions and concerns.
Danielle (my transition case manager) came to see me. I had seen her before at the New Lisbon Trading Post when I got coffee. She talked with me, and my staff, about the people who are important to me. Danielle shared this information with Trace, my support coordinator.	• Relationship maps completed by Transitional Case Manager and then shared with Supports Coordinator. Planning Teams are established.
Trace and Natalie, who work together, called the people who were closest to me to learn about what is important to me and important for me and my general likes, dislikes, and needs. Trace and Natalie also found out from Danielle when Brenda, my favorite	• Information gathering for first steps in plan development.

staff person, and I could go out with them. Trace and Natalie picked Brenda and I up in a blue mini-van and we went out to Anapa's Diner where we got to know each other better. At the end of our lunch we set up a time when we could all go out again along with Bob and Ann. They are all part of the team of people helping me move. I am excited to go out with Trace and Natalie again because we had a great time. The next time we went out to a library and met some more people (my team). My mom met us at the library. When we were there Trace showed me information he recorded on his really cool computer at our last meeting. He asked me, my mom, and Brenda if he got it right. We then answered some more questions for him. There were some questions about where I wanted to live and things that I wanted to do that I just didn't know the answers to, so I went out with some of my new friends and Brenda to learn more. I saw houses where I could live with other people, apartments, and other types of homes. I got an idea of where and how I might like to live. I also visited some places in town where I could do some of my favorite things (like the local pet shelter because I like animals) so I could see what jobs I might have in the future. After looking at a lot of things, and meeting with my team a few more times, I finally made a decision about how and where I was going to live. I would live in Somerset (near my mom) in a two-bedroom fully accessible place. I would live with a friend of Brenda's (Betty), who shares some of my interests and was looking for a place to live. She would be my staff person at night and would get to live in the house for free. I would hire staff for other times of the day when I was home. And, I would need someone to: help me find my home, get a job working with animals, meet new people in Somerset and find other fun things that I could do. Trace told me about people called housing specialists, who could help me find a place to live; and people called community connectors who could	• Transitional Case Manager coordinates visit with individual, supports coordinator, and DC staff to gather information and move further in planning process. • Informal Information Gathering • First draft of plan written by supports coordinator. • First draft of plan written and more information gathered and support given with larger team. • More formalized information gathering and plan development. • Visits with team to look at different types of community living arrangements and activities. ❖ Exploration of Both Participant directed and Provider Managed housing options. ❖ Looked at: Group Homes, Supervised Apartments, Condominiums, and other housing options. ❖ Explored possible communities of residence. • Plan written and first steps toward community living begin to be put into place. • Supports Coordinator begins to work with qualified providers and look at different housing specialists,

help me get involved in my new community. He also talked to me about hiring someone to help me find a job.	community connectors, and employment specialist
My team and I interviewed a couple of housing specialists and community connectors and decided on the right ones for me. I soon started working with Dave, my housing specialist (he's a member of SHA and has a lot of knowledge about accessible housing) to find a home. He took me out to see places, helped me qualify for my housing voucher, and when I found the right place, helped me get accessibility modifications. My staff at NLDC and my mom had a lot of input on exactly what I need and had the opportunity to visit and ensure it was right for me.	• Hiring of housing specialists. • Housing specialist works with team to locate appropriate location. • Housing specialist works with individual, team, current staff, family, and qualified providers to make sure house is appropriate and accessible
I also met with Jenny, my community connector. She helped me start a circle of friends and visit places to get to know people in Somerset. I've spent some time at the local Starbucks and the Silver Diner where everyone is very friendly; by the time I move I will already know people in town.	• Hiring of Community Connector • Begin transitioning into local community.
Once I knew where I was going to live, my team and I started looking for staff. We interviewed several people and found a wonderful provider agency that will provide me with 40 hours of staff a week, plus all my back up coverage. That way, if I have an emergency, or if someone calls out unexpectedly, I can call my agency and they will send someone right over.	• Person and team begin to hire staff to truly put plan into place. • Emergency Back up plan established.
I also hired Betty to do some hours for me through the Fiscal Agent. She works for me, but the Fiscal Agent pays her. I still needed staff for the weekend, so we interviewed staff connectors and found one (on the qualified provider list) who would help me locate the rest of my staff. Shawn had experience working with a provider for many years and knows how to write ads, develop flyers, and interview possible staff. We made a flyer, which we put up in my new Starbucks, the Silver Diner and the library. We got a great response from the flyers and found two staff.	• Continuation of staff hiring through Fiscal Agent.
*Now that I have my home, and my staff, and have started to know people, I'm buying furniture and	• Plan is put in place and move date set. • Furniture purchased and utility hook

getting ready for my move. My team and I researched accessible public transportation in my area before I selected my place. My new place is on the bus line so I am eligible for this. I can get anywhere by calling and scheduling a ride.	up done.
I am also now working with Debbie, who is helping me find a job. I can volunteer at the shelter 2X a week and I am waiting to hear if I got a position at the pet store. Debbie helped me develop a resume, find potential positions, and go out to interviews. She also helped prospective employers figure out what kind of accommodations I might need.	• Employment Specialist hired. • Job Development Process Started
*With everything all set, Betty and I are moving into the new place this weekend. Some of my new friends from Starbucks (who have joined my circle), some of my friends from New Lisbon, and my Mom are all helping me move. My staff will start working as soon as I move in. I'll start my volunteer job on Monday. We have a big house warming party planned for Saturday night to which I have invited both my close friends from New Lisbon and my new friends.	• Person Moves

STATE OF NEW JERSEY

DEVELOPMENTAL DISABILITIES

HABILITATION ASSESSMENT FORM (HAF)

Revised 3/9/06

Prepared by DD Planning Institute
New Jersey Institute of Technology

Prepared for State of New Jersey
Division of Developmental Disabilities

Individual Name/
MIS Number

DD Center Name/
Cottage Name

Respondent Name/
Respondent ID Number

Date Completed ____ ____/ ____ ____/ ____ ____

PURPOSE

THIS ASSESSMENT COLLECTS FACTUAL INFORMATION ABOUT THE INDIVIDUAL.

YOU CAN HELP BY ANSWERING SPECIFIC QUESTIONS ABOUT THIS INDIVIDUAL BECAUSE OF YOUR SPECIALIZED EXPERTISE AND TRAINING.

PLEASE COMPLETE THIS FORM ON THE BASIS OF YOUR OBSERVATION OF THE INDIVIDUAL'S RECENT ACTUAL FUNCTIONING OR SITUATION, NOT ON WHAT YOU THINK MIGHT BE POSSIBLE IN THE FUTURE.

THANK YOU FOR YOUR ASSISTANCE.

		NO	YES
1.	**Currently,** does the individual regularly leave the cottage during weekdays to attend day program (e.g., greenhouse, fine arts, workshop, or supported employment)?	0	1

a. If yes above, does the individual attend this day program on grounds, off grounds, or both on and off grounds?

1. On Grounds Only
2. Off Grounds Only
3. Both On and Off Grounds

		NO	YES
2.	Has the individual smoked cigarettes, cigars, or a pipe in the **last 3 months**?	0	1
3.	Has the individual worn **dentures** in the **last 3 months**?	0	1

If PRESCRIBED, BUT NOT USED BY INDIVIDUAL IN THE LAST 3 MONTHS, ANSWER "NO."

4. Date of most recent IHP ____/____/____
MM DD YY

5. Did **any members of the family** attend the individual's most recent IHP meeting?

0. Not Applicable – No Known Family
1. No
2. Yes

6. Indicate whether the individual **has done** any of the following **cognitive tasks** in the **last 4 weeks.**

	NO	YES
A. *Spatial/Perceptual Abilities*		
a. Knows difference between the colors of red, blue, green, and yellow?	0	1
b. Knows difference between the sizes of big and small?	0	1
c. Knows difference between the shapes of circle, square, and triangle?	0	1
d. Finds way around the home by himself/herself? (If mobility issues prevent him/her from moving from room to room by himself/herself, but he/she knows where different rooms are located, answer "yes.")	0	1
B. Number Awareness	NO	YES
a. Uses numbers even if inaccurately?	0	1
b. Counts to 10 without help?	0	1
c. Does simple addition?	0	1
d. Does simple subtraction?	0	1
C. Writing Skills (Include Braille or Typing)	NO	YES
a. Prints or writes single letters without a model or tracing?	0	1
b. Prints or writes own first name without a model or tracing?	0	1
c. Prints or writes single words – other than his/her name – without a model or tracing?	0	1
d. Prints or writes simple sentences without a model or tracing?	0	1
D. Reading and Sign Skills	NO	YES
a. Recognizes his/her own first and last name when it is written?	0	1
b. Reads and comprehends simple words?	0	1
c. Reads and comprehends simple sentences?	0	1
d. Reads and comprehends a simple story?	0	1
E. Associating Time with Events and Actions	NO	YES
a. Remembers events that happened a month or more ago?	0	1
b. Associates events with time in the past, present, or future such as knowing the difference between yesterday, today, and tomorrow?	0	1
c. Associates regular events with a specific hour such as knowing that 6 pm is time for dinner?	0	1
d. Tells time to nearest five minutes such as knowing the difference between *5* minutes to 6 pm and *5* minutes after 6 pm?"	0	1

7. Which **best** describes how the individual **typically** performs each **self-care** activity in the **last 4 weeks?**

	NOT ABLE	LOTS OF ASSISTANCE Hands-on Help	MAINLY SUPERVISION Verbal Prompts	INDEPENDENT No Prompts or Help	NO OPPORTUNITY TO DO
a. Feeding self	0	1	2	3	4
b. Drinking from glass or cup	0	1	2	3	4
c. Chewing and/or swallowing bite-size foods	0	1	2	3	4
d. Toileting skills related to bladder	0	1	2	3	4
e. Toileting skills related to bowels	0	1	2	3	4
f. Dressing self	0	1	2	3	4
g. Moving around in familiar settings (cottage)	0	1	2	3	4
a. Washing hands	0	1	2	3	4
b. Washing face	0	1	2	3	4
c. Brushing or combing hair	0	1	2	3	4
d. Wiping or blowing nose with tissue	0	1	2	3	4
e. Adjusting water temperature for washing hands or bathing	0	1	2	3	4
f. Tying or fastening velcro on own shoes	0	1	2	3	4
g. Drying entire body after bathing	0	1	2	3	4
a. Making bed	0	1	2	3	4
b. Cleaning room	0	1	2	3	4
c. Doing laundry	0	1	2	3	4
d. Caring for own clothes such as folding or putting them away	0	1	2	3	4
e. Using money	0	1	2	3	4
f. Making or counting change	0	1	2	3	4
a. Using public transportation for a direct trip	0	1	2	3	4
b. Choosing food when shopping for simple meal	0	1	2	3	4
c. Preparing foods that do not require cooking	0	1	2	3	4
d. Using stove or microwave	0	1	2	3	4
e. Washing dishes or loading/unloading dishwasher	0	1	2	3	4
f. Choosing items want to buy	0	1	2	3	4
g. Making minor purchases	0	1	2	3	4
h. Ordering food in public	0	1	2	3	4

8. Which **best** describes the individual's actions with **social-emotional tasks** during the **last 4 weeks**?

	NEVER	OCCASIONALLY	OFTEN
a. Initiates interaction with or responds to a caregiver or staff person by using eye contact, sound, or gesture	0	1	2
b. Initiates interaction with or responds to a peer by using eye contact, sound, or gesture	0	1	2
c. Uses socially acceptable behaviors with others	0	1	2
d. Participates in group games or activities	0	1	2
e. Offers help to other persons	0	1	2
f. Shows respect for others' belongings	0	1	2
g. Shows consideration for others' feelings	0	1	2
h. Gives direction or leadership to others when needed	0	1	2
i. Understands and is able to wait and take turns	0	1	2
j. Maintains proper caution with strangers	0	1	2

9. Please indicate whether the individual has participated in the **last 3 months** in any formal or informal activities or training aimed at improving his/her skills in the following areas. **If he/she has NOT participated for ANY reason,** please indicate whether you believe that the individual could benefit from such activities or training in these areas if they were available.

		PARTICIPATED IN ACTIVITIES AIMED AT…?		**IF NO**, COULD INDIVIDUAL BENEFIT FROM THEM?	
		NO	YES	NO	YES
Interpersonal Relationships					
a.	Improving Social Skills with Peers	0	1	0	1
b.	Improving Relationships with Family	0	1	0	1
Money Skills					
c.	Recognizing Value of Money	0	1	0	1
d.	Making Purchases with Money	0	1	0	1
Recreation					
e.	Developing Personal Recreational Interests	0	1	0	1
f.	Getting Along with Others in Recreation Activities	0	1	0	1
Personal					
g.	Understanding Concept of Privacy	0	1	0	1
h.	Learning about Personal Boundaries/Space	0	1	0	1
i.	Learning to Make Own Decisions or Choices	0	1	0	1
j.	Taking Medications Independently	0	1	0	1
k.	Understanding Appropriate Sexual Behavior	0	1	0	1
l.	Using Proper Personal Hygiene	0	1	0	1
m.	Using Appropriate Anger Management Skills	0	1	0	1

10. First, please indicate whether the individual used the following **COMMUNITY** resources in the **last 3 months. Regardless of whether he/she has gone,** please indicate whether it would be beneficial for these resources to be readily accessible to the individual if he/she moved to **ANY** residence (a community residence or to another DD Center).

		USED IN THE COMMUNITY IN LAST 3 MONTHS?		**FOR ALL RESOURCES LISTED**, WOULD INDIVIDUAL BENEFIT FROM EASY ACCESS IF MOVED?	
		NO	YES	NO	YES
a.	Grocery or Department Store	0	1	0	1
b.	Restaurant	0	1	0	1
c.	Place of Worship (Church/Synagogue)	0	1	0	1
d.	Park	0	1	0	1
e.	Public Transportation	0	1	0	1

11. Which of the following special environmental supports will be necessary, if any, for this individual to live comfortably in **ANY** residence (a community residence or to another DD Center) if he/she moved?

	NO	YES
a. Smoke-free environment	0	1
b. Pet-free environment	0	1
c. Own room	0	1
d. Calm and quiet living environment	0	1
e. Busy and active living environment	0	1
f. Living with people his/her own age	0	1
g. Living with people of his/her own gender (same sex)	0	1
h. Having a day program outside the home or living environment	0	1

Thank you for your assistance!

Appendix C8

STATE OF NEW JERSEY

DEVELOPMENTAL DISABILITIES

NURSING ASSESSMENT FORM (NAF)

Revised 2/22/06

Prepared by DD Planning Institute
New Jersey Institute of Technology

Prepared for State of New Jersey
Division of Developmental Disabilities

Individual Name/
MIS Number

DD Center Name/
Cottage Name

Respondent Name/
Respondent ID Number

Date Completed ____ ____/ ____ ____/ ____ ____

PURPOSE

THIS ASSESSMENT COLLECTS FACTUAL INFORMATION ABOUT THE INDIVIDUAL.

YOU CAN HELP BY ANSWERING SPECIFIC QUESTIONS ABOUT THIS INDIVIDUAL BECAUSE OF YOUR SPECIALIZED EXPERTISE AND TRAINING.

PLEASE COMPLETE THIS FORM ON THE BASIS OF YOUR OBSERVATION OF THE INDIVIDUAL'S RECENT ACTUAL FUNCTIONING OR SITUATION, NOT ON WHAT YOU THINK MIGHT BE POSSIBLE IN THE FUTURE.

THANK YOU FOR YOUR ASSISTANCE.

1. Please indicate whether the individual has been **DIAGNOSED** with any of these developmental disabilities.

		NO	YES
a.	Cerebral Palsy	0	1
b.	Epilepsy/Seizure Disorder	0	1

If has epilepsy/seizure disorder, please indicate the time period since the last seizure.

In Last 3 Months	4-6 Months	7-12 Months	More than a Year
1	2	3	4

c.	Spina Bifida	0	1
d.	Down's Syndrome	0	1

2. Please provide information on the **individual's medical status** by completing the following 3 sections as described below.

   A. Please circle whether or not the individual has had any of the following **DIAGNOSED** conditions or illnesses in the **last 2 years**.

   B. **ONLY IF INDIVIDUAL HAS CURRENT DIAGNOSIS**, circle whether individual has seen or been reviewed by a doctor during the **last 3 months SPECIFICALLY** for this condition.

   C. **ONLY IF INDIVIDUAL HAS CURRENT DIAGNOSIS**, circle whether **THIS CONDITION** needs medical attention by a doctor **more often than once per year**.

		IF HAS CONDITION(S), ANSWER BOTH					
		A. Has Condition?		B. Seen or Reviewed by Doctor in the **Last 3 Months** for this Condition?		C. Condition Needs Medical Attention **More Than Yearly**?	
		NO	YES	NO	YES	NO	YES
a.	**Respiratory Conditions** such as asthma, emphysema, cystic fibrosis?	0	1	0	1	0	1
b.	**Cardiovascular/Circulatory Conditions** such as heart disease, high blood pressure, anemia or other blood disorders?	0	1	0	1	0	1
c.	**Digestive Conditions** such as ulcers, colitis, liver/bowel disorders?	0	1	0	1	0	1
d.	**Swallowing Conditions** such as difficulty swallowing, gastric reflux, aspiration?	0	1	0	1	0	1
e.	**Bladder or Kidney Conditions**?	0	1	0	1	0	1
f.	**Conditions of the Nervous System** such as multiple sclerosis, organic brain syndrome, Parkinson's disease?	0	1	0	1	0	1
g.	**Hormone or Endocrine Conditions** such as diabetes, thyroid problems, hormone replacement therapy?	0	1	0	1	0	1
h.	**Chronic Conditions related to Skin, Hair, or Nails** such as thick toenails, eczema, dermatitis?	0	1	0	1	0	1
i.	**Allergies** such as those for foods, medications, or seasonal?	0	1	0	1	0	1

3. Please indicate whether the individual has been seen by or utilized any of the following health services in the **last 3 months** in any setting for routine or non-routine care.

	NO	YES
a. Been to an Emergency clinic/room in an **outside** hospital?	0	1
b. Stayed overnight in an **outside** hospital?	0	1
c. Seen a podiatrist (specialist for feet) in or outside the DD Center?	0	1

4. Please indicate whether any medical treatments/services have been performed on individual in the **last 3 months** in any setting for routine or non-routine care.

		NO	YES
a.	Use of special bowel or colostomy equipment – not laxatives or enemas?	0	1
b.	Catheterization or catheter care?	0	1
c.	Suctioning at least once a day to remove internal fluids?	0	1
d.	Special breathing or respiratory care (e.g., inhalers or oxygen)?	0	1
e.	Turning or positioning to protect skin integrity?	0	1
f.	Dressing or wound care?	0	1
g.	Dialysis or use of kidney machine?	0	1
h.	Any medications by injection or intravenously, not immunizations?	0	1
i.	Staff assistance due to choking incident(s) (e.g., staff had to clear food from mouth with hand, Heimlich Maneuver, etc.)?	0	1

5. Regardless of where the individual lives, what services might be necessary, if any, from these health care professionals?

		None Needed	Needed On An Occasional Basis	Needed On a Frequent Basis
a.	Podiatrist (specialist for feet)	1	2	3
b.	Nursing	1	2	3
c.	Physician (General Practice)	1	2	3

6. Which answer best describes the individual's **vision** in the **last 4 weeks**?

IF WEARS GLASSES, INDICATE STATUS OF VISION WITH GLASSES.

1. Normal range
2. Mild impairment (color blind or has difficulty seeing small objects)
3. Moderate impairment (has trouble with depth perception, seeing curbs, or recognizing people by sight, blind in one eye, etc.)
4. Severe impairment (sees only light or shadow)
5. Profound impairment (total blindness)

7. Please indicate any **adaptive or special equipment** that the individual used at any time in the **last 3 months**.

IF PRESCRIBED, BUT NOT USED BY INDIVIDUAL IN THE LAST 3 MONTHS, ANSWER "NO."

		NO	YES
a.	Glasses or other visual aids?	0	1
b.	Helmet?	0	1

8. Please indicate whether individual has taken any of the following types of prescription medications in the **last 3 months**.

(If do not know medication classifications, simply list all medications taken in the **last 3 months** on the bottom of the page. PLEASE PRINT.)

	NO	YES
a. Antidepressants? (e.g., Lithium, Elavil)	0	1
b. Antipsychotics? (e.g., Thorazine, Mellaril, Haldol)	0	1
c. Antianxiety agents for spasticity or behavior control? (e.g., Librium, Valium)	0	1
d. Anti-seizure medications for seizure or behavioral control? (e.g., Tegretol, Phenobarbital, Dilantin)	0	1

e. If the individual is taking any of the medication types (a-d) listed above, please indicate date of **last** medication review here

___ ___/ ___ ___/ ___ ___

f. Diabetes medications? (e.g., Insulin)	0	1

If you do not know medication classifications, simply list medications taken in the **last 3 months** here. Dosages and administration times are not needed. PLEASE PRINT.

Thank you for your assistance!

STATE OF NEW JERSEY

DEVELOPMENTAL DISABILITIES

NUTRITION ASSESSMENT FORM (NAF)

Revised 3/9/06

Prepared by DD Planning Institute
New Jersey Institute of Technology

Prepared for State of New Jersey
Division of Developmental Disabilities

Individual Name/
MIS Number

DD Center Name/
Cottage Name

Respondent Name/
Respondent ID Number

Date Completed ____ ____/ ____ ____/ ____ ____

PURPOSE

THIS ASSESSMENT COLLECTS FACTUAL INFORMATION ABOUT THE INDIVIDUAL.

YOU CAN HELP BY ANSWERING SPECIFIC QUESTIONS ABOUT THIS INDIVIDUAL BECAUSE OF YOUR SPECIALIZED EXPERTISE AND TRAINING.

PLEASE COMPLETE THIS FORM ON THE BASIS OF YOUR OBSERVATION OF THE INDIVIDUAL'S RECENT ACTUAL FUNCTIONING OR SITUATION, NOT ON WHAT YOU THINK MIGHT BE POSSIBLE IN THE FUTURE.

THANK YOU FOR YOUR ASSISTANCE.

1. Please indicate whether any special services have been performed for the individual in the **last 3 months.**

	NO	YES
a. Any increases in fluids?	0	1
b. Tube feeding?	0	1
(Answer c-d for all individuals who receive food by mouth. If tube fed only – skip c-d.)		
c. Special food preparation (e.g., pureed, chopped)?	0	1
d. Special dietary foods or restrictions (e.g., low salt)?	0	1

2. Regardless of where the individual lives, what services, if any, might be necessary from a dietitian for a specialized diet?

    1. None Needed
    2. Needed on an Occasional Basis
    3. Needed on a Frequent Basis

Thank you for your assistance!

STATE OF NEW JERSEY

DEVELOPMENTAL DISABILITIES

OCCUPATIONAL THERAPY ASSESSMENT FORM (OTAF)

Revised 3/9/06

Prepared by DD Planning Institute
New Jersey Institute of Technology

Prepared for State of New Jersey
Division of Developmental Disabilities

Individual Name/
MIS Number

DD Center Name/
Cottage Name

Respondent Name/
Respondent ID Number

Date Completed ____ ____/ ____ ____/ ____ ____

PURPOSE

THIS ASSESSMENT COLLECTS FACTUAL INFORMATION ABOUT THE INDIVIDUAL.

YOU CAN HELP BY ANSWERING SPECIFIC QUESTIONS ABOUT THIS INDIVIDUAL BECAUSE OF YOUR SPECIALIZED EXPERTISE AND TRAINING.

PLEASE COMPLETE THIS FORM ON THE BASIS OF YOUR OBSERVATION OF THE INDIVIDUAL'S RECENT ACTUAL FUNCTIONING OR SITUATION, NOT ON WHAT YOU THINK MIGHT BE POSSIBLE IN THE FUTURE.

THANK YOU FOR YOUR ASSISTANCE.

		NO	YES
1.	Has the individual used adaptive eating equipment (e.g., plate guard, special utensils, not feeding tube) at any time in the **last 3 months**? IF PRESCRIBED, BUT NOT USED BY INDIVIDUAL IN THE LAST 3 MONTHS, ANSWER "NO."	0	1

2. Which of the following special environmental supports would be beneficial, if any, if this individual lived in **ANY** residence (a community residence or to another DD Center)?

		NO	YES
a.	Adaptations for the visually impaired	0	1
b.	Adaptations for the physically impaired such as:		
	to open/close doors	0	1
	to turn on/off lights	0	1
	to turn on/off faucets	0	1
	to flush toilets	0	1
	to access cabinets and closets	0	1
	to use the stove	0	1

3. Which of the following special environmental supports will be necessary, if any, for this individual to live comfortably in **ANY** residence (a community residence or to another DD Center)?

	NO	YES
a. Wheelchair access to get into the home	0	1
b. Ranch-style home or living environment without stairs	0	1

	NO	YES
4. Please indicate whether the individual has received occupational therapy in the **last 3 months** in any setting.	0	1

5. Regardless of where the individual lives, what level of service would be necessary from an occupational therapist based on the individual's current functioning?

    1. None Needed
    2. Needed on an Occasional Basis
    3. Needed on a Frequent Basis

Thank you for your assistance!

STATE OF NEW JERSEY

DEVELOPMENTAL DISABILITIES

PHYSICAL THERAPY ASSESSMENT FORM (PTAF)

Revised 3/9/06

Prepared by DD Planning Institute
New Jersey Institute of Technology

Prepared for State of New Jersey
Division of Developmental Disabilities

Individual Name/
MIS Number

DD Center Name/
Cottage Name

Respondent Name/
Respondent ID Number

Date Completed ____ ____/ ____ ____/ ____ ____

PURPOSE

THIS ASSESSMENT COLLECTS FACTUAL INFORMATION ABOUT THE INDIVIDUAL.

YOU CAN HELP BY ANSWERING SPECIFIC QUESTIONS ABOUT THIS INDIVIDUAL BECAUSE OF YOUR SPECIALIZED EXPERTISE AND TRAINING.

PLEASE COMPLETE THIS FORM ON THE BASIS OF YOUR OBSERVATION OF THE INDIVIDUAL'S RECENT ACTUAL FUNCTIONING OR SITUATION, NOT ON WHAT YOU THINK MIGHT BE POSSIBLE IN THE FUTURE.

THANK YOU FOR YOUR ASSISTANCE.

1. Please provide information on the **individual's medical status** by completing the following 3 sections as described below.

   A. Please circle whether or not the individual has had the following **DIAGNOSED** condition or illness in the **last 2 years**.

   B. **ONLY IF INDIVIDUAL HAS CURRENT DIAGNOSIS,** circle whether individual has seen or been reviewed by a doctor during the **last 3 months SPECIFICALLY** for this condition.

   C. **ONLY IF INDIVIDUAL HAS CURRENT DIAGNOSIS,** circle whether **THIS CONDITION** needs medical attention by a doctor **more often than once per year.**

	A. Has Condition?		IF HAS CONDITION(S), ANSWER BOTH			
			B. Seen or Reviewed by Doctor in the **Last 3 Months** for this Condition?		C. Condition Needs Medical Attention **More Than Yearly**?	
	NO	YES	NO	YES	NO	YES
Muscular-Skeletal Conditions such as muscular difficulties with the arms and/or legs, arthritis, osteoporosis?	0	1	0	1	0	1

2. Which best describes the individual's **mobility** with each of the following tasks in the **last 4 weeks**?

	NOT ABLE	NEEDED HELP	INDEPENDENTLY
a. Rolling from back to stomach	0	1	2
b. Pulling self to standing	0	1	2
c. Going up stairs	0	1	2
d. Going down stairs	0	1	2
e. Picking up small objects	0	1	2
f. Transferring an object from hand to hand	0	1	2
g. Crawling, creeping, or scooting such as getting something from under a bed or chair	0	1	2
h. Sitting without support such as on a stool or piano bench for at least 5 minutes	0	1	2

3. Which answer **best** describes the individual's level of **walking** mobility in the **last 4 weeks**?

0. Can not walk by self or with assistance
1. Walks only with assistance from another person (with or without a corrective device)
2. Walks independently with corrective device (walker, crutches, brace)
3. Walks independently, but with difficulty (no corrective device)
4. Walks independently

4. Does the individual use a wheelchair or electric scooter?

   0. Yes, uses at all times (if yes, go to question #5)
   1. Yes, uses for long trips or as needed (if yes, go to question #5)
   2. No, does not use (if no, go to question #8)

5. Please indicate which of the following have been used by the individual in the **last 4 weeks**.

   IF PRESCRIBED, BUT NOT USED BY INDIVIDUAL IN THE LAST 4 WEEKS, ANSWER "NO."

	NO	YES
a. Non-motorized Wheelchair	0	1
b. Motorized Wheelchair	0	1
c. Electric Scooter	0	1

6. Which answer **best** describes the individual's ability to **transfer himself/herself** in or out of the wheelchair/scooter?

   0. Regularly required 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 or to be lifted by one other person when transferring
   2. Needs only minimal assistance from one other person when transferring
   3. Can transfer independently without assistance

7. Which **best** describes the individual's ability to **move his/her wheelchair/scooter** from place to place?

   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 distances

	NO	YES
8. Please indicate whether the individual has received physical therapy in the **last 3 months** in any setting.	0	1

9. Regardless of where the individual lives, what services might be necessary, if any, from a physical therapist?

    1. None Needed
    2. Needed on an Occasional Basis
    3. Needed on a Frequent Basis

10. Please indicate any **adaptive or special equipment** that the individual used at any time in the l**ast 3 months**.

IF PRESCRIBED, BUT NOT USED BY INDIVIDUAL IN THE LAST 3 MONTHS, ANSWER "NO."

		NO	YES
a.	Walker?	0	1
b.	Crutches or cane?	0	1
c.	Brace/splint?	0	1
d.	Orthopedic shoes?	0	1
e.	Special Bed or Bed Modifications? (e.g., side rails, special mattress, elevation)	0	1

Thank you for your assistance!

STATE OF NEW JERSEY

DEVELOPMENTAL DISABILITIES

PSYCHOLOGY ASSESSMENT FORM (PAF)

Revised 3/9/06

Prepared by DD Planning Institute
New Jersey Institute of Technology

Prepared for State of New Jersey
Division of Developmental Disabilities

Individual Name/
MIS Number

DD Center Name/
Cottage Name

Respondent Name/
Respondent ID Number

Date Completed ____ ____/ ____ ____/ ____ ____

PURPOSE

THIS ASSESSMENT COLLECTS FACTUAL INFORMATION ABOUT THE INDIVIDUAL.

YOU CAN HELP BY ANSWERING SPECIFIC QUESTIONS ABOUT THIS INDIVIDUAL BECAUSE OF YOUR SPECIALIZED EXPERTISE AND TRAINING.

PLEASE COMPLETE THIS FORM ON THE BASIS OF YOUR OBSERVATION OF THE INDIVIDUAL'S RECENT ACTUAL FUNCTIONING OR SITUATION, NOT ON WHAT YOU THINK MIGHT BE POSSIBLE IN THE FUTURE.

THANK YOU FOR YOUR ASSISTANCE.

1. Please indicate whether the individual has been **DIAGNOSED** with any of these conditions.

	NO	YES
a. Autism	0	1
b. Psychiatric/Mental Health Problem with Diagnosis (This does not include Mental Retardation, Pervasive Developmental Disorder, or Autism)	0	1
If yes, indicate specific diagnosis _____		
c. Prader-Willi Syndrome	0	1

2. Which **best** indicates the frequency, on average, of these behaviors during the **last 6 months**?

A. Inappropriate or Rule-Violating Behaviors (Circle for each behavior.)

	Not in Last 6 Months	Less than Once/Month	Once/ Month	Once/ Week	Several Times/ Week	Once/ Day or More
a. Has Tantrums or Outbursts	0	1	2	3	4	5
b. Displays Sexual Predatory Behavior(s)	0	1	2	3	4	5
c. Masturbates in Public	0	1	2	3	4	5
d. Sexually Touches Others Without Their Consent	0	1	2	3	4	5
e. Displays Self-Stimulating Behavior (such as Body Rocking or Hand Flashing)	0	1	2	3	4	5
f. Takes Off Clothes in Public	0	1	2	3	4	5
g. Smears Feces	0	1	2	3	4	5
h. Makes Noises, Curses, or Other Inappropriate Vocalizations	0	1	2	3	4	5
i. Disrupts Activities of Others	0	1	2	3	4	5

Which **best** indicates the frequency, on average, of these behaviors during the **last 6 months**?

A. Inappropriate or Rule-Violating Behaviors (cont.) (Circle for each behavior.)

	Not in Last 6 Months	Less than Once/Month	Once/ Month	Once/ Week	Several Times/ Week	Once/ Day or More
j. Does Not Obey Known Directions (Non-Compliant)	0	1	2	3	4	5
k. Other _____	0	1	2	3	4	5

B. Behaviors Dangerous to Self (Circle for each behavior.)

	Not in Last 6 Months	Less than Once/Month	Once/ Month	Once/ Week	Several Times/ Week	Once/ Day or More
a. Runs Away/Wanders	0	1	2	3	4	5
b. Repeatedly Gets Out of Bed at Night	0	1	2	3	4	5
c. Eats or Mouths Inedible Objects	0	1	2	3	4	5
d. Scratches Own Body	0	1	2	3	4	5
e. Hits Own Body	0	1	2	3	4	5
f. Hits Own Face or Head	0	1	2	3	4	5
g. Bangs Head	0	1	2	3	4	5
h. Bites Self	0	1	2	3	4	5
i. Other _____	0	1	2	3	4	5

C. Behaviors Dangerous to Others (Circle for each behavior.)

	Not in Last 6 Months	Less than Once/Month	Once/ Month	Once/ Week	Several Times/ Week	Once/ Day or More
a. Verbally Threatens Others	0	1	2	3	4	5
b. Physically Threatens Others	0	1	2	3	4	5
c. Hits Others	0	1	2	3	4	5
d. Kicks Others	0	1	2	3	4	5
e. Uses Objects to Harm Others	0	1	2	3	4	5
f. Bites Others	0	1	2	3	4	5
g. Grabs or Scratches Others	0	1	2	3	4	5
h. Head-Butts Others	0	1	2	3	4	5
i. Pulls Hair of Others	0	1	2	3	4	5
j. Chokes or Attempts to Choke Others	0	1	2	3	4	5
k. Other _____	0	1	2	3	4	5

D. Other

	Not in Last 6 Months	Less than Once/Month	Once/ Month	Once/ Week	Several Times/ Week	Once/ Day or More
a. Individual is Target or Victim of Inappropriate Behavior by Others	0	1	2	3	4	5

3. As a result of **any** behavior problem(s), please indicate whether any of the following have occurred **in last 6 months.**

	NO	YES
a. Have any behavioral problems prevented this individual from moving to a less supervised or less restrictive building, section of a building, or cottage?	0	1
b. Have any specific behavioral modification/support procedures **actually** been used?	0	1
c. Has the individual's environment been carefully structured due to behavior?	0	1
d. Has the staff sometime intervened physically - by physical or mechanical restraint - or to guide individual out of a room?	0	1
e. Was a supervised time-out needed to an area within or outside the room?	0	1
f. Did the individual require one-on-one supervision due to behavioral issues?	0	1
g. Were any medications increased or used as needed (prn) to reduce/control behaviors?	0	1

4. Please indicate whether the individual has been seen by any of the following professionals in the **last 6 months** in any setting for routine or non-routine care.

	NO	YES
a. Seen a psychiatrist?	0	1
b. Seen a behavior specialist (such as a behavioral analyst)?	0	1
c. Seen a psychologist for counseling or behavior management?	0	1

5. Regardless of where the individual lives, what services might be necessary, if any, from these specialists?

		None Needed	Needed On An Occasional Basis	Needed On a Frequent Basis
a.	Behavior Specialist	1	2	3
b.	Psychiatrist	1	2	3
c.	Psychotherapy or Counseling	1	2	3

6. Regardless of where the individual lives, what level of **behavioral monitoring and support** will be necessary to reduce risk of harm to self or others? This behavioral monitoring and support may be due to **either** inappropriate behaviors that the individual would exhibit or behaviors that would result due to his/her lack of awareness of danger.

	None	Periodic Visual Checks	Within Constant Eyesight	Within Constant Eyesight AND Physically Near
1. Inside the Cottage/Home	0	1	2	3
2. When Using the Bathroom	0	1	2	3
3. By Himself/Herself	0	1	2	3
4. Sitting Outside Cottage/Home	0	1	2	3
5. Crossing a Street with Traffic	0	1	2	3
6. Inside a Store or Restaurant	0	1	2	3
7. Around Other People's Possessions	0	1	2	3
8. With Strangers	0	1	2	3
9. With Small Children	0	1	2	3
10. With People of the Opposite Sex	0	1	2	3
11. With People of the Same Sex	0	1	2	3
12. When Sleeping	0	1	2	3
13. In Group Leisure Activities	0	1	2	3
14. Other _____	0	1	2	3

Thank you for your assistance!

Appendix C31

STATE OF NEW JERSEY

DEVELOPMENTAL DISABILITIES

SOCIAL WORK ASSESSMENT FORM (SWAF)

Revised 2/22/06

Prepared by DD Planning Institute
New Jersey Institute of Technology

Prepared for State of New Jersey
Division of Developmental Disabilities

Individual Name/
MIS Number

DD Center Name/
Cottage Name

Respondent Name/
Respondent ID Number

Date Completed ____ ____/ ____ ____/ ____ ____

PURPOSE

THIS ASSESSMENT COLLECTS FACTUAL INFORMATION ABOUT THE INDIVIDUAL.

YOU CAN HELP BY ANSWERING SPECIFIC QUESTIONS ABOUT THIS INDIVIDUAL BECAUSE OF YOUR SPECIALIZED EXPERTISE AND TRAINING.

PLEASE COMPLETE THIS FORM ON THE BASIS OF YOUR OBSERVATION OF THE INDIVIDUAL'S RECENT ACTUAL SITUATION, NOT ON WHAT YOU THINK MIGHT BE POSSIBLE IN THE FUTURE.

THANK YOU FOR YOUR ASSISTANCE.

		NO	YES
1.	Is the individual **currently** on a status of probation, county or state parole, or commitment relating to a criminal type of offense?	0	1
2.	Is the individual **currently** considered to be his/her own guardian for medical and legal decisions?	0	1

If yes, which best describes his/her status?

1. Individual has been determined as capable of being his/her own guardian.
2. Individual is of legal age and no change is guardianship is being considered at this time.
3. Guardianship is in process of being determined (paperwork being processed).

If guardianship is in process, who is likely to be appointed the individual's guardian?

1. Bureau of Guardianship Services (BGS)
2. Relative(s) of the Individual
3. Other (Specify:_____)

If no, who is his/her guardian?

1. Guardian is the Bureau of Guardianship Services (BGS).
2. Guardian is relative of the individual.
3. Guardian is someone other than BGS or relative.
   (Specify:_____)

		NO	YES
3.	If there was a medical or any other type of emergency, does the individual have family members (including those who may be his/her guardian) who would need to be notified?	0	1

4. Please indicate whether the individual has had contact by letter, phone, or visits within the **last 3 months** with **any** known family members. Indicate "no" for each question if there are no known family members.

	NO	YES
a. In the **last 3 months,** has the family written or e-mailed the individual or the staff that work in his/her residential setting? Include contacts from all family members.	0	1
b. In the **last 3 months,** has the family talked on the phone with the individual or the staff that work in his/her residential setting? Include contacts from all family members.	0	1
c. In the **last 3 months,** has the family seen or visited the individual? Include contacts from all family members.	0	1
d. In the **last 3 months,** has the individual visited overnight with the family? Include overnight visits at any family member's home.	0	1

5. In which of the following counties in New Jersey, does the individual's **PRIMARY** family contact live?
(Indicate place of residence of family member who serves as guardian, if applicable, if more than one family member is very active.)

0. Out of State
1. Atlantic
2. Bergen
3. Burlington
4. Cape May
5. Camden
6. Cumberland
7. Essex
8. Gloucester
9. Hudson
10. Hunterdon
11. Mercer
12. Middlesex
13. Monmouth
14. Morris
15. Ocean
16. Passaic
17. Salem
18. Somerset
19. Sussex
20. Union
21. Warren
22. No Known Family

Write in name of town here if you are unsure of the county location:

_____

6. Is community placement **currently** recommended in the individual's most recent IHP by the interdisciplinary team (IDT) comprised of DD Center professionals?

ANSWER THIS QUESTION SOLELY BASED ON THE JUDGMENTS OF THE DD CENTER PROFESSIONALS.

0. No
1. Yes
2. Not Sure

7. **To the best of your knowledge,** has the individual visited a community residence (e.g., a group home) in the **last 5 years**?

0. No
1. Yes

8. If the **INDIVIDUAL** were given a **CHOICE,** would he/she want to move out of this DD Center **within the next year**? DO not assess whether you or others feel that the individual's preference is appropriate or realistic. Simply indicate the individual's choice below.

0. INDIVIDUAL HAS NO KNOWN PREFERENCE OR IS UNABLE TO EXPRESS

1. YES – INDIVIDUAL DOES WANT TO MOVE

If yes, to where would the individual **MOST** want to move?

a. Home with family
b. To a community residence
c. To another DD Center
d. To some other residence (Specify:_____)

2. NO – INDIVIDUAL DOES NOT WANT TO MOVE

9. If he/she moved to a community residence or to another DD Center, **WOULD THIS INDIVIDUAL HAVE PREFERENCES** in any of the following areas of choice? Do not consider whether you or others feel that these individual preferences are appropriate or consider family wishes when answering these questions. Simply indicate the extent to which you believe that the **INDIVIDUAL** would have preferences in these areas.

		NO *PREFERENCE*	SLIGHT *PREFERENCE*	STRONG *PREFERENCE*
a.	Geographic area (county/town) where to live	0	1	2
b.	Who to live with	0	1	2
c.	Who to live near	0	1	2
d.	Room alone or with others	0	1	2
e.	Number of persons in residence	0	1	2
f.	Type of atmosphere in residence (busy, quiet, active)	0	1	2
g.	Type of community services which were readily available (stores, church, park, etc.)	0	1	2
h.	Whether the residence is smoking or non-smoking	0	1	2
i.	Type of day program that would attend or work	0	1	2

10. Would the **FAMILY** be in favor of the individual moving out of this DD Center **within the next year**?

0. NOT APPLICABLE – NO KNOWN FAMILY

1. FAMILY HAS NO KNOWN PREFERENCE

2. YES – FAMILY DOES WANT INDIVIDUAL TO MOVE

If yes, to where would the family **MOST** want the individual to move?

a. Home with family
b. To a community residence
c. To another DD Center
d. To some other residence (Specify:_____)

3. NO – FAMILY DOES NOT WANT INDIVIDUAL TO MOVE

Thank you for your assistance!

STATE OF NEW JERSEY

DEVELOPMENTAL DISABILITIES

SPEECH ASSESSMENT FORM (SPAF)

Revised 3/9/06

Prepared by DD Planning Institute
New Jersey Institute of Technology

Prepared for State of New Jersey
Division of Developmental Disabilities

Individual Name/
MIS Number

DD Center Name/
Cottage Name

Respondent Name/
Respondent ID Number

Date Completed ____ ____/ ____ ____/ ____ ____

PURPOSE

THIS ASSESSMENT COLLECTS FACTUAL INFORMATION ABOUT THE INDIVIDUAL.

YOU CAN HELP BY ANSWERING SPECIFIC QUESTIONS ABOUT THIS INDIVIDUAL BECAUSE OF YOUR SPECIALIZED EXPERTISE AND TRAINING.

PLEASE COMPLETE THIS FORM ON THE BASIS OF YOUR OBSERVATION OF THE INDIVIDUAL'S RECENT ACTUAL FUNCTIONING OR SITUATION, NOT ON WHAT YOU THINK MIGHT BE POSSIBLE IN THE FUTURE.

THANK YOU FOR YOUR ASSISTANCE.

1. Indicate whether the individual **has done** each of the following **communication** tasks in the **last 4 weeks.**

A. Receptive Communication	NO	YES
a. Does (name) respond to his/her name when it is spoken or signed?	0	1
b. Does (name) understand the meaning of "yes" and "no"?"	0	1
c. Does (name) understand a one-step direction such as "Look at me"?	0	1
d. Does (name) understand a two-step directions such as "Turn your head and look at me"?	0	1
e. Does (name) understand a joke or story?	0	1

B. Expressive Communication	NO	YES
a. Uses **at least a few** simple words or signs to name specific objects like clothing or food?	0	1
b. Uses **many** simple words or signs to name specific objects like clothing or food?	0	1
c. Asks simple questions using words or signs?	0	1
d. Uses complete sentences when carrying on a conversation?	0	1
e. Tells a simple story such as about a television show?	0	1

Indicate whether the individual **has done** each of the following **communication** tasks in the **last 4 weeks.**

C. Clarity of Verbal Speech	NO	YES
a. Says "yes" or "no" to a simple question?	0	1
b. Is his/her speech easily understood by strangers?	0	1
c. Is his/her speech easily understood by those who know him/her well?	0	1

2. Has the individual received speech therapy in the **last 3 months** in any setting? 0 1

3. Regardless of where the individual lives, what services might be necessary, if any, from a speech therapist (for either speech or dysphagia)?

1. None Needed
2. Needed on an Occasional Basis
3. Needed on a Frequent Basis

	NO	YES
4. Has the individual used a picture book or any other communication device at any time in the l**ast 3 months**? IF PRESCRIBED, BUT NOT USED BY INDIVIDUAL IN THE LAST 3 MONTHS, ANSWER "NO."	0	1
5. If a picture book or any other communication device were made available In his/her living environment, could the individual benefit from using it?	0	1
6. Has the individual used a hearing aid at any time in the l**ast 3 months**? IF PRESCRIBED, BUT NOT USED BY INDIVIDUAL IN THE LAST 3 MONTHS, ANSWER "NO."	0	1

7. Which answer best describes the individual's **hearing** in the **last 4 weeks**?

IF USES HEARING AID, INDICATE STATUS OF HEARING WITH AID.

1. Normal range
2. Mild loss (often difficult to hear normal speech)
3. Moderate loss (have to turn up the TV or speak loudly to hear, deaf in one ear, etc.)
4. Severe loss (can hear only if someone is shouting)
5. Profound loss (can't hear)

8. Please provide information on any **swallowing conditions** that the individual might have by completing the following 3 sections as described below.

   A. Please circle whether or not the individual has had the following **DIAGNOSED** condition or illness in the **last 2 years**.

   B. **ONLY IF INDIVIDUAL HAS CURRENT DIAGNOSIS,** circle whether individual has seen or been reviewed by a doctor during the **last 3 months SPECIFICALLY** for this condition.

   C. **ONLY IF INDIVIDUAL HAS CURRENT DIAGNOSIS,** circle whether **THIS CONDITION** needs medical attention by a doctor **more often than once per year.**

	A. Has Condition?		IF HAS CONDITION(S), ANSWER BOTH			
			B. Seen or Reviewed by Doctor in the **Last 3 Months** for this Condition?		C. Condition Needs Medical Attention **More Than Yearly**?	
	NO	YES	NO	YES	NO	YES
Swallowing Conditions such as difficulty swallowing, gastric reflux, aspiration?	0	1	0	1	0	1

	NO	YES
9. Has the individual had to be physically fed with utensils by staff or others in the **last 3 months** in any setting?	0	1

THIS QUESTION ASKS ABOUT PHSYCIAL ASSISTANCE WITH FEEDINGS USING ONE'S MOUTH.
IF NO FOOD IS GIVEN BY MOUTH, ANSWER "NO."

Thank you for your assistance!

Appendix D1:
Demographic Information, Support Needs and Preferences

Some of the basic demographic information, support needs and preferences of individuals derived from the assessment of people living in the developmental centers, are below. Findings from all people living in the DCs, the group of 1,005 where the IDT, individual, and family have no opposition to the person moving to a community setting, the 1,298 people where IDT and individual do not oppose and the family opposes community placement, 154 people where IDT does not oppose and individual opposes community placement, and the 582 people where the IDT does not recommend community placement are provided for comparison.

	All People Living in the Centers	1,005 People Where IDT, Individual and Family Do Not Oppose Community Placement	1,298 People Where IDT and Individual Do Not Oppose and Family Opposes Community Placement	154 People Where IDT Does Not Oppose and Individual Opposes Community Placement	582 People Where IDT Does Not Recommend Community Placement
Average Age (Years)	50.1	48.8	50.1	56.2	51.0
% Female	40%	42%	39%	36%	40%
% with a Psychiatric Diagnosis	53%	57%	42%	69%	67%
% with Cerebral Palsy	25%	24%	12%	21%	20%
% with History of Epilepsy	52%	49%	57%	44%	44%
% with Active Epilepsy.	21%	18%	26%	21. %	17%
% with Autism	14%	16%	12%	10%	18%
% with Visual Impairment	43%	39%	49%	42%	36%
% with Health Conditions involving the cardiovascular/circulatory, digestive, muscular/skeletal or epidermal systems.	40 – 62%, depending on the condition.	40 - 60%, depending on the condition.	36 – 57%, depending on the condition.	47 - 62%, depending on the condition.	33 - 55%, depending on the condition.
% Using a Behavioral Specialist	29%	39%	21%	21%	34%

Appendix D2:
Demographic Information, Support Needs and Preferences (continued)

	All People Living in the Centers	1,005 People Where IDT, Individual and Family Do Not Oppose Community Placement	1,298 People Where IDT and Individual Do Not Oppose and Family Opposes Community Placement	154 People Where IDT Does Not Oppose and Individual Opposes Community Placement	582 People Where IDT Does Not Recommend Community Placement
% with special dietary requirements or special food preparation.	65 – 71%, depending on the supports needed.	61 – 74%, depending on the supports needed.	68 – 71%, depending on the supports needed.	53 - 78%, depending on the supports needed.	60 - 71%, depending on the supports needed.
% needing regular assistance turning or positioning the body.	20%	18%	21%	21%	17%
% using a wheelchair.	47%	45%	53%	44%	39%
% using physical therapy.	24%	23%	20%	34%	32%
% taking psychotropic medication.	37%	40%	28%	48%	48%
% who could benefit from environmental adaptations in lighting, cabinets, closets, faucets or doors.	19 – 25%, depending on the environmental adaptation.	14 – 21%, depending on the environmental adaptation.	23 – 30%, depending on the environmental adaptation.	31 – 34%, depending on the environmental adaptation.	9 – 15%, depending on the environmental adaptation.
% with personal preferences, such as who they, having their own room, a smoke free home or a calm/quiet home.	36 – 53%, depending on the preference.	32 – 47%, depending on the preference.	30 – 55%, depending on the preference.	69 – 80%, depending on the preference.	43 – 50%, depending on the preference.

Self Care Support Needs

DDD Individualized Resource Tool
Level 1 to 4

The Individual Resource tool is a scientific instrument designed to gauge in general "how much" service a person needs and how much DDD funding will be allocated. The resource tool is designed on a model that assumes that the less an individual's capacity for self care the more s/he will need the assistance of others. Services and/or resources can be differentially allocated to these levels to ensure equity in system.

Level I

Lowest Support Time Needed, Highest Self Care Score

Description: A majority of people can do all activities of daily living, but may need help with public transportation.

Level II

Low Support Time Needed, Medium Self Care Score

Description: A majority of people can eat, drink, toilet, care for clothing, make bed, clean room, use microwave, prepare foods, and wash dishes. Not able to shop, count change, or do laundry.

Level III

Medium Support Time Needed, Low Self Care Score

Description: A majority of people can eat, drink, toilet, and dress. Not able to care for own clothing, use money, or count change. Caregivers spend a lot of time supporting individuals.

Level IV

High Support Time Needed, Lowest Self Care Score

Description: Many people may not be able to do anything for themselves, but a majority can eat and drink. Unable to toilet or dress themselves. Caregivers spend most time providing support

Appendix E2:
Levels of Self Care Support Need

Percentage of people in the Levels of Self Care Support Need, derived from the assessment of people living in the developmental centers, are below. Findings from all people living in the DCs, the group of 1,005 where the IDT, individual, and family have no opposition to the person moving to a community setting, the 1,298 people where IDT and individual do not oppose and the family opposes community placement, 154 people where IDT does not oppose and individual opposes community placement, and the 582 people where the IDT does not recommend community placement are provided for comparison.

Self Care Support Need	All People Living in the Centers (%)	1,005 People Where IDT, Individual and Family Do Not Oppose Community Placement (%)	1,298 People Where IDT and Individual Do Not Oppose and Family Opposes Community Placement (%)	154 People Where IDT Does Not Oppose and Individual Opposes Community Placement (%)	582 People Where IDT Does Not Recommend Community Placement (%)
Lowest Level of Need (Level 1)	10.1%	13.6%	3.9%	18.8%	15.3%
Low Level of Need (Level 2)	16.8%	16.3%	14.2%	38.3%	17.5%
Medium Level of Need (Level 3)	34.4%	30.9%	40.8%	28.6%	27.7%
High Level of Need (Level 4)	38.7%	39.0%	41.1%	14.3%	39.2%

Appendix F

Medical and Behavioral Supports Levels Table

Medical Supports

Level 1: No On-Site Specialized Medical and No Ambulation Support Required Persons may have one or more medical conditions (i.e., high blood pressure, asthma, ulcers, etc.), but no special medical attention is needed on-site besides that normally provided by day and residential support staff such as, but not limited to, medication administration, scheduling of medical appointments, transportation to doctor's appointments, etc. Persons are able to walk independently with or without corrective devices and/or independently use wheelchairs – needing no assistance transferring or moving from place to place.	Level 2: No On-Site Specialized Medical, but Ambulation Support Required Persons may have one or more medical conditions (i.e., high blood pressure, asthma, ulcers, etc.), but no special medical attention is needed on-site besides that normally provided by day and residential support staff such as, but not limited to, medication administration, scheduling of medical appointments, transportation to doctor's appointments, etc. However, Persons can walk only with assistance from another person and/or use wheelchairs and need assistance from staff when transferring and/or moving from place to place.
Level 3: Specialized Medical Supports Required, but No Ambulation Support Required Persons have one or more medical conditions (i.e., respiratory, digestive, cardiovascular, etc.) and these conditions require special medical attention by on-site day and residential staff (non-nursing) who have received appropriate training. Treatments may include, but are not limited to, dressing or wound care; catheter or colostomy emptying and maintenance; monitoring of oxygen use; insulin administration; turning and positioning; use of Epi Pen for allergic reactions; and administration of enemas. Agency is responsible for providing and maintaining the appropriate medical training for staff. Training may be accessed through and/or provided by local Visiting Nurses' Associations (VNAs), agency nurses, hospitals, Persons' physicians, etc. Persons are able to walk independently with or without corrective devices and/or independently use wheelchairs – needing no assistance transferring or moving from place to place	Level 4: Specialized Medical and Ambulation Support Required Persons have one or more medical conditions (i.e., respiratory, digestive, cardiovascular, etc.) and these conditions require special medical attention by on-site day and residential staff (non-nursing) who have received appropriate training. Treatments may include, but are not limited to, dressing or wound care; catheter or colostomy emptying and maintenance; monitoring of oxygen use; insulin administration; turning and positioning; use of Epi Pen for allergic reactions; and administration of enemas. Agency is responsible for providing and maintaining the appropriate medical training for staff. Training may be accessed through and/or provided by local Visiting Nurses' Associations (VNAs), agency nurses, hospitals, Persons' physicians, etc. Persons can walk only with assistance from another person and/or use wheelchairs and need assistance from staff when transferring and/or moving from place to place.
Level 5: Specialized On-Site Nursing, but No Ambulation Support Required Persons have one or more medical conditions (i.e., respiratory, digestive, cardiovascular, etc.) and these conditions require on-site nursing care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Treatments may include, but are not limited to: oral and/or nasal suctioning; Intravenous medications; tube feeding; and catheterization. Nurses may also be responsible for overseeing medication administration, and medical management of Person care with off-site medical providers. Agency is responsible for providing and maintaining the appropriate medical training for staff. Training may be accessed through and/or provided by local Visiting Nurses' Associations (VNAs), agency nurses, hospitals, Persons' physicians, etc. Persons are able to walk independently with or without corrective devices and/or independently use wheelchairs – needing no assistance transferring or moving from place to place.	Level 6: Specialized On-Site Nursing and Ambulation Support Required Persons have one or more medical conditions (i.e., respiratory, digestive, cardiovascular, etc.) and these conditions require on-site nursing care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Treatments may include, but are not limited to: oral and/or nasal suctioning; Intravenous medications; tube feeding; and catheterization. Nurses may also be responsible for overseeing medication administration, and medical management of Person care with off-site medical providers. Agency is responsible for providing and maintaining the appropriate medical training for staff. Training may be accessed through and/or provided by local Visiting Nurses' Associations (VNAs), agency nurses, hospitals, Persons' physicians, etc. Persons can walk only with assistance from another person and/or use wheelchairs and need assistance from staff when transferring and/or moving from place to place.

Behavioral Supports

Level 1: No On-Site Specialized Behavioral Supports Required Persons do not currently exhibit any inappropriate/rule violating, property destruction, self-injurious, or aggressive behaviors.	Level 2: Minimal Behavioral Supports Required Persons may exhibit some inappropriate/rule violating behaviors, including, but not limited to self-stimulation (body rocking/hand flashing), noises or other inappropriate vocalizations, non-compliance, and/or being disruptive, but no special behavioral support or environmental modifications are required by day and residential support staff.
Level 3: Formal Behavioral Supports Required Persons have one or more inappropriate/rule violating, self-injurious, or aggressive behaviors and these conditions require special behavioral support and/or environmental modifications by on-site day and residential staff who have received appropriate training. Support may include redirection, providing additional supervision, personal controls, and implementation of a formal behavioral plan. Behaviors may include, but are not limited to, having tantrums/outbursts, smearing feces, hitting own body/face/head, hitting others, property destruction, and/or kicking others. Agency is responsible for determining type and intensity of behavioral supports needed according to regulations developed by DDD. Agency is also responsible for preparing formal behavioral plans and providing staff training as needed.	Level 4: Intensive Behavioral Supports Required Persons have one or more inappropriate/rule violating, self-injurious, or aggressive behaviors and these conditions require a very high level of behavioral support and environmental modifications by on-site day and residential staff who have received appropriate training. Support may include providing one-on-one supervision, personal controls, and implementation of a formal behavioral plan. Behaviors may include, but are not limited to, sexual predatory behaviors, running away, eating or mouthing inedible objects, scratching self/others, hitting self/others, biting self/others, head-butting others, choking others, and/or kicking others. Agency is responsible for determining type and intensity of behavioral supports needed according to regulations developed by DDD. Agency is also responsible for preparing formal behavioral plans and providing staff training as needed.

Appendix G:
Medical Support Levels

Percentage of people in the Medical Support Levels, derived from the assessment of people living in the developmental centers, are below. Findings from all people living in the DCs, the group of 1,005 where the IDT, individual, and family have no opposition to the person moving to a community setting, the 1,298 people where IDT and individual do not oppose and the family opposes community placement, 154 people where IDT does not oppose and individual opposes community placement, and the 582 people where the IDT does not recommend community placement are provided for comparison.

Medical Level of Support	All People Living in the Centers (%)	1,005 People Where IDT, Individual and Family Do Not Oppose Community Placement (%)	1,298 People Where IDT and Individual Do Not Oppose and Family Opposes Community Placement (%)	154 People Where IDT Does Not Oppose and Individual Opposes Community Placement (%)	582 People Where IDT Does Not Recommend Community Placement (%)
Ambulatory Level 1	19.8%	21.6%	16%	27.3%	23.7%
Non Ambulatory Level 2	1.2%	1.5%	1.3%	2.6%	.3%
Ambulatory Level 3	39.4%	37.0%	42.2%	36.4%	39.7%
Non Ambulatory Level 4	28.8%	27.1%	33%	26.0%	24.6%
Ambulatory Level 5	1.6%	2.3%	0.7%	2.6%	2.2%
Non Ambulatory Level 6	7.4%	8.4%	6.9%	4.5%	8.2%

Appendix H:
Behavioral Support Levels

Percentage of people in the Behavioral Support Levels, derived from the assessment of people living in the developmental centers, are below. Findings from all people living in the DCs, the group of 1,005 where the IDT, individual, and family have no opposition to the person moving to a community setting, the 1,298 people where IDT and individual do not oppose and the family opposes community placement, 154 people where IDT does not oppose and individual opposes community placement, and the 582 people where the IDT does not recommend community placement are provided for comparison.

Behavioral Support Level	All People Living in the Centers (%)	1,005 People Where IDT, Individual and Family Do Not Oppose Community Placement (%)	1,298 People Where IDT and Individual Do Not Oppose and Family Opposes Community Placement (%)	154 People Where IDT Does Not Oppose and Individual Opposes Community Placement (%)	582 People Where IDT Does Not Recommend Community Placement (%)
No Special Behavioral Supports - Level 1	21.9%	21.5%	23.3%	22.9%	19.2%
Minimal Behavioral Supports – Level 2	1.4%	1.9%	0.4%	1.9%	2.2%
Formal Behavioral Supports – Level 3	45.1%	43.2%	49.5%	44.2%	38.5%
Intensive Behavioral Supports – Level 4	31.6%	33.2%	26.7%	31.1%	39.7%

	Self-Directed		Provider Managed			
	Supportive Housing	**Other Self-Directed Housing Options**	**Supportive Housing**	**Group Homes/ Supervised Apartments**	**Supported Living**	**Community Care Residences**
Key Policy Distinctions	Lease or mortgage in person's name Person has control of hiring staff, decision-making and budget Housing & supports are separated	Person lives with relative Shared lease Lease in someone else's name Housing & supports are separate	Lease or mortgage in person's name Person has control over decision making preferences & flexible supports will be certified	Provider has contract with DDD to provide a residential licensed service	Provider has contract with DDD to provide supports in certified facility Individual or Agency has lease	Person lives in a skill or treatment home. These are licensed
Budget	Use Fiscal Intermediary to pay for supports Individual has control of what supports are purchased	Person controls resources	Funding is put in a contract with the provider and the person decides how it is spent	Budget is controlled by agency	Budget controlled by agency	Skill provider paid by the Division to provide residential service
Service Plan	Individual designs plan & has control of choices	Individual designs plan & has control of choices	Individual designs plan & has control of choices	Agency develops w/ input from individual & team	Agency develops w/ input from individual & team	Develop by case manager w/ input from individual & team

Residential Choices (A Comparative Table)

Appendix I2

Residential Choices (A Comparative Table)

	Self-Directed		Provider Managed			
	Supportive Housing	**Other Self-Directed Housing Options**	**Supportive Housing**	**Group Homes/ Supervised Apartments**	**Supported Living**	**Community Care Residential**
Oversight of Plan development	Support Coordinator	Support Coordinator or Case Manager	Case Manager, provider	Case Manager	Case Manager	Case Manager
Standards Utilized	Housing standards used by HUD	Combination of guidelines	Certification regulation	Licensing regulations	Certification regulation	Licensing regulations
DDD Contribution to Care	NO: used benefits/ income to contribute to rent	NO	NO	YES	NO, if individual uses benefit to pay rent income	YES
Use of Rental Subsidy or other subsidized housing	DD Funding not used for purchasing housing/only for supports Section 8 or other subsidy Apartment must be Section 8 eligible/can be state-subsidized	NO	YES, utilities, food, clothing	NO, except for HUD facilities	NO	NO

DSP Career Path Development

Training Process

Guiding Principles

The goal of having a career path for direct support professionals (DSP) is to improve the quality of life for people with disabilities, families, and direct support professionals.

We believe that Direct Support Professionals are valued professionals and should have a career path that…

- Is consistent statewide
- Is flexible and accessible
- Is competency-based
- Is supported by creative management that respects the voice of DSPs
- Leads to salary increases as credentials are obtained
- Is applicable to DSPs working in developmental centers, agencies and providing self-directed supports
- Involves key stakeholders
- Provides portable credentialing
- Is Doable – little development time needed
- Is Affordable

Developed by Colleen McLaughlin of UMDNJ Boggs Center for the NJ Direct Support Professional Workforce Development Coalition

<table>
<tr><th colspan="2">Pre-Service Training</th></tr>
<tr><td>NJ Trainers Network Training Modules:
Overview of Developmental Disabilities
Medication
Preventing Abuse and Neglect
Red Cross First Aid
Red Cross Adult CPR</td><td>CDS Trainings that are similar to Trainers Network:
Introduction to Developmental Disabilities
Introduction to Medication Support
Maltreatment of Vulnerable Adults and Children
First Aid (upcoming)</td></tr>
<tr><th colspan="2">Level I</th></tr>
<tr><td>College of Direct Support Courses
Direct Support Professionalism
Safety at Home and in the Community
Documentation
Community Inclusion</td><td>College of Direct Support Courses
Individual Rights and Choices
Elective 1 (either Teaching People w/DD or Cultural Competence)
Elective 2 (Disability Specific Course or course not taken in Elective 1)</td></tr>
<tr><th colspan="2">Level II</th></tr>
<tr><td>College of Direct Support Courses
Employment Supports: Exploring Individual Preferences and Opportunities for Job Attainment
Person-Centered Planning
Supporting Healthy Lives
You’ve got a Friend: Supporting Family Connections, Friends, Love and the Pursuit of Happiness</td><td>College of Direct Support Courses
Positive Behavior Support
Elective 1 (either Teaching People w/DD or Cultural Competence or Disability Specific)
Elective 2 (Disability Specific Course)</td></tr>
<tr><th colspan="2">Level III (Specialization) *Amount of required training and mentoring TBD</th></tr>
<tr><td>Upcoming CDS Courses (may also be electives in I & II):
Civil Rights and Advocacy
Aging and Disability
Accommodation of Physical Disability
Personal Care and Self-Care
Household and Domestic Skills
Functional Assessment
Working with Disabilities
Teams and Team Building
Communication Supports</td><td>Other Training Options:
DD Lecture Series Topics
Supported Employment
Direct Support Management (I, II, & III)
Person-Centered Thinking (PCT)
Essential Lifestyle Planning (ELP)
Positive Behavior Support (PBS)
Other Seminar Courses or College Credit Courses</td></tr>
</table>

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Description of Following Table:

Community Support Skill Standards (Column 1):
The table on the following page lists the CSSS competencies and related skill standards. The Community Support Skill Standards (CSSS) were created as part of an effort to define the core skills at the heart of community support work. The CSSS were developed by pulling together Direct Support Professionals (DSP) from a variety of human services settings, and working with them to identify and define the skills that DSPs need in order to support people with disabilities in leading self-directed lives, contributing to their communities and encouraging the attitudes and behaviors that enhance inclusion in the community. The CSSS are not a set of minimal criteria that a person needs to start in direct support. They reflect the skills, knowledge and attitudes of an experienced worker who is recognized by peers and supervisors as skilled and competent.

Levels of Training/Certification (Columns 2 - 5):
Training required to be completed in order to receive certification/credentialing at the specific level listed. Successful mentoring in each topic is also required to receive certification/ credentialing. Completion of training and mentoring at each level is anticipated to lead to a change in title (NJ DSP I, II or III) and a salary increase.

Apprenticeship Standards (Column 6):
This column reflects the Work Experience Competencies as listed by the Department of Labor (DOL) in its Standards of Apprenticeship for the Human Services Direct Support Professionals Apprenticeship Program. The competencies listed in the table are headings for the competencies listed by the DOL. Specific knowledge and tasks listed under each heading can be found in the Standards of Apprenticeship. It is stated in the standards that the order in which the apprentice learns the information/skills is determined by the flow of the work in the job and not necessarily in the order listed. It is anticipated in NJ that proof of having specific skills/knowledge (determined through mentoring/apprenticeship) will be needed to compete a level. It is anticipated that completion of Pre-Service, Level I, and Level II trainings as well as the 3000 – 4400 hours of mentoring will meet the Department of Labor's Standards of Apprenticeship.

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Appendix J4

Competency Area & Community Support Skill Standard	Pre-Service	Level I (CDS)	Level II (CDS)	Level III and Electives	Apprenticeship Standard
Participant Empowerment • Supports participants to develop strategies, make choices, follow through with responsibilities, and take risks • Assists the participant in design and maintenance of support process, consulting the person and involving him/her in the support process • Provides opportunities for the participant to be a self-advocate by increasing awareness of self-advocacy methods and techniques, encouraging and assisting the participant to speak on his/her own behalf and providing information on peer support and self-advocacy groups. • Provides information about human, legal, civil rights and other resources and facilitates access to such information and assists the participant to use information for self-advocacy and decision making about living, work, and social relationships.	• Overview (NJ)	• Individual Rights and Choice • Teaching People with Developmental Disabilities	• You've got a Friend • Person-Centered Planning	• Person-Centered Thinking (NJ) • Civil Rights and Advocacy (Upcoming CDS)	II. Contemporary Best Practices in Community Support (customized for unique support environment/special population) III. Advocacy, Supporting Empowerment and Recognition, Prevention and Reporting of Abuse, Neglect and Exploitation VI. Teaching and Supporting Others
Communication • Uses effective, sensitive communication skills to build rapport and open communication by recognizing and adapting to the range of participant communication styles • Uses modes of communication that are appropriate to the communication needs of participants • Uses terminology appropriately, making clarifications as necessary for understanding	• Overview (NJ)			• Communication Supports (Upcoming CDS) • PCT (NJ)	V. Communication VI. Teaching and Supporting Others

Developed by Colleen McLaughlin of UMDNJ Boggs Center for the NJ Direct Support Professional Workforce Development Coalition

Competency Area & Community Support Skill Standard	Pre-Service	Level I (CDS)	Level II (CDS)	Level III and Electives	Apprenticeship Standard
Assessment • Initiates or assists in the assessment process by gathering information and informing participant about what to expect • Conducts or arranges for assessments to determine needs, preferences and capabilities of the participant using appropriate tools and strategies, reviewing the process for inconsistencies and making corrections as necessary • Discusses the findings and recommendations from the assessment with the participant in an clear and understandable manner, following up on results and re-evaluating as necessary		• Documentation?	• Person-Centered Planning • Positive Behavior Support (PBS)	• Functional Assessment (Upcoming CDS) • IHP (NJ) • PCT/ELP (NJ) • PBS (NJ)	V. Communication VI. Teaching and Supporting Others VII. Crisis Management
Community and Service Networking • Identifies the needs of the participant for community supports, work with informal support system, assist with/initiate identified community connections • Researches, develops, and maintains information on community and other resources relevant to the participant's needs • Ensures participant access to need community resources and coordinating supports across agencies • Participates in outreach to potential participants		• Community Inclusion • Cultural Competence	• You've got a Friend	• Working with Families and Support Networks (Upcoming CDS)	II. Contemporary Best Practices in Community Support (customized for unique support environment/special population)

Developed by Colleen McLaughlin of UMDNJ Boggs Center for the NJ Direct Support Professional Workforce Development Coalition

Appendix J6

Competency Area & Community Support Skill Standard	Pre-Service	Level I (CDS)	Level II (CDS)	Level III and Electives	Apprenticeship Standard
Facilitation of Services • Maintains collaborative professional relationships with the participant & all support team members, follows ethical standards of practice & recognizes his/her own personal limitations • Facilitates the development of an individualized plan based on participant preferences, needs & interests • Assists/Facilitates in the implementation of the plan to achieve specific outcomes derived from the participant's preferences, needs & interests • Facilitates the review of achievement of participant outcomes	• Medications (NJ)?	• Direct Support Professionalism • Individual Rights and Choice • Community Inclusion • Cultural Competence	• Person-Centered Planning	• PCT/ELP (NJ) • IHP (NJ) • Functional Assessment (Upcoming CDS)	II. Contemporary Best Practices in Community Support (customized for unique support environment/special population) III. Advocacy, Supporting Empowerment and Recognition, Prevention and Reporting of Abuse, Neglect and Exploitation
Community Living Skills & Supports • Assists the participant to meet his/her physical management needs by teaching skills, providing supports & building on individual strengths & capabilities • Assists with household management & transportation to maximize participant skills, abilities and independence • Assists with identifying, securing & using needed equipment & therapies • Supports the participant in the development of friendships & other relationships • Assists in the recruitment & training of service providers as needed	Medications (NJ & CDS)	• Safety at Home and in the Community • Community Inclusion • Teaching people with DD • Cultural Competence	• Supporting Healthy Lives	• Accommodation of Physical Disability (Upcoming CDS) • Household and Domestic Skills (Upcoming CDS) • Working with Families and Support Networks (Upcoming CDS)	II. Contemporary Best Practices in Community Support (customized for unique support environment/special population) IV. Wellness Issues (customized to work setting or special population) VI. Teaching and Supporting Others

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Competency Area & Community Support Skill Standard	Pre-Service	Level I (CDS)	Level II (CDS)	Level III and Electives	Apprenticeship Standard
Education, Training and Self-Development • Completes required training, education, certification, continues professional development and keeps abreast of relevant resources and information • Educates participants, co-workers and community members about issues by providing information, support and facilitating training		• Direct Support Professionalism • Teaching People with DD		• College courses	I. Introduction to Direct Support Role and Orientation of the Work Environment
Advocacy • Identifies advocacy issues with the participant by gathering information, reviewing and analyzing all aspects of the problem • Has current knowledge of laws, services and community resources to assist and educate participants to secure needed supports • Facilitates, assists and/or represents the participant when there are barriers to his/her services needs and lobbies decision makers when appropriate to overcome barriers to services. • Interacts with and educates community members and organizations when relevant to the participant's needs or services		• Individual Rights and Choices		• Civil Rights and Advocacy (Upcoming CDS)	III. Advocacy, Supporting Empowerment and Recognition, Prevention and Reporting of Abuse, Neglect and Exploitation

Competency Area & Community Support Skill Standard	Pre-Service	Level I (CDS)	Level II (CDS)	Level III and Electives	Apprenticeship Standard
Vocational, Educational & Career Support • Explores with the participant his/her vocational interests and aptitudes, assists in preparing for job or school entry and reviews opportunities for continued career growth • Assists the participant in identifying job/training opportunities and marketing his/her capabilities and services • Collaborates with employers and school personnel to support the participant, adapting the environment and providing job retention supports			• Employment Supports: Exploring Individual Preferences and Opportunities for Job Attainment	• Working with Families and Support Networks (Upcoming CDS) • PCT/ELP (NJ) • Supported Employment (NJ)	VI. Teaching and Supporting Others
Crisis Intervention • Identifies the crisis, defuses the situation, evaluates and determines an intervention strategy and contacts necessary supports • Continues to monitor crisis situations, discusses the incident with authorized staff and participant(s), adjusts supports to the environment, and complies with regulations for reporting	• Agency Specific Training (NJ)		• PBS	• PBS (NJ)	I. Introduction to Direct Support Role and Orientation of the Work Environment VI. Teaching and Supporting Others VII. Crisis Management

Appendix J9

Competency Area & Community Support Skill Standard	Pre-Service	Level I (CDS)	Level II (CDS)	Level III and Electives	Apprenticeship Standard
Organization Participation • Contributes to program evaluations and helps to set organizational priorities to ensure quality • Incorporates sensitivity to cultural, religious, racial, disability and gender issues in to daily practices and interactions • Provides and accepts co-worker support, participating in supportive supervision, performance evaluation and contributing to the screening of potential employees • Provides input into budget priorities, identifying ways to provide services in a more cost-beneficial manner		• Direct Support Professionalism • Cultural Competence		• Dan Baker Trainings (NJ) • Agency Specific • Teams sand Team Building (Upcoming CDS)	I. Introduction to Direct Support Role and Orientation of the Work Environment V. Communication
Documentation • Maintains accurate records, collecting, compiling and evaluating data, and submitting records to appropriate sources in a timely fashion • Maintains standards of confidentiality and ethical practice • Learns and remains current with appropriate documentation systems, setting priorities and developing a system to manage documentation.	• Medications (NJ & CDS) • Abuse/Neglect (NJ & CDS) • Agency Specific Training (NJ)	• Documentation			I. Introduction to Direct Support Role and Orientation of the Work Environment IV. Wellness Issues (customized to work setting or special population) V. Communication VII. Crisis Management

Developed by Colleen McLaughlin of UMDNJ Boggs Center for the NJ Direct Support Professional Workforce Development Coalition

Other Competency Areas	Pre-Service	Level I	Level II	Level III and Electives	Apprenticeship Standard
Knowledge of Developmental Disabilities	• Overview (NJ) • Introduction to DD (CDS)				I. Introduction to Direct Support Role & Orientation of the Work Environment
Computer Skills	Needed for All CDS Courses				
Mental Health and Behavioral Issues/Dual Diagnosis	• Overview (NJ)				
Aging and Disability				• Aging and Disability (Upcoming CDS) • Aging Workshops (NJ)	
Medically Fragile/Physical Needs				• Accommodation of Physical Disability (Upcoming CDS) • Functional Assessment (Upcoming CDS)	I. Introduction to Direct Support Role & Orientation of the Work Environment IV. Wellness Issues (customized to work setting or special population)
Abuse and Neglect	• Abuse and Neglect (NJ & CDS)				I. Introduction to Direct Support Role & Orientation of the Work Environment III. Advocacy, Supporting Empowerment & Recognition, Prevention & Reporting of Abuse, Neglect & Exploitation

Developed by Colleen McLaughlin of UMDNJ Boggs Center for the NJ Direct Support Professional Workforce Development Coalition

Appendix K1

Qualified Services for Self Direction

Services and Definitions	Rates and Maximum Approved Hours
Habilitation: Habilitation is the process of providing those comprehensive services that are deemed necessary to meet the needs of individuals with developmental disabilities in programs designed to achieve objectives of improved health, welfare and the realization of individuals' maximum physical, social, psychological and vocational potential for useful and productive activities. Although the specific services will be described in an individual's Plan of Care, habilitation services are designed to develop, maintain and/or maximize the individual's independent functioning in self-care, physical and emotional growth, socialization, communication, and vocational skills.	$80 dollars per day or Special Needs Adult Training $18,400 Regular Adult Training $14, 300
Individual Supports Individual support services are self-care and habilitation-related tasks performed and/or supervised by service provider staff in an individual's own or family home or in certified community-based settings, in accordance with approved Plans of Care. Assistance to, as well as training and supervision of individuals as they learn and perform the various tasks that are included in basic self-care, social skills, activities of daily living and behavior shaping will be provided.	$ 20 per hour
Respite Respite care is a service provided to individuals with developmental disabilities in a temporary absence or disability of a parent, guardian, or other immediate caregiver in accordance with guidelines developed by the Division of Developmental Disabilities. Respite services may be furnished either at the business location or private home of the provider or in the home of the individual,. and be provided by licensed community residences, home health or other service agencies or by individuals qualified by the DDD.	$20 per hour

Services and Definitions	Rates and Maximum Approved Hours
Home and Vehicle Modifications/Assistive Devices Those physical adaptations to the home or vehicle required by the individual's annual Plan of Care, which are necessary to ensure that health, welfare and safety of the individual or which enable the individual to function with greater independence in the home & community and without which the individual would require institutionalization. Examples: ramps; grab-bars; widening doorways; van lifts.	Up to $11,000 in one plan year
Housing Specialist A provider qualified by the DDD who assists individuals with developmental disabilities with the process of finding & securing affordable & accessible supportive housing. This service requires the lease or mortgage be in the individual's name.	$50 per hour with a maximum of 40 hours in a given plan year.
Employment Specialist A provider qualified by the DDD who assists an individual who is not eligible for DVR services, to develop employment, self employment, and/or volunteer opportunities.	$51 per hour with a maximum of 120 hours in a given plan year.
Certified Career Counselor A provider qualified by the DDD who only provides services related to "pre-placement", such as: career testing and assessment; career/life coaching; job search strategies; resume writing; interview preparation; salary negotiations etc.	$51 per hour with a maximum of 20 hours in a given plan year.
Staff Connector I A provider qualified by the DDD who assists individuals with developmental disabilities to recruit, hire, train and manage their own staff. The Fiscal Agent will be the employer of record.	$50 per hour with a maximum of 80 hours in a given plan year.
Staff Connector II A provider qualified by the DDD who assists individuals with developmental disabilities to recruit and hire their own staff. The Fiscal Agent will be the employer of record.	$35 per hour with a maximum of 20 hours in a given plan year.
Community Connector I A provider qualified by the DDD who assists an individual to develop & maintain relationships, social networks, recreational options & strong connections & natural supports within their community.	$50 per hour with a maximum of 40 hours in a given plan year.

Services and Definitions	Rates and Maximum Approved Hours
Community Connector II A provider qualified by the DDD who assists an individual to develop and maintain relationships, social networks, recreational options and strong connections and natural supports within their community.	$35 per hour with a maximum of 40 hours in a given plan year.
Non-Medical Transportation Services This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation Services are only provided as independent waiver services when transportation is not included in the rate charged for the related waiver service. Needed transportation services must be documented in the individual's Plan of Care, and be related to enabling an individual to access specific waiver services and fulfill outcomes in the Plan of Care. Services in this category include driver, taxi fares, train and bus tickets, or transportation services such as Access Link, or other private contractors. The service chosen must be the most cost effective means of transport that the individual is able to access. Reimbursement for mileage will not exceed the rate established by the State.	**Self hire** – Person providing transportation is employed directly by DDD individual and family. $.40 per mile **Agency hires** – DDD individual and family contract with an agency to provide this service. $.40 per mile plus an hourly wage for the category of service. **Transportation Provider Agencies** – **Ambulatory vehicle:** $40.00 one time/round trip charge per individual and individual's personal support staff Plus $1.50 per mile, one way and round trip $2.00 per mile, one way and round trip in excess of 15 miles one way **Mobility Assistance Vehicle:** $50.00 one time/round trip charge per individual and individual's personal support staff Plus $1.50 per mile, one way and round trip $2.00 per mile, one way and round trip in excess of 15 miles one way

Appendix L1

Department of Human Services
Division of Developmental Disabilities
Community Placements-P&A/Olmstead

Assumptions:

- Each person transitioning to the community will have an individual budget based on his/her assessment of self-care and support needs.

- Funding for 1,850 individuals is included in this plan.

- The Self Care and Medical/Behavioral needs of 2303 individuals residing in the developmental centers have been assessed. Based on the assessment, funding levels have been assigned to purchase appropriate services. Projections use maximum funding levels within each Self Care level.

- For this analysis, the funding levels of individuals assessed have been factored into a weighted average used for the projection of housing and service support costs.

- Ongoing Family Support funding will be transferred to the overall Divisional budget after FY 2009.

- Medicaid State Plan costs reflect the cost of services to be rendered to transitioned individuals by Medicaid providers in the community rather than at the developmental center.

- As individuals transition from the developmental centers to the community, the Division will reallocate the resources of developmental center to Community Services. In order for the projected savings contained in this Appendix to be realized the following must occur:

    - The Division's appropriation will not be reduced;

    - COLAs will continue to be added to the salary base at the Division;

    - The State allows DDD to shift salary funding from the developmental centers to Community Services in the Salary, Non-Salary, and Contract Accounts;

    - DDD works with OMB to make the necessary Technical Adjustments to achieve this end.

Department of Human Services
Division of Developmental Disabilities
Community Placements-P&A/Olmstead Cont.

- The offset for contribution to care is based on the general assumption that 60% of the individuals leaving the developmental centers will be eligible for SSI benefits.

- Fixed overhead costs in the developmental centers will not be prorated as individuals transition to the community.

- In order to ensure sufficient housing, the plan has included the cost of down payments and ongoing mortgage costs for all housing associated with this plan. As provider agencies are able to access funding through the Special Needs Housing Trust Fund the need for this funding will be reduced.

Department of Human Services
Division of Developmental Disabilities
Summary of Olmstead Plan Costs
Subject to Appropriations

2008	Individuals Transitioned	TOTAL COST	State Need	Federal Need
Individuals Transitioning		100		
Total Year One Costs		$33,615,114	$23,294,842	$10,201,688
2009				
Individuals Transitioning		250		
Total Year Two Costs	100	$95,457,953	$65,596,021	$29,184,891
2010				
Individuals Transitioning		250		
Total Year Three Costs	350	$139,740,866	$95,844,910	$42,252,051
2011				
Individuals Transitioning		250		
Total Year Four Costs	600	$165,368,885	$114,544,350	$48,383,088
2012				
Individuals Transitioning		250		
Total Year Five Costs	850	$190,269,413	$132,953,421	$54,055,469
2013				
Individuals Transitioning		250		
Total Year Six Costs	1,100	$216,694,060	$152,791,276	$59,801,070
2014				
Individuals Transitioning		250		
Total Year Seven Costs	1,350	$246,344,427	$174,841,843	$66,536,967
2015				
Individuals Transitioning		250		
Total Year Eight Costs	1,600	$272,407,270	$194,882,038	$71,672,387
2016				
Ongoing Yearly Costs				
Infrastructure		$17,873,185	$15,287,802	$2,585,383
Annualized Individual Budgets		$339,772,599	$224,249,915	$115,522,684
Medicaid State Plan Increase		$5,006,100	$2,503,050	$2,503,050
State Staffing Need		$26,248,571	$15,749,142	$10,499,428
Contribution to Care			($6,076,120)	
Total Year Nine Costs	1,850	$207,390,454	$155,513,490	$45,800,845

Department of Human Services
Division of Developmental Disabilities
Summary of Olmstead Plan Costs
Subject to Appropriations (cont.)

Cumulative Costs FY 2008 - FY 2015				
Infrastructure		**$124,170,580**	**$106,900,985**	**$17,269,595**
Housing Costs and Svc Supports		**$556,485,581**	**$367,280,484**	**$189,205,098**
Annualized PYs Individual Budgets		**$1,039,142,611**	**$685,834,123**	**$353,308,488**
Medicaid State Plan Increase		**$19,591,440**	**$9,795,720**	**$9,795,720**
State Staffing Need		**$130,427,777**	**$78,256,666**	**$52,171,111**
DC Staffing Reduction to be Reallocated		**($509,920,000)**	**($270,257,600)**	**($239,662,400)**
Contribution to Care			**($23,061,676)**	
Total Plan Costs	**1,850**	**$1,359,897,989**	**$954,748,702**	**$382,087,611**

Appendix L5

Department of Human Services
Division of Developmental Disabilities
Housing Budget Calculation Worksheet

1) ***Enter the number of years in the plan.***

8

2) ***Enter the starting FY.***

2008

3) ***What is the assumed inflation rate?***

3.50%

4) ***Enter the total number of individuals for this analysis.***

1,850

5) ***Enter the total number of individuals to be placed per year***

2008	100	**2009**	250	**2010**	250	**2011**	250	**2012**	250
2013	250	**2014**	250	**2015**	250				

1850

6) ***Enter the % of individuals at each level. If more than 1 level, enter the % at each level with a maximum of 5.***

1	2	3	4	5
			100%	

9) ***Enter number of individuals per group home***

4

10) ***If there are contracted infrastructure start up costs, enter amount here.***

11) ***What is your phase in level by Year?***

2008	40%	**2009**	50%	**2010**	75%	**2011**	75%	**2012**	75%
2013	75%	**2014**	75%	**2015**	75%				

12) What is the name of this project?

Community Placements - P&A/Olmstead

Then proceed to the other worksheets. Please note, you may only enter to the Placement Costs, General Background, Self Direction Budget Model, and Staffing worksheets. For the first and third, you may only enter to the blue cells.

Appendix L6

Department of Human Services
Division of Developmental Disabilities
Community Placements-P&A/Olmstead

	Cumulative Annualized	FY Starting 2008	Housing Components	State Need	Fedl Need
Individuals Transitioning		**100**			
Infrastructure & Family Support		$7,504,000		$6,469,520	$1,034,480
Housing Costs and Svc Supports		21,467,697		14,168,680	7,299,017
Development			400,000		
Start-up			14,635,417		
Service Budgets - phased in			6,432,280		
Annualized Budgets					
Contribution to Care				(118,584)	
Medicaid State Plan Increase		108,240		54,120	54,120
State Staffing Need		4,535,178		2,721,107	1,814,071
DC Staffing Reduction to be Reallocated		0		0	0
Total Year One Costs		**$33,615,114**		**$23,294,842**	**$10,201,688**
		2009			
Individuals Transitioning		**250**			
Infrastructure & Family Support		$14,243,000		$12,656,520	$1,586,480
Housing Costs and Svc Supports		59,708,546		39,407,641	20,300,906
Development			1,035,000		
Start-up			37,869,141		
Service Budgets - phased in			20,804,406		
Annualized PY Individual Budgets	**100**	16,080,700		10,613,262	5,467,438
Contribution to Care				(677,041)	
Medicaid State Plan Increase		608,850		304,425	304,425
State Staffing Need		10,546,856		6,328,114	4,218,743
DC Staffing Reduction to be Reallocated		(5,730,000)		(3,036,900)	(2,693,100)
Total Year Two Costs		**95,457,953**		**65,596,021**	**29,184,891**
		2010			
Individuals Transitioning		**250**			
Infrastructure		$16,825,546		$14,578,123	$2,247,423
Housing Costs and Svc Supports		72,564,625		47,892,653	24,671,973
Development			1,071,225		
Start-up			39,194,561		
Service Budgets - phased in			32,298,840		
Annualized PYs Individual Budgets	**350**	57,689,511		38,075,077	19,614,434
Contribution to Care				(1,643,905)	
Medicaid State Plan Increase		1,454,475		727,238	727,238
State Staffing Need		12,516,708		7,510,025	5,006,683
DC Staffing Reduction to be Reallocated		(21,310,000)		(11,294,300)	(10,015,700)
Total Year Three Costs		**139,740,866**		**95,844,910**	**42,252,051**

Department of Human Services
Division of Developmental Disabilities
Community Placements-P&A/Olmstead Cont.

		2011			
Individuals Transitioning		**250**			
Infrastructure		$16,633,223		$14,305,657	$2,327,566
Housing Costs and Svc Supports		75,104,387		49,568,896	25,535,492
Development			1,108,718		
Start-up			40,566,370		
Service Budgets - phased in			33,429,299		
Annualized PYs Individual Budgets	**600**	100,754,631		66,498,056	34,256,575
Contribution to Care				(2,441,447)	
Medicaid State Plan Increase		2,130,975		1,065,488	1,065,488
State Staffing Need		15,035,669		9,021,401	6,014,268
DC Staffing Reduction to be Reallocated		(44,290,000)		(23,473,700)	(20,816,300)
Total Year Four Costs		**165,368,885**		**114,544,350**	**48,383,088**

		2012			
Individuals Transitioning		**250**			
Infrastructure		$16,334,151		$13,908,030	$2,426,121
Housing Costs and Svc Supports		77,733,041		51,303,807	26,429,234
Development			1,147,523		
Start-up			41,986,193		
Service Budgets - phased in			34,599,325		
Annualized PYs Individual Budgets	**850**	145,327,030		95,915,840	49,411,190
Contribution to Care				(3,260,523)	
Medicaid State Plan Increase		2,807,475		1,403,738	1,403,738
State Staffing Need		17,237,717		10,342,630	6,895,087
DC Staffing Reduction to be Reallocated		(69,170,000)		(36,660,100)	(32,509,900)
Total Year Five Costs		**190,269,413**		**132,953,421**	**54,055,469**

		2013			
Individuals Transitioning		**250**			
Infrastructure		$16,752,582		$14,274,611	$2,477,971
Housing Costs and Svc Supports		80,453,697		53,099,440	27,354,257
Development			1,187,686		
Start-up			43,455,710		
Service Budgets - phased in			35,810,301		
Annualized PYs Individual Budgets	**1100**	191,459,463		126,363,245	65,096,217
Contribution to Care				(4,101,714)	
Medicaid State Plan Increase		3,483,975		1,741,988	1,741,988
State Staffing Need		20,074,343		12,044,606	8,029,737
DC Staffing Reduction to be Reallocated		(95,530,000)		(50,630,900)	(44,899,100)
Total Year Six Costs		**216,694,060**		**152,791,276**	**59,801,070**

Department of Human Services
Division of Developmental Disabilities
Community Placements-P&A/Olmstead Cont.

		2014			
Individuals Transitioning		**250**			
Infrastructure		$17,574,346		$15,025,992	$2,548,354
Housing Costs and Svc Supports		83,269,577		54,957,921	28,311,656
Development			1,229,255		
Start-up			44,976,660		
Service Budgets - phased in			37,063,661		
Annualized PYs Individual Budgets	**1350**	239,206,530		157,876,310	81,330,220
Contribution to Care				(4,965,617)	
Medicaid State Plan Increase		4,160,475		2,080,238	2,080,238
State Staffing Need		24,803,499		14,882,099	9,921,400
DC Staffing Reduction to be Reallocated		(122,670,000)		(65,015,100)	(57,654,900)
Total Year Seven Costs		**246,344,427**		**174,841,843**	**66,536,967**

		2015			
Individuals Transitioning		**250**			
Infrastructure		$18,303,732		$15,682,532	$2,621,200
Housing Costs and Svc Supports		86,184,012		56,881,448	29,302,564
Development			1,272,279		
Start-up			46,550,843		
Service Budgets - phased in			38,360,890		
Annualized PYs Individual Budgets	**1600**	288,624,746		190,492,332	98,132,414
Contribution to Care				(5,852,845)	
Medicaid State Plan Increase		4,836,975		2,418,488	2,418,488
State Staffing Need		25,677,806		15,406,684	10,271,122
DC Staffing Reduction to be Reallocated		(151,220,000)		(80,146,600)	(71,073,400)
Total Year Eight Costs		**272,407,270**		**194,882,038**	**71,672,387**

Ongoing Yearly Costs

		2016			
Infrastructure		$17,873,185		$15,287,802	$2,585,383
Annualized Individual Budgets	**1850**	339,772,599		224,249,915	115,522,684
Medicaid State Plan Increase		5,006,100		2,503,050	2,503,050
State Staffing Need		26,248,571		15,749,142	10,499,428
DC Staffing Reduction to be Reallocated		(181,510,000)		(96,200,300)	(85,309,700)
Contribution to Care				(6,076,120)	
Total Year Nine Costs		**207,390,454**		**155,513,490**	**45,800,845**

Department of Human Services
Division of Developmental Disabilities
Community Placements-P&A/Olmstead Cont.

Cumulative Costs FY 2008 - FY 2015

Infrastructure		$124,170,580		$106,900,985	$17,269,595
Housing Costs and Svc Supports		$556,485,581		$367,280,484	$189,205,098
Development			$8,451,687		
Start-up			$309,234,894		
Service Budgets - !st Yr phase in			$238,799,001		
Annualized PYs Individual Budgets	**1850**	$1,039,142,611		$685,834,123	$353,308,488
Medicaid State Plan Increase		$19,591,440		9,795,720	9,795,720
State Staffing Need		$130,427,777		$78,256,666	52,171,111
DC Staffing Reduction to be Reallocated		($509,920,000)		($270,257,600)	(239,662,400)
Contribution to Care				($23,061,676)	
Total Plan Costs		$1,359,897,989		$954,748,702	$382,087,611

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Department of Human Services
Division of Developmental Disabilities
Community Placements-P&A/Olmstead
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Infrastructure FY	Category	Full Yr. Amount	Current Amt	State	Fedl	Total	Phase In	Assumptions
2007	In Home supports	2,000	2,000	2,000	0	2,000	100%	
2007	Family Support	1,200	1,200	1,200	0	1,200	100%	
2007	Program Staffing - Providers	480	480	317	163	480	100%	
	Olmstead Capital							
2007	DC Support Coordination	302	302	157	145	302	100%	
2007	Crisis Response System-							
	Trinitas Stabilization Services	280	280	280	0	280	100%	80% Elig
2007	Emergency Residential Capacity (4)	0	0	0	0	0	40%	30% Elig
2007	Susan Hammerman- Supports Trng for Families	50	25	25	0	25	50%	
2007	National Core Indicators – QIE	12	12	6	6	12	100%	
	Total 2007	4,324	4,299	3,985	314	4,299		
	Cumulative 2007	4,324	4,299	3,985	314	4,299		
2008	In Home supports	2,100	2,100	2,100	0	2,100	100%	
2008	Family Support	1,300	1,300	1,300	0	1,300	100%	
2008	Program Staffing	320	320	211	109	320	100%	
	Olmstead Capital	0	0	0	0	0		
2008	DC Support Coordination	1,316	1,316	684	632	1,316	100%	
2008	Crisis Response System-							
	Trinitas Stabilization Services	916	916	916	0	916	100%	
2008	Emergency Residential Capacity (4)	1,800	1,440	1,152	288	1,440	80%	
2008	Susan Hammerman-Supports Trng for Self Adv	100	100	100	0	100	100%	
2008	National Core Indicators - QIE	12	12	6	6	12	100%	
	Total 2008	7,864	7,504	6,470	1,034	7,504		
	Cumulative 2008	12,188	11,803	10,454	1,349	11,803		

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Department of Human Services
Division of Developmental Disabilities
Community Placements-P&A/Olmstead

2009	In Home supports	2,100	2,100	2,100	0	2,100	100%	
2009	Family Support	1,300	1,300	1,300	0	1,300	100%	
2009	Program Staffing	320	320	211	109	320	100%	
	Olmstead Capital	280	280	280	0	280	100%	
2009	DC Support Coordination	1,316	1,316	684	632	1,316	100%	
2009	Crisis Response System-							
	Trinitas Stabilization Services	2,199	2,199	2,199	0	2,199	100%	
2009	Emergency Residential Capacity (8)	4,200	4,200	3,360	840	4,200	100%	
2009	Susan Hammerman-Supports Trng for Self Adv	100	100	100	0	100	100%	
2009	National Core Indicators - QIE	12	12	6	6	12	100%	
	Total 2009	11,827	11,827	10,241	1,586	11,827		
	Cumulative 2009	24,015	23,630	20,695	2,935	23,630		
2010	In Home supports	2,000	2,000	2,000	0	2,000	100%	
2010	Family Support		0	0	0	0	100%	
2010	Program Staffing - Providers	852	852	562	290	852	100%	
	Olmstead Capital	1,074	1,074	1,074	0	1,074	100%	
2010	DC Support Coordination	1,316	1,316	684	632	1,316	100%	
2010	Crisis Response System-							
2010	Trinitas Stabilization Services	2,199	2,199	2,199	0	2,199	100%	80% Elig
2010	Emergency Residential Capacity (12)	6,600	6,600	5,280	1,320	6,600	100%	30% Elig
2010	Susan Hammerman-Supports Trng for Self Adv	100	100	100	0	100	100%	
2010	National Core Indicators - QIE	12	12	6	6	12	100%	
	Total 2010	14,154	14,154	11,906	2,247	14,154		
	Cumulative 2010	38,169	37,784	32,601	5,183	37,784		

Department of Human Services
Division of Developmental Disabilities
Community Placements-P&A/Olmstead

2011	In Home supports	2,100	2,100	2,100	0	2,100	100%
2011	Family Support		0	0	0	0	100%
2011	Program Staffing	1,088	1,088	718	370	1,088	100%
	Olmstead Capital	1,150	1,150	1,150	0	1,150	100%
2011	DC Support Coordination	1,316	1,316	684	632	1,316	100%
2011	Crisis Response System-						
	Trinitas Stabilization Services	2,199	2,199	2,199	0	2,199	100%
2011	Emergency Residential Capacity (12)	6,600	6,600	5,280	1,320	6,600	100%
2011	Susan Hammerman-Supports Trng for Self Adv	100	100	100	0	100	100%
2011	National Core Indicators - QIE	12	12	6	6	12	100%
	Total 2011	14,565	14,565	12,238	2,328	14,565	
	Cumulative 2011	52,734	52,349	44,839	7,510	52,349	
2012	In Home supports	2,100	2,100	2,100	0	2,100	100%
2012	Family Support		0	0	0	0	100%
2012	Program Staffing	1,378	1,378	909	468	1,378	100%
	Olmstead Capital	1,365	1,365	1,365		1,365	100%
2012	DC Support Coordination	1,316	1,316	684	632	1,316	100%
2012	Crisis Response System-						
	Trinitas Stabilization Services	2,199	2,199	2,199	0	2,199	100%
2012	Emergency Residential Capacity (12)	6,600	6,600	5,280	1,320	6,600	100%
2012	Susan Hammerman-Supports Trng for Self Adv	100	100	100	0	100	100%
2012	National Core Indicators - QIE	12	12	6	6	12	100%
	Total 2012	15,070	15,070	12,644	2,426	15,070	
	Cumulative 2012	67,804	67,419	57,483	9,936	67,419	

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Department of Human Services
Division of Developmental Disabilities
Community Placements-P&A/Olmstead

2013	In Home supports	2,000	2,000	2,000	0	2,000	100%	
2013	Family Support		0	0	0	0	100%	
2013	Program Staffing - Providers	1,530	1,530	1,010	520	1,530	100%	
	Olmstead Capital	1,427	1,427	1,427	0	1,427	100%	
2013	DC Support Coordination	1,316	1,316	684	632	1,316	100%	
2013	Crisis Response System-							
	Trinitas Stabilization Services	2,199	2,199	2,199	0	2,199	100%	80% Elig
2013	Emergency Residential Capacity (12)	6,600	6,600	5,280	1,320	6,600	100%	30% Elig
2013	Susan Hammerman-Supports Trng for Self Adv	100	100	100	0	100	100%	
2013	National Core Indicators - QIE	12	12	6	6	12	100%	
	Total 2013	15,185	15,185	12,707	2,478	15,185		
	Cumulative 2013	82,989	82,604	70,189	12,414	82,604		
2014	In Home supports	2,100	2,100	2,100	0	2,100	100%	
2014	Family Support		0	0	0	0	100%	
2014	Program Staffing	1,737	1,737	1,147	591	1,737	100%	
	Olmstead Capital	1,638	1,638	1,638	0	1,638	100%	
2014	DC Support Coordination	1,316	1,316	684	632	1,316	100%	
2014	Crisis Response System-							
	Trinitas Stabilization Services	2,199	2,199	2,199	0	2,199	100%	
2014	Emergency Residential Capacity (12)	6,600	6,600	5,280	1,320	6,600	100%	
2014	Susan Hammerman-Supports Trng for Self Adv	100	100	100	0	100	100%	
2014	National Core Indicators - QIE	12	12	6	6	12	100%	
	Total 2014	15,702	15,702	13,154	2,548	15,702		
	Cumulative 2014	98,691	98,306	83,343	14,963	98,306		

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Department of Human Services
Division of Developmental Disabilities
Community Placements-P&A/Olmstead

2015	In Home supports	2,100	2,100	2,100	0	2,100	100%
2015	Family Support		0	0	0	0	100%
2015	Program Staffing	1,952	1,952	1,288	664	1,952	100%
	Olmstead Capital	1,849	1,849	1,849	0	1,849	100%
2015	DC Support Coordination	1,316	1,316	684	632	1,316	100%
2015	Crisis Response System-						
	Trinitas Stabilization Services	2,199	2,199	2,199	0	2,199	100%
2015	Emergency Residential Capacity (12)	6,600	6,600	5,280	1,320	6,600	100%
2015	Susan Hammerman-Supports Trng for Self Adv	100	100	100	0	100	100%
2015	National Core Indicators - QIE	12	12	6	6	12	100%
	Total 2015	16,128	16,128	13,507	2,621	16,128	
	Cumulative 2015	114,819	114,434	96,850	17,584	114,434	
2016	In Home supports	2,100	2,100	2,100	0	2,100	100%
2016	Family Support		0	0	0	0	100%
2016	Program Staffing	1,846	1,846	1,218	628	1,846	100%
	Olmstead Capital	0	0	0	0	0	100%
2016	DC Support Coordination	1,316	1,316	684	632	1,316	100%
2016	Crisis Response System-						
	Trinitas Stabilization Services	2,199	2,199	2,199	0	2,199	100%
2016	Emergency Residential Capacity (12)	6,600	6,600	5,280	1,320	6,600	100%
2016	Susan Hammerman-Supports Trng for Self Adv	100	100	100	0	100	100%
2016	National Core Indicators - QIE	12	12	6	6	12	100%
	Total 2016	14,173	14,173	11,588	2,585	14,173	
	Cumulative 2016	128,992	128,607	108,438	20,169	128,607	

A total of 40 existing homes through SFY 2015 will be made accessible for people moving from developmental centers.

Olmstead Budget Costs
Modify Existing Housing for Accessibility

	# of Homes	Capital Cost Per Home	Total Capital	Staff Annualized Per Home	Total Staff Annualized	Staffing Cost 25% Phase-In	Accessible Vehicle	Operating Per FY	Operating Annualized	Yearly Need
		Inflation = 3.5%		Inflation = 3.5%			Inflation = 3.5%	(Staff + Veh)	(Staff)	(Staff + Veh)
SFY 2007	8	$62,500	$500,000	$40,000	$320,000	$80,000	$50,000	$480,000	$320,000	$480,000
SFY 2008	0	$0	$0	$0	$0	$0	$0	$0	$320,000	$320,000
SFY 2009	0	$0	$0	$0	$0	$0	$0	$0	$320,000	$320,000
SFY 2010	8	$69,295	$554,360	$44,349	$354,792	$88,698	$55,436	$532,186	$354,792	$852,186
SFY 2011	6	$71,720	$430,322	$45,901	$275,407	$68,852	$57,376	$413,109	$275,407	$1,087,901
SFY 2012	6	$74,231	$445,383	$47,508	$285,047	$71,262	$59,384	$427,568	$285,047	$1,377,768
SFY 2013	4	$76,829	$307,314	$49,171	$196,682	$49,171	$61,463	$295,022	$196,682	$1,530,268
SFY 2014	4	$79,518	$318,070	$50,891	$203,566	$50,891	$63,614	$305,348	$203,566	$1,737,276
SFY 2015	4	$82,301	$329,203	$52,673	$210,691	$52,673	$65,841	$316,035	$210,691	$1,951,529
TOTAL	**40**		**$2,884,653**	**$330,493**	**$1,846,185**	**$461,546**	**$413,114**	**$2,769,269**	**$2,486,185**	**$9,656,928**
SFY 2016	Continuation of Annualization									**$1,846,185**

A 3.5% inflation/COLA factor was added to renovation costs, accessible vehicles and additional staff per year.
One staff per home is added due to the anticipation of increased needs of individuals with ambulation support needs.
At least 40 people from developmental centers will benefit from the accessible renovations along with the existing people living in the homes.

RESERVE CAPITAL FOR MAJOR MAINTENANCE

	New Homes	Existing Homes	Capital Per Home	Yearly New Funding	Total Funding	Annual Funding Needed	Total Infrastructure to Budget
SFY 2007	0		$0	$0	0	$0	
SFY 2008	25		$8,000	$200,000	100	$200,000	$200,000
SFY 2009	62	$2,000,000	$8,000	$496,000	348	$2,696,000	$2,696,000
SFY 2010	62	$2,000,000	$8,000	$496,000	596	$3,192,000	$3,746,360
SFY 2011	62	$1,100,000	$8,000	$496,000	844	$2,788,000	$3,218,322
SFY 2012	62		$8,000	$496,000	1,092	$2,184,000	$2,629,383
SFY 2013	63		$8,000	$504,000	1,344	$2,688,000	$2,995,314
SFY 2014	63		$8,000	$504,000	1,596	$3,192,000	$3,510,070
SFY 2015	63		$8,000	$504,000	1,848	$3,696,000	$4,025,203
TOTAL	**462**	**5,100,000**		**$3,696,000**		**$20,636,000**	

Homes are projected to have a capacity of 4 consumers.
Agency will be credited with $2000 of maintenance costs annually for each consumer.

Individual Budget Levels

Living Arrangement	With Family				Own Home - Not with Family			
Consumer Level of Need	Level 1	Level 2	Level 3	Level 4	Level 1	Level 2	Level 3	Level 4
Core Budget	$23,050	$37,050	$47,400	$65,100	$23,050	$37,050	$ 47,400	$ 65,100
Day Activities	$ -	$ -	$ -	$ -	$ 30,000	$30,000	$ 40,000	$ 50,000
Financial Asst Toward Housing Expenses	$ -	$ -	$ -	$ -	$ 8,500	$8,500	$ 8,500	$ 8,500
Rental Assistance	$ -	$ -	$ -	$ -	$ 15,084	$ 15,084	$ 15,084	$ 15,084
Transportation	$ -	$ -	$ -	$ -	$ 5,000	$ 5,000	$ 5,000	$ 5,000
Development of a Housing Plan; Connecting & Coordinating Services & Supports	$ -	$ -	$ -	$ -	$ 15,000	$ 15,000	$ 15,000	$ 15,000
Total	**$23,050**	**$ 37,050**	**$47,400**	**$ 65,100**	**$ 96,634**	**$110,634**	**$130,984**	**$158,684**
Supplemental Behavioral Needs Levels 1 and 2 = $0 3 = $10000 4 = $15000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000
Supplemental Medical Needs Levels 1 and 2 = $0 3 and 4 = $10000 5 and 6 = $15000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000
Annual Maximum Funding	**$38,050**	**$52,050**	**$62,400**	**$80,100**	**$111,634**	**$125,634**	**$145,984**	**$173,684**
Start up - 1st year only -1X Cost	$ -	$ -	$ -	$ -	$ 5,000	$ 5,000	$ 5,000	$ 5,000
Estimated 1st Year Cost	**$38,050**	**$52,050**	**$62,400**	**$80,100**	**$116,634**	**$130,634**	**$150,984**	**$178,684**

Legend is located in Appendix L19

Individual Budget Levels

Living Arrangement	Agency Operated Supportive Housing				Agency Operated SA/GH			
Consumer Level of Need	Level 1	Level 2	Level 3	Level 4	Level 1	Level 2	Level 3	Level 4
Core Budget	$ 23,050	$ 37,050	$ 47,400	$ 65,100	$ 23,050	$ 37,050	$ 47,400	$ 65,100
Day Activities	$ 30,000	$ 30,000	$ 40,000	$ 50,000	$ 30,000	$ 30,000	$ 40,000	$ 50,000
Financial Asst Toward Housing Expenses	$ 8,500	$ 8,500	$ 8,500	$ 8,500	$ 40,000	$ 40,000	$ 40,000	$ 40,000
Rental Assistance	$ 15,084	$ 15,084	$ 15,084	$ 15,084	$ -	$ -	$ -	$ -
Transportation	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000
Development of a Housing Plan; Connecting & Coordinating Services & Supports	$ 15,000	$ 15,000	$ 15,000	$ 15,000	$ -	$ -	$ -	$ -
Total	**$ 96,634**	**$110,634**	**$130,984**	**$158,684**	**$ 98,050**	**$112,050**	**$132,400**	**$160,100**
Supplemental Behavioral Needs Levels 1 and 2 = $0 3 = $10000 4 = $15000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000
Supplemental Medical Needs Levels 1 and 2 = $0 3 and 4 = $10000 5 and 6 = $15000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000	$10,000 To $15,000
Annual Maximum Funding	**$111,634**	**$125,634**	**$145,984**	**$173,684**	**$113,050**	**$127,050**	**$147,400**	**$175,100**
Start up - 1st year only -1X Cost	$5,000	$5,000	$ 5,000	$ 5,000	$ -	$ -	$ -	$ -
Estimated 1st Year Cost	**$116,634**	**$130,634**	**$150,984**	**$178,684**	**$113,050**	**$127,050**	**$147,400**	**$175,100**

Legend is located in Appendix L19

Appendix L19

Individual Budget Levels

Individual Budget Summary

NOTE: All dollar figures presented represent "Up To" amounts for each category.
Each budget is individualized based upon level of need as determined by the DDRT Assessment.
Individual budgets will follow the person.
Rental Assistance is based on Fair Market Rent and HUD guidelines.
Agency Operated SA/GH are provided 2 months "seed" funding.
Individual receives behavioral OR medical supplemental monies, whichever is highest based upon the level established from their DDRT.

Core Budget	The Core Budget dollar amounts based on the DDRT Self Care Assessment are to be spend on residential support needs. For those individuals living with their families, day activities are also included in the Core Budget. Annual
Day Activities	The Day Activities dollar amounts are available except for those individuals living with their families as day activities are already included in the Core Budget. Annual
Financial Asst Toward Housing Expenses	Amount provided to offset utility, phone, basic cable, food, and laundry costs. Annual
Rental Assistance	Amount provided for rent. Annual
Transportation	Amount provided to allow an individual to lease a vehicle and insure it. These dollars can also be used to purchase transportation supports. Annual
Development of a Housing Plan; Connecting & Coordinating Services & Supports	Hiring of a Staffing, Community, and Housing connector. Annual
Supplemental Behavioral Needs Levels 1 and 2 = $0 3 = $10000 4 = $15000	Supplemental Behavioral Need dollar amounts are based upon needs identified in the DDRT Behavioral Assessment.
Supplemental Medical Needs Levels 1 and 2 = $0 3 and 4 = $10000 5 and 6 = $15000	Supplemental Medical Need dollar amounts are based upon needs identified in the DDRT Medical Assessment.
Start up - 1st year only -1X Cost	One time only funding to cover cost of security deposit, furniture, utility deposits, and turn on fees.