# CLIENT TRACKING FORM

**New Jersey Department of Human Services**  
**Division of Aging Services**  
**Office of Long Term Services and Supports**  
**Quality Management**

To:  
- □ Care Management Provider OR  
- □ DHS Regional Office of Community Choice Options (OCCO)

From:  
- □ Assisted Living/Adult Family Care (AL/AFC) Provider OR  
- □ Care Management Provider

## MLTSS PARTICIPANT INFORMATION

<table>
<thead>
<tr>
<th>Participant Name</th>
<th>Provider Medicaid Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant Medicaid Number</td>
<td>□ Pending</td>
</tr>
<tr>
<td>Social Security Number</td>
<td></td>
</tr>
<tr>
<td>Relative/Contact Name</td>
<td>Daytime Phone Number</td>
</tr>
</tbody>
</table>

## AL/AFC PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Provider Medicaid Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Street Address, City, State, Zip Code</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Contact Person</th>
<th>Provider Phone Number</th>
</tr>
</thead>
</table>

## ACTION TO NOTE

For Use by AL/AFC Providers *(Check one)*:

- □ Admission Date to AL/AFC:  
  - Date: 
  - Destination: 
  - Phone: 

- □ Participant has entered a hospital, nursing facility (NF) or sub-acute rehab:  
  - Date: 
  - Destination: 
  - Phone: 

- □ Readmission Date to AL/AFC:  
  - Date: 

- □ Permanent Discharge/Transfer from AL/AFC Facility:  
  - Date: 
  - Destination: 
  - Phone: 
  - Reason: 

- □ Non-medical Leave from AL/AFC (> 14 days):  
  - Date: 

- □ Request for Pre-Admission Screening (PAS)

For Use by Care Management Sites:

- □ Request for Pre-Admission Screening (PAS)

Completed By *(Print Name)*  
Title

Signature  
Date