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| **COVER SHEET** Page 1  (used to share information with prospective providers) | | | | | | | |
| 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. | | DOB: Click or tap to enter a date. |
| Gender:  Male  Female | | | Current Provider Agency: Click or tap here to enter text. | | | | |
| NJCAT: Self-care: Choose an item. Behavioral: Choose an item. Medical: Choose an item. Tier: Click or tap here to enter text. | | | | | | | |
| Current Address: Click or tap here to enter text. | | | Current county of residence:  Click or tap here to enter text. | | Phone: Click or tap here to enter text. | | |
| Requested Program Type:  Licensed  Unlicensed | | | Requested Counties:  Click here to enter text. | | Interested in Statewide opportunities:  Yes  No | | |
| Initial placement from own home | | | | Residential transfer due to preference  Provider discharge which has been approved by DDD | | | |
| **Support Coordination Agency Information** | | | | | | | |
| Support Coordinator Name:  Click here to enter text. | | Support Coordinator Phone: Click here to enter text. | | | | Support Coordinator Email:  Click here to enter text. | |
| Name of SC Supervisor: Click or tap here to enter text. | | Phone number of SC Supervisor: Click or tap here to enter text. | | | | Email address of SC Supervisor: Click or tap here to enter text. | |
| Support Coordination Agency Name:Click here to enter text. | | | | | | | |
| **Guardian Information** | | | | | | | |
| Guardian Name:  Click here to enter text. | | Guardian Phone: Click here to enter text. | | | | Guardian Email: Click here to enter text. | |
| **Is this request urgent (risk of imminent peril or homelessness)  Yes  No If yes, please check appropriate box below** | | | | | | | |
| Hospital Disposition issue  Change in need that current provider cannot address Choose an item. | | | | Health/safety concern. Describe: Click or tap here to enter text.  Date of IDT to review concerns: Click or tap to enter a date. | | | |
| **Referral Documents to be Submitted to the Provider Agency (Ensure documents are uploaded to the i-record)** | | | | | | | |
| NJISP / Service Plan  Behavior Support Plan  Psychological Evaluation(s)  Medical Documentation  Guardianship Paperwork  HSRS (if available)  Other (Example: physical, consults, etc…) List here: Click or tap here to enter text. | | | | | | | |
| **Cover Sheet (Page 2)** | | | | | | | |
| **Individual’s name:**Click or tap here to enter text. | | | | **DDD ID#:** Click or tap here to enter text. | | | |
| **Overview of the Individual’s Needs.** Provide clear support needs within each corresponding category, especially for NJCAT score of 3 or higher | | | | | | | |
| **Self-Care:** Click or tap here to enter text.  **Behavioral:** Click or tap here to enter text. | | | | **Medical:** Click or tap here to enter text.  **Supervision:** Click or tap here to enter text. | | | |
| **Current Services** | | | | | | | |
| Service Type/Provider of Service | | | Frequency/Duration | | Funding Source | | |
| Click here to enter text. | | | Click here to enter text. | | Click here to enter text. | | |
| Click here to enter text. | | | Click here to enter text. | | Click here to enter text. | | |
| Click here to enter text. | | | Click here to enter text. | | Click 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. | | |
| **Housing and Individual Support Needs** | | | | | | | |
| Ambulation Choose an item.  Other Accessiblity Needs Click here to enter text.  Barrier Free  Hearing Impaired  Visually Impaired | | On-site Nursing Required  Reason for On-Site Nursing: Click here to enter text.  Specialized DietChoose an item.  PICA | | | | Behavioral Supports  Describe behavioral support needs:  Click here to enter text.  Sexually Inappropriate  Megan’s Law  Aggressive to Others  Dual Diagnosed | |

**Instructions for Support Coordinator- page 3**

This form should not be used if the team has identified an alternate vacancy with the same provider.

SC should document history of the request in case notes and by uploading team meeting minutes, as applicable.

If the residential provider has given notice that they intend to discharge the individual from the residential program, the provider should advise the individual/family and send the Notice to Discharge letter to [DDD.PPMU@dhs.nj.gov](mailto:DDD.PPMU@dhs.nj.gov) in accordance with the CCP Manual section 12.4.1. The SC should await further direction from the SCU Monitoring Unit before submitting the RTR as Division approval is required before the discharge request moves forward.

If a residential transfer or initial out of home placement **for a CCP eligible individual** is requested:

1. The SC should make direct referrals (use the RTR page 1 as Cover Sheet) to prospective providers identified by the individual, guardian, family OR by conducting independent research using the I-Record Provider Search located at  <https://irecord.dhs.nj.gov/providersearch>.
2. If the referral is urgent (**risk of imminent peril or homelessness**), upload the completed referral to iRecord and send an email to the [DDD.SCHelpdesk@dhs.nj.gov](mailto:DDD.SCHelpdesk@dhs.nj.gov) using this subject line: Residential Transfer Referral (ID#) (SCA) URGENT. A monitor will be assigned to guide you throughout the placement process, as needed. The monitor will provide the referral documents to CDU for upload to the secure server\*.
3. If the family would like to write a letter about their concerns involving a provider, direct that letter to the [DDD.PPMU@dhs.nj.gov](mailto:DDD.PPMU@dhs.nj.gov)

If the SC will be conducting independent referrals but would like to have the referral documents added to the File Transfer Program Secure (FTPS) server, upload the RTR to iRecord and email the [DDD.SCHelpdesk@dhs.nj.gov](mailto:DDD.SCHelpdesk@dhs.nj.gov) using the subject line ‘Residential Transfer Referral (ID#) (SCA) FTPS only’. SC is responsible to provide any additional information which may be requested by the provider.

**SC will:**

* **Facilitate all referrals**
* **Coordinate times for prospective providers to meet the individual and their guardian (referred to as Meet & Greet)**
* **Facilitate pre-placement meeting**

\*A monitor will be assigned to screen the referral, provide initial guidance, and serve as the point person for questions throughout the process

**Background (will not be shared with prospective providers)-** page 4

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| --- | --- |
| **Individual Name:**Click or tap here to enter text. | **DDD ID#:** Click or tap here to enter text. |
| **Please describe the reason the individual/family/guardian has requested placement or transfer.** | |
| Click or tap here to enter text. | |
| **Attestation:** | |
| Signature of Individual/guardian attests that:   * Requested counties list on page one are accurate * Description provided by the SC above is accurate * Transfer has been requested * I understand that in urgent situations involving homelessness or imminent peril, geographic preference will be considered but cannot be guaranteed.  The emergent situation must be remedied as immediately as possible and the individual/guardian will have the option to request a transfer for preference once housing, health and safety have been assured. | |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |