New Jersey Department of Human Services
Division of Aging Services
Office of Community Choice Options

Referral for Onsite OCCO Clinical Assessment

Type of Hospital: ☐ Traditional/Acute ☐ Acute Rehab (LTAC) ☐ Psychiatric - Identify type: ☐ Long-term or ☐ Short-term

PLEASE PRINT

Hospital: _____ Date: _____

Referred By: _____ Telephone #: _____

Provider/Referent Email: _____

PATIENT INFORMATION

Name: _____ DOB: _____
(Last) *(First)* *(MI)*
Sex ☐ Male ☐ Female

Medicaid #: _____ SS#: _____

Home Address:

_____

Responsible Party: _____

Home Telephone No.: ( ) _____ Work Telephone No.: ( ) _____

HOSPITAL ADMISSION INFORMATION

Date of Admission: _____ Floor: _____

Admitted From: _____ Room #: _____

Primary Admitting Diagnosis: _____

Secondary Admitting Diagnosis: _____

PASRR

PASRR Level I Screen Outcome: ☐ Positive ☐ Negative ☐ N/A (d/c other than NF) Date: _____

If positive, PASRR Level II Determination: ☐ Does not require specialized services Date: _____

☐ Does require specialized services Date: _____

Important: If being discharged to NF and the PASRR Level I is Positive, a copy of PASRR Level I, as well as the Level II Evaluation and Determination must accompany this form.
A new PASRR Level II Evaluation and Determination is required for all instances of a discharge from any type of psychiatric hospital prior to NF transfer, and a copy of the determination must accompany this form.

DISCHARGE PLAN (Required for all referrals from Psychiatric settings)

Anticipated Discharge Date: _____ Expected Location: ☐ Nursing Facility ☐ ALR ☐ CRS ☐ Home
☐ SCNF (type): ☐ Other: _____

Discharge Location Name and Address (if known): ☐ Same as residential address identified above

_____

MEDICAID ELIGIBILITY STATUS

☐ Currently Medicaid Eligible
☐ Application in Process
☐ 180 Days Potentially Eligible

Date Referred to CWA: _____