New Jersey Department of Human Services
Division of Aging Services

PARTICIPANT RECORD TRANSFER COVER SHEET

Name of Participant: _____ Date of Birth: _____

Program: ☐ Jersey Assistance for Community Caregiving (JACC)
☐ Other

Date of Transfer: _____

Medicaid/JACC Number: _____ Social Security Number: _____

Residential Setting: ☐ Private Residence ☐ Class B Boarding Home

Address Change? ☐ Yes ☐ No

Old Address: _____ New/Current Address: _____

_____ _____

Old County: _____ New/Current County: _____

Participant Phone Number: _____

Emergency Contact Person/Phone: _____

The participant identified above has been transferred to your agency for care management (CM).

Receiving Care Management Agency contact information:

Agency: _____ Phone: _____

Address: _____

Enclosed care copies of information from the original Referral Packet:

☐ PA-4 ☐ CP-2/SINQ ☐ CP-5 ☐ NJ Choice

☐ Release of Information ☐ Choice of Care ☐ Agreement of Understanding

Enclosed are also copies of the most recent documents:

☐ Monitoring Record (for month of enrollment and for past 12 months/I year
☐ Assisted Living/Adult Family Care Cost Share, if applicable
☐ LOC Reevaluation (WPA-1) ☐ NBCAT
☐ Plan of Care (WPA-2) ☐ HCBS Database update:
☐ Service Cost Record (including ☐ ISAs and ☐ new CM Agency)
☐ PEP Approval Documentation **High Risk**: ☐ No ☐ Yes ☐ Critical*
☐ MCO: _____ ***If Critical, date of CM phone conference:** _____
☐ Other: _____

	Date:		Date:	Next Due
Change of Address Notification Made: ☐ N/A		Monthly Contact completed on:		
County Welfare Agency		Quarterly Visit completed on:		
Office of Community Choice Options ☐ Northern ☐ Southern		Plan of Care completed on:		
Social Security Administration		LOC Reevaluation completed on:		

Sending Care Management Agency contact information:

Care Manager Name: _____ Agency: _____

Address: _____ County: _____

Phone: _____ Email Address: _____

_____ _____

Sending Care Manager Signature **Date** **Sending CM Supervisor Signature** **Date**