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| DDD/SC Staff Completing Form: Click here to enter text. | DDD/SC Staff Phone: Click here to enter text. |
| Name of Division QAS/Mentor: | QAS/Mentor: Phone Number: |  |
| Individual’s Name: Click here to enter text. | DOB: Click here to enter text. | DDDiD: Click here to enter text. |
| Guardianship: Plenary: [ ]  Limited: [ ]  Self: [ ]  | Guardian Name: Click here to enter text.Guardian Address: Click here to enter text. |
| Level of Care (LOC) Eligible?Yes: [ ]  No: [ ]  In Process: [ ]  Comments: Click here to enter text.NJCAT/DDRT Scores: Click here to enter text. | CCW Eligible:Yes: [ ]  No: [ ]  In Process: [ ]  Comments: Click here to enter text. |
| Medicaid Number(s): Click here to enter text. | Medicare Number: Click here to enter text. |
| Currently Placed In: (Check One) State Psychiatric Hospital: [ ]  Nursing Facility: [ ]  |
| Current Facility Name: Click here to enter text. | Current Facility Address: Click here to enter text. | Date of Admission:Click here to enter text. |
| Originating ALA Provider or Own Home (OH) Name:Click here to enter text. | Originating ALA or OH Address:Click here to enter text. | Contact at Provider/OH: Click here to enter text.Telephone Number: Click here to enter text. |
| **Support Coordination Agency Information** |
| Name of Support Coordination Agency:      Name of Support Coordinator:       Phone Number:       Email:      Name of Support Coordinator Supervisor:       Phone Number:       Email:      Name of Division QAS/Mentor:       Phone Number:       Email:       |
| ***The following must be completed and outcomes known before case transfer can occur.******Please note that Intake and Eligibility must be completed before case transfer.*** |
| 1. Discussion with originating provider about allowing the individual to return to residence has occurred (Required if person was placed with an agency immediately prior to hospitalization)?

Yes [ ]  No [ ] Please describe outcome in detail (Offers of additional supports, etc…)Click here to enter text. |
| 1. Referral to Emergency Capacity Systems (Required if person meets LOC)?

Yes [ ]  No [ ] Please describe outcome in detail (Offers of additional supports, etc…)Click here to enter text. |
| 1. Referral to available vacancy (Required if person meets LOC)?

Yes [ ]  No [ ] Please describe dates of referral(s) and outcome(s) in detail (Offers of additional supports, etc. Specify if residential placement has been confirmed with the individual’s guardian.) |
| 1. In-Home Supports/Supports Program discussed with family (When applicable, especially when LOC is at issue)?

Yes [ ]  No [ ] Please describe outcome in detail:Click here to enter text. |
| 1. Referral to available day program?

Yes [ ]  No [ ] Please describe dates of referral(s) and outcome(s) in detail (Offers of additional supports, etc…)Click here to enter text.*For Olmstead Unit Use Only* |
| Request Made By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Request:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Case Transfer Approved: Yes [ ]  No [ ] If transfer not approved, provide reason: Click here to enter text. |