New Jersey Department of Human Services
Division of Aging Services

ASSISTED LIVING/ADULT FAMILY CARE (AL/AFC) REFERRAL FOR THE GLOBAL OPTIONS FOR LONG-TERM CARE (GO) MEDICAID WAIVER

APPLICANT BACKGROUND INFORMATION

Name of Applicant *(First, Middle Initial, Last)*	Social Security Number
Street Address	Date of Birth
City, State, Zip Code	Telephone Number

Medicaid Application Filed at CWA? ☐ Yes ☐ No	County of Application
Caregiver/Legal Representative	Telephone Number
Referring AL/AFC Provider	Telephone Number

Reason for Referral ☐ Spend Down ☐ New Admit	*NOTE: The processing of the AL/AFC Referral Form does not constitute enrollment on the GO Medicaid Waiver nor does it guarantee residency for the applicant at the referring AL/AFC facility.*

APPLICANT CLINICAL INFORMATION

Diagnosis

Check off the level of assistance the applicant requires for <u>EACH</u> Activity of Daily Living (ADL):

Activities of Daily Living (ADL)	Independent	Supervision/ Cueing	Limited Assist or Greater
Bathing			
Dressing			
Bed Mobility			
Eating			
Locomotion			
Toilet Use			
Transfer			

Cognitive Status	Intact	Impaired
Short Term Memory		
Procedural Memory		
Decision Making		

GO Waiver Target Population Criteria	
Aged 65+, or Physically Disabled Age 21-64	☐Yes ☐No
Age 21-64 with MR/DD/Chronic MI	☐Yes* ☐No

** If Yes, the applicant is ineligible for GO and the AL facility is to counsel the applicant on other options.*

Other Care Needs

Social Information/Family Supports

APPLICANT FINANCIAL INFORMATION

Monthly Income		Resources (bank accounts, stocks, bonds, etc.)
Social Security		
Pension		
Other		
Total Monthly Income		
Face Value of Life Insurance Policy(ies), if known:		

Name of Individual Completing Form (Print)	Title
Signature	Date

Note: If applicant is found eligible for the GO Medicaid Waiver, there may be a cost share to the applicant, which is dependent on his or her income and allowable deductions.