Involuntary Transfer Monitoring Record

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| Date of On-Site Visit:  Date of Referral from DoAS Central office: Reason for Involuntary Transfer Request:  | Name of Assessor/CM Completing Form:Assessor/CM Phone Number: [ ] OCCONRO [ ] OCCOSRO[ ]  Aetna [ ]  Amerigroup [ ]  Horizon [ ]  United [ ]  Wellcare |

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| Resident Name: | Medicaid [ ]  Yes [ ]  No [ ]  PendingMedicaid Number:  |
| Facility Name: | Social Security Number: Date of Birth:  |
| Facility Address: City, State, Zip Code:  | Facility Phone:  Fax:   |
| Facility Social Worker Name:  Phone:  Fax:   | Facility Administrator Name: Phone:  Fax:   |
| PASRR Level I Date:  [ ] Negative [ ]  Positive MI[ ] Positive ID/DD/RC[ ] Positive MI & ID/DD/RCPASRR Level II MI Date:   [ ] Requires Specialized Services [ ]  No Specialized Services Required PASRR Level II DDD Date:   [ ] Requires Specialized Services [ ]  No Specialized Services Required  | Responsible Party Contact:Name/Relationship: Phone: Guardian: [ ] Yes [ ]  NoName:       Phone:        |
| Clinical Eligibility Date: MLTSS: [ ] Yes [ ]  No Change in Condition/Reassessment needed?[ ] Yes [ ]  No  |  MLTSS/DDD Referral Needed?[ ] Yes [ ]  No |

Administrator Meeting Summary:

Social Worker Meeting Summary:

Resident Meeting Summary:

Responsible Party Meeting Summary:

Options Counseling Summary:

Discharge Plan:

Follow Up Visit Notes:

Date emailed to Doas.trenton@dhs.nj.gov:

DoAS Central Office Comments: