

## OFFICE OF RESIDENTIAL SERVICES CONSULTATION REQUEST PROCESS AND FORM

**RECENT PROCESS CHANGE:** *To request Office of Residential Services consultation, please complete the following steps:*

- 1) *Upon receiving the OOH IOS Determination, the Care Manager (CM) shall complete the attached Office of Residential Services Consultation Request Form.*
- 2) *CM will upload this form to the Doc tab of the youth's CYBER record:*
  - *Doc Type: Clinical*
  - *Doc Subtype: Cover Letter with the Office of Residential Services Checklist*
- 3) *CM will send an e-mail to [SRTUconsultation@dcf.nj.gov](mailto:SRTUconsultation@dcf.nj.gov) (ORS Consultation as the subject line). Please include the youth's CYBER ID# and care manager's contact information within your e-mail. DO NOT ATTACH THIS COVER LETTER TO THE E-MAIL (WHICH PREVENTS THE NEED FOR ENCRYPTED E-MAILS); Encrypted e-mails will delay the Office of Residential Services consultation process.*

*Upon receipt of this request, the referral will be assigned for Office of Residential Services consultation. The name/contact information of the assigned Office of Residential Services consultant will be viewable on the Provider tab of the youth's CYBER face sheet. Upon assignment, the Office of Residential Services consultant has up to three (3) business days to provide recommendations.*



**OFFICE OF RESIDENTIAL SERVICES CONSULTATION REQUEST FORM**

<b>YOUTH NAME</b>	
<b>CYBER ID</b>	
<b>DATE OF IOS DETERMINATION</b>	

**ORS QUALIFYING CRITERIA (check all that apply):**

*Required for ORS Consultation		**Optional for ORS Consultation	
Intensive-IDD IOS		Diabetes	
IPCH-IDD IOS		Other Specialized Medical Needs (specify here): _____	
PCH-IDD IOS		GH-1 IDD IOS	
PCH IOS		GH-2 IDD IOS	
SPEC IOS		Human Trafficking	
SPEC IDD-IOS		Parenting with Child	
		Pregnant	
		RTC-BH/DD IOS	
		RTC-BH/SU IOS	
		SSH-IDD IOS	
		Transgendered Youth	

*\*REQUIRED indicates that only Office of Residential Services may provide OOH referral recommendations for these IOSs*

*\*\*OPTIONAL indicates that Office of Residential Services consultation is not required as Youth Link auto-assigns these referrals. In these instances, Office of Residential Services can provide additional troubleshooting support if requested by the CMO.*

**STATUS OF IDD ELIGIBILITY (check off the criteria that applies):**

DEEMED I/DD ELIGIBLE	
DEEMED I/DD INELIGIBLE	
PENDING I/DD ELIGIBILITY DETERMINATION (APPLICATION WAS SUBMITTED)	
PENDING I/DD ELIGIBILITY DETERMINATION (APPLICATION <b>NOT</b> YET SUBMITTED)	
NOT APPLICABLE (NO I/DD NEEDS EXIST)	

**YOUTH'S CURRENT LOCATION (check off applicable blue box and complete location section):**



NEW JERSEY DEPARTMENT OF  
CHILDREN AND FAMILIES

<b>HOME:</b>		ADDRESS:	COUNTY:
<b>OOH PROGRAM:</b>		NAME OF PROGRAM SITE:	DATE OF ADMISSION:
<b>HOSPITAL:</b>		HOSPITAL NAME:	DATE OF ADMISSION:
<b>DETENTION:</b>		DETENTION CENTER:	DATE OF ADMISSION:
<b>OTHER:</b>		SPECIFY TYPE AND ADDRESS:	EFFECTIVE DATE:

<b>Care Manager Name:</b>	
<b>Care Manager E-Mail:</b>	
<b>Care Manager Phone:</b>	
<b>Care Manager Supervisor Name:</b>	
<b>Care Manager Supervisor E-Mail:</b>	
<b>Care Manager Supervisor Phone:</b>	

**COMPLETE IF YOUTH IS INVOLVED WITH DCP&P:**

<b>DCP&amp;P Worker Name:</b>	
<b>DCP&amp;P Worker E-Mail:</b>	
<b>DCP&amp;P Worker Phone:</b>	
<b>DCP&amp;P Supervisor Name:</b>	
<b>DCP&amp;P Supervisor E-Mail:</b>	
<b>DCP&amp;P Supervisor Phone:</b>	

By signing this cover letter, I acknowledge that all information is complete and accurate.

\_\_\_\_\_  
Care Manager/Date

\_\_\_\_\_  
Care Manager Supervisor/Date