New Jersey Department of Human Services

LONG TERM SERVICES AND SUPPORTS REFERRAL

☐ Penalty Case

To	OCCO Regional Office or AAA/ADRC Location	Date
From (Agency Name/Care Management Site/NF Provider/CCC)		
Name of Caseworker/CM/D/C Planner	Title	Telephone Number
Name of Participant	Date of Birth	Medicaid No./JACC No.
Participant Address	Telephone Number	SSN

Caregiver/Authorized Representative: _____ Relationship to Participant: _____

Address: _____

_____

Telephone Number (Work/Home): _____

E-mail: _____

FINANCIAL INFORMATION

Check appropriate box, indicating date of financial eligibility determination and monthly gross income:

☐ Medicaid Application Date: _____

☐ Medicaid Eligible Date: _____ Income Amount: $ _____

☐ SSI Date: _____ Income Amount: $ _____

☐ Potentially Medicaid Eligible (180 days) Date: _____ Income Amount: $ _____

FOR NF TRANSITIONS - CWA VERIFIES FINANCIAL ELIGIBILITY FOR WAIVER PROGRAM PARTICIPATION:

Name of CWA Employee: _____ Verification Date: _____

PARTICIPANT INFORMATION

Participant and Family interested in:

☐ Community-Based Waiver Program Specify Program: _____

☐ JACC ☐ GO ☐ ADHS ☐ PACE ☐ Initial Fast Track Referral ☐ Final Fast Track Financial Determination

☐ Section Q Options Counseling

☐ Medicaid Nursing Facility Placement

☐ PA-4 Sent ☐ PA-4 Given Date: _____ To: _____

☐ Physician Name: _____

Previous Program/Waiver Enrollment: _____

Participant's Location at this Time:

☐ Own Home ☐ Assisted Living Facility ☐ Hospital

☐ Relative's Home ☐ Residential Health Care Facility ☐ Nursing Home

☐ Other (specify): _____

Date Admitted: _____ Planned Discharge Date: _____ Days _____

Address: _____

_____

Telephone Number: _____

LONG TERM SERVICES AND SUPPORTS REFERRAL, Continued

Name of Participant	Medicaid No./JACC No.

PARTICIPANT INFORMATION, Continued

Participant is currently eligible for or receiving:

☐ HIC Medicare Number: _____ ☐ Part A ☐ Part B ☐ Part D

☐ Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program

☐ Medicaid Managed Healthcare

☐ Other Insurance:

Name: _____

Policy Number: _____

☐ Other Governmental Programs (specify): _____

☐ Community Services (specify): _____

Is the client enrolled in any other Special Program, including Hospice? ☐ Yes ☐ No

OPTIONS COUNSELING SECTION

Complete for Programs:

☐ JACC ☐ PACE ☐ GO ☐ ADHS ☐ Other (specify): _____

Participant/Family have been advised of and clearly understand:			Comments
Overview of Program:	☐ Yes	☐ No	
Financial Eligibility:	☐ Yes	☐ No	
Medical Eligibility:	☐ Yes	☐ No	
Services Available and Limitations:	☐ Yes	☐ No	
No Retroactive Eligibility:	☐ Yes	☐ No	
Cost:	☐ Yes	☐ No	

Other Pertinent Information:
(Family members or other significant persons who request to be present at the assessment; psychological/physical disabilities which would make participant interviewing difficult; foreign primary language; where the participant wants to receive services; participant/ family expectation of the long-term care programs)

Authorized Signature	Telephone Number	Fax Number	Date