New Jersey Department of Human Services
Division of Aging Services

INSTRUCTIONS FOR COMPLETING THE
ASSISTED LIVING/ADULT FAMILY CARE REFERRAL (AL-6) FORM

APPLICANT BACKGROUND INFORMATION

Please print and complete all referral information in the **"Applicant Background Information"** section.

Name of Applicant:	Enter the first name, middle initial and last name.
Street Address City, State, Zip Code:	Enter applicant's street address, town and zip code.
Social Security Number:	Enter the applicant's nine-digit social security number.
Date of Birth:	Enter the applicant's date of birth (month/day/year).
Telephone Number:	Enter the telephone number of the applicant.
Medicaid Application Filed at CWA?:	Indicate whether the applicant has filed an application for Medicaid Application with the County Welfare Agency to determine financial eligibility.
County of Application:	Enter the County in which the Medicaid Application was filed.
Caregiver/Legal Representative:	If applicant has a legal representative (or family member), include his or her name and relationship.
Telephone Number:	Enter the phone number of the Applicant's caregiver or Legal Representative.
Referring AL/AFC Provider:	Enter the name of the AL/AFC provider submitting this Referral Form.
Telephone Number:	Enter the phone number of the AL/AFC provider.
Reason for Referral:	Indicate whether applicant is spending down or will be a new admission.

APPLICANT CLINICAL INFORMATION

Diagnosis:	Provide the applicant's medical diagnosis, if known.
Activities of Daily Living:	Check the level of assistance the applicant requires for **all** Activities of Daily Living.
Cognitive Status:	Check whether the applicant is impaired or cognitively intact in the areas of short-term memory, decision making, and making self understood.
Target Population:	Indicate if the applicant is within the target population for the MLTSS Medicaid Waiver by checking either Yes or No. If the applicant is not within the target population, the applicant is ineligible for MLTSS and the AL facility is to counsel the applicant on other options.
Other Care Needs:	State the care needs that the AL/AFC staff has identified for the applicant.
Social Information/Family Supports:	Provide current living situation, if known, and activities in which the applicant participates on a daily or weekly basis.

APPLICANT FINANCIAL INFORMATION

To the extent gathered in the AL/AFC admission interview, provide the following:

a. Monthly Income:	Provide the monthly total for Social Security, Pension and any other income.
b. Resources:	Include bank accounts, stocks, bonds and sources.
c. Face Value of Life Insurance Policy(ies)	(Cash value if known.)
Signature and Date	AL/AFC representative completing the Referral Form shall print and sign his/her name, indicate his/her title, then date the document.

When using the AL/AFC Referral Form, the provider shall remind the applicant that:
1) processing the AL/AFC Referral Form does not constitute enrollment in the MLTSS Medicaid Waiver;
2) nor does it guarantee residency for the applicant at the referring AL/AFC facility; and
3) if the applicant is found eligible for the MLTSS Medicaid Waiver, there may be a Cost Share to the applicant, which is dependent on his or her income and allowable deductions.