New Jersey Department of Human Services
Division of Aging Services

INSTRUCTIONS FOR COMPLETING THE CLIENT TRACKING FORM (ACS-13)

To: ..... Enter the name of the person to whom this form is being submitted.
Check whether the receiving person is located at either a (1) Care Management site, or (2) the Department of Human Services (DHS), Regional Office of Community Choice Options.
From: ..... Enter the name and phone number of the person who is sending this form.
Check whether the sending person represents (1) an Assisted Living/Adult Family Care provider or (2) a Care Management provider.
Date: ..... Enter the date this form is completed (month/day/year).

MLTSS PARTICIPANT INFORMATION
Participant Name: ..... Enter participant's first name and last name.
Participant Medicaid Number: ..... Enter participant's 12 digit Medicaid Number.
Pending: ..... Enter an "X" in the box if participant's Medicaid Number is pending.
Social Security Number: ..... Enter participant's Social Security Number.
Relative/Contact Name: ..... Provide the full name of the participant's relative/contact person.
Daytime Phone Number: ..... Enter the daytime phone number of the participant's contact.

AL/AFC PROVIDER INFORMATION
Complete this section if the provider submitting this form is an Assisted Living/Adult Family Care provider; otherwise check: ☐ N/A
Provider Name: ..... Enter name of facility/program/sponsor agency.
Provider Medicaid Number: ..... Enter provider's Medicaid number.
Provider Street Address: ..... Enter provider's street address.
City, State, Zip Code ..... Enter provider's city, state, and zip code.
Provider Contact Person: ..... Enter the full name of the provider contact person.
Provider Phone Number: ..... Enter contact person's phone number.

ACTION TO NOTE
(Check <u>ONE</u> of the boxes for the appropriate option.)

<u>For Use by AL/AFC Providers</u>
Admission Date to AL/AFC: ..... Enter the date the participant was admitted to AL/AFC facility/program.
Participant has entered a hospital,
NF or sub-acute rehab: ..... Enter an "X" in the box if participant has entered a hospital, NF or sub-acute rehab.
Date: ..... Enter date of participant's transfer to a hospital/NF/rehab facility
Destination: ..... Enter participant's new address.
Phone: ..... Enter the participant or new facility's phone number.
Readmission Date to AL/AFC: ..... Enter the date the participant was readmitted to AL/AFC facility/program from a hospital, nursing facility, or sub-acute care.
Permanent Discharge/Transfer
from AL/AFC: ..... Enter an "X" in the box if participant has been discharged from facility/program.
Date: ..... Enter the date of the discharge.
Destination: ..... Enter participant's new address and identify location as relative's home, boarding house, other AL Facility, hospital, etc.
Phone: ..... Enter phone number of new location.
Reason: ..... Enter reasons for permanent discharge.

Non-medical leave from AL/AFC
(> 14 days): ..... Enter the dates that the participant has been out of the AL/AFC for non-medical reasons above 14 days.
Request for Pre-Admission
Screening: ..... Enter an "X "in the box to advise Care Manager to request a PAS for a resident to determine appropriateness for AL/AFC services.
Date of Death: ..... Enter an "X" in the box to report participant's death and enter the date of death.

<u>For Use by Care Management Sites</u>
Request for Pre-Admission
Screening: ..... Enter an "X" in the box to request a PAS for a resident to determine appropriateness for AL/AFC services.

<u>Completed By</u>
Completed by Print Name, Title,
Signature and Date: ..... Person preparing this form prints his or her Name and Title, and signs and dates the form.