

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.

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: <input type="checkbox"/> Care Manager <input type="checkbox"/> Provider <input type="checkbox"/> Self-referral <input type="checkbox"/> 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:	<input type="checkbox"/> Aetna Better Health of New Jersey	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	Age:
	<input type="checkbox"/> Fidelis Care <input type="checkbox"/> Fee-For-Service (FFS)		
	<input type="checkbox"/> Horizon NJ Health	DOB: (mm/dd/yyyy)	
	<input type="checkbox"/> UnitedHealthcare (UHC) <input type="checkbox"/> Wellpoint		
Address:			
street address		city county state zip code	
Home Phone:		Cell Phone:	
Preferred Language:	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Chinese-Mandarin <input type="checkbox"/> Chinese-Cantonese
	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Tagalog	<input type="checkbox"/> Korean <input type="checkbox"/> Other: _____
Member Consent (if applicable; if POA is appointed, add information below): <input type="checkbox"/> Yes <input type="checkbox"/> No		Healthcare Power of Attorney (POA)? <input type="checkbox"/> Yes <input type="checkbox"/> 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)	<table border="0" style="width: 100%;"> <tr> <td style="width: 20%;">Adult:</td> <td> <input type="checkbox"/> Alzheimer’s or other dementias <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> ESRD or Chronic Kidney Disease <input type="checkbox"/> Degenerative neural condition (i.e. Parkinsons, severe neurodegenerative disorders) </td> <td> <input type="checkbox"/> Cancer (Stage III or IV) <input type="checkbox"/> Cirrhosis or liver disease <input type="checkbox"/> Stroke <input type="checkbox"/> Other <input type="checkbox"/> No – member has no serious disease </td> <td> <input type="checkbox"/> COPD <input type="checkbox"/> Diabetes <input type="checkbox"/> AIDS </td> </tr> <tr> <td>Children:</td> <td> <input type="checkbox"/> Pulmonary Disease End-stage Liver Disease <input type="checkbox"/> Metabolic/Inclusion Disease <input type="checkbox"/> Orthopedic Disorders <input type="checkbox"/> Neurological Disorder </td> <td> <input type="checkbox"/> Cardiac Disease <input type="checkbox"/> Genetic Disorders <input type="checkbox"/> Infection Disease <input type="checkbox"/> Other <input type="checkbox"/> No – member has no serious disease </td> <td> <input type="checkbox"/> Neonatal <input type="checkbox"/> Renal Disease <input type="checkbox"/> Cancer Gastrointestinal Disease or Conditions </td> </tr> </table>	Adult:	<input type="checkbox"/> Alzheimer’s or other dementias <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> ESRD or Chronic Kidney Disease <input type="checkbox"/> Degenerative neural condition (i.e. Parkinsons, severe neurodegenerative disorders)	<input type="checkbox"/> Cancer (Stage III or IV) <input type="checkbox"/> Cirrhosis or liver disease <input type="checkbox"/> Stroke <input type="checkbox"/> Other <input type="checkbox"/> No – member has no serious disease	<input type="checkbox"/> COPD <input type="checkbox"/> Diabetes <input type="checkbox"/> AIDS	Children:	<input type="checkbox"/> Pulmonary Disease End-stage Liver Disease <input type="checkbox"/> Metabolic/Inclusion Disease <input type="checkbox"/> Orthopedic Disorders <input type="checkbox"/> Neurological Disorder	<input type="checkbox"/> Cardiac Disease <input type="checkbox"/> Genetic Disorders <input type="checkbox"/> Infection Disease <input type="checkbox"/> Other <input type="checkbox"/> No – member has no serious disease	<input type="checkbox"/> Neonatal <input type="checkbox"/> Renal Disease <input type="checkbox"/> Cancer Gastrointestinal Disease or Conditions
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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)	<table border="0" style="width: 100%;"> <tr> <td> <input type="checkbox"/> Difficulty completing daily activities without assistance (e.g., bathing, dressing, using the bathroom, moving around, eating) <input type="checkbox"/> Emergency room visits </td> <td> <input type="checkbox"/> Hospitalizations <input type="checkbox"/> Other (please describe): <input type="checkbox"/> No – no impairment </td> </tr> </table>	<input type="checkbox"/> Difficulty completing daily activities without assistance (e.g., bathing, dressing, using the bathroom, moving around, eating) <input type="checkbox"/> Emergency room visits	<input type="checkbox"/> Hospitalizations <input type="checkbox"/> Other (please describe): <input type="checkbox"/> No – no impairment						
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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.									