New Jersey Department of Human Services  
Division of Aging Services  
LONG TERM CARE RE-EVALUATION

1. Participant Name *(Print)*  
2. Care Manager Name *(Print)*  
3. JACC Number  
4. Date *(mm/dd/yyyy)*  
5. Previous Re-evaluation Date *(mm/dd/yyyy)*  
6. Program  
   - JACC  
   - Other

7. Functional Status

<table>
<thead>
<tr>
<th>Task</th>
<th>Independent</th>
<th>Set Up</th>
<th>Supervision</th>
<th>Limited Assistance</th>
<th>Extensive Assistance</th>
<th>Maximal Assistance</th>
<th>Total Dependence</th>
<th>Did Not Occur</th>
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<td>Bed Mobility</td>
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<td>Transfer</td>
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<td>Toilet Use</td>
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<td>Locomotion in Home/Building</td>
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<td>Locomotion Outside Home/Building</td>
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G. Nursing Facility Level of Care Criteria:

1. Does Participant meet the ADL Index criteria of 6 or greater and have any 3 ADL’s (limited assist or greater)? ......................................................... Yes  
   No  
   **NOTE: If 3 ADL criteria is not met, conference case with OCCO.**

2. Does participant meet the CPS Score criteria of 3 or greater and have any 3 ADLs (supervision or greater)? ......................................................... Yes  
   No  
   **NOTE: If 3 ADL criteria is not met, conference case with OCCO.**

3. Does Participant meet the ADL Assistance criteria by requiring limited assistance or greater in Locomotion, Dressing, AND Bathing? ......................... Yes  
   No  
   **NOTE: Participant must meet at least one of the above three (3) criteria to continue to meet clinical eligibility for Nursing Facility Level of Care.**

8. Social Support Network
1. Participant Name (Print)  

3. JACC Number

9. Physical Environment

10. Verification of Nursing Facility Level of Care

I have assessed the above participant and verify *(check one)*:

A. □ Participant continues to require nursing facility services, as defined by the New Jersey Medicaid regulations (NJAC 8:85-2.1 nursing facility services; eligibility).

B. □ Participant no longer requires nursing facility services, as defined by the New Jersey Medicaid regulations (NJAC 8:85-2.1 nursing facility services; eligibility).

□ I discussed voluntary withdrawal from the program and other service options with the participant.

□ Referred to OCCO for Nursing Facility Level of Care Assessment on *(date):* ______________

Outcome of OCCO assessment done on *(date):* ______________

□ Eligible □ Ineligible

Signature of Care Manager

Date

Reviewed by (Name)  

Title

Date