**New Jersey Department of Human Services**

**Division of Developmental Disabilities**

**Community Transitions Unit (CTU) Case Transfer Form**

Used for Individuals, currently in a long-term facility, interested in returning to the community.

When complete, Support Coordinators upload in iRecord and notify the [DDD SCHelpdesk](mailto:DDD.SCHelpdesk@dhs.nj.gov).

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| **General Information** | |
| Name: Click to enter text.  DDD ID: Click to enter text.  Date of Birth: Click to enter text. | NJCAT score: Self-Care, Behavioral, Medical  Tier: Choose an item.  Date of Assessment: Click to enter text. |
| Guardianship Status: Choose an item.  Name of Guardian: Click to enter text.  Relationship: Click to enter text.  Address: Click to enter text.  Phone Number: Click to enter text.  Email address: Click to enter text. | Current Facility Type: Choose an item.  Date of Admission: Click to enter text.  Name of Facility: Click to enter text.  Address: Click to enter text.  Contact Person: Click to enter text.  Phone Number: Click to enter text. |
| Medicaid Number: Click to enter text. | Medicare Number, if applicable: Click to enter text. |
| Current Program Enrollment: Choose an item.  If **not** on CCP at this time, is CCP eligibility in process? Yes No Please explain: Click to enter text. | |
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| **Originating Placement Information** | |
| Where was the Individual living prior to placement in a facility? Choose an item.  If a provider managed setting, enter the agency’s name: Click to enter text.  Originating Address: Click to enter text. | |
| Contact Person’s Name and Relationship:  Click to enter text. | Phone Number and Email Address:  Click to enter text. |
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| **Documentation** | |
| Have these documents been uploaded to iRecord?   1. DDD Eligibility letter: Yes  No   If no, contact the local [DDD Intake Unit](https://www.state.nj.us/humanservices/ddd/about/contactus/communityservices/) to request a copy be uploaded, **and** enter a case note.   1. Guardianship Judgment: Yes  No  N/A 2. All current, relevant Medical, Behavioral, Psychiatric, etc. Evaluations: Yes  No | |

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| Have these documents been **located**?   1. Birth Certificate: ***(Do not upload to iRecord.)*** Who is in possession of the Birth Certificate?   Service Provider  Individual/Legal Guardian/Family  DDD Paper File  Enter a contact person’s name and phone number: Click to enter text.  Unknown – Describe efforts to locate: Click to enter text.   1. Social Security Card: ***(Do not upload to iRecord.)*** Who is in possession of the Social Security Card?   Service Provider  Individual/Legal Guardian/Family  DDD Paper File  Enter a contact person’s name and phone number: Click to enter text.  Unknown – Describe efforts to locate: Click to enter text. |

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| **Additional Information** |
| 1. Provide a brief summary explaining why the Individual is living in a facility: Click to enter text.   Provide a brief overview of the Individual’s care needs: Click to enter text.   1. If original setting was provider managed, has the provider submitted a discharge request to DDD? Yes  No  (A provider cannot discharge an Individual without written permission from DDD.)   If no, has discussion occurred regarding the Individual returning to the residence? (This is required. Ensure documentation is up to date in case notes / Planning Team meeting minutes.)  Yes  No  N/A  (Use N/A only if the original setting was the Individual’s own home.)  Describe the outcome of discussion with the provider: Click to enter text.   1. Has discussion occurred with the Individual/legal guardian/family regarding CCP in-home supports or Supports Program with housing subsidy? (Use the Independent Living Discussion Tool as needed.)   Yes  No  If yes, describe outcome of discussion. If no, please explain: Click to enter text.   1. If on the CCP, have residential referrals been completed?   Yes  No  If yes, list the date of referral, provider agency name and outcome or status of each referral:  Click to enter text.   1. Was the Individual previously attending a day program, or was there involvement from DVRS?   Yes  No  If yes, please explain and be sure to name the service provider: Click to enter text.  Have day program referrals been completed?  Yes  No  If yes, list the date of referral, provider agency name and outcome or status of each referral:  Click to enter text. |

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| **Support Coordination Agency Information** | |
| SCA Name: Click to enter text. | |
| Support Coordinator Name:  Click to enter text. | Phone Number / Email Address:  Click to enter text. |
| SC Supervisor Name:  Click to enter text. | Phone Number / Email Address:  Click to enter text. |
| ***This form completed by:*** | |
| Name: Click to enter text. Title: Click to enter text. Date: Click to enter a date. | |

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| ***To be completed by the Community Transitions Unit:*** |
| Request made by: Click to enter text. Date request was received: Click to enter a date.  Case transfer accepted? Yes  No  If **no**, explain the reason and copy/paste the explanation in iRecord case notes:  Click to enter text. |