**New Jersey Department of Human Services**

**Division of Developmental Disabilities**

**Intensive Case Management (ICM) Referral**

Used to refer an individual to the DDD ICM Unit, in response to an emergency request for enrollment onto the Community Care Program (CCP). Do not use this form if the individual is already enrolled on the CCP.

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| **Instructions** |
| 1. When CCP is requested, review the [CCP Frequently Asked Questions](https://www.state.nj.us/humanservices/ddd/assets/documents/support/CCP-Frequently-Asked-Questions-March-2023.docx) handout with the individual/family/legal guardian. 2. Ensure that all services available through the Supports Program budget have been **added to the ISP** to address the individual’s needs. 3. If the individual’s NJCAT self-care score is a 1 or 2, ensure that a housing voucher with supports **and/or** a boarding home/residential health care facility has been explored. 4. Obtain a signed, dated, written statement from the individual/legal guardian(s) requesting addition to the CCP waiver, **and** upload in iRecord using this format: “ICM Letter of Request, (DDD ID#)”. 5. Complete the ICM Referral and upload in iRecord using this format: “ICM Referral, (DDD ID#)”. 6. The SC Supervisor sends an email, **without** an attachment, to [DDD.SCHelpdesk@dhs.nj.gov](mailto:DDD.SCHelpdesk@dhs.nj.gov) with the subject line: “ICM Referral, (DDD ID#), (SCA)”. (Ensure all supporting documents are uploaded.) |

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| **General Information** | |
| Date of Request: Click to enter a date. | Requested CCP Service: Choose an item. |
| Individual’s Name: Click to enter text.  DDD ID #: Click to enter text.  Address: Click to enter text.  County: Choose an item. | Date of Birth: Click to enter text.  NJCAT Score: Self-Care, Behavioral, Medical  Tier: Choose an item.  Date of Assessment: Click to enter text. |
| Person making the request: ***(If this person is a legal guardian, leave blank and complete the next column.)***  Click to enter text.  Relationship: Click to enter text.  Phone Number: Click to enter text.  Email Address: Click to enter text. | Guardianship Status: Choose an item.  Name of Guardian: Click to enter text.  Relationship: Click to enter text.  Address: Click to enter text.  Phone Number: Click to enter text.  Email Address: Click to enter text. |
| Current Program Enrollment:  Choose an item. | Is the individual Medicaid eligible?  Yes  No |
| On what date did the SC review the “Community Care Program: Frequently Asked Questions” handout with the individual/family/legal guardian? Click to enter a date. | |
| Does the NJCAT continue to be an accurate reflection of supervision and support needs? Yes  No  If no, on what date was a Reassessment Request submitted? (or explain the status): Click to enter text.  ***(Ensure a copy of the request and the NJCAT with comments are uploaded in iRecord.)*** | |

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| **Support Coordination Agency Information** |
| Support Coordination Agency Name: Click to enter text.  Support Coordinator Name: Click to enter text.  SC Phone Number and Email Address: Click to enter text. |

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| **Emergency Criteria** |
| **For CCP approval, there must be an issue of homelessness or imminent peril, which cannot be resolved through the Supports Program, and the individual must meet institutional Level of Care (LOC) criteria.** |

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| **Homelessness** |
| Is the individual currently homeless, or at risk of immediate homelessness? Yes  No  **If yes:**   1. Contact the Division immediately through the Support Coordination Helpdesk: [DDD.SCHelpdesk@dhs.nj.gov](mailto:DDD.SCHelpdesk@dhs.nj.gov) subject line: “(DDD ID#), Homelessness”   (Outside of normal business hours, contact the Division’s on-call system.)   1. Please explain: Click to enter text. |

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| ***If the individual’s NJ CAT Self-Care score is 1 or 2, answer each of the following:***  Would a Housing Subsidy alleviate the emergent situation? Yes  No  Please explain: Click to enter text.  Would a boarding home or residential health care facility alleviate the emergent situation? Yes  No  Please explain: Click to enter text. |

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| **Imminent Peril** |
| Describe how the individual’s support needs, **related to the** **developmental disability**, create a risk to health/safety in the home:  Click to enter text. |
| Provide current **specific examples** demonstrating risk to health/safety:  Click to enter text. |
| Explain why services/supports available through the Supports Program budget are not able to address the individual’s needs and the risk to health/safety:  Click to enter text. |
| If residential placement is requested, has the individual been asked where they want to live? Yes  No  If yes, please describe. If no, please explain: Click to enter text. |
| Provide any additional information you may have regarding the circumstances prompting the ICM Referral: Click to enter text. |
| Has a bump-up or Wrap-Around emergency assistance been provided to address the current situation?  Yes  No  Explain if needed: Click to enter text. |

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| **Caregiver Information** |
| Is the **age** or **health** of the caregiver(s) prompting the ICM Referral? Yes  No  If yes, list the name, age and health concerns/diagnosis(es) of each caregiver in the home, and  explain the impairment preventing the caregiver(s) from providing the needed support : |
| Click to enter text. |

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| **Crisis Services** |
| Has there been police involvement within the past year? Yes  No  If yes, are charges filed or pending? Yes  No  Please explain: Click to enter text. |
| Has Adult Protective Services been involved with this individual or family? Yes  No  If yes, please explain: Click to enter text. |
| Has the individual or caregiver(s) been hospitalized within the past year? Yes  No  If yes, provide the dates and reasons for hospitalization (i.e., behavioral, psychiatric, medical):  Click to enter text. |

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| **Services and Supports** | | | |
| ***Use the drop down list to show the status for EACH of the following services and provide a description/explanation.***  ***If the individual currently receives the service, complete the Provider name, Frequency/Duration, Funding Source and Cost to Budget for that service.*** | | | |
| **Day Habilitation / Community Inclusion / Employment**: Choose an item. | | | |
| Describe or explain: Click to enter text. | | | |
| Provider Name | Frequency/Duration | Funding Source | Cost to budget |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| **Community Based Supports**: Choose an item. | | | |
| Describe or explain: Click to enter text. | | | |
| Provider Name | Frequency/Duration | Funding Source | Cost to budget |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| **Self-Directed Employee**: Choose an item. | | | |
| Describe or explain: Click to enter text. | | | |
| Provider Name | Frequency/Duration | Funding Source | Cost to budget |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| **Natural Supports Training:** Choose an item. | | | |
| Describe or explain: Click to enter text. | | | |
| Provider Name | Frequency/Duration | Funding Source | Cost to budget |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| **Mental Health Services**: Choose an item. | | | |
| Describe or explain: Click to enter text. | | | |
| Provider Name | Frequency/Duration | Funding Source | Cost to budget |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| **Personal Preference Program (PPP) / Personal Care Attendant (PCA)**: Choose an item. | | | |
| Describe or explain: Click to enter text. | | | |
| Provider Name | Frequency/Duration | Funding Source | Cost to budget |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| **Behavioral Supports (including CARES, DDHA, Serv)**: Choose an item. | | | |
| Describe or explain: Click to enter text. | | | |
| Provider Name | Frequency/Duration | Funding Source | Cost to budget |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| **Non-DDD Funded Services:** Choose an item. | | | |
| Describe or explain: Click to enter text. | | | |
| Provider Name | Frequency/Duration | Funding Source | Cost to budget |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |

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| Describe **all** natural supports the individual receives from family, relatives, neighbors, friends, etc.:  Click to enter text. |
| In situations where a caregiver is paid through the Personal Preference Program (PPP) or works for a Community Based Support (CBS) Provider, would the emergent situation be mitigated if Service Provider staff provided this support, instead of the caregiver?  Yes  No  N/A  Please explain: Click to enter text. |
| Is the current budget fully utilized? Yes  No  If no, please explain: Click to enter text. |
| Does the current ISP contain services **not being utilized** or **not needed**, that could be stopped to create room in the budget for other needed services? Yes  No  Please explain: Click to enter text. |
| What is the date of the last SC home visit? Click to enter text.  Based on that home visit, describe observations suggesting the need for increased support or services:  Click to enter text. |

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| **SC Supervisor Attestation** | |
| The emergent circumstance and changes in support needs are documented in case notes/MTs/the ISP.  A signed, dated letter of request from the individual/legal guardian is uploaded in iRecord. | |
| The SCS and SC have reviewed this ICM Referral. | Date: Click to enter a date. |
| SC Supervisor Name:  Click to enter text. | Phone Number / Email Address:  Click to enter text. |