The New Jersey Department of Human Services

Division of Developmental Disabilities

Transfer Requests and Pre-Placement Meeting Requirements

May 21,2018

Division of Developmental Disabilities

State of New Jersey DHS Department of Human Services

Overview

1) Transfer Requests
- What is a Transfer Request
- Transfer Request Process
- Transfer Request Form

2) Residential Referrals
- How to create a referral packet
- Provider Response Form
- Offer of Placement Form

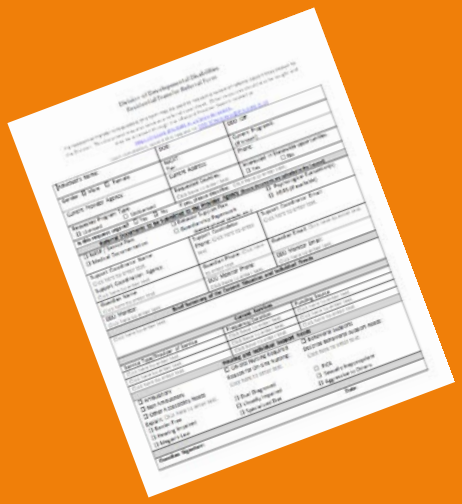
3) Meet & Greets and Tours
- Best Practice

4) Pre-Placement Meetings (PPM)
- How to facilitate a PPM
- Pre-Placement Transition Document

5) Moving Day
- Moving Day Checklist

6) Questions

What is a Transfer Request?



A transfer request is generated when an individual/legal guardian asks to move based on their **preference.** Examples include:

- Preference to reside in a different Type of Residence
- Preference to utilize a different Service Provider
- Preference to live in different Geographic Area

An internal transfer within the same residential provider agency does not require a Transfer Request Form (but does require an updated service plan and interdisciplinary team (IDT) meeting, N.J.A.C. 10:44A-4.2).

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Transfer Request

Transfer Request Scenario	Urgent Transfer Request Scenario
Prefer to live in a different geographic area	Provider initiated discharge
Prefer to live in a different type of residence	Loss of housing on a certain date
Prefer to switch to a different service provider	Health/Safety concerns that cannot be resolved

Questions to ask the Service Provider

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Has there been an IDT meeting to see if any of the concerns (if applicable) can be resolved?

Are there additional supports that may alleviate the situation? Can these additional supports be put in place now?

Is there another location within their service system that can provide an opportunity to alleviate the immediate situation?

Urgent Transfer Request

Division Circular 36 – Transfer or Discharge From Residential Provider.

- Emergency means the individual is in imminent peril. **NOTE: this is a slightly different definition of emergency than what is in the placement rule (NJAC 10:46B). It does not include homeless. If the provider serves the individual he or she cannot become homeless in this situation.**

- Imminent peril means that there is a situation, which could reasonably be expected to cause serious risk to the health, safety or welfare of the individual receiving services or another person in the current living arrangement. Imminent peril does not exist if the Division can put supports into the living arrangement, which eliminates the serious risk to the individual. (NJAC 10:46B-1.3)

Discontinuing Services in the Community Care Program (CCP)

Section 12.4 of the Community Care Program (CCP) Manual

In order for a provider to discontinue services with an individual, the following steps must occur:

- The service provider must notify the individual, guardian, family of their intention to end services;
- NJ Division of Developmental Disabilities CCP Policies & Procedures Manual (Version 2.0) May 2018
- The service provider must provide the reasons for which they can no longer serve the individual – these reasons should align with the provider's Policies & Procedures related to discharge;
- The service provider must notify the individual's Support Coordinator at least 30 days prior to discontinuing services so the Support Coordinator can assist the individual in accessing a replacement provider(s) and/or service(s) as needed and revise the ISP; and
- The service provider will continue to support the individual until he/she finds a new service provider and can coordinate services beginning with that new provider.

http://www.state.nj.us/humanservices/ddd/documents/ccp-policymanual-may2018.pdf

Transfer Request Form

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Division of Developmental Disabilities
Residential Transfer Referral Form

If a residential transfer is requested, this form may be used to request a review of referral opportnites known to the Division. This document may also serve as a referral coversheet. Other resources should also be sought and may be accessed through the I-Record Provider Search located at https://irecord.dhs.state.nj.us/providersearch.
Upon completion, submit this request to DDD.SCHelpdesk@dhs.state.nj.us

Individual's Name:	DOB:	DDD ID#:
Gender: ☐ Male ☐ Female	NJCAT: Tier:	Current Program#: (If known)
Current Provider Agency:	Current Address:	Phone:
Requested Program Type: ☐ Licensed ☐ Unlicensed	Requested Counties: Click here to enter text.	Interested in Statewide opportunities: ☐ Yes ☐ No
Is this request urgent? ☐ Yes ☐ No	If yes, please describe: Click here to enter text.	
Referral Documents to be Submitted to the Provider Agency (Ensure documents are uploaded to the i-record)		
☐ NJISP / Service Plan ☐ Medical Documentation	☐ Behavior Support Plan ☐ Guardianship Paperwork (Example: physical, consults, etc...)	☐ Psychological Evaluation(s) ☐ HSRS (if available)
Support Coordinator Name: Click here to enter text. Support Coordination Agency: Click here to enter text.	Support Coorindator Phone: Click here to enter text.	Support Coordinator Email: Click here to enter text.
Guardian Name: Click here to enter text.	Guardian Phone: Click here to enter text.	Guardian Email: Click here to enter text.
Brief Summary of the Current Situation and Individual Needs		
Click here to enter text.		
Current Services		
Service Type/Provider of Service	Frequency/Duration	Funding Source
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
Housing and Individual Support Needs		
☐ Ambulatory ☐ Non Ambulatory ☐ Other Accessiblity Needs Explain: Click here to enter text.	☐ On-site Nursing Required Reason for On-Site Nursing: Click here to enter text.	☐ Behavioral Supports Describe behavioral support needs: Click here to enter text.
☐ Barrier Free ☐ Hearing Impaired ☐ Megan's Law	☐ Dual Diagnosed ☐ Visually Impaired ☐ Specialized Diet	☐ PICA ☐ Sexually Inappropriate ☐ Aggressive to Others
Guardian Signature:		**Date:**

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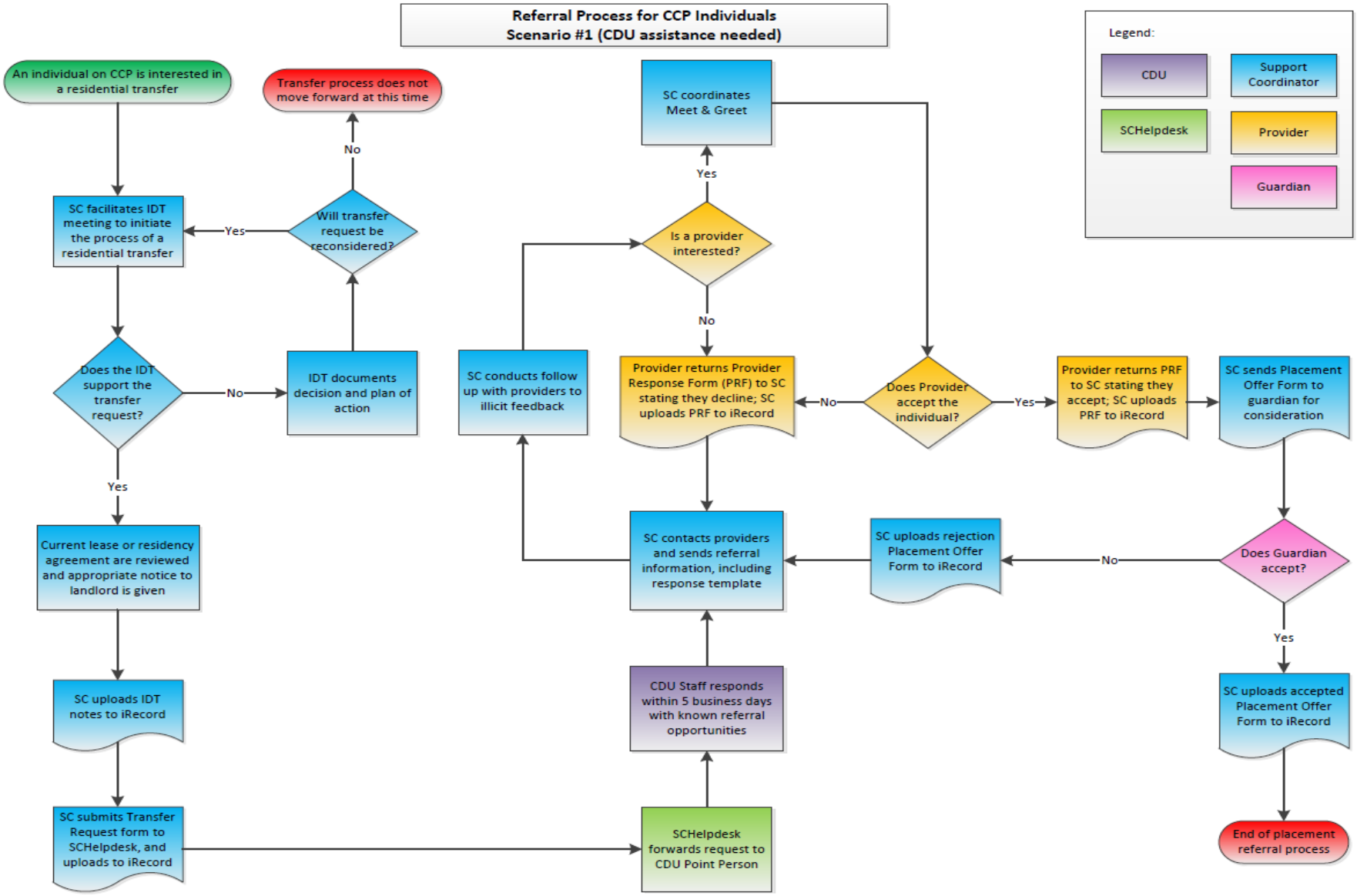
Transfer Request Scenario #1

Support Coordinator needs assistance with referral opportunities

- Support Coordinator facilitates an IDT meeting with family and current service providers to discuss the transition request and current lease requirements
- Support Coordinator submits a transfer request form to DDD.SCHelpdesk@dhs.state.nj.us
- DDD Community Development Unit (CDU) staff will respond to the request with known residential referral opportunities within 5 business days.
  - The referral opportunities known to the Division DO NOT include ALL available openings
  - **Support Coordinators should also conduct independent outreach to providers**
- Support Coordinator sends the referral package with Provider Response form to residential provider agencies
- Meet & Greets Occur
- Provider returns Provider Response Form with acceptance

Transfer Request Scenario #1

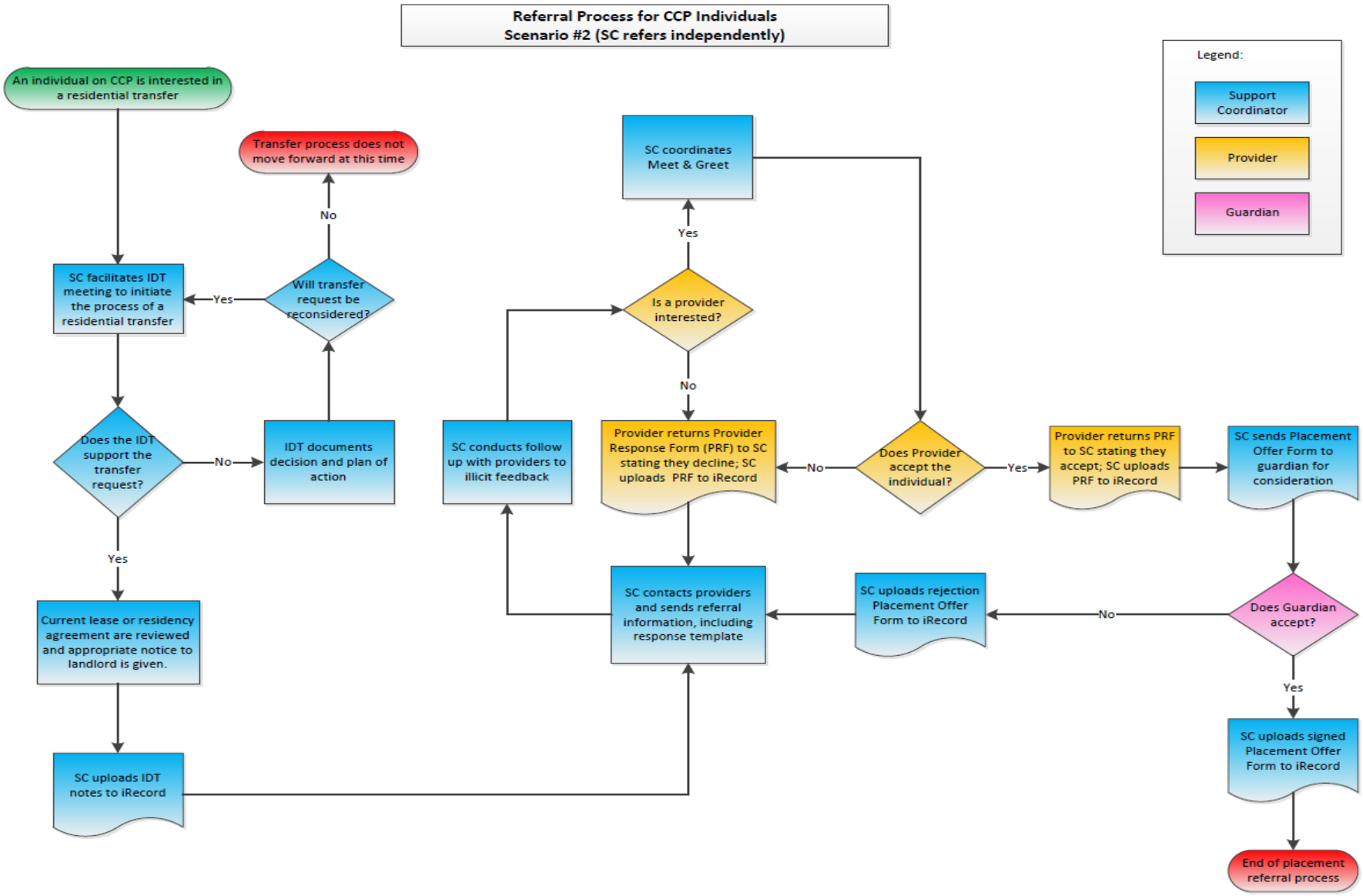


Transfer Request Scenario #2

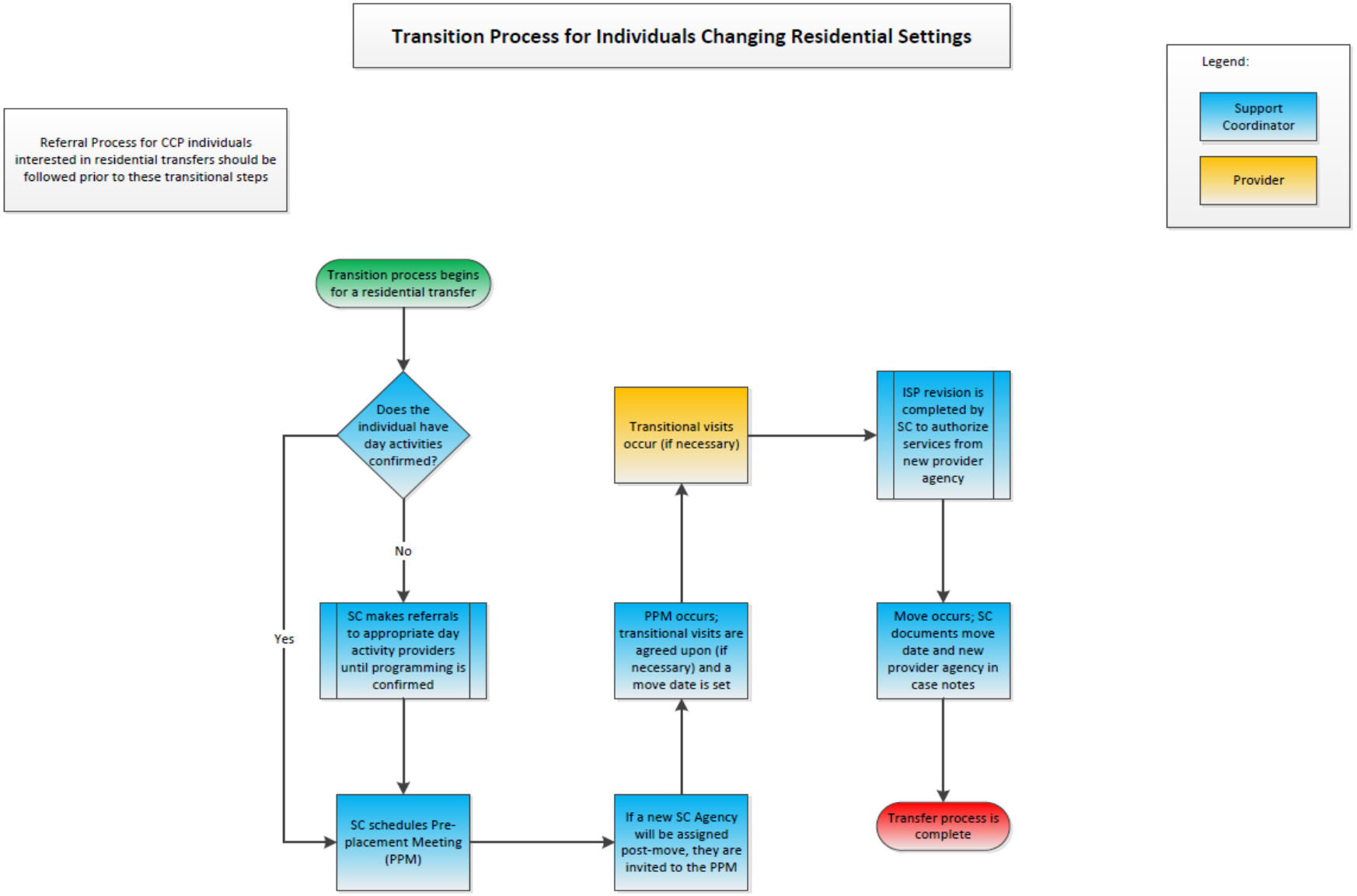
Support Coordinator does not need assistance with referral opportunities

- Support Coordinator facilitates an IDT meeting with family and current service providers to discuss the transition request and current lease requirements
- Support Coordinator sends the referral package with Provider Response form to residential provider agency.
- Meet & Greets occur.
- Residential Provider returns Provider Response form with acceptance.

Transfer Request Scenario #2



Transfer Request Scenarios 1 & 2, cont.



HIPAA Compliance

All communication must be protected in accordance with HIPAA.

Transfer Responsibilities

- The individual/legal guardian will provide appropriate notification to the service provider.
  - The individual/legal guardian should refer to the lease/residency agreement regarding notification to move.
  - The rep payee may be liable to pay the contribution to care for the remainder of the lease/residency agreement terms. DDD subsidies will only pay for one location at a time.
- Support Coordinator will hold an interdisciplinary team (IDT) meeting to engage everyone in supporting the individual while planning for service needs to ensure a smooth transition to the new provider.

Residential Referral Packet

Transfer Request Form serves as the cover page

Additional Documents to include:

- ISP/PCPT
- Most recent Medical Evaluation
- Behavior Support Plan (if applicable)
- Psychological/Psychiatric Evaluation (if available)
- Provider Response Form

All correspondence must be HIPAA compliant

Provider Response Form

Provider Response

Please return by fax or secure email within 10 business days to the Support Coordinator (SC) listed below:

Individual:	**SC Name:**
Agency:	**SC Fax#:**
Program Referred:	**SC Email:**

☐ We have reviewed the referral package and will offer services to this individual.

Placement Location: _____

Date Available for Admission: _____

This opportunity will be held for this individual until (Date)_____.
Until this date, the placement will not be offered to another individual.

☐ We have reviewed the referral package and are unable to offer services at this time.
The reason for this determination is:

_____
_____
_____

Please list additional referral opportunities that are available within your agency:

Group Homes: _____
_____
_____

Supervised Apartments: _____
_____
_____

Unlicensed: _____
_____
_____
_____

Additional information:

_____
_____

Agency Representative: _____ **Date:** _____

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Placement Offer Form

When a placement is offered, the individual, legal guardian, and/or family shall be notified by telephone and in writing. Alternate forms of communication shall be provided as appropriate. The written notification shall ask that the individual or legal guardian respond in writing within the allotted time frame indicated on the provider responder response form.

Residential Placement Offer

Dated:

To: (Support Coordination Agency Name)

I, (Guardian Name), have been notified by (Support Coordination Agency Name) of the following offer of residential placement for (Individual Name).

Residential Provider Agency:
Group Home Name/Address:

I understand that this placement will be available until (add date provided on response letter). After this date, the provider agency may offer this opportunity to another prospective resident.

I have checked the box below indicating my decision with regard to this offer of residential placement:

☐ **I accept** this offer of residential placement

☐ **I do not accept** this offer of residential placement

If this offer of residential placement is not accepted, please explain:

_____

_____

_____

_____

_____

_____

Please sign and date this Response Form and forward to the address above.

_____
Legal Guardian Signature

_____
Date

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Things to Consider When Seeking Residential Placement

- The age, sex and functioning level of the individual and the geographic proximity of the proposed placement to interested family and/or friends;
- The present needs of the individual as well as anticipated future needs;
- Preferences including where the individual wishes to live, with whom the individual wishes to live and how geo-graphically close to family and friends the individual wishes to live;
- The ability of the placement to meet the individual's needs;
- The likelihood of the success of the placement, including a review of past clinical or diagnostic history;
- The stability of the individual's present placement, including how well the placement meets the behavior and/or medical needs of the individual;
- The availability of continued funding of a current placement by a party other than the Division

Important to Know

- Individuals on the Supports Program cannot move into a licensed CCP setting.
  - Individuals eligible for the CCP either have an NJCAT self-care score of 3 or 4 OR have a self-care score of 1 or 2 and have gone through a level of care review and were determined to meet the level of care for the CCP.
    - These individuals meet the criteria as outlined in the definition of "Personal guidance" in accordance with N.J.A.C. 10:44A-4.3 (c); meaning the assistance provided to an individual with developmental disabilities in activities of daily living because he or she routinely requires help completing such activities of daily living and/or cannot direct someone to complete such activities when physical handicaps prevent self completion; or there is a documented health or mental health problem requiring supervision of the person for the protection of the individual or others. In the absence of a court determination, the interdisciplinary team determines the need for personal guidance for each individual.

Licensed vs Unlicensed Sites

- DDD licensed residences are licensed in accordance with N.J.A.C 10:44A-4.3(c)
  - Group Home: living arrangements operated in residences leased or owned by the licensee, which provide the opportunity for individuals with developmental disabilities to live together in a home, sharing in chores and the overall management of the residence. Staff in a group home provide supervision, training, and/or assistance in a variety of forms and intensity as required to assist the individuals as they move toward independence.
  - Supervised Apartment: apartments that are occupied by individuals with developmental disabilities and leased or owned by the licensee. Staff provide supervision, guidance, and training as needed in activities of daily living as defined by the individual's needs and targeted future goals, in accordance with the requirements in N.J.A.C. 10:44A-4.3(c).
  - Unlicensed settings - These are locations that are not licensed under N.J.A.C 10:44A-4.3 (c).

How to learn more about a Provider Agency

- Information provided by the agency
- Program Description (available through provider)
- Outreach to Providers-Networking
- Research

Meet and Greets and Tours

- When a placement is offered, the individual, legal guardian and/or family shall be given an opportunity to tour the placement and the site of any day activities to be provided.
- *Support Coordinator will link families with providers to schedule Meet and Greets and Tours. It is best practice for the Support Coordinator to accompany the individual/family through these steps of the process in order to ensure a smooth transition.*

A Guide for Families

Questions for Residential Providers

Date: _____ Agency: _____
Agency Contact: _____ Phone #: _____
Residential Address: _____

Question:	Response:
Is the home already open or in development?	
How many people reside in the home? Is it co-ed?	
What is the age range in the home?	
Would it be a shared bedroom? What kind of furniture does the agency provide?	
How do the other people living in the home communicate and do they have any behaviors?	
Is the backyard fenced in? What is the neighborhood like?	
Is it possible to have a TV & cable in the bedroom? Is there Wi-Fi access for an i-pad, computer, etc.?	
What type of recreational activities take place in and out of the home?	
How structured is the schedule? What does the daily schedule/routine look like for this home?	
What kinds of skills training are provided? (Ex. cooking, shopping, preparing meals, etc.)	
Who cooks the meals, does the food shopping, and creates the menus?	
Could the same doctors continue to be utilized? Closest Hospital?	
What do you provide transportation for?	
How often can the family visit and/or take their loved one home overnight?	
What is the staffing ratio on all shifts?	
What is the chain of command for this home? How often does upper management visit the home?	
Are background checks conducted?	
What training does the staff receive?	
Is there nursing/clinical/behavioral staff?	
How are emergencies handled?	
How many group homes does your agency have? What towns/counties?	
What experience does the staff have with specialized diets? Ex. Kosher, pureed, etc.	
Does your agency require transfer of payee-ship?	
What is your contribution to care rate?	
Are we able to schedule a tour to see the home when the other residents are there?	

Pre-Placement Meeting (PPM) Development and Attendees

- The assigned SC implements an individualized transition plan prior to a projected community move. The SC/CM will schedule a PPM to be held at least 30 days prior to the move date. The meeting will be recorded by the SC on the Pre-Placement Transition Plan form. (Attachment 1)
- Invitees to attend the PPM will be:
  - Individual;
  - Family;
  - Guardian;
  - Support Coordinator (SC)
  - Residential and Day Services Agencies; and
  - Community Case Manager (CCM); if applicable
  - Others as requested by individual/guardian
- It is important that all team members attend the meeting to assure that major safety needs and staff trainings are clear to residential provider prior to the move

Pre-Placement Meeting
Essential Parts

- Establish a move date for the individual; based on information obtained from the provider

- Finalize the Transition Plan and assure all supports are reflected in the individual's Pre-Placement Transition Plan form
  - In the case of residential placements, it is expected in most cases that an overnight visit will occur. The over-night visit may be waived or additional visits required upon mutual agreement of the individual or legal guardian, the Division and the prospective provider. (N.J.A.C. 10:46B-4.1)
  - 'Pre-Placement Transition Plan Guide' contains more detailed instructions on the development and implementation of an individualized transition plan for individuals moving to a community placement; and can be located: ___

- Review/Revise the current service plan

PPM Document

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PRE-PLACEMENT TRANSITIONAL PLAN

Attachment 1

Client Name: **Meeting Date:**

Serial #: **Projected Placement Date:**

Services	Goals/Objectives Prior To Placement	Frequency/Comment	Person(s) Responsible
Support Coordination (SC) / Case Management (CM)	Current SC /CM: Current SC/CM Supervisor: Receiving SC/CM: Receiving SC/CM Supervisor: Annual Plan Date:		Sending SC/CM is responsible for securing information.
Living Arrangement	Current Living Arrangement: New Living Arrangement- Name: Address: Telephone # : Ambulation Concerns? In-service training needed? Identify the number of transition visits needed: Shadow visits: _____ Day visits: _____ Overnight visits: _____ Identify issues related to placement:	Discuss the need for a fire drill to be completed during the first overnight visit to the new home.	Sending SC/CM is responsible for securing information.
Identification Documentation	Birth Certificate: Yes ☐ No ☐ Social Security Card: Yes ☐ No ☐ State ID: Yes ☐ No ☐ Other ID: Health Insurance Cards: Yes ☐ No ☐	Discuss whether original documents are needed or if copies will be accepted.	Sending SC/CM/Natural Support is responsible for securing information.
Employment/ Education/ Habilitation	Current Job/Day Program: Name/site of new Job/Day Program: Referrals sent, if site is not identified above: Transportation arrangements: Contact Person: Telephone #: Date of visit to site:	Work / Day Program hours of operation:	Sending SC/CM is responsible for securing supports and services.
Family/ Community Contacts	Family Contacts: Address: Telephone Number: Religious/Civic Affiliations: DCF/APS Contacts:	Frequency of contact identified by client:	Sending SC/CM is responsible for securing information.
Fiscal	CCW Eligible: Yes☐ No☐ Supports Program Eligible: Yes☐ No☐ SSA Benefits: Yes☐ No☐ SSI Benefits: Yes☐ No☐ Other Benefits: Payee Name:	Discuss Contribution to Care with individual and family: Cash on Hand should be brought on the day of move. Discuss amount:	Sending SC/CM is responsible for securing information.

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PRE-PLACEMENT TRANSITIONAL PLAN

	Address: Telephone: Willingness to transfer payeeship to agency: Yes☐ No☐ Agency Name: _____ (Attach completed Choice, SCAT, & CERT) Contribution to Care amount: Click here to enter text.	Amount of money individual can hold on their person at any time:	
Guardianship	Guardianship status: eg. (private, self, BGS) Date Established: Name: Address: Telephone #: Relationship:	How involved is the guardian? *Agency needs a copy of official guardianship paperwork.	Sending SC/CM/Natural Support is responsible for securing information.
Health	Medical Insurance: Yes ☐ No ☐ Carrier: Medicaid ID#: Group #: Private Insurance Carrier: Phone #: Chosen Community HMO: Annual Medical- Date: Annual Dental- Date: 72 hr. free from Contagious- Date: Primary care physician: Dentist: Specialty Physician: Mental Health Professionals: Prescriptions for: ▪ Special needs/Equipment (DME): ▪ Medications: Lab Work: Special diet: Allergies: Diagnosis: Significant Medical issues- explain: Will any physicians change? If so, provide name and contact info. *Attach list of Medications; include dosage, times of administration and treatment purpose.	Medicare: Medicaid HMO: How is medication administered (whole with water, crushed in pudding, etc): How does individual handle doctor visits and blood work (any special instructions): *Discuss Over the Counter form (provide a copy to individual or family if they do not have one already) The receiving provider agency will coordinate the receipt of prescriptions for medication and durable medical equipment (DME) along with Letters of Medical Necessity.	Receiving Provider Agency is responsible for securing supports and services.
Personal Care	Level of support needed for ADL's: Unsupervised Time in home: Yes ☐ No ☐ Unsupervised Time in community: Yes ☐ No ☐ (Attach completed Unsupervised Time assessment- Self Medicating?: Yes ☐ No ☐ (Attach completed Assessment for clients currently self medicating)	Describe the level of assistance the individual needs with each Activity of Daily Living (ADL): *This individual requires 24 hour on-site supervision until Unsupervised Time Assessment is completed by agency.	Sending SC/CM is responsible for securing information.
Significant Issues	Behavior Plan? Yes ☐ No ☐ Behavioral issues? Legal Issues?		Sending SC/CM is responsible for securing information.

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PPM Document, cont.

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PRE-PLACEMENT TRANSITIONAL PLAN

Team Members **Title** **Agency**

Comments:

Review/Approval

SC/CM Supervisor: _____ **Date:** _____

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Pre-Placement Plan Finalization

- Within 5 working days of the meeting, the Pre-Placement Transition Plan document should be completed and submitted to Supervisor for review and approval.
- The SC will upload the approved Pre-Placement Transition Plan form into the i-record.
- Pre-placement plan is distributed to team members once finalized.

Housing Subsidies

- When an individual moves from one licensed setting to another licensed setting, it is the responsibility of the service providers and Support Coordinator to notify the DDD Housing Subsidy Unit of changes.
  - Payment changes will be made effective the date that the individual moves to the new location.
  - Refer to the Residency Agreement for Notification Requirements

Housing Subsidies Continued

- Obtaining signatures on leases from BGS Guardians
  - The Housing Subsidy Unit will obtain lease signatures from BGS
- Residency Agreements or Leases: leave the guardian signature blank
  - The Service Provider will provide
    - The name, address, phone number, and email address of the individual's payee; and
    - The name, address, phone number and email address of the representative at the service provider agency, along with the signed document to Courtney.Davey@Dhs.state.nj.us.

Moving Day

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What is needed prior to a Group Home move?

Required:

- ☐ **Annual Medical Form** completed by the doctor current within 1 year
- ☐ **New Prescriptions** for all routine medications with administration times (if pills need to be crushed, please make sure that is documented on the script whether or not the pill can be crushed)
- ☐ **Over the counter medication** orders current within 1 year signed by doctor
- ☐ **Prescriptions for any adaptive equipment** utilized (example: wheelchair, walker, incontinence products, specialized feeding utensils, nebulizer etc.) including administration times if necessary for that piece of adaptive equipment
- ☐ **Prescription for special diet** (example: Diabetic diet) or specialized food consistency (chopped, ground, pureed, cut up in dime sized pieces, etc.)
- ☐ **Detailed write up of any special procedures** needed and signed by doctor (example: seizure precautions, Diabetic care/blood sugar ranges, etc.)
- ☐ **Day program** secured & approved by family (DDD will submit referrals if needed & family tours the program)
- ☐ **Community Care Waiver (CCW)** is secured (DDD will submit referral & let you know whether a self-attestation form is needed vs. full application)
- ☐ **Pre-placement meeting** occurs 30 days prior to move-in
  - a.) Family/Guardian, Individual under services (when appropriate), Group Home Staff, Day program staff & DDD will be present
  - b.) Additional information will be discussed of everything needed before the move can occur
  - c.) Scheduling of any transition visits (dinner visits, overnight visits, etc.) will be discussed

Ask the agency you choose if they need the following:

- ☐ **Mantoux/PPD** current within 1 year
- ☐ **Free from Communicable Diseases** Statement completed by doctor no more than 72 hours prior to move-in
- ☐ **Dental Visit Form** completed by the dentist current within 1 year (if possible)

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Main Steps

- Transfer Request
- Referrals/ Follow-up
- Pre-Placement Meeting
- Individual Moves

Additional Resources and Forms

- Additional Technical Assistance is available if requested.
  - The SC Helpdesk is available for general inquiries, information, and assistance.
  - Division Staff will provide additional training regarding the Pre-placement Meetings and Moves upon request. Please make requests to the SC Helpdesk if you are interested in additional training.