**New Jersey Department of Human Services**

**Division of Developmental Disabilities**

**Residential Referral Coversheet**

Used for residential referrals conducted by SCAs and DDD, for individuals already on the CCP

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| **Individual Information** | | |
| Name:  Click to enter text. | Date of Birth:  Click to enter text. | Current Date:  Click to enter a date. |
| DDD ID: Click to enter text.  On CCP? Yes  No  Reminder: CCP is required | NJCAT Score and Tier:  Click to enter Score.  Click to enter Tier. | Biological Sex: Male  Female Identifies as:  Male  Female  Non-binary |
| Guardianship Status:  Choose an item. | Name of Guardian:  Click to enter text.  Relationship: Click to enter text.  Phone Number: Click to enter text.  Email address: Click to enter text. | Other Contact Name:  Click to enter text.  Relationship: Click to enter text.  Phone Number: Click to enter text.  Email address: Click to enter text. |
| Interested in Statewide Opportunities? Yes  No | Preferred Counties:  Click to enter text. | Requested Program Type:  Choose an item. |

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| **Support Coordination Agency Information** | |
| SCA Name:  Click to enter text. | Agency Status:  Choose an item. |
| Support Coordinator Name:  Click to enter text. | Phone Number / Email Address:  Click to enter text. |
| SC Supervisor Name:  Click to enter text. | Phone Number / Email Address:  Click to enter text. |

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| **Current Residential Information** | |
| Current Program Type:  Choose an item. | Current Residential Provider Name:  Click to enter text. |
| Current Address:  Click to enter text. | Current County:  Choose an item. |
| Provider Contact Name:  Click to enter text. | Phone Number / Email Address:  Click to enter text. |

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| **Reason for the Referral** | |
| Answer **one** of the following: |  |
| If **urgent**, what is the reason?  Choose an item. | If **not urgent**, what is the reason for the referral?  Choose an item. |
| Is the individual currently hospitalized? Yes  No  If yes, date of admission: Click to enter text.  Name of Hospital: Click to enter text. | |
| Has the Planning Team/IDT met to address concerns? (Ensure Meeting Minutes are uploaded to iRecord.)  Yes  No  Dates: Click to enter text.  If yes, briefly describe the outcome of Planning Team/IDT meetings: Click to enter text. | |
| Briefly explain relevant, current information regarding the reason for the referral (400 character maximum): | |
| **Support Needs** | |
| Describe Self-Care Support Needs  Click here to enter text. | Describe Behavioral Support Needs  Click here to enter text. |
| Describe Medical Support Needs  Click here to enter text. | Supervision Needs in the Home and Community:  Click here to enter text. |
| List **Day Program** and **all** current services: Service Type, Provider, Frequency / Duration, Funding Source:  Click to enter Day Program information.  Click to enter all other service information. | |
| Check each of the following that applies: | |
| Ambulation Support  Barrier-Free Setting Required  Hearing Impaired  Visually Impaired  Adaptive Equipment / Medical Equipment  Specialized Diet  Non-Routine Medical Needs  On-Site Nursing (RN or LPN)  Prader Willi Syndrome | PICA  Fire Setting  Elopement Risk  Aggressive Behaviors  Behavior Support Plan  Sexually Inappropriate Behaviors  Megan’s Law Involvement  Dual Diagnosis / Mental Health Diagnosis  Other |
| Provide a brief description for each item checked:  Click or tap here to enter text. | |

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| **Attestation** |
| Entering your name below confirms the following was reviewed with the Individual/Legal Guardian:   * Preferred counties listed on page one are accurate. * The Individual/Legal Guardian has requested a residential referral. * The Individual/Legal Guardian understands that in urgent situations involving homelessness or imminent peril, geographic preference will be considered but cannot be guaranteed.  The emergent situation must be remedied as immediately as possible. The Individual/Legal Guardian will have the option to request a transfer for preference once housing, health and safety have been assured.   Name of SCA staff completing this form: Click to enter text. Title: Click to enter text.  Date of discussion with Individual/Legal Guardian: Click to enter a date. (Ensure case notes are up to date.) |

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| Documents included with this referral: | |
| ISP  PCPT  NJCAT Assessment  Annual Medical | Behavior Support Plan  Guardianship Judgment  Psychological  Other: Medical, Behavioral, Psychiatric evals. etc. |
| Please Specify: Click or tap here to enter text. | |