



# AHCA Med-Serv 3008 Referral Cover Sheet

TO: CARES PSA \_\_\_\_\_

FROM: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Fax: \_\_\_\_\_

This form is being submitted to CARES to request a Level of Care for the specified individual below who is applying for Florida Medicaid Institutional Care Program (ICP) through the Florida Department of Children and Families (DCF).

Please check Yes or No to each below:

Yes  No *AHCA Med-Serv 3008 Medical Certification for Nursing Facility/Home and Community Based Services Form (MCNF/HCBS) form/related medical documentation is attachments*

Yes  No *AHCA Med-Serv 2040 Informed Consent for applicant is attached*

To assist in processing the request for Level of Care, please provide the following information:

Please check Yes or No to each below:

Yes  No *DCF ACCESS online application submitted for applicant*

Yes  No *DCF ACCESS application faxed/mailed to DCF*

Comments: \_\_\_\_\_

Total Number of Pages Submitted  
(Including this cover sheet): \_\_\_\_\_

(FOR ONLINE APPLICANTS)  
PLEASE INCLUDE DCF ACCESS  
CONFIRMATION NUMBER  
BELOW:  
\_\_\_\_\_

Applicant SSN: \_\_\_\_\_

Name of Applicant  
(First, MI, Last): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Marital Status: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_

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**(A) FACILITY INFORMATION**

Facility From \_\_\_\_\_  
 Admission Date \_\_\_\_\_ Discharge Date \_\_\_\_\_

Facility To \_\_\_\_\_

**(B) DEMOGRAPHIC INFORMATION**

Individual's DOB \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_

Individual's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Individual's Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Nearest Relative/Health Care Surrogate \_\_\_\_\_ Phone Number \_\_\_\_\_

**PHYSICIAN INFORMATION**

Name \_\_\_\_\_

Will you care for individual in NF?  Yes  No  
 If no, referred to \_\_\_\_\_

Principal Diagnosis \_\_\_\_\_

Secondary Diagnosis \_\_\_\_\_

Discharge Diagnosis \_\_\_\_\_  
 (Problem List may be attached)

Surgery Performed & Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Allergy/Drug Sensitivity \_\_\_\_\_

**MEDICATION AND TREATMENT ORDERS (copies may be attached)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**(C) PREADMISSION SCREENING FOR MENTAL ILLNESS/MENTAL RETARDATION**  
 (Complete for admission to NF only)

1. Is dementia the primary diagnosis?  Yes  No

2. Is there an indication of, or diagnosis of mental retardation (MR), or has the individual received MR services within the last 2 years?  Yes  No

3. Is there an indication of, or diagnosis of serious mental illness (MI), such as (check all that apply)

<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Panic or severe anxiety disorder
<input type="checkbox"/> Mood disorder	<input type="checkbox"/> Personality disorder
<input type="checkbox"/> Somatoform disorder	<input type="checkbox"/> Other psychotic or mental disorder leading to chronic disability
<input type="checkbox"/> Paranoia	

4. Has the individual received MI services within the past two years?  Yes  No

5. Is the individual a danger to self or others? (please attach explanation)  Yes  No

6. Is the individual on any medication for the treatment of a serious mental illness or psychiatric diagnosis?  Yes  No

7. If yes, is the MI or psychiatric diagnosis controlled with medication?  Yes  No

8. Is the individual being admitted from a hospital after receiving acute inpatient care?  Yes  No

9. Does the individual require nursing facility services for the condition for which he/she received care in the hospital?  Yes  No

10. Has the physician certified the individual is likely to require less than 30 days of nursing facility services?  Yes  No

**(D) ADDITIONAL ORDERS (Orders may be attached)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**(E) HISTORY & PHYSICAL AND LABS**

1. PHYSICAL EXAM (History & Physical may be attached)

Head Ears Eyes Nose & Throat (HEENT) \_\_\_\_\_

Neck \_\_\_\_\_

Cardiopulmonary \_\_\_\_\_

Abdomen \_\_\_\_\_

GU \_\_\_\_\_

Rectal \_\_\_\_\_

Extremities \_\_\_\_\_

Neurological \_\_\_\_\_

Other \_\_\_\_\_

Free from communicable diseases  Yes  No

2. LABORATORY FINDINGS (Reports may be attached)

TB Test  Yes  No Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Results \_\_\_\_\_

Chest X-Ray  Yes  No Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Results \_\_\_\_\_

**(F) IMMUNIZATIONS GIVEN**

<input type="checkbox"/> Pneumococcal Vaccine	Date _____ / _____ / _____
<input type="checkbox"/> Influenza Vaccine	Date _____ / _____ / _____
<input type="checkbox"/> Tetanus and Diphtheria Vaccine	Date _____ / _____ / _____
<input type="checkbox"/> Herpes Zoster Vaccine	Date _____ / _____ / _____

**(G) PHYSICAL THERAPY (Attach Orders)**

New Referral  Continuation of Therapy

**FREQUENCY OF THERAPY INSTRUCTIONS**

<input type="checkbox"/> Stretching	<input type="checkbox"/> Coordinating Activities	<input type="checkbox"/> Progress bed to wheelchair
<input type="checkbox"/> Passive Range of Motion (ROM)	<input type="checkbox"/> Non-weight bearing	<input type="checkbox"/> Recovery to full function
<input type="checkbox"/> Active assistive	<input type="checkbox"/> Partial weight bearing	<input type="checkbox"/> Wheelchair independent
<input type="checkbox"/> Active	<input type="checkbox"/> Full weight bearing	<input type="checkbox"/> Complete ambulation
<input type="checkbox"/> Progressive resistive	Sensation Impaired: <input type="checkbox"/> Yes <input type="checkbox"/> No	

**PRECAUTIONS**

Cardiac  Restrict Activity:  Yes  No

Other \_\_\_\_\_

**ADDITIONAL THERAPIES (Attach Orders)**

<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Respiratory Therapy
<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Other _____

**(H) TREATMENT AND EQUIPMENT NEEDS (Attach Orders)**

<input type="checkbox"/> Catheter Care	<input type="checkbox"/> Diabetic Care
<input type="checkbox"/> Changing Feeding Tube	<input type="checkbox"/> Monitor Blood Sugar/Frequency _____
<input type="checkbox"/> Dressing Changes	<input type="checkbox"/> Administer Insulin _____
<input type="checkbox"/> Ostomy Care	<input type="checkbox"/> Tube Feeding _____
<input type="checkbox"/> Wound Care	<input type="checkbox"/> Oxygen (Select from below)
<input type="checkbox"/> Suctioning	<input type="checkbox"/> PRN _____
<input type="checkbox"/> Trach Care	<input type="checkbox"/> Continuous @L/min _____

Instructions \_\_\_\_\_

**(I) SPECIAL DIET ORDERS (Orders may be attached)**

\_\_\_\_\_

\_\_\_\_\_

**(J) TYPE OF CARE RECOMMENDED (MUST BE COMPLETED AND SIGNED)**

Check one

Skilled Nursing Extended Care Facility (ECF), Duration \_\_\_\_\_

Intermediate Care: Duration \_\_\_\_\_

I certify that this individual requires ECF Nursing Facility Care for the condition for which he/she received care during hospitalization.

I certify that this individual is in need of Medicaid Waiver Services in lieu of Institutional placement.

Rehab Potential (check one)  Good  Fair  Poor

Admission Date to Nursing Facility \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Effective Date of Medical Condition \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

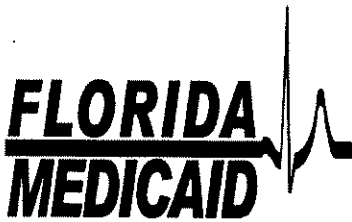
Print Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax \_\_\_\_\_

Email Contact Address \_\_\_\_\_





**STATE OF FLORIDA**

**AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA)  
DEPARTMENT OF ELDER AFFAIRS (DOEA)**

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**INFORMED CONSENT FORM**

**CLIENT'S NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**An assessment is required for all persons applying for or receiving assistance for long-term care. This includes the Institutional Care Program (ICP) and Home and Community-Based Services (HCBS) waiver programs.**

**In order to evaluate my needs, I am giving my consent to the following:**

- I agree to an assessment to identify my need for long-term care, and to determine if my needs can be met in the community instead of a nursing facility.**
- I authorize DOEA staff to access my medical records. I understand and agree that DOEA may need to talk to my doctor and other health professionals. I also understand that they may need to interview my family members, close friends and social services professionals about my situation.**

\_\_\_\_\_  
**Individual or Representative**

\_\_\_\_\_  
**Relationship (if representative signs)**

\_\_\_\_\_  
**Date**