**Intensive Case Management (ICM) Referral for Support Coordination**

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| **Do not use this form if the individual is already enrolled on the Community Care Program (CCP)**Instructions:1. If the individual/family requests placement or an in-home CCP budget, review the **Community Care Program (CCP) FAQ** with them.
2. Ensure that the issue prompting the ICM Request is documented in a case note and/or a Monthly Monitoring Tool.
3. Ensure that all services available thru the budget have been inserted to address the need(s).
4. If the individual’s self-care score is a 1 or 2, ensure that a housing voucher with supports OR a boarding home have been explored.
5. Obtain a SIGNED Letter of Request (from the legal guardian/individual/family) and upload to iRecord using this format: ICM Letter of Request (ID#).
6. Complete the ICM Referral form and upload to iRecord using this format: ICM Request (ID#)
7. SCS attests their support of the referral

The SC Supervisor should then send an email to DDD.SCHelpdesk@dhs.nj.gov using subject line: ICM Request (ID#) (SCA). **Do not include any attachments with this email. All supporting documents should be uploaded.**  |
| **REFERRAL/DEMOGRAPHIC INFORMATION** |
| **Requested CCP service:** Choose an item. | **Date:** Click or tap to enter a date. |
| **Individual’s Name:** Click or tap here to enter text. | **DDD ID #:** Click or tap here to enter text. **Date of Birth:** Click or tap to enter a date. |
| **Supports Program** [ ] **Interim** [ ]  | **Full address:** Click or tap here to enter text. |
| **County:** Click or tap here to enter text. | **Phone Number:** Click or tap here to enter text. |
| **Name of Legal Guardian:** Click or tap here to enter text.**Ensure guardianship judgment is uploaded** | **Phone Number:** Click or tap here to enter text. |
| **Self-Care- Behavioral-Medical Score:** Click or tap here to enter text. **Tier:** Click or tap here to enter text. | **Medicaid Eligible:** Choose an item. |
| **SUPPORT COORDINATION AGENCY INFORMATION** |
| **Name of Support Coordination Agency:** Click or tap here to enter text. | **Name of Division Quality Assurance Specialist:** Click or tap here to enter text. |
| **Name of Support Coordinator:** Click or tap here to enter text. | **Phone Number:**Click or tap here to enter text. | **Email:**Click or tap here to enter text. |
| **Name of Support Coordinator Supervisor:** Click or tap here to enter text. | **Phone Number:** Click or tap here to enter text. | **Email:** Click or tap here to enter text. |
| **Has the planning team recommended a reassessment due to a significant change in need and are these changes documented in case note(s), MMTs, and iRecord tiles**? Choose an item. | **If applicable, on what date was the NJCAT Request for Reassessment submitted? Click or tap here to enter text.****Ensure request and corrected proc is uploaded.** |
|  **EMERGENT CRITERIA****For Emergency Access to the CCP (placement or in-home CCP budget), the individual must be homeless and/or be in imminent peril AND meet an institutional level of care. Further, it must be demonstrated that supports/services through the Supports Program do not / will not mitigate the emergent risk to health/safety.**  |
| **On what date did the SC review the Community Care Program (CCP) FAQ** **sheet with the Guardian / family?**Click or tap to enter a date. |
| **Is or will the person be homeless and what are the details?** Choose an item.**\*If the individual will be homeless today/tomorrow, refer to the Escalation Procedure on the Communication Protocol and contact DDD.****Would a Housing Voucher alleviate the emergent situation?** Choose an item.**Rationale:** Click or tap here to enter text.**Would a Boarding Home alleviate the emergent situation?** Choose an item.**Rationale:** Click or tap here to enter text. |
| **If placement is requested, has the individual been asked where he/she wants to live? If yes, please describe. If no, why not.** Click or tap here to enter text. |
| **If the age of the caregiver prompted the referral, please list the name and age of each caregiver in the home:** Click or tap here to enter text. |
| **If the health of the caregiver prompted the referral, please provide diagnosis and impairment that prevents the caregiver from providing support in the home:** Click or tap here to enter text. |
| **How does the care and supervision needs of the individual put the individual/caregivers/others in the home at risk?** Click or tap here to enter text. |
| **Describe current examples of risk to health or safety that may be contributing to imminent peril.**Click or tap here to enter text.**Why do services/supports through the Supports Program not address the emergent risk?** Click or tap here to enter text.**Has a Bump Up or any Wrap funding been providedspecific to the emergent need(s) outlined in this request?** Click or tap here to enter text.**If self-care score is 1 or 2, describe support needs not currently being met.** Click or tap here to enter text. |
| **Has there been police involvement in the past year?** Choose an item.**If yes, have charges been filed?** Click or tap here to enter text.**Details:** Click or tap here to enter text.**Has Adult Protective Services been involved with this individual or family?** Choose an item.**If yes, please describe:** Click or tap here to enter text. |
| **What is the date of the last home visit?** Click or tap to enter a date.**Based on that home visit, describe your observations about the individual’s behavior or home environment that suggested there was a need for increased supports or services:** Click or tap here to enter text. |
| **Have there been any hospitalizations in the past year?** Choose an item.**If yes, what were the dates and reason(s) for Hospitalization (Behavioral/Mental Health or Medical):** Click or tap here to enter text. |
| **SUPPORTS and SERVICES****All applicable fields must be completed.** **Each service type requires a response even if service is not presently being utilized** |
| **Service Type/ Provider of Service** | **Provider Name** | **Frequency/Duration** | **Funding Source** | **Cost** | **Status / Comment** **\*Required even if service not received.**  |
| **Community Based Supports (CBS)** | Click or tap here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Choose an item.Comment:Click or tap here to enter text. |
| **Natural Supports**  | Click or tap here to enter text.**Relationship:**Click or tap here to enter text. | Click here to enter text. | Natural / Generic | N/A  | Choose an item.Comment:Click or tap here to enter text. |
| **Self-Directed Employee(s)** | Click or tap here to enter text.**Relationship:**Click or tap here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Choose an item. Comment:Click or tap here to enter text. |
| **Day Hab/Community Inclusion/****Employer** | Click or tap here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Choose an item.Comment:Click or tap here to enter text. |
| **Mental Health Services**  | Click or tap here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Choose an item.Comment:Click or tap here to enter text. |
| **Personal Preference Program (PPP) or Personal Care Attendant (PCA)**  | Click or tap here to enter text.**Relationship:**Click or tap here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Choose an item.Comment:Click or tap here to enter text. |
| **Behavioral Supports including CARES, DDHA, Serv**  | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Choose an item.Comment:Click or tap here to enter text. |
| **Other Services** | Click or tap here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Choose an item.Comment:Click or tap here to enter text. |
| **Is the full budget being utilized?** Click or tap here to enter text.**If no, please explain:** Click or tap here to enter text. |
| **Are there services presently listed in the ISP that are not being utilized that could be stopped to free up Units for other needed services?** Click or tap here to enter text.**Are there “extracurricular” services that because of the present situation are not determined beneficial at this time and could be stopped to free up units for needed services?** Click or tap here to enter text. |
| **Do you have any additional detail about what circumstance prompted the request for Intensive Case Management?** Click or tap here to enter text. |
| **SC SUPERVISOR SECTION** |
| **SC Supervisor Attestation:** Click or tap here to enter text. **(SCS NAME) reviewed the ICM Referral with the SC on** Click or tap to enter a date.[ ]  **The emergent circumstance and any changes in need have been documented in IRecord (notes, MMT, ISP tiles)**[ ]  **I support this request.** [ ]  **Signed/Dated Letter of request from Legal Guardian/Family/Individual is uploaded to iRecord** |