New Jersey Department of Human Services
Division of Aging Services

LONG TERM CARE RE-EVALUATION

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

7. Functional Status

A. Can Participant recall 3 items from memory after 5 minutes? ☐ Yes ☐ No

B. Can Participant perform or verbalize all or almost all steps in a multi-task sequence without cues for initiation? ☐ Yes ☐ No

C. How well does participant make decisions about organizing the day? *(Check one)*

☐ Independent ☐ Modified Independence ☐ Minimally Impaired ☐ Moderately Impaired ☐ Severely Impaired

D. How well does participant express or make self understood? *(Check one)*

☐ Understood ☐ Usually Understood ☐ Often Understood ☐ Sometimes Understood ☐ Rarely/Never Understood

E. Does participant receive nourishment through an enteral tube feeding? ☐ Yes ☐ No

F. ADL Self Performance *(score over past 3 days)*:

	Independent	Set Up	Supervision	Limited Assistance	Extensive Assistance	Maximal Assistance	Total Dependence	Did Not Occur
Bed Mobility	☐	☐	☐	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐	☐	☐	☐
Transfer	☐	☐	☐	☐	☐	☐	☐	☐
Toilet Use	☐	☐	☐	☐	☐	☐	☐	☐
Locomotion in Home/Building	☐	☐	☐	☐	☐	☐	☐	☐
Locomotion Outside Home/Building	☐	☐	☐	☐	☐	☐	☐	☐
Upper Body Dressing	☐	☐	☐	☐	☐	☐	☐	☐
Lower Body Dressing	☐	☐	☐	☐	☐	☐	☐	☐
Bathing (score over past 7 days)	☐	☐	☐	☐	☐	☐	☐	☐

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

LONG TERM CARE RE-EVALUATION
(Continued)

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