**Support Coordination Request for Intensive Case Management (ICM)**

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| **Do not use this form if the individual is enrolled in the Community Care Program (CCP)**  Instructions:   1. If the individual/family requests placement or an in-home CCP budget, review the NJ DDD CCP and Housing FAQs with them. 2. Ensure that the issue prompting the ICM Request is documented in a case note and/or a Monthly Monitoring Tool. 3. Ensure that all services available thru the budget have been inserted to address the need(s). 4. If the individual’s self-care score is a 1 or 2, ensure that a housing voucher with supports OR a boarding home have been explored. 5. Obtain a SIGNED Letter of Request (from the legal guardian/individual/family) and upload to iRecord using this format: ICM Letter of Request (ID#). 6. Complete the ICM Request form and upload to iRecord using this format: ICM Request (ID#) 7. SCS attests their support of the referral   The SC Supervisor should then send an email to [DDD.SCHelpdesk@dhs.state.nj.us](mailto:DDD.SCHelpdesk@dhs.state.nj.us) using this subject line: ICM Request (ID#) (SCA). **Do not include any attachments with this email. All supporting documents should be uploaded.** | | | | | | | | |
| **REFERRAL/DEMOGRAPHIC INFORMATION** | | | | | | | |
| **Requested CCP service:** | | | | **Date:** | | | |
| **Name of Individual:** Click or tap here to enter text. | | | | **Date of Birth:** | | | |
| **Supports Program  Interim** | | | | **Full address:** | | | |
| **County:** Click or tap here to enter text. | | | | **Phone Number:** | | | |
| **Name of Legal Guardian:**  **Ensure guardianship judgment is uploaded** | | | | **Phone Number:** | | | |
| **Self-Care- Behavioral-Medical Score:**  **Tier:** | | | | **Medicaid Eligible:** | | | |
| **SUPPORT COORDINATION AGENCY INFORMATION** | | | | | | | |
| **Name of Support Coordination Agency:** | | | | **Name of Division Quality Assurance Specialist:** | | | |
| **Name of Support Coordinator:** | | | | **Phone Number:** | | **Email:** | |
| **Name of Support Coordinator Supervisor:** | | | | **Phone Number:** | | **Email:** | |
| **Individual/Family FAQ and Waiting List History** | | | | | | | |
| **On what date did the SC review the CCP Frequently Asked Questions sheet with the family?** Click or tap to enter a date. | | | | | | | |
| **Has the individual’s name been added to the CCP Waiting List (WL)?** Choose an item. | | | | **If yes, what date (Refer to Waiver and Medicaid History of iRecord)?** Click or tap to enter a date.**.** | | | |
| **Emergent Criteria**  **For Emergency Access to the CCP (placement or in-home CCP budget), the individual must be homeless and/or be in imminent peril (supports/services will not mitigate the emergent risk to health/safety) AND meet an institutional level of care.** | | | | | | | |
| **Is or will the person be homeless and what are the details?** Choose an item.  **If the individual will be homeless today/tomorrow then refer to the Escalation Procedure on the Communication Protocol and contact DDD.** | | | | | | | |
| **Describe current examples of risk to health or safety that may be contributing to imminent peril.**  Click or tap here to enter text. | | | | | | | |
| **Why would services/supports not address the emergent risk?** Click or tap here to enter text. | | | | | | | |
| **Has the planning team recommended a reassessment due to a significant change in need and are these changes documented in case note(s), MMTs, and iRecord tiles**?Choose an item. | | | | **If applicable, on what date was the NJCAT Request for Reassessment submitted? Click or tap here to enter text.**  **Ensure request and corrected proc is uploaded.** | | | |
| **If self-care score is 1 or 2, describe support needs not currently being met.** Click or tap here to enter text. | | | | | | | |
| **If placement is requested, has the individual been asked where he/she wants to live? If yes, please explain. If no, why not.** Click or tap here to enter text. | | | | | | | |
| **CURRENT SUPPORTS and SERVICES. Ensure that all services available (both generic and thru the budget) have been inserted to address the need(s).** | | | | | | | |
| **Service Type/ Provider of Service** | **Provider Name** | **Frequency/Duration** | **Funding Source** | | **Cost** | | **Comment** |
| **Day Program/**  **Employer** |  | Click here to enter text. | Click here to enter text. | | Click here to enter text. | | Click here to enter text. |
| **Mental Health Services** |  | Click here to enter text. | Click here to enter text. | | Click here to enter text. | | Click here to enter text. |
| **Personal Preference Program (PPP) or Personal Care Attendant (PCA). Information required** |  | Click here to enter text. | Click here to enter text. | | Click here to enter text. | | If a referral for PPP or PCA has not been explored/is approved but not utilized please provide justification: Click or tap here to enter text. |
| **Behavioral Supports including CARES, DDHA, Serv Information required if individual has behavioral support needs** | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. | | If a referral for Behavioral Supports has not been explored, please provide justification. Click or tap here to enter text. |
| **Other Services** |  | Click here to enter text. | Click here to enter text. | | Click here to enter text. | | Click here to enter text. |
| **Are there any services that are pending/being requested?**  **If yes, please describe:** | | | | | | | |
| **Are there any barriers to inserting supports or services?** Choose an item.  **Is the full budget being utilized?** Click or tap here to enter text.  **If no, please explain:** | | | | | | | |
| **Has the budget been exhausted?**  **Please provide detail:** Click or tap here to enter text. | | | | | | | |
| **If the age of the caregiver prompted the referral, please list the name and age of each caregiver in the home:** Click or tap here to enter text. | | | | | | | |
| **If the health of the caregiver prompted the referral, please provide diagnosis and impairment that prevents the caregiver from providing support in the home:** Click or tap here to enter text. | | | | | | | |
| **How does the care and supervision needs of the individual put the individual/caregivers/others in the home at risk?**  Click or tap here to enter text. | | | | | | | |
| **Would a Housing Voucher alleviate the emergent situation?** Choose an item.  **Rationale:** | | | | | | | |
| **Would a Boarding Home alleviate the emergent situation?** Choose an item.  **Rationale:** Click or tap here to enter text. | | | | | | | |
| **If the concern pertains to the individual’s reported risk of financial exploitation, has a referral been made to a representative payee program?:** Choose an item.  **If no, please explain:** Click or tap here to enter text. | | | | | | | |
| **Has there been police involvement in the past year?** Click or tap here to enter text.  **If yes, have charges been filed?** Click or tap here to enter text.  **Details:** Click or tap here to enter text.  **Has Adult Protective Services been involved with this individual or family?**  **If yes, please describe:** | | | | | | | |
| **What is the date of the last home visit?** Click or tap to enter a date. | | | | | | | |
| **Based on that home visit, describe your observations about the individual’s behavior or home environment that suggested there was a need for increased supports or services:** Click or tap here to enter text. | | | | | | | |
| **Provide an overall assessment of the current situation and service needs, including services offered:** | | | | | | | |
| **Do you have any additional detail about what circumstance prompted the request for Intensive Case Management?** Click or tap here to enter text. | | | | | | | |
| **HISTORY OF HOSPITALIZATIONS** | | | | | | | |
| **Have there been any hospitalizations in the past year.** Click or tap here to enter text.  **If yes, what were the dates and reason(s) for Hospitalization:** | | | | | | | |
| **SC SUPERVISOR SECTION** | | | | | | | |
| **SC Supervisor Attestation:** Click or tap here to enter text. **(SCS NAME) reviewed the ICM Referral with the SC on** Click or tap to enter a date.  **The emergent circumstance and any changes in need have been documented in IRecord (notes, MMT, tiles)**  **I support this request.**  **Signed/Dated Letter of request from Legal Guardian/Family/Individual is uploaded to iRecord** | | | | | | | |