

**New Jersey Department of Health and Senior Services
LONG TERM CARE REFERRAL**

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

FINANCIAL INFORMATION

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

- Medicaid Application Date: _____
 Categorically Eligible Date: _____ Income Amount: _____
 Institutionally Eligible Date: _____ Income Amount: _____

DISABILITY INFORMATION

FOR WAIVER PROGRAMS:

Check appropriate box, indicating date of disability determination:

- Social Security Date: _____
 Disability Review Section 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: _____
 Family Member Name: _____
 Address: _____
 Telephone Number: _____

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: _____

Supportive Relative: _____ Relationship to Participant: _____

Address: _____
 Telephone Number (Work/Home): _____

LONG TERM CARE REFERRAL, Continued

| | |
|---------------------|-----------------------|
| Name of Participant | Medicaid No./JACC No. |
|---------------------|-----------------------|

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): _____

Complete for Programs:

JACC
 PACE
 GO
 ADHS
 Other (specify): _____

| | |
|--|----------|
| Participant/Family have been advised of and clearly understand: | Comments |
| Overview of Program: <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Financial Eligibility: <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Medical Eligibility: <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Services Available and Limitations: <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| No Retroactive Eligibility: <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Cost: <input type="checkbox"/> Yes <input type="checkbox"/> 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 | Date |
|----------------------|------------------|------|