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| cid:image002.jpg@01DA9C9B.873348C0 | **Residential Referral Coversheet** |

The Residential Referral Coversheet is completed when the individual/legal guardian requests residential referrals **and** the individual is in, or approved for, the Community Care Program (CCP). The coversheet provides an overview to help providers identify individuals they may be able to serve.

**Note**: If the referral source is a Division staff, use this form and work directly with the appropriate Division unit.

**Instructions for Support Coordinators**

Review below to identify the applicable situation type, and follow the corresponding steps.

1. **To conduct independent referrals:** (Division involvement is not necessary.)
2. Complete the form and upload in iRecord.
3. Identify prospective providers using the [Provider Search](https://irecord.dhs.state.nj.us/ProviderSearch) database, knowledge of community resources and any other sources of information. (For individuals assigned an acuity factor, use [Provider Search](https://irecord.dhs.state.nj.us/ProviderSearch) to verify potential providers are approved to provide acuity services.)
4. Use this form as a coversheet when sending referral packages to prospective providers.
5. Coordinate the exchange of additional information as needed.
6. Coordinate meetings between providers and the individual/legal guardian (meet & greet meetings).
7. **To request Division assistance with *urgent* situations:**
8. Ensure the completed form and all referral documents are uploaded in iRecord.
9. Support Coordinators email [DDD.SCHelpdesk@dhs.nj.gov](mailto:DDD.SCHelpdesk@dhs.nj.gov) with subject line: **Urgent Residential Referral, (DDD ID), (SCA name)**. If the Division accepts a referral as urgent, the Division takes the lead with placement planning, and the following applies:
   1. The plan coordinator does not send additional referrals.
   2. The plan coordinator provides a summary of all placement efforts to the Division, including referral agencies and outcomes, to prevent duplication. The Division follows up on pending referrals.
10. **To request addition to the File Transfer Program Secure (FTPS) server:**

The FTPS server is a secure online site for providers to review prospective referrals.

1. Complete the form and upload in iRecord with all referral documents.
2. Email [DDD.SCHelpdesk@dhs.nj.gov](mailto:DDD.SCHelpdesk@dhs.nj.gov) with subject line: **FTPS Residential Referral (DDD ID), (plan coordinator’s agency name)**.
3. Division staff reviews the referral, provides confirmation and uploads to the FTPS server.
4. The plan coordinator may continue conducting independent referrals.

**Reminders**

1. Include the *Residential Provider Response Form* and supporting documentation with every referral.
2. Plan Coordinators are not required to obtain a written request from the individual/legal guardian unless directed to do so by the Division.
3. When a provider makes an offer of residential placement, complete the following:
   1. Use the *Offer of Residential Placement Notification and Response* form to document the individual/legal guardian’s response to the offer of placement and upload in iRecord.
   2. Use the *Pre-Placement Meeting Transition Plan* tool to help facilitate a pre-placement meeting.

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| cid:image002.jpg@01DA9C9B.873348C0 | **Residential Referral Coversheet** |

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| **Identifying Information** | | |
| Individual’s name: Enter text.  Date of Birth: Enter text.  DDD ID #: Enter text.  NJCAT Score: Self-Care, Behavioral, Medical  NJCAT Date: Enter text.  Tier: Choose an item. | Date: Enter a date.  Biological Sex: Male  Female  Identifies as: Male  Female  Non-binary  Is Personal Guidance needed? Yes  No  On or approved for the CCP? Yes  *(Reminder: CCP is required)* | |
| *To add rows for co-guardians or additional contacts, click below and click the blue plus sign,* **+**. | | |
| Guardianship Status: Choose an item.  Name of Guardian: Enter text.  Relationship: Enter text.  Address: Enter text.  Phone Number: Enter text.  Email Address: Enter text. | Other Contact: Enter text.  Co-guardian?  Yes  No  Relationship: Enter text.  Address: Enter text.  Phone Number: Enter text.  Email Address: Enter text. | |
| Current residence type: Choose an item. | Current county: Choose an item. | |
| Interested in statewide vacancies? Yes No | Preferred counties: Enter text. | |
| **Referral Source** | | |
| Support Coordination Agency or Division Unit: Enter text. | | |
| Plan Coordinator: Enter text. | Phone Number: Enter text.  Email Address: Enter text. | |
| Plan Coordinator’s Supervisor: Enter text. | Phone Number: Enter text.  Email Address: Enter text. | |
| **Reason for the Referral** | | |
| Is ***urgent*** assistance requested from the Division? | | Yes  No |
| **Check all that apply:** | | |
| Immediate health/safety concern (imminent peril)  Homeless or imminent homelessness  Provider discharge approved by DDD  Disposition issue from hospital or rehab facility  Planned return to community from hospital/rehab  NJ Dept. of Children and Families (DCF) Age-Out  Local Educational Agency (LEA) Age-Out | Individual/legal guardian transfer request  Own home individual/legal guardian requesting  placement in a licensed setting for the first time  Upload to the FTPS server  Discharge from DC/SNF/state psychiatric hospital  Incarcerated, pending release  Other: Enter text. | |
| If the individual is currently in a hospital or other facility, enter the following:  Name of hospital/facility: Enter text. Date of admission: Enter text. | | |

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| *Briefly* summarize current, relevant information regarding the reason for residential referral: | | | | | |
| Enter text. | | | | | |
| *Complete this section* ***only*** *if requesting* ***urgent*** *assistance from the Division.* | | | | | |
| Please include any *additional* information, explaining the urgent request: | | | | | |
| Enter text. | | | | | |
| Has the Planning Team met to address concerns? | | | | | Yes  No |
| Date(s): Enter text. *(Ensure meeting minutes are uploaded in iRecord.)* | | | | | |
| If Yes, briefly describe the outcome. If No, please explain why not: | | | | | |
| Enter text. | | | | | |
| Please list all services currently received, including natural/generic supports and times of day. | | | | | |
| Enter text. | | | | | |
| **Services and Supports** | | | | | |
| What does the individual currently do during the week? Choose an item. | | | | | |
| Please describe, including whether or not it is important to keep this arrangement: | | | | | |
| Enter text. | | | | | |
| Are other services anticipated, in addition to Individual Supports Daily Rate? | | | | | Yes  No |
| If yes, please explain: Enter text. | | | | | |
| *Briefly* summarize support needs in each of the following areas: | | | | | |
| Self-care: Enter text. | | | | | |
| Behavioral: Enter text. | | | | | |
| Medical: Enter text. | | | | | |
| Supervision at home: Enter text. | | | | | |
| Supervision in the community: Enter text. | | | | | |
| Check all that apply: | | | | | |
|  | Ambulation support needed |  | | Prader-Willi Syndrome diagnosis | |
|  | Barrier-free setting required |  | | Eats/Mouths inedible objects (Pica) | |
|  | Hearing impairment |  | | Risk of choking / aspiration | |
|  | Vision impairment |  | | Dual diagnosis / Mental health diagnosis | |
|  | Adaptive equipment / Medical equipment |  | | Trained service animal in place | |
|  | Restrictive supports (ex: helmet for SIB) |  | | Walkaway risk | |
|  | Specialized diet |  | | Behavioral acuity / Risk to self, others, property | |
|  | Non-routine medical needs |  | | Substance use / Addiction | |
|  | Medical acuity / On-site nursing (RN or LPN) needed |  | | Other: Enter text. | |
| Provide a brief description for each item checked: | | | | | |
| Enter text. | | | | | |
| **Required Documentation** | | | | | |
| Indicate documents included with this referral *(missing information will delay processing)*: | | | | | |
| Residential Provider Response Form  NJ ISP / IHP for individuals leaving a DC  ☐ Annual medical | | | PCPT or Supports Needed Checklist  NJCAT assessment  Social History | | |
| Addressing Enhanced Needs Form *(required with behavioral and/or medical acuity)* | | | | | |
| *If any of the following apply, documentation is* ***required.*** | | | | | |
| ☐ Behavioral assessment / Behavior support plan\*  ☐ Fire-setting information *or* risk assessment\*  ☐ Psychosexual information *or* risk assessment\*  ☐ Megan’s Law documentation / conditions  ☐ Dept. of Children/Families (DCF) Documentation | | | Guardianship judgment / Power of attorney  Hospital records if currently hospitalized  Legal involvement  Other: medical, psychiatric, psychological, etc.  Please specify: Enter text. | | |
| *\*If a formal assessment is not in place, a description in the ISP and/or a separate explanation is required.* | | | | | |
| **Attestation** | | | | | |
| **By submitting this form, the referral source attests to the following:**   * Preferred counties on page 1 were reviewed with the individual/legal guardian and are accurate. * The individual/legal guardian has requested residential referral(s). * The individual/legal guardian understands that in urgent situations involving homelessness or imminent peril, geographic preference will be considered but cannot be guaranteed. After the emergent situation is resolved, the individual/legal guardian will have the option to request a transfer based on preference.   Name: Enter text.  Date of discussion with individual/legal guardian: Enter a date.  *(Ensure case notes are up to date.)* | | | | | |