

**New Jersey Department of Human Services  
LONG TERM SERVICES AND SUPPORTS REFERRAL**

<input type="checkbox"/> Penalty Case
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To	OCCO Regional Office AAA/ADRC Location	Date
From (Agency Name/Care Management Site/NF Provider/CCC)		
Name of Caseworker/CM/D/C Planner	Title	Telephone Number
Name of Participant	Date of Birth	Medicaid No./JACC No.
Participant Address		SSN

**FINANCIAL INFORMATION**

Check appropriate box, indicating date of financial eligibility determination and monthly gross income:

<input type="checkbox"/> Medicaid Application	Date: _____	
<input type="checkbox"/> Medicaid Eligible	Date: _____	Income Amount: \$ _____
<input type="checkbox"/> SSI	Date: _____	Income Amount: \$ _____
<input type="checkbox"/> Potentially Medicaid Eligible (180 days)	Date: _____	Income Amount: \$ _____
<input type="checkbox"/> Non-Medicaid Eligible	Date: _____	Income Amount: \$ _____

**FOR NF TRANSITIONS - CWA VERIFIES FINANCIAL ELIGIBILITY FOR WAIVER PROGRAM PARTICIPATION:**

Name of CWA Employee: _____	Verification Date: _____
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**PARTICIPANT INFORMATION**

Participant and Family interested in:

<input type="checkbox"/> Community-Based Waiver Program	Specify Program: _____
<input type="checkbox"/> JACC <input type="checkbox"/> GO <input type="checkbox"/> ADHS <input type="checkbox"/> PACE	<input type="checkbox"/> Initial Fast Track Referral <input type="checkbox"/> Final Fast Track Financial Determination
<input type="checkbox"/> Section Q Options Counseling	
<input type="checkbox"/> Medicaid Nursing Facility Placement	
<input type="checkbox"/> Non-Medicaid HCBS Services	
<input type="checkbox"/> PA-4 Sent <input type="checkbox"/> PA-4 Given	Date: _____ To: _____
<input type="checkbox"/> Physician Name: _____	
<input type="checkbox"/> Family Member Name: _____	
Address: _____	
Telephone Number: _____	

Previous Program/Waiver Enrollment: \_\_\_\_\_

Participant's Location at this Time:

<input type="checkbox"/> Own Home	<input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> Hospital
<input type="checkbox"/> Relative's Home	<input type="checkbox"/> Residential Health Care Facility	<input type="checkbox"/> Nursing Home
<input type="checkbox"/> Other (specify): _____		
Date Admitted: _____	Planned Discharge Date: _____	Days _____
Address: _____		
Telephone Number: _____		

Supportive Relative: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number (Work/Home): \_\_\_\_\_

## LONG TERM SERVICES AND SUPPORTS REFERRAL, Continued

Name of Participant _____	Medicaid No./JACC No. _____
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### PARTICIPANT INFORMATION, Continued

Participant is currently eligible for or receiving:

HIC Medicare Number: \_\_\_\_\_     
  Part A     
  Part B     
  Part D

Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program

Medicaid Managed Healthcare

Other Insurance:
   
 Name: \_\_\_\_\_
   
 Policy Number: \_\_\_\_\_

Other Governmental Programs (specify): \_\_\_\_\_

Community Services (specify): \_\_\_\_\_

Is the client enrolled in any other Special Program, including Hospice?     
  Yes     
  No

Complete for Programs:

JACC   
  PACE   
  GO   
  ADHS   
  Other (specify): \_\_\_\_\_

Participant/Family have been advised of and clearly understand:	Comments
Overview of Program: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Financial Eligibility: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical Eligibility: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Services Available and Limitations: <input type="checkbox"/> Yes <input type="checkbox"/> No	
No Retroactive Eligibility: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cost: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Other Pertinent Information:

(Family members or other significant persons who request to be present at the assessment; psychological/physical disabilities which would make participant interviewing difficult; foreign primary language; where the participant wants to receive services; participant/family expectation of the long-term care programs)

Authorized Signature _____	Telephone Number _____	Fax Number _____	Date _____
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