QUARTERLY CONTRACT MONITORING REPORT (QCMR)
CLIENT MOVEMENT REPORT

DMHS LICENSED BEDS - RESIDENTIAL SERVICES

USTF PROJECT CODE: _____	**REPORTING QUARTER: (CHECK ONE):**	
NAME OF AGENCY: _____	**JULY 1 TO SEPTEMBER 30**	**1 ____**
NAME OF PROGRAM: _____	**OCTOBER 1 TO DECEMBER 31**	**2 ____**
PERSON COMPLETING FORM/PHONE #: _____	**JANUARY 1 TO MARCH 31**	**3 ____**
DATE SUBMITTED: _____	**APRIL 1 TO JUNE 30**	**4 ____**

CHECK AGENCY REPORTING QUARTER:	**1 ____**	2 _____	3 _____	4 _____

1. _____	2. _____	3. _____	4. _____	5. _____	6. _____
Beginning Active Caseload (First Day of Qtr.)	**New Enrollees to Program Element During Qtr.**	**Transfers to Program Element During Qtr**	**Transfers From Program Element During Qtr**	**Terminations From Program Element During Qtr.**	**Ending Active Caseload (Last Day of Qtr.)**

TARGET GROUPS		7. Number of Target Group Members: NEW ENROLLEES	TRANSFERS
7A.	Clients who were Discharged from State Hospitals and Enrolled in this Program Within 30 Days of Discharge.	_____	_____
7B.	Clients who were Discharged from County Hospitals and Enrolled in this Program Within 30 Days of Discharge.	_____	_____
7C.	Clients who were Discharged from a Short-Term Care Facility/Involuntary Psychiatric Unit and Enrolled in this Program within 30 Days of Discharge.	_____	_____
7D.	Clients who were Discharged from another Hospital and Enrolled in this Program Within 30 Days of Discharge.	_____	

8.	Of the Ending Caseload how many individuals are: A. Medicaid/Familycare Enrolled (8A. + 8B. must equal ending caseload)	_____	B. Medicaid/Familycare Non-Enrolled	_____

CLIENT MOVEMENT REPORT

BEGINNING ACTIVE CASELOAD: Consist of clients who have had at least one face-to-face contact with your agency in the last 90 days and were active on the last of the previous quarter. **The Beginning Caseload is equal to the Ending Caseload of the previous reporting quarter.**

NEW ENROLLEES: Clients who were newly enrolled in your agency during the reporting quarter and were enrolled in this program element prior to enrollment in any other program element within your agency.

TRANSFERS TO: Refers to clients who are already registered within your agency in another program element, and are being transferred to this program element service.

TRANSFERS FROM: Refers to clients who are registered within your agency in this program element, but for whom this program has ceased to provide services on an ongoing basis and for whom another program element of your agency is going to provide services on an ongoing basis.

TERMINATIONS: Clients who are no longer receiving services at your agency.

ENDING ACTIVE CASELOAD: Is the active caseload on the last day of the reporting quarter. It is calculated in the following manner: **Add #1 (**Beginning Active Caseload) **+ #2** (New Enrollees) **+ #3** (Transfers To). **Subtract #4** (Transfers From) and **#5** (Terminations) = **Ending Caseload #6**.

DUPLICATED COUNT OF TARGET GROUP MEMBERS AMONG "NEW ENROLLEES" AND "TRANSFERS TO": Refers to the count of clients who entered this program element within 30 days of their discharge from the hospital. The definitions of "New Enrollees" and "Transfers To" are the same as stated above. Therefore, the number of "New Enrollees" or Transfers To" indicated in categories 7A, 7B, 7C, and 7D, should be the same or less than the number indicated in items #2 and #3 of this form.

7A. STATE HOSPITAL: Refers to the states five psychiatric hospitals located in New Jersey only: Greystone Park, Trenton, Ancora, Hagedorn, and Ann Klein.

7B. COUNTY HOSPITALS: Refers to the six county hospitals located in New Jersey only: Essex, Burlington, Camden, Hudson, Bergen, and Union.

7C. SHORT-TERM CARE FACILITIES: Refers to inpatient, community-base mental health treatment facilities that provide acute care and assessment services to the mentally ill. The Commissioner, Department of Human Services must designate the facility.

7D. OTHER HOSPITAL: Refers to any psychiatric hospital or psychiatric unit within a hospital that is not a State, County or STCF Hospital in New Jersey; include as "Other" any Facility located outside of New Jersey.

QUARTERLY CONTRACT MONITORING REPORT (QCMR)
LEVEL OF SERVICE REPORT

DMHS LICENSED BEDS - RESIDENTIAL SERVICES

USTF PROJECT CODE: _____	**REPORTING QUARTER: (CHECK ONE)**	
NAME OF AGENCY: _____	**JULY 1 TO SEPTEMBER 30**	**1** ____
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Insert Spcialized Program (see chart below)	**Supervised A+**		**Supervised A**		**Supervised B**		**Supervised C**		**Family Care**	
E = MICA; G = Crisis; I = Deaf/Blind; J = Gero-Psych; K = DD										
	Apt	GH	Apt	GH	Apt	GH	Apt	GH	Apt	GH
1. Capacity at Beginning of Qtr										
2. Housing Units Beg. Of Qtr										
3. Occupancy/Caseload at Beginning of Quarter										
4. Clients Newly Enrolled/Transf. in During Quarter										
5. Clients Terminated/Transf. out During Quarter										
6. Occupancy/Caseload at End of Qtr.										
7. Housing Units End of Qtr.										
8. Capacity at End of Qtr.										
9. Actual Occupied Bed Days										
10. Vacant bed days during bed hold period										
11. Vacant bed days beyond bed hold period										
12. All other vacant days										
13. Individual Units of Service										
14. Group Units of Service										

DMHS LICENSED – RESIDENTIAL SERVICES

DMHS-licensed supervised residential options offering on-site staff support and assistance with activities of daily living according to clients' needs. Housing opportunities include supervised apartments, group homes, and family care homes. Additionally, residences may be targeted to address special needs: MICA, short-term Respite Care, Crisis, Deaf/Blind, Geropsychiatric, Developmentally Disabled individuals.

FOR ALL LEVEL GROUP HOMES AND APARTMENTS:

Residential Care Days (Items 9-12 above):

1. Actual occupied bed days = where consumer was physically in the program for all or part of the day;
2. Bed days relating to days the bed was held vacant during the 30 day bed hold period;
3. Bed days relating to days the bed was held vacant beyond the 30 day bed hold period;
4. All other vacant bed days.

IN ADDITION, FOR B APARTMENTS AND C HOUSING (APT. /GH):

Individual Units of Service: face to face contact with one consumer for 15 continuous minutes. If a contact exceeds more than 15 continuous minutes, count as multiple contacts. If two staff members simultaneously serve one client, count as one staff contact. Travel time to and from contact is to be excluded from overall contact time.

Group Units of Service: face to face contact where one staff member serves between two and six clients simultaneously for 15 continuous minutes, count as one group contact per client (group contacts of seven or more clients by one staff member are not reportable). Travel time to and from contact is to be excluded from overall contact time.

SUPERVISED RESIDENCE A+: Refers to housing with on-site staff coverage 24 hours per day, seven days per week.

SUPERVISED RESIDENCE A: Refers to housing with on-site staff coverage of less than 24 hours per day, but at least 12 hours per day of on-site coverage, Monday through Friday and at least 12 hours on-site coverage on weekends and holidays.

SUPERVISED RESIDENCE B: Refers to housing with on-site supervision by program staff at least 4 hours, but less than twelve hours a day within each 24 hour period.

SUPERVISED RESIDENCE C: Refers to housing with on-site staff coverage at a minimum of one hour per week. Typically, staff is on-site providing services three to four hours per week.

FAMILY CARE: Refers to private home or apartment in which an individual resides and provides services to as many as five clients who also reside in the home.

SPECIALIZED PROGRAMS: If a program is designed for one of the specialized services listed, enter the appropriate code in row G; otherwise, leave blank.

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15. Number of Clients Transferred within the Residential Program:

A. Who moved to less Supervised Housing _____ B. Who moved to more Supervised Housing _____

16. Number of Clients who Graduated and were Placed in Non-Contract Housing: _____

17. Total Units of Service Provided: Individual _____ Group _____

18. Of the ***Individual*** Units of Service Provided **(for B Apt. and C Apt./GH ONLY)** how many are:

A. Medicaid/Familycare Enrolled _____ B. Medicaid/Familycare Non-Enrolled _____
(18A. + 18B. must equal total **individual** units of service for B Apt. and C Apt./GH)

19. Of the ***Group*** Units Of Service Provided **(for B Apt. and C Apt./GH ONLY)** how many are:

A. Medicaid/Familycare Enrolled _____ B. Medicaid/Familycare Non-Enrolled _____
(19A. + 19B. must equal total **group** units of service for B Apt. and C Apt./GH)