**Department of Human Services**
**Division of Aging**
**Office of Community Choice Options**

# Involuntary Transfer Monitoring Record

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|---|---|
| Date of On-Site Visit:<br>Date of Referral from DoAS Central office:<br>Reason for Involuntary Transfer Request: | Name of Assessor/CM Completing Form:<br><br>Assessor/CM Phone Number:<br><br>☐ OCCO NRO ☐ OCCO SRO<br>☐ Aetna ☐ Amerigroup<br>☐ Horizon ☐ United ☐ Wellcare |
| Resident Name: | Medicaid ☐ Yes ☐ No ☐ Pending<br>Medicaid Number: |
| Facility Name: | Social Security Number: Date of Birth: |
| Facility Address:<br><br>City, State, Zip Code: | Facility Phone:<br><br>Fax: |
| Facility Social Worker Name:<br>Phone: Fax: | Facility Administrator Name:<br>Phone: Fax: |
| PASRR Level I Date: ☐ Negative ☐ Positive MI<br>☐ Positive ID/DD/RC ☐ Positive MI & ID/DD/RC<br>PASRR Level II MI Date:<br>☐ Requires Specialized Services<br>☐ No Specialized Services Required<br>PASRR Level II DDD Date:<br>☐ Requires Specialized Services<br>☐ No Specialized Services Required | Responsible Party Contact:<br>Name/Relationship:<br>Phone:<br><br>Guardian: ☐ Yes ☐ No<br>Name: Phone: |
| Clinical Eligibility Date:<br>MLTSS: ☐ Yes ☐ No<br>Change in Condition/Reassessment needed?<br>☐ Yes ☐ No | MLTSS/DDD Referral Needed?<br>☐ 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: