New Jersey Department of Human Services

**NURSING FACILITY TRANSITION TO THE COMMUNITY (NON-MFP)**

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| --- | --- |
| Date Faxed | Name of Person/ Title Completing Form |
| To: Alisa Mead Assistant MFP Director  (732) 509-2052 (Phone)  (732) 777-3617 (FAX)  Alisa.mead@dhs.nj.gov |  |
| Phone Number |

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| --- | --- | --- | --- | --- | --- |
| Participant Name | | | | Social Security Number | |
| Date of Birth | | Age | | SSI Recipient  Yes  No | |
| Medicaid Number | | Effective Date | | | |
| Medicare Number | | Met MLTSS eligibility and did not transition due to meeting the Cost Effectiveness Threshold. | | | |
| Discharge Services:  State Plan Services  Private Pay  MLTSS  Medicare Services  Case Conference Initiated | | Cost Effective IDT requested  Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_ | | | |
| Discharge Facility Name | | | Facility Type  NF: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  SCNF:  Type: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| Discharge Facility Address | | |
| Date of Admission to NF/SCNF | IDT Done  Yes  No | | | | Date |
| Date of Discharge from NF/SCNF | Discharge To  Private Home/Apartment  ALR/CPCH  AFC  RHCF | | | | |
| Phone | Address | | | | |
| Name of Care Manager | | | | | Phone |
| Email of Care Manager | | | | | |

**What constitutes a transition?**

To be considered a discharge or transition from a NF to the community and reported to OCCO, contact must be made at the facility through a NJ Choice Assessment, follow-up, Options Counseling, and/or a Section Q referral. Options Counseling and any assistance given to the client needs to be documented in the IPOC section of the NJ Choice Assessment and your monitoring notes. **NOTE: IF TRANSITION IS A MFP, USE MFP 75**