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| --- | --- |
| **General Information****Individual Name:** Click here to enter text.**Date of Birth:** Click or tap to enter a date.**DDD ID:** Click here to enter text.**Waiver Type:** Choose an item.**Medicaid:** [ ]  Yes [ ]  No**Individual Address:** Click here to enter text.**County of Residence:** Click here to enter text.**Living Arrangement:** [ ]  Own Home [ ]  Licensed Residence\*[ ]  Non-licensed Agency Residence\***\*Residential Provider Information (if applicable)****Provider Name**: Click here to enter text.**Provider Contact**: Click here to enter text.**Contact Phone:** Click here to enter text.**Individual Plan Information****NJCAT Score/Tier:** Click here to enter text.**Acuity Factor:** [ ]  Yes [ ]  No (If yes, AENF must be attached)**Date of NJCAT:** Click or tap to enter a date.**Has a reassessment been requested?** [ ]  Yes [ ]  No**If yes, date of request:** Click or tap to enter a date. **ISP Approval Date:** Click or tap to enter a date.**PCPT Date:** Click or tap to enter a date. | **Family/Guardianship Information****Guardian Status:** Choose an item.**Guardian Name:** Click here to enter text.**Guardian Telephone:** Click here to enter text.**Guardian Email:** Click here to enter text.**Family Involvement:** [ ]  Yes [ ]  No**Family Member Name:** Click here to enter text.**Family Member Telephone:** Click here to enter text.**Family Member Email:** Click here to enter text.**Support Coordination Information****Support Coordination Agency**: Click here to enter text.**Support Coordinator:** Click here to enter text.**Telephone:** Click here to enter text.**Email:** Click here to enter text.**Support Coordination Supervisor:** Click here to enter text.**Telephone:** Click here to enter text.**Email:** Click here to enter text.**Date of Last Contact:** Click here to enter a date.**Date of Last Home Visit:** Click here to enter a date.**Division QAS/Mentor:** Click here to enter text.**Telephone:** Click here to enter text.**Email:** Click here to enter text. |
| **Request Rational***Please answer the following questions regarding, background, actions taken to date and outcomes.* 1. What is the reason for referral? Choose an item.
	1. Please provide details including medical appointments, diagnoses, crisis interventions/restraints, medications, need for nursing services/ 24 hour continuous plan of care related to DD: Click here to enter text.
2. Has there been an increase in Incident Reports? [ ]  Yes [ ]  No
	1. If yes, provide details about this increase: Click here to enter text.
3. Has there been an increase in hospitalizations?
	1. Reason(s) for Hospitalization: Click here to enter text.
	2. Date of Hospitalization(s): Click or tap to enter a date.
		1. If more than one please list and provide details: Click here to enter text.
4. Has there been an increase in staffing to support the increased support needs? [ ]  Yes [ ]  No
	1. If yes, provide details about this increase: Click here to enter text.
5. What needs are not currently being meet at the current living arrangement? Click here to enter text.
6. What additional supports havebeen requested/explored to maintain services in the individual’s current home? Click here to enter text.
	1. What was the outcome? Click here to enter text.
7. Have alternate community living arrangements been explored? [ ]  Yes [ ]  No
	1. If yes, what was the outcome? Click here to enter text.
	2. If no, why not? Click here to enter text.
8. Has PPMU been involved with the current residential provider to explore technical assistance options? [ ]  Yes [ ]  No
	1. If yes, when and what was the outcome? Click here to enter text.
9. Has a Clinical Team been involved in the past? [ ]  Yes [ ]  No
	1. If yes, provide details (who, what, where, when, why): Click here to enter text.
10. Has a request for ICM been submitted?[ ]  Yes [ ]  No
	1. If yes, when and what was the outcome? Click here to enter text.
11. Date the IDT was held, with all team members present, to discuss concerns leading to the request? Click or tap to enter a date.
12. Are all IDT members, including the individual, in agreement with this request? [ ]  Yes [ ]  No

**Additional Comments/Details**Click here to enter text. |
| **CURRENT SUPPORTS AND SERVICES** |
| **Service Type:** Choose an item. **Service Provider:** Click here to enter text.**Start/End Date of Service:** Click here to enter text.**Are services being rendered in accordance with service plan?** [ ]  Yes [ ]  No**If no, why?** Click here to enter text. | **Unit Type:** Click here to enter text.**Frequency:** Click here to enter text.**Duration:** Click here to enter text.**Rate:** Click here to enter text.**Units:** Click here to enter text.**Total Cost:** Click here to enter text. |
| **Service Type:** Choose an item. **Service Provider:** Click here to enter text.**Start/End Date of Service:** Click here to enter text.**Are services being rendered in accordance with service plan?** [ ]  Yes [ ]  No**If no, why?** Click here to enter text. | **Unit Type:** Click here to enter text.**Frequency:** Click here to enter text.**Duration:** Click here to enter text.**Rate:** Click here to enter text.**Units:** Click here to enter text.**Total Cost:** Click here to enter text. |
| **Service Type:** Choose an item. **Service Provider:** Click here to enter text.**Start/End Date of Service:** Click here to enter text.**Are services being rendered in accordance with service plan?** [ ]  Yes [ ]  No**If no, why?** Click here to enter text. | **Unit Type:** Click here to enter text.**Frequency:** Click here to enter text.**Duration:** Click here to enter text.**Rate:** Click here to enter text.**Units:** Click here to enter text.**Total Cost:** Click here to enter text. |
| **ATTACHED DOCUMENTS** |
| **[ ]  Current Plan of Care (ISP)** **[ ]  PCPT** **[ ]  Letter from Family requesting emergency placement****[ ]  NJ CAT**  | **[ ]  AENF (If applicable)** **[ ]  Any medical, psychological, neurological, hospital records related to developmental disability and current needs.****[ ]  Legal documents (attorney/court involvement)** |
| **Signatures**  |
| **Support Coordinator Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_** **Support Coordination Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**  |