New Jersey Department of Health and Senior Services

CLIENT PROFILE

☐ CCPED (8) ☐ AFC (22) ☐ CPCH (28) ☐ ALR (29) ☐ ALP (30) ☐ JACC ☐ CAP (31)

ENROLLMENT DATE: ____ / ____ / ____ (YEAR / MM / DAY) BIRTHDATE: ____ / ____ / ____ (YEAR / MM / DAY)

1. LAST NAME: ____ FN: ____ MI: ____

2. MEDICAID #: ____ 3. SS#: ____ - ____ - ____

4. STREET ADDRESS: ____

5. CITY: ____ CO.: ____ ZIP: ____ - ____

6. ENTRY SOURCE: ____ 7. SEX: ____ 8. RACE: ____ 9. LIVING ARRANG: ____ 10. MARITAL STATUS: ____

11. CARE GIVER: ____ 12. INCOME: ____ 13. REASON FOR APPL.: ____ 14. DX: ____

15. PRIMARY SERVICE: ____ 16. PRIOR STATUS: ____

17. CM SITE: ____ 18. A. L. SITE: ____

19. ADL SUMMARY:

	INDEPENDENT	NEEDS ASSISTANCE	DEPENDENT
A. MOBILITY			
B. DRESSING			
C. EATING			
D. TOILET USE			
E. GROOMING			
F. BATHING			
G. TRANSFERRING			

20. JACC # **0 0** ____ **X** 21. CMG LOCATION: ____

CASE MANAGER'S NAME (PRINT) DATE

X = JACC# 8TH DIGIT - **Enter #1** if enrollee is on **CCPED waiting list**. **Enter #9** if enrollee is **presumptively eligible**.

WPA-6 (AL-24)
NOV 02