

New Jersey Department of Human Services  
Division of Aging Services  
Office of Long Term Care Options

**HOSPITAL PREADMISSION SCREENING REFERRAL**

Type of Hospital:     Traditional/Acute     Acute Rehab     Psychiatric     Other

***PLEASE PRINT***

Hospital \_\_\_\_\_ Date \_\_\_\_\_

Referred By \_\_\_\_\_

Telephone Number \_\_\_\_\_

**PATIENT INFORMATION**

Name \_\_\_\_\_ (Last) (First) (MI)    DOB \_\_\_\_\_

Sex     Male     Female

HSP # \_\_\_\_\_    SS# \_\_\_\_\_

Home Address \_\_\_\_\_

Responsible Party \_\_\_\_\_

Home Telephone No. (    ) \_\_\_\_\_    Work Telephone No. (    ) \_\_\_\_\_

**ADMISSION INFORMATION**

Date of Admission \_\_\_\_\_    Floor \_\_\_\_\_

Admitted From \_\_\_\_\_    Room # \_\_\_\_\_

Primary Admitting Diagnosis \_\_\_\_\_

Secondary Admitting Diagnosis \_\_\_\_\_

**PASRR [Level 1 Screen must be completed by Hospital before submitting to OCCO for PAS.]**

Date PASRR Level I Screen Completed \_\_\_\_\_

Level I PASRR Outcome:     Positive     Negative

**ELIGIBILITY STATUS**

Currently Medicaid Eligible

Date Referred to CWA \_\_\_\_\_

Application in Process

180 Days Potentially Eligible