FLORIDA MEDICAID

MEDICAL CERTIFICATION FOR NURSING FACILITY/HOME- AND COMMUNITY-BASED SERVICES FORM
(Replaces Patient Transfer and Continuity of Care Form)

(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)
   - ☐ Schizophrenia
   - ☐ Mood disorder
   - ☐ Somatoform disorder
   - ☐ Paranoia
   - ☐ Panic or severe anxiety disorder
   - ☐ Personality disorder
   - ☐ Other psychotic or mental disorder leading to chronic disability
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

- ☐ Pneumococcal Vaccine Date _____/_____/_____
- ☐ Influenza Vaccine Date _____/_____/_____
- ☐ Tetanus and Diphtheria Vaccine Date _____/_____/_____
- ☐ Herpes Zoster Vaccine Date _____/_____/_____

(G) PHYSICAL THERAPY (Attach Orders)

☐ New Referral ☐ Continuation of Therapy

FREQUENCY OF THERAPY _____

INSTRUCTIONS _____

- ☐ Stretching
- ☐ Passive Range of Motion (ROM)
- ☐ Active assistive
- ☐ Active
- ☐ Progressive resistive
- ☐ Coordinating Activities
- ☐ Non-weight bearing
- ☐ Partial weight bearing
- ☐ Full weight bearing
- ☐ Progress bed to wheelchair
- ☐ Recovery to full function
- ☐ Wheelchair independent
- ☐ Complete ambulation

Sensation Impaired: ☐ Yes ☐ No

Restrict Activity: ☐ Yes ☐ No

PRECAUTIONS

- ☐ Cardiac
- ☐ Other _____

ADDITIONAL THERAPIES (Attach Orders)

- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Respiratory Therapy
- ☐ Other _____

(H) TREATMENT AND EQUIPMENT NEEDS (Attach Orders)

- ☐ Catheter Care
- ☐ Changing Feeding Tube
- ☐ Dressing Changes
- ☐ Ostomy Care
- ☐ Wound Care
- ☐ Suctioning
- ☐ Trach Care
- ☐ Diabetic Care
- ☐ Monitor Blood Sugar/Frequency _____
- ☐ Administer Insulin
- ☐ Tube Feeding
- ☐ Oxygen *(Select from below)*
  - ☐ PRN
  - ☐ Continuous @L/min _____

Instructions

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

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

Check one

Rehab Potential (check one) ☐ Good ☐ Fair ☐ Poor

☐ Skilled Nursing Extended Care Facility (ECF), Duration _____

☐ Intermediate Care: Duration _____

Admission Date to Nursing Facility _____/_____/_____

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.

Print Physician's Name _____

Address _____

Phone Number _____ **Fax** _____

Email Contact Address _____

Effective Date of Medical Condition _____/_____/_____

_____/_____/_____

Physician's Signature and Date Required

FOR ONLINE APPLICANT USE ONLY

IF APPLYING FOR MEDICAID, PLEASE INCLUDE DCF ACCESS CONFIRMATION NUMBER BELOW:

AHCA MEDSERV-3008 form, May 2009--(Replaces Patient Transfer and Continuity of Care Form 3008 July 2006 - CF Med 3008)

FLORIDA MEDICAID

NURSING/SOCIAL WORK ASSESSMENT
[Page 2 may be completed by a Nurse or Social Worker]

INDIVIDUAL'S NAME _____ **DOB** _____

ADLs ARE AT TIME OF NF ADMISSION

(K) VISION (w/glasses if used)	☐ 1. Good ☐ 2. Fair ☐ 3. Poor ☐ 4. Blind	**AMBULATION**	☐ 1. No assistance ☐ 2. With assistive device ☐ 3. With supervision ☐ 4. Requires assistance* ☐ 5. Total help ☐ 6. Bed bound
HEARING (w/aid if used)	☐ 1. Good ☐ 2. Fair ☐ 3. Poor ☐ 4. Deaf	**ENDURANCE**	☐ 1. Tolerates distance (250 feet sustained activity) ☐ 2. Needs intermittent rest ☐ 3. Rarely tolerates short acitivities ☐ 4. No tolerance
SPEECH	☐ 1. Good ☐ 2. Fair ☐ 3. Poor ☐ 4. Gestures or signs ☐ 5. Unable to speak	**TRANSFER**	☐ 1. No assistance ☐ 2. With assistive device ☐ 3. With supervision ☐ 4. Requires assistance* ☐ 5. Bed bound
COMMUNI-CATION	☐ 1. Transmits messages/receives information ☐ 2. Limited ability ☐ 3. Nearly or totally unable	**WHEELCHAIR USE**	☐ 1. No assistance ☐ 2. Assistance with difficult maneuvering ☐ 3. Wheels a few feet ☐ 4. Unable ☐ N/A
MENTAL AND BEHAVIOR STATUS	☐ 1. Alert ☐ 2. Confused ☐ 3. Disoriented ☐ 4. Comatose ☐ 5. Aggressive ☐ 6. Disruptive ☐ 7. Apathetic ☐ 8. Wanders ☐ 9. Safety restraints needed ☐ 10. Well motivated	**TOILETING**	☐ 1. No assistance ☐ 2. With assistive devices ☐ 3. With supervision ☐ 4. Requires assistance ☐ 5. Total assistance ☐ A- Bathroom ☐ B - Bedside commode ☐ C- Bedpan
SKIN CONDITION	☐ 1. Intact ☐ 2. Dry/Fatigue ☐ 3. Irritations (rash) ☐ 4. Open Wound ☐ 5. Decubitus Site:_____ Stage:_____ Size:_____	**BLADDER CONTROL**	☐ 1. Continent ☐ 2. Occasional incontinence - once/week or less ☐ 3. Frequent incontinence - up to once a day ☐ 4. Total incontinence ☐ 5. Catheter - indwelling
DRESSING	☐ 1. No assistance ☐ 2. Supervision ☐ 3. Requires assistance* ☐ 4. Has to be dressed	**BOWEL CONTROL**	☐ 1. Continent ☐ 2. Occasional incontinence-once/week or less ☐ 3. Frequent incontinence - up to once a day ☐ 4. Total incontinence ☐ 5. Ostomy
BATHING	☐ 1. No assistance ☐ 2. Supervision ☐ 3. Requires assistance* ☐ 4. Is bathed ☐ A- Tub ☐ B - Shower ☐ C- Sponge Bath	**FEEDING**	☐ 1. No assistance ☐ 2. Tray set up only ☐ 3. Requires assistance ☐ 4. Is fed ☐ 5. Aspirates
TEACHING NEEDS	☐ 1. Diabetic ☐ 2. Cardiac ☐ 3. Ostomy ☐ 4. Other (specify):	**DIET**	☐ 1. Full ☐ 2. Mechanical Soft ☐ 3. Pureed ☐ 4. Other (specify):

***(HANDS ON NEEDED)**

Comments:_____

SIGNATURE AND TITLE_____ **DATE**_____/_____/_____

(L) SOCIAL WORK ASSESSMENT

Prior Living Arrangement_____

Long Range Plan/Agency Referrals_____

Adjustments to Illness or Disability_____

Comments _____