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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 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 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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| **Identifying Information** |
| Individual’s name: Enter text.Date of Birth: Enter text.DDD ID #: Enter text.NJCAT Score: Self-Care, Behavioral, MedicalNJCAT 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 [x] *(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 [ ]  NoRelationship: 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.)* |