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| DDD/SC Staff Completing Form: Click here to enter text. | | | DDD/SC Staff Phone: Click here to enter text. | | | |
| Name of Division QAS/Mentor: | | | QAS/Mentor: Phone Number: | | |  |
| Individual’s Name: Click here to enter text. | | | DOB: Click here to enter text. | | DDDiD: Click here to enter text. | |
| Guardianship:  Plenary:  Limited:  Self: | | Guardian Name: Click here to enter text.  Guardian Address: Click here to enter text. | | | | |
| Level of Care (LOC) Eligible?  Yes:  No:  In Process:  Comments: Click here to enter text. NJCAT/DDRT Scores: Click here to enter text. | | CCW Eligible:  Yes:  No:  In Process:  Comments: Click here to enter text. | | | | |
| Medicaid Number(s): Click here to enter text. | | Medicare Number: Click here to enter text. | | | | |
| Currently Placed In: (Check One)  State Psychiatric Hospital:  Nursing Facility: | | | | | | |
| Current Facility Name: Click here to enter text. | Current Facility Address: Click here to enter text. | | | Date of Admission:  Click here to enter text. | | |
| Originating ALA Provider or Own Home (OH) Name:  Click here to enter text. | Originating ALA or OH Address:  Click here to enter text. | | | Contact at Provider/OH: Click here to enter text.  Telephone Number: Click here to enter text. | | |
| **Support Coordination Agency Information** | | | | | | |
| Name of Support Coordination Agency:  Name of Support Coordinator:       Phone Number:       Email:  Name of Support Coordinator Supervisor:       Phone Number:       Email:  Name of Division QAS/Mentor:       Phone Number:       Email: | | | | | | |
| ***The following must be completed and outcomes known before case transfer can occur.***  ***Please note that Intake and Eligibility must be completed before case transfer.*** | | | | | | |
| 1. Discussion with originating provider about allowing the individual to return to residence has occurred (Required if person was placed with an agency immediately prior to hospitalization)?   Yes  No  Please describe outcome in detail (Offers of additional supports, etc…)  Click here to enter text. | | | | | | |
| 1. Referral to Emergency Capacity Systems (Required if person meets LOC)?   Yes  No  Please describe outcome in detail (Offers of additional supports, etc…)  Click here to enter text. | | | | | | |
| 1. Referral to available vacancy (Required if person meets LOC)?   Yes  No  Please describe dates of referral(s) and outcome(s) in detail (Offers of additional supports, etc. Specify if residential placement has been confirmed with the individual’s guardian.) | | | | | | |
| 1. In-Home Supports/Supports Program discussed with family (When applicable, especially when LOC is at issue)?   Yes  No  Please describe outcome in detail:  Click here to enter text. | | | | | | |
| 1. Referral to available day program?   Yes  No  Please describe dates of referral(s) and outcome(s) in detail (Offers of additional supports, etc…)  Click here to enter text.  *For Olmstead Unit Use Only* | | | | | | |
| Request Made By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Request:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Case Transfer Approved: Yes  No  If transfer not approved, provide reason: Click here to enter text. | | | | | | |