|  |  |
| --- | --- |
| cid:image002.jpg@01DA9C9B.873348C0 | **Intensive Case Management (ICM) Referral** |

**Instructions**

1. When an individual/legal guardian contacts their Support Coordinator (SC) to request immediate access to the Community Care Program, the SC reviews the [Community Care Program (CCP) Fact Sheet](https://www.nj.gov/humanservices/ddd/assets/documents/providers/ccp-fact-sheet.pdf) with them.
2. The SC ensures that all services available through the Supports Program (SP) budget have been added to the ISP to address the individual’s needs.
3. If the individual’s NJCAT self-care score is a 1 or 2, the SC ensures that a housing voucher with supports and/or a boarding home/residential healthcare facility has been explored.
4. The SC ensures that all supporting documents are uploaded in iRecord.
5. The SC completes the Intensive Case Management (ICM) Referral, reviews with the SC Supervisor and uploads it in iRecord using this format: “ICM Referral, (DDD ID#)”.
6. The SC Supervisor sends an email *without* an attachment to DDD.SCHelpdesk@dhs.nj.gov to request a review, with the subject line: “ICM Referral, (DDD ID#), (SCA)”.

**Emergency Criteria**: For CCP approval, there must be an issue of homelessness or imminent peril, which cannot be resolved through the Supports Program, and the individual must meet institutional Level of Care (LOC) criteria.

**Note**: This form is not used for individuals already on the CCP.

|  |
| --- |
| **Identifying Information** |
| Date of Request: Enter a date. | Requested CCP Service: Choose an item. |
| Name: Enter text.DDD ID #: Enter text.Address: Enter text.County: Choose an item. | Date of Birth: Enter text.NJCAT Score: Self-Care, Behavioral, MedicalTier: Choose an item.Date of Assessment: Enter text. |
| Is the individual in a temporary living situation such as hospital, shelter, hotel, facility, etc.? | Yes [ ]  No [ ]  |
| If Yes, please specify: Enter text. |
| Contact person’s name and phone number: Enter Name, Enter Phone. |
| Person making the request: *(If this person is a legal guardian, leave blank and complete the next column.)*Enter text.Relationship: Enter text.Phone Number: Enter text.Email Address: Enter text. | Guardianship Status: Choose an item.Name of Guardian: Enter text.Relationship: Enter text.Address: Enter text.Phone Number: Enter text.Email Address: Enter text. |
| Current Program Enrollment:Choose an item. | Is the individual Medicaid eligible?  | Yes [ ]  No [ ]  |
| On what date did the SC review the [Community Care Program (CCP) Fact Sheet](https://www.nj.gov/humanservices/ddd/assets/documents/providers/ccp-fact-sheet.pdf) with the individual/legal guardian?  | Enter a date. |
| Does the NJCAT continue to be an accurate reflection of supervision and support needs? | Yes [ ]  No [ ]  |
| If No, on what date was a Reassessment Request submitted? (or explain the status): Enter text.*(If completed, ensure a copy of the Reassessment Request and the NJCAT with comments are uploaded in iRecord.)* |

|  |
| --- |
| **Homelessness** |
| Is the individual currently homeless, or at risk of immediate homelessness? | Yes [ ]  No [ ]  |
| **If Yes:**1. Contact the Division immediately through the Support Coordination Helpdesk: DDD.SCHelpdesk@dhs.nj.gov subject line: “(DDD ID#), Homelessness”. (Outside of normal business hours, contact the Division’s on-call system.)
2. Please explain: Enter text.
 |
| If the individual’s NJCAT Self-Care score is 1 or 2, answer both of the following questions:For “No” answers, describe the need for assistance on a daily basis (personal guidance) and the outcomes to boarding home or residential healthcare facility referrals, as applicable. |
| Would a Housing Subsidy alleviate the emergent situation? | Yes [ ]  No [ ]  |
| Please explain: Enter text. |
| Would a boarding home or residential healthcare facility alleviate the emergent situation? | Yes [ ]  No [ ]  |
| Please explain: Enter text. |
| **Imminent Peril** |
| Describe how the individual’s support needs, *related to the developmental disability*, create a risk to health/safety in the home: |
| Enter text. |
| Provide current, *specific*examples demonstrating risk to health/safety: |
| Enter text. |
| Explain why services/supports available through the Supports Program budget are not able to address the individual’s needs and the risk to health/safety: |
| Enter text. |
| If the individual is requesting residential placement, have they been asked where they want to live? | Yes [ ]  No [ ]  |
| If Yes, please provide details. If no, please explain: Enter text. |
| Provide any additional information you may have regarding the circumstances prompting the ICM Referral:  |
| Enter text. |
| Has a bump-up or wraparound emergency assistance been provided to address the current situation? Explain if necessary: Enter text. | Yes [ ]  No [ ]  |
| **Caregiver Information** |
| Is the age and/or health of the caregiver(s) prompting the ICM Referral? | Yes [ ]  No [ ]  |
| If Yes, list the name, age and health concerns/diagnosis(es) of each caregiver in the home, andexplain the impairment preventing the caregiver(s) from providing the needed support: |
| Enter text.  |
| **Crisis Services** |
| Has there been police involvement within the past year? | Yes [ ]  No [ ]  |
| If Yes, are charges filed or pending? | Yes [ ]  No [ ]  |
| Please explain: Enter text. |
| Has there been Adult Protective Services involvement within the past year? | Yes [ ]  No [ ]  |
| If Yes, please explain: Enter text. |
| Has the individual or caregiver(s) been hospitalized within the past year? | Yes [ ]  No [ ]  |
| If Yes, provide the dates and reasons for hospitalization (i.e., behavioral, psychiatric, medical):Enter text. |
| **Services and Supports** |
| For each service, use the drop down list to select the status and provide a description/explanation.If the individual receives the service, enter the provider’s name, funding source and cost to budget.If a service is received through more than one provider, use the “enter” key to list additional information. |
| **Day Habilitation / Community Inclusion / Employment**: Choose an item. |
| Describe or explain: Enter text. |
| Provider Name | Funding Source | Cost to Budget |
| Enter text. | Enter text. | Enter text. |
| **Community Based Supports**: Choose an item. |
| Describe or explain: Enter text. |
| Provider Name | Funding Source | Cost to Budget |
| Enter text. | Enter text. | Enter text. |
| **Self-Directed Employee**: Choose an item. |
| Describe or explain: Enter text. |
| Provider Name | Funding Source | Cost to Budget |
| Enter text. | Enter text. | Enter text. |
| **Natural Supports** (family, relatives, neighbors, friends, etc.)**:** Choose an item. |
| Describe or explain: Enter text. |
| Name and Relationship | Funding Source | Cost to Budget |
| Enter text. | N/A | N/A |
| **Mental Health Services**: Choose an item. |
| Describe or explain: Enter text. |
| Provider Name | Funding Source | Cost to Budget |
| Enter text. | Enter text. | Enter text. |
| **Personal Preference Program (PPP) / Personal Care Assistant (PCA)**: Choose an item. |
| Describe or explain: Enter text. |
| Provider Name | Funding Source | Cost to Budget |
| Enter text. | Enter text. | Enter text. |
| **Behavioral Supports (including CARES, DDHA, Serv)**: Choose an item. |
| Describe or explain: Enter text. |
| Provider Name | Funding Source | Cost to Budget |
| Enter text. | Enter text. | Enter text. |
| **Other Medicaid or NJ Funded Services:** Choose an item. |
| Describe or explain: Enter text. |
| Provider Name | Funding Source | Cost to Budget |
| Enter text. | Enter text. | Enter text. |

|  |  |
| --- | --- |
| In situations where a caregiver is paid through the Personal Preference Program (PPP), a DDD Self-Directed Employee model or works for a Community Based Supports (CBS) Provider, would the emergent situation be mitigated if Service Provider staff provided this support, instead of the caregiver? | Yes [ ]  No [ ] n/a [ ]  |
| For either Yes or No, please explain: Enter text. |
| Is the current budget fully utilized? | Yes [ ]  No [ ]  |
| If No, please explain: Enter text. |
| Does the current ISP contain services *not being utilized* or *not needed*, that could be stopped to create room in the budget for other needed services? | Yes [ ]  No [ ]  |
| Please explain: Enter text. |
| What is the date of the last SC home visit? Enter text.Based on that home visit, describe observations suggesting the need for increased support or services:Enter text. |
| **Weekly Schedule** |
| For each service the individual currently receives, including natural/generic supports, enter the name of the service and the times of day the service is offered. ***(****To add rows, click on the last row and click the Plus Sign,* **+***.)* |
| Service | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
| Enter Service | Enter Times | Enter Times | Enter Times | Enter Times | Enter Times | Enter Times | Enter Times |
| Enter Service | Enter Times | Enter Times | Enter Times | Enter Times | Enter Times | Enter Times | Enter Times |
| Enter Service | Enter Times | Enter Times | Enter Times | Enter Times | Enter Times | Enter Times | Enter Times |

|  |
| --- |
| **Support Coordination Agency Information** |
| Support Coordination Agency: Enter text. |
| Support Coordinator: Enter text. | Phone Number: Enter text.Email Address: Enter text. |

|  |
| --- |
| **SC Supervisor Attestation** |
| [ ]  The emergent circumstance and changes in support needs are documented in case notes/MTs/the ISP. |
| [ ]  The SCS and SC have reviewed this ICM Referral. | Date: Enter a date. |
| SC Supervisor Name: Enter text. | Phone Number: Enter text.Email Address: Enter text. |