AHCA 5000-3008 REFERRAL COVER SHEET

Total number of pages (including this cover sheet): ☐

TO: CARES PSA ____________________

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Phone: ____________________

FAX: ____________________

FROM: ____________________

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Phone: ____________________

FAX: ____________________

This form is being submitted to CARES to request a Level of Care for the specified individual below who is applying for the 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 Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form – AHCA 5000-3008 (JUN 2016) and related medical documentation is attached

☑ Yes ☐ No 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: ____________________

____

Applicant's Social Security Number: ____________________

Applicant's Name: ____________________
First MI Last

Address: ____________________

(For Online Applicants)
Please include DCF ACCESS confirmation number below:
____

Phone: ____________________ Marital Status: ____________________

Date of Birth: ____________ Sex: __________ Race: ____________

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