New Jersey Department of Human Services
Division of Developmental Disabilities

Support Coordination Agency CHANGE Form

NOTE: Support Coordination Agency changes are made at the beginning of the month.

Individual's Name: _____ Date of Birth: _____

County of Residence: _____ DDD ID #: _____

Would you like to talk with someone from DDD about this change request? ☐ YES ☐ NO

If YES, provide phone number: _____ and/or complete the Change Request Feedback Form:

www.nj.gov/humanservices/ddd/documents/sca-change-request-feedback(fillable).pdf

I prefer a Support Coordinator who speaks: _____
(Enter preferred language)

Choose either Preferred Agencies or Auto-Assignment by DDD below:

☑ **Preferred Agencies** Please identify first and second choice. If the agency you choose does not serve your county or does not have the capacity to provide you with services at this time, DDD will auto-assign an agency for you.

First Choice Support Coordination Agency: Spectrum Care Management & Counseling

*Preferred Support Coordinator Name, if known**: _____

Second Choice Support Coordination Agency: Spectrum Care Management & Counseling

*Preferred Support Coordinator Name, if known**: _____

** Agencies cannot guarantee and are not required to assign a preferred Support Coordinator.*

☐ **Auto-Assignment by DDD** I do not have a preferred agency and would like DDD to auto-assign an agency for me. (Auto-Assignment cannot accommodate a preferred language request.)

Printed Name: _____ Date: _____

Email Address: _____ Phone: _____

CHOOSE ONLY ONE METHOD TO SUBMIT THIS FORM

Email To: DDD.SCAChoice@dhs.nj.gov **(Preferred)**

Or Mail To:
NJ Division of Developmental Disabilities
ATTN: SCA Choice
PO Box 726
Trenton, NJ 08625