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| New Jersey Department of Human ServicesDivision of Aging Services**LONG TERM CARE RE-EVALUATION** |
| 1. Participant Name *(Print)* | 4. Date *(mm/dd/yyyy)* |
| 2. Care Manager Name *(Print)* | 5. Previous Re-evaluation Date *(mm/dd/yyyy)* |
| 3. JACC Number | 6. Program[ ]  JACC [ ]  Other |
| **7. Functional Status** |
| A. Can Participant recall 3 items from memory after 5 minutes? [ ]  Yes [ ]  NoB. Can Participant perform or verbalize all or almost all steps in a multi-task sequence without cues for initiation? [ ]  Yes [ ]  NoC. How well does participant make decisions about organizing the day? *(Check one)* [ ]  Independent [ ]  Modified [ ]  Minimally [ ]  Moderately [ ]  Severely Independence Impaired Impaired ImpairedD. How well does participant express or make self understood? *(Check one)* [ ]  Understood [ ]  Usually [ ]  Often [ ]  Sometimes [ ]  Rarely/Never Understood Understood Understood UnderstoodE. Does participant receive nourishment through an enteral tube feeding? [ ]  Yes [ ]  NoF. ADL Self Performance *(score over past 3 days)*: |
|  | Independent | Set Up | Supervision | Limited Assistance | Extensive Assistance | Maximal Assistance | Total Dependence | Did Not Occur |
|  Bed Mobility | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|  Eating | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|  Transfer | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|  Toilet Use | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|  Locomotion in Home/Building | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|  Locomotion Outside Home/Building | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|  Upper Body Dressing | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|  Lower Body Dressing | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|  Bathing  (score over past 7 days) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| G. Nursing Facility Level of Care Criteria: 1. Does Participant meet the ADL Index criteria of 6 or greater and have any 3 ADL’s (limited assist or greater)? [ ]  Yes [ ]  No **\*\* NOTE: If 3 ADL criteria is not met, conference case with OCCO.** 2. Does participant meet the CPS Score criteria of 3 or greater and have any 3 ADLs (supervision or greater)? [ ]  Yes [ ]  No **\*\* NOTE: If 3 ADL criteria is not met, conference case with OCCO.** 3. Does Participant meet the ADL Assistance criteria by requiring limited assistance or greater in Locomotion, Dressing, AND Bathing? [ ]  Yes [ ]  No **\*\*NOTE: Participant must meet at least one of the above three (3) criteria to continue to meet clinical eligibility for Nursing Facility Level of Care.**  |

| **8. Social Support Network** |
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| **9. Physical Environment** |
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| **10. Verification of Nursing Facility Level of Care** |
| **I have assessed the above participant and verify *(check one)*:****A.** **[ ]  Participant continues to require nursing facility services, as defined by the New Jersey Medicaid regulations (NJAC 10:166-2.1 nursing facility services; eligibility).****B. [ ]  Participant no longer requires nursing facility services, as defined by the New Jersey Medicaid regulations (NJAC 10:166-2.1 nursing facility services; eligibility).**[ ]  I discussed voluntary withdrawal from the program and other service options with the participant.[ ]  Referred to OCCO for Nursing Facility Level of Care Assessment on *(date)*: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Outcome of OCCO assessment done on *(date)*: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**[ ]  Eligible [ ]  Ineligible |
| Signature of Care Manager | Date |
| Reviewed by (Name) | Title | Date |