SPECIAL PARENT ADVOCACY GROUP

SPAG

A Respite Agency

FOR THE STATE OF NEW JERSEY

Welcome to Weekend Respite North Jersey, please read all of the enclosed materials and feel free to call us if you have any questions.

PHONE 609-203-5995/201-509-8961

WWW.TSPAG.ORG

1 US Route 46 W
Suite 102
Elmwood Park, NJ
07407

"Creating Pathways to Equitable Education for Children with Special Needs"

FOR MORE INFORMATION, CONTACT:
Persy @ 609-203-5995 ext 105 pmcneill@tspag.org
Cathie @ 609-203-5995 ext 110 chall@tspag.org

Special Parent Advocacy Group

Self-Hired Respite (SHR) TO DO List

The following checklist is designed to help you organize and make sure that all appropriate steps are followed as you designate your SHR respite worker and get set up for reimbursement.

SHR WORKER:

- Find a candidate to serve as your SHR Worker. (this could be any one you feel would assist your child best)
- Sit with you SHR worker and create a respite service plan Please submit that plan with your packet
- Complete the Special Parent Advocacy Group (SPAG) Mini Application
- Send your Mini app, the signed statement that you saw the negative TB results, Community Agency Head that is signed by your worker. and your respite care plan.
- After you receive your confirmation email with the welcome packet, your chosen SHR Worker can begin servicing your child.

Please Note* A *fingerprinting form will be received in your welcome packet. Your worker must be printed and cleared within 60 days of admission.***

ALL Documentation can be emailed to SHR@tspag.org or faxed to 609-642-2398

Special Parent Advocacy Group

Self-Hired Respite (SHR) Mini App

Date_____

Childs Name _____

Nickname _____

Parent/Guardians Name _____

Childs D.O.B _____

Home Address _____

Home Phone _____

Parent/Guardians Cell Phone Number _____

Childs Diagnosis _____

Workers Name _____

Parent Signature _____

ALL PAPER WORK MUST BE RECIEVED WITHIN 7 DAYS OF THE RECIEPT OF THIS PACKET

**** Note: Fingerprints need to be completed within 60 days of admission forms will be given in your welcome packet**

State of New Jersey

DEPARTMENT OF CHILDREN AND FAMILIES

CHRIS CHRISTIE
Governor
KIM GUADAGNO
Lt. Governor

ALLISON BLAKE, PH.D., L.S.W.
Commissioner

December 29, 2015

Dear Families employing Self Hired Respite workers:

Effective January 1, 2016, the Children's System of Care (CSOC), a division of New Jersey's Department of Children and Families (DCF), will begin paying on a fee for service basis the agency that provides you with self-hired respite (SHR) reimbursement funds. The change in this method of payment will allow the CSOC to expand self-hired respite to more families throughout New Jersey.

Although CSOC's method of paying the agencies will change, the agencies will continue to reimburse you for the hours of service your SHR worker provided you. This letter explains the requirements that you and your respite worker must satisfy in order for your agency to reimburse you without interruption.

It has come to CSOC's attention these requirements will take longer to complete than expected. Therefore, **we are extending the implementation period six months to June 30, 2016,** but our mutual experiences in these initial months will further inform the reasonableness of this goal. Families can be assured they will not lose self-hired respite reimbursement between January 1, 2016 and June 30, 2016, at the very least, because of the inability to meet all of the requirements. Families will be given sufficient time to come into compliance with the new requirements. CSOC further advised providers not to withhold payment to families for self-hired respite services while families attempt to comply with these new requirements.

1. The Definition of Self-Hired Respite (SHR):

The following is the definition of self-hired respite found in the contract between your agency and DCF:

> ***Self-Hired Respite (SHR):*** *This service is provided to families who want to recruit and hire their respite worker of choice. The family must ensure that their employment of the SHR worker is consistent with all Federal and New Jersey requirements and that the SHR worker has a Tax Identification Number (TIN) or an Individual Tax Identification Number (ITIN)*. The SHR worker is responsible for reporting all earned income and paying any/all applicable Federal and New Jersey income tax withholding and employment-related taxes in compliance with all Federal and New Jersey requirements in a timely manner. The family pays the worker directly and sends*

the paperwork in support of reimbursement to the provider agency on a monthly basis. The monthly documentation the families and the facilitating provider agency must maintain includes the number of respite service hours provided, copies of the respite worker's progress notes and daily log, and the amount of the self-hired stipend to be reimbursed. Agency providers of SHR dollars to families are also expected to provide training, the form of which is left to the provider, to ensure family selected respite workers are aware of and have access to the agency provider's expertise. SHR is limited to up to 60 hours per 90 days. Families can utilize the 60 hours as needed within the 90 day authorization.

**A Tax Identification Number (TIN) is the social security number and an Individual Tax Identification Number (ITIN) is a number issued for individuals who cannot obtain a social security number.*

2. <u>The Documentation of A SHR Worker's Service in Progress Notes:</u>

The progress notes and daily logs referenced in this definition refer to your SHR worker's brief description of the service visit and the youth's response to the visit. For example: *"During our three hour visit, parents were able to go out and we ate lunch and played a game, youth enjoyed the visit."*
Progress notes are signed and dated by the individual that provided the service. Provider agencies may have their own format for progress notes/daily logs. For your convenience, CSOC has provided a sample Progress Note/Daily Log template, below, that may be used. This documentation of the provided service must be sent to the provider agency in order for you to receive reimbursement for the hours provided. This documentation will be kept on file at the agency.

Sample Progress Note/Daily Log template for Self-Hired Respite workers:

YOUTH'S FULL NAME:				**DOB:**
LOCATION OF SERVICE: **TYPE OF SERVICE: SHR**				
Reason for Respite	**How Often**	**Length of Time**	**Total Time**	**Goal(s)**

DATE	**START TIME**	**END TIME**	**PROGRESS NOTE: BRIEF DESCRIPTION OF SERVICE VISIT, YOUTH'S RESPONSE, SIGNATURE**

3. The Completion of A Tuberculin Skin Test (TB), Fingerprinting, and A Respite Service Plan:

In addition to the above referenced progress notes and daily logs, this year CSOC is requiring that all respite workers have a Tuberculin (TB) skin test and be fingerprinted. Families and provider agencies must also develop a respite service plan. If you hire a new respite worker, that individual should complete the TB test prior to starting work and apply for the background check with fingerprinting. The worker may work for up to six months while waiting for the background check and fingerprinting results.

a) One-Time Tuberculin Skin Test (TB)

Individuals may obtain a TB test from multiple sources: private physician, Federally Qualified Health Center (FQHC), County Health Department, Clinics in local hospitals, and some select CVS and Walgreens pharmacies. FQHC charge using a sliding fee scale, based on income and ability to pay; County Health Departments are generally free, and CVS and Walgreens charge a set fee. It is your SHR worker's responsibility to obtain and pay for the TB test. It is your responsibility to obtain proof of completion and send the provider agency a statement that the self-hired respite worker has completed the TB test and is able to work. Do not send protected health information (actual medical records); you may keep that for your own records.

b) Fingerprinting and Background Checks (paid for by DCF CSOC)

The provider agency managing your respite service will assist you in obtaining a background check with fingerprinting of your respite worker. The provider agency will obtain the required forms (New Jersey Universal Fingerprint Form and "Exhibit D", Community Agency Head and Worker Certification, Permission for Background Check and Release of Information) from CSOC and give it to you for your respite worker to complete in order to submit to the fingerprinting service. The SHR worker and you, as witness, will sign and return "Exhibit D" to the provider agency. The SHR worker will take the fingerprint form to the fingerprinting agency and get fingerprinted. Once the fingerprinting results are completed, the fingerprinting agency will directly send the results back to the provider agency managing the SHR or to DCF. The results of the fingerprinting will be kept on file at DCF CSOC.

c) A Respite Service Plan

CSOC is also asking families to complete a yearly respite service plan which you and the provider agency can jointly create at the beginning of your service year. You will have until the end of the year of the current application period (the date by which a new Family Support Services (FSS) application must be completed) to develop a respite service plan, this can be a simple statement which gives the purpose of the service and a goal or goals you expect the service to achieve. Respite services as part of a service plan can achieve several goals: avoid "burnout"; reduce stress; prevent family disruption; and enhance relationships. For your convenience, CSOC has provided two sample respite service plans, below.

Here are a couple of examples of a respite service plan:

Reason for Respite	How Often	Length of Time	Total Time	Type of Respite (AHR,SHR, AAS, AWR, OVR)	Goal(s)
Primary Caregiver needs one on one time with other child	Twice a month	10 hours	20 hours/month	SHR	Enhance parent/child relationship, Prevent Family Disruption

Reason for Respite	How Often	Length of Time	Total Time	Type of Respite (AHR,SHR, AAS, AWR, OVR)	Goal(s)
Primary Caregiver would like time to relax at home	Two days per week	2 hours	16 hours/month	SHR	Reduce stress, Avoid "burnout"

4. <u>The Payment of an Increase to Your Respite Worker:</u>

You will continue to pay the respite worker directly just as you are doing now. However, the hourly reimbursement is now increased to $11.00 per hour. The respite worker must also sign off that s/he is receiving $11.00 per hour reimbursement from you.

Also, please encourage respite workers to take advantage of training materials and training sessions that may be offered by the provider agency.

We realize this is a lot of information and our goal is to work with providers and families to implement these changes in the manner least disruptive to service provision. If you have questions, please do not hesitate to contact the provider agency which is managing your SHR or PerformCare at 1-877-652-7624.

Sincerely,

Elizabeth Manley,
Assistant Commissioner

YOUR WORKER MUST SIGN PG 2 & Select an OPTION. ONLY VALID FOR 60 DAYS

COMMUNITY AGENCY HEAD AND EMPLOYEE CERTIFICATION, PERMISSION FOR BACKGROUND CHECK AND RELEASE OF INFORMATION

I hereby authorize the Department of Children and Families to conduct a criminal history background check and I agree to be fingerprinted in order to complete the State and Federal background check process. I further authorize the release of all information regarding the results of my background check to the Department of Children and Families. Check one of the options listed below.

Option **1** - I hereby certify under penalties of perjury, that I have not been convicted of any of the offenses listed below and no such record exists in the State Bureau of Identification in the Division of State Police or in the Federal Bureau of Investigation, Identification Division.

Option **2** - I hereby affirm that I have been convicted of the following offense listed below _____

on_____. (date)

If I have checked Option 2 or the criminal history background check reveals any conviction(s) for the offenses listed below, I understand that I may be subject to termination from employment.

FOR PROVISIONAL EMPLOYEES ONLY: As a provisional employee, I further understand that I may be employed by the agency for a period not to exceed six months during which time a background check will be completed. I understand that I will work under the supervision of a superior where possible.

Offenses covered under P.L. 1999, c.358:
In New Jersey, any crime or disorderly person offense:

--involving danger to the person as set forth in N.J.S.A. 2C:11-1 et seq. through 2C:15-1 et seq. including the following:

i. Murder

ii. Manslaughter

iii. Death by auto

iv. Simple assault

v. Aggravated assault

vi. Recklessly endangering another person

vii. Terroristic threats

viii. Kidnapping

ix. Interference with custody of children

x. Sexual assault

xi. Criminal sexual contact

xii. Lewdness

xiii. Robbery

--against the children or incompetents as set forth in N.J.S.A. 2C:24-1 et seq. including the following:

i. Endangering the welfare of a child

ii. Endangering the welfare of an incompetent person

--a crime or offense involving the manufacture, transportation, sale, possession or habitual use of a controlled dangerous substance as defined in N.J.S.A. 2C:24-1 et seq.

--in any other state or jurisdiction, conduct which, if committed in New Jersey, would constitute any of the crimes or disorderly persons offenses described above.

FOR COMMUNITY AGENCY HEAD: I understand the results of this background check will be reported to the President of the Board of my agency.

PLEASE LIST THE NAME AND HOME OR BUSINESS ADDRESS OF THE BOARD PRESIDENT.

_____

_____

_____

Employee Name (please print)	Employee (Signature Date)
Witnessed by (please print)	Witness (Signature Date)

Special Parent Advocacy Group

TB Test Acknowledgement

Date: _____

Name of Child: _____

Child's Date of Birth: _____

Name of Parent: _____

Name of SHR Worker: _____

I_____(name of Parent) hereby acknowledge that I've seen the results of my Self-Hire Respite Worker's_____(name of Worker) Tuberculosis Test. I certify that the results are negative which means that my Worker is clear to care for my child.

_____ _____

Parents Name Printed Parents Name Signed

_____ _____

Workers Name Printed Workers Name Signed

Special Parent Advocacy Group

Respite Service Plan (Annual Plan)

(simple statement that gives the purpose of the service and the goals)

Parent's Name	Parent's Signature	Date

Agency SHR Director Name	Signature	Date

Special Parent Advocacy Group

Greetings:

Welcome to the Self Hired Respite Program managed by Special Parent Advocacy Group. We are honored that you have chosen to allow us to be your provider agency. Attached you will find:

- An original copy of the log sheet where your respite provider will log their hours and activities. Please make copies as needed so that you have an ample supply.
- You will find a template for progress notes to be kept on your child by yourself and your respite provider.
- You will find an updated payment schedule with all pertinent reimbursement information.
- A PrimePoint Direct Deposit form that needs to be filled out and returned.

Again, we thank you for allowing us to assist you in providing your child with the services that are best for them, and we look forward to this new partnership.

Sincerely,

Nicole A Whitfield

Nicole Whitfield
Executive Director

20 Scotch Rd Ewing, NJ 08628 609-203-5995

Special Parent Advocacy Group

SHR FAQ's

Q: What documents are required to enroll my child in Self Hired Respite (SHR)?

A: To be admitted we need the 1. Mini Application 2. The Community Agency Head Form signed by the worker and witnessed by the parent, and 3. The results from the Tuberculin test or PPD. * You have 60 days to get us the receipt for their finger print appointment.

Q: What is the rate of pay for my worker?

A: The pay rate is $11.00 per hour.

Q: How many hours of services will I be reimbursed for?

A: Perform Care reimburses for 60 hours per 90 days. We suggest doing 20 hours per month to spread your service hours out.

Q: How many workers can I have?

A: You can hire as many workers as you like to service your child but we need all of the for mentioned forms for each one.

Q: When do I submit my log sheets? And When will I receive my reimbursements?

A: When you are admitted, you will receive a welcome packet that has a payment schedule that gives you the submission dates and payment dates for the entire year.

Q: Who do I contact If I do not receive my reimbursement.

A: You can call our central office and you will be directed to the appropriate person.

Q: How will my reimbursement be paid out?

A: Reimbursements can be directly deposited in your account or you can request to have a paper check mailed to your home.

Q: Who do I contact if I want to change my servicer, or type of service.?

A: If you want to change your service organization you can call our central office and speak to the SHR staff. If you want to change the type of program your child is enrolled in you must call PerformCare @ 1877-652-7624.

Special Parent Advocacy Group

Memo

To: SPAG SHR Parents

From: SPAG Self Hired Respite (SHR) Department

cc: SPAG SHR Staff

Date: April 13, 2017

Re: Procedure & Policy Updates

Greetings SHR Families,

Thank you for allowing SPAG to provide your SHR needs. To reiterate a few important pieces of information. At any time you can email the Program Director, Wanda Carter at wcarter@tspag.org and request your authorization dates/period and it will be provided to you. Please NOTE all log sheets must be either mailed, faxed, or emailed. The fax number is (609) 642-2398. The ***NEW*** email address that has been set up just for log sheet submission, is SHR@tspag.org. If you choose to use postal mail for your log sheets, please mail 7 days prior to due date to allow adequate time to reach our office for processing. The mailing address for SPAG is Special Parent Advocacy Group, 1 US 46 West. Ste 102 Elmwood Park, NJ 07407. When submitting your log sheets please be SURE to **TOTAL** your hours, and make sure that your service dates fall within the correct start and end date of your authorization period. **The new policies that will go into effect immediately:**

1. All enrolled SHR youth must be using at minimum 80% of their respite hours per authorization period or youth will be discharged.

2. Any missing or incorrect reimbursements must be reported to the billing department within 7 days of disbursement date.

If you have any general questions you can reach the SHR coordinator at pmcneill@tspag.org, or call 201-509-8961 or 609-203- 5995 ext. 105 and ask for Persy. If you have a payment issue or question, please direct your questions to our Accounting and Billing Office. The contact person is Wanda Carter wcarter@tspag.org or reach her via phone at 609-203-5995 ext. 112. Enclosed is also the annual schedule and a survey. Please complete the survey and submit it with your next timesheet.

IdentoGO
By MorphoTrust USA

New Jersey Universal Fingerprint Form

www.bioapplicant.com/nj

1(1) Originating Agency Number (ORI #)	(2) Category	(3) Statute Number	
NJ920540Z	**HSK**	**30:6D-64**	
(4) Reason for Fingerprinting		(5) Document Type	(6) Payment Information
HUMAN SERVICES PRIVATE CONTRACTOR		**RB2**	**BILL STATE AGENCY**
(7) Contributor's Case # (Unique Identifier)		(8) Miscellaneous	
PC1661 **(enter 4 digit cost code after PC)**			

(9) First Name	(10) MI	(11) Last Name		
(12) Daytime Phone Number	(13) Social Security Number (Optional)	(14) Date of Birth	(15) Height	(16) Weight
( ) -				
(17) Maiden or Alias Last Name	(18) Place of Birth (US State if US Citizen; Country for all others)		(19) Country of Citizenship	

(20) Home Address

Address City State Zip

(21) Gender (Select one)	(22) Hair Color	(23) Eye Color	(24) Race (Select One)
[ ] Female [ ] Male [ ] Both			[A] Asian/ Pacific Islander (includes Asian Indian) [B] Black [I] American Indian / Alaska Native [W] White (Includes Hispanic/ Spanish Origin) [U] Unknown

(25) Occupation / Position (with respect to Requirement)	(26) Employer / Organization Name (with respect to Requirement) Employer Address City State Zip

Identification Requirement - *Identification must be presented at the time of printing.* Identification presented MUST be one (1) document that is current (not expired). A combination of documents will not be accepted. The single document must include the following criteria; Photo, Name, Address (home/employer), Date of Birth and is issued by a Federal, State, County or Municipal entity for Identification purposes. Examples of acceptable ID are: 1) Valid U.S. State Photo Driver's License/ Non Driver's License, 2) U.S. Passport, 3) USCIS Permanent Resident ID Card (issued after 5/10/2010), and 4) USCIS Employment Authorization Card (issued after 10/31/2010).

Please READ this form carefully

and follow all of the instructions provided by your agency/employer to complete the fingerprint process. You must have this form (Blocks 1 through 26) completed prior to scheduling your fingerprint appointment via the website or call center. ***PLEASE PRINT LEGIBLY.*** *It is* ***required*** *you* ***present*** *this completed Universal Fingerprint Form, IDG_NJAPP_020115_V2, at your scheduled appointment.*

Appointment Scheduling:

Scheduling is available anytime at **www.bioapplicant.com/nj.** Appointments may also be scheduled through our Call Center. English and Spanish speaking agents are available at **1-877-503-5981**, Monday through Friday, 8:00AM to 5:00PM EST and Saturday, 8:00AM to 12 Noon EST.

Payment:

When an Applicant is responsible for payment, Payment Is Required at the time of scheduling. The following forms of payment are accepted: Visa, MasterCard, or electronic debit (ACH) from a checking account; accounts will be debited immediately.

Cancel/ Reschedule:

Appointments may be canceled or rescheduled via the website or the call center before the deadline of 5PM EST the business day prior to the scheduled appointment (Saturday Noon for Monday appointments). An appointment fee of $10.00 will be incurred by applicants who do not cancel/reschedule their appointment prior to the deadline. MorphoTrust will refund the remainder of the fee paid (state/federal search fees) to the original payment method.

Unable to be Fingerprinted:

An applicant is considered "Unable to be Fingerprinted" for any of the following reasons: Failure to appear for scheduled appointment; Inability to present proper Identification; Inability to present this completed Universal Fingerprint Form IDG_NJAPP_020115_V2; Information on this form does not exactly match the information provided during the scheduling process. Applicants unable to be fingerprinted will incur a $10.00 appointment fee; MorphoTrust will refund the remainder of the fee paid (state/federal search fees) to the original payment method.

PCN and Receipts:

Upon the completion of fingerprinting you will be assigned a PCN number. The PCN will be recorded on this form and on your receipt. MorphoTrust will not provide *duplicate receipts, PCN Numbers or any appointment/printing information after the time of printing.*

Applicant ID Number:	Payment Authorization:	PCN:
Scheduled Day & Date:	Scheduled Time:	Scheduled Site:
Agency Information: **STATE AND FBI BACKGROUND CHECK**		

You **MUST** retain a copy of this form and the receipt of printing for your personal records.

APPLICANTS MUST NOT ALTER, SHARE, OR REUSE THIS FORM

Employee Direct Deposit Enrollment/Change Form

One Account Per Form

Use Additional Forms for Additional Accounts

PLEASE READ AND SIGN BEFORE SUBMITTING

I hereby authorize my employer to initiate credit entries and initiate, if necessary, debit entries and adjustments for any credit entries to my account at the financial institution indicated on this form.

This authorization is to remain in full force and effect until Primepoint has received written notification from me, and Primepoint and Bank have a reasonable opportunity to act on it.

ParentName:_____ Date: _____

Parent Signature:_____

NEW ACCOUNT INFORMATION – Sample check below indentifies the routing and account numbers

Bank Name _____

Routing # ___ ___ ___ ___ ___ ___ ___ ___ ___ Account # _____

I wish to: (check one)

- ☐ Deposit Net into account
- ☐ Deposit_____% into account
- ☐ Deposit $_____into account

Account Type: (check one)

- ☐ Checking
- ☐ Savings
- ☐ HSA

REVISE / REMOVE EXISTING ACCOUNT (Please circle the action requested)

Bank Name _____

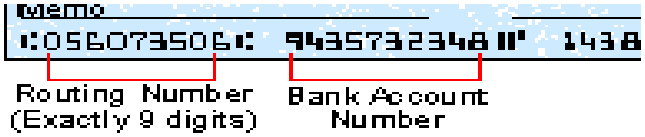
Routing # ___ ___ ___ ___ ___ ___ ___ ___ ___ Account # _____

I wish to: (check one)

- ☐ Deposit Net into account
- ☐ Deposit_____% into account
- ☐ Deposit $_____into account
- ☐ Remove from Direct Deposit

Account Type: (check one)

- ☐ Checking
- ☐ Savings
- ☐ HSA



Include a voided check or bank specification sheet for each account. DO NOT SEND A DEPOSIT SLIP.

Submit Log sheets to SHR@tspag.org or fax to 609-642-2398

Daily Log Templates for Self-Hired Respite Workers:

YOUTH'S FULL NAME:		DOB:		
LOCATION OF SERVICE:				
TYPE OF SERVICE: SHR				
Reason for Respite	How Often	Length of Time	Total Time	Goal(s)

DATE	START TIME	END TIME	PROGRESS NOTE: BRIEF DESCRIPTION OF SERVICE VISIT, YOUTH'S RESPONSE, SIGNATURE