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| New Jersey Department of Human Services  Division 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  No  B. Can Participant perform or verbalize all or almost all steps in a multi-task sequence without cues for initiation?  Yes  No  C. How well does participant make decisions about organizing the day? *(Check one)*  Independent  Modified  Minimally  Moderately  Severely  Independence Impaired Impaired Impaired  D. How well does participant express or make self understood? *(Check one)*  Understood  Usually  Often  Sometimes  Rarely/Never  Understood Understood Understood Understood  E. Does participant receive nourishment through an enteral tube feeding?  Yes  No  F. 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 |