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  Pending  Medicaid 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/RCPositive MI & ID/DD/RC  PASRR 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  No  Name:       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: