Program Eligibility Screening Tool

NJ FamilyCare Community Based Palliative Care

Palliative care is extra support for people with serious illnesses. It helps manage symptoms, reduce stress, and works alongside other treatments. An interdisciplinary care team (IDT) listens to what matters to the member and supports their choices—so they can focus on quality of life.

The Community Based Palliative Care (CBPC) benefit provides team-based support for people with serious disease and helps members manage symptoms and navigate the care system. CBPC is not hospice care. Members do not need a terminal diagnosis to receive services and may continue curative or disease-directed treatments while enrolled in the benefit.

Guidance

This screening tool supports identification and referral of members who may benefit from Community-Based Palliative Care (CBPC). Completion of this form does not determine eligibility and does not replace the Comprehensive Medical Assessment Tool (CMAT).

This form may be completed by providers, care managers, members, caregivers, or other community partners using available information about serious illness and quality-of-life impacts. If screening indicates potential eligibility, submit the completed form to the member's health plan via their MCO's Provider Portal (for FFS members, scan and email to MAHS.CBPC@dhs.nj.gov) or to an in-network palliative care provider. Providers should also store the screener in the member's electronic health record.

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General Guidance

- Use legible handwriting or fill electronically
- Complete all fields, using 'N/A' where applicable
- Attach any relevant clinical notes or supporting documentation
- Ensure timely submission to avoid care delays
- If you have questions about form completion, contact MAHS.CBPC@dhs.nj.gov

Section-by-Section Guidance

SECTION A: REFERRAL INFORMATION

- Provide information about the person completing the form and any recommended palliative care provider, if known

SECTION B: MEMBER DEMOGRAPHICS

- Enter member demographic, contact, language, and consent information

SECTION C: PRIMARY CARE PHYSICIAN INFORMATION

- Provide the member's primary care provider name and contact information to support care coordination

SECTION D: ELIGIBILITY SCREENING FORM

- Indicate whether the member has a serious illness, whether it is affecting quality of life, and briefly describe the primary need prompting this screening

SECTION E: SUBMITTING THE COMPLETED FORM

- Submit the completed screening to the member's health plan via their MCO's provider portal (for FFS members, scan and email to MAHS.CBPC@dhs.nj.gov) or to an in-network palliative care provider to support referral for an initial Comprehensive Medical Assessment and potential entry into the CBPC benefit. Providers should also store the screener in the member's electronic health record.

SECTION A: REFERRAL INFORMATION

Referral Date:	Expected Discharge Date: (if applicable)
Referring Person Title: ◯ Care Manager ◯ Provider ◯ Self-referral ◯ Other: _____	
Referring Person Name:	
Referring Person Email:	Referring Person Phone Number:
Recommended Palliative Care Provider(s): (if applicable)	

SECTION B: MEMBER DEMOGRAPHICS

Member Name: (last, first, mi)		Medicaid ID #:	
Health Plan:	◯ Aetna Better Health of New Jersey ◯ Fidelis Care ◯ Fee-For-Service (FFS) ◯ Horizon NJ Health ◯ UnitedHealthcare (UHC) ◯ Wellpoint	Gender: ◯ M ◯ F ◯ Other	Age:
		DOB: (mm/dd/yyyy)	
Address: street address city county state zip code			
Home Phone:		Cell Phone:	
Preferred Language:	◯ English ◯ Spanish ◯ Chinese-Mandarin ◯ Chinese-Cantonese ◯ Portuguese ◯ Tagalog ◯ Korean ◯ Other:_____		
Member Consent (if applicable; if POA is appointed, add information below): ◯ Yes ◯ No		Healthcare Power of Attorney (POA)? ◯ Yes ◯ No	

Caregiver/Alternate Contact Information

If no Caregiver, enter 'None'; if Healthcare POA is Yes, enter Medical Decision Maker information

Name:	Relationship:
Email Address:	Cell Phone Number:

SECTION C: PRIMARY CARE PHYSICIAN INFORMATION

Name:	
Address: street address city state zip code	
Office Phone Number:	Fax Number:

SECTION D: ELIGIBILITY SCREENING FORM

Section 1

Does the member have any serious diseases? (select all that apply)	Adult:	☐ Alzheimer's or other dementias ☐ Congestive Heart Failure ☐ ESRD or Chronic Kidney Disease ☐ Degenerative neural condition (i.e. Parkinsons, severe neurodegenerative disorders)	☐ Cancer (Stage III or IV) ☐ Cirrhosis or liver disease ☐ Stroke ☐ Other ☐ ***No – member has no serious disease***
	Children:	☐ Pulmonary Disease ☐ End-stage Liver Disease ☐ Metabolic/Inclusion Disease ☐ Orthopedic Disorders ☐ Neurological Disorder	☐ Cardiac Disease ☐ Neonatal ☐ Genetic Disorders ☐ Renal Disease ☐ Infection Disease ☐ Cancer ☐ Gastrointestinal Disease or Conditions ☐ Other ☐ ***No – member has no serious disease***

Other Serious Illness Not Included Above & Description:	
ICD-10 Code: (if known/applicable)	ICD-10 Code Description: (if known/applicable)

Section 2

Is serious disease impairing the member's quality of life? (select all impairments)	☐ Difficulty completing daily activities without assistance (e.g., bathing, dressing, using the bathroom, moving around, eating)	☐ Hospitalizations ☐ Other *(please describe)*:
	☐ Emergency room visits	☐ ***No – no impairment***

Section 3

Specify the greatest need of the member and/or caregiver that prompted this screening to be performed and provide a brief synopsis of this request:

SECTION E: SUBMITTING THE COMPLETED FORM

If the member answers anything other than 'No' in **Section 1** AND in **Section 2** of **Section D**, they may qualify for Community Based Palliative Care. **Submit this screening form to the member's healthcare provider or health plan via their MCO's Provider Portal (for FFS members, scan and email to MAHS.CBPC@dhs.nj.gov) to help the member access this benefit**. Providers should also store the screening in the member's electronic health record. A Comprehensive Medical Assessment must be conducted to confirm member eligibility.