New Jersey Department of Human Services
Division of Aging Services
Office of Long Term Services and Supports
Quality Management

CLIENT TRACKING FORM

To: _____ Date: _____

☐ Care Management Provider OR
☐ DHS Regional Office of Community Choice Options (OCCO)

From: _____ Phone: _____

☐ Assisted Living/Adult Family Care (AL/AFC) Provider OR
☐ Care Management Provider

MLTSS PARTICIPANT INFORMATION	
Participant Name	
Participant Medicaid Number ☐ Pending	Social Security Number
Relative/Contact Name	Daytime Phone Number

AL/AFC PROVIDER INFORMATION ☐ **N/A**	
Provider Name	Provider Medicaid Number
Provider Street Address, City, State, Zip Code	
Provider Contact Person	Provider Phone Number

ACTION TO NOTE

For Use by AL/AFC Providers *(Check one)*:

☐ Admission Date to AL/AFC: _____

☐ Participant has entered a hospital, nursing facility (NF) or sub-acute rehab:
- Date: _____
- Destination: _____
- Phone: _____

☐ Readmission Date to AL/AFC: _____

☐ Permanent Discharge/Transfer from AL/AFC Facility:
- Date: _____
- Destination: _____
- Phone: _____
- Reason: _____

☐ Non-medical Leave from AL/AFC (> 14 days): _____

☐ Request for Pre-Admission Screening (PAS)

☐ Date of Death: _____

For Use by Care Management Sites:

☐ Request for Pre-Admission Screening (PAS)

Completed By *(Print Name)*	Title
Signature	Date