COMPREHENSIVE ASSESSMENT AND REVIEW FOR LONG–TERM CARE SERVICES PROGRAM (CARES)

POLICY HANDBOOK

March 2017
DOEA Mission Statement

To help Florida’s elders remain healthy, safe, and independent

DOEA Vision

All Floridians aging with dignity, purpose, and independence.

DOEA Goals

Ensure that any Floridian in need of long-term care services receives a timely and appropriate assessment of need.

Protect vulnerable Floridians and their families by establishing the Office of Public and Professional Guardians.

Expand the Dementia Care and Cure Initiative (DCCI) across Florida.

Complete all federal and state statutory and regulatory requirements effectively by maximizing the number of elders served.
CARES PROGRAM POLICY HANDBOOK
EMPLOYEE ACKNOWLEDGEMENT FORM

I hereby acknowledge receipt of a copy of the Department of Elder Affairs, Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program Policy Handbook, dated March 2017.

I understand it is my responsibility to review these documents and request any necessary clarification from my supervisor. By signing this Acknowledgement, I declare that I have read the entire handbook, including all appendices.

I also understand that this signed acknowledgement of receipt will become a permanent part of my personnel file.

_________________________________________  ______________________
Signature of Employee                      Date

Typed or Printed Name of Employee

_________________________________________  ______________________
Signature of Supervisor                     Date

Typed or Printed Name of Supervisor
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EMPLOYEE REVIEW CHECKLIST

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S. Form 610 – Review of NLOC

T. Form 603 – Level of Care

U. Form 2506 – Client Discharge/Change Notice
The current CARES Program Policy Handbook is posted on the CARES SharePoint site.

Changes to the handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update may be issued as either replacement pages in an existing handbook or a completely revised handbook.

Replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the preceding replacement page with a numeric character in ascending order. (For example: page 1-3 may be followed by page 1-3.1 to avoid reprinting the entire chapter.)

CARES staff can use the update log to determine if they have received all of the updates to the handbook.

When the handbook is updated, CARES staff will be notified by email.

**Update** describes the change that was made. **Effective Date** is the date that the update is effective.

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~ INTRODUCTION ~

This handbook is the official document of the Department of Elder Affairs (DOEA) for the operation of the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program. CARES is Florida’s federally mandated preadmission screening program for Medicaid long-term care applicants. CARES policies and procedures are provided as they relate to the processes for Preadmission Screening and Resident Review (PASRR) of all nursing facility applicants aged 21 and older for serious mental illness or intellectual disability. CARES policies and procedures are also provided for determining medical eligibility (Level of Care) for individuals applying for home and community-based Medicaid programs and nursing facility Medicaid. In addition, the handbook outlines program eligibility criteria, services, Client Information and Registration Tracking System (CIRTS) coding, and follow-up schedules for long-term care services programs.

LEGAL AUTHORITY

Title XIX of the Social Security Act established the Medicaid program in 1965 for the purpose of helping recipients of public assistance and other low-income persons meet the cost of necessary medical care. Florida implemented the Medicaid program on January 1, 1970. Medicaid provides reimbursement for care of eligible individuals in nursing facilities and home and community-based long-term care services. Payment for skilled nursing services is mandatory under federal regulations for Medicaid and is provided by the state. Intermediate care is an optional Medicaid service under federal regulations, and the State of Florida has elected to provide payment for this service. Florida has also elected to provide payment for home and community-based services.

The Medicaid program is authorized by: Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code.

The CARES program is authorized by: Title XIX of the Social Security Act of 1965, 42 CFR 456, 42 CFR 483.100-483.138 (Subpart C); Sections 409.985, Florida Statutes; Chapter 59G-4.180 and Chapter 59G-4.290, Florida Administrative Code.

ABUSE, NEGLECT, OR EXPLOITATION

All state employees are legally required to report any suspected abuse, neglect, or exploitation of an elder. Listed below is information included in the Florida Statutes to cover mandatory reporting, penalties, and immunity from liability. Do not assume someone else who has knowledge of a client’s situation will initiate a report to the Florida Abuse Registry.
Section 415.102(28), Florida Statutes, defines a vulnerable adult as a person 18 years or age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging.

Section 415.1034, Florida Statutes, requires that any state employee who knows, or has reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited shall immediately report such knowledge or suspicion to the central abuse hotline. Section 415.111(1), Florida Statutes, further requires that, “A person who knowingly and willfully fails to report a case of known or suspected abuse, neglect, or exploitation of a vulnerable adult, or who knowingly and willfully prevents another person from doing so, commits a misdemeanor of the second degree…” Section 415.111(2), Florida Statutes requires that, “A person who knowingly and willfully makes public or discloses any confidential information contained in the central abuse hotline, or in other computer systems, or in the records of any case of abuse, neglect, or exploitation of a vulnerable adult, except as provided in ss. 415.101-415.113, commits a misdemeanor of the second degree.” “Section 415.111(5), Florida Statutes, requires that, “A person who knowingly and willfully makes a false report of abuse, neglect, or exploitation of a vulnerable adult, or a person who advises another to make a false report, commits a felony of the third degree…” Section 415.1036(1), Florida Statutes states that, “Any person who participates in making a report under s. 415.1034 or participates in a judicial proceeding resulting therefrom is presumed to be acting in good faith. . . . is immune from any liability, civil or criminal, that otherwise might be incurred or imposed.” Section 415.1036(1), Florida Statutes.

It is the responsibility of the person suspecting abuse, neglect, exploitation to make a report to the Abuse Hotline at 1-800-ABUSE (1-800-962-2873). For review of this statute in its entirety, see: Title XXX, Chapter 415, Florida Statutes: http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0415/0415ContentsIndex.html&StatuteYear=2016&Title=%2D%3E2016%2D%3EChapter%20415
CHAPTER 1
~ ORGANIZATION AND ADMINISTRATION ~

AHCA, DCF AND DOEA

The Agency for Health Care Administration (AHCA), Department of Children and Families (DCF), and Department of Elder Affairs (DOEA) coordinate and facilitate policies and procedures related to Medicaid long-term care services eligibility.

AHCA is the single state agency designated to administer the state’s Medicaid program in accordance with federal regulations. AHCA is responsible for enforcing federal Medicaid policies and procedures and developing state Medicaid policies and procedures for nursing facilities and all other services offered under the Medicaid program.

- AHCA has regulatory oversight for CARES and has delegated responsibility for preadmission screening of nursing facility applicants and determining Level of Care for Medicaid long-term care services to DOEA. AHCA administers CARES related activities through an interagency agreement with DOEA pursuant to Section 409.985(2), Florida Statutes.

DCF is the state agency responsible for the administration of social and economic services. The Automated Community Connection to Economic Self-Sufficiency (ACCESS) is a program within DCF that is responsible for policies and procedures related to financial eligibility for Medicaid. Within each geographic DCF service district, ACCESS staff determine financial eligibility for nursing facility Medicaid and other long-term care Medicaid programs.

DOEA is the state agency that has lead responsibility for administering human service programs for the elderly and for developing policy recommendations for long-term care.

Within DOEA’s Division of Statewide Community-Based Services (SCBS), there are three bureaus:

1. **Community and Support Services (CSS)** – includes most non-Medicaid community-based programs that help elders remain in their own homes. CSS also provides technical assistance and oversight for the Aging and Disability Resource Centers’ non-Medicaid programs.

2. **Long-Term Care and Support (LTCS)** – assists with Medicaid programs in partnership with AHCA, including areas such as monitoring contract compliance of the Long-Term Care managed care plans and Program of All-Inclusive Care for the Elderly (PACE). LTCS also provides technical assistance and oversight for the Aging and Disability Resource Centers’ Medicaid programs.
3. **Comprehensive Assessment and Review for Long-Term Care Services (CARES)** – conducts the following activities mandated by federal law:

- Preadmission screening on all nursing facility applicants age 21 and older for the presence of serious mental illness or intellectual disability. Preadmission screening is performed to ensure that long-term care services are provided in the setting most appropriate to the needs of the person, to prevent premature institutionalization, and to determine if further evaluation is needed.

- Comprehensive face-to-face assessment or medical case file desk review to determine medical eligibility for individuals seeking Medicaid nursing facility placement or Medicaid long-term care services in the community.

**CARES ORGANIZATION**

For operating efficiency, the CARES Program is divided into four geographic regions of the state and are overseen by the Regional Program Supervisors (RPSs). The RPSs report directly to the Deputy Chief for Field Operations. The Deputy Chief for Field Operations reports directly to the CARES Bureau Chief who has the authority and responsibility for the CARES Program.

There are 17 CARES field offices located in Planning and Service Areas (PSAs) which are supervised by Program Operations Administrators (POAs). The POAs are responsible for the supervision of the staff in each CARES field office and report directly to their respective RPS.

The primary functions of the CARES field office are:

- Preadmission screening on all nursing facility applicants age 21 and older and comprehensive assessment of individuals referred for nursing facility Medicaid (the Institutional Care Program), the Statewide Medicaid Managed Care Long-term Care Program, the Adult Cystic Fibrosis Waiver (CF), Familial Dysautonomia Waiver (FD), Program of All-Inclusive Care for the Elderly (PACE), Project AIDS Care (PAC), and the Traumatic Brain and Spinal Cord Injury Program (TBSCIP),

- Level of Care Determination; and

- Follow-up.

**COMPOSITION AND RESPONSIBILITIES OF THE CARES FIELD OFFICES**

The CARES office consists of highly professional multi-disciplinary staff that includes a POA, Senior CARES Assessor, Assessors, Registered Nurse Specialists (RNSs),
Physician Consultant, and administrative support staff. Some larger field offices also include CARES Assessor Supervisor(s) (CAS). Each staff member in a field office is an integral, important part of the CARES Program and process, performing their duties timely and professionally in order to ensure that elders and adults with disabilities receive needed services as quickly and efficiently as possible.

The main duties and responsibilities of each member of the CARES office are as follows:

**PROGRAM OPERATIONS ADMINISTRATOR (POA)**

- Supervises, coordinates, and monitors the activities of the CAS(s) (if applicable), Senior Assessors, Assessors, RNSs and administrative support staff.
- Monitors case files of Assessors, Senior CARES Assessors, and RNSs.
- Coordinates and directs interdisciplinary staffing team for Level of Care determinations; provides guidance and offers technical and supervisory support; reviews assessment information; participates in the staffing process including Level of Care decisions.
- Monitors both expense and OPS budgets to ensure that overspending does not occur.
- Identifies staffing/equipment needs, hires new employees, arranges for orientation and appropriate training, supervises and appraises staff performance, completing performance evaluations as required, and institutes disciplinary action as necessary.
- Has direct responsibility for preparation of statistical reports, as requested, relative to CARES activities and daily monitoring, as well as ensuring that data is forwarded to Central Office as required.
- Provides public education, physician education, and in-service orientation for Department staff.
- Participates in disaster recovery efforts throughout the State of Florida.

**CARES ASSESSOR SUPERVISOR (CAS)**

(For offices without a CAS, the duties below fall to the POA)

- Supervises, assigns and monitors the activities of Assessors, Senior Assessors, and administrative support staff.
- Monitors case files of Assessors and Senior Assessors.
CARES Program Policy Handbook

- Provides training on assessment procedures.
- Participates as a member of an interdisciplinary staffing team for Level of Care determinations.
- Conducts regular reviews and audits of exception reports, CIRTS reports, and Ad Hoc reports; assists in evaluative and reporting efforts as needed.
- Prepares and develops plans for case assignment and workload distribution for a CARES field office including geographic or facility based assignments for each Assessor, Senior Assessor and RNS, for field, office, and staffing schedules.
- Ensures that cases are staffed in accordance with CARES time standards and in accordance with current policy and procedure.
- Hires new employees; arranges for orientation and appropriate training, supervises and appraises direct report performance, completing performance evaluations as required, and institutes disciplinary action as necessary in accordance with Department policies and procedures.
- Participates in disaster recovery efforts throughout the State of Florida.
- Acts as delegate for the POA as assigned.

**Senior Assessor/Assessor**

- Coordinates and conducts comprehensive assessments of applicants for nursing facility placement and home and community-based services; evaluates the Level of Care and recommends the most appropriate placement.
- Conducts preadmission screening activities of applicants for nursing facility placement, as appropriate.
- Maintains accurate and up-to-date information on clients in CIRTS on cases assigned; ensures timely follow-up with individuals in accordance with established CARES policies and procedures.
- Participates as a member of an interdisciplinary staffing team for Level of Care determinations.
- Participates in disaster recovery efforts throughout the State of Florida.
- Senior Assessors function as the lead caseworker within the unit.
- Senior Assessors act as delegate for POA or CARES Assessor Supervisor, as assigned.
REGISTERED NURSE SPECIALISTS

- Coordinates and conducts comprehensive assessments of applicants for nursing facility placement and home and community-based services; evaluates the Level of Care and recommends the most appropriate placement.

- Conducts preadmission screening activities of applicants for nursing facility placement, as appropriate.

- Maintains accurate and up-to-date information on clients in CIRTS on cases assigned; ensures timely follow-up with individuals in accordance with established CARES policies and procedures.

- Participates as a member of an interdisciplinary staffing team for Level of Care determinations; conducts R.N. staffing; determines and signs Level of Care and placement in accordance with the certifying physician and CARES policies and procedures.

- Conducts in-service trainings for team members on medical topics.

- Participates in disaster recovery efforts throughout the State of Florida.

PHYSICIAN CONSULTANTS

- Participates as a member of an interdisciplinary staffing team for Level of Care determinations; provides medical interpretation; determines and signs appropriate Levels of Care.

- Assists in evaluative and reporting efforts as needed.

ADMINISTRATIVE SUPPORT STAFF

- Receives, screens, and routes calls appropriately; provides general information to callers on the CARES Program.

- Sorts and date stamps incoming referrals, mail and faxes; records appropriate information on the Referral Log Sheet; routes daily incoming mail to appropriate staff; prepares outgoing mail.

- Follows CARES office policy to assign case referrals to staff; prepares case files.

- Types notification letters and other correspondence.

- Prepares and submits monthly expense report for travel reimbursement; orders equipment and supplies for office staff, as needed.
COMPOSITION AND RESPONSIBILITIES OF THE CARES CENTRAL OFFICE (CO)

The CARES Central Office, located in Tallahassee, Florida, is comprised of the CARES Bureau Chief, Deputy Bureau Chief of Field Operations, government analysts, administrative support, a Registered Nurse Consultant, and a Systems Project Analyst. Central Office staff provide various functions to support the program and field offices.

The CARES Central Office is responsible for:

- Developing and implementing CARES Program policy and procedures in consultation with AHCA.
- Developing and implementing methods of monitoring the CARES Program for effectiveness, uniformity, and compliance with policies and procedures.
- Providing training, orientation, consultation, and technical assistance to CARES staff regarding program policies and procedures.
- Evaluating the effectiveness of policies and procedures in accordance with AHCA and developing procedural changes and modifications as necessary.
- Evaluating the impact of the CARES program by on-site visits to CARES offices and meetings with staff and providing two-way communications between the field and central office.
- Representing the Department by attending meetings concerning the CARES Program.
- Obtaining, assimilating, and distributing applicable and pertinent information regarding the CARES Program to federal and state agencies and professional organizations.
CHAPTER 2
~ CASE RECORDS ~

CONFIDENTIALITY/RELEASE OF INFORMATION

The Department of Elder Affairs places great emphasis on the protection of the privacy of persons served in all DOEA funded programs and services.

CARES may release client information to any DOEA division or to those individuals who are performing client related functions that the Department is mandated to perform. It is also permissible to release information from CARES records to the Centers for Medicare and Medicaid Services (CMS), AHCA, the Long-Term Care Ombudsman Program (LTCOP), the Agency for Persons with Disabilities (APD), and DCF, including but not limited to, Substance Abuse and Mental Health (SAMH) or its designee and ACCESS. CARES may also release client information to the Medicaid Fraud Control Unit (MFCU) of the Attorney General’s Office. CARES cannot release information to unauthorized parties, including family members and attorneys, unless the client or legal representative gives permission or is ordered to do so by any district court or court of appeals of the United States that has the power and legal authority to hear and determine specific matters. Should questions arise regarding the release of confidential information, the CARES’ RPS should be contacted for authorization prior to releasing any CARES case record or information from the record.

CIRTS

Client information is maintained electronically and in hard copy case records. The majority of client information is maintained in DOEA’s database for client, program, and service information called the Client Information and Registration Tracking System (CIRTS). Data entry requirements for CIRTS are based on federal and state mandates. CARES utilizes CIRTS to maintain case information on Level of Care determinations, track client follow-ups, maintain Preadmission Screening and Resident Review (PASRR) information, and produce reports for monitoring purposes. The Aging and Disability Resource Centers (ADRCs) utilize CIRTS to manage client assessment data, register clients for services, plan client services, and maintain program waiting lists. For detailed information on how to use CIRTS, refer to the CIRTS User Guide for CARES located at:
https://fldoea.sharepoint.com/sites/CARES/_layouts/15/start.aspx#/Systems%20Information/Forms/AllItems.aspx

CASE RECORD ORGANIZATION

Case records should contain information pertinent to determining LOC as detailed below. Case information contained in CIRTS should not be printed or placed in the paper case record. This includes: the computer generated assessment, case notes, and Client Information Forms (CIFs). The two sections of a paper case record with content requirements are as follows:
• Medical information and the CARES Intake Form (DOEA-CARES Form 611), if applicable, – 1st brad inside the front cover of the file. Inclusions are to be in the following order, top down: Notification of Level of Care (DOEA-CARES Form 603), Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (AHCA 5000-3008) (or equivalent form for some Medicaid Waivers), followed by any additional medical information, PASRR forms, and Form 611 (if applicable). Incomplete or incorrect documents should not be destroyed and should be filed underneath the correct version of the documents. Only exact duplicate items can be destroyed.

• Other forms and communications: – 2nd brad inside the back cover of the file.

Inclusions are to be in descending chronological order: copies of correspondence to the client from CARES regarding time frames, Informed Consent Form (AHCA-MedServ Form 2040), DCF Notice of Case Action, Health Insurance Portability and Accountability Act (HIPAA) Form and any other forms the client signed related to programs and LOC determination.

Cases will be identified by label placed on the tab, by client name, last name first, first name, followed by social security number. Color coding of labels is at the discretion of the CARES office POA.

(All forms mentioned above are available in the CARES Forms section of the CARES SharePoint site: https://fldoea.sharepoint.com/sites/CARES/_layouts/15/start.aspx#/SitePages/Home.aspx. Copies can also be found in the Appendices of this handbook.

CASE RECORD STORAGE

RETENTION AND DESTRUCTION OF CASE RECORDS

CARES case records that are in the office or in off-site storage are to be retained for a period of six years after the date of last contact and case closure. After six years of inactivity, these records must be destroyed. However, if a case record contains PASRR documentation, the case record cannot be destroyed unless the PASRR documentation has been stored electronically.

Destruction of CARES case records must be done in a manner that safeguards all confidential material. Prior to case record destruction, the CARES office must send a request for case record destruction to the CARES Central Office and the request must be approved in accordance with established CARES policies.

OFF-SITE STORAGE OF CASE RECORDS

CARES utilizes a records storage vendor for offsite storage of case records. The contract with the vendor is managed and administered by the designated CARES
Central Office staff. Contact CARES Central Office for vendor contact information and any information not covered below.

- The offsite records storage vendor has an online web-based tracking system. Each CARES office has a login to the system and designated staff members in each office have access to the system. The web-based system enables each office to add case record inventory, view inventory, and place orders for case record retrieval and/or pickup of boxes of case records that need to be stored offsite.

- The vendor utilizes case record box barcode labels. Upon request from a CARES office, the vendor will mail box barcode labels to the CARES office. The barcodes are pre-assigned to each CARES office and are unique to that CARES office. The barcode labels are used to track the location of the case record box. When the vendor picks up boxes from the CARES office, the barcode labels are scanned into the vendor's system.

- Case records that need to be stored offsite must be placed in boxes that are designed for document storage only. The barcode label should be placed on the box (on one of the shorter sides) in the lower right hand corner. Do not place barcodes on box lids or underneath the lids.

- Case record box identifying information is entered into the vendor's web-based system by CARES office staff. Information such as dates, descriptions, destruction dates, etc. is captured for each box that is picked up for storage. This information is linked to the barcode label for easy retrieval of a case record.

- To retrieve a case record, CARES staff must send the request via encrypted email to the vendor. The vendor will scan the case record and return the case record by encrypted email. In the event that a case record is too large to send via email, the vendor will send the case record directly to the CARES office using FedEx next day delivery service.

CASE RECORD STORAGE – SECURITY AND PROTECTED HEALTH INFORMATION (PHI)

CARES field offices must adhere to the following three basic principles across all environments:

1. Clients’ case records and PHI must be kept in an area that is not readily accessible by unauthorized non-CARES personnel;

2. Clients’ case records and PHI must be kept in appropriate facilities behind at least two locked doors when not being utilized by CARES staff; and

3. Clients’ case records and PHI must be secured by CARES staff, when out in the field, in a way that is not readily accessible by unauthorized non-CARES personnel.
CASE RECORD STORAGE WITHIN CARES OFFICES

Case records must not be left where they are accessible to unauthorized non-CARES employees.

- All case records, whether active or closed, are to be stored in lockable filing cabinets or in a lockable file room when practical.

- During non-business hours, the filing cabinets and file room must be locked. File rooms containing filing cabinets without locks must have a door with a lock and a key.

- Filing cabinets located in hallways that contain clients’ case records must be kept locked at all times.

- If space issues exist, active case records may be stored in a worker’s office. Case records that are kept in workers’ offices must be in locked filing cabinets or locked desk drawers when not in use. During non-business hours, desks must be locked.

- Duplicate keys for all locks must be available and individually identified for all filing cabinets, desks, and doors to allow access to case records.

- Duplicate keys must be secured in an appropriate receptacle such as a locking key case or the supervisor’s locked desk drawer which must be accessible to supervisory staff or designee.

- Always secure client information to keep it safe from disclosure. (For further safeguards, reference http://elderaffairs.state.fl.us/english/hipaa_admin.php)

CASE RECORD STORAGE OUTSIDE OF CARES OFFICES

As a standard of practice, CARES staff should not take the paper case record from the secure on-site location. If it is necessary to manage PHI in the field, the following principles should be followed:

- In cases where information from the paper case record is needed, the information should be scanned and e-mailed with PHI maintained strictly on the CARES field staff’s laptop computer and deleted when it is no longer necessary.

- When removal of the case record from the secure facility is the only option, supervisory approval must be obtained and only the minimum necessary PHI required to complete the current assessment should be removed. After completion of the assessment, the PHI must be returned directly to the client’s paper case record. CARES staff should adhere to the HIPAA principles of “minimum necessary” (Reference definition at http://elderaffairs.state.fl.us/english/hipaa_minimum.php)
• In the field, when PHI is obtained in the regular course of completing CARES duties, staff should secure PHI in a manner that does not allow unauthorized non-CARES employees’ access to the PHI. PHI must be secured and placed in the CARES paper case record as soon as practical.

All CARES offices must have a check out system for case records that allows for tracking and location of case records. A master log must be utilized to track all outgoing records and documents including transfer of records to another CARES office.

• The master log should minimally contain the client’s full name and birth date as well as the date the case record was removed and the date it was returned.

• All documents should be listed for tracking purposes. This includes, but is not limited to, documentation transported to agencies such as the Department of Children and Families, or the Aging and Disability Resource Centers.

• CARES staff must sign and date the master log upon taking and removing the client’s case record.

• The master log must be located in a designated area in each office or electronically on the CARES office’s SharePoint site.

All CARES staff that work outside of the office (field staff), will be held responsible for maintaining case records and PHI in a secure location while out of the CARES office.

• All case records, when not in use during business hours, will be stored and locked in the trunk of the field staff’s car or covered in the rear of the vehicle, if the vehicle does not have a trunk available.

• Case records that are kept out overnight will be kept in the staff’s home. It is the responsibility of field staff to retain case records in a location of the home that ensures that case records are not damaged, stolen or PHI exposed. Client case records must not be left unattended and unsecured in the home or vehicle of any individual including CARES staff.

CASE RECORD STORAGE IN ELECTRONIC FORMAT (I.E., LAPTOP COMPUTERS):

All staff must keep their laptop secure at all times.

• Laptops are encrypted devices. While a laptop is generally considered protected in the event of loss or theft, keeping passwords in a secure place separate from the laptop is the only way to ensure the laptop will not be accessed by unauthorized individuals. Example: Never keep password information inside the laptop, such as on a note or business card taped inside the cover. (Reference http://elderaffairs.state.fl.us/english/hipaa_access.php)

• Never leave a laptop unattended in a facility.
• When using a laptop in the field, utilize it in a manner to ensure the most secure environment for PHI information that may be displayed.

• When it is necessary to leave a laptop in the car, it must be secured and out of sight. Do not leave a laptop in a hot car or exposed to humidity for prolonged periods of time. Heat and moisture can damage internal components and affect performance.

• CARES field staff going on Extended Leave (which is defined as more than five business days) must complete the following steps to secure the electronic data and PHI:
  o Staff must return the laptop to the office prior to the anticipated leave of absence, unless prior approval is granted due to a special circumstance.
  o The supervisor must secure the laptop in an appropriate locked receptacle;
  o The laptop must not be left unsecured in the worker’s workstation when the worker will be out of the office.

• USB or “Jump Drives” are not acceptable methods of storing or transferring data.

• Emailing or copying client information PHI to any DOEA non-encrypted storage format is prohibited.

**PROCEDURE TO FOLLOW IN THE EVENT OF ANY BREACH OF CASE RECORDS OR PHI:**

CARES staff must notify their direct supervisor immediately of any breach of PHI.

A breach can consist of:

• Loss of a laptop or any client case records (NOTE: Any loss due to theft must be reported to law enforcement immediately);

• Someone other than CARES staff or a DOEA employee having unauthorized access to PHI.

CARES staff will document in writing how the breach occurred including providing:

• a copy of the police report, if due to theft;

• a statement by the CARES staff regarding the status of any PHI that was stored with the laptop (including a description of password security protocols);

• a completed DOEA Report of Unaccounted for Inventory Item. (This report can be found in DOEA Policy 545.70 Property Management located on the Human Resource SharePoint site under Policies.)
The CARES Supervisor must communicate the breach, along with the CARES staff’s written report and any other reports or relevant information, to the CARES Bureau Chief, the Deputy Bureau Chief, and the Regional Program Supervisor. The Bureau Chief and/or Deputy Bureau Chief will notify the Department’s HIPAA Privacy Officer per the Department’s HIPAA Policy and Procedure and Federal regulations (CFR reference: 45 CFR Parts 160 through 164).
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CHAPTER 3

~ CASE NOTE DOCUMENTATION ~

The purpose of case notes is to provide a chronological and concise record of the actions that have occurred on behalf of an individual and to eliminate any gaps of information in the case. This chapter provides general guidelines to follow when completing case notes. It also provides further information and instruction on case note completion for specific activities that occur when processing a case.

GENERAL GUIDELINES

CARES case notes are maintained in CIRTS and must document the status of the case from the date the case is assigned until the case has been closed. Case notes should be written whenever relevant information is sent or received, including recording the receipt of documents related to confidentiality, medical information, and additional information significant to the progress of the case.

Use the following guidelines when completing case notes:

- Document in chronological order actions or events as they occur. If a case note cannot be entered in CIRTS on the date an action or event occurred, the reason for the late entry must be documented in case notes. (Remember, if it is not documented, you did not do it!)

- Case notes must follow the progression of the case and document the circumstances and actions that led to the case outcome. Months or years after a case is closed, there may be cause to review the case; workers may not be available or be able to recall all the particular aspects of the case. Anyone reading the case in the future should be able to easily understand the circumstances and actions taken leading to the case outcome.

- Case notes should be essential to the case and must not contain opinion or hearsay. When determining if information should be entered in a case note, consider whether it is relevant to determining a Level of Care (LOC) and appropriate to put in case notes. Information should be omitted that does not provide pertinent information to determining the correct Level of Care or a placement/program recommendation.

- Case notes must contain evidence of professional conclusions regarding the reasons for temporary or long term placement recommendations and specific Level of Care. Conclusions must be based on the assessment, medical documentation, direct observation of the client, discussions with representatives, and/or medical personnel as appropriate.
• Case notes become part of the permanent record and are equivalent to a legal and medical document which can be used as evidence in a court of law. If an error is discovered, a new case note entry must be created to explain the discrepancy using the CIRTS case note category “CORRECTION.” The case note that is being corrected must be referenced.

• Use professional terminology, correct punctuation, and spelling. It is acceptable to type case notes into a software program such as Microsoft Word, then cut and paste the documentation into the appropriate case note section of CIRTS. Using Word allows the worker to check spelling, punctuation, and grammar. The Word document must be deleted once the case note is added to CIRTS and should not be printed out and stored in the paper case file or considered part of the client record.

• Use the CARES-approved abbreviation lists included in Appendix B and Appendix C. Do not create abbreviations for diagnoses or use abbreviations for any other word unless approved by CARES CO staff.

• When referencing approved acronyms and abbreviations in case notes, put the acronyms and abbreviations in parentheses after the initial full spelling. The acronym and abbreviation may be used thereafter. For example: Department of Children and Families (DCF); and Agency for Health Care Administration (AHCA). Refer to the DOEA Style Sheet on the Communications SharePoint site.

• Avoid the use of pronouns such as “he,” “she,” or “they.” Instead, use the person’s name or relationship to the client, such as “the client’s daughter, Ms. Granger.”

• Document the type or method of contact (face-to-face, email, fax), the date of the contact and where the contact occurred.

• Document the date that information is received and the source of the information.

• Document the client’s informed decisions and review of confidentiality policies.

Note: Prior to adding a new case note, **always** review any previous case notes to determine if additional tasks should be completed or information should be added and initiate follow-up if necessary.

**CIRTS CASE NOTES**

When a case is opened in CIRTS, some case notes are automatically generated by the system based on the data entered; other case notes are manually typed in CIRTS by the user. The following information explains the various automatic case notes generated based upon specific activities and provides guidelines for proper completion of CIRTS manual case notes. For a complete listing of the case notes categories, see the CIRTS User Guide for CARES.
CASE ASSIGNMENT – CIRTS GENERATED

An automatic case note is generated when a case is opened in CIRTS identifying the assigned case worker, referral source, Special Project case indication, and the reason the case was opened.

An automatic case note is also generated to indicate that the 3008 received is complete or incomplete.

SCHEDULING AN ASSESSMENT – USER GENERATED

The worker must enter a case note showing what action was taken to set up an appointment for an assessment, for example, Phone Call-Outgoing, Email-Outgoing, etc.

Any additional contacts made regarding scheduling the assessment, or relevant information such as receipt of medical information, must be entered by the worker using the appropriate notes category.

ASSESSMENT – CIRTS GENERATED

CIRTS will automatically generate a case note that documents information entered into the on-line completed assessment form.

ASSESSMENT HISTORY – USER GENERATED

A worker generated case note must be entered for the Assessment History.

Assessment History case notes should provide an accurate “picture” of the client and their current circumstance including: living situation, availability of a caregiver or support system, client and caregiver’s abilities and limitations, and any other circumstances relevant to what necessitated the need for a CARES assessment.

A complete assessment history case note must answer the following questions:

1) How did the client get to their current situation?

- Document the referral source: ADRC (if EMS release, review 701S), family, hospital (why are they in the hospital?), nursing facility, etc.
- Are they living alone and in need of services due to a medical condition?
- Were they living alone, or with other, had to be hospitalized, and then had to come to the nursing facility for rehab?
• Are they living with a caregiver? Has the client’s and/or caregiver’s situation or condition changed to warrant the need for services? Does the caregiver work outside the home, or have any limitations?

• For annual MCFR: Document at each annual which LTC plan, the case manager’s name, how they got on Medicaid Waiver (EMS, NF stay, PAC release, etc.)

2) Where was the assessment conducted?

• Document that a face-to-face assessment occurred. Note the specific setting: living room, at dining room table, in client’s bedroom, etc.

• If the assessment occurred in a facility (such as a nursing facility, assisted living facility, hospital, adult family care home, adult day care, or mental health facility), document the name of the facility. If not, was it in a personal residence? If so, is it the client’s residence?

• Do they live with others? Are there caregivers?

• Who was present during the interview?

• For annual MCFR: Document the case as a MCFR, but provide documentation regarding where they were at the time the case manager conducted the assessment.

3) What is the client’s current situation?

• If the client is in a nursing facility, what services are they receiving? Are they adjusting to their environment?

• What was the demeanor of the client? Did they appear calm, nervous, distracted, etc.? 

• If the client is in the home, are they receiving any help? If not, what do they express as their greatest need(s)?

• If the client is receiving services what services are they receiving?

• For annual MCFRs: Document the services that the client is receiving (if known), any changes from the previous assessment, and other relevant information gathered during the assessment, including calls to the client or case manager for verification or clarification of the assessment information.
4) What are the future plans for the client?

- Have goals been established at this time? Are there challenges to meet the goal?
- If the client is in the nursing facility, is the plan short-term or long-term care?
- If the client is in the hospital, is the client going to a NF? (Short-term, long-term, unknown?)
- If the client is at home, is the plan to stay there, move in with family or others, or move to an alternative living arrangement?
- For annual MCFR: Does the assessment provide any information regarding any changes in the client’s situation? If not, note this as well.

In addition to answering the questions above, Assessment History case notes should:

- Include any information from the Comment Sections of the assessment instrument that are relevant to determining a Level of Care.

- Document any request from the client or representative for information on long-term care options other than the long-term care option originally requested. Refer them to the ADRC, if appropriate, and document the discussion and referral to the ADRC. For example, the client/caretaker originally expressed an interest in NF services and staff assessed the client in the community; now the client is interested in home and community-based services but has not been screened or placed on the wait list.

- Document specific information related to LOC that is not reflected in the automatic case note entry for the assessment instrument and any additional information that needs to be reiterated.

- Document that the client signed the Informed Consent form (Appendix G) if applicable, the HIPAA form (Appendix H), and that the client or representative was given a copy of the Social Security request notice.

- Document any client delay in performing the assessment and the reason for the delay. Delay reasons due to the CARES worker are inappropriate to include in the CIRTS record unless the delay is due to office closure or determined by CARES Central Office.

**LEVEL OF CARE JUSTIFICATION – USER GENERATED**

A worker generated case note must be entered for Level of Care (LOC) Justification. An individualized case note for every client is critical to determining whether the
client meets medical eligibility for LOC and specific programs. LOC Justification case notes should be unique to the client and the information should correlate to what was documented in the assessment process.

LOC is based on the specific criteria found in 59G-4.290, and 59G-4.180, Florida Administrative Code. (Appendix Q and Appendix R).

A complete LOC Justification case note must answer the following questions:

1) **What makes the client meet LOC?**
   - What medical condition(s) require(s) the availability of 24-hour medical observation and care? Document the specific medical conditions (chronic, severe, serious and/or complex) and how these medical conditions are related to the information in the administrative code. Explain why the client cannot manage their medical condition(s).

   *Consider: What condition(s) caused them to be hospitalized, in a NF, and unable to live independently?*

2) **What LOC is recommended?**
   - Document the specific LOC (Skilled, Intermediate I, Intermediate II) based on criteria found in 59G-4.290 and 59G-4.180, Florida Administrative Code. For Medicaid Waivers that use Risk of Hospitalization, see specific Waiver requirements in Chapter 7.

   - The LOC justification should define the specific service, treatment, therapy that:
     a) correlates to the medical condition that makes them meet LOC, and
     b) documents the medical condition that is the highest priority for the client at the time of assessment.

3) **What recommendation(s) is being given?**
   - Document the clinical/technical criteria the client meets to be eligible for the specific program, or waiver: (age, meets LOC or ROH, lives in the service area, etc).

   - For clients who do not meet Level of Care criteria, follow the procedures found in the Assessments with No Level of Care (NLOC) Recommendations Chapter 4.
**Staffing – CIRTS Generated/User Generated**

CIRTS will automatically generate a case note for staffing.

A worker generated case note must also be entered to document additional information such as letters or notices that were sent as a result of the staffing, information that was communicated concerning the case during the staffing, and any delays in completing the staffing.

A worker generated case note must be entered for NLOC determinations to document that the POA and the Physician Consultant agreed with the NLOC recommendation and that the NLOC was staffed with the Physician Consultant.

**PASRR – CIRTS Generated/User Generated**

CIRTS will automatically generate a case note from specific information documented in the PASRR section.

If a Level II is required, a case note must be entered by the worker regarding the referral to the Level II evaluator, what method was used (provider portal, fax, email, etc.) and the date of the referral. Document subsequent information regarding the progress of the case such as additional information requested by the Level II evaluator, and any delay by the Level II evaluator in completing the case in a timely manner (7 business days). The worker must document efforts made to provide information to the contractor, if needed, and/or that the worker’s supervisor was informed in the event of a delay in receiving the Level II Evaluation and Determination. Any effort the supervisor made in the process must also be included in the case notes.

If a request for a Level II is received but CARES determines that a Level II is not required, a case note must be entered by the worker that documents who requested the Level II, and why a Level II is not required. (If there is no case, enter this information in the Information Tab.)

**NOTE:** If the Level of Care effective date is based on the completion of PASRR, a case note must be entered that explains the effective date.

**Follow-Up – CIRTS Generated/User Generated**

CIRTS will automatically generate a case note from specific information documented in the Follow-Up section of CIRTS.

A worker generated case note must be created to document additional information not contained in the CIRTS generated case note. For example, who did the worker
talk to regarding the client’s current situation? When is the next follow-up scheduled?

**ENROLLMENT BROKER – CIRTS GENERATED**

CIRTS will automatically generate a case note documenting that the staffing information was sent to AHCA’s Enrollment Broker for those cases with Program Recommendation of PACE, Managed Long-Term Care Nursing Facility (MLTCN), or Managed Long-Term Care Community (MLTCC).

**CASE CLOSURE – CIRTS GENERATED/USER GENERATED**

CIRTS will automatically generate a case note that documents case closure.

If there is additional information relevant to the closing of the case, the worker must enter a user generated case note to document the relevant information regarding why CARES is closing a case due to change of living arrangement, placement recommendation, or other circumstances related to the client’s situation.
CHAPTER 4
~ GENERAL OPERATIONS ~

INTRODUCTION

The CARES process for determining Level of Care and eligibility for Medicaid programs consists of the following steps: (1) client intake and case opening, (2) client assessment using the Department’s standard assessment instruments, (3) medical certification for nursing facility or home and community-based services (by the client’s physician), (4) interdisciplinary review of the DOEA assessment and medical certification to determine Level of Care, placement and program recommendation, (5) client follow-up, and (6) case closure.

This chapter describes the CARES process including the sources from which cases are received, the requirements for accepting cases, and the manner in which referrals are processed. This chapter also explains the policies and procedures for case assessment, case staffing, and client follow-up.

Note: Forms and letters mentioned in this chapter are located on the CARES SharePoint site and in the appendices at the end of this handbook.

CASE INTAKE

EDUCATIONAL ACTIVITIES

CARES field offices are responsible for ongoing educational activities in their area. These activities include:

- Providing information regarding the purpose of the CARES program, the availability of an assessment for nursing facility services, and education on the ADRCs and their function.

- Providing education and training on CARES functions to agencies, nursing facilities, hospitals, and service organizations upon request, or when technical assistance is needed.

REFERRAL SOURCES

The CARES field offices may receive referrals from a variety of sources, such as:

- Hospital Social Services’ Discharge Planners or Social Workers referring a patient who has been identified by the attending physician as needing or potentially needing Medicaid nursing facility placement and/or PASRR Level II evaluation.
• DCF ACCESS staff referring Institutional Care Program (ICP) applicants for an assessment. Referral information will be forwarded to the CARES office on the Access/CARES Communication Form (CF-MED Form 3007).

• DCF Adult Protective Services’ staff referring individuals for an ICP assessment.

• Nursing facility staff referring ICP applicants or potential residents.

• Public and private agencies and organizations referring individuals for an ICP assessment.

• An individual/representative referring an individual for an ICP assessment.

• Assisted Living Facility (ALF) and Adult Family Care Home (AFCH) operators referring individuals for an ICP assessment. (The client must be aware of the referral prior to the ALF/AFCH making the referral.)

• Medicaid waiver programs referring individuals who are applying for ICP and who require preadmission screening prior to nursing facility placement.

• Medicaid waiver programs referring individuals for an initial assessment.

• PACE organizations referring individuals for an initial assessment.

• Aging and Disability Resource Centers (ADRCs) forwarding clients released from the Enrollment Management System (EMS) per the procedures described in Chapter 6 – Statewide Medicaid Managed Care Program.

**Referral Processing**

CARES referrals are accepted and processed in the following manner:

• Each hard copy referral will be date stamped 8:00 AM - 4:00 PM, Monday through Friday, on the same business day that the referral is received in the office. If a referral comes in after 4:00 PM, on the weekend, or on a holiday, it will be date stamped on the following business day. However, at the discretion of the supervisor, if a referral is received after 4:00 PM, an office may choose to date-stamp the referral on the date received. Referrals received via email will be printed and CARES staff will follow the same procedure as above.

• The CARES Intake Form (DOEA CARES Form 611) must be used for all incoming telephone referrals. The SSN Request Notice (Appendix I) will be read to the individual to explain the reason for requesting the individual’s SSN number and that the SSN will only be used for application purposes.

• Referrals will be entered daily into the electronic Intake/Referral Log. A hard copy manual form is allowable only as a second resource, if needed. The referral log
and instructions for accessing and completing the pertinent information on the log will be maintained on the CARES office SharePoint site. This log is a chronological listing of all cases referred to CARES for assessment.

- Referral data will also be entered daily into CIRTS, i.e., using the Demographic, Case Assignment, and Information Only screens, if applicable.

- Incomplete referrals for a LTC Program annual waiver recertification, or other Medicaid waiver annual waiver recertification will be returned and documented in the case notes of the previous closed case. The case will not be opened and assigned in CIRTS.

- Referrals for an ICP assessment are accepted from any source and by any means of transmission: fax, mail, courier, walk-in, email, or telephone.

- At the discretion of the POA, in order to avoid a lengthy delay, ICP referrals may be logged in and assessed without receipt of a 3008 form. (If, however, a complete 3008 is not received within 12 business days from the initial referral, the case should be staffed as Withhold Level of Care on the 603 form, and all copies of the 603 retained in the CARES’ case record.)

- Enrollment Management System (EMS) released individuals referred to CARES from the ADRC must be accompanied by a complete 3008 and include all attachments, if indicated. If a complete referral is not received, the case should not be opened and assigned in CIRTS. (For further information regarding EMS release procedures, see Chapter 6 – Statewide Medicaid Managed Care Program.)

- Referrals received for individuals living outside the service area of the receiving office will be redirected or forwarded to the appropriate CARES office where the individual is currently residing.

**CROSS PROGRAM CHECK FOR MEDICAID PROGRAMS**

Referrals to the CARES office will be screened by examining client information in CIRTS, DCF’s FLORIDA System, and the Florida Medicaid Management Information System (FMMIS) to determine if the individual has filed an ICP application, is ICP eligible, or is already enrolled in the LTC Program, PACE, or other Medicaid waiver program. Reviewing this information assists staff to determine appropriate handling and assignment of the referral, e.g., whether the referral is an initial request for medical eligibility determination, an annual request for Level of Care, or a referral that must be returned to the referral source with the reason for the return provided.

**CASE ASSIGNMENT/SPECIALIZATION**

In the specialization model, staff are assigned field responsibilities or office responsibilities. There can be slight variations on the distribution of responsibilities
depending upon the size and geographic makeup of the office. Field staff generally specialize in conducting the initial contact with a client and completing on-site assessments. Office staff specialize in handling cases that do not need an on-site assessment. Staff, both field and office, may be divided into teams so that each field team member will know who to ‘hand off’ cases to for completion of the steps necessary to ensure a complete assessment, staffing, and follow-up. Generally, field staff are assigned incoming cases based upon zip codes, while office staff are assigned medical case file reviews through a round robin process. Cases are assigned on the day received, if received before 4:00 p.m. The rationale for the specialized assignments is to promote worker efficiency and productivity with the programmatic goal of decreasing the time it takes to move from the initial referral to assessment completion and to increase the office’s total number of cases processed to completion.

Note: Assignment of Assessors and RNS to field or office duties are based solely on the needs of the office and are at the discretion of the POA.

CASE ASSESSMENT

PURPOSE

The assessment instrument and process provides necessary information required to establish Level of Care and determine if the client requires nursing facility placement or home and community-based services. Assessments are conducted on-site and face-to-face with the client, except in circumstances where medical case file reviews are allowed (see policy later in this chapter).

INFORMED CONSENT

At the time of each assessment, the individual or representative must sign and date an Informed Consent form (AHCA-Med Serv 2040 Form). This form explains the nature of the assessment, assures them of confidentiality, and permits access to medical records. If the individual has already completed an ICP application, this form may have been signed. If the applicant is hospitalized and the consent form has not already been signed as part of the ICP application process, CARES may request that the Informed Consent form be signed and sent as part of the referral packet prior to assessment, however, if not received, CARES staff must obtain the Informed Consent form when the on-site assessment is conducted. If the case management agency is assessing an individual, it is the responsibility of the case manager to obtain a signed and dated Informed Consent form. If the applicant is in the community, it is the responsibility of CARES to obtain a signed and dated Informed Consent form.

If the Informed Consent form cannot be obtained* with an appropriate signature, the DOEA Assessment Instrument cannot be completed. The Informed Consent form is not required for a medical case file review.
**Note:** The Level of Care cannot be determined through a medical case file review if a client requires a PASRR Level II Evaluation and Determination.

*An Informed Consent form is not required for individuals that have been placed in the custody of DCF Adult Protective Services by a court order. CARES will request a copy of the court order, if not provided by DCF with the referral. The court order authorizes DCF to make decisions regarding placement and the safety and well-being of the individual.

**LANGUAGE INTERPRETATION SERVICES**

CARES staff interact with many clients who are non-English speaking. In the event that there is no family or representative who speaks English, DOEA has contracted with a language interpretation services company to provide telephonic (over the phone) language interpretation services. This service can be used to assist with scheduling an on-site visit, using a three-way telephone call between the worker, the client, and the interpreter. It can also be used to complete an on-site assessment by sharing a speaker phone with the client.

**Note:** Before using this service to conduct an assessment, every effort should be made to find a family member or representative that can interpret for the client.

For more information about how to use this service and to print a card that contains the basic information needed for CARES staff to access the language interpretation services, click on the link to access the CARES SharePoint site: https://fldoea.sharepoint.com/sites/CARES/_layouts/15/start.aspx#/Propio_Language_Translation/Forms/AllItems.aspx

**INTERPRETATION SERVICES FOR THE HEARING IMPAIRED, BLIND OR SPEECH DISABLED**

CARES staff interact with many clients who are hearing impaired, blind, or speech disabled. There may be a situation where CARES staff will need to communicate with a hearing impaired, blind, or speech disabled client on the telephone. The Florida Relay System is available for people who are deaf, hard of hearing, deaf/blind, or speech disabled. Through the Florida Relay Service, people who use specialized telephone equipment can communicate with people who use standard telephone equipment. (TTY/TDD or Telecommunication Device for the Deaf is a machine that the hearing impaired use to type messages back and forth on telephone lines.) To call Florida Relay, dial 7-1-1, or use the appropriate toll free numbers:

- 1-800-955-8771 (TTY)
- 1-800-955-8770 (Voice)
- 1-877-955-8773 (Spanish)

Florida Relay customer service is available 24 hours a day. The customer service telephone numbers are:
Specialized telephone equipment is provided free of charge to Florida residents with hearing or speech loss. For more information on Florida Relay services, click on the link: http://www.ftri.org/.

SCHEDULING ON-SITE VISITS

The following steps will be taken when scheduling all community on-site visits:

- The first telephone attempt to schedule an on-site visit will occur within one-to-three business days of receipt of the referral in the office. (If the telephone number is incorrect, contact the referral source for an alternate telephone number.)

- If unsuccessful, the second telephone attempt to schedule an on-site visit will occur within ten business days of receipt of the referral in the office.

- If the client cannot be reached, the referral source will be notified within 10 business days of the referral date.

- If there is no response from the second attempt, the CARES Contact Letter (612 form, Appendix F) will be sent to the client 20 calendar days following the referral received date. This letter informs the client that the case will be closed on the 30th calendar day if no response is received.

- The case will be closed when unsuccessful attempts have occurred and 30 calendar days from the date the referral was received have passed.

- All attempts to schedule an on-site visit will be documented in CIRTS case notes.

CIRCUMSTANCES IN WHICH AN ON-SITE ASSESSMENT IS COMPLETED

Comprehensive on-site, face-to-face assessments are completed in the following circumstances:

- For EMS released individuals referred to CARES from the ADRC.

- For individuals referred to CARES by a PACE organization.

- For each Medicaid applicant or recipient residing in a nursing facility or community setting that is requesting services under the Institutional Care Program (ICP).
Note: For nursing facility residents, prior to scheduling the on-site assessment and at the discretion of the POA, medical documentation may be reviewed. If, in the opinion of the Assessor/RN, the individual has the ability to return to the community without services (e.g., short-term stay for rehab purposes), a medical case file review (MCFR) may be completed to determine Temporary LOC and an on-site assessment will not be conducted (unless the individual remains in the NF at the 90 day follow up, per below). The POA will document the office procedures with their RPS, and the reasons behind the allowance of MCFRs, e.g., rehab population of the facility, workload of the office, etc.

- For individuals seeking nursing facility admission, regardless of payment source, who are presumed mentally ill and/or intellectually disabled and may require a Level II Determination and Evaluation prior to admission (see Chapter 5 – Preadmission Screening and Resident Review).

- For individuals residing in an Intermediate Care Facility or a behavioral health facility who are seeking nursing facility admission.

- For each individual who appears to not meet a LOC.

- For individuals with a Temporary Level of Care who remain in the nursing facility at the 90-day follow-up.

- For individuals that at the time of the referral were in a NF, but prior to assessment, have been discharged to a hospital or behavioral health facility with the intent of returning to a NF, and it appears there may be a PASRR issue.

Note: For out-of-state individuals seeking admission to a nursing facility, the case cannot be assessed and staffed until the individual is in Florida and CARES has completed an on-site assessment using the DOEA Assessment Form 701B (Appendix J).

CIRCUMSTANCES IN WHICH A MEDICAL CASE FILE REVIEW (MCFR) IS COMPLETED

A medical case file review utilizing Form 3008 may only be completed in the following circumstances:

- For individuals in a nursing facility applying for ICP who refuse to sign the consent form, a medical case file review can be completed on a case-by-case basis, if the 3008 form is completed correctly and the supporting medical documentation clearly indicates a Level of Care. In certain circumstances, a refusal to sign the consent form could stop the CARES process. If a client who appears to be mentally competent or the representative of a client refuses to sign the consent form, document the refusal and reason why (if known) in the case notes. Discuss these cases with the POA for a decision on how to proceed. A medical case file review cannot be completed for individuals who are applying for nursing facility placement who have a diagnosis or suspected diagnosis of a
serious mental illness and/or intellectual disability and require a Level II Evaluation and Determination (See Chapter 5 – Preadmission Screening and Resident Review).

- For individuals applying for a waiver program through a case management agency who clearly meet medical criteria (excluding initial SMMC LTCC cases).

- For hospital patients or nursing facility residents (including swing bed and hospital-based nursing facility applicants) who are on contact isolation, or too ill to participate in an on-site assessment, as determined by the POA, CAS, or Senior CARES Assessor.

- For individuals who are residents of a state mental health hospital who are 65 years and older requesting to receive Medicaid ICP coverage in the state mental health hospital under the State Mental Health Hospital Program. The SMMH hospital forwards Form 034 to CARES to request a “Mental Health” Level of Care.

- For ICP payment only cases, such as clients who are discharged home prior to receipt of the referral.

- For nursing facility residents who expire prior to receipt of the referral.

- For those individuals previously assessed on-site and staffed as Withhold Level of Care due to non-receipt of the 3008, when the 3008 is received within 30 days of the Withhold LOC staffing date, and the assessment is less than 90 days old. (See “Withhold LOC Procedures” later in this chapter.)

- For nursing facility residents, determined through review of the 3008 and other accompanying medical documentation, to have the ability to return to the community without services (e.g., short term stay for rehab purposes). This option is at the discretion of the POA. The POA shall document the office procedures with their RPS and the reasons behind the allowance of MCFRs, e.g., rehab population of the facility, workload of the office, etc.

- For any other special circumstances as determined by client need and approved by CARES Central Office.

**THE ASSESSMENT INSTRUMENT AND PROCESS**

The DOEA Assessment Form, 701B or 701T (Appendix J or Appendix K), will be used for all on-site assessments. All CARES staff who conduct DOEAs’s assessment instruments must complete the on-line assessment training and pass the certification test before conducting an assessment. The POA will retain a copy of the Certificate of Achievement for all CARES staff who conduct assessments.
COMMUNITY

For initial referrals currently located in the community, CARES staff will:

- Review the referral information for completion.

- Contact the client or representative within 3 business days of receipt of the referral to schedule an on-site assessment. Arrange for a foreign language interpreter or TDD service to assist with conducting the assessment, if needed.

- In situations when a client or representative cannot be reached, or in situations where an appointment for a home visit cannot be completed, the referral source will be notified within 10 calendar days from the referral date that the assessment could not be completed. CARES staff will follow the Scheduling On-site Visits procedures outlined earlier in this chapter.

- Complete the on-site assessment within 10 calendar days of the receipt of the referral. (Indicated through the Initial Date or Date Reassessment Requested in CIRTS).

- Obtain signature(s) on the Informed Consent form and the HIPAA form. The HIPAA form only needs to be provided to the client/representative one time.

- Give the client or their representative a copy of the Social Security Request Notice which explains why CARES collects their Social Security number.

- Complete the 701B assessment if the individual is an EMS release referred to CARES from the ADRC.

- Complete the DOEA Assessment Form 701T if the individual requires 24-hour nursing care and observation due to complex medical issues, has moderate to severe cognitive deficits, and it appears that the client will be unable to remain in the community.

**Note:** Explain to the client/representative that if the client becomes eligible for nursing facility Medicaid and remains in the facility for more than 60 consecutive days, the client will be enrolled in the LTC Program (See Chapter 6 – Statewide Medicaid Managed Care Program, LTC section of the handbook). Explain that once the client is enrolled in the LTC Program, there could be the possibility of receiving services in the community, however, if the individual discharges from the facility prior to enrollment, and without the assistance of a LTC Plan, they will not have this opportunity. If the client/representative is interested in this future choice, complete the 701B assessment.

- Complete Assessment Form 701B or 701T with someone knowledgeable of the individual’s condition if the individual is unable to participate due to confusion or memory loss. If the client has designated a representative, power of attorney,
health care surrogate, or the individual has a legal guardian, the assessment should be completed with the assistance of these individuals.

- Complete the DOEA Assessment Form 701B if the client meets the preadmission screening criteria for serious mental illness and/or intellectual disability and may need specialized services (See Chapter 5 – Preadmission Screening and Resident Review).

- Contact other individuals knowledgeable of the situation in order to gain additional information as needed.

**Note:** All assessments should be entered into CIRTS by close of business on the same day that the assessment is conducted. If there are problems with connectivity or system problems, and it is necessary to use a paper form to complete the assessment, CARES staff will notify their supervisor and document that permission was received to use the paper form.

**HOSPITAL**

For initial referrals currently located in a hospital, CARES staff will:

- Review the referral information for completeness.

- Contact the hospital social services department and/or individual or representative within 1 business day of receipt of the referral to schedule an on-site assessment. CARES may request that the Informed Consent form be signed and sent as part of the referral packet prior to assessment, however, if not received, CARES staff must obtain the Informed Consent form when the on-site assessment is conducted. CARES can conduct the assessment prior to completion of the 3008 form; however, the 3008 must be received before a Level of Care can be determined.

- Complete the on-site assessment as soon as possible but no later than 3 business days of receipt of the CARES referral.

- Obtain signature(s) on the Informed Consent form and the HIPAA form. The HIPAA form only needs to be provided to the client/representative one time.

- Give the client or their representative a copy of the Social Security Request Notice which explains why CARES collects their Social Security number.

- Complete the DOEA Assessment Form 701B or 701T, per guidelines described in the Community referrals section above.

- Discuss the case with the hospital social service worker or discharge planner. Review the patient’s medical chart and obtain copies of pertinent medical or social information.
• Contact the individual's private physician as needed.

• Contact other individuals as needed.

**Nursing Facility**

For initial referrals located in long-term care facilities, CARES staff will:

• Review the referral information.

• Contact the individual/representative within three business days of receipt of the referral.

• Conduct an on-site assessment within 10 calendar days of receipt of the referral information unless it is determined that a medical case file review is justified based on exceptions listed previously under “Circumstances in which a Medical Case File Review is Completed.”

• Obtain signature(s) on the Informed Consent form and the HIPAA form. The HIPAA form only needs to be provided to the client/representative one time.

  **Note:** Medical Case File Reviews do not require an Informed Consent Form.

• If the individual requires 24-hour nursing care and observation due to complex medical issues and/or has moderate to severe cognitive deficits, appears to lack community potential, and wishes to remain in the nursing facility, the DOEA Assessment Instrument 701T will be used.

  **Note:** Explain to the client/representative that if the client becomes eligible for nursing facility Medicaid and remains in the facility for more than 60 days, the client will be enrolled in the LTC Program (See SMMC LTC Program section of the handbook). Explain that once the client is enrolled in the LTC Program, there could be the possibility of receiving services in the community, however, if the individual discharges from the facility prior to enrollment, and without the assistance of a LTC Plan, they will not have this opportunity. If the client/representative is interested in this future choice, complete the 701B assessment.

• Complete Assessment Form 701B or 701T with someone knowledgeable of the individual’s condition if the individual is unable to participate due to confusion or memory loss. If the client has designated a representative, power of attorney, health care surrogate, or the individual has a legal guardian, the assessment should be completed with the assistance of these individuals. A representative of the nursing facility should only be used if no other source of client information is available. Document in case notes efforts made to reach other sources of information.
• Discuss case with the facility staff, determine date of admission, review resident’s chart, and obtain copies of pertinent medical or social information related to determining Level of Care.

• Contact the individual’s private physician as needed.

• Contact other individuals as needed.

**ASSESSMENT OF PRIVATE PAY INDIVIDUALS**

Private pay individuals who are seeking admission to a Medicaid certified nursing facility must be screened by the discharging hospital or the admitting nursing facility for serious mental illness and/or intellectual disability prior to nursing facility placement. If the individual requires a Level II Evaluation and Determination, an on-site assessment must be conducted by CARES staff utilizing the DOEA Assessment Instrument 701B. (See Chapter 5 – Preadmission Screening and Resident Review, for more detailed information.)

**REASSESSMENTS**

A reassessment will be completed if an individual has been previously assessed and:

• At follow-up, the client remains in the nursing facility and in the opinion of the CARES professionals involved, there is reason to believe the client may no longer meet Level of Care criteria. CARES staff will complete the 701B assessment form. After the assessment is complete and all relevant documentation is reviewed, if appropriate, follow the No Level of Care procedures.

• At the 90-day follow-up, a client with a Temporary Level of Care remains in the nursing facility. CARES staff will complete an on-site assessment. * If the client has potential to return to the community, complete the 701B. If the client continues to meet a Level of Care and wishes to remain in the facility, complete the 701T. (CARES staff will re-staff the individual as Nursing Home Placement Recommendation and Program Recommendation LTCN.) *If a 701B/701T was completed initially, at the 90-day follow-up, a MCFR can be completed.

• The client’s Medicaid ICP or waiver services have been denied or terminated.

• The client is a current waiver enrollee and an annual LOC is required. (The case open reason in CIRTS must be entered as “AR” and not “RE” even if the LOC has expired.)
PROCEDURES FOR REASSESSMENTS

When reassessments are performed, the client information is updated in CIRTS and cross-referenced with the previous entries.

The case is reassessed utilizing the DOEA Assessment Form 701B/701T, as appropriate. A medical case file review may be conducted based on the exemptions described in the section of the handbook titled “Circumstances in which a Medical Case File Review is Completed.”

The reassessed case will be staffed according to requirements outlined in the Case Staffing section further in this chapter.

ASSESSMENT/REASSESSMENT PROCESS – TIME STANDARDS

Time standards for completion of the assessment process are necessary in order to ensure compliance with policy and procedures. The goal is to be responsive to the health and service needs of the individuals referred for assessment. Staff must notify the supervisor and provide documentation in CIRTS case notes when normal case processing time standards are not met.

- **Initial**: All initial referrals for CARES assessments must be assessed within 10 calendar days of receipt of the referral and staffed within twelve business days of receipt of all information required to complete staffing.

- **Reassessment**: All referrals for reassessment will be assessed and staffed within twelve business days from the date that complete staffing information is received.

ASSESSMENTS WITH NO LEVEL OF CARE RECOMMENDATIONS

CARES staff will follow the written office procedure for No Level of Care (NLOC) recommendations. This procedure will ensure that every NLOC recommendation is reviewed prior to staffing the case with the Physician Consultant. The procedure will include a provision that if the POA is unavailable, the POA’s delegate will assume the responsibility of the case file review.

The NLOC review applies to all Medicaid applicants or recipients that are referred to CARES for an initial Level of Care determination or Level of Care reassessment.

Some situations may require obtaining updated or additional medical documentation as well as consulting with a CARES Registered Nurse Specialist.

**Note**: RPSs may reserve the right to review all NLOC recommendations before cases are staffed with the Physician Consultant.
Following the case file review, if the POA agrees with the NLOC decision, the POA will check the appropriate box on the Individual Review of No Level of Care Recommendation (610 form) (Appendix S) and complete the Justification for Decision section providing adequate reasons for their agreement with the recommendation. The case will be returned to the assigned Assessor/R.N. to complete the staffing with the Physician Consultant.

Following the case file review, if the POA does not agree with the NLOC recommendation, the POA will check the appropriate box on the 610 and complete the Justification for Decision section of the form providing adequate reasons for their disagreement with the recommendation. The case will be returned to the assigned Assessor/R.N. to complete the staffing with the Physician Consultant.

If the POA is unable to determine whether they agree or disagree with the NLOC recommendation (after consulting with a CARES Registered Nurse Specialist and securing updated or additional medical information, if necessary), the POA will forward the 610 and relevant case file documents (i.e., case notes, the 3008, assessment, and other medical documentation) to the appropriate RPS within three business days or less. The case file documents can be sent electronically, via fax, or overnight mail. If the RPS is unavailable for more than five business days, the information should be forwarded to another available RPS.

Following the case file review, if the RPS agrees with the NLOC recommendation, the RPS will check the appropriate box on the 610 and complete the Justification for Decision section providing adequate reasons for their recommendation. The case file review will be completed as soon as possible, but no later than three business days from the receipt of the case file documents. The RPS will communicate the final recommendation back to the POA by scanning and emailing the completed 610.

If the RPS does not agree with the NLOC recommendation, the RPS will check the appropriate box on the 610 and complete the Justification for Decision section providing adequate reasons for their non-agreement with the recommendation. The RPS will communicate the final recommendation back to the POA by scanning and emailing the completed 610. The RPS will also discuss the justification for issuing a Level of Care with the POA by telephone. The final recommendation will be communicated as soon as possible, but no later than three business days from receipt of the case file documents.

The RPS will consult with a CARES Registered Nurse Specialist and/or a local physician, if necessary, during the case file review and, when appropriate, the RPS will consult with Central Office staff on NLOC decisions.

When the final recommendation is received from the RPS, the POA will return the case to the assigned Assessor/R.N. for staffing with the Physician Consultant.

The Assessor/R.N. will document in the Level of Care Justification case notes that a NLOC recommendation was discussed with the POA and the reasons for the recommendation. The Assessor/R.N. will use the following standard case note to
document the discussion: “A potential No Level of Care recommendation due to (give reason) was prepared and submitted to the POA for review and discussion.”

NLOC determinations will **not** be entered in case notes until the POA agrees with the recommendation, returns the 610 to the worker, and the case has been staffed with the CARES Physician Consultant for final determination. The Assessor/R.N. will document the NLOC determination in the Staffing case note and that the POA and Physician Consultant agreed with the NLOC recommendation.

**DCF AND NLOC PROCEDURES**

If the client has an ICP Medicaid case, PACE, or Medicaid waiver case with DCF, DCF will need to be notified of the NLOC status. Following are the procedures for CARES to follow:

- For NLOC nursing facility, PACE, or Medicaid waiver cases other than SMMC cases, CARES staff will fax DCF a copy of the NLOC 603 form and document in case notes that the 603 was sent to DCF.

- For NLOC SMMC LTC Program Annual Waiver Recertifications, CARES staff will fax DCF a copy of the NLOC 603 form and a 2515 form with the box for section III. c checked and the reason “Does Not Meet LOC criteria.” Document in case notes that the 603 and 2515 were sent to DCF and notify the designated Central Office staff of the NLOC.

Individuals who do not meet Level of Care should be referred to the ADRC Elder Helpline to explore alternative community programs, if appropriate.

**CASE STAFFING**

**PURPOSE**

After a comprehensive assessment is completed, CARES must determine if an individual meets medical criteria (Level of Care) for nursing facility Medicaid or community-based Medicaid waiver programs. CARES must also determine if an individual’s needs can be met in the community or if nursing facility is the most appropriate placement. These decisions are finalized in an interdisciplinary team meeting called “staffing”. The goal of staffing is to assign the appropriate and correct Level of Care, program recommendation, and placement recommendation.

**STAFFING TEAM**

The CARES professional staff participating in the interdisciplinary staffing may include:

- Program Operations Administrator or designee,
• CARES Assessor Supervisor,
• Senior CARES Assessor,
• Assessor,
• Registered Nurse Specialist, and/or
• Physician Consultant.

**PREPARATION FOR STAFFING**

CARES staff will prepare case findings for individuals assessed for nursing facility placement or community-based services by familiarizing themselves with all aspects of the case. CARES staff will come to staffing prepared to explain and support their recommendations, justified by the individual’s medical condition and need for services, for Level of Care, program, and placement.

Any indication or diagnosis of a mental illness and/or intellectual disability and the Level II determination in regards to specialized services or appropriate placement should be addressed prior to staffing.

In preparation for staffing, case notes should be completed and entered into CIRTS all the way through the LOC Justification case note.

Under no circumstances shall CARES assessors or registered nursing staff present a case for staffing without completing the appropriate case assessment procedures.

**STAFFING TIME STANDARDS**

All referrals for CARES assessments will be staffed within 12 business days of receipt of complete staffing information (Staffing Information Received date in CIRTS, per below). This time standard may be waived due to office closure, or as determined by CARES Central Office.

After assessment, if all staffing information (excluding PASRR Level II referrals) is not received within 12 business days of referral receipt, the case will be staffed as Withhold Level of Care following the procedures outlined in the section Withhold Level of Care Procedures in this chapter.

**NOTE:** CARES staff will not staff cases as Withhold Level of Care while waiting for the Level II evaluator to complete the PASRR Level II/Resident Review Determinations. These cases will remain open and the “Staffing Information Received Date” in CIRTS will be the date the Level II Determination is received by CARES.
**Staffing Information Received:** This is the date entered in CIRTS that CARES received all required medical documentation (including history and physical, etc.) needed to staff the case in the following situations:

- For ICP, SMMC LTC Program, and PACE, it is the date the completed Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (AHCA 5000-3008 form, Appendix N) was received*;

- For other Medicaid Waivers, it is the date that the appropriate medical documentation was received (see Chapter 7 of the handbook, for appropriate medical documentation);

- If a request for a Level II PASRR Evaluation and Determination (See PASRR Chapter 5) was requested, enter the date of receipt of the Level II Evaluation and Determination Summary;

- For cases that have been assessed but medical documentation/3008 has not been received within 12 business days from receipt of the referral, the case will be staffed on the 12th business day as “Withhold” and the staffing information received date in CIRTS will be this date. Supervisor discretion can be given to adjust the date staffed to less than 12 days if the worker is informed they will not be receiving the medical documentation required to staff the case, or more than 12 days if the worker is informed that they will receive the medical documentation within a reasonable period.

*When CARES receives a correctly completed 3008 from the ADRC for an EMS released individual, the referral date and the Staffing Info Date will be the same. The date of the actual on-site assessment should not be entered in the Staffing Info Received date as part of the medical documentation received. CARES reports that show the average time period from date of assessment to staffing will correctly report these time periods.

**CONDUCTING THE CASE STAFFING**

In order to conduct the case staffing for an on-site assessment, the completed DOEA Assessment Form (701B/T); 3007, if received; and the 3008 will be in the electronic or hardcopy case file.

For medical case file reviews, the 3008, or equivalent forms for specific Medicaid Waivers, e.g., the Adult Cystic Fibrosis Medicaid Waiver Program Physician Referral and Request for Level of Care Determination form, Physician Referral and Diagnosis Confirmation To Determine Level of Care Familial Dysautonomia Waiver (FD 1 Form), PAC Waiver Physician Referral and Request for Level of Care Determination (DOEA-CARES 607), Traumatic Brain Injury and Spinal Cord Injury Program BSCIP Request for Level of Care can be used. (See Chapter 7 Additional Medicaid Waivers) for an example of these specific forms.)
CARES professional staff will be prepared to present the required documentation to the Physician Consultant and/or Registered Nurse Specialist for review.

Staffing will be conducted by the POA or designee, in all cases, to assist with determining if an individual meets the minimum criteria for a Level of Care recommendation.

The case staffing will result in the completion of the 603 form (Appendix T) and the staffing section of CIRTS. All data must be entered into CIRTS immediately following staffing.

**REGISTERED NURSE SPECIALIST AND PHYSICIAN CONSULTANT SIGNATURES ON DOEA 603**

During the staffing, the 603 will be signed and dated by the Physician Consultant or CARES Registered Nurse Specialist indicating agreement with the Level of Care recommendation. The 603 is an official medical document and the Physician/RNS is attesting to their agreement with the recommendation on the date the form is signed.

CARES staffing policy defines the responsibilities of the CARES Registered Nurse Specialist and Physician Consultant to sign the 603.

The CARES RNS will use their Registered Nurse license to sign the 603 in the following circumstances when they are not the assigned caseworker:

- All annual Medicaid Waiver cases.
- All cases designated as temporary nursing facility placement (NHTP) with the program recommendation “none”.
- All non-contested nursing facility cases where the living arrangement is nursing home, and the placement recommendation is nursing home.
- All cases for clients residing in the community that are requesting nursing facility placement and Level of Care.
- All cases where a Level II PASRR indicates nursing home placement is appropriate.

The CARES RNS will use their Registered Nurse license to sign the 603 in the following circumstances when they are the assigned caseworker:

- All cases staffed Withhold Level of Care where the 3008 or supporting medical documentation is not received.
- Re-issues of the 603 when a previously issued Level of Care is greater than 100 days old and, after reassessment, the individual’s condition remains unchanged.

Physician Consultants will sign the 603 for the following cases:
• All No Level of Care cases.
• All initial Medicaid Waiver cases including the LTC Program LTCC cases.
• All initial PACE cases.
• All contested nursing home cases. A case is contested when the CARES placement recommendation or program recommendation does not agree with the 3008. However, a difference between the Level of Care recommendation (Skilled, Intermediate I, or Intermediate II) on the 3008 and the CARES physician or nurse approved Level of Care determination is not considered a contested case.
• All cases where the assigned caseworker has concerns with the client’s health, safety, or welfare.
• All cases where a Request for Level II PASRR indicates nursing home placement is not appropriate.

The Registered Nurse Specialist has the discretion to require additional information prior to making a determination, and, as needed, the RNS may refer a case for staffing to the Physician Consultant. The reason for referring the case to the Physician Consultant will be entered in CIRTS case notes.

If a situation occurs where the CARES time standard would not be met, cases required to be staffed with the Registered Nurse Specialist may be staffed with the Physician Consultant with prior supervisory approval. The reason for referring the case to the Physician Consultant will be entered in CIRTS case notes.

**Basis for Level of Care**

The Level of Care is based on the client’s medical condition, therapies, treatments, and services that the client is receiving on the date of the assessment.

The Level of Care effective date (line #7 on 603) will be the “effective date of medical condition” on the 3008. If no effective date is entered, or a partial effective date is entered on the 3008, the Level of Care effective date will be the physician’s signature date on the 3008.

**Note:** For nursing facility clients, the effective date for the LOC is dependent upon successful completion of PASRR; see Chapter 5 – Preadmission Screening and Resident Review, for applicable effective dates.

When determining Level of Care for retroactive Medicaid or posthumous approvals, the Level of Care is based upon the individual’s condition for the months(s) requested on the 3007.
Each individual given the Intermediate Level of Care determination must meet the criteria outlined in Section 59G-4.180, Florida Administrative Code: https://www.flrules.org/gateway/ruleno.asp?id=59G-4.180&Section=0 (Appendix Q).

Each individual given the Skilled Level of Care determination must meet the criteria outlined in Section 59G-4.290, Florida Administrative Code: https://www.flrules.org/gateway/ruleno.asp?id=59G-4.290&Section=0 (Appendix R).

For ICP Medicaid and specific Medicaid waivers, if the individual does not require skilled or intermediate care, a Level of Care is not established (No Level of Care) and the No Level of Care Process should be followed (See Assessments with No Level of Care Recommendations in the CASE ASSESSMENT Section of this chapter). (Also, see Chapter 7 for specific Medicaid waivers LOCs.)

**LEVEL OF CARE TIME STANDARDS**

A Level of Care determination for nursing facility placement is valid for 45 days (from the signature date on the 603) pending placement. Day one begins on the staffing date. If the individual is not admitted to a nursing facility within 45 days of the signature date on the 603, a new Level of Care is needed.

A Level of Care for an individual that has not yet submitted an ICP Medicaid application (no 3007 form has been received) is valid if:

- The individual is admitted to a nursing facility within 45 days from the signature date on the 603 and the individual applies for ICP Medicaid (DCF sends CARES a 3007 form) within 100 days from the date the Physician Consultant/RNS signed the 603.

- If the client applied outside of the 100 days, a new Level of Care is needed.

- If the individual was not placed within 45 days, a new Level of Care is needed.

For ICP Medicaid reapplications, DCF staff may use the existing Level of Care if the following two conditions are met:

- The individual was admitted to a nursing facility within 45 days of the signature date on the 603, and

- The reapplication was filed within 100 days of the signature date on 603.

**WITHHOLD LEVEL OF CARE PROCEDURES**

Cases that do not warrant CARES issuing a Level of Care are taken to staffing and are staffed as Withhold Level of Care. CARES withholds a Level of Care in the following situations:
• A Request for Level II PASRR Evaluation and Determination indicates that the individual requires specialized services and those services cannot be provided in a nursing facility;

• A Request for Level II PASRR Evaluation and Determination indicates the individual is not appropriate for nursing facility placement;

• A 3008 or supporting medical documentation has not been received.

If a client has been assessed, and a 3008 is not received as requested, the case will be staffed within 12 business days of referral receipt, recommending a Withhold Level of Care. Staff will continue attempts to obtain a 3008 during this time. If, after this period of time, a 3008 cannot be obtained, a CARES 3008 Letter (DOEA 613, Appendix L) will be sent to the client informing the client that the case will be closed if the 3008 is not received. The letter will be sent 10 days prior to the end of the 30-day period. An Unscheduled Follow-up will be created by staff as a way of tracking the need for the 3008 and the case will remain open until completion of the 30-day follow-up.

**Placement Recommendations**

Placement recommendations will be based on the client’s current living situation, and/or their potential to safely return or remain in the community. CARES staff will recommend placements that are the least restrictive, most appropriate living situation in which the individual can receive needed care and services.

**Temporary Nursing Facility Placements** will be recommended in the following circumstances:

• If an individual is determined to have a serious mental illness and/or intellectual disability and is placed in a nursing facility as an exempt hospital discharge. (See Chapter 5 – Preadmission Screening and Resident Review).

• If the individual has the ability to return to the community without services (e.g., short term stay for rehab purposes).

• If the individual is making significant progress in therapies and potentially may not meet a Level of Care upon completion of therapies.

• If the individual has already discharged to the community and retroactive LOC determination is requested.

The chart below outlines Temporary NF Placement scenarios, the method for assessing the individual in those scenarios, appropriate coding in CIRTS, and how that coding contributes to interactions with the Enrollment Broker for the SMMC LTC Program. For more information on the SMMC LTC Program, see Chapter 6.
Temporary Nursing Facility Placement Chart

<table>
<thead>
<tr>
<th>Assessment Type</th>
<th>Placement Recommendation</th>
<th>Program Recommendation</th>
<th>Info Sent to Enrollment Broker?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request for retro NF services is received</td>
<td>Medical Case File Review</td>
<td>NHTP</td>
<td>NONE</td>
</tr>
<tr>
<td>Request for NF services – preliminary review shows potential short term stay</td>
<td>Medical Case File Review</td>
<td>NHTP</td>
<td>NONE</td>
</tr>
<tr>
<td>Client remains in NF 90 days (continues to meet LOC)</td>
<td>701T if client wishes to remain in NF; 701B if client indicates desire to return to community with services</td>
<td>NUHO</td>
<td>MLTCN</td>
</tr>
<tr>
<td>Request for NF services – review shows client likely to require services long-term</td>
<td>701T if client wishes to remain in NF; 701B if client indicates desire to return to community with services</td>
<td>NUHO</td>
<td>MLTCN</td>
</tr>
</tbody>
</table>

*Nursing Facility/Long-Term Care* placement will be recommended in the following circumstances:

- If it is determined that a client’s needs can only be met in a nursing facility, and there is no potential for future return to the community.

- If it is determined that the individual does not have the ability to return to the community without services, but will continue to require long-term care services either through the NF or possibly home and community-based services at a later date.

- When an individual residing in the community or hospital wishes to enter a NF and meets Level of Care for NF services. The *Program Recommendation* for these individuals will be “**None**” until the individual actually resides in the NF. When the individual is placed in the nursing facility, CARES staff will complete a Medical Case File Review (if the assessment is less than 90 days old), and re-staff the individual as Nursing Home Placement Recommendation with Program Recommendation MLTCN.

Nursing facility placement recommendations require the completion of the Level I PASRR Screen (AHCA-Med Serv 004 Part A). (See Chapter 5 – Preadmission Screening and Resident Review)
**DOCUMENTATION AND DISTRIBUTION OF DOCUMENTS**

When a 3007 form is received from DCF for ICP only cases, a copy of the 603 will be faxed or mailed to the appropriate DCF eligibility specialist in the ACCESS unit no later than two business days after the Level of Care determination or when the 3007 is received.

The client/representative or hospital may be notified of the determination and the recommended placement by other means, if requested.

Send a copy of the 603 to the nursing facility where the client currently resides.

If the client was assessed for nursing facility placement but remains in the community or hospital at staffing, the 603 will be retained in the case file until CARES is notified that the individual has been admitted to a nursing facility.

For Medicaid waiver clients (excluding the LTC Program), a copy of the 603 will be forwarded to the appropriate case manager within two business days of staffing.

For the LTC Program, the ADRC will run CIRTS report “Authorized LOCs sent to Enrollment Broker for SMMC LTC” to obtain the Level of Care and include the information on the 2515 form that is sent to DCF. (See Chapter 6 – Statewide Medicaid Managed Care Program, LTC section for more detailed information.)

If CARES completed the Level I PASRR Screen, a copy of the Level I PASRR Screen and Determination (AHCA-Med Serv Form 004 Part A, see Chapter 5 – Preadmission Screening and Resident Review) will be forwarded to the nursing facility at admission.

Upon verbal or written request from the client, a copy of the CARES assessment and/or 603 may be released to the client. If the client’s legal representative requests a copy of the assessment and/or 603, the representative must provide CARES with written authorization that allows them to request the information.

A copy of all forms not maintained electronically will be retained in the client’s hard copy case file.

**REFUSAL OF SERVICES**

An individual has the right to refuse any or all services recommended by CARES. An individual may refuse nursing facility or community care, even if he/she is eligible, and such care has been recommended by the CARES staff and the attending physician. CARES will document the refusal in CIRTS case notes.

If a client refuses an assessment to determine LOC for an initial or annual waiver recertification, CARES will explain to the client and/or their legal representative that refusal could impact their ability to receive Medicaid coverage for medical and pharmaceutical needs. Documentation should be entered into case notes that the client was informed of possible consequences.
NOTE: If the annual waiver recertification requires an on-site assessment due to suspected NLOC, or inappropriate enrollment procedure, and the client refuses the on-site assessment, notify the designated CO staff and the managed care organization.

HEARINGS

For a complete guide on Hearings and CARES role in the Hearings process, see Chapter 9: Fair Hearings.

CASE FOLLOW-UP

For certain case types, CARES staff are required to follow and update the case status at various intervals after staffing. Follow-ups are required:

- For all cases where a temporary nursing facility placement is recommended except when the client is deceased or is already discharged from the nursing facility prior to the staffing date or 90-day follow-up.
- When a long-term nursing facility placement is recommended and a PASRR level II evaluation recommends specialized services.
- For individuals assessed for long-term nursing facility placement in a hospital or community setting.
- For individuals residing in a rural hospital swing bed.
- For individuals residing in a hospital-based skilled nursing facility bed.

The Follow-up screen in CIRTS must be completed by CARES staff indicating the findings of each follow-up.

FOLLOW-UP SCHEDULING

All follow-ups are required to be completed within 15 calendar days prior to or following the scheduled date (see requirements that follow). Additional follow-ups may be completed at the discretion of the CARES POA when the health, social, or mental status of an individual indicates a need for additional follow-ups.

FOLLOW-UP FOR EMS RELEASED INDIVIDUALS

For EMS released individuals, verify that all demographic information (name, date of birth, social security number and Medicaid ID number) in CIRTS matches the demographic information in FMMIS. If errors are found, correct the CIRTS information to match FMMIS information. (If, according to the client, the information in FMMIS is incorrect, encourage them to contact DCF or the Social Security Administration for correction, CARES will continue to use FMMIS information until the client has had the
information corrected with the appropriate agency. Document in CIRTS case notes that the information was reviewed in FMMIS or that there was no FMMIS record. After staffing, and verification that the staffing information has been sent to the Enrollment Broker, the case can be closed and no follow-up is required.

**FOLLOW-UP FOR TEMPORARY NURSING FACILITY PLACEMENT RECOMMENDATIONS**

Follow-up for nursing facility residents who have Temporary Level of Care recommendations will involve:

- Monitoring individuals referred to DCF’s Substance Abuse and Mental Health (SAMH) contractor and/or Agency for Persons with Disabilities’ contractor when specialized services are recommended.

- Ensuring the individual continues to meet a Level of Care while in the nursing facility.

- Arranging for the Placement Recommendation and Program Recommendation to be revised to Nursing Facility and MLTCN per Chapter 6 – Statewide Medicaid Managed Care Program, when the individual continues to reside in the NF and continues to meet Level of Care.

Follow-ups are completed to evaluate the progress of individuals as it relates to Level of Care criteria and community potential.

Follow-ups will be completed at 30 and 90 days based on the most recent staffing date.

The 90-day follow-up will be completed on-site if the individual continues to reside in the nursing facility to determine if they continue to have community potential and meet a Level of Care. If it is determined at follow-up that the individual will continue to require services long-term, whether in the NF or the community, a 701B/701T assessment must be completed (if not completed previously) and staffed with Placement Recommendation of Nursing Home and Program Recommendation Managed Long-Term Care Nursing Facility (MLTCN).

**NOTE:** If the client remains in the nursing facility until the 90-day follow up, and it appears that the client will be discharging home without the need for services in the community, do not change the Program Recommendation at the 90 day follow up. CARES staff will continue to follow the client until the client is discharged.

Unscheduled follow-ups can be scheduled at the discretion of the CARES POA.

**DISCHARGED HOME/COMMUNITY**

At follow-up, if an individual was discharged home prior to the 90-day follow-up, CARES staff will update the demographics in CIRTS, change the Placement Recommendation
to Community and close the case manually with Case Closed Reason NN=No Longer Needed.

**Note:** If the client is deceased at follow-up, close the case manually with Case Closed Reason CD=Client Deceased.

**FOLLOW-UP FOR NURSING FACILITY (LONG-TERM CARE) PLACEMENT RECOMMENDATIONS**

For Nursing Facility Placement Recommendations, the case will automatically close at staffing if the client’s residence is nursing facility, and Program Recommendation is MLTCN. No follow-up is required.

For Nursing Facility Placement Recommendations in which the client has not been placed in a nursing facility, two 30-day telephone follow-ups are required.

- If the individual is admitted to a nursing facility by the second 30-day follow-up, update the demographics in CIRTS, record the date of placement, complete a medical case file review, and change the Program Recommendation to MLTCN. The case will close at staffing.

- If the individual is not admitted to a nursing facility by the second 30-day follow-up, determine the reason that nursing facility placement was not pursued and refer to the ADRC if services are needed or requested. Notify the individual or representative that the case will be closed, add a user generated Follow-Up case note in CIRTS that documents the conversation with the individual or representative, change the placement recommendation in CIRTS to PRRE, and close the case.

For Nursing Facility Placement Recommendations where the individual was assessed in a hospital, the individual remains in the hospital with no potential to return to the community, and nursing facilities refuse to accept the individual, CARES staff will complete at least one 30-day follow-up and close the case.

**FOLLOW-UP FOR “NEEDS SPECIALIZED SERVICES” NURSING FACILITY PLACEMENTS**

For NF Placement Recommendations where the PASRR Level II entity has determined specialized services are needed, CARES is responsible for contacting the NF at prescribed intervals to confirm that the individual continues to receive specialized services. The Level II evaluator is responsible to ensure these services are delivered in a timely manner and is also responsible for confirming that the individual continues to need specialized services. CARES staff will report to designated Central office staff on any findings where specialized services are still required but are not being provided.

Follow-ups will be completed at 30, 90, and 180 days, as well as on an ongoing annual basis until the client no longer “needs specialized services,” the client is discharged from the nursing facility, or the case is manually closed.
If the Level II evaluator subsequently determines that the individual no longer needs specialized services, CARES will close the case if the individual no longer has community potential.

**Follow-Up for Rural Hospital Swing Bed Recommendations**

A licensed rural hospital with 100 or fewer beds may designate acute care hospital beds as swing beds. Swing beds may be used as hospital beds, skilled nursing facility beds, or intermediate care facility beds. The stay in the swing bed must be determined medically necessary by CARES.

The maximum length of stay in swing beds is 60 days unless CARES has given an extension for a longer length of stay. An extension of a resident’s stay in a swing bed can be requested from CARES, and there is no limit to the number of extensions that can be approved.

- CARES will complete the initial follow-up at 30 days. If the client remains in the swing bed, an unscheduled follow-up must be completed again in 30 days.

- If the client remains in the facility longer than 60 days, the hospital must request an extension. Extension requests must be submitted in writing by the hospital for approval by CARES. The written request must be received 15 days before the current approval expires.

- If granted, CARES must complete another unscheduled follow-up for 30 or 60 days, depending on the length of the extension. Unscheduled follow-ups will be completed every 30 or 60 days, if extensions are granted, until the client is discharged, there is a change in the program recommendation, or the case is manually closed.

Extensions are approved when:

- The resident is determined by CARES to be too medically complex for a nursing facility, or

- The resident chooses to remain in the swing bed.

Medical documentation is required for residents who are too medically complex for a nursing facility. If no nursing facility beds are available, the hospital must provide CARES with names of nursing facilities contacted, the date contacted, and names of the persons contacted.

Availability of a nursing facility bed in the resident’s county of residence or within 30 minutes travel time and the resident’s preference are taken into account when an extension is under consideration.
If the individual is subsequently admitted to a nursing facility, the Placement Recommendation will be changed to Nursing Facility, and the case will be closed.

**FOLLOW-UP FOR HOSPITAL-BASED SKILLED NURSING FACILITY BEDS**

If a hospital has obtained a certificate of need for skilled nursing beds and enrolled as a Medicaid Hospital-Based Skilled Nursing Facility, it may designate acute care beds that are located in a distinct part of the hospital as a skilled nursing unit. These beds may be used only for skilled nursing care. The maximum length of stay for hospital-based skilled nursing care is 30 days per episode.

Generally, CARES is not required to determine a Level of Care for individuals in these beds since this is a Medicare covered service. However, if the individual does not have Medicare and is applying for Medicaid long-term care services, CARES will be involved. The initial follow-up will be completed at 30 days.

After the initial 30 days, CARES may grant one extension of 15 days if the resident’s physician verifies in writing that the resident requires additional short term rehabilitative or recuperative services. Requests for extensions must be submitted in writing to the local CARES office at least five days before the expiration of the original 30 days. If the client remains in the facility, CARES must complete an unscheduled follow-up within 15 days of the initial follow-up. A new Level of Care is not needed.

**CASE TRANSFER**

When a case is assigned in one PSA but the client moves to another PSA prior to assessment, verify the client’s new address, and close the case by entering the code TR (Case Transfer) into the Close Case Screen in CIRTS. The new PSA will open, assess, and staff the case. Upon request from the new PSA for the paper case file, the transferring CARES office will scan any information contained in the original file prior to forwarding the original file and email the scanned copy to the new CARES office. All files must be sent and tracked through the sending service (e.g., FedEx or USPS). Once the new CARES office confirms that the original file was received with no issues, the scanned copy will be deleted. (See CIRTS User Guide for more detailed information.)

If a client moves outside of the CARES service area while the case is active (open), verify the individual’s new address and change the address in CIRTS. Active cases that have been assessed and staffed should not be closed. Upon request from the new PSA for the paper case file, the transferring CARES office will forward any information contained in the original file to the new CARES office per the instructions above. (See CIRTS User Guide for more detailed information.)

Cases that are closed or in offsite storage do not need to be transferred unless the “receiving” CARES office requests the case.
CASE CLOSURE

A CARES case will be closed in the following circumstances:

- Death of the individual;
- Voluntary withdrawal of the individual;
- The individual moves out of the state;
- The individual/representative requests no further contact by CARES;
- Long-term nursing facility placement;
- PACE cases once LOC is authorized;
- Medicaid Waiver cases initiated by a case management agency once LOC is authorized; or
- EMS released individuals assessed by CARES when CARES confirms the individual’s demographic information in CIRTS is correct according to FMMIS (if there is a FMMIS record).
CHAPTER 5
~ PREADMISSION SCREENING AND RESIDENT REVIEW ~
(PASRR)

PURPOSE

The federal government requires that all individuals seeking placement in a Medicaid-certified nursing facility (NF), regardless of payment source, receive a preadmission screening prior to NF placement in order to:

- Determine if they have a serious mental illness (SMI) and/or intellectual disability (ID) or related condition;
- Be offered the most appropriate setting to meet their needs; and,
- Receive services needed in the most appropriate setting.

If a state fails to follow these requirements for individuals seeking admission to a Medicaid-certified NF, the state is considered to be non-compliant with the Medicaid State Plan and is subject to loss of Federal Financial Participation (FFP), i.e., federal funds, for NF Medicaid beneficiaries.

BACKGROUND

The Federal Omnibus Budget Reconciliation Act of 1987 and 1989 (OBRA ’87-’89) contained a series of reforms amending Title XIX of the Social Security Act and requiring implementation of the Preadmission Screening and Resident Review (PASRR) program for NF applicants.

Title 42, Subpart C, Sections 483.100 through 483.138, Code of Federal Regulations (CFR) was promulgated to govern the PASRR Program. In addition, 59G-1.040, Florida Administrative Code, contains the latest state rule for the program. https://www.flrules.org/gateway/ruleno.asp?id=59G-1.040

In accordance with the Centers for Medicare and Medicaid Services (CMS) regulations, each state is responsible for developing the criteria for preadmission screening, determining the need for NF care, and what specialized services are provided to individuals. For Medicaid eligible individuals, the state of legal residence is responsible for payment of the PASRR process and any specialized services that are required.

No individual may be admitted to a NF, and the NF cannot bill Medicaid for services provided in the NF, until the PASRR process is complete. This includes the Level I screen, and, if required, the Level II Evaluation and Determination. The LOC effective date, therefore, will be the effective date on the 3008 if completed prior to NF admission or the PASRR completion date if completed after NF admission.
The single state Medicaid agency, AHCA, is ultimately responsible for operation of the PASRR Program, developing the program criteria, and potentially delegating some of the functions to other agency partners. However, the Social Security Act specifically delineates certain roles and responsibilities for the program, noting that this is one of the few instances in which Medicaid law mandates activities that are to be carried out by agencies other than the single state agency. For this reason, state mental health and intellectual disability authorities (or their delegates) are responsible for ensuring individualized evaluations are completed and recommending specialized services if determined necessary; this is the Level II Evaluation and Determination process of PASRR. In Florida, the State Agency for Mental Health (SAMH) is DCF; the ID authority is the Agency for Persons with Disabilities (APD).

AHCA has delegated oversight of the PASRR process for adults to CARES through an interagency agreement. CARES is responsible for either completing or overseeing the Level I screens and coordinating the Level II requests for adults.

**PASRR DEFINITIONS**

**Intellectual Disability:** As defined in Title 42, Subpart C, Section 483.102(b)(3), Code of Federal Regulations, individuals are determined to have ID (mild, moderate, severe, or profound) according to the criteria in the American Association on Intellectual Disability's Manual on Classification in Intellectual Disability (1983). Intellectual Disability refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior (the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for age and cultural group) and manifested during the developmental period (the period of time between conception and the 18th birthday.)

**Related Conditions**

ID includes related conditions, i.e., individuals who have a severe, chronic disability that meets all of the following conditions:

1. Is attributable to:
   a. Cerebral palsy or epilepsy; or
   b. Any other condition, other than mental illness, found to be closely related to ID because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons diagnosed with ID, and requires treatment or services similar to those required for these persons;

2. Is manifested before the person reaches age 22;

3. Is likely to continue indefinitely; and
4. Results in substantial functional limitations in three or more of the following areas of major life activity:
   a. Self-care;
   b. Understanding and use of language;
   c. Learning;
   d. Mobility;
   e. Self-direction; or
   f. Capacity for independent living.

**SERIOUS MENTAL ILLNESS:** As defined in Title 42, Subpart C, Section 483.102(b)(1), Code of Federal Regulations, an individual is considered to have an SMI, if the individual meets the following requirements on diagnosis, level of impairment (disability), and duration of illness:

1. **Diagnosis:** A major mental disorder under the Diagnostic and Statistical Manual of Mental Disorders (3rd Ed., Revised 1987), such as a schizophrenic, mood, paranoid, panic, or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability, but not a primary diagnosis of dementia, including Alzheimer’s disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder.

2. **Level of Impairment:** Functional limitations in major life activities within the past three to six months that would be appropriate for the individual’s developmental stage; an individual typically has at least one of the following characteristics on a continuing or intermittent basis, or is likely to exhibit one of the following characteristics without continued treatment or intervention:
   a. Serious difficulty interacting appropriately and communicating effectively with other persons, a possible history of altercations, evictions, firing, fear of strangers, or avoidance of interpersonal relationships and social isolation;
   b. Serious difficulty in sustaining focused attention for long enough to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifest difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks; or
   c. Serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated
signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system;

3. Recent Treatment: A treatment history indicating the individual has experienced at least one of the following:

   a. Psychiatric treatment more intensive than outpatient care (for example, partial hospitalization or inpatient hospitalization); or

   b. Due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

Significant Change: A major decline or improvement in the resident’s status. A major decline in a resident’s status involves changes that require intervention to correct the decline through staff involvement and/or through implementation of standard disease-related clinical interventions that: (i) are anticipated to impact more than one area of the resident’s health status; (ii) requires interdisciplinary review or revision of the care plan; or, both (i) and (ii). A major improvement in a resident’s status involves changes in a resident’s circumstances that: (i) are anticipated to impact more than one area of the resident’s health status; (ii) requires interdisciplinary review or revision of the care plan; or, both (i) and (ii).

Specialized Services: Services that are not covered in the NF per diem and are required for appropriate placement in the NF setting for individuals with ID or SMI whose needs are such that continuous supervision, treatment, and training by qualified mental health or intellectual disability personnel is necessary. Specialized services are specified by the state and, combined with the services provided by the NF, result in continuous and aggressive implementation of an individualized plan of care. PASRR Level II evaluations and determinations include a written plan of care when specialized services are needed and ensure that individuals requiring specialized services receive those services.

- Specialized services for ID are directed toward the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible and toward the prevention or deceleration of regression or loss of current optimal functional status, to include behavior analysis services and training services.

- Specialized services for SMI are utilized to address episodes of mental illness and are rendered at levels required to avert or eliminate the need for acute inpatient psychiatric care. Specialized services are developed and supervised by a qualified mental health professional and include one or all of the following: psychiatric consultation and evaluation, psychotropic medication management, psychological evaluation, and/or psychotherapy.
PREADMISSION SCREENING AND RESIDENT REVIEW PROCESS

The PASRR process is divided into three categories:

- **Level I** – A Level I screen is completed on every individual seeking admission to a Medicaid-certified NF to determine whether the individual has, or is suspected of having, an SMI and/or ID or related condition.

- **Level II** – The Level II Evaluation and Determination is conducted prior to NF admission or expiration of provisional, or exemption time parameters, and includes an individualized, in-depth evaluation of the individual to confirm or rule out a suspected diagnosis, and make a determination of the appropriateness of NF placement and need for Specialized Services.

- **Resident Review** – A Resident Review is the reevaluation as a result of a significant change of an individual diagnosed with SMI, ID or both or a newly evident or possible diagnosis of SMI/ID or both, and the reassessment of appropriateness of continued NF placement and recommended services following a significant change in the resident’s physical or mental condition.

**Level I Screen**

The first step in the PASRR process is the screening of all individuals seeking admission to a Medicaid-certified NF, regardless of payment source, to determine if there is a suspicion of, or a diagnosis of an SMI and/or ID or related condition. This is considered the Level I screening process and encompasses all steps starting with the Level I screening form through collection of additional information and the on-site assessment, if needed, to submit a Level II request. The Level I screen can be requested by any source assisting with NF admission for an individual.

In the state of Florida, Level I screeners are:

- AHCA (or its delegate) for children under the age of 21; AHCA has delegated this function to the Florida Department of Health (DOH) Children’s Medical Services (CMS).

- CARES (or its delegates) for adults 21 and older; CARES has delegated this function in part to acute care hospital, or NF staff. Hospital or NF staff must be licensed clinical social workers, physicians, physician assistants, registered nurses, mental health counselors, psychologists, or persons who hold a Master’s Degree in Social Work. All Level I screeners must comply with rule 59G-1.040, Florida Administrative Code, completing the Level I screen fully and accurately.

**Note:** Individuals enrolled in the Statewide Medicaid Managed Care Long-Term Care Program are subject to the same PASRR requirements. Managed care plan case managers may not complete the Level I screen.
Note: Credentialed staff working in a facility that is specifically a state mental health institution, or a psychiatric hospital, or any hospital that is not licensed as an acute care hospital, are not approved Level I screeners.

Note: Credentialed staff working for hospice or in a hospice facility are not approved Level I screeners.

Using the PASRR Level I Screen form (AHCA MedServ Form 004 Part A), the delegated Level I screener completes the form prior to the individual's admission to the NF, and forwards it to the local CARES office. The Level I form and instructions are included at the end of this chapter, the CARES Forms Library on SharePoint, and may also be found at AHCA’s PASRR website: http://ahca.myflorida.com/Medicaid/PASRR/index.shtml.

When completing the Level I screen, the screener should not rely only on “known diagnosis”, but should review all available client data to “look behind” symptoms, behaviors, and actions. Level I screeners must accurately reflect an individual’s condition and their expected length of stay in a NF. Incomplete and incorrect Level I screens will be returned by CARES to the entity which completed the form with errors identified using the PASRR Return Fax Cover Sheet found at the end of this chapter and in the CARES Forms Library on SharePoint. The Level I screen must then be corrected and re-submitted to CARES to be considered valid (see Incorrect/Incomplete PASRR Forms section later in this chapter for more detail on receiving and returning incorrect forms). As part of CARES’ responsibility for oversight of the Level I process, continued non-compliance will be reported to AHCA by CARES Central Office.

The Level I screening form must be completed and submitted to CARES, if CARES is not the Level I screener. Based on information reviewed and assessment of the individual, the Level I determination will reflect:

- The individual does not have a suspicion of, or diagnosis of, an SMI and/or ID or related condition:

- The individual is not subject to a Level II Evaluation and Determination, therefore, the process ends with CARES recording the information for the Level I screen.

- The individual has a suspicion of, or diagnosis of, a SMI and/or ID or related condition and meets one of the following scenarios:
  - 30-Day Hospital Discharge Exemption
    This exemption allows the individual to be admitted to the NF without having a Level II Evaluation completed prior to admission. The 30-day hospital exemption must be selected in Section III of the Level I screening form and used only when appropriate; the individual must be discharged from a hospital directly to a Medicaid-certified NF, and an attending hospital physician must designate by signing on the Level I form that the length of stay for the individual in the NF is not expected to exceed 30
calendar days. The Level I form must be submitted to CARES. If it appears that the individual will remain in the facility past the 30 days, the NF must notify CARES by the 25th calendar day, and a request for a Level II Evaluation and Determination is required. The Level II request must be submitted in time for the Level II entity to complete their evaluation before the 40-day expiration period, i.e., 40 calendar days from the date of admission.

**Note:** CARES is responsible for tracking 30-day hospital exemptions. The CARES CIRTS report “Level II Due Date for 30 Day Hospital Exemptions” should be run no less than twice a month to assist with keeping track of the exemptions.

- If the NF has not notified CARES by the 25th calendar day, and it is determined the individual will continue to reside in the NF for at least 30 calendar days, CARES will schedule an on-site to complete an assessment and submit for a Level II to be completed prior to the 40th calendar day of admission.

**Note:** Only acute care licensed hospitals can designate a 30-day hospital discharge exemption on the Level I screen. Nursing facilities cannot designate a 30-day hospital exemption.

**Note:** If the client is admitted to the NF on a 30-day hospital discharge exemption, is re-hospitalized and then re-admitted to the NF, the original date of admission to the nursing facility is the date that starts the 30-day exemption.

- **Provisional Admission**

  A provisional admission allows the individual to be admitted to the NF without having a Level II Evaluation completed prior to admission and should only be marked on the Level I screening form when appropriate. Provisional admissions include:

  - *Delirium* – length of stay no longer than 7 calendar days after the delirium clears

  - *Adult Protective Services* – length of stay no longer than 7 calendar days

  - *Respite* – length of stay no longer than 14 calendar days twice a year

The Level I screener must submit the Level I screening form to CARES prior to admission to the NF. Upon receipt of the Level I screen, CARES must complete a 701B comprehensive assessment and submit a request for a Level II Evaluation and Determination to ensure the Level II Evaluation and Determination is completed prior to the deadlines above.
No Exemption or Provisional Admission

If there is no exemption or provisional admission indicated on the Level I screening form, CARES must be contacted within 2 business days of completion of the Level I to complete a 701B comprehensive assessment. CARES staff will follow the time standards required for hospital referrals as indicated in Chapter 4 – General Operations, to conduct the on-site assessment. Upon completion of the assessment, CARES will send a Level II Evaluation and Determination request to the Level II evaluator. In these situations, the Level II must be completed prior to admission to a NF.

Note: A Level I screen must be completed on any subsequent NF admission unless it is:

- a readmission (the individual is returning to a NF after 90 calendar days or less in a hospital); or,
- an interfacility transfer (NF to NF).

Note: Individuals cannot appeal a Level I determination because it is a part of the Medicaid eligibility process.

Note: Nursing facilities must maintain copies of all PASRR screenings, evaluations, reevaluations, and determinations in the individual’s file for the duration of their stay in the facility and for a period of five years after the individual has been discharged or transferred to another facility.

CARES is responsible for storing and maintaining all PASRR documents created or received by CARES and may not destroy any PASRR documents without the written consent of AHCA unless the PASRR documents have been stored electronically or are exact duplicates of a previously received document.

NOTE: For initial and additional PASRRs received, if the case is closed, the office receiving the PASRR should enter the PASRR in CIRTS. If the case is open, the office receiving the PASRR should forward the PASRR to the office with the open case.

Level II Evaluation and Determination and Resident Review

The Level II Evaluation and Determination process is initiated in the following situations:

- When the Level I screen reveals a suspicion or diagnosis of SMI and/or ID or a related condition and the 30-day hospital exemption or a provisional admission cannot be applied for a NF applicant;
- When the time parameters for the 30-day hospital exemption or provisional admission is expected to expire before the individual leaves the NF;
• When a NF resident diagnosed with SMI/ID, or both, is hospitalized over 90 calendar days;

• When a NF resident diagnosed with SMI/ID, or both, or is hospitalized less than 90 calendar days and a NF or hospital requests a new Level II evaluation.

The Resident Review process is initiated in the following situations:

• When a NF resident exhibits a significant change in their mental or physical condition and based upon a Resident Review, reveals a suspicion or diagnosis of SMI and/or ID or a related condition; The Resident Review – Evaluation Request (AHCA MedServ Form 004, Part A1) found at the end of this chapter, and in the CARES Forms Library on SharePoint, will be completed to request the Resident Review.

• When a NF resident, diagnosed with SMI/ID or both, with a previous Level II, exhibits a significant change in their mental or physical condition (either improvement or decline) based upon a Resident Review; The Resident Review – Evaluation Request (AHCA MedServ Form 004, Part A1) will be completed to request the Resident Review.

Special NOTE to clarify Resident Review:

Resident Review

• Current NF resident diagnosed with SMI/ID, or both, or newly evident or suspected SMI/ID, or both, has a significant change in condition
  o Significant change
    ✓ Decline in condition that will not improve without intervention by staff or by implementing standard disease-related clinical interventions
    ✓ Impacts more than one area of the resident’s health status
    ✓ Improvement in condition for individual receiving specialized services that could impact the need for further specialized services

  o If the individual returns to NF after less than a 90-day stay, the NF may determine that a Resident Review is needed upon re-admission (due to significant change criteria)

• NF resident with SMI/ID, or both, or newly evident or suspected SMI/ID, is admitted to a hospital for psychiatric or medical reasons
  o If hospitalized less than 90 calendar days, a Resident Review is not needed unless the NF or hospital requests
  o If hospitalized more than 90 calendar days, a Resident Review is needed prior to admission
Level II Evaluation and Determinations and Resident Reviews are conducted by the following entities:

- The Department of Children and Families Substance Abuse and Mental Health Program’s contracted entity for individuals suspected of having, or diagnosed with SMI.
- The Agency for Persons with Disabilities’ contracted entity for individuals suspected of having, or diagnosed with ID or a related condition.

**Individuals Who Can Be Admitted to a Nursing Facility prior to a Level II Request:**

- NF applicants with a suspicion or diagnosis of SMI and/or ID or a related condition who meet the 30-day hospital discharge exemption criteria can be admitted to a NF.
- NF applicants with a suspicion or diagnosis of SMI and/or a related condition who meet provisional criteria may be admitted to a NF without completion of the Level II as long as CARES has received the Level I screen, scheduled the 701B on-site assessment, and submitted the request for the Level II Evaluation and Determination, if needed. This process is necessary due to the 7 or 14-day exemption time period allowed for provisional admissions. The Level II Determination and Evaluation must be completed before the end of the provisional admission.

**Individuals Who Cannot Be Admitted to a Nursing Facility prior to a Level II Request**

- NF applicants with a suspicion or diagnosis of SMI and/or ID or a related condition who do not meet the 30-day hospital exemption or provisional criteria cannot be admitted to a NF until the Level II Evaluation and Determination is complete and allows admittance based on the results of the evaluation.
- A NF applicant who received a Level II Evaluation and Determination that did not prohibit NF placement, but did not enter the NF within 30 calendar days, must have another Level II Evaluation and Determination prior to admission to the NF.

**NOTE:**

- An individual in the community with a suspicion or diagnosis of SMI, and/or ID, or a related condition, who is seeking nursing facility placement, must have a Level II Evaluation and Determination prior to admission to the NF.
- It is the admitting facility or client/representative’s responsibility to contact CARES to request another Level II Evaluation and Determination on those individuals who are ready to be admitted to a NF, and had a previous Level II Evaluation and Determination that is greater than 30 calendar days old.
SUBMISSION OF LEVEL II OR RESIDENT REVIEW REQUESTS

CARES is responsible for coordinating all Level II and Resident Review requests. If a Level II/Resident Review is needed, CARES will request the Level II/Resident Review within 2 business days of the Level I Screen or Resident Review being accurately completed and all necessary medical and other relevant mental health and intellectual disability information is received. If a Level II Evaluation and Determination or Resident Review is needed, CARES staff will submit the following information with the Level II or Resident Review request:

- Request for Level II PASRR Evaluation (found at the end of this chapter and in the CARES Forms Library on SharePoint) or Resident Review Evaluation Request (AHCA MedServ Form 004 Part A1).

- Completed Level I PASRR screen (AHCA MedServ Form 004 Part A). (If Level II request; If Resident Review request, the Level I is not needed).

- Informed Consent as documented on the Level I PASRR Screen (If the client is unwilling, unable, or has no legal representative or health care surrogate to sign the consent for the Level II evaluation, the Level I screener should document the reason for the inability to obtain the signature. If CARES receives a Level I screen, a Level II is needed, and the client’s signature and explanation is missing, CARES will attempt to obtain a completed and signed Informed Consent form (AHCA MedServ-2040) when the 701B is completed.

- AHCA 5000-3008 form

- Other medical documentation including relevant case notes or records of treatment/medication administration records

- Psychiatric or psychological evaluation (if available)

- DOEA 701B comprehensive assessment or the NF completed Minimum Data Set (MDS), as appropriate.

CARES is also responsible for notifying the individual or their legal representative that a request has been made for a Level II Evaluation and Determination or Resident Review. Within the same two business days, when a Level II request is submitted, CARES will send the PASRR Notice letter (found at the end of this chapter and in the CARES Forms Library on SharePoint) to the individual and, if applicable, their legal representative. This notification will inform them that the individual has, or is suspected of having, an SMI, ID, or a related condition, and a Level II Evaluation and Determination is being requested.

Required Level II or Resident Review documentation will be sent to or gathered by CARES from the nursing facility or hospital. If the Level II is needed, and the facility is a registered user of the Level II evaluator’s Portal, the facility may upload the information...
indicated above and notify the local CARES office that Level II or Resident Review documentation has been uploaded. The facility will send a notification email to the local CARES office PASRR email box. (For more specific information on the PASRR email box, see the PASRR Email Box document at the end of this chapter.) Nursing facilities and hospitals that are not registered users of the Level II evaluator’s portal may fax the Level II or Resident Review documentation to the local CARES office.

Required Level II or Resident Review request documentation will be submitted by CARES to the Level II evaluator. When submitting Level II or Resident Review requests to the Level II evaluator, CARES staff must utilize the Level II evaluator’s web portal. (If there are issues with uploading documentation due to the size of the files, CARES staff can use the portal for the initial Level II request, then fax the remaining documentation to the Level II evaluator.)

If the Level I screen or Resident Review is determined to be inaccurately completed, it will be returned using the PASRR Return Fax Cover for Level I or Level II and must be corrected and re-submitted to CARES to be re-considered (see Incorrect/Incomplete PASRR Forms Processing section later in this chapter for more detail on receiving and returning incorrect forms).

**NOTE:** CARES staff will not staff cases as Withhold Level of Care while waiting for the Level II evaluator to complete the PASRR Level II/Resident Review Determinations. These cases will remain open and the “Staffing Information Received Date” in CIRTS will be the date the Level II/RR Determination is received by CARES.

**LEVEL II EVALUATION AND DETERMINATION SUMMARY**

The Level II evaluator will make a determination and issue a Level II Evaluation and Determination Summary regarding the following:

1. Confirmation or ruling out of an SMI and/or ID or related condition.
   - If SMI and/or ID or a related condition is ruled out, the review process stops and the Level II evaluator submits their determination. In these instances, the individual can be admitted to the NF and CARES can release a Level of Care, if requested.
   - If SMI and/or ID or a related condition are confirmed, steps 2 and 3 must be followed.

2. A determination regarding whether the individual’s SMI and/or ID needs can be met in the NF or alternative setting.
   - If it is determined an individual’s needs can be met in the NF, the individual can be admitted and CARES can release a Level of Care, if requested. If enrolled in the SMMC program alternative placement options may be offered by the individual’s managed care plan.
• If it is determined an individual's needs cannot be met in the NF, the individual cannot be admitted and alternative placement options must be made. CARES cannot release a Level of Care, if requested, and is not responsible for making alternative placement options. However, CARES will staff the case as “Withhold LOC” and inform the NF and DCF (if appropriate) via Form 603.

3. A determination whether Specialized Services are needed and if they can be provided in the NF.

• If Specialized Services are not needed and the individual’s needs can be met in the NF, the individual can be admitted to the NF. Services of a lesser intensity will be identified if beneficial to the individual. CARES can release a Level of Care, if requested.

• If Specialized Services are needed and can be provided in a NF, CARES can release a Level of Care, if requested, and will conduct follow up as appropriate. (See Chapter 4 – General Operations, section Case Follow up). The Program Recommendation will be NHSS for Specialized Services.

• If Specialized Services are needed and cannot be provided in a NF, the individual cannot be admitted and alternative placement options must be made. CARES cannot release a Level of Care, if requested, and is not responsible for making alternative placement options. CARES will staff the case as “Withhold LOC.”

Once the Level II Evaluation and Determination or Resident Review is requested, to meet state compliance requirements, the Level II Evaluation and Determination or Resident Review must be completed and returned to CARES within an average of 7 business days. The Level II evaluator will provide a copy of the Notification of Determination letter to:

• CARES

• Individual evaluated or, if applicable, their legal guardian

• Admitting or retaining NF (if applicable)

• Individual’s attending physician

• Discharging hospital (if applicable)

If an individual or their legal guardian disagrees with the Level II Evaluation and Determination, they may request an administrative appeal through a Fair Hearing.
OUT-OF-STATE PASRR REQUIREMENTS

Per federal regulations, the current state where an individual resides is the state responsible for PASRR.

- If an individual resides out of state, CARES will accept the other state’s Level I and Level II. CARES will also accept a Level I and Level II from the other state completed on Florida’s PASRR forms as long as the forms are completed correctly and signed by the appropriate credentialed screeners. If the other state’s Level I does not indicate a need for a Level II, there is no need for a Level II when the individual is admitted to a Florida NF.

- If the other state’s Level I does indicate a need for a Level II, and the Level II determination indicates NF placement is appropriate, (regardless of whether specialized services are needed or not) the individual may be admitted to a Florida NF. Upon admission, the NF should submit a Resident Review to CARES to verify that no Specialized Services are needed in Florida.

- Upon admission, if the Florida NF determines that a significant change or new indication of SMI is apparent, a Resident Review is needed.

If an individual residing in Florida wishes to be admitted to a NF out of state, Florida is responsible for the PASRR process. After the Level I is completed, if the need for a Level II is indicated, CARES will conduct the on-site assessment, gather all necessary documentation, and submit the Level II request to the Level II evaluator.

PASRR AND LOC EFFECTIVE DATES

The Level of Care effective date is based on either the effective date of the Medical Certification for Medicaid Long-Term Care Services and Patient Transfer form (Form 5000-3008) per instructions found in Chapter 4, or the timely completion of PASRR. Therefore, the Level of Care effective date is based on the following:

- If the PASRR (Level 1 and/or Level II) is completed correctly prior to nursing facility admission, the Level of Care effective date is based on the 3008: the date the physician, ARNP, or PA signed the 3008 or the effective date, if one is entered on the 3008.

- If the PASRR (Level I, and/or Level II) is completed (this includes corrected) after nursing facility admission, the Level of Care effective date is based on the completion of PASRR: the date the Level I was completed, or the date the Level II was completed (if required).

This ensures that NFs do not receive Medicaid reimbursement until PASRR has been completed timely. The following scenarios are included to provide clarification:
LEVEL OF CARE EFFECTIVE DATE BASED ON THE 3008:

Level I, and when appropriate Level II, must be completed and correct prior to NF admission.

1. Level I completed prior to NF admission and no Level II required (this includes Level II submissions by CARES where the Level II Evaluation and Summary determination indicates “SMI No” or “SMI: N/A” (Level I reaffirmed=No).

2. Level I and Level II completed prior to NF admission and:
   - Specialized services not needed and NF placement is appropriate, or;
   - Specialized services needed and can be provided in the NF, and NF placement is appropriate.

3. Level I completed prior to NF admission but was incorrect and a Level II was not needed. Level I must be corrected by screener and re-submitted to CARES prior to admission.

4. Level I completed prior to NF admission and a time limited exclusion applied.
   - Exempted Hospital Discharge: NF stay did not exceed 30 calendar days or the individual remained in the NF and the Level II was completed within 40 calendar days of admission.
   - Delirium: NF stay did not exceed 7 calendar days or the individual remained in the NF and a Level II was completed within 7 calendar days after delirium cleared.
   - Protective Services emergency placement: NF stay did not exceed 7 calendar days or the individual remained in the NF and a Level II was completed within the first 7 calendar days of admission.
   - Respite Care for in-home caregivers: NF stay did not exceed 14 calendar days (14-day stay allowed twice a year) or the individual remained in the NF and a Level II was completed prior to expiration of the 14 calendar days.

Note: If any of the scenarios above apply, Medicaid payment to the NF can begin on the effective date of the Level of Care (based upon the 3008) or date of admission, whichever is later. DCF will be notified via the 603 form of the effective date for medical eligibility. It is the responsibility of the NF to bill Medicaid accurately and appropriately based on the notification of approval from DCF.
LEVEL OF CARE EFFECTIVE DATE BASED ON COMPLETION OF PASRR:

Level I, and if appropriate, Level II, was completed or corrected after NF admission.

1. Level I not completed prior to NF admission and no Level II required.

2. Level I completed prior to NF admission, but Level II required.

3. Level I and Level II not completed prior to NF admission.

4. Level I completed prior to NF admission, but was incorrect and a Level II was needed.

5. Level I completed prior to NF admission, but was incorrect and a Level II was not needed.

6. Level I completed and Level II needed, but client admitted prior to Level II determination (regardless of outcome).

7. Level I completed prior to NF admission and a time limited exclusion was applied:

   - Exempted Hospital Discharge: NF stay exceeded 30 calendar days and a Level II was not completed within 40 calendar days of admission. **NOTE:** If the NF complied with notifying CARES by the 25th calendar day that a Level II was needed, as long as the Level II Evaluation and Determination documents that NF placement is appropriate, the LOC date can go back to the 3008 date.

   - Delirium: NF stay exceeded 7 calendar days and a Level II was not completed within the 7 days after delirium cleared.

   - Protective Services emergency placement: NF stay exceeded 7 calendar days and a Level II was not completed within the first 7 calendar days of admission.

   - Respite Care for in-home caregivers: NF stay exceeded 14 calendar days (14-day stay allowed twice a year) and a Level II was not completed prior to expiration of the 14 calendar days.

8. Level I and II completed prior to NF admission, but NF admission delayed greater than 30 calendar days and another Level II evaluation was not completed.

**Note:** If any of the scenarios above apply, Medicaid payment to the NF can begin on the date of the completion of the Level I, and/or Level II, as applicable. DCF will be notified via the 603 form of the effective date for medical eligibility. If PASRR is not received as
requested, a Level of Care will not be authorized. It is the responsibility of the NF to bill Medicaid accurately and appropriately based on the notification of approval from DCF.

**INCORRECT/INCOMPLETE PASRR FORMS PROCESSING**

**Completed by Hospital**

If a Level I screen is completed by a hospital and it is determined to be incorrect or incomplete, CARES will return the screen and attach the PASRR Return Fax Cover Sheet identifying the item(s) that need to be corrected or completed. Action taken will be noted in the Information screen or case notes as appropriate.

**No Request for LOC:**

- If the hospital returns the corrected/completed Level I screen, enter the information in CIRTS.

- If the hospital does not return the corrected/completed Level I screen and the individual does not enter a NF, CARES will remediate to encourage compliance. If the hospital continues to be non-compliant, CARES will notify CARES Central Office.

- If the hospital does not return the corrected/completed Level I screen and the individual is discharged to a NF, the NF is responsible for submitting a correct and complete Level I screen to CARES. If CARES has knowledge of the admitting NF, CARES will send the CARES Letter “Notification to Nursing Facility” to notify the NF that a Level I is needed and that if the individual subsequently needs ICP Medicaid, payment to the NF may be affected. (See “Notification to Nursing Facility” found at the end of this chapter and in the CARES Forms Library on SharePoint.)

**Request for LOC:**

- If the hospital returns the corrected/completed Level I screen, enter the information in CIRTS.

- If the hospital does not return the corrected/completed Level I screen and the individual remains in the hospital, CARES will conduct an on-site assessment, provide remediation with the hospital, and/or technical assistance, complete a Level I screen, and request a Level II if needed.

- If the hospital does not return the corrected/completed Level I screen and the individual was discharged to a NF prior to a CARES assessment, the NF should complete a Level I screen upon admission and submit to CARES.
Completed by Nursing Facility

If a NF submits a Level I screen or a request for a Level II/RR and it is determined to be incorrect or incomplete, CARES will return the Level I screen or Level II/Resident Review request and attach the PASRR Return Fax Cover Sheet identifying the item(s) that need to be corrected or completed. Action taken will be documented in the Information screen or case notes as appropriate.

- If it appears, based on the information reviewed in documents submitted by the NF, a Level II/Resident Review is needed, CARES will complete a 701B (or obtain MDS) and submit the request to the Level II evaluator as appropriate. The NF will receive remediation and/or technical assistance, as appropriate, from CARES on proper documentation needed for the PASRR process. If, after remediation and/or training, the NF continues to fail to submit timely, accurate, and correct PASRR information, CARES will notify CARES Central Office.

No Request for LOC:

- If the NF returns the corrected/completed Level I screen, enter the information in CIRTS.
- If the NF returns the corrected/completed Level II/Resident Review, submit the information to Level II evaluator.
- If the NF does not return the corrected/completed Level I screen, CARES will fax the CARES Letter “Notification to Nursing Facility” to notify the NF again that a Level I is needed, and that if the individual subsequently needs ICP Medicaid, payment to the NF may be affected. If the NF continues to be non-compliant, CARES will notify CARES Central Office.
- If the NF does not return the correctly completed Level II/Resident Review, CARES will complete the Level I screen, complete a 701B or obtain a MDS, and, if appropriate, submit a request to the Level II evaluator.

Request for LOC:

- If, at the time of the on-site assessment, a Level I is not already in CIRTS, CARES will complete a Level I if the NF cannot provide one at time of assessment. Enter the information in CIRTS.
- If, at the time of the on-site assessment, it is determined that a Level II/Resident Review is required and the NF did not submit one, CARES will complete a 701B and submit the information to Level II evaluator.
- If, at the time of the MCFR, a Level I is not already in CIRTS, the NF will be requested to send a Level I screen by faxing the CARES Letter “Notification to Nursing Facility”. If the NF does not return a correct/complete Level I screen
within two business days and the individual remains in the NF, CARES will schedule and conduct an on-site assessment, complete a Level I screen, and request a Level II if needed.

- If, at the time of the MCFR, it appears that a Level II/Resident Review is needed, CARES will request the NF submit the documents needed for a Level II/RR. If CARES does not receive the appropriate documents within two business days and the individual remains in the NF, CARES will schedule and conduct an on-site.

- If an individual is no longer in the NF at the time of the MCFR, and a Level I is not already in CIRTS, the NF will be requested to send a Level I screen. If the NF does not return a complete/correct Level I, the case will be staffed Withhold.

- If, at the time of the MCFR, it is determined from the medical documentation that a Level I was completed but a Level II/Resident Review should have been requested at admission or prior to a provisional admission expiration and wasn’t, and the individual is no longer in the NF, the LOC cannot be issued and the case will be staffed Withhold.

When CARES completes an on-site assessment or MCFR and discovers a Level I has not been completed by the NF, CARES will complete the Level I screen, and the LOC effective date will be based on the date CARES completed the Level I (or Level II if needed).
Preadmission Screening and Resident Review (PASRR) Level I Screen Form


**Instructions**

### A. Acronyms and abbreviations:

- **AHCA** – Agency for Health Care Administration
- **CARES** – Florida Department of Elder Affairs’ Comprehensive Assessment and Review for Long-Term Care Services Program
- **CFR** – Code of Federal Regulations
- **CMAT** – Children’s Multidisciplinary Assessment Team
- **DOH** – Florida Department of Health
- **DOEA** – Florida Department of Elder Affairs
- **F.A.C.** – Florida Administrative Code
- **HIPAA** – Health Insurance Portability and Accountability Act
- **ID** – Intellectual Disability or Related Conditions
- **MI** – Mental Illness
- **MID** – Medicaid Identification Number
- **MM/DD/YYYY** – Month, Day, Year
- **N/A** – Not Applicable
- **NF** – Nursing Facility
- **PASRR** – Preadmission Screening and Resident Review
- **RR** – Resident Review
- **SMI** – Serious Mental Illness

### B. Instructions

The Level 1 PASRR Screen, AHCA MedServ Form 004 Part A, March 2017, must be fully and accurately completed and submitted in accordance with Rule 59G-1.040, F.A.C. Incomplete submissions will not be accepted, and may prohibit Florida Medicaid payment for nursing facility services. Information inserted manually must be legible. Any illegible information will result in the Level 1 Screen Form being deemed unacceptable.

**Steps to Complete the Screen:**

**Page 1**

Fill in the blanks with the individual’s demographic, screening site, insurance information, etc. Check the boxes to best answer the individual’s current location at time of screening, and include the individual’s parent, guardian, or legal representative’s information if applicable.

Enter the Medicaid or ‘Other Health Insurance’ identification information if available.

Enter up to three NFs (if uncertain), in the section entitled ‘Requesting Admission to’.

**Page 2**

Fill in the name of the individual being evaluated and date of birth at the top of this page and each page going forward.

**Section 1: PASRR Screen Decision-Making**

1. Review any pertinent medical information available for condition(s) to consider for a suspicion or diagnosis of SMI, ID or both.

   Check the appropriate box(es) in column A for history or suspicion of an MI and specify, if applicable, any other diagnosis or condition that is not listed on the form.

AHCA MedServ Form 004 Part A, March 2017 (incorporated by reference in Rule 59G-1.040, F.A.C.)
Check applicable box(es) in column B for history or suspicion of ID and specify, if applicable, any other diagnosis or condition that is not listed on the form.

2. Check the appropriate box if the individual has, has had, or has been referred for services from an agency or entity that serves individuals with an intellectual or developmental disability such as the Agency for Persons with Disabilities (APD), or provides services for an MI.

3. Include additional information if necessary pertaining to MI or ID history.

Indicate the source of all the information gathered for the individual’s Level I PASRR screen.

Page 3

Section II: Other Indications for PASRR Screen Decision-Making

Check ‘Yes’ or ‘No’ in the box after each question as it pertains to the individual.

The boxed text contains additional information in relation to the decision-making process, throughout the Level I PASRR screen.

If the box checked in question four of Section III is ‘Yes,’ a Level II evaluation must be requested.

Page 4

Section II: Other Indications for PASRR Screen Decision-Making, continued

Continue to check the appropriate box pertaining to the individual concerning questions five through seven.

The boxed text contains additional information in relation to the decision-making process.

Section III: PASRR Screen Provisional or Hospital Discharge Exemption

If the individual being admitted is not a provisional admission, check the box indicating such and proceed to Section IV.

If the individual being admitted is a provisional admission, or a hospital discharge exemption, check the appropriate box. Check only one box.

Check the box for the type of provisional admission. Fill in the blank where indicated with the anticipated Level II evaluation completion date based on the type of provisional admission.

If the individual is being admitted under the hospital discharge exemption, check the box and ensure the section is signed by the attending physician. A hospital discharge exemption only pertains to the timeframe for completion of the Level II PASRR evaluation and determination. The box for a hospital discharge exemption is not to be checked if the individual has no diagnosis or suspicion of SMI, ID, or both. An individual being admitted with no diagnosis or suspicion of SMI, ID, or both, is not a hospital discharge exemption according to PASRR regulations.

Page 5

Section IV: PASRR Screen Completion

1. Determine whether the individual may, or may not, be admitted to an NF and check the applicable box indicating the finding.

2. Fill in the information field pertaining to the person who has completed the screen.

3. If the individual requires a Level II evaluation, forward the Level I PASRR along with other required documentation, to the appropriate Level II screener as follows:
   - CARES for individuals age 21 years and older
   - DOH for individuals under the age of 21 years

ASCA MedSer Form 304 PA, March 2017 (incorporated by reference in Rule 3961-040, P.A. 5)
Complete the distribution area of the form indicating where the Level I PASRR screen and accompanying documents must be sent, as appropriate. Check all that apply.

Obtain the signature for consent for the Level II evaluation and determination, if applicable, from the individual being assessed or the individual's legal representative.

If an individual is unwilling or unable, and has no legal representative or health care agent to sign the consent for a Level II PASRR evaluation, information regarding the reason for the inability to obtain the signature must be documented.
LEVEL I SCREEN

For Serious Mental Illness (SMI) and/or Intellectual Disability or Related Conditions (ID)

For Medicaid Certified Nursing Facility (NF) Only

Name of Individual Being Evaluated (print) __________________________

Social Security Number* __________________________ Date of Birth ______________

☐ Male    ☐ Female __________________________ Age __________________________

Individual’s or Residency Phone Number __________________________

Present Location of Individual Being Evaluated

☐ NF    ☐ Hospital    ☐ Home    ☐ Assisted Living Facility    ☐ Group Home    ☐ Other: __________________________

Legal Representative’s Name (if applicable) __________________________

Street Address, City __________________________ State, Zip __________________________

Representative’s Phone Number __________________________

Street Address, City __________________________ State, Zip __________________________

Medical Identification Number if Applicable __________________________

Other Health Insurance Name and Number if Applicable __________________________

☐ Private Pay

(If applicable, you may document up to three facilities)

<table>
<thead>
<tr>
<th>NF Name</th>
<th>Street Address</th>
<th>City, State, Zip Code</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
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*WHY ARE WE ASKING FOR YOUR SOCIAL SECURITY NUMBER (SSN)? Federal law permits the State to use your SSN for screening and referral to programs or services that may be appropriate for you. 42 CFR § 435.910. We use the SSN to create a unique record for every individual that we serve, and the SSN ensures that every person we serve is identified correctly so that services are provided appropriately. Any information the State collects will remain confidential and protected under penalty of law. We will not use it or give it out for any other reason unless you have signed a separate consent form that includes us to do so or if required by law.

AHCA Medicaid Form 014 Part A, March 2017 (incorporated by reference in Rule 596-140, F.A.C.)

Page 1 of 5
### Section 1: PASRR Screen Decision Making

#### A. MI or suspected MI (check all that apply):

- [ ] Anxiety Disorder
- [ ] Bipolar Disorder
- [ ] Depressive Disorder
- [ ] Dissociative Disorder
- [ ] Panic Disorder
- [ ] Personality Disorder
- [ ] Psychotic Disorder
- [ ] Schizoaffective Disorder
- [ ] Schizophrenia
- [ ] Somatic Symptom Disorder
- [ ] Substance Abuse
- [ ] Other (specify): __________________________

#### B. ID or suspected ID (check all that apply):

- [ ] Current diagnosis of an ID, mild, moderate, severe or profound
- [ ] IQ of 70 or less, if available.
- [ ] Onset prior to 18 years of age. Age of onset: ________
- [ ] Impaired adaptive behavior

**Related Conditions**

- [ ] Onset prior to 22 years of age. Age of onset: ________
- [ ] Autism
- [ ] Cerebral Palsy
- [ ] Down Syndrome
- [ ] Epilepsy
- [ ] Muscular Dystrophy
- [ ] Prader Willi
- [ ] Ospina Bifida
- [ ] Traumatic Brain Injury
- [ ] Other (specify): __________________________

**Functional Criteria:**

- [ ] Likely to continue indefinitely

Results in substantial functional limitations in three or more major life activities (check all that apply):

- [ ] Capacity for independent living
- [ ] Learning
- [ ] Mobility
- [ ] Self care
- [ ] Self direction
- [ ] Understanding and use of language

**Services:**

- [ ] Currently receiving services for MI
- [ ] Previously received services for MI
- [ ] Referred for MI services
- [ ] Currently receiving services for ID
- [ ] Previously received services for ID
- [ ] Referred for ID services

**Additional Information:** __________________________

**Finding is based on (check all that apply):**

- [ ] Documented History
- [ ] Behavioral Observations
- [ ] Individual, Legal Representative or Family Report
- [ ] Medications
- [ ] Other (specify): __________________________
Name of Individual Being Evaluated

Date of Birth

Section II: Other Indications for PASRR Screen Decision-Making

1. Is there an indication the individual has or may have had a disorder resulting in functional limitations in major life activities that would otherwise be inappropriate for the individual’s developmental stage?  □ Yes  □ No

2. Does the individual typically have or may have had at least one of the following characteristics on a continuing or intermittent basis?
   
   A. Interpersonal交往: The individual has serious difficulty interacting appropriately and communicating effectively with others, has a possible history of alterations, evictions, fear of strangers, avoidance of interpersonal relationships, social isolation, or has been dismissed from employment.  □ Yes  □ No
   
   B. Concentration, persistence, and pace: The individual has serious difficulty in maintaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifest difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requests assistance in the completion of these tasks.  □ Yes  □ No
   
   C. Adaptation to change: The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or seeks intervention by the mental health/judicial system.  □ Yes  □ No

3. Is there an indication that the individual has received recent treatment for a mental illness which is an indicator that the individual has experienced at least one of the following?
   
   A. Psychiatric treatment more intensive than outpatient care (e.g., partial hospitalization or inpatient hospitalization).  □ Yes  □ No
   
   B. Due to the mental illness, the individual experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.  □ Yes  □ No

A Level II PASRR evaluation must be completed prior to admission if any box in Section I.A. or I.B. is checked and there is a ‘yes’ checked in Section I.I. or I.II, unless the individual meets the definition of a provisional admission or a hospital discharge exemption.

4. Has the individual exhibited actions or behaviors that may make them a danger to themselves or others?  □ Yes  □ No

Section II: Other Indications for PASRR Screen Decision-Making, Continued:

5. Does the individual have a primary diagnosis of:
   - Dementia? [ ] Yes [ ] No
   - Related Neuropsychiatric Disorder (including Alzheimer's disease)? [ ] Yes [ ] No

6. Does the individual have a secondary diagnosis of dementia, related neuropsychiatric disorder (including Alzheimer's disease) and the primary diagnosis is an SMI or ID?
   [ ] Yes [ ] No

7. Does the individual have validating documentation to support the dementia or related neuropsychiatric disorder (including Alzheimer's disease)?
   [ ] No
   [ ] Yes (Check all that apply. Send accompanying documentation with completed Level I PASRR scrutiny):
   - Dementia work-up
   - Comprehensive mental status exam
   - Medical/Functional history prior to onset
   - Other - Specify: 

   A Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neuropsychiatric disorder, and a suspicion or diagnosis of an SMI, ID, or both. A Level II PASRR may only be terminated by the Level II PASRR evaluator in accordance with 42 CFR §483.121(a)(7)(iv) or 42 CFR §483.121(b)(7)(iv).

Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption

- [ ] Not a provisional admission
- [ ] Hospital Discharge Exemption
- [ ] Provisional admission (choose one)

If a provisional admission or hospital discharge exemption is indicated, the individual may enter an NF without a Level II PASRR evaluation/determination if the Level I screen indicates a suspicion of SMI, ID, or both, and the box in Section II.A is checked “no.” A Level II evaluation must be completed, if required, by submitting the documentation for the Level II evaluation to CARES® for adults or DCF® for individuals under the age of 21 years within the time frames indicated in this section.

- [ ] The individual being admitted has delirium. The Level II evaluation must be completed within 7 days after the delirium clears.
- [ ] The individual is being admitted on an emergency basis requiring protective services. The Level II evaluation must be completed within 7 days of admission, or before (date)

- [ ] The individual is being admitted for caregiver’s respite. The Level II evaluation must be completed in advance of the expiration of 14 days of the stay is expected to exceed the 14-day stay limit, or before (date)

- [ ] The individual is being admitted under the 30-day hospital discharge exemption. If the individual’s stay is anticipated to exceed 30 days, the NF must notify the Level I screener on the 25th day of stay and the Level II evaluation must be completed no later than the 40th day of admission, or before (date)

An attending physician’s signature is required for those individuals admitted under a 30-day hospital discharge exemption.

ATTENDING PHYSICIAN’S SIGNATURE ________________________________ DATE ________________________________
Section IV: PASRR Screen Completion

Individual may be admitted to an NF (check one of the following):

☐ No diagnosis or suspicion of SMI or ID indicated. Level II PASRR evaluation not required.

☐ Provisional admission

☐ Hospital Discharge Exemption

Individual may not be admitted to an NF. Use this form and required documentation to request a Level II PASRR evaluation because there is a diagnosis of or suspicion of (check one of the following):

☐ SMI

☐ ID

☐ SMI and ID

*Incomplete forms will not be accepted*

By signing this form below, I attest that I have completed the above Level I PASRR screen for the individual to the best of my knowledge.

Screener’s Name (Printed) ___________________________ Signature ___________________________

Credentials ___________________________ Date __________ Phone ___________________________

Place of Employment ___________________________ Fax ___________________________

Completed Level I screen distributed to (check all that apply):

☐ Local DOH* office, for individuals under the age of 21 years

☐ Accompanying documents attached

Date: __________

☐ Local CARES* office, for adults age 21 years or older

Date: __________

☐ Accompanying documents attached

☐ Nursing Facility

Date: __________

☐ Discharging Hospital (if applicable)

Date: __________

Name: ___________________________ Date: __________

Consent for Level II Evaluation and Determination

In order to access my records, by signing above, I consent to an evaluation of my medical, psychological, and social history. I understand and agree that evaluators may need to talk to my doctor, my family, and close friends to talk about my situation.

*Florida Department of Health

AHCIA MedSvr Form 004 Part A March 2017 (incorporated by reference in Rule 590-1.046, F.A.C.)
PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) NOTICE

DATE:

RE:

Dear

The Federal Government requires all states to look at persons asking for admission to a Medicaid nursing facility to see if they have a mental illness (MI) and/or intellectual disability (ID). The purpose of this letter is to let you know that medical records were obtained from your doctor and reviewed. This review, known as a Level I Pre-Admission Screening, looks for any signs of serious mental illness (MI) or intellectual disability (ID). Later, the reviewing unit makes a decision as to whether you possibly have serious mental illness (MI) and/or intellectual disability (ID).

Should signs of MI and/or ID be found, federal law requires an additional review to decide whether or not special services are needed in the nursing home you enter. This step, if needed, is called a Level II Evaluation, which is completed by the state of Florida's mental illness or intellectual disability office. The result of the Level I Screen is as follows:

- □ Signs of MI found at the Level I Screen, and a Level II Mental Health Evaluation and final review of the need for specialized services is needed. Results of the Level II Evaluation and Determination will be sent to you once they are done.

- □ Signs of ID found at the Level I Screen, and a Level II ID Evaluation and final review of the need for specialized services is needed. Results of the Level II Evaluation and Determination will be sent to you once they are done.

If you have any questions regarding this letter, please feel free to contact:

Sincerely,

cc Legal Representative

PASRR Notice Letter
December 2014
Pursuant to federal regulations and 593-1.040, Florida Administrative Code, all individuals seeking placement in a Medicaid-certified nursing facility, regardless of payment source, must receive a pre-admission screening for serious mental illness and/or intellectual disability prior to placement in a nursing facility.

The Agency for Health Care Administration (AHCA) has delegated oversight of the Pre-Admission and Resident Review (PASRR) process for adults 21 and older to the Comprehensive Assessment and Review for Long-Term Care Services Program (CARES). CARES has received information that the client named above is a resident in your facility, and the Level 1 PASRR form has not been completed.

Please complete a PASRR Level 1 Screen form by DUE DATE - 2 BUSINESS DAYS and fax it to CARES at XXX-XXX-XXXX.

Failure to comply with this request could result in a reduction of payment from Medicaid if the resident subsequently needs Medicaid coverage, and/or a report of non-compliance to AHCA.

Thank you for your prompt attention to this matter.

Sincerely,

SUPERVISOR’S NAME
SUPERVISOR’S TITLE

CARES OFFICE, ADDRESS, CITY, STATE, ZIP
PHONE: XXX-XXXX-XXXX FAX: XXX-XXXX-XXXX
LEVEL I PASRR SCREEN RETURN

Date: 

Please Deliver To: 

FAX # 

From: DOE A CARES PASA. 

PHONE #: 

FAX #: 

ADDRESS: 

A PASRR Level I form was received on for SSN: 

It is being returned for the reason(s) indicated below:

☐ The Level I screen was completed on a form that is no longer approved for use. Please complete a new Level I screen on the October 2015 Medicaid Form 004 and return to CARES within 2 business days.

Demographic Information

☐ Name is missing ☐ SSN is missing ☐ DOB is missing ☐ Gender is missing
☐ Name of Present Location is missing ☐ Address of Present Location is missing
☐ Category of Present Location is not indicated

Section I: PASRR Screen Decision Making

☐ Section A is incomplete ☐ “Other” diagnosis listed in Section A does not indicate SMI
☐ Section B is incomplete ☐ “Other” diagnosis listed in Section B does not indicate ID
☐ “Finding is based on” is incomplete

Section II: Other Indications for PASRR Screen Decision Making

☐ Question 1 not answered ☐ Question 2A not answered ☐ Question 2B not answered ☐ Question 2C not answered
☐ Question 3A not answered ☐ Question 3B not answered ☐ Question 4 not answered

Section III: PASRR Screen Provisional Determination

☐ “Not a Provisional Admission” or “Provisional Admission” is not selected
☐ “Not a Provisional Admission” or “Provisional Admission” is not correct
☐ “Provisional Admission” is selected but type of provisional admission is not selected
☐ “Today hospital discharge exemption” is selected, but physician’s signature and/or signature date is missing
☐ AHCA 5000-3008 form is not attached

Section IV: PASRR Screen Completion

☐ Specific reason individual may or may not be admitted to the NF is not selected
☐ Screener’s printed name is missing ☐ Screener’s signature is missing ☐ Screener’s credentials are missing
☐ Date is missing ☐ Screener’s fax # is missing ☐ Screener’s phone # is missing
☐ Screener’s place of employment is missing ☐ Screener is not an LCSW, MSW, ARNP, RN, or attending physician

Additional Comments:

CARES Worker 

Title 

Date 

Please FAX the completed/corrected PASRR Level I form back to CARES at the number indicated above.
PASRR LEVEL II NOT REQUIRED

DATE: ____________

PLEASE DELIVER TO:

NAME: __________________________

FACILITY: __________________________

PHONE #: __________________ FAX #: ____________

FROM:

AGENCY: Florida Department of Elder Affairs – CARES PSA ____________

ADDRESS: __________________________

PHONE #: __________________ FAX #: ____________

A request for a PASRR Level II evaluation was received on, 
For __________________________
Social Security Number XXX - XX - ____________

Based on a review of the documentation submitted, it has been determined that a PASRR Level II evaluation is NOT required, and the case will NOT be forwarded to the Level II evaluator at this time.

If you have questions concerning this decision, please contact the individual below.

(CARES Worker) __________________________ (Title) __________________________

DCE/ACARES February 2018
Preadmission Screening and Resident Review (PASRR)
Resident Review (RR) - Evaluation Request Form
Instructions

A. Acronyms and abbreviations:
   
a. AHCA - Agency for Health Care Administration
   
b. CARES - Florida Department of Elder Affairs' Comprehensive Assessment and Review for Long-Term Care Services Program
   
c. CFR - Code of Federal Regulations
   
d. CMAT - Children's Multidisciplinary Assessment Team
   
e. DOH - Florida Department of Health
   
f. DOEA - Florida Department of Elder Affairs
   
g. F.A.C. - Florida Administrative Code
   
h. HIPAA - Health Insurance Portability and Accountability Act
   
i. ID - Intellectual Disability or Related Conditions
   
j. MI - Mental Illness
   
k. MLD - Medicaid Identification Number
   
1. MM/DD/YYYY - Month, Day, Year
   
m. NA - Not Applicable
   
n. NF - Medicare-certified Nursing Facility
   
o. PASRR - Postadmission Screening and Resident Review
   
p. RR - Resident Review
   
q. SMI - Serious Mental Illness

B. Instructions

The Resident Review - Evaluation Request, AHCA MedServ Form 004 Part A1, March 2017, must be fully and accurately completed and submitted in accordance with Rule 590-1.040, F.A.C. Incomplete submissions will not be accepted, and any prohibitive Florida Medicaid payment for nursing facility services. Information inserted manually must be legible. Any illegible information will result in the RR Evaluation Request being deemed unacceptable.

The Resident Review - Evaluation Request, AHCA MedServ Form 004 Part A1, March 2017, is to assist an NF to request an RR for a resident who has experienced a significant change in condition, as defined in Rule 590-1.040, F.A.C.

The NF must notify the State authority for SMI or ID of the necessity for the RR evaluation and determination in accordance with 42 United States Code 1396a. The Resident Review - Evaluation Request Form 004 Part A1, March 2017, must be completed and sent with all accompanying documents to the designated Level I screening agency, CARES or DOH, as appropriate. The Level I screening agency will forward the request to the appropriate State authority.

Page 1

Fill in the blanks with the individual's demographics, name and contact information of the legal representative, insurance information, etc. Do not leave any area blank, check the appropriate box that applies.

Section I

Fill in the blanks for the individual's current NF location. Continue to provide information as requested.

Section II

Fill in the date the significant change was first identified, using the MM/DD/YYYY format.

AHCA MedServ Form 004 Part A1, March 2017 (incorporated by reference in Rule 590-1.040, F.A.C.)
Page 2

Fill in the individual’s name and date of birth at the top of this page, and each continuing page.

Check the box(es) for information indicating a decline or an improvement in the individual’s status. Continue to check the box(es) describing the reason for identifying a decline or improvement, as applicable. For dates, use the MMDDYYYY format. Fill in areas that require further information as applicable.

Add any additional information that may assist the state SMI or ID authority in evaluating the resident.

Section III: Attestation of Requestor

Fill in the attestation information using the name of the staff person completing the form and other information requested.

Page 3, Section IV: Completion of Evaluation Request

Check the appropriate agency box for distribution of the completed Resident Review Evaluation Request Form 004, Part A1, March 2017, according to the resident’s age and fill in the date the information is being sent to CARES or DCH, as applicable. Use the MMDDYYYY format for the date.

Check the box(es) for all documentation that will accompany the request. Fill in any other information that is not listed.

Check the box(es) indicating the notice to the individual and the individual’s representative as applicable. Request the resident’s signature for consent, or indicate the reason the individual is unable or unwilling to sign the form.

Ensure all distributions of the PASRR Resident Review – Evaluation Request form and required documents maintain HIPAA compliance.
**State of Florida Agency for Health Care Administration**  
**Pre-admission Screening and Resident Review (PASRR)**

**RESIDENT REVIEW (RR) – EVALUATION REQUEST**

For a Significant Change for Serious Mental Illness (SMI)  
and/or Intellectual Disability or Related Conditions (ID)  
For Medicaid Certified Nursing Facility (NF) Only

<table>
<thead>
<tr>
<th>Name</th>
<th>Social Security Number*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- □ Male □ Female  
- □ Date of Birth  
- □ Legal Guardian Name, Address, City, State Zip (if applicable)  
- □ Phone Number  
- □ Pay Source: □ Private Pay □ Medicaid □ Medicare □ Private Insurance

- □ Medicaid Number

*We are asking for your Social Security Number (SSN) in Federal law requires the State to use your SSN for screening and referral to programs or services that may be appropriate for you (22 USC 14332(b)(1)). We use the number to create a unique record for each individual that we care for, and the SSN ensures that the person we care for is identified correctly so that services are provided appropriately. Any information the State collects will remain confidential and protected under penalty of law. We will not use it for any other socio-economic reasons or to collect data to do so as required by law.

### Section I: Current Location

<table>
<thead>
<tr>
<th>Name, Address, City, State, Zip</th>
<th>Phone Number</th>
<th>NF License Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- □ NF  
- □ Date of Admission  
- □ Date of Level I PASRR  
- □ Date of most current Level II PASRR or RR (if applicable)

- □ Previous Level II PASRR Determination: □ SMI □ ID □ SMI and ID □ N/A

### Section II: Significant Change

<table>
<thead>
<tr>
<th>Date of Onset: / /</th>
</tr>
</thead>
</table>

ARCA MedStar Form 1045 Rev A, March 2017 (incorporated by reference in Rule 500-10.08, F.A.C.)

Page 1 of 3
Individual's Name
Date of Birth

Describe significant changes in the resident's condition.

- **Decline in Resident's Status**
  - [ ] Increase in behavioral, psychiatric, or mood-related symptoms.
  - [ ] Behavioral, psychiatric, or mood-related symptoms that have not responded adequately to ongoing treatment.
  - [ ] Sudden increase or decrease in weight.
    - Current weight: Date / / 
    - Prior weight: Date / / 
    - Reason for change: 

- [ ] Change in behavior, psychiatric, or mood suggestive of a suspicion of SMI (where dementia is not the primary diagnosis)

- [ ] Will not resolve itself without intervention by staff or the implementation of standard disease-related clinical interventions and/or modification of care plan.

- [ ] In more than one area of resident's health status (check all that apply):
  - [ ] Behavior change not due to a medical condition.
  - [ ] Adaption to change.
  - [ ] Medical condition exacerbating current SMI/IDS symptomatology.
  - [ ] Other conditions or additional information.

- **Improvement in Resident's Status**
  - [ ] Decrease in behavioral, psychiatric, or mood-related symptoms.
  - [ ] Behavioral, psychiatric, or mood-related symptoms that have responded adequately to ongoing treatment.
  - [ ] Improvement in medical condition requiring interdisciplinary review and/or modifications in the plan of care.
  - [ ] Improvement in more than one area of resident's health status. Areas affected:

- [ ] Has required implementation and/or modification in care plan. Specifically:

- [ ] No longer requires specialized services.

---

**Section III: Attestation of Requester**

By signing this form below, I attest that I have completed the above request for the individual to the best of my knowledge.

Name: ________________________________ Signature: ________________________________

Credentials: ________________________________

Date: ____________ Phone: _______________ Fax: _______________

Place of Employment: ________________________________

*Incomplete forms will not be accepted*
Section IV. Completion of Evaluation Request

Resident Review Request for Level III Evaluation Distributed to:

☐ Local DCH** office, under the age of 21 years Date: __/__/____

☐ Local CARES*** office, age 21 years or older Date: __/__/____

Documentation included (Check all that apply):

☐ Completed Resident Review – Evaluation Request, AHCA MedServ Form 004 Part A, March 2017

☐ Level 1 PASRR screen, AHCA MedServ Form 004 Part A, March 2017

☐ Level 1 PASRR evaluation and determination or most recent Resident Review, as applicable

☐ Most recent Minimum Data Set

☐ Case Notes

☐ Record of treatment

☐ Medication Administration Record

☐ Psychiatric or psychological evaluation, if available

☐ Other: ______________________________________________________

Notice of referral for Resident Review evaluation distributed to (including how to obtain the evaluation):

☐ Individual

☐ Representative

Consent for Resident Review

In order to assess my needs, by signing above, I consent to an evaluation of my medical, psychological and social history.

I understand and agree that evaluators may need to talk to my doctors, my family, and close friends to talk about my situation.

Signature __________________________ Date __________________________

If an individual is unwilling, or unable, or has no legal representative or health care agent to sign the consent for Level II PASRR evaluation, information regarding the reason for the inability to obtain the signature must be documented here:

________________________________________

**Department of Health

***Department of Elder Affairs’ Comprehensive Assessment and Review for Long-Term Care Services
REQUEST FOR LEVEL II PASRR EVALUATION

Section I: Request Information

Date: 

From: ___________________________ Agency: ___________________________ Phone: ___________________________

To: ___________________________ Agency: ___________________________ Phone: ___________________________

An indication of, or a diagnosis of, a serious mental illness or intellectual disability or related condition was identified on the Level I Pre-Admission Screen for the individual listed below. The Level II PASRR Evaluation should be completed within 7 to 10 days and returned to Comprehensive Assessment and Review for Long-Term Care Services (CARES). The Level II Reviewer should notify the individual or legal guardian of the right to appeal the Level II PASRR Evaluation.

Section II: Individual Information

Name: ___________________________ DOB: ___________________________

Current Location: ___________________________

M/I/D Indicator: [ ] MI (Serious Mental Illness)  [ ] ID (Intellectual Disability)  [ ] Both (MI and ID)

Section III: Required Documents for Level II PASRR Evaluation (Check box for all documents that are attached)

[ ] Level I PASRR Screen (AHCA MedServ Form 004 Part A, October 2015)
[ ] Informed Consent Form (AHCA Med Serv 2040, May 2008)
[ ] Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (AHCA Form 5000-3000)
[ ] Other Medical Documentation including Relevant Case Notes or Records of Treatment, Medication Administration Record (MAR)
[ ] Psychiatric Evaluation Forms (DOE-AWV Form 1911-A, Aug 01, and DOE-AWV Form 1911-B, Aug 01) (if available)
[ ] DOE Assessment Instrument (DOEA 701B, April 2013)

Section IV: Additional Comments

________________________________________

________________________________________

________________________________________

January 2016
PASRR EMAIL BOXES

A PASRR email box has been configured for each of the CARES field offices. The address is ‘caresXXXpasrr@elderaffairs.org’, with XXX referring to the office number (i.e., cares01pasrr@elderaffairs.org, cares02apasrr@elderaffairs.org, cares11bpasrr@elderaffairs.org).

Each of the email boxes has been set up with ‘PENDING’ and ‘COMPLETED’ folders to supplement the inboxes. Messages can be moved from the INBOX (unread) to PENDING (requires action) to COMPLETED (no further action required) as the items are processed.

Authorized staff members can access their office’s PASRR email box in one of two ways:

1. From the office’s SharePoint home page, click on the PASRR MAILBOX icon. This will open the email box in a new web browser tab.

![PASRR MAILBOX](image)

2. From within Outlook365, click on the user silhouette, select ‘Open another mailbox’, and enter the office’s PASRR mailbox.

![User Silhouette](image)

Please note:

- Currently the purpose of this email box is to receive notifications when a facility has submitted a Resident Review/Level II request through the online SAMH contracted vendor’s portal system.

- Each office should give out their PASRR email address to the facilities in their respective areas that are signed up to use the portal system and are submitting their Level II/Resident Reviews in this way.

- Please ensure that staff use the PENDING and COMPLETED folders appropriately; notification emails regarding Resident Review/Level IIs submissions should not be deleted.

- Please establish a generic signature block for any emails sent or notifications responded to from the PASRR box, e.g., CARES 01 Office/PASRR. If your staff sends an email or responds to a notification from the PASRR box, please be sure to have them include their initials to the generic signature block in order to be easily identified, e.g. (pjj).
PASRR PROCESS

Individual seeking Medicaid/NF placement

<21

Individual in hospital seeking NF admission, or individual was NF resident, had previous Level III, and in hospital for >90 days

Individual in community applying for NF Medicaid (ICF)

Individual in hospital seeking NF admission, or individual was NF resident, had previous Level III, and in hospital for >90 days

Individual in community applying for NF Medicaid (ICF)

NF resident exhibits significant change or new diagnosis of SMH or ID (Resident Reviewer)

Is there indication of diagnosis of SMH or ID or related condition?

NO

Process stops
Send Level I to CARES
Individual can be admitted to NF

YES

Individual is deemed to be at risk for others (no apparent SMH/ID diagnosis)?

NO

Proceed with pre-admission screening

YES

CARES will submit request for Level II evaluation at a später

Individual is deemed to be at risk for others (no apparent SMH/ID diagnosis)?

NO

STOP

Individual can be discharged prior to 30th day of stay
Level II not required

YES

Individual must be discharged prior to 30th day of stay
Level II not required

Is NF stay expected to exceed 30 days?

NO

YES

The Level II must indicate the exemption and be signed by a physician. Individual can be admitted to NF

Does person meet criteria for 30 day hospital exemption?

NO

CARES will complete 702B and request Level III

YES

Does person meet provisional admission requirements?

NO

Individual is deemed to be at risk for others (no apparent SMH/ID diagnosis)?

YES

CARES will complete 702B and request Level III

NO

Individual is deemed to be at risk for others (no apparent SMH/ID diagnosis)?

STOP

Need for NF? (NF recommended)

NO

Individual is deemed to be at risk for others (no apparent SMH/ID diagnosis)?

Yes

Individual can be admitted to NF

Specialized Services Recommended?

NO

Individual can be admitted or retained in NF

YES

Services of lesser intensity may be recommended and NF must add to care plan and ensure implementation

Legend:

CMAT = Children’s Medical Assessment Team

ID = Intellectual Disability/Related Condition

LI = Level I

LI = Level II

NF = Nursing Facility

SMH = Serious Mental Illness

SS = Specialized Services

2.20.2017

***Hospitals and NF will need to contact CARES to determine assessment to meet time parameters
BACKGROUND AND LEGISLATION

During the 2011 Florida Legislative Session, the legislature passed HB 7107 and HB 7109 which required AHCA to implement a cost effective, integrated statewide Medicaid managed care program. Through a competitive contracting process, AHCA chose qualified managed care plans to ensure that enrollees have a choice between plans. The managed care plans contract with a variety of healthcare providers to ensure that enrollees have access to the healthcare that they need. Based on a regional enrollment schedule, enrollment of eligible Medicaid recipients began in September 2013 with full implementation by August 2014.

There are two components of the SMMC program: The Long-term Care (LTC) Program and the Managed Medical Assistance (MMA) Program. The LTC Program provides nursing facility services and home and community-based (HCBS) waiver services. The MMA Program provides services such as primary care physicians, specialty care physicians, hospital, medical supplies, prescribed drugs, etc. Certain participating managed care plans are considered Comprehensive SMMC Plans because they are providers of both components of the program. Some Medicaid recipients are required to enroll in both the LTC and MMA programs. For more information on the MMA Program, visit AHCA’s website: http://ahca.myflorida.com/medicaid/statewide_mc/index.shtml.

Implementation of the LTC Program resulted in the consolidation of six HCBS waivers. Medicaid recipients who were enrolled in one of the six HCBS waiver programs were transitioned into the LTC Program as each region went live. Upon full implementation of the new LTC Program, the following waivers ended:

- Aged and Disabled Adult Waiver;
- Assisted Living for the Frail Elder Waiver;
- Channeling Services for Frail Elders Waiver;
- Consumer-Directed Care Plus Program;
- Frail Elder Option; and
- Nursing Home Diversion Waiver.

The legislation also designated how certain aspects of the LTC Program would be governed:
As the single-state agency, AHCA was given the responsibility of administering the program, its policy, and contracting with the managed care plans.

CARES was designated as the entity to determine medical eligibility, while DOEA was also given responsibility for monitoring and quality assurance of the LTC managed care plans.

The Aging and Disability Resource Centers (ADRCs), operated by the 11 Area Agencies on Aging, were given the responsibility to function as a single, coordinated system for education about, and access to, the LTC Program and other long-term care services; The Bureau of Long-Term Care and Support (LTCS) monitors DOEA’s contracts with the ADRCs and monitors their Medicaid functions.

The Enrollment Broker (EB), AHCA’s choice counseling vendor, was given responsibility to provide information to LTC potential enrollees on available plan choices, including their provider networks, and to process enrollments, disenrollments, and plan change requests from enrolled members.

**SMMC LONG-TERM CARE PROGRAM**

Following are the eligibility requirements, services provided, and operational policies and procedures concerning the LTC Program.

**ELIGIBILITY GUIDELINES**

Individuals who meet the following criteria are required to enroll in the Long-term Care Program:

- Age 65 and older and eligible for Medicaid or
- Age 18 and older and eligible for Medicaid by reason of disability and
- Be determined by CARES to meet a nursing facility level of care

Individuals who are enrolled in the following programs are NOT required to enroll, although they may choose to enroll if they are released from the EMS priority list and they meet a nursing facility Level of Care:

- Adult Cystic Fibrosis Waiver;
- Developmental Disabilities Waiver Program;
- Familial Dysautonomia;
- Program of All-Inclusive Care for the Elderly;
• Project AIDS Care Waiver; and
• Traumatic Brain and Spinal Cord Injury Waiver.

Individuals who are enrolled in the above programs and choose to enroll in the LTC Program must first disenroll from the above programs. (CARES staff should inform the individual that they cannot be enrolled in two Medicaid Waiver programs and the choice of enrolling in the LTC Program or staying with the current program is up to the individual.)

**LTC Program and Hospice**

Hospice Medicaid recipients who reside in the community who wish to enroll in the LTC Program, must be released from the EMS priority list, be determined by CARES to meet NF Level of Care, and have DCF change their Hospice Medicaid eligibility to Medicaid Waiver eligibility.

Hospice Medicaid recipients who are enrolled in an MMA Plan and reside in a nursing facility are mandatory for enrollment in the LTC Program. The referral to CARES may come from DCF or the MMA Plan. The MMA Plan must send CARES a signed Informed Consent, and a 5000-3008 form.

Individuals who may NOT enroll in the LTC Program are:

• Individuals residing in State psychiatric facilities

**LTC Program Services**

Individuals may receive the following services in the program:

• Adult Companion
• Adult Day Care (Adult Day Health Care)
• Assistive Care Services
• Assisted Living Facility Services
• Attendant Care
• Behavioral Management
• Caregiver Training
• Case Management
• Home Accessibility Adaptation
• Home Delivered Meals
• Homemaker
• Hospice
• Intermittent and Skilled Nursing
• Medical Equipment and Supplies
• Medication Administration
• Medication Management
• Nursing Facility Care
• Nutritional Assessment and Risk Reduction
• Occupational Therapy
• Personal Care
Note: LTC Plans are responsible for identifying the LTC Program enrollee’s freedom of choice to receive services in the community or nursing facility. LTC Plans are responsible for providing 24-hour care if medically necessary.

**Enrollment Management System**

Nursing facility services are a State Plan entitlement service; individuals meeting criteria for the State’s Institutional Care Program (ICP) who are in need of long-term care services, and have been in a nursing facility for at least 60 consecutive days, must be provided eligibility and will be enrolled in the LTC Program with a managed care provider.

Home and community-based services are not a State Plan entitlement and generally require a prioritizing system. Effective July 1, 2013, DOEA implemented a single, statewide priority system called the Enrollment Management System (EMS). When individuals are interested in long-term care services and reside in the community, they are referred to the ADRC, telephonically screened by ADRC staff using assessment form 701S, and placed on the Assessed Priority Consumer List (APCL). Completion of the screening form generates a priority score and rank in CIRTS based on frailty and need for services. When funding is available, DOEA, in consultation with AHCA, releases individuals from the EMS using the individual’s most recent CIRTS rank and priority score. The highest priority is assigned to the frailest individuals.

**EMS Release Process**

When an individual is released from the EMS, the ADRC makes contact and verifies continued interest in enrolling in the LTC Program. If the individual is interested in enrolling, the ADRC explains the financial and medical eligibility process for enrollment and updates the CIRTS enrollment field from APCL to APPL (Applicant List). The ADRC also sends out correspondence to the individual that contains information on the enrollment process, the requirement for returning a completed 5000-3008 form, instructions for applying for Medicaid (if not already Medicaid eligible) and notification that the ADRC is available to assist with the Medicaid application.

When the completed 5000-3008 is received by the ADRC, the ADRC records the date the 5000-3008 is received on the Medicaid Waiver Timeline screen in CIRTS. Following the receipt of the 3008 by the ADRC, the ADRC requests a LOC from CARES by emailing the CARES office a PDF copy of the 5000-3008 to a PSA-specific Intake email box per CARES office. Designated CARES staff will review the inbox at least twice daily. Each email referral will be printed out and date stamped 8:00 AM - 4:00 PM, Monday through Friday, on the same business day that the referral is received in the
office. If a referral comes in after 4:00 PM, on the weekend, or on a holiday, it will be date stamped on the following business day. The POA will designate CARES staff to review the 5000-3008 for completeness and correctness prior to entering the referral information in CIRTS.

NOTE: Upon receipt of a referral from the ADRC, CARES staff will verify that the LTCC Program Enrollment Status field on the Enrollment tab in CIRTS has been changed to APPL. If not, CARES will contact the ADRC.

5000-3008 Completed and Correct

If the 5000-3008 received by CARES is completed correctly and less than a year old, a case will be created in the CIRTS Assignment Screen on the date received. The “3008 Received” field on the assignment screen is entered as “Y” and “Y.” The case is assigned to CARES field staff to complete an on-site 701B Assessment (See Chapter 4 – General Operations, section “Scheduling On-Site Visits” for required steps and timeframes.)

If the individual cannot be reached by CARES to complete a 701B Assessment within 30 calendar days, and the required steps and timeframes have been followed as referenced in Chapter 4, Scheduling On-Site Visits, CARES will close the case as “Lost Contact.” CARES will also notify the ADRC of the no contact status by sending an email to the ADRC Intake Inbox. (See specific ADRC Intake Inbox addresses at the end of this chapter.) When the ADRC receives information from CARES that there has been no contact with the individual, the ADRC will send written correspondence to the individual that they have been terminated from the LTC Program priority list. The ADRC will enter a termination code in the enrollment span on the enrollment screen.

5000-3008 Not Completed and/or NOT Correct

If the 5000-3008 is NOT complete, a case will not be opened in CIRTS. CARES will document that the 5000-3008 is not complete on the Client Information screen in CIRTS, if no previous case exists, or in the case notes if there is an existing case record. CARES will then return the 5000-3008 to the ADRC, notifying the ADRC of the corrections that are needed. Designated staff will complete a 3008 Return Cover Memo (Appendix M) indicating the problem areas with the 5000-3008 and return this memo with the incomplete 5000-3008. The cover memo and the incomplete 5000-3008 will be emailed to the specific ADRC Intake Inbox for follow-up and attainment of a completed 5000-3008. The returned 5000-3008 will be renamed in the naming convention of the file as follows:

- ADRC designation Client ID#_RET.MEMO_Date Returned (yyyy.mm.dd)
  (example: PSA 3_oooooooooo_RET.MEMO_2014.12.15)

LOC Requests from the ADRC for Individuals Not Included in an EMS Release

The ADRC will replace the ‘EMS” portion of the standard naming convention when sending an LOC request for individuals not included on an EMS release, which includes
individuals referred by APS for SMMC ALF services, and individuals needing reenrollment assistance following a SIXT benefit span and SMMC LTC termination.

For individuals referred by APS for SMMC ALF services, the ADRC will replace “EMS” with the word “APS”. The ADRC must also attach the original APS for SMMC LTC ALF services referral, and any additional referral documents provided by DCF, to the LOC request email.

For individuals needing reenrollment assistance after SIXT, the ADRC will replace the word “EMS” with the word “SIXT.” This will signify to CARES the special condition of the LOC request for individuals not included on an EMS release.

**CASE FILE**

The CARES case file will contain the following:

- Notification of Level of Care (DOEA-CARES Form 603)
- Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (AHCA 5000–3008)
- Additional medical information indicated on the 5000-3008 form
- Informed Consent Form (AHCA MEDSERV–2040)
- Notice of Privacy Practices
- Client letters and correspondence

**ASSESSMENT AND STAFFING**

On-site assessments must be completed within 10 calendar days of receipt of referral unless the client is unable to schedule the visit within this period. Any delays in scheduling the assessment should be appropriately recorded in CIRTS case notes. Once the assessment is completed by CARES, it will be staffed with the CARES Physician Consultant. (Staffing requirements for the LTC Program must abide by the same staffing requirements outlined in Chapter 4 – General Operations, Case Staffing section).

CARES will complete the Notification of Level of Care Form (DOEA-CARES Form 603) and the Physician Consultant will sign with the community recommendation, if appropriate. The appropriate LOC will be entered into CIRTS with the program recommendation of MLTCC (Managed Care/Community). The 603 LOC form will not be sent to the ADRC or other entity. The ADRC will access LOC information via the “Authorized LOCs Sent to Enrollment Broker for SMMC LTC Report” in CIRTS. If it is determined that the client does not meet LOC, the NLOC procedures (see Chapter 4, Assessments with No Level of Care Recommendations) will be followed and the case
will be staffed accordingly. CARES will also notify the ADRC via email to the ADRC Intake Inbox that the client did not meet medical eligibility.

**NOTE:** If during the assessment process of an EMS release, the client decides that they want to pursue nursing facility placement, follow the procedures as outlined in Chapter 4 and notify the ADRC that the client chose nursing facility placement.

When the LOC is generated by CARES, as documented for the ADRC in CIRTS via the LOC staffing date, the ADRC will complete the Certification of Enrollment Status Home and Community-Based Services (CF-ES 2515 form), including the staffing date of the potential recipient’s LOC, and submit the form to DCF. Submission of Form 2515 by the ADRC to DCF with LOC information is not required for individuals that already have SSI Medicaid eligibility.

**NOTE:** For EMS release individuals, on-site 701B assessments are valid for six months from the date of the assessment. If the individual does not have Medicaid eligibility determined by the end of the sixth month, upon request from the ADRC, CARES will open a new case and complete an on-site 701B assessment and staffing.

**LTC PROGRAM NURSING FACILITY PLACEMENT**

Individuals eligible for ICP Medicaid, who have resided in a NF for at least 60 consecutive days, and continue to need long-term care services will be enrolled in managed care through the LTC Program. CARES staff will follow the policies and procedures outlined in Chapter 4 – General Operations, for Case Assessment and Case Staffing, in addition to the PASRR procedures outlined in Chapter 5 – Preadmission Screening and Resident Review.

**ENROLLMENT BROKER PROCESS**

Once the LOC is recorded in CIRTS, the LOC is sent from CIRTS to the Enrollment Broker’s (EB) system (Health Track), as part of a daily data feed. The file containing all new staffings (entered the day before) is transmitted each morning at approximately 6:00 a.m. Health Track already contains the full Medicaid eligibility file from FMMIS with both active and inactive records, but receives daily data feeds from FMMIS adding and updating any authorized eligibility. The EB also receives a daily data feed from DCF with notification of Medicaid application submissions.

The EB will link the LOC information received from CIRTS with either a FMMIS record already contained in Health Track, or with a new record created from the Medicaid application data feed from DCF. If LOC and Medicaid application/record are linked, the EB will mail the individual a welcome packet within five days of receiving the individual’s LOC and Medicaid application information. For SSI Medicaid recipients, a welcome packet will be mailed to the recipient within five days of the linkage of the LOC data to the recipient’s Medicaid record in Health Track.
Note: Check the individual’s record in FMMIS before staffing to ensure that the Medicaid ID number and other demographic information in CIRTS matches the demographic information in FMMIS. Demographic information such as Medicaid ID number, Social Security number, date of birth, and name spelling must be accurately entered into CIRTS. An incorrect Medicaid ID number can cause the LOC to be applied to an incorrect individual’s file or not at all. If problems are discovered, contact the designated Central Office staff for resolution. A spreadsheet of LOC issues is sent to AHCA daily to manually update individual’s records.

Note: Only Program Recommendations of MLTCN (Managed Long-Term Care Nursing Home) and MLTCC (Managed Long-Term Care Community) in CIRTS are transmitted to the EB for the LTC Program.

- If the Placement Recommendation is Temporary Nursing Home (NHTP), the Level of Care will not be transmitted to the EB. The correct Program Recommendation for NHTP is None.

- Individuals with Placement Recommendation of Nursing Home (NUHO) who need specialized services and therefore have Program Recommendation of NHSS will not be transmitted to the EB. For these few individuals, the POA will forward the client’s name and SSN number to the designated Central Office staff for the LOC to be updated manually in Health Track.

Once the welcome packet is received, the individual should contact the EB to choose a LTC plan and/or to choose the Medicaid Pending enrollment option, if desired. The individual can access the EB’s services by telephoning the Call Center: 1-877-711-3662; TDD 1-866-467-4970 or by website: http://www.flmedicaidmanagedcare.com/

The Medicaid Pending option is available to individuals who have been determined to meet LOC, filed a Medicaid application, but have not yet received Medicaid eligibility determined by DCF. This option is available only to EMS released clients applying for community-based services. Nursing facility residents will only become enrolled once LOC has been issued and the Medicaid application has been approved. (SSI Medicaid individuals also do not have the pending option since their financial eligibility has already been determined and they may enroll for the upcoming month after their LOC is issued.) If the individual does not choose the Medicaid Pending option, enrollment will not begin until after the individual’s Medicaid application has been approved. When the Medicaid application is approved, the individual will either be enrolled in the plan of their choice or be auto-assigned to a LTC plan if no choice was made within 30 days.

DOEA updates CIRTS three times a month with enrollment information from FMMIS. Active enrollment spans for the LTC Program will be reflected on the Enrollments Screen in CIRTS using the MLTC ACTV code.

**Follow-Up Schedule**

- **EMS**: After staffing and verification that the staffing information has been sent to
the Enrollment Broker per CIRTS automated case notes, the case can be closed and no follow-up is required.

- **NF Placement Recommendation:** For nursing facility cases, the case will automatically close at staffing if the client’s residence is nursing facility, Program Recommendation is MLTCN, and Placement Recommendation is nursing facility. No follow-up is required.

  - For Nursing Facility Placement Recommendations in which the client has not been placed in a nursing facility, two 30-day telephone follow-ups are required. Follow the procedures in Chapter 4, Follow-up for Nursing Facility (Long-Term Care) Placement Recommendations.

- **Temporary Nursing Facility Placement Recommendation:** For Temporary Nursing Facility Placement (code NHTP) recommendations, the follow-up schedule is 30 and 90 days.

  - If the client is residing in the nursing facility, and discharges to the community prior to the 90-day follow-up, CARES will update the demographics in CIRTS, change the Placement Recommendation to Community, and close the case manually with Case Closed Reason NN=No Longer Needed.

  - If the client remains in the nursing facility until the 90-day follow-up, CARES will conduct an on-site 701B assessment of the individual. (If the individual appears to continue to meet level of care criteria and desires to remain in the facility, the 701T assessment form may be used.) If a 701B/T was completed initially, and is less than 90 days old, a MCFR will be completed. CARES will re-staff the individual with Program Recommendation MLTCN and Placement Recommendation Nursing Facility. This will cause the LOC information to be transmitted to the Enrollment Broker for appropriate enrollment. If the client is able to transition to the community at a later date, the managed care plan will assist the client with transitioning to the community.

**NOTE:** If the client remains in the nursing facility until the 90-day follow-up, and it appears that the client will be discharging home without the need for services in the community, do not change the Program Recommendation at the 90-day follow-up. The Program Recommendation will remain “None.” CARES staff will continue to follow the client until the client is discharged, or until it is determined that the client will not return to the community. If the client is not returning to the community, complete a MCFR, staff the case, change the Program Recommendation to LTCN, and close the case.

  - If it appears that the individual does not meet level of care criteria, a 701B assessment must be completed. CARES will follow No Level of Care procedures outlined in Chapter 4 – General Operations.
LTC PROGRAM ENROLLEES WHO CHANGE RESIDENCE

A key component of the LTC Program is the ability of the managed care plan to provide long-term care services either in nursing facilities or community settings that include alternative living arrangements such as assisted living facilities or adult family group homes. After a certain time period, individuals who originally enrolled in the program while in the nursing facility, may find it better suits their wishes to live in an alternative setting, whereas some individuals who met NF Level of Care and enrolled while in the community might find that a NF setting becomes more beneficial. While both settings are appropriate for the LTC Program, and a new Level of Care is not required except in how annual recertifications are necessary (see section below for Annual Recertifications for the LTC Program), the individual’s financial eligibility must be updated with DCF.

- Enrollees residing in a nursing facility who transition into the community with assistance from the LTC Plan will have their eligibility revised from ICP to HCBS eligibility. The LTC Plan submits the Certification of Enrollment Status Home and Community Based Services (HCBS), CF-ES 2515 form to DCF to make this change.

- Enrollees residing in the community who transition into a nursing facility for more than 30 days must have their financial eligibility changed from HCBS to ICP. The LTC Plan submits the Client Referral/Change, CF-ES 2506A form, to DCF to make this change. DCF should already have the LOC on file unless the individual is an SSI recipient. The following is the procedure for SSI recipients:

  - Upon receipt of the 3007 from DCF, CARES staff will review the case to determine that the client has a current LOC for LTCC.

    If the client has a current LOC for LTCC, CARES staff will:

    o Indicate on the bottom of the 3007 form that the LOC is valid for ICP Medicaid,

    o sign and date the 3007 form,

    o make a copy of the 603 form, and

    o return the 603 and 3007 forms to DCF.

    If the client does not have a LOC for LTCC, CARES staff will:

    o Follow the regular procedures for assessing and determining LOC for ICP Medicaid.

Copies of the 2506A, 2515, and instructions are located on the CARES SharePoint site and in the appendices at the end of this handbook.
ANNUAL LOC RECERTIFICATIONS FOR THE LTC PROGRAM

Enrollees in the LTC Program receiving HCBS services must be re-assessed annually; enrollees residing and remaining in the NF are exempt from the annual level of care requirement. The managed care plans receive the LOC information and staffing date for each of their members on the Supplemental file from the EB. They are responsible for conducting the face-to-face reassessment using Assessment Form 701B.* The 701B must have been completed in the last 90 days. CARES is responsible for annual LOC recertifications. Following are procedures for annual recertifications.

*In 2015, AHCA allowed the LTC Plans to begin using the 701T to fulfill their contractual duty of completing an annual assessment on long-term nursing facility residents. However, if the LTC Plan is requesting an annual LOC from CARES, they must complete the assessment using a 701B.

NOTE: If the referral that is received is incomplete, a case should not be opened. The annual LOC recertification request should be returned to the LTC Plan and the information should be noted in the case notes of the previous closed case.

Nursing Facility Enrollees

- Enrollees who reside and remain in the nursing facility are exempt from the annual level of care recertification requirement.

- Enrollees who reside in the nursing facility for more than 12 months, then transition to the community (the LTC Plan should indicate when the enrollee was discharged from the NF):
  - Annual LOC recertification is due 12 months from the date of discharge.
  - A new 5000-3008 is required and must be submitted with the Annual request.
  - The managed care plan must submit the 701B and 5000-3008 to CARES 30 days prior to the anniversary date of discharge from the nursing facility.

- Enrollees who reside in the nursing facility for less than 12 months, then transition to the community:
  - Annual LOC recertification is due 12 months from the previous LOC.
  - New 5000-3008 is not needed (if the LOC has not expired and a significant change has not occurred).
- The managed care plan must submit the 701B no earlier than 60 days and no later than 30 days prior to the LOC certification date (Physician’s signature date on previous 603 Form).

**Note:** If the client is in the NF at the time of the Annual LOC recertification and the client has potential to return to the community, Program Recommendation remains MLTCC, Placement Recommendation remains Community with living arrangement nursing facility. If at the following Annual, the client is still in the NF, the Program Recommendation will be changed to MLTCN and the Placement Recommendation will be changed to Nursing Facility. No future Annuals are required.

- **COMMUNITY ENROLLEES**
  - Enrollees who reside and remain in the community:
    - Annual LOC recertification is due 12 months from the previous LOC.
    - New 5000-3008 is not needed (if the LOC has not expired and a significant change has not occurred).
    - The managed care plan must submit the 701B no earlier than 60 days and no later than 30 days prior to the LOC determination date (physician’s signature date on previous 603 Form).
  - Enrollees who reside in the community, enter the nursing facility for a short-term stay, then return to the community:
    - Annual LOC recertification is due 12 months from the previous LOC.
    - New 5000-3008 is not needed (if the LOC has not expired and a significant change has not occurred).
    - The managed care plan must submit the 701B no earlier than 60 days and no later than 30 days prior to the LOC certification date (Physician’s signature date on previous 603 Form).
  - Enrollees who reside in the community, then enter the nursing facility for a long-term stay:
    - Annual LOC recertification is due 12 months from the previous LOC.
    - New 5000-3008 is not needed (if the LOC has not expired and a significant change has not occurred).
    - The managed care plan must submit the 701B no earlier than 60 days and no later than 30 days prior to the LOC certification date (Physician’s signature date on previous 603 Form).
**Note**: Revise Program Recommendation to MLTCN and Placement Recommendation to Nursing Facility. If the client transitions out of the NF, the Annual LOC recertification will be due based on whether they have remained in the NF more than 12 months or less than 12 months. (More than 12 months, a new 5000-3008 is needed.)

**LTC PROGRAM ANNUAL LOC RECERTIFICATION SCHEDULE**

### NURSING FACILITY:

<table>
<thead>
<tr>
<th>SCENARIO</th>
<th>ANNUAL DUE DATE</th>
<th>NEED NEW 5000-3008?</th>
<th>COMMENTS</th>
<th>ADDITIONAL COMMENTS</th>
<th>LTC SUBMISSION DUE DATE TO CARES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Originally ICP (LTCN) remains in the NF</td>
<td>No Annual required</td>
<td>No</td>
<td></td>
<td></td>
<td>No submission required.</td>
</tr>
<tr>
<td>Originally ICP (LTCN) stays in the NF for more than 12 months, then transitions to community</td>
<td>12 months from the date of discharge</td>
<td>Yes</td>
<td></td>
<td></td>
<td>30 days prior to the anniversary date of discharge from the nursing facility.</td>
</tr>
<tr>
<td>Originally ICP (LTCN) stays in the NF for less than 12 months, transitions to the community</td>
<td>12 months from the initial LOC</td>
<td>No</td>
<td></td>
<td></td>
<td>No earlier than 60 days and no later than 30 days prior to the one year anniversary date of the previous Notification of Level of Care form.</td>
</tr>
</tbody>
</table>

### COMMUNITY:

<table>
<thead>
<tr>
<th>SCENARIO</th>
<th>ANNUAL DUE DATE</th>
<th>NEED NEW 5000-3008?</th>
<th>COMMENTS</th>
<th>ADDITIONAL COMMENTS</th>
<th>LTC SUBMISSION DUE DATE TO CARES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Originally community waiver (LTCC), remains in the community</td>
<td>12 months from the previous LOC</td>
<td>No</td>
<td></td>
<td></td>
<td>No earlier than 60 days and no later than 30 days prior to the one year anniversary date of the previous Notification of</td>
</tr>
</tbody>
</table>
### Level of Care form.

| Originally community waiver (LTCC), enters NF for a short term stay | 12 months from the previous LOC | No | If the client is in the NF at the time of the Annual and the client has potential to return to the community, Placement Recommendation remains community and Program Recommendation remains LTCC with living arrangement nursing home. PASRR procedures apply. | If at the following Annual, the client is still in the NF, the Placement recommendation will be changed to NUHO and the Program Recommendation will be changed to LTCN. No future Annuals are required. | No earlier than 60 days and no later than 30 days prior to the one year anniversary date of the previous Notification of Level of Care form. |
| Originally community waiver (LTCC), enters NH for long term stay | 12 months from the initial LOC | No | Revise Placement Recommendation to NUHO and Program Recommendation to LTCN. PASRR procedures apply | If the client transitions out of the NF, the Annual will be due based on whether they have remained in the NF more than 12 months or less than 12 months. (More than 12 months, a new 5000-3008 is needed.) | No earlier than 60 days and no later than 30 days prior to the one year anniversary date of the previous Notification of Level of Care form. |

### PASRR and Annual Recertifications

If the client is in a nursing facility at the time of the annual LOC recertification request, and a Level I is not already in CIRTS, CARES will request the Level I from the nursing facility and enter the Level I in CIRTS. If the Level I received from the nursing facility is incomplete or incorrect, CARES will remediate with the NF to ensure compliance with the PASRR rule.

If the client is currently in a community setting at the time of the annual recertification request, but had a nursing facility stay sometime within the last 12 months, and a Level I is not already in CIRTS, CARES will request the Level I from the nursing facility and enter the Level I in CIRTS. If CARES does not receive a Level I from the nursing facility, CARES staff will document the attempts they made to obtain the Level I in case notes and proceed with the annual LOC recertification.

**NOTE:** The LTC Plan is responsible for ensuring that PASRR is completed on LTC Program enrollees prior to nursing facility placement. The LTC Plan is not responsible
for providing the completed Level I PASRR screen to CARES. In the event that a LTC Program community enrollee transitions to a nursing facility and the annual LOC recertification is due, it is CARES responsibility to obtain the PASRR from the nursing facility.

**LTC LOC Recertifications Who Do Not Meet LOC Criteria**

After reviewing the documentation from the LTC Plan, if it appears that the client does not meet LOC criteria, CARES must schedule an on-site and complete a 701B assessment. Enter the CARES 701B assessment into CIRTS. Do not enter the LTC Plan’s assessment in CIRTS. CARES will also follow the No Level of Care procedures in Chapter 4. The following additional procedures are specific to the LTC Program:

Clients who have Title XIX (Title 19) MWA coverage code open on FMMIS

- On the “Does Not Meet LOC Criteria” 603, enter the DCF case number, if known.
- On the 2515, in section III., check the box for c) “will not be enrolled in the Medicaid waiver (HCBS).” Enter the reason, “Does Not Meet LOC Criteria,” on the line below box c).
- Fax the 603 and 2515 to DCF using fax number 866-873-0473.
- Document in CIRTS case notes that the 603 and 2515 were sent to DCF.
- Forward the client’s name and CIRTS ID or SSN number to the designated Central Office staff for tracking. After DCF closes the Medicaid Waiver case, CO will have the LOC terminated in Health Track to prevent the client from being re-enrolled Medicaid Pending in the waiver.

Clients who have SSI coverage code open in FMMIS

- After staffing the case “Does Not Meet LOC Criteria,” forward the client’s name and CIRTS ID or SSN number to the designated Central Office staff for tracking.

**Inappropriate Enrollments**

Individuals who were given an LTCN Program Recommendation that did not reside in the nursing facility for 60 consecutive days, and were not transitioned out of the facility by a LTC Plan, or individuals who were enrolled in the LTC Program who were not released from EMS, are considered inappropriate enrollments. These enrollments are usually discovered during a follow-up, or at annual recertification. When inappropriate enrollments are discovered, CARES must contact the individual and complete an on-site 701B assessment to determine if the individual continues to meet level of care. If the individual does not meet LOC, follow the No Level of Care procedures in Chapter 4, and the specific additional procedures above. If the individual continues to meet LOC, the CARES Physician Consultant must sign the 603. (A new 3008 is not required if the LOC has not expired.)
NOTE: If the inappropriate enrollment is discovered before enrollment occurs, contact the designated Central Office staff to facilitate canceling the LOC in Health Track.

AGING OUT LTC PROGRAM ENROLLMENT PROCEDURES

MMA Plans (including CMS Specialty Plan which is an MMA Plan) are required to cover nursing facility services for enrollees under the age of 18 years. In order to ensure a seamless transition to the LTC Program, MMA Plans are required to submit a referral to CARES for enrollees turning 18 who reside in nursing facilities. The referral must be sent to CARES six months prior to the enrollee turning the age of 18.

Individuals who are receiving skilled private duty nursing services must be transitioned to the LTC Program prior to their 21st birthday. MMA Plans are required to refer enrollees receiving private duty nursing services to CARES six months prior to the enrollee’s 21st birthday. These individuals do not have to complete the 701S screening and waitlist placement, but must meet all LTC financial and Level of Care eligibility requirements prior to enrollment.

Enrollment Steps

- The referral for LOC determination from the MMA Plan must contain a current AHCA 5000-3008 form, Informed Consent (AHCA MedServ 2040), and the following:
  - The most recent Department of Health Children’s Multidisciplinary Assessment Team (CMAT) or eQHealth Solutions staffing documentation and any other medical documentation necessary to justify the eligibility criteria for CARES review. Note that the 5000-3008 may not be signed by the CMAT staffing physician, physician assistant, or affiliated nurse practitioner; or
  - The most recent MMA Plan multidisciplinary team’s (MDT) staffing documentation and any other medical documentation necessary to justify the eligibility criteria for CARES review.

- Before setting up a case and scheduling an onsite appointment, CARES will confirm that the individual has an open MMA enrollment span in FMMIS, and that the individual is either in a skilled nursing facility or is receiving skilled private duty nursing services in the community.

- If the individual meets the above criteria and the referral packet is complete, CARES will contact the referring entity to notify them that contact will be made with the individual’s representative within three business days to schedule an onsite 701B assessment and complete the assessment within 15 business days.

- CARES staff will provide basic information to the individual’s representative on how enrollment in the LTC Program occurs.
• If determined to meet the LTC eligibility criteria, CARES will staff the Level of Care as appropriate and enter the appropriate program recommendation in CIRTS based on where the enrollee resides at the time of staffing: LTCC for Managed Long Term Care-Community or LTCN for Managed Long Term Care-Nursing Facility.

• If there is no enrollment span in FMMIS, or the individual is not receiving skilled private duty nursing services or resides in a skilled nursing facility, the referral will be returned, and the individual will be referred to the ADRC for waitlist prioritization. CARES staff will enter a case note in the “Information tab.”

NOTE: If there are questions on the validity of a referral, contact the RPS for routing to designated Central Office staff.

CLIENT MOVES TO ANOTHER PSA

Enrollees of the LTC Program who are relocating to another PSA in a different region should first work with their LTC Plan case manager to see if their current LTC Plan is also available in the new region. If their current plan is not available in the new region, the individual must be prepared to make a new LTC Plan choice upon moving. LTC Plans are required to cover out-of-region services for the short time period necessary for enrollees to update their new address on file with the eligibility systems and choose a new Plan in the new region.

Working with their case manager, upon moving, the member must contact either DCF or the Social Security Administration (whichever agency is the source of their financial eligibility) to notify them of the date of the move and the new address. Once corrected at the source, this information will be transmitted nightly to AHCA’s Medicaid system, FMMIS, and then to the Enrollment Broker’s system, Health Track, the following day. Once Health Track is updated, the Enrollment Broker will provide them with their choices in the new PSA and they will be allowed to make a plan choice to be effective the following month. At the point CARES receives an Annual request on this client in the new PSA, the case transfer procedures outlined in Chapter 4 – General Operations, Case Transfers should be followed.

Special Note: If a CARES Office receives an Annual recertification request for an enrollee who has been placed in a nursing facility for long-term care in another PSA, the CARES office that receives the request will process the Annual and close the case. If the enrollee is subsequently able to transition to the community, the next Annual would be due based on the length of time they resided in the facility and would be completed by the Cares office where the enrollee resides. (See Annual LOC Recertification Schedule above.)
**Voluntary Disenrollment**

Individuals in the community that are enrolled in the LTC Program may voluntarily disenroll from the program at any time. When the individual telephones the enrollment broker, the enrollment broker will record the individual’s choice to disenroll. The request then gets forwarded to the DOEA Inbox in Health Track. The DOEA Inbox is checked daily by a staff member of the LTCS Bureau. When a disenrollment request is received, the LTCS staff member contacts the individual to ensure that he/she understands the consequences of disenrolling from the LTC Program. Once the contact with the individual has been made, the LTCS staff member approves or disapproves the disenrollment, as appropriate.

LTC Program enrollees who reside in nursing facilities may not disenroll.

**Involuntary Disenrollment**

Individuals who lose Medicaid eligibility will remain enrolled with their LTC Plan for sixty days following the loss of financial eligibility. This period of enrollment is called SIXT and allows the individual to continue receiving services while Medicaid eligibility is being re-established. If the individual does not regain Medicaid eligibility within the 60 days, the individual will be involuntarily disenrolled. If the individual contacts the ADRC to re-enroll in the LTC Program, the procedures contained in the most current Enrollment Management System Procedures Manual will be followed. A copy of this manual can be found on the CARES SharePoint site.

**CIRTS Coding**

**Assignment**

| Referral Source | Initial EMS Release = ADRC
| Annual LOC Recertification = Managed Care Organization |
| Living Arrangement | PRRE = Private Residence
| AFCH = Adult Family Care Home
| ALFS = Assisted Living Facility,
| NF = Nursing Facility |
| Living Situation | Set as appropriate |
| Special Project Case | N = None |
| Provider Name | Set as appropriate |
| Primary Caregiver | Set as appropriate |
### ASSESSMENT

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor</td>
<td>Set as appropriate: Initial = CARES</td>
</tr>
<tr>
<td></td>
<td>Annual Recertification = MCO</td>
</tr>
<tr>
<td>Living Arrangement</td>
<td>PRRE = Private Residence</td>
</tr>
<tr>
<td></td>
<td>AFCH = Adult Family Care Home</td>
</tr>
<tr>
<td></td>
<td>ALFS = Assisted Living Facility</td>
</tr>
<tr>
<td></td>
<td>NF = Nursing Facility</td>
</tr>
<tr>
<td>Special Project Case</td>
<td>N = None</td>
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<tr>
<td>Provider Name</td>
<td>Set as appropriate</td>
</tr>
<tr>
<td>Waiver Recertification</td>
<td>N if initial certification</td>
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<td>Y if annual</td>
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<tr>
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<tr>
<td>Assessment Type</td>
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</tr>
<tr>
<td>Living Situation</td>
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</table>

### STAFFING

<table>
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<tr>
<th>Description</th>
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<tr>
<td>Staffing Instrument</td>
<td>U = 5000-3008</td>
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<tr>
<td>Living Arrangement</td>
<td>PRRE = Private Residence</td>
</tr>
<tr>
<td></td>
<td>AFCH = Adult Family Care Home</td>
</tr>
<tr>
<td></td>
<td>ALFS = Assisted Living Facility</td>
</tr>
<tr>
<td></td>
<td>NF = Nursing Facility</td>
</tr>
<tr>
<td>Living Situation</td>
<td>Set as appropriate</td>
</tr>
<tr>
<td>Placement Recommendation</td>
<td>Set as appropriate</td>
</tr>
<tr>
<td>Program Considered</td>
<td>MLTCC or MLTCN</td>
</tr>
<tr>
<td>Program Recommendation</td>
<td>MLTCC or MLTCN</td>
</tr>
<tr>
<td>Primary Caregiver</td>
<td>Set as appropriate</td>
</tr>
<tr>
<td>Level of Care</td>
<td>INO = Intermediate One</td>
</tr>
<tr>
<td></td>
<td>INT = Intermediate Two</td>
</tr>
<tr>
<td></td>
<td>SKD = Skilled</td>
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</tbody>
</table>

### FOLLOW-UP

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
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<tbody>
<tr>
<td>Living Arrangement</td>
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<td></td>
<td>AFCH = Adult Family Care Home</td>
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<td>ALFS = Assisted Living Facility</td>
</tr>
<tr>
<td></td>
<td>NF = Nursing Facility</td>
</tr>
<tr>
<td>Living Situation</td>
<td>As appropriate</td>
</tr>
<tr>
<td>Primary Caregiver</td>
<td>As appropriate</td>
</tr>
<tr>
<td>Placement Recommendation</td>
<td>Set as appropriate</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Program Recommendation</td>
<td>MLTCC or MLTCN</td>
</tr>
</tbody>
</table>
| Living Arrangement       | PRRE = Private Residence  
                          | AFCH = Adult Family Care Home  
                          | ALFS = Assisted Living Facility  
                          | NF = Nursing Facility |
| Living Situation         | As appropriate |
| Follow up Site           | OFFC = Office |
| Primary Caregiver        | As appropriate |

**ADRC Intake Inboxes**

<table>
<thead>
<tr>
<th>PSA</th>
<th>Email Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><a href="mailto:adr1_intake@nwflaaa.org">adr1_intake@nwflaaa.org</a></td>
</tr>
<tr>
<td>2</td>
<td><a href="mailto:psa2adrcentake@aaaf.org">psa2adrcentake@aaaf.org</a></td>
</tr>
<tr>
<td>3</td>
<td><a href="mailto:PSA3_CARES@agingresources.org">PSA3_CARES@agingresources.org</a></td>
</tr>
<tr>
<td>4</td>
<td><a href="mailto:PSA4_ADRC_intake@myeldersource.org">PSA4_ADRC_intake@myeldersource.org</a></td>
</tr>
<tr>
<td>5</td>
<td><a href="mailto:psa5-intake@aaapp.org">psa5-intake@aaapp.org</a></td>
</tr>
<tr>
<td>6</td>
<td><a href="mailto:cares@agingflorida.com">cares@agingflorida.com</a></td>
</tr>
<tr>
<td>7</td>
<td><a href="mailto:ADRC@sraflorida.org">ADRC@sraflorida.org</a></td>
</tr>
<tr>
<td>8</td>
<td><a href="mailto:client.services.fax@srchoices.org">client.services.fax@srchoices.org</a></td>
</tr>
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<td>9</td>
<td><a href="mailto:eFaxIntakeCares@YourADRC.org">eFaxIntakeCares@YourADRC.org</a></td>
</tr>
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<td>10</td>
<td><a href="mailto:psa10triage@adrcbroward.org">psa10triage@adrcbroward.org</a></td>
</tr>
<tr>
<td>11</td>
<td><a href="mailto:adrc@allianceforaging.org">adrc@allianceforaging.org</a></td>
</tr>
</tbody>
</table>
(This page intentionally left blank.)
# Client Referral/Change

## Case #: 

<table>
<thead>
<tr>
<th>TO: Dept. of Children &amp; Families</th>
<th>FROM: (Facility Name or Managed Care Plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Fax #: __________________</td>
<td>Contact Name: __________________________</td>
</tr>
<tr>
<td>Date: ________________________</td>
<td>Telephone: ____________________________</td>
</tr>
<tr>
<td></td>
<td>Nursing Facility: __________________</td>
</tr>
<tr>
<td></td>
<td>Address: ______________________________</td>
</tr>
</tbody>
</table>

## Section A: Resident’s Information
- Resident’s name: __________________
- SSN: __________________
- Date of Birth: __________________
- Medicaid ID #: __________________

## Section A.1: Representatives Information
- Representative: __________________
- Address: ________________________
- Telephone #: ____________________
- Relationship: ____________________

## Section B: This section will be completed by the nursing facility or Managed Care Plan to refer a resident who does not have Institutional Care (MI) Medicaid in FLMMS.

- Is the individual an SSI Direct Enrollee? □ Yes □ No
- Active Aid Category/Coverage Group: __________________

- The resident was admitted to the above referenced facility on: __________________
- From: □ Hospital □ Home □ ALF

- Prior Residential Address: __________________

## Section C: This section will be completed by the nursing facility or Managed Care Plan to report a resident enrolled in a Long-Term Care (LTC) Managed Care Plan was discharged from a nursing facility.

- RESIDENT DISCHARGED/TRANSFERRED FROM THE FACILITY ON: __________________
  - TO: □ ALF □ Home □ Hospital □ Nursing Home □ Other (specify): __________________
  - Address: __________________
  - □ Due to Death on: __________________

## Section D: This section will be completed by the Managed Care Plan to notify DCF when a nursing home resident has enrolled in the Long Term Care Managed Care Plan.

- □ The above named resident has enrolled in a managed care plan. Effective date: __________________
- □ The above named resident has changed managed care plans. Effective date: __________________

- Managed Care Plan: __________________
- MCP Contact Person Information:
  - Name: __________________
  - Address: __________________
  - Telephone #: __________________
  - Email Address: __________________
# Client Referral/Change Form

**CF-ES 2506A, 06/2014**

Instructions for Medicaid LTC Program

**Purpose:**
This form is used by Medicaid Nursing Facilities (NF) or Medicaid Long-Term Care (LTC) managed care plans to communicate with the Department of Children and Families (DCF) regarding individuals seeking nursing facility services or requesting a change to their Medicaid eligibility file. It should be used by the entities designated below for the following situations:

<table>
<thead>
<tr>
<th>Event</th>
<th>Responsible Party</th>
<th>Completing Form</th>
</tr>
</thead>
</table>
| **Initial Eligibility:**  
A resident needs Institutional Care Program (ICP) Medicaid | Nursing Facility | Complete Sections: Header, Top Left, Top Right, A, A.1, B. |
| **Initial LTC Plan enrollment:**  
An LTC Program NF recipient has selected their first LTC plan, is now enrolled, and the LTC Plan needs to be listed as the case manager on record. | Medicaid LTC Plan or LTC plan case manager | Complete Sections: Header, Top Left, Top Right, A, A.1, D. |
| **Change in LTC Plans:**  
An LTC Program NF recipient changes LTC Plans and the new LTC Plan needs to be listed as the case manager on record. | New Medicaid LTC Plan or LTC plan case manager | Complete Sections: Header, Top Left, Top Right, A, A.1, D. |
| **Community LTC Program enrollee moves to a NF:**  
An individual residing in the community with Medicaid waiver eligibility (aid category code is MW A) and enrolled with a Medicaid LTC Plan is moving into a NF and will be receiving NF services. | Medicaid LTC Plan or LTC plan case manager | Complete Sections: Header, Top Left, Top Right, A, A.1, B. |
| **Recipient Deceased:**  
An individual enrolled with an LTC plan a NF member is now deceased. | Medicaid LTC Plan, LTC plan case manager, or NF | Complete Sections: Header, Top Left, Top Right, A, A.1, C. |
| **Recipient Transfer/Move:**  
An individual residing in a NF and enrolled with an LTC plan is transferred/moves to another NF and the correct NF information must be updated. If the new location is a nursing facility, the 2515 form should NOT be used. Instead, the 2506A form should be completed and submitted to DCF. | Medicaid LTC Plan or LTC plan case manager | Complete Sections: Header, Top Left, Top Right, A, A.1, C. |
| **Recipient Discharge:**  
An individual residing in a NF and enrolled with an LTC Plan is discharged from the facility. If the discharge is to the community (ALF or private residence), and the individual will be receiving home and community based waiver services, the 2506A form should NOT be used. Instead, the 2515 form should be completed by the LTC Plan or LTC Plan case manager and submitted to DCF. | TBD – will not be the Medicaid LTC Plan or LTC plan case manager | Complete Sections: Header, Top Left, Top Right, A, A.1, C. |
## Client Referral/Change Form

**CF-ES 2506A, 06/2014**

**Instructions for Medicaid LTC Program**

### Section by Section Instructions

#### Header Section:

| Case # | For those residents who are already known to DCF’s system, enter the resident’s DCF assigned Case Number. Note: this is not the resident’s 10-digit Medicaid ID number. |

#### Top Left Section:

| Local Fax # | Enter the DCF local fax number used to fax the form. DCF local fax numbers can be located on the DCF website at the following link: http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/locate-service-center-your-area |
| Date | Enter the date the form is being submitted/faxed to DCF. |

#### Top Right Section:

| From | Enter the name of the entity that is submitting the form. This can either be the nursing facility in which the individual is residing or the Medicaid LTC managed care plan in which the resident is enrolled. |
| Contact Name | Enter the person’s name, telephone number, and email address at either the nursing facility or the Medicaid LTC managed care plan who can answer any questions regarding the form’s submission. |
| Telephone # | |
| Nursing Facility Address | Enter the full address of the nursing facility where the individual is residing. |

#### Section A: Resident’s Information

| Resident’s name | Enter the resident’s demographic information including full name, social security number, date of birth, and Medicaid identification number (if known). |
| SSN | |
| Date of Birth | |
| Medicaid ID# | |

#### Section A1: Representative Information

| Representative Address | If the resident has an authorized representative, enter their name, full address, telephone number, and their relationship to the resident. This allows DCF to notify the representative regarding any activity on the resident’s case. |
| Telephone # | |
| Relationship | |

#### Section B:

This section should only be used if the resident does not have active Institutional Care Program (ICP) Medicaid eligibility verified on the Florida Medicaid Management Information System (FMMIS). ICP Medicaid eligibility categories are designated by codes beginning with ‘MI’.

| Is the individual an SSI Direct Enrollee? | Check the ‘Yes’ box if the resident currently has verified SSI Medicaid eligibility; this eligibility is designated by the code ‘MS’. |
Section C:

This section should be completed to report a resident’s discharge or transfer when the resident is enrolled in a Medicaid LTC managed care plan. It should NOT be used if the resident is enrolled in a Medicaid LTC plan and will be receiving home and community-based waiver services upon discharge. In those instances, the LTC Plan must submit the 2515 form to DCF.

<table>
<thead>
<tr>
<th>Active Aid Category/Coverage Group</th>
<th>If the resident has verified Medicaid eligibility that is NOT 'MS', enter the aid category code.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The resident was admitted to the above referenced facility on</td>
<td>Enter the nursing facility admit date.</td>
</tr>
<tr>
<td>From</td>
<td>Check the appropriate box (Hospital, Home, ALF) where the resident was located prior to being admitted to the nursing facility.</td>
</tr>
<tr>
<td>Prior Residential Address</td>
<td>Enter the full address where the resident was residing prior to being admitted to the nursing facility.</td>
</tr>
</tbody>
</table>

| Resident Discharged/Transferred from the facility on | Enter the date the resident left the facility. |
| To | Check the appropriate box (ALF, Home, Hospital, Nursing Home, Other) where the resident was going upon discharge/transfer. If 'Other' is checked, please specify the location. Enter the full address for the ALF, Home, Hospital, or Other location. |
| Due to Death on | If the resident was discharged due to death, enter the date of death. |

Section D:

This section should be completed by the resident’s Medicaid LTC Plan to notify DCF when a nursing facility resident has enrolled in the Long Term Care Managed Care Program. This section should also be used by the new Medicaid LTC Plan to notify DCF if the resident changes LTC Plans at a later date. This information allows the LTC plan/provider to be copied on DCF notices sent to the resident.

| The above named resident has enrolled in a managed care plan. Effective date | The LTC plan or its designee should check this box and enter the effective date when the resident is initially enrolled in the LTC Program with their plan. |
| The above named resident has changed managed care plans. Effective date | The new LTC plan or its designee should check this box when the resident was previously enrolled with a Medicaid LTC plan and has now changed plans. Enter the effective date of enrollment with the new LTC plan. |

| Managed Care Plan: | Enter the name of the Medicaid LTC plan and contact information for the managed care plan in which the resident initially becomes enrolled or in which the resident becomes enrolled after a change, whichever is appropriate. Include the contact’s name, full address, telephone number, and email address. |
| MCP Contact Person Information | Name |
| Address |
| Telephone # |
| Email Address |
CERTIFICATION OF ENROLLMENT STATUS
HOME AND COMMUNITY BASED SERVICES (HCBS)

I. Department of Children & Families
Economic Self-Sufficiency Services

II. RE:

Name of Applicant/Recipient

Client Social Security Number

Designated Representative

III. This certifies that the above named applicant/recipient:

a) □ was enrolled in the Medicaid waiver (HCBS) on ____________.

b) □ (For SMMC Long-Term Care waiver only) Level of Care effective date: ____________

(State Medicaid Managed Care)

   Level of Care (check one): □ Skilled □ Intermediate I □ Intermediate II

c) □ will not be enrolled in the Medicaid waiver (HCBS). (Enter reason below.)

d) □ has a change in living arrangement. (Complete next page.)

e) □ was disenrolled from the Medicaid waiver (HCBS) on ____________.

IV. Case Management Agency: __________________________________________

Waiver Program: ______________________________________________________

Mailing Address: ______________________________________________________

Telephone Number (include area code): _________________________________

V. If the above named applicant/recipient is enrolled in waiver services, you must report any
changes to DCF/Economic Self-Sufficiency Services staff immediately.

VI. □ Certified By:

   Case Manager’s Name (Print) ________________________________
   Case Manager’s Signature
   Date ________________

CF-ES 2015, PDF 05/2013

Page 1
CHANGE IN HCBS RECIPIENT’S LIVING ARRANGEMENT UPDATE INFORMATION

VII. LIVING ARRANGEMENT INFORMATION:
   a) Current address: ____________________________
   b) New address: ____________________________
   c) Effective date of new address: ____________
   d) Note type of living arrangement (e.g., nursing home, hospital, living with relatives, etc.): ________________

NOTE: Do not complete the following sections unless the above change in the HCBS recipient’s address results in a change in DCF circuit/county or in the Case Management Agency.

VIII. CASE MANAGER COORDINATION CHECKLIST:
   a) Has the current DCF eligibility specialist been notified? □ NO □ YES (Date): ____________
   b) Has the new DCF (circuit/county) eligibility specialist been contacted? □ NO □ YES
      If yes, date: ____________

IX. CHANGE IN CASE MANAGER INFORMATION:
   a) □ Recipient transferred to another Medicaid waiver Case Manager on (date) ____________.
   b) □ New form CF-ES 2515 has been completed by the new Case Manager and forwarded to
      the new DCF Economic Self-Sufficiency Specialist’s address.

X. NEW CASE MANAGER INFORMATION:
   Case Management Agency: ____________________________
   Contact Person: ____________________________
   Mailing Address: ____________________________
   Telephone Number (include area code): ____________________________
CERTIFICATION OF ENROLLMENT STATUS
HOME AND COMMUNITY BASED SERVICES (HCBS)
CF-ES 2515, 06/2014
Instructions for Medicaid LTC Program

Purpose:
This form is used to communicate with the Department of Children and Families (DCF) regarding home and community-based services (HCBS) waiver recipients. While the form is used by several Medicaid waiver providers, these instructions are specific to the Medicaid Managed Care Long-Term Care (LTC) Program waiver only. This form should be used by the entities designated below for the following situations:

<table>
<thead>
<tr>
<th>Event</th>
<th>Responsible Party</th>
<th>Completing Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Eligibility:</td>
<td>Aging and Disability Resource Centers (ADRCs)</td>
<td>Check “Application” and complete Sections II., III. a) and b), IV., VI., and VII. c) (if appropriate)</td>
</tr>
<tr>
<td>Initial LTC Plan enrollment:</td>
<td>Medicaid LTC Plan or LTC plan case manager</td>
<td>Check “Change” and complete Sections II., IV., VI., and IX.</td>
</tr>
<tr>
<td>Change in LTC Plans:</td>
<td>New Medicaid LTC Plan or LTC plan case manager</td>
<td>Check “Change” and complete Sections II., IV., VI., and IX.</td>
</tr>
<tr>
<td>Nursing Facility Transition:</td>
<td>Medicaid LTC Plan or LTC plan case manager</td>
<td>Check “Change” and complete sections II., III. d), IV., VI., and VII.</td>
</tr>
<tr>
<td>Recipient Deceased:</td>
<td>Medicaid LTC Plan or LTC plan case manager</td>
<td>Check “Change” and complete sections II., III. f), IV., and VI.</td>
</tr>
<tr>
<td>Recipient Move</td>
<td>Medicaid LTC Plan or LTC plan case manager</td>
<td>Check “Change” and complete sections II., III. d), IV., VI., and VII.</td>
</tr>
<tr>
<td>Disenrollment:</td>
<td>TBD – will not be the Medicaid LTC Plan or LTC plan case manager</td>
<td></td>
</tr>
</tbody>
</table>

Page 1 of 3
### Header Section:

| Application | Check this box when the information contained on the form is for an individual applying for Medicaid HCBS waiver eligibility, if the individual already has existing Medicaid (other than SSI coverage, i.e., MS aid category code), select the “change” box. |
| Change | Check this box when the information contained on the form is for an individual already receiving HCBS eligibility or already receiving another form of Medicaid eligibility (other than SSI) and needs to change to HCBS eligibility. |

### Section II.

| Name of Applicant/Recipient | Enter the full name of the individual for whom the request is being made, their social security number, and, if appropriate, their designated/authorized representative. |
| Client Social Security Number |
| Designated Representative |

### Section III.

Check the appropriate box for either a), b), c), d), e) or f)

| a) was enrolled in the Medicaid (HCBS) waiver on | Enter the date the applicant was initially authorized to be enrolled in the LTC Program waiver. This information should be completed by the ADRC only. |
| b) Level of Care effective date: | Check the appropriate Level of Care box (Skilled, Intermediate I, Intermediate II) and enter the Level of Care effective date. This information should be completed by the ADRC only. |
| c) will not be enrolled in the Medicaid HCBS waiver | If the individual filed an application with DCF to receive HCBS but will not be enrolled in the waiver, enter the reason why. For the LTC Program, this item should only be completed by the ADRC or CARES staff. |
| d) has a change in living arrangement | If there has been any change in the individual’s living arrangement, this box must be checked and the accompanying information in Section VII., must also be completed in its entirety. |
| e) was disenrolled from the Medicaid waiver (HCBS) on: | This section should never be completed by the LTC Plan/case manager. |
| f) died on | Enter the date of death for the individual. |

### Section IV.

| Case Management Agency | For the LTC Program, enter either the ADRC’s agency name or the LTC Plan’s name. This information will be included in the individual’s record in order to receive future eligibility notices. |
| Waiver Program | Enter SMMC LTC Program |
| Mailing Address | Enter either the corresponding ADRC full address or LTC Plan’s full address in order to receive copies of the eligibility notices. |
| Telephone Number (include area code) | Enter either the ADRC’s phone number or the LTC Plan’s phone number. |
### Section VI.

| Certified By: | The individual completing the form at the ADRC or the LTC Plan must print their name, sign, and date the form prior to submitting the document to DCF. This individual should be knowledgeable to answer any questions regarding the submitted form. |
| Case Manager’s Name (print) |  |
| Case Manager’s Signature |  |
| Date |  |

### Section VII. LIVING ARRANGEMENT INFORMATION:

| a) Previous address: | Enter the full address for where the individual was living prior to the change being reported. This applies to Nursing facility transitions as well as community moves. |
| b) New address: | Enter the full address for where the individual is now residing. |
| c) Effective date of new address: | Enter the actual date when the individual moved. |
| d) Note type of living arrangement | Indicate whether or not the individual is now living in the community, has moved into an Assisted Living Facility (ALF), etc. If the individual has moved into a nursing facility and will need ICP Medicaid, STOP. Do not use this form. Submit the 2506A form to DCF. |
| e) For ALFs only: Usual and Customary Room and Board Rate documentation provided: | In order to appropriately calculate the individual’s patient responsibility amount and complete the financial eligibility, documentation of the ALF’s usual and customary room and board rate is required. |

The assisted living facility (ALF) statement must provide the following information on the ALF’s letterhead:
1. ALF’s name, address, and telephone number;
2. Date letter was completed;
3. Resident’s first and last names;
4. Date resident placed in the ALF;
5. A statement that: “The usual and customary charge for a semi-private room and 3 meals in _______ (name of ALF) is currently $________ per day, or $________ per month.”;
6. Printed name and signature of person with ALF that is providing the information; and
7. Printed title of person with ALF that is providing the information.

Submitting this documentation with the 2515 form alerting DCF of this living arrangement will expedite processing and prevent the change request or application from pending for this documentation.

### Section VIII. CASE MANAGER COORDINATION CHECKLIST:

| Has a current DCF eligibility specialist been notified? | This section should only be used to alert DCF that the 2515 is a resubmission from a prior request. If known that the current submission of the form is a resubmission for the same event, check yes. If not, check no. |
| No/Yes |  |
| Date |  |

### Section IX. NEW CASE MANAGER INFORMATION:

| Recipient transferred to another Medicaid waiver Case Manager on (date): | For the LTC Program, when an individual first becomes enrolled with a Medicaid managed care LTC Plan and if/when the individual changes LTC Plans, the new LTC Plan should complete this section. Enter the new LTC Plan’s name, the name of the assigned contact who can answer any questions regarding the individual’s enrollment into the plan/waiver, the LTC Plan’s full mailing address, and telephone number where the contact person can be reached. |
CHAPTER 7
~ ADDITIONAL MEDICAID WAIVERS AND PROGRAMS ~

INTRODUCTION

This chapter provides general program information, eligibility criteria, and services provided, for additional Medicaid Waivers and programs in which CARES is responsible for determining initial and annual waiver recertification. The chapter also contains the specific CARES policies and procedures for determining Level of Care, annual recertification, CIRTS Coding, and follow-ups for these various programs.

BACKGROUND

The Social Security Act authorizes multiple waiver and demonstration authorities to allow states the flexibility to offer home and community-based Medicaid Waiver programs as an alternative to nursing facility placement. Each authority has a distinct purpose and distinct requirements. Florida Medicaid has used these waiver authorities, either singly or in combination, to develop and implement various programs. Below is a listing and brief description of the different waiver types.

SECTION 1115 RESEARCH AND DEMONSTRATION PROJECTS: This section provides the Secretary of Health and Human Services broad authority to approve projects that test policy innovation likely to further the objectives of the Medicaid program. Generally, a waiver is approved for a five-year period, subject to annual review. These waivers permit a state to further the purposes of Title XIX “to make more adequate provisions for aged persons, blind persons, dependent and crippled children, maternal and child welfare, and public health….”

SECTION 1915(b) MANAGED CARE/FREEDOM OF CHOICE WAIVERS: Section 1915(b) of the Social Security Act authorizes the Secretary of Health and Human Services to waive compliance with certain portions of the Medicaid statute that prevent a state from mandating that Medicaid beneficiaries obtain their care from a single provider or health plan. These waivers must be approved by the Centers for Medicare & Medicaid Services (CMS) and are good for two-year periods.

SECTION 1915(c) HOME AND COMMUNITY-BASED SERVICES WAIVERS: This section provides the Secretary of Health and Human Services authority to waive Medicaid provisions in order to allow long-term care services to be delivered in settings other than institutions. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings (such as hospital, nursing facility or Intermediate Care Facility). These waivers are good for three years; after which they may be renewed every five years.

SECTION 1915 (b) AND (c) COMBINATION WAIVERS: In the last decade some states have become interested in providing long-term care services in a managed care setting.
Previously, this could not be done since section 1915(b) waivers do not accommodate special eligibility populations targeted by 1915(c) waivers for Medicaid. In addition, standard 1915(c) waivers do not allow states to limit the pool of eligible providers. As a result, certain states have opted to seek authority from CMS for both 1915 (b) and (c) waivers simultaneously, called “combination proposals” to provide a continuum of services to the elderly and/or disabled populations.

ANNUAL WAIVER RECERTIFICATIONS

Federal regulations require that Level of Care must be determined by CARES at least annually for home and community-based waiver programs. Along with the LTC Program, the following programs fall under this requirement:

- Adult Cystic Fibrosis Waiver,
- Familial Dysautonomia Waiver,
- Project AIDS Care Waiver,
- Program of All-Inclusive Care for the Elderly, and
- Traumatic Brain and Spinal Injury Cord Program.

- Annual Level of Care recertifications must be completed within one year of the approval date entered on the most recent 603 form.
- A Level of Care recertification may be needed sooner if there is reason to believe significant changes have occurred in the client’s condition.
- If the Level of Care is determined within the one-year time frame and a significant change has not occurred, a new physician certification is not needed.
- If the one-year time frame is exceeded, a new physician certification (AHCA 5000-3008 form, or equivalent forms for specific Medicaid waivers) is required. Following are the physician certification forms required for each waiver.

  - **Adult Cystic Fibrosis:** Adult Cystic Fibrosis Medicaid Waiver Program Physician Referral and Request for Level of Care Determination
  - **Familial Dysautonomia:** Physician Referral and Diagnosis Confirmation to Determine Level of Care Familial Dysautonomia Waiver (FD 1 Form)
  - **Project AIDS Care:** PAC Waiver Physician Referral and Request for Level of Care Determination (DOEA-CARES Form 607)
  - **Traumatic Brain Injury and Spinal Cord Injury Program:** Traumatic Brain Injury and Spinal Cord Injury Program BSCIP Request for Level of Care
• It is the responsibility of the client’s case manager to track Level of Care recertifications to ensure they are conducted at least annually. It is also the responsibility of the case manager to get an updated physician certification if the one-year time frame is exceeded or when significant changes have occurred in the client’s condition.

  ▪ With the exception of PACE, requests for annual Level of Care recertifications for the Medicaid Waivers covered in this chapter, must be received by CARES within two to four weeks of the approval date of the previously completed 603 form.

  ▪ PACE annual recertification requests must be received by CARES no earlier than 60 days, and no later than 30 days prior to the LOC determination date (physician’s signature date on previous 603 Form).

  ▪ The assessment for Medicaid Waivers and PACE must have been completed within the previous 90 days.

**NOTE on Eligibility Criteria:** CARES is responsible for determining LOC. CARES is not responsible for verifying Medicaid or disability eligibility.
ADULT CYSTIC FIBROSIS WAIVER

Cystic Fibrosis is a life-threatening genetic disease that causes mucous to build up and clog some organs in the body leading to problems in the lungs and digestive system. This specific 1915(c) Medicaid Waiver is tailored to meet the needs of adult individuals who have a diagnosis of Cystic Fibrosis and are at risk of requiring medical care without which, the individual would be at risk for hospitalization. There must also be a reasonable expectation that with the provision of appropriate services and supports, the person can remain or return to a community-based setting, and function independently.

Referrals to this program may be self-referrals, from family members, or any health care professional. All referrals should use the number for the BSCIP Central Registry which is 1-800-342-0778 or individuals can apply through DOH’s website at http://www.floridahealth.gov/diseases-and-conditions/adult-cystic-fibrosis/index.html.

ELIGIBILITY CRITERIA

The following criteria must be met in order for an individual to be eligible for the Adult Cystic Fibrosis waiver:

- Reside in a community setting;
- Be age 18 or older;
- Be registered with the BSCIP Central Registry;
- Meet financial eligibility requirements for the waiver;
- If under age 65, meet federal disability criteria as determined by the Social Security Administration;
- Be at risk of hospitalization;
- Have a diagnosis of cystic fibrosis; and
- Demonstrate a need for services provided under the waiver.

SERVICES PROVIDED

Waiver services include the following:

- Chore
- Community Support Coordination
- Counseling, Individual and Family
- Dental Services
- Home-Delivered Meals
- Homemaker
• Massage Therapy
• Nutritional Supplements
• Personal Care
• Personal Emergency Response (Initial Installation)
• Personal Emergency Response System Maintenance and Monitoring
• Physical Therapy Evaluation
• Physical Therapy
• Prescribed Drugs
• Respiratory Therapy
• Respite Care
• Skilled Nursing
• Specialized Medical Equipment and Supplies

LEVEL OF CARE

Referrals come from the Department of Health. A medical case file review is completed for this waiver. The following items are required from the case management agency to determine a Level of Care:

• Summary Cover/Demographic Information Sheet
• DOEA Form 701B Comprehensive Assessment
• Physician Referral and Request for Level of Care Determination (AHCA Form)
• Informed Consent Form (AHCA MEDSERV–2040) (Required for initial LOC; not required for annual recertification.)

LEVEL OF CARE FORM (603) WILL BE COMPLETED AS FOLLOWS:

• Level of Care: Risk of Hospitalization
• Program Recommendation: Cystic Fibrosis
• Placement Recommendation: Community

CARES CASE FILE

The CARES hard copy case file will contain the following:

• Notification of Level of Care (DOEACARES Form 603)
• Physician Referral and Request for Level of Care Determination (AHCA Form)
• Informed Consent Form (AHCA MEDSERV–2040)
### CIRTS Coding

#### Assignment

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#### Assessment

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<td>Special Project Case</td>
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<td>Provider Name</td>
<td>Set appropriate</td>
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| Waiver Recertification | N if initial certification  
                      Y if annual |
| Assessment Site | OFFC = Office |
| Assessment Type | 701B |
| Primary Caregiver | Set as appropriate |
| Living Situation | Set as appropriate |

#### Staffing

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<tr>
<td>Level of Care</td>
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</table>

### Follow-up Schedule

CARES will close the case at staffing. No follow-up is required.
## Adult Cystic Fibrosis Medicaid Waiver Program

**Physician Referral and Request for Level of Care Determination**

Please complete all items. If non-applicable please enter 'NA'. Attach extra sheets as necessary.

### Diagnosis

- Cystic Fibrosis: [ ] YES  [ ] NO

### Diagnosis Code(s)

Other medical diagnoses and ICD-9 codes

### Date of most recent Pulmonary Function Test

FEV1%: 

### Condition

<table>
<thead>
<tr>
<th>All body systems (vision and hearing, respiratory, gastrointestinal, genitourinary, cardiovascular, musculoskeletal, and neurological) have been reviewed, and specific physical findings are listed.</th>
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<tr>
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<tr>
<td>Respiratory</td>
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<tr>
<td>Digestive</td>
</tr>
<tr>
<td>Sinus</td>
</tr>
<tr>
<td>CF Related Diabetes (CFRD)</td>
</tr>
<tr>
<td>Transplant</td>
</tr>
<tr>
<td>Other</td>
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</tbody>
</table>

### Physician Checklist

**Can the patient perform the following activities?**

- Running, heavy lifting, yard work
- Pushing a vacuum, household chores
- Carrying or lifting groceries
- Participate in health club regime
- Use household chemicals

### Recommended CF Treatments / Comments

<table>
<thead>
<tr>
<th>Airway Clearance</th>
<th>IV Fluids</th>
<th>Dialysis</th>
<th>Physical Therapy</th>
<th>Occupational Therapy</th>
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<tbody>
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<td>Tube Feedings</td>
<td>Oxygen (how often?)</td>
<td>Other,</td>
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<tr>
<td>IV Medications</td>
<td>Other,</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Social Services and Activities Needed

- Yes  [ ] No  [ ]

### Type of service:

Based on the patient’s medical history and condition, I certify that this patient is disabled, and I believe there is reasonable indication that this patient might require hospitalization in the absence of home and community-based services provided through the Adult Cystic Fibrosis Program and the Medicaid Waiver program.

**Physician’s Signature:** __________________________ ________________ **Date:** 

**Physician’s Name:** __________________________ **License #:** 

**Address:** __________________________ **Telephone #:** (____) 

**EFFECTIVE DATE for Level of Care at Risk of Hospitalization:** 

AHCA May 07

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FAMILIAL DYSAUTONOMIA WAIVER

Familial Dysautonomia is a genetic disorder that affects the development and survival of certain nerve cells. The disorder disturbs cells in the autonomic nervous system, which controls involuntary actions such as digestion, breathing, production of tears, and the regulation of blood pressure and body temperature. It also affects the sensory nervous system, which controls activities related to the senses, such as taste and the perception of pain, heat, and cold. Familial Dysautonomia is also called hereditary sensory and autonomic neuropathy, type III.

The Familial Dysautonomia (FD) Waiver was approved by the Florida Legislature to provide waiver services for no more than 20 individuals. This 1915(c) waiver is operated by AHCA and provides services to individuals who are diagnosed with Familial Dysautonomia who would otherwise require hospitalization were it not for the receipt of home and community-based services. All waiver services must be authorized as medically necessary and limited to an annual total amount of $20,900.00. FD Waiver was implemented in 2006.

ELIGIBILITY CRITERIA

The following criteria must be met in order for an individual to be eligible for the Familial Dysautonomia waiver:

- Be at least 3 years old or older, and not older than 65;
- Meet federal disability criteria as determined by the Social Security Administration, the Division of Disability Determinations, or the District Medical Review Team;
- Be diagnosed with Familial Dysautonomia;
- Demonstrate a need for medically necessary services provided by the waiver;
- Be Medicaid eligible; and
- Be at risk of hospitalization.

SERVICES PROVIDED

Waiver services include the following:

- Behavioral Services
- Consumable Medical Supplies
- Dental Services
- Durable Medical Equipment
- Non-Residential Support Services (NRSS)
- Respite Services
• Support Coordination

LEVEL OF CARE

Referrals for Level of Care will come from the Familial Dysautonomia waiver case managers. A medical case file review is completed for this waiver and the following items are required for CARES to establish a Level of Care:

• Physician Referral and Diagnosis Confirmation to Determine Level of Care Familial Dysautonomia Waiver (FD 1 Form)

• Support Plan Face Sheet

• Certification of Enrollment Status Home and Community Based Service (CF-ES 2515), when appropriate

• Informed Consent Form (AHCA MEDSERV–2040) (Required for initial LOC; not required for annual recertification.)

LEVEL OF CARE FORM (603) WILL BE COMPLETED AS follows:

• Level of Care: Risk of Hospitalization

• Program Recommendation: FD Waiver

• Placement Recommendation: Community

CARES CASE FILE

The CARES hard copy case file will contain the following:

• Notification of Level of Care (DOEA-CARES Form 603)

• FD 1 Form

• Support Plan Face Sheet

• Certification of Enrollment Status Home and Community-Based Services (CF-ES 2515) when appropriate
CIRTS CODING

ASSIGNMENT

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<tr>
<td>Provider Name</td>
<td>APD = Agency for Persons with Disabilities</td>
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<tr>
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ASSESSMENT

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<td></td>
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STAFFING

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<tr>
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<td>Set as appropriate</td>
</tr>
<tr>
<td>Level of Care</td>
<td>ROH = Risk of Hospitalization</td>
</tr>
</tbody>
</table>

FOLLOW-UP SCHEDULE

CARES will close the case at staffing. No follow-up is required.
PHYSICIAN REFERRAL AND CONFIRMATION
FAMILIAL DYSAUTONOMIA WAIVER

Patient Name: __________________________ Date of Birth: __________________________
Diagnosis: __________________________
Medication(s); List all prescribed medications:
**See attached RX and None RX Lists:
All body systems have been reviewed and specific findings are listed:

________________________________________

________________________________________

Medical History:

________________________________________

________________________________________

Mental and physical limitations:

________________________________________

________________________________________

Treatment and therapies:

________________________________________

________________________________________

Diet: Normal (___) or Special (please describe):

________________________________________

________________________________________

Social services and activities recommended:

________________________________________

________________________________________

Individual’s prognosis:

________________________________________

________________________________________

Based on the individual’s medical history and current condition, I certify that this individual is disabled and I believe there is reasonable indication that this individual might require hospitalization in the absence of home and community-based services provided through the Familial Dysautonomia Model Waiver program.

Physician Signature: __________________________ Date: __________________________

Physician Name (print): __________________________

Physician Address: __________________________

Incomplete forms will be returned. If not applicable, please indicate with N/A. Attach extra sheets of supporting documentation, if necessary. Return to: Medicaid Services, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop #20, Tallahassee, Florida 32308
PROJECT AIDS CARE WAIVER

Acquired immune deficiency syndrome (AIDS) is caused by human immunodeficiency virus, or HIV. The virus weakens a person's ability to fight infections and cancer. People with HIV are said to have AIDS when they develop certain infections or cancers or when the body’s white blood cell count (specifically a subset called CD4 or helper T cells) is less than 200. HIV attacks the body’s white blood cells. This attack allows opportunistic infections to take advantage of a weakened immune system, and can lead to illnesses, cancers, or neurological problems. For a list of the more common opportunistic infections and complications of opportunistic infections, see the reverse side of Form 607.

The Project AIDS Care (PAC) Waiver provides home and community-based services to Medicaid eligible persons with a documented diagnosis of AIDS that choose to live at home and in the community. This specific 1915(c) Medicaid Waiver is to promote, maintain, and optimize the health of persons living with AIDS in order to delay or prevent institutionalization. CARES Level of Care determination verifies that an individual is at risk of hospitalization or nursing facility placement without the provision of PAC waiver services.

Following are the procedures for new enrollments and reenrollments in the PAC Waiver:

- Case management agencies forward completed enrollment and reenrollment applications with supporting documentation to the AHCA PAC Waiver State Analyst.

- AHCA will send the case management agency a Notice of Approval in order to enroll an individual in the waiver.

- No new enrollments or reenrollments are permitted without prior AHCA approval.

- If the individual meets eligibility criteria and a slot is not available, the individual will be placed on a waitlist until a slot becomes available.

- If the individual does not meet eligibility criteria, the individual will receive a Notice of Denial.

- When CARES receives an enrollment packet from the case management agency for a new enrollment, or a reenrollment (an individual who disenrolled or was disenrolled from the waiver but is reenrolling), the Notice of Approval from AHCA must be included in the packet.

Special Note on Annual Recertifications: Clients who were enrolled with a Level of Care based on the old policy of using the client’s CD4 count may remain in the waiver when reviewed for annual Level of Care requests. Effective January, 2014, all new requests for Level of Care determination will be based on the eligibility criteria documented below.
ELIGIBILITY CRITERIA

To qualify for the PAC Waiver, an individual must:

- Have a diagnosis of AIDS documented by a physician
- Have the presence of AIDS-related opportunistic infection(s);
- Be Medicaid eligible under Supplemental Security Income (SSI), MEDS-AD, or the Institutional Care Program (ICP);
- Be determined by CARES to be at risk of hospitalization or institutionalization in a nursing facility;
- Be determined disabled according to Social Security Administration standards;
- Not be enrolled in any other Medicaid waiver program;
- Not be enrolled in a Medicaid HMO except one contracted as part of the 1915(b) HIV/AIDS Specialty Waiver;
- Be capable of remaining safely in the home and community;
- Need and receive PAC waiver case management services; and
- Have completed, signed and dated a PAC Waiver Enrollment Application.

SERVICES PROVIDED

Waiver services include the following:

- Case Management
- Chore
- Day Health Care
- Education and Support
- Environmental Accessibility Adaptations
- Home-Delivered Meals
- Homemaker
- Personal Care
- Restorative Massage
- Skilled Nursing
- Specialized Medical Equipment and Supplies
- Specialized Personal Care for Children in Foster Care
- Therapeutic Management of Substance Abuse
LEVEL OF CARE

Referrals come from a certified case management agency. A medical case file review is completed for this waiver.

For initial cases, the following items are required from the case management agency to determine a Level of Care:

- DOEA Form 623 (Project AIDS Care Waiver Program Referral)
- AHCA Notice of Approval Letter
- Informed Consent (AHCA MEDSERV–2040) (Required for initial LOC; not required for annual recertification.)
- Physician Referral and Request for Level of Care Determination (Form 607)

For Annual Recertifications, the following items are required from the case management agency to determine a Level of Care:

- DOEA Form 623 (Project AIDS Care Waiver Program Referral)
- DOEA Form 624 (Project AIDS Care Waiver Annual Update Information Sheet)

LEVEL OF CARE FORM (603) WILL BE COMPLETED AS FOLLOWS:

- Level of Care: Risk of Hospitalization
- Program Recommendation: PAC
- Placement Recommendation: Community

CARES CASE FILE

The CARES hard copy case file will contain the following:

- Notification of Level of Care (DOEA-CARES Form 603)
- Physician Referral and Request for Level of Care Determination (Form 607) and any needed medical attachments
- Informed Consent (AHCA MEDSERV–2040)
- Notice of Approval from AHCA (if new enrollment or re-enrollment since January, 2014)
CIRTS CODING

ASSIGNMENT:

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<tr>
<th>Referral Source</th>
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FOLLOW-up SCHEDULE

CARES will close the case at staffing. No follow-up is required.
PROJECT AIDS CARE

PHYSICIAN REFERRAL and REQUEST for LEVEL OF CARE DETERMINATION
( Clients Diverted from Hospitals )

Incomplete forms will be returned. Please complete all items. If non-applicable please indicate with N/A. Attach extra sheets or supporting documentation if necessary.

Client’s Name: __________________________ SSN# __________ DOB __________

1. AIDS Diagnosis (initial, if yes) □ (Please indicate Opportunistic infections on reverse side of form)

2. CD4 count □ % □ Viral Load □ as of □ (Date)

   Defining AIDS without opportunistic infection: .... CD4 Absolute count of less than 200 OR CD4 Percentage of less than 14

3. Medications (please list all prescribed medications):

4. All body systems have been reviewed and specific physical findings are checked below.

   □ Vision and Hearing □ Normal □ Moderate Impairment □ Severe Impairment
   □ Respiratory □ Normal □ Moderate Impairment □ Severe Impairment
   □ Gastrointestinal □ Normal □ Moderate Impairment □ Severe Impairment
   □ Geriatric-Urinary □ Normal □ Moderate Impairment □ Severe Impairment
   □ Cardiovascular □ Normal □ Moderate Impairment □ Severe Impairment
   □ Musculoskeletal □ Normal □ Moderate Impairment □ Severe Impairment
   □ Neurological □ Normal □ Moderate Impairment □ Severe Impairment

5. Medical History Significant to Home Based Care:

   ____________________________________________
   ____________________________________________
   ____________________________________________

6. Treatment & therapies: Please check all that apply.

   □ Physical Therapy □ Occupational Therapy □ Respiratory Therapy
   □ Substance Abuse Treatment □ Massage Therapy □ Other __________________________

7. Dist: _______________________________________

8. Prognosis: □ Good □ Poor □ Fair
   Rehabilitation Potential: □ Good □ Poor □ Fair

9. Unmet Home based care needs:
   ____________________________________________
   ____________________________________________
   ____________________________________________

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### Opportunistic Infections

<table>
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<td>Thrombocytopenia</td>
<td>Peripheral Neuropathy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hematopoietic Palsy/ Dementia</td>
</tr>
</tbody>
</table>

10. Other: Repeated manifestations of HIV infection resulting in significant, documented symptoms of one or more of the following:

- [ ] Restrictions in activities of daily living (Check all that apply):
  - Ambulation
  - Transfer Skills
  - Eating Skills
  - Dressing Skills
  - Personal hygiene Skills

Specify other ADL restrictions:

- [ ] Restrictions in Maintaining Social Functioning (Inability to interact appropriately and communicate effectively with others).

- [ ] Difficulties in Completing and Maintaining Tasks in a Timely Manner Due to Deficiencies in Concentration, Persistence, or Focus (Cannot perform these activities due to fatigue or effects of medication on concentration and coordination).

Specify other mental or physical limitations:

11. Do you believe the client is a danger to self and/or others? YES[ ] NO[ ]

Comments:

12. Based on the patient’s medical history and current condition, I certify that this individual is disabled and I believe there is reasonable indication that this individual might require hospitalization in the absence of home and community-based services provided through a Medicaid waiver program.

Effective Date of Level of Care “At Risk of Hospitalization”

13. Physician signature:

Physician’s name: 

Address: 

Telephone: 

CARERS FORM 697, revised Aug 01
(Formerly the HRS 3088A)
PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

The Program of All-Inclusive Care for the Elderly (PACE) is a unique capitated managed care program for the frail elderly provided by a not-for-profit or public entity. The PACE Program features a comprehensive medical and social service delivery system using an interdisciplinary team approach in an adult day health center (PACE Center) that is supplemented by in-home and referral services in accordance with the participant’s needs. While enrolled in a PACE program, the participant must receive all Medicare and Medicaid benefits solely through the PACE organization. In addition, the PACE enrollee must accept the PACE center physician as their Medicare primary care physician.

PACE organizations receive both Medicare and Medicaid capitated payments in exchange for the responsibility of offering the full continuum of acute and long-term care services, including nursing facility care when needed. The capitation payment PACE receives from CMS covers Medicare acute care and prescription drug (Part D) services. The capitation payment PACE receives from the State covers Medicaid services. Medicare enrollees who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but are not responsible for deductibles, coinsurance, or any other type of Medicare or Medicaid cost-sharing.

The statute defining PACE falls under the authority of Section 1115 of the Social Security Act. Sections 4801 and 4802 of the Balanced Budget Act (BBA) of 1997 contain the requirements that define the PACE program as a permanent provider.

COUNTIES OF OPERATION

PACE Centers are authorized by the Florida Legislature, and enrollment slots are funded through the legislative budget process. Currently, PACE is operational in seven counties: Lee, Charlotte, Collier, Pinellas, Broward, Palm Beach, and Miami-Dade.

COMPOSITION OF INTERDISCIPLINARY TEAM

At a minimum, the interdisciplinary team is composed of a primary care physician, nurse, social worker, physical therapist, occupational therapist, recreational therapist or activity coordinator, dietitian, PACE center supervisor, home care liaison, health workers/aids, or their representatives, and drivers or their representatives.

ELIGIBILITY CRITERIA

To qualify for the PACE Program, an individual must:

- Be age 55 or older;
- Live in a PACE service area;
• Meet nursing facility Level of Care as determined by CARES; and
• Be able to live safely in the community at the time of enrollment.

A potential PACE enrollee may be, but is not required to be, any or all of the following: entitled to Medicare Part A; enrolled under Medicare Part B; or eligible for Medicaid. A PACE enrollee may also be private-pay.

SERVICES PROVIDED

PACE services include, but are not limited to, all Medicare and Medicaid services. At a minimum, there are 16 additional services that a PACE organization must provide: e.g., social work, prescription drugs, NF care. Minimum services that must be provided in the PACE center include primary care services, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals.

Each PACE organization must provide transportation to bring members to the PACE center.

LOCATION OF SERVICE PROVISION

The service delivery settings include an adult day health center, home, and inpatient facilities.

PROVISION OF HOSPICE CARE

Since comprehensive care is provided to PACE participants, those participants who need end-of-life care will receive the appropriate medical, pharmaceutical, and psychosocial services through the PACE organization. If the participant specifically wants to elect the hospice benefit from a certified hospice organization, then the participant must voluntarily disenroll from the PACE organization.

PROVISION OF MENTAL HEALTH SERVICES

The PACE program is required to provide all health, medical and social services necessary to restore and preserve the participant's level of well-being. This includes mental health services. The organization can contract with mental health specialists to provide these services.

LEVEL OF CARE

Referrals for Level of Care come from the PACE organization. CARES will conduct an on-site assessment and forward the LOC to the PACE organization. The PACE LOC is also uploaded by CIRTS to the enrollment broker. The following items are required for CARES to establish a level of care for the PACE Program:
- Informed Consent (AHCA-MedServ 2040) (Required for initial LOC; not required for annual recertification.)
- Medical Certification for Medicaid Long-Term Care and Patient Transfer Form (AHCA 5000-3008)
- DOEA Form 701B Comprehensive Assessment
- CARES Intake Form (DOEA-CARES Form 611) with the Demographic and Additional Client Information section completed, if needed.

**LEVEL OF CARE FORM (603) WILL BE COMPLETED AS FOLLOWS:**

- Level of Care: Intermediate I, Intermediate II, Skilled
- Program Recommendation: PACE
- Placement Recommendation: Community

**CARES CASE FILE**

The CARES hard copy case file will contain the following:

- Notification of Level of Care (DOES-CARES Form 603)
- Medical Certification for Medicaid Long-Term Care and Patient Transfer Form (AHCA MEDSERV-3008)
- Informed Consent (AHCA MEDSERV–2040)
- CARES Intake Form (DOEA CARES Form 611) with the Demographic and Additional Client Information section completed if needed

**CIRTS CODING**

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### FOLLOW-UP SCHEDULE

CARES will close the case at staffing. No follow-up is required.
TRAUMATIC BRAIN AND SPINAL CORD INJURY

The Traumatic Brain and Spinal Cord Injury Program (BSCIP) is a 1915(c) Waiver that allows for a unique set of home and community-based services for clients who have sustained a brain or spinal cord injury. It is designed to allow individuals to remain or return to the community and be maintained at an appropriate level of functioning within the community. Individuals in this waiver must be determined at risk of institutionalization and meet a Nursing Facility Level of Care. Referrals to this program may be self-referrals, from family members, or any health care professional. All referrals should use the number for the BSCIP Central Registry which is 1-800-342-0778 or apply through DOH’s website at http://www.floridahealth.gov/diseases-and-conditions/brain-and-spinal-cord-injuries/index.html.

ELIGIBILITY CRITERIA

To qualify for the Traumatic Brain and Spinal Cord Injury Program, an individual must:

- Be age 18 or older;
- Be diagnosed with a traumatic brain injury or spinal cord injury as defined in Chapter 381.745, Florida Statutes;
- Be referred to the State’s Central Registry, created by Section 381.74, Florida Statutes;
- Be medically stable, which is defined as the absence of any of the following:
  - An active, life threatening condition (e.g., sepsis, respiratory, or other condition requiring system therapeutic measures),
  - IV drip to control or support blood pressure, or,
  - Intracranial pressure or arterial monitor;
- Be eligible for Medicaid;
- Meet the level of care criteria for Intermediate II, or higher (i.e., Intermediate II, Intermediate I or Skilled) as stated in 56G-4.180 and 59G-4.290, Florida Administrative Code.
- Be enrolled in the TBI/SCI Waiver Program. Recipient “enrollment” means being determined financially and medically eligible following a determination of available TBI/SCI waiver funds.

SERVICES PROVIDED

Waiver services include the following:
- Assistive Technologies
- Attendant Care
- Behavioral Programming
- Community Support Coordination
- Companion Services
- Consumable Medical Supplies
- Emergency Alert Response System Installation
- Emergency Alert Response System Monitoring and Maintenance
- Environmental Accessibility Adaptations
- Life Skills Training
- Occupational Therapy
- Personal Adjustment Counseling
- Personal Care Services
- Physical Therapy
- Rehabilitation Engineering Evaluation
- Residential Habilitation
- Transition Case Management
- Transition Environmental Accessibility Adaptations

**LEVEL OF CARE**

Referrals come from Department of Health and a medical case file review is completed for this waiver. The following items are required from the case management agency to determine a Level of Care:

- BSCIP Referral to CARES Cover Sheet
- Brain Injury and Spinal Cord Injury Program Request for Level of Care
- DOEA Form 701B Comprehensive Assessment
- Informed Consent Form (AHCA MEDSERV–2040) Required for initial cases only; not required for annual recertifications.

**LEVEL OF CARE FORM (603) WILL BE COMPLETED AS FOLLOWS:**

- Level of Care: Intermediate I, Intermediate II, or Skilled
- Program Recommendation: Brain and Spinal Cord Injury
- Placement Recommendation: Community
CARES CASE FILE

The CARES hard copy case file will contain the following:

- Notification of Level of Care (DOEA-CARES Form 603)
- BSCIP Referral to CARES Cover Sheet
- Brain Injury and Spinal Cord Injury Program Request for Level of Care

CIRTS CODING

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**FOLLOW-UP SCHEDULE**

CARES will close the case at staffing. No follow-up is required.
To: DOE CARES
From: Case Manager: 
Department of Health
Brain and Spinal Cord Injury Program
Phone: 

BSCIP REFERRAL TO CARES

SECTION I  DEMOGRAPHICS

Clients Name:
Last: ___________________ First: ___________________ Middle: ___________________
Social Security #: ___________________ DOB: ___________ Race: ___________ Mental Status: ___________
Address:
Street: ___________________ City: ___________________ Zip Code: ___________________
Phone Number: ___________________
Living Arrangement: _______ Alone _______ With family _______ With friend _______ Other _______
Medicaid Number: ___________________
Next of Kin/Responsible Party: ___________________
Relationship: ___________________
Address: ___________________
Phone Number: ___________________
Physician: ___________________
Phone Number: ___________________

SECTION II  TYPE OF REFERRAL

• _______ New
• _______ Annual
• _______ Reapply

SECTION III  MEDICATIONS

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BSCIP Representative Completing Form ____________________________

Title _____________________________  Date _______________________

(form to USC #)

______________________________
### Brain and Spinal Cord Injury Program Request for Level of Care

**REFERRED INDIVIDUAL:**

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#### I. MEDICAL STABILITY: Does the Patient have any of the following?
- A. Active, life threatening condition present, (e.g., severe, respiratory, or other condition requiring systemic therapeutic measures).
  - [ ] Yes  [ ] No
- B. IV drip to control or support blood pressure.
  - [ ] Yes  [ ] No
- C. Intracranial pressure or arterial monitor.
  - [ ] Yes  [ ] No
- D. Ventilator support (does not disqualify for TBI SCI Medicaid Waiver).
  The patient may have a tracheotomy for airway protection without ventilator, gastrostomy or feeding tube, or IV access for non-life threatening illness.
  - [ ] Yes  [ ] No

#### II. MEDICAL ELIGIBILITY

**SPINAL CORD INJURY (SCI)**
- A. Did the injury result from trauma to the spinal cord or cauda equina?
  - [ ] Yes  [ ] No
- B. Did the lesion result in significant involvement and functional limitation of two or more of the following?
  1. Motor Deficit
  2. Sensory Deficit
  3. Bowel Bladder Dysfunction
  - [ ] Yes  [ ] No
- C. If SCI patient has also sustained a brain injury, functional level is at a Rancho Level IV or greater.
  - [ ] Yes  [ ] No

**BRAIN INJURY (BI)**
- A. Did the injury occur from external trauma?
  - [ ] Yes  [ ] No
- B. Which of the following were produced by the injury resulting in functional limitations?
  1. Altered State of Consciousness
  2. Motor Deficit Present
  3. Sensory Deficit Present
  4. Cognitive/Behavioral Deficit
  - [ ] Yes  [ ] No
- C. RANCHO LEVEL: (Rate is attached Adult Rancho Les Analog Guide)
  Adult: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

*Signature of Physician/Physician's Representative Completing Form* [Title/Facility]

**CERTIFICATE OF ELIGIBILITY**

FOR BSCP USE ONLY: There is reasonable expectation that the individual will benefit from services based on the goal of community reintegration.

*Signature of BSCP Case Manager*

D-2  April 2005
STATE MENTAL HEALTH HOSPITAL PROGRAM

In Florida, individuals residing in a state mental health (SMH) hospital who need nursing facility services may remain in the SMH hospital to receive those services through the Medicaid State Mental Health Hospital Program. The purpose of the Medicaid State Mental Health Hospital Program is to provide medically necessary, long-term inpatient mental health services to Medicaid recipients 65 years or older.

Residents of state mental health hospitals receive physician, nursing, dietary, pharmaceutical, personal care, rehabilitative, and restorative services. To receive these specific services, an individual must meet Medicaid ICP eligibility requirements and meet a state mental health hospital Level of Care. To meet state mental health hospital level-of-care criteria, an individual must meet the medical and voluntary, or involuntary, commitment criteria.

- To meet medical Level of Care criteria, the individual must require 24-hour medical observation and care as determined by CARES.
- To meet voluntary commitment criteria, a physician and the individual agree that inpatient psychiatric hospitalization is necessary for treatment of the symptoms of mental illness.
- To meet involuntary commitment criteria, the individual poses an immediate safety risk to themselves or others and does not agree to voluntary inpatient psychiatric hospitalization.

PASRR AND SMH HOSPITALS

PASRR is not required while an individual remains in the state mental hospital because the individual has been diagnosed with a mental illness and is receiving specialized services in that setting. However, if the individual is being discharged from the state mental health hospital to a nursing facility, an on-site 701B assessment and a PASRR Level II Evaluation and Determination must be completed prior to discharge from the state mental health hospital to the nursing facility.

LEVEL OF CARE

CARES determines Level of Care for the SMH program by completing a medical case file review and staffing the case with the Physician Consultant. For the time that an individual is committed to an SMH hospital and nursing facility services are needed, an application must be made for nursing facility services that are provided in the SMH facility. The SMH hospital will forward a Physician Certification State Mental Health Hospital Services (AHCA-MedServ Form 034) to CARES. Form 034 is equivalent to the AHCA 5000-3008 form and is used in place of the 3008 form for this program. The SMH hospital will apply for ICP coverage through DCF and DCF will forward Form 3007 to
CARES. If a 3007 is not received from DCF, CARES will complete the assessment and staffing according to CARES assessment and staffing time standards.

**LEVEL OF CARE FORM (603) WILL BE COMPLETED AS FOLLOWS:**

- Level of Care section: write “Mental Health” in this section of the form; the current 603 form does not contain a Mental Health LOC option;
- Program Recommendation: leave blank;
- Placement Recommendation: State Mental Health Hospital;
- Level of Care effective date: the date the Physician signed Form 034;
- Comments: "Mental Health Level of Care for ________ (fill in the name of the state mental hospital) ONLY."

The completed 603 form will be forwarded to the state mental health hospital. If a 3007 is received from DCF, the 603 will be faxed to DCF.

**LOC JUSTIFICATION CASE NOTE**

When completing the level of care justification case note in CIRTS, use the standard case note below, filling in the blanks appropriately:

```
“Based on Form 034, the client has a written order for state mental health hospital services and has met the voluntary or involuntary commitment criteria. In addition, based on review of the submitted diagnoses, which are__________; medical findings and medical history, which is __________; current medications, which are __________; and physical capacity indicated, which is __________, the client appears to meet NF LOC.”
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<td>Living Situation</td>
<td>AL = Alone</td>
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</tbody>
</table>

**STAFFING**

<table>
<thead>
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<th>M = 3036/State Mental Hospital</th>
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<tr>
<td>Staffing Instrument</td>
<td></td>
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<tr>
<td>Living Arrangement</td>
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<td>AL = Alone</td>
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<tr>
<td>Placement Recommendation</td>
<td>SMHO = State Mental Hospital</td>
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<tr>
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<td>Program Recommendation</td>
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<tr>
<td>Level of Care</td>
<td>MEN = Mental Health</td>
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</table>

**FOLLOW-UP SCHEDULE**

CARES will close the case at staffing. No follow-up is required.

For more detailed information, see the State Mental Health Services Coverage and Limitations Handbook at: [https://ahca.myflorida.com/medicaid/review/Specific/CL_10_100701_Hospital_MH_Hndbk.pdf](https://ahca.myflorida.com/medicaid/review/Specific/CL_10_100701_Hospital_MH_Hndbk.pdf)
PHYSICIAN CERTIFICATION
STATE MENTAL HEALTH HOSPITAL SERVICES

To be completed by Comprehensive Assessment and Review for Long Term Care Services (CARES)

Name: ___________________________ Date of Birth: ______________ Medicaid #: ___________________________
Race: ___________________________ Sex: __________________ Marital Status: ___________________________
Current Location: __________________ Telephone #: __________________ Date of Admission: _____________
Attending Physician (please print): __________________

Last State Mental Health Hospital Stay: From ___________ To ___________ N/A ___________

1. Diagnosis: ________________________________________________________________

2. Summary of Current Medical Findings: __________________________________________

3. Medical History and Current Medications: _________________________________________

4. Mental and Physical Capacity: _________________________________________________

5. Prognosis: _________________________________________________________________

6. Meets the following clinical criteria: (42 CFR § 441.102, 42 CFR § 441.103, 409.965(22), Florida Statutes)
   A. Ambulatory care resources available in the community do not meet the treatment needs of the individual.
   B. Proper treatment of the individual’s psychiatric condition requires services on an inpatient basis under
      the direction of a psychiatrist.
   C. Services can reasonably be expected to improve the individual’s condition or prevent further regression
      so that the services will no longer be needed.

☐ Recommended to receive State Mental Health Hospital Services Effective Date: _____________

Attending Physician Signature: ___________________________ Date: _________________

Consulting Psychiatrist Signature: ___________________________ Date: _________________

(Required if Attending Physician is not a Psychiatrist)

Comments: ________________________________________________________________

AHCA-Med Serv Form 054, Page 1, January 2008, incorporated by reference in 590-4.300, F.A.C.

JUNE 2010
PHYSICIAN CERTIFICATION STATE MENTAL HEALTH HOSPITAL SERVICES INSTRUCTIONS

Name, Date of Birth, and Medicaid Number: Should be filled out accurately and as completely as possible.

Race, Sex, and Marital Status: Should be filled out accurately and as completely as possible.

Current Location and Telephone Number: Where the individual is located during the time the level of care is requested and the contact telephone number.

Date of Admission: The date the individual was admitted into the current facility.

Attending Physician: The physician responsible for coordinating clinical care for the individual.

Last State Mental Health Hospital Stay: Dates the individual previously received state mental health hospital services, if known.

Diagnosis: All medical and psychiatric diagnoses for the individual.

Summary of Current Medical Findings: Any significant medical conditions that impact the individual (lab results, radiology reports, etc).

Medical History and Current Medications: All pertinent historical medical information and any medications currently prescribed for the individual. A copy of individual’s medical history and current medications may be attached.

Mental and Physical Capacity: Current mental and physical capabilities and deficits of the individual.

Prognosis: Indicate poor, fair, or good.

Meets the following criteria: Individual meets each of the criteria as described in the 42 Code of Federal Regulations 441.152 (a), and detailed in the State Mental Health Hospital Services Handbook.

Recommended to receive State Mental Health Hospital Services: By checking this box, the attending physician and/or consulting psychiatrist certifies placement is recommended in a state mental health hospital.

Effective Date: The date the attending physician and/or consulting psychiatrist certifies the individual meets the medical and psychiatric criteria for state mental health hospital services.

Attending Physician Signature: The original signature of the medical doctor (MD) or doctor of osteopath (DO) that is providing medical care to the individual, is required.

Date: The date the physician signs the form.

Consulting Psychiatrist Signature: The original signature of the psychiatrist providing care to the individual if the attending physician is not a psychiatrist, is required.

Date: The date the psychiatrist signs the form.

Comments: The attending physician or consulting psychiatrist may provide additional comments here relevant to the individual or level of care.


JUNE 2010
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CHAPTER 8
~ QUALITY ASSURANCE ~

MONITORING BY THE PROGRAM OPERATIONS ADMINISTRATOR (POA)

For the effective operation of a CARES field office, POAs must monitor the activities of administrative and CARES professional staff. To assist the POA in the process of monitoring an office, reports on assessments, management, staffing, and PASRR are available in CIRTS. POAs can also access a CIRTS “CARES Assignments report” for individual professional staff that contains information on assessments, staffings, and follow-ups. Referral processing, workload distribution, case processing time standards, and follow-up completions are monitored monthly. CIRTS reports can be run daily, weekly, monthly, quarterly, or annually to meet the needs of the office.

POAs and CASs also complete monthly case file reviews to identify training needs, measure employee performance, and to ensure that CARES policies and procedures are followed. A sample of case files for each professional staff is chosen monthly. Case files are reviewed:

- To verify that LOC, Program Recommendation and Placement Recommendation are correct and accurate.
- To ensure that assessments, medical forms, and client correspondence are complete and correct and that case note documentation is complete and accurate.
- To ensure that cases are entered into CIRTS correctly and accurately and that PASRR was completed appropriately.

Case files that contain errors are returned to the worker for corrections and then are returned to the POA for review. This process identifies training needs and individual conferences can be held or larger group trainings can be scheduled.

POAs are also responsible for monitoring the expenses of the field office to remain within the fiscal budget allocation for the office. In order to track the office expenditures, designated office staff enter incurred expenses for travel, equipment, and operations on an expense tracking worksheet on the CARES SharePoint site. Expenses can be totaled by category, month, or year-to-date summary. The expense tracking worksheet allows the POA to stay within their office’s allocation by comparing the office’s year-to-date expenditures against their annual budget.

MONITORING BY THE REGIONAL PROGRAM SUPERVISORS (RPS)

To support the CARES offices within a region, RPSs visit each of the CARES offices within their region at least quarterly to provide technical assistance to the POA, to make
themselves available to the office staff, and to monitor the activities of the POAs and CARES offices.

At least annually, the RPS completes a comprehensive monitoring of each CARES office to determine if CARES policies and procedures are being followed in accordance with DOEA policies and procedures, the CARES Program handbook, Florida Administrative Code, and the Code of Federal Regulations. The comprehensive monitoring tool that is utilized is called a TAV, short for Technical Assistance Formal Site Visit Checklist. The TAV consists of sections of monitoring information that include: Staffing, case records storage and security, equipment adequacy, training requirements, hiring practices, workload distribution, adherence to time standards for case processing, fiscal responsibility, coordination of activities with the Aging Network, office procedures, compliance of case records with state and federal guidelines, and compliance with PASRR regulations.

Upon completion of the TAV, the TAV is reviewed with the POA, and, if corrections are needed, the POA must submit a written corrective action plan to the RPS. A copy of each TAV is sent to the CARES Central Office for approval by the Deputy Chief for Field Operations and the CARES Bureau Chief.

**Monitoring by the Bureau of Long-Term Care and Support**

Each CARES office is monitored annually by a Registered Nurse Specialist (RNS) from the Long-Term Care and Support Bureau. The purpose of the monitoring is to verify that CARES records comply with federal and state criteria for determining Medicaid medical eligibility (i.e., Level of Care) for nursing facilities and Medicaid Waivers. The monitoring is completed by desk review and by on-site visit.

Approximately one month before the scheduled on-site monitoring date, the RNS sends the POA an email to confirm the date of the monitoring, the time of the physician staffing, and to request a list of current assessors and nurses.

When the list of assessors and nurses is received, a random sample of files is chosen from CIRTS for each assessor and nurse for all programs. A “Client File Review List” is created from the sample. At least five days prior to the scheduled monitoring visit, the RNS emails the POA with the “Client File Review List” and requests that files are pulled and ready for review at the time of the visit. The RNS also makes a request to accompany a CARES Assessor or RN on an initial assessment during the monitoring visit.

Prior to the on-site visit, a desk review is completed on each client file using case notes, assessments, staffing information, and the Client Information Form (CIF) in CIRTS. The purpose of the desk review is to verify that the Level of Care is correct and justified in case notes, and that the Placement Recommendation is appropriate. The RNS also verifies that the client meets the criteria for the recommended program and that the Level of Care and program criteria is documented and justified in case notes. The monitoring
for each case file is recorded electronically on CARES “Case Record Review Tool” (CRRT).

During the on-site visit, the RNS observes staffing with the physician consultant to document that CARES staff were prepared for staffing, that all possible options to nursing facility placement were explored; that there was a discussion of community alternatives; that the assessment instrument was utilized in staffing; that the CARES physician consultant actively participated in staffing and was knowledgeable of community resources; and that barriers to community placement, if any, were identified and discussed.

In addition, client files are reviewed on-site for information that was not available from CIRTS. The RNS verifies all required forms and medical documentation are in the physical case file, any documents received after the initial referral are date stamped, client letters and correspondence are included in the case file, and “Notice of Approval” letter from AHCA is included for new and re-enrollments for the Project AIDS Care waiver. The reviewer also checks to see that MedServ 5000-3008 (or equivalent) is complete, including legible name and contact information for the MD/DO/ARNP/PA, and ensures the “Level of Care Notification”, Form 603, is in the case file and is consistent with staffing case notes.

Following staffing with the physician consultant and review of case files, an exit interview is held with the POA and RPS (on-site, by SKYPE, or by telephone) to review observations and any findings.

Following the on-site visit, a monitoring report is provided to the Long-Term Care and Support Bureau Chief, CARES Central Office staff, and the CARES Bureau Chief.

**Federal Performance Measures and Monitoring**

The U.S. Department of Health and Human Services allows states to waive certain Medicaid statutory requirements by offering home and community-based services (HCBS) as an alternative to institutionalization. The Centers for Medicare and Medicaid Services (CMS) have the responsibility and authority to approve State requests for HCBS waiver programs. CMS must assess each waiver program to determine that State assurances to protect the health and welfare of waiver program recipients are met. CMS requires that States develop and monitor performance measures on waiver programs. DOEA has the responsibility of reviewing performance measures and monitoring the performance of managed care organizations that contract with the State to provide HCBS services under the SMMC LTC waiver program. Designated monitoring staff within the Division of SCBS Bureau of Long-Term Care and Support and the CARES RN Consultant complete quarterly reviews of performance measures.

The following Level of Care performance measures must be monitored and remediated if necessary:

- All new applicants will receive a Level of Care prior to enrollment.
• Enrollees will receive a Level of Care based on the 701B DOEA assessment instrument.

• All Level of Care determinations will be made by qualified CARES staff.

Designated monitoring staff complete an analysis of CIRTS data to determine compliance with performance measures. Discrepancies are forwarded to the CARES RN Consultant. The RN Consultant reviews CARES data entries and case notes to determine if remediation is required. If remediation by CARES is required, the RN Consultant forwards the specific remediation to the CARES field office. When corrections are made, the RN Consultant notifies the monitoring staff. If remediation by managed care organizations is required, the information is provided to monitoring staff and remediation is requested from the managed care organization. Monitoring staff are responsible for reporting on performance measures to CMS through the Agency for Health Care Administration.

PASRR MONITORING AND REPORTING

MONITORING

As part of CARES’ responsibility for oversight of the Level I process for adults, AHCA has given CARES the responsibility for certain monitoring functions. These areas include:

• Tracking 30-day hospital exemptions and provisional admissions to ensure requests for Level IIs are submitted prior to expiration of allowable time periods.

• Tracking timeliness of completion/receipt of Level II findings/evaluations.

REPORTING

The CARES Central Office is required to provide a quarterly report to AHCA that includes the following information:

• The number of Level I PASRR screenings that were completed during the preceding quarter;

• The entity that performed the Level I screening (e.g. CARES, nursing facility, or hospital, as appropriate);

• The list of individuals for whom a PASRR Level I screening was completed and who required a PASRR Level II referral based on a suspicion of or diagnosis of SMI or ID.

The CARES CO is also required to review a statistically valid sample of cases each year that required a PASRR Level I screening to ensure the evaluation was conducted
in accordance with state and federal laws. The CO is required to send the report to AHCA by September 30th of each year.
CHAPTER 9
~ FAIR HEARINGS ~

A fair hearing is a review of an agency, department, or managed care plan action to determine if the agency, department, or managed care plan action is correct. Anyone who applies for, or receives Medicaid, has the right to request a fair hearing if they believe their benefits have been improperly reduced, denied, or delayed. AHCA and DCF are responsible for administering and conducting Medicaid fair hearings in Florida.

When an individual requests a fair hearing, the notice of hearing rights provides instructions specifying whether AHCA or DCF is responsible for providing a Medicaid Fair Hearing. The fair hearing responsibilities and contact information for AHCA and DCF are provided below:

AHCA

The AHCA Office of Fair Hearings will administer and conduct the following Medicaid fair hearings:

- Medicaid fair hearings related to Medicaid programs directly administered by AHCA.
- Medicaid fair hearings related to Florida’s Statewide Medicaid Managed Care (SMMC) program and associated federal waivers.

A Medicaid fair hearing may be requested orally, in writing, or by email, from AHCA’s Medicaid Hearing Unit by contacting:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906
Telephone:(877) 254-1055 (toll-free)
Fax: (239) 338-2642
E-mail: MedicaidHearingUnit@ahca.myflorida.com

DCF

DCF’s Office of Appeal Hearings will administer and conduct the following Medicaid fair hearings:

- All fair hearings arising from Medicaid financial eligibility determinations made by DCF.
- All fair hearings arising from eligibility determinations or service denials,
reductions, terminations or suspensions pertaining to the iBudget Waiver administered by the Florida Agency for Persons with Disabilities.

- All fair hearings arising from the Preadmission Screening and Resident Review, as mandated by Section 1917(e)(7) of the Social Security Act and Title 42, Code of Federal Regulations (CFR), Sections 483.100 through 483.138, Subpart C.

- All fair hearings resulting from resident transfers or discharges as those terms are defined in Section 400.0255, Florida Statutes.

A Medicaid fair hearing may be requested orally, in writing, or by email, from DCF’s Office of Appeal Hearings by contacting:

Department of Children and Families
Office of Appeal Hearings
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Telephone: (850) 488-1429
Fax at (850) 487-0662
Email at appeal.hearings@myflfamilies.com

HEARING PROCESS

Hearings are conducted by Hearing Officers. Hearings conducted by AHCA will be held by telephone. Hearings conducted by DCF are held by telephone, however, the petitioner can request an in-person hearing. The parties to the Medicaid fair hearing are the applicant/recipient (referred to as the petitioner) and/or the petitioner’s representative, and the respondent which is AHCA, DCF, or the managed care plan.

The following are hearing procedures:

- All hearings are electronically recorded.

- The Hearing Officer gives a brief explanation of the hearing process, identifies the parties, and swears in the parties that will be providing testimony.

- In some cases, both parties are provided an opportunity to give an opening statement.

- Testimony begins with the party that has the burden of proof. The burden of proof is on the party that brings the issue. The burden of proof is on AHCA, or the managed care plan, if the issue presented is the suspension, reduction, or termination of a previously authorized service.

- After each witness has presented the evidence, the other party has the opportunity to ask questions.
Both parties are provided an opportunity to make a closing statement or submit a Proposed Final Order.

The Hearing Officer provides closing instruction. If the record is left open for submission of additional evidence, a deadline date is given for submission of the evidence.

A written Final Order will be issued to the parties by the Hearing Officer stating the Finding of Fact (the legal analysis of the facts), and a decision. The Final Order is mailed to the parties.

CARES is a witness for AHCA or DCF. As such, copies of Final Orders, interim orders, or evidence packets provided to the parties by each side, will not be sent directly to CARES. AHCA or DCF must provide information to CARES.

CARES ROLE IN THE FAIR HEARING PROCESS

There are two types of hearings involving CARES:

- The determination of medical eligibility (Level of Care)
- Level of Care (LOC) based on the completion of Preadmission Screening and Resident Review (PASRR)

When a fair hearing has been scheduled, DCF, AHCA, or the managed care plan should contact CARES when CARES is needed as a witness.

- DCF, or AHCA, should provide a copy of the Notice of Hearing to CARES. The Notice of Hearing contains the hearing date, time, and the telephone number to call-in for the hearing.
- A copy of the Notice of Hearing should be forwarded to designated staff in the Central Office for tracking purposes.
- When contacted by DCF, or AHCA, a hearing packet should be prepared, scanned, and sent to the contacting entity within one business day by encrypted email.

The following is a guide for preparing the hearing packet:

For hearings pertaining to LOC that do not involve determinations based on PASRR, the packet should contain copies of:

- Notification of Level of Care (DOEA-CARES form 603)
- Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (AHCA 5000-3008)
- 701B Comprehensive Assessment or 701T Non-Community Placement Assessment
CARES TESTIMONY

Before the date of the scheduled fair hearing, CARES should prepare for the hearing by reviewing the case, and the hearing packet that was sent to DCF, or AHCA. The Assessor or R.N. that completed the assessment should be prepared to testify. All CARES staff that will provide testimony should be prepared to discuss their education, training and experience. The following are CARES hearing procedures:

1. All testimony for hearings in which CARES is the witness should begin with an explanation of the responsibilities of CARES:

- The CARES Program performs federally mandated functions for Medicaid long-term care programs and is administered by the Agency for Health Care Administration through an interagency agreement with the Department of Elder Affairs. The primary responsibilities of the CARES Program are:

- Informed Consent form (AHCA MedServ 2040)
- Relevant medical documentation such as History and Physical and/or medical consults
- CIRTS Case Notes
- 59G-4.180, (F.A.C.), for Intermediate Care Services and 59G-4.290, F.A.C., for Skilled Services
- 409.985, Florida Statutes (F.S.)

For hearings pertaining to LOC based on the completion of PASRR, the packet should contain copies of:

- Notification of Level of Care (DOEA-CARES form 603)
- Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (AHCA 5000-3008)
- 701B Comprehensive Assessment or 701T Non-Community Placement Assessment
- CIRTS Case Notes
- Relevant medical documentation such as History and Physical, Psychiatric consults and/or other medical consults
- PASRR Level I Screen (AHCA MedServ Form 004 Part A)
- Informed Consent form (AHCA MedServ 2040) (if applicable)
- Documentation of the Request for a PASRR Level II Evaluation, if applicable
- PASRR Evaluation and Determination Summary from KEPRO, if applicable
- 59G-4.180, F.A.C., for Intermediate Care Services and 59G-4.290, F.A.C., for Skilled Services
- 409.985, F.S.
- 59G-1.040, F.A.C., (PASRR Rule)
a. To determine medical eligibility for adults applying for Medicaid to pay for the cost of nursing facility care or home and community-based Medicaid Waiver services.

b. To conduct preadmission screening on all nursing facility applicants age 21 and older for the presence of serious mental illness or intellectual disability.

2. After the responsibilities of CARES have been explained, CARES testimony should establish the criteria for Level of Care by citing Florida Administrative Code (F.A.C.) 59G-4.180 for Intermediate Care Services and 59G-4.290 for Skilled Services, and reference CARES’ authority for determining Level of Care by citing 409.985, Florida Statutes. If the hearing is related to PASRR, reference CARES’ authority as the Level I PASRR screener and cite 59G-1.040, F.A.C.

3. Once the criteria for LOC has been established, if the reason for the hearing is that CARES determined that the individual did not meet medical eligibility, CARES will provide an explanation of how the determination was reached, including the facts of the on-site assessment. The Assessor or R.N that completed the assessment should provide testimony on the assessment and determination, relating the determination back to Florida Administrative Code. CARES testimony should also include that the determination was reviewed by the CARES Physician Consultant who agreed with the determination and signed the Notification of Level of Care form.

4. If the reason for the hearing is LOC based on the completion of PASRR, CARES will provide an explanation of the effective date of the LOC beginning with the completion of the Level I screen, any efforts to obtain corrected forms, the assessment (if applicable), the date that the Level II was received (if applicable), and any other evidence relating to the completion of PASRR, relating the testimony back to the PASRR Rule.

**IMPORTANT NOTE:** If the petitioner has retained the services of an attorney, and CARES was not notified in advance that the petitioner is represented by legal counsel, immediately ask the Hearing Officer for a continuance so that the hearing can be rescheduled. When the petitioner is represented by an attorney, CARES must notify the RPS, and designated Central Office staff so that DOEA’s General Counsel will be notified. The role of the DOEA General Counsel is to provide guidance to DOEA staff.
CHAPTER 10
~ CODE OF CONDUCT ~

It is not out of the ordinary that a client known to a DOEA/CARES employee outside the workplace will be referred to CARES for an assessment. When these situations arise, it is critical that they be handled professionally, ethically and without partiality, as defined by the DOEA’s code of Ethics, the National Association of Social Workers (NASW) Code of Ethics, and the American Nurses Association (ANA) Code of Ethics.

DOEA Code of Ethics 550.30, Section I: Employees shall avoid any unethical conduct or conduct that may appear to be unethical, whether in the carrying out of their state job, or in financial relationships, or social relationships. Employees are expected to safeguard their ability to make objective fair, and impartial decisions, therefore, employees shall not exhibit questionable or preferential behavior.

The NASW Code of Ethics 1.06 Conflicts of Interest: “Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment.”

The ANA Code of Ethics with Interpretive Statements: “Nurses may experience conflict arising from competing loyalties in the workplace, including conflicting expectations from patients, families, physicians, colleagues, healthcare organizations, and health plans.....Nurses address such conflicts in ways that ensure patient safety and that promote the patient’s best interests while preserving the professional integrity of the nurse and supporting interprofessional collaboration......Any perceived or actual conflict of interest should be disclosed to all relevant parties and, if indicated, nurses should withdraw, without prejudice, from further participations.”

A Conflict of Interest is defined as: A situation in which a person is in a position to derive personal benefit from actions or decisions made in their official capacity.

In accordance with DOEA’s Code of Ethics, the following policies are intended to eliminate, to the extent possible, actual or perceived preferential treatment of clients known to CARES staff outside the workplace.

In the event an assessor or RNS is assigned the case of an individual who is personally known to them outside of the work place, the assessor/RNS should immediately notify their POA to determine if there is a potential conflict of interest, and the following steps taken to avoid an appearance of impropriety.

1) In the event an employee is assigned a referral of a family member, friend, or family member of a friend, the case should be brought to the attention of the POA and reassigned. Assessors/RNS’ should never:
• Assess a member of their family under any circumstances. This includes parents, grandparents, spouses, children and known relatives.

• Assessor/RNS’s should never assess friends or relatives of friends.

2) In a situation where it is known that a client is a relative of a colleague, friend of a colleague, or a family member of the colleague’s friend, the case should be brought to the attention of the POA and the following actions taken:

• The POA will review the case record prior to staffing to ensure CARES policies and procedures were followed and the proposed LOC is supported by medical documentation.
• The colleague who has the relationship with the client is forbidden from accessing the case record through CIRTS or discussing the outcome of the assessment with the assigned Assessor/RNS prior to staffing.

NOTE: If a CARES employee is the caregiver of an individual referred to CARES, they may participate in the assessment but cannot discuss the outcome/LOC with the assigned assessor/RNS prior to staffing.

NOTE: Any attempt by CARES staff (known to the assessed individual outside of the workplace) to influence the outcome of the assessment should be reported to the POA immediately.

3) In the event the client is a family member, friend, or family of a friend known to the POA or CAS outside of the workplace, the case should be brought to the attention of the RPS and the following actions taken:

• The referral should be transferred to the nearest PSA for assessment and staffing to avoid the appearance of undue influence of the assessment process by the POA/CAS.
• The RPS will review the case record prior to staffing to ensure CARES policies and procedures were followed and the proposed LOC is supported by medical documentation.
• The POA/CAS are forbidden from accessing the case record in CIRTS or discussing the outcome of the assessment with the assigned Assessor/RNS prior to staffing.

NOTE: If the POA/CAS is the caregiver of an individual referred to CARES, they may participate in the assessment but cannot discuss the outcome/LOC with the assigned assessor/RNS prior to staffing.

NOTE: Any attempts by the POA/CAS to influence the outcome of the assessment should be reported to the RPS immediately.
4) Any other relationship with a client outside the workplace not specifically outlined above, shall also be brought to the attention of the POA (or RPS if applicable) to determine if there is a potential conflict of interest or the employee’s ability to make objective fair, and impartial decisions may be compromised. If there is any potential for an appearance of impropriety, the case should be reassigned and the following actions taken:

- The POA/RPS will review the case record prior to staffing to ensure CARES policies and procedures were followed and the proposed LOC is supported by medical documentation.
- The colleague who has the relationship with the client is forbidden from accessing the case record through CIRTS, or discussing the outcome of the assessment with the assigned Assessor/RNS prior to staffing.

**NOTE:** If a CARES employee is the caregiver of an individual referred to CARES, they may participate in the assessment but cannot discuss the outcome/LOC with the assigned assessor/RNS prior to staffing.

**NOTE:** In the event a known prior relationship with a client is not disclosed to the POA/RPS, and/or proper protocol is not followed as outlined above, disciplinary action up to and including dismissal will be taken.
~ GLOSSARY ~

A

AUTOMATED COMMUNITY CONNECTION TO ECONOMIC SELF-SUFFICIENCY (ACCESS) – A program administered by the Department of Children and Families (DCF) that allows clients to apply for public assistance benefits online. ACCESS Economic Self-Sufficiency staff determine financial eligibility for Medicaid long-term care services. See SSI-Related (public assistance for the aged, blind and disabled) Programs Fact Sheet http://www.dcf.state.fl.us/programs/access/docs/ssifactsheet.pdf

ACTIVITIES OF DAILY LIVING (ADLS) – The functions and tasks for self-care, including ambulation, bathing, dressing, eating, grooming, toileting, transferring, and other similar tasks.

ADULT CYSTIC FIBROSIS WAIVER – A Medicaid waiver program that provides home and community-based services to adults 18 years and older who are living with cystic fibrosis. Participants must be at higher risk of hospitalization as determined by CARES. The Adult Cystic Fibrosis Medicaid Waiver Program Physician Referral and Request for Level of Care Determination form is used to request a level of care. (See Chapter 7 Additional Medicaid Waivers/Programs for more information.)

ADULT FAMILY CARE HOME (AFCH) – A private residence for up to five older persons or adults with a disability, who are not related to the owner. The AFCH is licensed to provide housing, meals, and personal care services to individuals who are unable to live independently. The owner of the AFCH must reside in the home.

ADULT PROTECTIVE SERVICES (APS) – A program administered by the Department of Children and Families responsible for protecting vulnerable adults age 18 years of age or older from abuse, neglect, or exploitation. See Chapter 415, Florida Statutes http://www.flsenate.gov/Laws/Statutes/2012/Chapter415, and for more information, see http://www.myflfamilies.com/service-programs/abuse-hotline.

AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA) – http://www.fdhc.state.fl.us/Medicaid/index.shtml – The single state agency that is responsible for administering the Medicaid program. AHCA is responsible for enforcing federal Medicaid policies and procedures and developing state Medicaid policies and procedures. They are also responsible for licensure and regulation of Florida’s health facilities. Medicaid program handbooks can be accessed at – http://portal.flmmis.com/FLPublic/Provider_ProviderServices/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/53/Default.aspx

AGENCY FOR PERSONS WITH DISABILITIES (APD) – http://www.apd.myflorida.com – The agency that provides critical services and supports for persons with developmental disabilities to allow them to reach their full potential in the home and community. The
agency also performs PASRR Level II screenings for suspected intellectual disabilities. The agency serves people with autism, cerebral palsy, Spina Bifida, intellectual disabilities, Down syndrome, Prader-Willi syndrome, Phelan McDermid syndrome, and children age 3-5 who are at a high risk of a developmental disability.

AGING AND DISABILITY RESOURCE CENTERS (ADRCs) – A single, coordinated system for information and access to services for all Floridians seeking long-term care resources. The ADRCs provide information and assistance about state and federal benefits, as well as available local programs and services. This system also offers the public access to a statewide database of local community resources, available on the internet or by calling the Elder Helpline toll-free at 1-800-96 ELDER (1-800-963-5337). The ADRCs are operated by the 11 Area Agencies on Aging.

AGING IN PLACE – The ability to live in one’s own home and community safely, independently, and comfortably for as long as possible.

AGING NETWORK – A comprehensive service delivery system for elders and their caregivers that encompasses a wide range of organizations and providers. The aging network in Florida is composed of 11 Area Agencies on Aging, 52 local community care lead agencies, 15 memory disorder clinics, numerous faith-based and non-profit community organizations, assisted living facilities, adult family care homes, nursing facilities and local governments.

ALTERNATIVE PLACEMENT – A type of community living arrangement where services are provided that meet the needs of elders and the disabled such as an assisted living facility, adult family care home, private home, or intermediate care facility for the developmentally disabled.

ASSISTED LIVING FACILITY (ALF) – Any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide housing, meals, and one or more personal services for a period exceeding 24 hours, to one or more adults who are not relatives of the owner or administrator. ALFs are licensed by AHCA.

C

CARE PLAN – An individualized written plan of care that identifies the assessed needs of a client and how the needs will be met with the provision of services. The care plan includes the services, duration, frequency, and provider of the services.

CARES ON-SITE ASSESSMENT – A comprehensive evaluation by CARES staff of an individual’s medical, functional, mental, social, financial and environmental status for the purpose of determining the individual’s need for long-term care services. The DOEA Assessment Form (Appendix J) is used to complete the assessment. Also see http://elderaffairs.state.fl.us/doea/publications.php
CARES FIELD OFFICES – There are 19 CARES offices located in planning and service areas (PSAs) throughout the state. Staff in these offices provide clients direct access to the CARES process. See CARES SharePoint home page for a map of CARES offices and directory or http://elderaffairs.state.fl.us/english/cares.php

CARES UNIT – An assessment unit composed of a supervisor, senior assessors, assessors, nurses, physician consultants and administrative staff. (Some offices also have a CARES Assessor Supervisor.) The unit is responsible for assessing and determining medical eligibility for the Medicaid Institutional Care Program, as well as the following home and community-based Medicaid waivers and programs – Adult Cystic Fibrosis Waiver, Familial Dysautonomia Waiver, Project AIDS Care Waiver, Program of All-Inclusive Care for the Elderly (PACE), State Mental Health Hospital Program, Statewide Medicaid Managed Care (SMMC) Long-Term Care Program, and Traumatic Brain and Spinal Cord Injury Program. Additionally, the unit is responsible for conducting or overseeing the preadmission screening of all nursing facility applicants age 21 and older for the presence of serious mental illness and/or intellectual disability.

CARES ASSESSOR SUPERVISOR (CAS) – A position in the CARES field office that assists the Program Operations Administrator in supervising, assigning and monitoring the activities of Senior Assessor(s) and administrative support staff.

CASE MANAGEMENT – The collaborative process of evaluating client service needs, planning and coordinating service delivery, and monitoring client progress. Case management also includes reassessment and follow-up.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) – http://www.cms.hhs.gov/default.asp – The federal agency responsible for administering both the Medicare and Medicaid programs.

CHOICE COUNSELING – The process of providing information on available managed care plan choices and information about each managed care plan’s provider network. This process is administered by AHCA’s enrollment broker. Individuals can access the enrollment broker’s services by telephoning the call center at 1-877-711-3662; TDD 1-866-467-4970 or by website – http://www.flmedicaidmanagedcare.com/

CLIENT INFORMATION REGISTRATION AND TRACKING SYSTEM (CIRTS) – The data system developed to assist CARES staff and the aging network staff in the management of clients. The system is designed to track clients over time, in addition to providing statewide and unit-specific statistical reports. For detailed information on how to use CIRTS, refer to the CIRTS User Guide for CARES located at – https://199.250.26.79/reports/cirts/CIRTS_User_Guide_for_CARES.pdf

CLIENT INFORMATION FORM (CIF) – The electronic data collection form that is completed by CARES staff on each CARES referral.

COMPREHENSIVE ASSESSMENT AND REVIEW FOR LONG TERM-CARE SERVICES (CARES) – A program operated by the Department of Elder Affairs through an interagency agreement with AHCA that is Florida’s federally mandated preadmission screening program for long-term care services. CARES is responsible for assessing and evaluating long-term care needs, establishing level of care (medical eligibility) and recommending the least restrictive, most appropriate placement for all individuals applying for the Medicaid Institutional Care Program and Medicaid waivers.

D

DEMENTIA – A progressive disorder of the brain characterized by the development of multiple cognitive deficits (including memory impairment, the loss of the ability to use or comprehend words and the inability to plan or carry out daily activities) that are due to the direct physiological effects of a general medical condition, to the persisting effects of a substance, or to multiple etiologies.

DEPARTMENT OF CHILDREN AND FAMILIES (DCF) – http://www.myflfamilies.com/ – The primary state agency responsible for protection of vulnerable populations such as children, the elderly, and the mentally ill, from abuse, neglect and exploitation. DCF is also responsible for financial eligibility determinations for Medicaid applicants.

DEPARTMENT OF CHILDREN AND FAMILIES SUBSTANCE ABUSE AND MENTAL HEALTH – The Substance Abuse and Mental Health (SAMH) Program is designated by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The program is responsible for the oversight of a statewide system of care for the prevention, treatment, and recovery of children and adults with serious mental illnesses or substance abuse disorders. For more information, see – http://www.myflfamilies.com/service-programs/mental-health

DEPARTMENT OF ELDER AFFAIRS (DOEA) – http://www.elderaffairs.state.fl.us/ – The primary state agency responsible for administering human services programs for the elderly. The mission of DOEA is to foster an environment that promotes well-being for Florida’s elders and enables them to remain in their homes and communities.

DOEA ASSESSMENT FORMS – DOEA assessment forms are used to screen and assess a client’s health, function, needs and resources. These forms are used for Medicaid and non-Medicaid programs. CARES staff utilize the 701B, the 701T, and 701D, as described below. To see a complete listing or to download a copy of all DOEA assessments forms, click on the link – http://elderaffairs.state.fl.us/doea/publications.php#assessments.

DOEA COMPREHENSIVE ASSESSMENT FORM (701B) – A comprehensive assessment form used to evaluate a person’s capabilities and deficits that is administered face-to-
face. The form is used to assess all case-managed clients regardless of the program in which they are enrolled. It is also used to determine the need for services in the community and to complete reassessments to evaluate or update significant changes in the client’s situation. The 701B is completed by the Assessor/Case Manager with information provided by the client, observed directly, or verified by records. A priority score and rank are generated.

**DOEA Assessment Instructions (701D)** – This document provides guidance for completion of the Department of Elder Affairs’ 701B Comprehensive Assessment (see CARES SharePoint site).

**DOEA Non-Community Placement Assessment Form (701T)** – A shortened version of the 701B Comprehensive Assessment for use by CARES staff for individuals residing in a nursing facility with no intent to return to the community or for individuals residing in the community seeking long-term placement in a nursing facility (Appendix K).

**Department of Health** – [http://www.doh.state.fl.us](http://www.doh.state.fl.us) – The state agency responsible for promoting and protecting the health and safety of Floridians through the delivery of quality public health services and the promotion of health care standards. Programs managed by the Department of Health include 67 county health departments; Cystic Fibrosis and Traumatic Brain and Spinal Cord Injury Medicaid Waivers; Children’s Medical Services; Children’s, Women’s, and Community Health Programs; Disability Determinations, Special Needs Shelters and Emergency Preparedness.

**Department of Health and Human Services Administration on Aging** – [http://www.aoa.gov](http://www.aoa.gov) – The federal agency responsible for providing information about the Older Americans Act including the authorization of a range of programs that offer services and opportunities for older Americans and their caregivers.

**Eligibility Specialist** – A member of the DCF ACCESS staff responsible for determining eligibility for the Medicaid Institutional Care Program (ICP) and other programs administered by DCF.

**Enrollment Broker** – A vendor contracted with AHCA to provide choice counseling services to SMMC enrollees. The enrollment broker provides information on available managed care plan choices and information about each managed care plan’s provider network. The enrollment broker also processes enrollment, disenrollment and completes the individual’s requested change of managed care plan. Individuals can access the enrollment broker’s services by telephoning the Florida Medicaid Managed Care Helpline at 1-877-711-3662 or by website at [https://www.flmedicaidmanagedcare.com/Default.aspx](https://www.flmedicaidmanagedcare.com/Default.aspx).

**Enrollment Management System (EMS)** – A management system utilized by DOEA to prioritize potential enrollees for the SMMC Long-Term Care Program when program
funding has reached capacity. When Individuals are interested in community-based services, they are telephonically screened by the ADRCs using assessment Form 701S and placed on the Assessed Priority Consumer List. Completion of the screening form generates a priority score and rank in CIRTS based on frailty and need for services. When funding is available, DOEA, in consultation with AHCA, releases individuals from the EMS using the individual’s most recent CIRTS rank and priority score. The highest priority is assigned to the frailest individuals.

EXTENDED CONGREGATE CARE FACILITY (ECC) – An ALF that is licensed to provide expanded services to allow residents to “age in place.” These expanded services include some skilled nursing services and assistance to residents with decreased ability to perform ADLs, including total bed care for up to 14 days, if necessary.

FAMILIAL DYSAUTONOMIA WAIVER (FD) – A Medicaid waiver program that provides expanded Medicaid coverage to individuals diagnosed with FD to enable them to safely remain in the community and avoid institutionalization.

F

FLORIDA SYSTEM – DCF uses the FLorida Online Recipient Integrated Data Access system to determine eligibility for Medicaid, Food Stamps, and Cash Assistance programs. For DCF regulated eligibility categories such as Medicaid Waiver or Institutional Care Program (ICP), FLORIDA is the “source” for eligibility determinations. Nightly, for each work day, the FLORIDA system transmits an eligibility file containing transactions for any file additions, updates or closures regarding eligibility processed by DCF staff throughout the day to Medicaid’s system, FMMIS. This can include eligibility changes or demographic changes on open individuals in FLORIDA.

FMMIS – The Florida Medicaid Management Information System is the system that contains information about an individual’s Medicaid eligibility, processes claims, makes payments to providers, and issues recipient Medicaid identification cards. Medicaid eligibility must be reflected on FMMIS in order for an individual to be enrolled in Medicaid managed care and/or for a provider to receive reimbursement. The system is maintained by AHCA’s contracted fiscal agent.

FOLLOW-UP – A contact either on-site, electronically, in writing, or by telephone, with an individual assessed by CARES, his/her representative, or case manager, in order to determine the individual’s current functional status, living arrangement, and type and frequency of services received.

H

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) – A federal law that was enacted in 1996. The primary intent of HIPAA is to provide better access to health insurance, protect the confidentiality and security of healthcare information, limit fraud and abuse, and reduce administrative costs. It is a federal mandate that
all clients be notified of their rights regarding privacy of their medical information. CARES staff must provide each client or his/her representative with a copy of the Florida Department of Elder Affairs Notice of Privacy Practices. The signature page is to be completed and placed in the CARES case record. This form is only required one time. If the client refuses or is unable to sign the form, and there is no legal guardian or authorized representative, note it on the signature page and file in the CARES case record (Appendix H). For more information regarding HIPAA, see http://elderaffairs.state.fl.us/english/hipaa.php

**HEALTH TRACK** – The enrollment broker’s computer system.

**HOSPITAL-BASED SKILLED NURSING FACILITY** – A distinct part of an acute care hospital that provides skilled nursing care and related services for patients who require medical or nursing care or rehabilitation for injured, disabled or sick patients. Medicaid funding is available for 30 days, with one 15-day extension if pre-approved by CARES for hospital-based nursing facility recuperative care beds. The hospital must be enrolled as a Medicaid provider for these services, and the individual must be certified by CARES as meeting a skilled Level of Care (LOC).

**INFORMED CONSENT FORM** – An AHCA form that must be signed at an assessment for long term care services. The form explains the nature of the assessment, assures the individual or representative of confidentiality, and permits access to medical records. For more information, see Informed Consent in Chapter 4 of the handbook or Informed Consent Form (AHCA-Med Serv 2040, Appendix G).

**INITIAL ASSESSMENT** – The first time an individual is assessed by CARES.

**INSTITUTIONAL CARE PROGRAM (ICP)** – A Medicaid program that helps people in nursing facilities pay for the cost of their care and provides general medical coverage. To qualify for ICP, an individual must meet a nursing facility Level of Care as determined by CARES and be financially eligible as determined by DCF. The DCF ACCESS program office is responsible for the ICP policies in accordance with ACCESS Policy and Procedures – http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cashprogram-policy-manual

**INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS)** – The tasks necessary for independent functioning in the community. They include cooking, cleaning, doing laundry, shopping, using the telephone and accessing means of transportation, taking medicines, and managing money.

**INTAKE** – The method in which CARES processes referrals, including the sources from which cases are received and the requirements for accepting cases. Referrals for ICP assessments are accepted from any source and by any means of transmission – fax, mail, courier, walk-in, email or telephone. For additional information see Case Intake in Chapter 4 of the handbook.
**Intermediate Care** – Services that include 24-hour observation and care with the constant availability of medical and nursing treatment and care, but not to the degree of care and treatment provided in a hospital or that which meets the criteria for skilled nursing services. Intermediate care is further defined in Chapter 59G-4.180, Florida Administrative Code (Appendix Q). Also see https://www.flrules.org/gateway/ruleno.asp?id=59G-4.180&Section=0.

**Intermediate Care Facility for the Intellectually Disabled (ICF/ID)** – A facility that provides specialized care for the developmentally disabled. Medicaid reimbursement for ICF/ID specialized services include, but are not limited to – nursing services, rehabilitation care, therapy, medical supplies and dental care.

**Level of Care (LOC)** – The type of care required by an applicant or recipient based on his/her medical needs. The criteria for Intermediate LOC is described in Chapter 59G-4.180, Florida Administrative Code (Appendix Q), or https://www.flrules.org/gateway/ruleno.asp?id=59G-4.180&Section=0.

The criteria for Skilled LOC is described in 59G-4.290, Florida Administrative Code (Appendix R), or https://www.flrules.org/gateway/ruleno.asp?id=59G-4.290&Section=0.

**Long Term Care Facility** – A nursing facility, assisted living facility, intermediate care facility for the developmentally disabled or tuberculosis hospital participating in the Medicaid program.

**Medicaid Pending** – A category that allows individuals to be referred to a SMMC Long-Term Care program provider prior to receiving financial eligibility determined by DCF. A prospective participant who is not Medicaid eligible but who has been determined to meet Level of Care for the SMMC Long-Term Care Program may choose to begin receiving SMMC Long-Term Care Program services. This option is available only to EMS released clients applying for community-based services. (SSI Medicaid individuals do not have the pending option since their financial eligibility has already been determined and they may enroll for the upcoming month after their LOC is issued.).

**Medicaid Waiver (Med Waiver) Program** – Also known as Home and Community-Based Services (HCBS) Waivers – Programs applied for by states and approved by CMS in order to waive certain requirements in Medicaid Law. Medicaid Waiver Programs allow states to provide home and community-based services to individuals who would otherwise require nursing facility services. For more information on the different types of Medicaid waivers, see Chapter 7 of the handbook.

**Medical Case File Review (MCFR)** – Also known as a Desk Review – The examination of medical records by the CARES Assessor, Registered Nurse
Specialist and/or physician consultant in the process of determining level of care when face-to-face client contact is not required. See Chapter 4 of the handbook for circumstances under which a medical case file review can be completed.

**MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM (AHCA 5000-3008 FORM)** – A form that is used by CARES in the process of determining medical eligibility for Medicaid long-term care services. It is also used by hospitals to transfer a patient from a hospital to a nursing facility. Additionally, the form is used by CARES and delegated Level I Screeners to complete the PASRR Level I Screen. The 3008 must be signed and dated by a Medical Doctor (MD), Doctor of Osteopathy (DO), an Advanced Registered Nurse Practitioner (ARNP) per Chapter 59G-4.205, Florida Administrative Code or a Physician Assistant (PA). Form 3008 captures the client’s medical, functional, mental status, and treatment.

**Note** – See 3008 instructions (JUNE 2016) for completion of the form: [http://elderaffairs.state.fl.us/doea/cares/Medical_Cert_for_Long_Term_Care_5000_3008.pdf](http://elderaffairs.state.fl.us/doea/cares/Medical_Cert_for_Long_Term_Care_5000_3008.pdf)

The 3008 must be signed by a licensed physician, ARNP, or PA. If the physician, ARNP, or PA is not licensed by the State of Florida but is similarly and appropriately licensed by the United States military, Veteran’s Affairs (VA), or another state in the United States of America, a copy of the physician, ARNP, or PA’s valid and current license must accompany the 3008 form.

**MEDICARE** – A federal health insurance program for individuals age 65 or older, under age 65 with certain disabilities, and individuals of all ages with End Stage Renal disease. Medicare consists of three parts – *Part A Hospital Insurance*, *Part B Medical Insurance*, and *Part D Prescription Drug Insurance*. For more information on Medicare coverage, costs and resources click on the links – [http://www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/index.html](http://www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/index.html) and [http://www.medicare.gov/](http://www.medicare.gov/)

**MINIMUM DATA SET (MDS)** – The Minimum Data Set (MDS) is a standardized, primary screening and assessment tool. The MDS measures physical, psychological and psychosocial functioning and is part of the federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing facilities. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing facility staff identify health problems. Resident Assessment Protocols (RAPs), are part of this process, and provide the foundation upon which a resident's individual care plan is formulated. MDS assessment forms are completed for all residents in certified nursing facilities, regardless of source of payment for the individual resident. MDS assessments are required for residents on admission to the nursing facility and then periodically, within specific guidelines and time frames. In most cases, participants in the assessment process are licensed health care professionals employed by the nursing facility. MDS information is transmitted electronically by nursing homes to the MDS database in their respective
States. MDS information from the State databases is captured into the national MDS database at Centers for Medicare and Medicaid Services (CMS).

**N**

**NO LEVEL OF CARE (NLOC)** – The term used by CARES when an individual does not meet level of care (LOC) criteria as defined in 59G-4.180 or 59G-4.290, Florida Administrative Code.

**NURSING FACILITY (NF)** – Nursing and rehabilitative facilities that are certified under Medicare/Medicaid to provide nursing services as defined in 59G-4.180 or 59G-4.290, Florida Administrative Code.

**O**

**OMNIBUS BUDGET RECONCILIATION ACTS (OBRA ’87-’89)** – The Acts passed by Congress in 1987 and 1989 that include the regulations governing preadmission screening and resident review (PASRR).

**ON-SITE VISIT (OSV)** – A visit to the location where a client is currently residing (home, hospital, nursing facility, etc.) to obtain client assessment or follow-up information. To be considered an on-site visit the client must be interviewed or seen at time of assessment or follow-up.

**OPTIONAL STATE SUPPLEMENTATION (OSS)** – A cash assistance program administered by the Department of Children and Families (DCF). It serves to prevent institutionalization by supplementing the person's income to help pay for alternative living arrangements in an assisted living facility (ALF), adult family care home (AFCH), or Mental Health Residential Treatment Facility (MHRTF).

**P**

**preadmission screening and resident review (PASRR)** – Under the Omnibus Budget Reconciliation Act of 1987 and 1989 (OBRA ’87-’89), a Preadmission Screening is required for all individuals entering nursing facilities that participate in the Medicaid program regardless of the individual’s payment source. This screening identifies suspected serious mental illness and/or intellectual disability and the need for specialized services. A Resident Review is required if the individual has a change in their mental or physical condition that warrants a determination of the need for specialized services. For more information, see Chapter 5 of the handbook and 42 CFR 483.100-483.138 – http://www.ecfr.gov/cgi-bin/text-idx?SID=e88c6fab938ed6d79a1421dbc0fc512&node=pt42.5.483&rgn=div5#sp42.5.483.c

**PASRR LEVEL I SCREEN FOR SERIOUS MENTAL ILLNESS (SMI) AND/OR INTELLECTUAL DISABILITY OR RELATED CONDITIONS (ID)** – AHCA MedServ Form 004 Part A – A form that must be completed on all individuals prior to admission to a Medicaid certified nursing facility (See Chapter 5 of the handbook). The process uses the
Medical Certification for Nursing Facility/Home and Community-Based Services Form (AHCA MEDSERV-3008),DOEA Assessment Form (701B),CMAT Assessment form and any other available medical information to identify the presence or suspicion of serious mental illness and/or intellectual disability.

**PASRR LEVEL II EVALUATION AND DETERMINATION** – An extensive, individualized in-depth evaluation of the individual to confirm or rule out a suspected diagnosis of SMI, ID or both. The Level II Evaluation is also used to determine whether nursing facility services and specialized services are needed. The Office of Substance Abuse and Mental Health (SAMH) or its designee is responsible for determining the need for specialized services for individuals suspected of having SMI and if nursing facility placement is appropriate. The Agency for Persons with Disabilities (APD) is responsible for determining the need for specialized services for individuals suspected of having ID and if nursing facility placement is appropriate. See Chapter 5 of the handbook and 42 CFR 483.112 and 42 CFR 483.130.

**PHYSICIAN CONSULTANT** – A licensed medical doctor (MD), or Doctor of Osteopathy (DO), employed by CARES on a part-time basis to provide medical or psychiatric expertise and consultation, as well as to approve Level of Care decisions, Placement Recommendations, and Program Recommendations for CARES clients.

**PRIVATE PAY APPLICANTS** – Applicants for nursing facility admission who expect to use private funds or assets, rather than Medicaid, to pay for nursing facility care.

**PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)** – A unique capitated managed care program that provides a comprehensive range of medical and home and community-based services for individuals who would otherwise qualify for placement in a nursing facility. PACE organizations provide primary care, social, restorative and supportive services for Medicaid and Medicare eligible individuals age 55 and over who live in a PACE service area. The PACE program is county specific. (See Chapter 6 of the handbook for more information.)

**PROJECT AIDS CARE (PAC) WAIVER** – A Medicaid waiver program designed to assist people with Acquired Immune Deficiency Syndrome (AIDS) to live in their home or community. Individuals with AIDS who are determined to be at risk of hospitalization or placement in a nursing facility are given the choice to remain at home and receive home and community-based services under the PAC waiver. This waiver is available statewide and is administered by the Agency for Health Care Administration. (See Chapter 7 of the handbook for more information).

**READMISSION** – The return to the same facility following a temporary absence for hospitalization or therapeutic leave. A patient in this status does not normally need a new level of care determination.
**REASSESSMENT** – The process used to assess an individual who has previously been assessed utilizing an assessment instrument. Under certain circumstances, if approved by the CARES supervisor, a medical case file review reassessment may be done. (See Chapter 4 of the handbook for more information.)

**REFERRAL** – The verbal or written submission of demographic, medical, nursing, or psychosocial information that initiates the CARES process.

**REGIONAL PROGRAM SUPERVISOR (RPS)** – Managerial staff responsible for providing technical support and supervision to the CARES PSA offices within an assigned region.

**RESIDENT REVIEW (RR)** – The federally required re-screening of nursing facility residents experiencing a change of mental or physical status due to significant change. (See Chapter 5 of the handbook for more information.)

**SKILLED CARE** – A level of care that requires services to be ordered by and remain under the supervision of a physician. Individuals must be sufficiently medically complex to require supervision, assessment, planning or intervention by a registered nurse. Services are required to be on a daily basis and must be reasonable and necessary to the treatment of a specific documented illness or injury. Services must be consistent with the nature and severity of the individual's condition or the disease state or stage. See Chapter 59G-4.290 FAC (Appendix R), or https://www.flrules.org/gateway/ruleno.asp?id=59G-4.290&Section=0.

**SPEND DOWN** – The process of reducing the assets of an individual to the Medicaid asset limit by using the individual's assets to pay for long term care needs in order to qualify for Medicaid.

**STAFFING** – An interdisciplinary team meeting of CARES professional staff, Program Operations Administrator, CARES Physician Consultant and/or Registered Nurse Specialist to review medical documentation and assessment information for CARES’ clients. The purpose of staffing is to determine appropriate and correct Level of Care, Program Recommendation and Placement Recommendation.

**SUBSTANCE ABUSE AND MENTAL HEALTH (SAMH) PROGRAM** – A program within the Department of Children and Families that provides for publicly funded services for the prevention, treatment and recovery of children and adults with serious mental illness or substance abuse disorders.

**SUPPLEMENTAL SECURITY INCOME (SSI)** – A cash assistance program administered by the Social Security Administration (SSA) for low-income elderly, disabled or blind individuals. In Florida, SSI recipients automatically qualify for Medicaid without a separate application with DCF.
SWING BEDS – A program that provides Medicaid funding for rural hospital beds that can “swing” to nursing facility beds when a patient needs nursing care rather than acute care services. The individual must be certified by CARES as being eligible for skilled or intermediate nursing care services under Medicaid.

TEMPORARY PLACEMENT – An individual in need of a temporary stay in a nursing facility or rehabilitation center who has potential for returning to the community. A client in a temporary placement who returns to the community is considered in an alternative placement at the time of return to the community.

TIME STANDARDS – The amount of time measured in days allowed to complete a CARES activity. Time standards are necessary to ensure timely compliance with CARES policies and ICP approval policy of DCF. The goals of time standards are to be responsive to the health needs of the individuals referred for assessment, to help the hospital expedite discharges when hospitalizations are longer than the authorized Medicaid limit, and to expedite the provision of services to individuals referred for assessment. (See Time Standards Chart, Appendix V).

TRAUMATIC BRAIN AND SPINAL CORD INJURY (BSCIP) WAIVER – A Medicaid waiver program that allows individuals with a traumatic brain injury or spinal cord injury to live in their homes or in community-based settings rather than living in a nursing facility. This waiver is available statewide and is operated by the Department of Health, Brain and Spinal Cord Injury Program. See Chapter 7 of the handbook for more information.

WITHHOLD LEVEL OF CARE – The term that applies to those cases that do not warrant CARES issuing a Level of Care. CARES withholds a Level of Care in the following situations:

- A Request for Level II PASRR Evaluation and Determination indicates that the individual requires specialized services and those services cannot be provided in a nursing facility;
- A Request for Level II PASRR Evaluation and Determination indicates the individual is not appropriate for nursing facility placement;
- A 3008 or supporting medical documentation has not been received.
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APPENDICES

~ ACRONYMS AND ABBREVIATIONS ~

A

AAA .......... Area Agency on Aging
ACCESS ..... Automated Community Connection to Economic Self-Sufficiency
ACF .......... Adult Cystic Fibrosis
ADL .......... Activities of Daily Living
ADRC ........ Aging and Disability Resource Center
AFCH ........ Adult Family Care Home
AHCA ........ Agency for Health Care Administration
ALF .......... Assisted Living Facility
AoA .......... Administration on Aging (U.S. Department of health and Human Services
APD .......... Agency for Persons with Disabilities
APS .......... Adult Protective Services
ARNP .......... Advanced Registered Nurse Practitioner

B

BSCIP .......... Brain and Spinal Cord Injury Program

C

CARES .......... Comprehensive Assessment and Review for Long-Term Care Services
CAS .......... CARES Assessor Supervisor
CFR .......... Code of Federal Regulations
CIF .......... Client Information Form
CIRTS ......... Client Information and Registration Tracking System
CM .......... Case Manager
CMS .......... Centers for Medicare and Medicaid
CO .......... Central Office

D

DCF .......... Department of Children and Families
DO .......... Doctor of Osteopathic Medicine
DOEA .......... Department of Elder Affairs
DOH .......... Department of Health

E

EB .......... Enrollment Broker
ECC .......... Extended Congregate Care
EMS .......... Enrollment Management System
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>FAC</td>
<td>Florida Administrative Code</td>
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<tr>
<td>FD</td>
<td>Familial Dysautonomia</td>
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<tr>
<td>FLORIDA</td>
<td>Florida Online Recipient Integrated Data Access</td>
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<tr>
<td>FMMIS</td>
<td>Florida Medicaid Management Information System</td>
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<tr>
<td>FS</td>
<td>Florida Statutes</td>
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<tr>
<td>HCBS</td>
<td>Home and Community-Based Services</td>
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<td>HIPAA</td>
<td>Health Insurance Portability and Accessibility Act</td>
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<td>HT</td>
<td>Health Track</td>
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<tr>
<td>IADL</td>
<td>Instrumental Activity of Daily Living</td>
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<tr>
<td>ICF/DD</td>
<td>Intermediate Care Facility for the Disabled</td>
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<tr>
<td>ICP</td>
<td>Institutional Care Program</td>
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<tr>
<td>ID</td>
<td>Intellectual Disability</td>
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<td>IO</td>
<td>Intermediate One</td>
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<td>IT</td>
<td>Intermediate Two</td>
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<tr>
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<td>LTCOP</td>
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<tr>
<td>MCFR</td>
<td>Medical Case File Review</td>
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<td>MD</td>
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<td>MDS</td>
<td>Minimum Data Set</td>
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<td>OAA</td>
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<td>OBRA</td>
<td>Omnibus Budget Reconciliation Act</td>
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<td>OSS</td>
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<td>Program of All-Inclusive Care for the Elderly</td>
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<td>PASRR</td>
<td>Preadmission Screening and Resident Review</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<td>---------</td>
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<td>PHI</td>
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<tr>
<td>POA</td>
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<td>PSA</td>
<td>Planning and Service Area</td>
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<td>R</td>
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<td>Substance Abuse and Mental Health</td>
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<td>Statewide Community-Based Services</td>
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<td>SS</td>
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<td>SMMC</td>
<td>Statewide Medicaid Managed Care</td>
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<td>T</td>
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<tr>
<td>TDD</td>
<td>Teletype (Telecommunication Device for the Deaf)</td>
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<tr>
<td>TTY</td>
<td>Telecommunication Device for the Deaf</td>
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<td>WH</td>
<td>Withhold</td>
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(This page intentionally left blank.)
### CARES Medical Abbreviations

**A**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tr>
<td>a.c.</td>
<td>before meals (<em>ante cibum</em>)</td>
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<tr>
<td>ad lib</td>
<td>as desired</td>
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<tr>
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<td>acquired immunodeficiency syndrome</td>
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<td>AKA</td>
<td>above-knee amputation</td>
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<tr>
<td>alb</td>
<td>albumin</td>
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<tr>
<td>Alk Phos</td>
<td>alkaline phosphatase</td>
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<tr>
<td>ALL</td>
<td>acute lymphocytic leukemia</td>
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<tr>
<td>ALS</td>
<td>Amyotrophic Lateral Sclerosis</td>
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<tr>
<td>a.m.; AM</td>
<td>before noon</td>
</tr>
<tr>
<td>AMA</td>
<td>against medical advice</td>
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<tr>
<td>AML</td>
<td>acute myelocytic (myelogenous) leukemia</td>
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<td>AMOX</td>
<td>amoxicillin</td>
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<tr>
<td>amt</td>
<td>amount</td>
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<tr>
<td>APAP</td>
<td>acetaminophen</td>
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<tr>
<td>approx.</td>
<td>approximately</td>
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<tr>
<td>ARC</td>
<td>AIDS-related complex</td>
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<tr>
<td>ARDS</td>
<td>acute respiratory distress syndrome</td>
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<tr>
<td>ART</td>
<td>automated reagin test</td>
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<tr>
<td>ASA</td>
<td>aspirin</td>
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<tr>
<td>ASHD</td>
<td>arteriosclerotic heart disease</td>
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<td>as tol</td>
<td>as tolerated</td>
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**B**

<table>
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<tr>
<th>Abbreviation</th>
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<tr>
<td>b.i.d.</td>
<td>twice a day (<em>bis in die</em>)</td>
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<tr>
<td>bilat</td>
<td>bilateral</td>
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<tr>
<td>BMR</td>
<td>basal metabolic rate</td>
</tr>
<tr>
<td>BP</td>
<td>blood pressure</td>
</tr>
<tr>
<td>BPH</td>
<td>benign prostatic hypertrophy</td>
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<tr>
<td>BS</td>
<td>blood sugar</td>
</tr>
<tr>
<td>Bx</td>
<td>biopsy</td>
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<td>BUN</td>
<td>blood urea nitrogen</td>
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</table>

**C**

<table>
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<td>CA</td>
<td>cancer</td>
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<tr>
<td>Ca</td>
<td>calcium</td>
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<td>CAD</td>
<td>coronary artery disease</td>
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<tr>
<td>cal</td>
<td>calorie</td>
</tr>
<tr>
<td>cap</td>
<td>capsule</td>
</tr>
<tr>
<td>cath</td>
<td>catheter, catheterize</td>
</tr>
<tr>
<td>CBC</td>
<td>complete blood count</td>
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</table>
C. diff .......... clostridium difficile infection
CD ............... communicable disease
CDC .............. Centers for Disease Control and Prevention
CHC .............. coronary heart disease
CHF .............. congestive heart failure
CHO .............. carbohydrate
Chol .............. cholesterol
CIS ............... carcinoma in situ
CI ................ chloride
cm ................ centimeter
CMV .............. cytomegalovirus
CNS .............. central nervous system
c/o .............. complaint of
CO₂ .............. carbon dioxide
COLPO .......... colposcopy
cont .............. continue
COPD ............ chronic obstructive pulmonary disease
CPK .............. creatinine phosphokinase
CPR .............. cardiopulmonary resuscitation
Creat ............ creatinine
CT .............. computerized tomography
CVA .............. cardiovascular accident; cerebrovascular accident
CVD .............. cardiovascular disease
CVD .............. cardiovascular system
CXR .............. chest x-ray
decub. .......... decubitus
disc. .............. discontinue
DM .............. diabetes mellitus
DOXY .......... doxycycline
dsg .............. dressing
dt .............. delirium tremens
DX .............. diagnosis
EBV .......... Epstein-Barr virus
ECG; EKG ......... electrocardiogram
EEG .............. electroencephalogram
EENT ............ eyes, ear, nose and throat
e.g. .............. for example
E-MYCIN .......... erythromycin
ENT .............. ear, nose and throat
ERT .............. estrogen replacement therapy
ESRD .......... end-stage renal disease
ETOH .............. ethyl alcohol

F
FBS .............. fasting blood sugar
Fe ................ iron
FeSO₄ ............ ferrous sulfate
FHx .............. family history
fl ................ fluid
FTT .............. failure to thrive
Fx ................ fracture

G
GI ................ gastrointestinal
Glu ................ glucose
gm .............. gram
gtt ................ drops (guttae)
GTT .............. glucose tolerance test
GU .............. genitourinary
GYN .............. gynecology

H
HBV ............... Hepatitis B virus
HCT ................ hematocrit
HDL .............. high-density lipoproteins
HEENT .......... head, eyes, ears, nose and throat
Hgb .............. hemoglobin
H&H .............. hemotocrit and hemoglobin
HIV .............. human immunodeficiency virus
H&P .............. history and physical
HPV ............... human papilloma virus
hr .............. hour
h.s. .............. hour of sleep (hora somni)
HSV .............. herpes simplex virus
HV .............. home visit
hx .............. history
H₂O .............. water
H₂O₂ .............. hydrogen peroxide
i.e. ................. that is
ig ................ immunoglobulin
IM ................ intramuscular
Ing ................ inguinal
I&O .............. intake and output
IPPB .............. intermittent positive-pressure breathing
IQ .............. intelligence quotient
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<td>IVDU</td>
<td>intravenous drug user</td>
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<td>IVP</td>
<td>intravenous pyelogram</td>
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<tr>
<td>K</td>
<td>potassium</td>
</tr>
<tr>
<td>KG</td>
<td>kilogram</td>
</tr>
<tr>
<td>KOH</td>
<td>potassium hydroxide</td>
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<td>KS</td>
<td>Kaposi’s Sarcoma</td>
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<td>L</td>
<td>left</td>
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<td>Lab</td>
<td>laboratory</td>
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<tr>
<td>LB</td>
<td>pound</td>
</tr>
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<td>LDH</td>
<td>lactic dehydrogenase</td>
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<tr>
<td>LDL</td>
<td>low-density lipoprotein</td>
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<td>LDL/HDL</td>
<td>risk ratio (lipids)</td>
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<td>large</td>
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<td>left lower lobe (lung)</td>
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<td>LLQ</td>
<td>left lower quadrant</td>
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<td>LUQ</td>
<td>left upper quadrant</td>
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<td>L&amp;W</td>
<td>living and well</td>
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<td>Mag. Sulfate</td>
<td>Epsom salts</td>
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<td>milligram</td>
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<td>Mg/dl</td>
<td>milligrams per deciliter</td>
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<td>myocardial infarction</td>
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<td>milliliter</td>
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<td>MM</td>
<td>millimeter</td>
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<td>month</td>
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<td>Mod</td>
<td>moderate</td>
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<td>milk of magnesia</td>
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<td>MRI</td>
<td>magnetic resonance imaging</td>
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<td>MRSA</td>
<td>methicillin-resistant staphylococcus aureus</td>
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<td>MS</td>
<td>multiple sclerosis</td>
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<td>MTB</td>
<td>mycobacterium tuberculosis</td>
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<td>MU</td>
<td>million units</td>
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<td>Multi</td>
<td>multiple</td>
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<td>MVP</td>
<td>mitral valve prolapse</td>
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<td>sodium</td>
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<td>non-insulin dependent diabetes mellitus</td>
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<td>NKA</td>
<td>no known allergies</td>
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<td>Norm</td>
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<td>Isophane insulin</td>
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<td>NPO; n.p.o.</td>
<td>nothing by mouth (nil per os)</td>
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<td>normal saline</td>
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<tr>
<td>nsg</td>
<td>nursing</td>
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<td>normal sinus rhythm</td>
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<td>nitroglycerin</td>
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<td>N&amp;V</td>
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<td>O</td>
<td>ointment</td>
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<td>oxygen</td>
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<td>organic brain syndrome</td>
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<td>over-the-counter</td>
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<td>oz</td>
<td>ounce</td>
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<td>PCN</td>
<td>penicillin</td>
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<td>physical examination</td>
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<td>per</td>
<td>by</td>
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<td>hydrogen ion concentration</td>
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<td>phosphorus</td>
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<td>pelvic inflammatory disease</td>
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<td>phenylketonuria</td>
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<td>p.m.; PM</td>
<td>afternoon</td>
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<tr>
<td>po</td>
<td>by mouth (per os)</td>
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<td>POS</td>
<td>positive</td>
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<tr>
<td>ppd</td>
<td>packs per day</td>
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<td>PPBS</td>
<td>postprandial blood sugar</td>
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<td>prn</td>
<td>as needed (pro re nata)</td>
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<td>prot</td>
<td>protein</td>
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<td>patient</td>
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<td>prothrombin time; physical therapy</td>
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<tr>
<td>q</td>
<td>every</td>
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<tr>
<td>q.d.</td>
<td>every day (quaque die)</td>
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<tr>
<td>q.h.</td>
<td>every hour (quaque hors)</td>
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<td>q.i.d.</td>
<td>four times a day (quarter in die)</td>
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<td>q.o.d.</td>
<td>every other day</td>
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<td>R</td>
<td>right</td>
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<td>RA</td>
<td>rheumatoid arthritis</td>
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<td>red blood cell</td>
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<td>rehabilitation</td>
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<td>RLL</td>
<td>right lower lobe (lung)</td>
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<td>right middle lobe (lung)</td>
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<td>RLQ</td>
<td>right lower quadrant</td>
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<td>Rm</td>
<td>room</td>
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<td>R/O</td>
<td>rule out</td>
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<td>ROM</td>
<td>range of motion</td>
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<td>ROS</td>
<td>review of symptoms</td>
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<td>rapid plasma reagin</td>
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<td>regular rate and rhythm</td>
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<td>right upper quadrant</td>
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<td>slight</td>
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<td>small</td>
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<tr>
<td>SOB</td>
<td>shortness of breath</td>
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<td>Spon</td>
<td>spontaneous</td>
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<tr>
<td>SROM</td>
<td>spontaneous rupture of membrane</td>
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<td>S&amp;S</td>
<td>signs and symptoms</td>
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<td>staph</td>
<td>staphylococcus aureus</td>
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<td>STAT; stat.</td>
<td>immediately</td>
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<td>sexually transmitted disease</td>
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<td>sexually transmitted infection</td>
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<tr>
<td>subcut; Subcu</td>
<td>subcutaneous</td>
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<td>symptom</td>
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<td>tablet</td>
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<tr>
<td>TB</td>
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<td>total bilirubin</td>
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<td>tablespoon</td>
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<td>tetracycline</td>
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<td>Temp</td>
<td>temperature</td>
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<tr>
<td>t.i.d.</td>
<td>three times daily <em>(ter in die)</em></td>
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<td>TMJ</td>
<td>temporomandibular junction/joint</td>
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<td>TNTC</td>
<td>too numerous to count</td>
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<td>top</td>
<td>topical</td>
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<tr>
<td>TPR</td>
<td>temperature, pulse, respiration</td>
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<td>trace</td>
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<td>tracheostomy</td>
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<td>triglycerides</td>
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<td>teaspoon</td>
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<td>TUR; TURP</td>
<td>transurethral resection</td>
</tr>
<tr>
<td>Tx</td>
<td>treatment</td>
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U
UA .................. urinalysis
UGI .................. upper gastrointestinal
unk .................. unknown
URI .................. upper respiratory infection
UTI .................. urinary tract infection
V
Vag .................. vaginal
VD .................. venereal disease
VIT .................. vitamins
VRSA ................. vancomycin-resistant staphylococcus aureus
VS .................. vital signs
W
WBC .................. white blood cells
WC .................. wheelchair
WD .................. well developed
wk .................. week
WN .................. well nourished
WNL ................. within normal limits
wt .................. weight
x .................. multiplied by
Y
yo; y/o .............. year old
yr .................. year
# CARES INTAKE FORM

## DEMOGRAPHIC

- **Social Security Number (SSN):** 
- **First Name:** 
- **Middle Initial (MI):** 
- **Last Name:** 
- **Date of Birth:** / /  
- **Medicaid Number:** 
- **Medicare Number:** 
- **Race:** (Circle)
  - Asian/Pacific Islander
  - Black
  - Native American
  - Other
  - Unknown
  - White
  - Hispanic
  - Other
  - Unknown
- **Sex:** (Circle)
  - Female
  - Male
- **Marital Status:** (Circle)
  - Divorced
  - Married
  - Separated
  - Single
  - Unmarried
- **Address:** 
  - Address 1: 
  - Address 2: 
- **Zip Code:** 
- **City:** 
- **State:** 
- **County:** 
- **Phone Number:** 
- **Primary Language:** 
- **Income:** 
- **Assets:**

## CASE ASSIGNMENT (Circle Choices)

- **Initial Date:** / /  
- **Assigned To:** (Circle)
  - Adult Foster Care
  - Adult Home Care
  - Adult Day Care
  - Babysitting
  - Boarding Home
  - Child Care
  - Companionship
  - Counseling
  - Day Care
  - Dementia Care
  - Discharge Planning
  - Dietitian
  - Direct Care
  - Elderly Care
  - Family Support
  - Financial Assistance
  - Home Health Care
  - Housing
  - Hospital
  - Nursing Home
  - Other
  - Personal Care
  - Physical Therapy
  - Psychiatric Care
  - Rehabilitation
  - Social Work
  - Transportation
  - Vocational Rehabilitation

- **Referral Source:** (Circle)
  - Adult Foster Care
  - Adult Home Care
  - Adult Day Care
  - Babysitting
  - Boarding Home
  - Child Care
  - Companionship
  - Counseling
  - Day Care
  - Dementia Care
  - Discharge Planning
  - Dietitian
  - Direct Care
  - Elderly Care
  - Family Support
  - Financial Assistance
  - Home Health Care
  - Housing
  - Hospital
  - Nursing Home
  - Other
  - Personal Care
  - Physical Therapy
  - Psychiatric Care
  - Rehabilitation
  - Social Work
  - Transportation
  - Vocational Rehabilitation

- **Cell Phone:** 
- **Business Phone:** 
- **Referral Source Name:** 
- **Home Phone:**

## ADDITIONAL CLIENT INFORMATION

- **Client Home Address:** 
- **City:** 
- **Zip Code:** 
- **Phone Number:**

- **Responsible Party/Caregiver:** 
- **Relationship:**

- **Home Phone:** 
- **Cell Phone:**

- **Business Phone:** 
- **Other Phone:**

- **Physician:** 
- **Phone Number:**

## INTAKE SIGNATURE: ___________________________  DATE: ___________________________
### ADDITIONAL INTAKE INFORMATION

**DIAGNOSES:**

---

**MEDICATIONS:**

---

**THERAPIES/TREATMENTS:**

---

**DIRECTIONS TO HOME/FACILITY:**

---

**OTHER INFORMATION:**

---
ACCESS/CARES COMMUNICATION

DATE: _____

TO: Department of Elder Affairs – CARES Unit
TO: Department of Children and Families – ACCESS

FROM: ___________ Fax: ___________
Phone: ___________ Email Address: ___________

FROM: ___________ Fax: ___________
Phone: ___________ Email Address: ___________

I. IDENTIFYING INFORMATION/DEMOGRAPHICS

Client’s Name: ___________ Case No: ___________ Date of Application: ___________
Client’s Present Location: □ Hospital □ Nursing Facility □ Home □ Other (specify): ___________
Name of Facility: ___________ Admit Date: ___________ Discharge Date: ___________
Current Address: ___________ Phone: ___________
Martial Status: □ Married □ Single □ Divorced □ Separated □ Widower: ___________
Medicaid PIN: ___________ SSN: ___________ DOB: ___________ Sex: ___________
Relative/Guardian: ___________ Relationship: ___________
Address: ___________ Phone: ___________
Attending Physician: ___________
Address: ___________ Phone: ___________

II. COMPLETED BY ACCESS STAFF

□ Initial Application for ICP □ ICP Application Denied for reason noted in Section IV
□ Client Pended for missing forms □ Attachments: 3008 2040 Other □ None Provided
□ Replication or Reactivation of Application □ Needed LOC Begin Date: ___________
□ Applicant pended to provide medical forms to CARES by ___________ (30 days from pending date)
□ Individual requested additional time to return requested forms to CARES. New due date: ___________
ACCESS staff will deny the ICP category on (date) _____ if the applicant or CARES does not request additional time.

III. COMPLETED BY CARES STAFF

□ LOC already completed on ___________
□ Individual returned requested forms within 30 days and level of care determination in progress.
□ Individual requested additional time to return requested forms. New due date, if after due date in Section II: ___________
□ Individual returned requested forms, but Level II PASSR requested and in progress.
□ Unable to complete LOC process for reason(s) indicated in Section IV.
□ Individual returned forms after 30 days on ___________. Please notify us if application is to be reactivated.

IV. COMMENTS OR SPECIAL INSTRUCTIONS

CF-MED 3007, Oct 2010
Dear Mr./Ms. INSERT NAME:

The Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program has attempted to schedule an appointment for an on-site visit with you unsuccessfully.

Attempted contacts were made on DATE and DATE in order to process your request for a medical eligibility determination. This requires a staff person to visit your home and conduct an on-site medical assessment to evaluate your need(s) and eligibility for programs.

Please contact the office at PHONE NUMBER, by INSERT DATE (DATE INSERTED IS 10 BUSINESS DAYS FROM DATE ON THIS LETTER). If you do not contact our office by this date, your request will be closed. You are encouraged to resubmit the request when it is convenient for you.

Thank you for your prompt attention to this matter.

Sincerely,

INSERT NAME

INSERT SUPERVISOR TITLE

CC:

(REFERRAL SOURCE)

NAME, TITLE

ADDRESS

CITY, STATE ZIP CODE

INSERT YOUR AGENCY’S ADDRESS, CITY, STATE ZIP CODE

INSERT PHONE NUMBER, FAX NUMBER
STATE OF FLORIDA

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

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

AHCA-Med Serv 2040, May 2008
(This page intentionally left blank.)
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Please Read It Carefully

Effective Date: September 22, 2013

Department of Elder Affairs’ Duties

This notice applies to the information and records we have about your health, health status, and the health care and service you receive from the Department in your personal file. It describes the information privacy practices followed by your employees, volunteers, staff and other office personnel. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We are required by law to notify you of our legal duties and privacy practices with respect to your health information. We are also required to maintain the privacy of your protected health information in our custody, and to follow the terms of this notice. If there is a breach involving your protected health information, we will notify you no later than 60 days following the discovery of the breach. The Department is required to abide by the terms of the notice of privacy practices that is currently in effect.

Uses and Disclosures of Your Protected Health Information

We may use or disclose your protected health information for the following purposes:

* Treatment - to provide you with medical treatment or services and to manage and coordinate your medical care. For example, your protected health information may be disclosed to a business associate of the Department to determine your medical eligibility for Medicare long-term care services.

* Payment - to bill and collect payment for your health-care services. We may disclose or use your protected health information to obtain or justify payment for your health-care services from various payment sources including federal and state funding programs such as Medicaid.

* Health care operations - to evaluate the performance of our staff in caring for you and to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective. We may also use your protected health information to: contact you as a reminder that you have a scheduled appointment for treatment or medical care, inform you of potential treatment alternatives or options, or inform you of health-related benefits that may be of interest to you.

We may not use or disclose your information in the following circumstances without your authorization:

* Psychotherapy Notes - Any use or disclosure of psychotherapy notes, unless the notes are being used for treatment, payment, or health care operations, including mental health training programs, oversight compliance, research purposes, or as part of a legal defense.

* Marketing - Any use or disclosure for marketing purposes, except for face-to-face communication or promotional gifts to the individual.

* Sale of Information - Any sale of protected health information to a third party. We may not exchange your protected health information to a third party for money unless you consent.

There are special situations which allow us to use or disclose your protected health information without your permission. These situations include:

* To Avert Serious Threat to Health or Safety - to prevent a serious threat to the health and safety of yourself, the public or another person. We may disclose information to a family member or a close friend if necessary to assist you in a life-threatening emergency.

* Required by Law - when required by federal, state or local law, we must disclose or use your information to the extent required.

* Research - for research projects that benefit elders in Florida. The Department may disclose your information for research projects that have been approved by an institutional review board or privacy board that has analyzed the research proposal to review the effect of the research on your privacy rights and related legal rights.

* Organ and Tissue Donation - we may release information to organizations that handle procurement or transplantation, such as an organ donation bank, as necessary to facilitate
organ or tissue donation and transplantation.

* Current or Previous Military, Veterans, National Security and Intelligence Members - when required by military command or other government authorities. We may also release information about foreign military personnel to the appropriate foreign military authority.

* Workers' Compensation - as authorized by and to the extent necessary to comply with laws relating to workers’ compensation or similar programs. Such programs provide benefits for work-related injuries or illness.

* Public Health Risks - to public health or other authorities charged with preventing or controlling disease, injury or disability. We may also disclose your information to report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with FDA regulated products.

* Health Oversight Activities - for audits, investigations, inspections, licensure purposes, or other activities necessary for appropriate oversight, as authorized by law. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

* Lawsuits and Disputes - in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose protected health information about you in response to a subpoena. We may also use or disclose your information to defend ourselves in the event of a lawsuit or administrative proceeding.

* Law Enforcement - for law enforcement purposes if required to do so by law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

* Coroners, Medical Examiners and Funeral Directors - to identify a deceased person or determine the cause of death. We may disclose your information to report vital events such as death, as permitted or required by law.

* Volunteers - to volunteers performing work for the Department, including, but not limited to, volunteers in programs such as SHINE, SAGE, Sunlight for Seniors and State Long-Term Care Ombudsman.

* Information Not Personally Identifiable - we may disclose health information that does not personally identify you or reasonably reveal who you are.

* Fundraising Activities - to contact you for fundraising activities. You may elect not to receive fundraising communications by contacting the Privacy Officer in the Office of General Counsel.

Other Uses and Disclosures

We will not use or disclose your protected health information for any purpose that is not addressed in this notice without your specific, written authorization. If you give us authorization, you may revoke it, in writing, at any time. If you revoke your authorization, we will no longer use or disclose information about you for the purposes covered by your written authorization. However, we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without your special signed, written authorization from you. This is different than the authorization and consent mentioned above.

In order to disclose HIV or substance abuse records for purposes of treatment, payment, or healthcare operations, we will need both your signed consent and a special written authorization that complies with the law governing those records.

Individual Rights

You have the right to inspect and copy your protected health information. In order to do so, you must submit a written request to inspect and/or copy your protected health information. Your request may be denied in certain limited circumstances. However, if your request is denied, you may ask that the denial be reviewed. We will comply with the outcome of the review. As provided by 45 CFR § 164.526, reasonable copy fees shall apply in accordance with State law.

You have the right to request a correction or change to your protected health information if you believe it is incorrect or incomplete, as provided by 45 CFR § 164.526. Your request must be in writing and include a reason to support the request. We may deny your request if you ask us to amend unrecorded information that:

a) we did not create, unless the person or entity that created the information is no longer available to make the amendment;

b) is not part of the health information that we keep, and/or

c) you would not be permitted to inspect and copy.

You have the right to request an accounting of disclosures, as provided by 45 CFR § 164.528. This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and healthcare operations. You may request an accounting of disclosures for a period up to six years prior to the date of your request. You must submit your request in writing. You are entitled to obtain one free copy of the accounting per 12-month period. For each additional request, we may charge you for the costs of providing the list, whether it is provided electronically or by paper copy. However, you may choose to withdraw or modify your request before any costs are incurred.
You have the right to request to receive communications of protected health information by alternative means or at alternative locations, as provided by 45 CFR 164.522(b). You may request that we communicate with you about medical matters in a certain way or at a certain location.

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations as provided by 45 CFR §164.522(a). If we agree to a requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment.

You have the right to a paper copy of this notice. If you have agreed to receive it electronically, you are still entitled to a paper copy upon request to the Privacy Officer in the Office of the General Counsel.

Changes to This Notice
We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. If this notice is revised or changed, we will post a summary of the current notice in the Department with its effective date. An up-to-date copy of this notice is available electronically on our website at www.elderaffairs.state.fl.us. You are entitled to a copy of the notice currently in effect.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint with our office or the Secretary of the U.S. Department of Health and Human Services, contact:

Privacy Officer, Office of the General Counsel
Department of Elder Affairs
4040 Esplanade Way
Tallahassee, FL 32399-7000
Voice Phone: (850) 414-2004
FAX: (850) 414-2001

Region IV, Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 3870
61 Forsyth Street S.W.
Atlanta, Georgia 30303-8909
Voice Phone: (800) 368-1019
FAX: (404) 562-7881
TED: (800) 557-7697

For Further Information
Requests for further information about topics covered in this notice may be directed towards the person who gave you the notice or to the Department of Elder Affairs, Privacy Officer, Office of the General Counsel at 4040 Esplanade Way, Tallahassee, FL 32399-7000 or by phone at (850) 414-2000.
I hereby acknowledge that I have received and read this Notice of Privacy Practices.

________________________________________
Signature

________________________________________
Printed Name

________________________________________
Date (DD/MM/YYYY)
WHY IS THE DEPARTMENT OF ELDER AFFAIRS
COLLECTING YOUR SOCIAL SECURITY NUMBER?

Your social security number is confidential under law. We may not collect your social security number unless we explain to you in writing the reason we need it.

The Department is collecting your social security number as part of its responsibility to conduct assessments. We do this in order to determine benefits or services, including federal benefits, that may be right for you. If there is any other reason, it will be listed below:

We will not use or give out your social security number for any other reason, including referrals to other agencies, unless you have signed a separate form consenting to the release of information to another agency.
Florida Department of Elder Affairs
701B Comprehensive Assessment
Rule: 58-A-1.010, F.A.C.

Provider ID: __________________________  Provider Assessor/CM ID: __________________________
Assessor/Case Manager (CM) Name: __________________________  Signature: __________________________

A. DEMOGRAPHIC SECTION

1. ASSSESSOR/CM: What is the purpose of this assessment?
   - Initial
   - Annual
   - Health
   - Living situation
   - Caregiver
   - Environment
   - Income

2. Social Security number: __________________________


4. Medicaid number: __________________________

5. Phone number: __________________________

6. Date of birth (mm/dd/yyyy): __________________________

7. Sex:  □ Male  □ Female

8. Race (Mark all that apply):  □ White  □ Black/African American  □ Asian  □ American Indian/Alaska Native  □ Native Hawaiian/Pacific Islander  □ Other

9. Ethnicity:  □ Hispanic/Latino  □ Other

10. Primary language:  □ English  □ Spanish  □ Other:

11. Does client have limited ability reading, writing, speaking, or understanding English?  □ No  □ Yes

12. Marital status:  □ Married  □ Partnered  □ Single  □ Separated  □ Divorced  □ Widowed

13. ASSSESSOR/CM: Current Physical Location Address (If type is a facility, enter facility name.)
   a. Street: __________________________
   b. City: __________________________  c. ZIP code: __________________________
   d. Type:  □ Private residence  □ Assisted living facility (ALF)  □ Nursing facility  □ Hospital  □ Adult day care  □ Other
   e. Name: __________________________

14. Home Address (If different from current physical location)
   a. Street: __________________________
   b. City: __________________________  c. ZIP code: __________________________

15. Is client's home address public housing?  □ No  □ Yes

16. Mailing Address (If different from current physical location)
   a. Street: __________________________  b. City: __________________________
   c. State: __________________________  d. ZIP code: __________________________

1  DOE 701B, April 2013
Florida Department of Elder Affairs: 701B Comprehensive Assessment

A. DEMOGRAPHIC SECTION, CONTINUED

17. ASSESSOR/CM: Assessment date: (mm/dd/yyyy)

18. ASSESSOR/CM: Assessment site:
   - [ ] Home
   - [ ] ALF
   - [ ] Nursing facility
   - [ ] Hospital
   - [ ] Adult day care
   - [ ] Other

19. ASSESSOR/CM: Referral date: (mm/dd/yyyy)

20. ASSESSOR/CM: Referral source:
   - [ ] Self/Family
   - [ ] Nursing facility
   - [ ] Case management agency
   - [ ] CARES
   - [ ] Aging out
   - [ ] Hospital
   - [ ] Department of Children and Families
   - [ ] Other

   APS: Select level of APS risk:
   - [ ] High
   - [ ] Intermediate
   - [ ] Low

21. ASSESSOR/CM: Transitioning out of a nursing facility?  [ ] No  [ ] Yes

22. ASSESSOR/CM: Imminent risk of nursing home placement?  [ ] No  [ ] Yes

23. Do you need outside assistance to evacuate?  [ ] No  [ ] Yes

24. Are you enrolled on a special needs registry?  [ ] No  [ ] Yes

25. Is there a primary caregiver?  [ ] No  [ ] Yes

26. Living situation:
   - [ ] With primary caregiver
   - [ ] With other caregiver
   - [ ] Alone

27. Individual monthly income: $  [ ] Refused

28. Couple monthly income: $  [ ] Refused  [ ] N/A

29. Estimated total individual assets: $  [ ] $0 to $2,000  [ ] $2,001 to $5,000  [ ] $5,001 or more  [ ] Refused

30. Estimated total couple assets: $  [ ] $0 to $3,000  [ ] $3,001 to $6,000  [ ] $6,001 or more  [ ] Refused  [ ] N/A

31. Are you receiving S/NAP (food stamps)?  [ ] No  [ ] Yes

32. Do you need other assistance for food?  [ ] No  [ ] Yes

33. ASSESSOR/CM: Is someone besides the client providing answers to questions?  [ ] No (Skip to 34)  [ ] Yes

   a. Name: ____________________________  b. Relationship: ____________________________

34. Besides your own children, how many children under age 19 do you live with and provide care for? (If zero, skip to 35)

   a. How many are grandchildren?
      - [ ] Name(s):

   b. How many are other related children?
      - [ ] Name(s):

   c. How many are other non-related children?
      - [ ] Name(s):

35. How many disabled adults age 19 to 59 do you live with and provide care for? (If zero, skip to 36)

   a. How many are grandchildren?
      - [ ] Name(s):

   b. How many are other relatives?
      - [ ] Name(s):

   c. How many are other non-relatives?
      - [ ] Name(s):

Notes & Summary:
### B. MEMORY SECTION

36. Has a doctor or other health care professional told you that you suffer from memory loss, cognitive impairment, any type of dementia, or Alzheimer’s disease?  
- No  
- Yes

37. **ASSSESSOR/CM: If the client is not answering questions, skip to Question 47 and check:** □

38. “I am going to say three words for you to remember. Please repeat the words after I have said them. The words are: sock (something to wear), blue (a color), and bed (a piece of furniture). Now you tell me the three words.”  
**ASSSESSOR/CM: Select the number of words correctly repeated after the first attempt:**

- Sock  
- Blue  
- Bed  

**Total number of correct words:**

- None  
- One  
- Two  
- Three

“Thank you. I will ask you to repeat these to me again later.”

39. Please tell me what year it is:  
- Correct  
- Missed by one year  
- Missed by two to five years

- Missed by five or more years

- No answer

40. Please tell me what month it is:  
- Correct  
- Missed by one month  
- Missed by two to five months

- Missed by five or more months

- No answer

41. Please tell me what day (of the week) it is:  
- Correct  
- Incorrect  
- No answer

42. “Let’s go back to an earlier question. What were those words I asked you to repeat back to me?”

- Sock  
- Blue  
- Bed

43. **ASSSESSOR/CM: Number of words correctly recalled without prompting:**

- None  
- One  
- Two  
- Three

44. Have any friends or family members expressed concern about your memory?  
- No  
- Yes

45. Have you become concerned about your memory or had problems remembering important things?  
- No (Skip to 47)  
- Yes

46. How often do you have problems remembering things?  
- Always  
- Often  
- Sometimes  
- Rarely  
- Don’t know

47. **ASSSESSOR/CM: In your opinion, are cognitive problems present?**

- No  
- Yes  
- Don’t know

---

**Notes & Summary:**
### C. GENERAL HEALTH, SENSORY & COMMUNICATION SECTION

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>48. How would you rate your overall health at this time?</td>
<td>☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor</td>
</tr>
<tr>
<td>49. Compared to a year ago, how would you rate your health?</td>
<td>☐ Much better ☐ Better ☐ About the same ☐ Worse ☐ Much worse</td>
</tr>
<tr>
<td>50. How often do you change or limit your activities out of fear of falling?</td>
<td>☐ Never ☐ Occasionally ☐ Often ☐ All of the time</td>
</tr>
<tr>
<td>51. How many times have you fallen in the last six months?</td>
<td>#</td>
</tr>
<tr>
<td>52. How often are there things you want to do but cannot because of physical problems?</td>
<td>☐ Never ☐ Occasionally ☐ Often ☐ All of the time</td>
</tr>
<tr>
<td>53. When you need medical care, how often do you get it?</td>
<td>☐ Always ☐ Most of the time ☐ Rarely ☐ Only in an emergency ☐ Never</td>
</tr>
<tr>
<td>54. When you need transportation to medical care, how often do you get it?</td>
<td>☐ Always ☐ Most of the time ☐ Rarely ☐ Only in an emergency ☐ Never</td>
</tr>
<tr>
<td>55. Do you drive a car or other motor vehicle?</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>56. How often do finances/insurance allow you to obtain health care and medications when you need them?</td>
<td>☐ Always ☐ Most of the time ☐ Rarely ☐ Only in an emergency ☐ Never</td>
</tr>
<tr>
<td>57. Have you visited the emergency room (ER) or been admitted to the hospital within the last year?</td>
<td>☐ No ☐ Yes; How many times? ER# ☐ Hospital #</td>
</tr>
<tr>
<td>58. In the last year were you in a nursing or rehabilitation facility?</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>59. Are you usually able to climb two or three stair steps?</td>
<td>☐ No ☐ Yes ☐ Don’t know</td>
</tr>
<tr>
<td>60. ASSESSOR/CMS: Are there any stairs within the dwelling or leading into/out of the dwelling?</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>61. Are you usually able to carry a full glass of water across a room without spilling it?</td>
<td>☐ No ☐ Yes ☐ Don’t know</td>
</tr>
<tr>
<td>62. Has a doctor told you that you currently have vision problems?</td>
<td>☐ No ☐ Yes ☐ Blind (if blind, skip to 63)</td>
</tr>
<tr>
<td>a. Have you had an eye exam in the past year?</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>b. Do you bump into objects (people, doorways) because you don’t see them?</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>c. Is your vision getting worse than it was last year?</td>
<td>☐ No ☐ In one eye ☐ Slightly worse ☐ Much worse</td>
</tr>
<tr>
<td>63. Has a doctor told you that you currently have hearing problems?</td>
<td>☐ No ☐ Yes ☐ Deaf (if deaf, skip to 64)</td>
</tr>
<tr>
<td>a. Have you had a hearing exam in the past year?</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>b. Can you understand words clearly over the telephone?</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>c. Is your hearing worse than it was last year?</td>
<td>☐ No ☐ In one ear ☐ Slightly worse ☐ Much worse</td>
</tr>
<tr>
<td>64. ASSESSOR/CMS: Does client rely on writing, gestures, or signs to communicate?</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>65. ASSESSOR/CMS: Are the client’s words formed properly, not slurred or clipped?</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>66. ASSESSOR/CMS: Are any sensory aids or assistive devices currently used?</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>If yes, please list the type(s) used:</td>
<td></td>
</tr>
<tr>
<td>67. ASSESSOR/CMS: Is there an unmet need for a sensory aid or assistive device?</td>
<td>☐ No ☐ Yes</td>
</tr>
<tr>
<td>If yes, please list the type(s) needed:</td>
<td></td>
</tr>
</tbody>
</table>
### D. ACTIVITIES OF DAILY LIVING SECTION

68. How much assistance do you need with the following tasks?

<table>
<thead>
<tr>
<th>Task</th>
<th>No assistance needed</th>
<th>Uses assistive device</th>
<th>Needs supervision or prompt</th>
<th>Needs assistance (but not total help)</th>
<th>Needs total assistance (cannot do at all)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Bathing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Dressing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Eating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Using the bathroom</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Transferring</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>f. Walking/Mobility</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

69. **ASSESSOR/CM: Is there an unmet need for an ADL assistive device?**

   - No
   - Yes

   **If yes, type(s) needed:**

70. How much assistance do you have with the following tasks?

<table>
<thead>
<tr>
<th>Task</th>
<th>No assistance needed</th>
<th>Always has assistance</th>
<th>Has assistance most of the time</th>
<th>Rarely has assistance</th>
<th>Never has assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Bathing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Dressing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Eating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Using the bathroom</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Transferring</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Walking/Mobility</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Notes & Summary:**
### E. INSTRUMENTAL ACTIVITIES OF DAILY LIVING SECTION

**71. How much assistance do you need with the following tasks?**

<table>
<thead>
<tr>
<th>Task</th>
<th>No assistance needed</th>
<th>Uses assistive device</th>
<th>Needs supervision or prompt</th>
<th>Needs assistance (but not total help)</th>
<th>Needs total assistance (cannot do at all)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Heavy chores</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Light housekeeping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Using the telephone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Managing money</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Preparing meals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Shopping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Managing medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Using transportation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**72. ASSESSOR/CM: Is there an unmet need for an IADL assistive device?**

- [ ] No
- [ ] Yes

*If yes, type(s) needed:*

**73. How much assistance do you have with the following tasks?**

<table>
<thead>
<tr>
<th>Task</th>
<th>No assistance needed</th>
<th>Always has assistance</th>
<th>Has assistance most of the time</th>
<th>Rarely has assistance</th>
<th>Never has assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Heavy chores</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Light housekeeping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Using the telephone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Managing money</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Preparing meals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Shopping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Managing medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Using transportation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Notes & Summary:*
F. HEALTH CONDITIONS & THERAPIES SECTION

74. Have you been told by a physician that you have any of the following health conditions?

**ASSESSOR/CMS** Indicate whether a problem occurred in the past by marking the first box and when a problem is current by marking the second box. Mark all that apply.

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Health Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Acid reflux/GERD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allergies, list:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Amputation, site:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anemia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Arthritis, type:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bed sore[s] (Decubitus), location:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blood pressure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Broken bones/fractures, location:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cancer, site:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chlamydia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cholesterol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dehydration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diabetes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dizziness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fibromyalgia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gallbladder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gonorrhea</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Heart problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Head, brain, or spinal cord trauma</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Herpes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Human Immunodeficiency Virus (HIV)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Human Papilloma Virus (HPV)/Genital warts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incontinence, bladder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incontinence, bowel</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kidney problems or renal disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Liver problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lung problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lupus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multiple Sclerosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Muscular Dystrophy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Osteoporosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parkinson’s disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paralysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seizure disorder, type &amp; frequency:</td>
</tr>
</tbody>
</table>

- High
- Low
- IDDM
- NIDDM
- Constant
- Frequent
- Occasional
- Rare
- CHF
- MI
- Other
- No
- Yes
- End stage?
## F. HEALTH CONDITIONS & THERAPIES SECTION, CONTINUED

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Health Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Shingles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stroke/CVA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Syphilis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thyroid problems/Graves/Myxedema</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tumor(s), site:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ulcer(s), site:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urinary Tract Infection (UTI)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other:</td>
</tr>
</tbody>
</table>

75. Provide information on the frequency of current therapies or specialty care:

<table>
<thead>
<tr>
<th>Treatment type:</th>
<th>N/A or None</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Several times a week</th>
<th>Daily</th>
<th>Several times a day</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Bladder/bowel treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>b. Catheter, type: ______________</td>
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<tr>
<td>c. Dialysis</td>
<td></td>
<td></td>
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<tr>
<td>d. Insulin assistance</td>
<td></td>
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<tr>
<td>e. IV Fluids/IV Medications</td>
<td></td>
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<tr>
<td>f. Occupational therapy</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>g. Ostomy, site: ______________</td>
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<tr>
<td>h. Oxygen</td>
<td></td>
<td></td>
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<tr>
<td>i. Physical therapy</td>
<td></td>
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<tr>
<td>j. Radiation/Chemotherapy</td>
<td></td>
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<tr>
<td>k. Respiratory therapy</td>
<td></td>
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<tr>
<td>l. Skilled nursing</td>
<td></td>
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<tr>
<td>m. Speech therapy</td>
<td></td>
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<tr>
<td>n. Suctioning</td>
<td></td>
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<tr>
<td>o. Tube feeding</td>
<td></td>
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<tr>
<td>p. Wound care/Lesion irrigation</td>
<td></td>
<td></td>
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<tr>
<td>q. Other therapy, type:</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Notes & Summary:**

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8 DOEA 701B, April 2013
## Florida Department of Elder Affairs: 701B Comprehensive Assessment

### G. MENTAL HEALTH SECTION

**ASSESSOR/CMS: If the client is not answering questions, skip to Question 81 and check: □**

76. How satisfied are you with your overall quality of life?
   - [ ] Very satisfied
   - [ ] Satisfied
   - [ ] Neither satisfied nor dissatisfied
   - [ ] Dissatisfied
   - [ ] Very dissatisfied

77. Thinking about how you were this time last year, how do you feel about the way things are now?
   - [ ] Much better
   - [ ] Better
   - [ ] About the same
   - [ ] Worse
   - [ ] Much worse

78. Over the past two weeks, how often have you been bothered by any of the following problems?
   (Adapted from the Patient Health Questionnaire PHQ-9, © Pfizer)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Little interest or pleasure in doing things</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>b. Feeling down, depressed, or hopeless</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>c. Trouble falling or staying asleep, or sleeping too much</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>d. Feeling tired or having little energy</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>e. Poor appetite or overeating</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>g. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>h. Moving or speaking so slowly that other people noticed – Or, the opposite, being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>i. Thoughts that you would be better off dead or of hurting yourself in some way*</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

*Thoughts of suicide or self-injury, hallucinations, or aggressive behaviors are potentially serious problems that should be reported immediately to a supervisor, primary care physician, emergency care, law enforcement, and/or Adult Protective Services, as appropriate.

**ASSESSOR/CMS: If the client answered “Not at all” to a-i above, skip to Question 81.**

79. How difficult have these problems made it for you in your daily life activities and interactions with others?
   - [ ] Not difficult at all
   - [ ] Somewhat difficult
   - [ ] Very difficult
   - [ ] Extremely difficult

80. Are you currently working with a professional to help with this condition? □ No □ Yes (Skip to 81)
   a. Have you or do you plan to discuss these issues with a professional? □ No □ Yes (Skip to 81)
   b. Do you talk about any of these issues with anyone else you know? □ No □ Yes

81. Have you been diagnosed with a mental condition or psychiatric disorder by a health professional?
   - [ ] No (Skip to 82)
   - [ ] Yes: List conditions:

---

9  DOE 701B, April 2013
## G. MENTAL HEALTH SECTION, CONTINUED

82. **ASSESSOR/CM: Indicate whether you noticed problem behaviors or any recurring problems have been reported to you by the client, caregiver, in-home worker, family, or staff, and note the frequency of occurrence in the last month. Provide details in the Notes & Summary section, below.**

<table>
<thead>
<tr>
<th>Problem behaviors</th>
<th>Not at all</th>
<th>Once</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Forgetful or easily confused</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Gets lost or wanders off</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Easily agitated or disruptive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Sexually inappropriate</td>
<td></td>
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<td></td>
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<tr>
<td>e. Threatens or is verbally hostile*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Physically aggressive or violent*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Intentionally injures or harms him/herself*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Expresses suicidal feelings or plans*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Hallucinates, hears/see things that are not there*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Thoughts of suicide or self-injury, hallucinations, or aggressive behaviors are potentially serious problems that should be reported immediately to a supervisor, primary care physician, emergency care, law enforcement, and/or Adult Protective Services, as appropriate.*

<table>
<thead>
<tr>
<th>83. <strong>ASSESSOR/CM: Does client need supervision?</strong></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

**Notes & Summary:**
### H. RESIDENTIAL LIVING ENVIRONMENT SECTION

84. **ASSESSOR/CNM:** If information about the client’s residence is reported to you, without your observation, check here and all that apply below. If residence issues are directly observed by you, use the list below to observe and check off the specific issue(s) with the potential for safety or accessibility problems.

<table>
<thead>
<tr>
<th>Check all that apply:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Exterior issue(s):</td>
<td></td>
</tr>
<tr>
<td>b. Interior issue(s):</td>
<td></td>
</tr>
<tr>
<td>c. Restroom issue(s):</td>
<td></td>
</tr>
<tr>
<td>d. Utility issue(s):</td>
<td></td>
</tr>
<tr>
<td>e. Furniture issue(s):</td>
<td></td>
</tr>
<tr>
<td>f. Telephone issue(s):</td>
<td></td>
</tr>
<tr>
<td>g. Temperature issue(s):</td>
<td></td>
</tr>
<tr>
<td>h. Unsanitary condition(s):</td>
<td></td>
</tr>
<tr>
<td>i. Other hazards:</td>
<td></td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Exterior issue(s):</td>
<td>Road</td>
</tr>
<tr>
<td>b. Interior issue(s):</td>
<td>Door</td>
</tr>
<tr>
<td>c. Restroom issue(s):</td>
<td>Door</td>
</tr>
<tr>
<td>d. Utility issue(s):</td>
<td>Door</td>
</tr>
<tr>
<td>e. Furniture issue(s):</td>
<td>Door</td>
</tr>
<tr>
<td>f. Telephone issue(s):</td>
<td>Door</td>
</tr>
<tr>
<td>g. Temperature issue(s):</td>
<td>Door</td>
</tr>
<tr>
<td>h. Unsanitary condition(s):</td>
<td>Door</td>
</tr>
<tr>
<td>i. Other hazards:</td>
<td>Door</td>
</tr>
</tbody>
</table>

85. Is there a pet in your home or yard?   
- No (Skip to 86)   
- Yes

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Please specify the type and size:</td>
</tr>
</tbody>
</table>

86. **ASSESSOR/CNM:** Please rate the level of risk in the client’s residential living environment:

- No/low apparent risk from current living conditions.
- Minor risk (One or more aspects are substandard and should be addressed in the following year to avoid potential injury.)
- Moderate risk (Major aspects are substandard and must be addressed in the next few months to remain in home safely.)
- High risk (Serious hazards are present. The client must change dwellings or immediate corrective action must be taken to correct the issues noted above.)

---

**Notes & Summary:**

---

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Florida Department of Elder Affairs: 701B Comprehensive Assessment

I. NUTRITION SECTION

87. Do you usually eat at least two meals a day? ☐ No ☐ Yes

88. On a typical day, what types of food do you eat for:
   a. Breakfast: __________________________________________
   b. Lunch: _____________________________________________
   c. Dinner: _____________________________________________
   d. Snacks: _____________________________________________

89. Do you eat alone most of the time? ☐ No ☐ Yes

90. How many cups of water, juice, or other liquid do you drink daily? (If more than eight, skip to 91)
   a. Do you ever limit the amount of fluids you drink? ☐ No (Skip to 91) ☐ Yes
   b. Why and when do you limit the fluids you intake?

91. On average, how many servings of fruits and vegetables do you eat every day? (One “serving”
is one small piece of fruit or vegetable, about one-half cup of chopped fruit or vegetable, or
one-half cup of fruit or vegetable juice.) ☐

92. On average, how many servings of dairy products do you have every day? (One “serving” of
dairy is about a slice of cheese, a cup of yogurt, or a cup of milk or dairy substitute.) ☐

93. Estimate your current height and weight: Height: ______ ft. ______ inches Weight: ______ lbs.

94. Have you lost or gained weight in the last few months? ☐ Unsure (Skip to 95) ☐ No (Skip to 95) ☐ Yes
   a. How much? ☐ Less than five pounds ☐ Five to ten pounds ☐ Ten pounds or more
   b. Was the weight loss/gain on purpose (i.e., dieting or trying to lose/gain weight)? ☐ No ☐ Yes

95. Are you on a special diet(s) for medical reasons? ☐ No (Skip to 96) ☐ Yes; check any/all:
   ☐ Calorie supplement ☐ Low fat/cholesterol ☐ Low salt/sodium ☐ Low sugar/carb ☐ Other
   a. How long have you been on this diet? __________________________
   b. Why are you on this diet?

96. Do you have any problems that make it hard for you to chew or swallow? ☐ No ☐ Yes; check any/all:
   ☐ Mouth/tooth/dentures ☐ Pain or difficulty swallowing ☐ Taste ☐ Nausea
   ☐ Saliva production ☐ Other, describe: __________________________

97. What working appliances do you have for storing/prepare food? ☐ None
   ☐ Refrigerator ☐ Microwave ☐ Toaster/Oven ☐ Stove ☐ Other: __________________________

Notes & Summary:

12 DOEA 701B, April 2013
### J. MEDICATIONS & SUBSTANCE USE SECTION

98. Do you take three or more prescribed or over-the-counter medications a day?  □ No  □ Yes

99. May I see all the medications you take, both regularly and those taken only as needed? Also, please show me all types of over-the-counter medications and any supplements that you regularly take.

**ASSESSOR/CM:** Check the original bottles in the medicine cabinet, nightstand, and refrigerator, as well as non-prescription drugs, over the counter drugs, sleep aids, herbal remedies, vitamins, and supplements.

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Prescribed dose</th>
<th>Prescribed Frequency</th>
<th>Taken as prescribed? Yes/No*</th>
<th>Administration method</th>
<th>Prescriber name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

If you have a printed list of meds managed by a facility, attach sheet. If there are more medications to record, use the Notes & Summary section or a blank sheet of paper to write the information.

100. *ASSESSOR/CM: Only ask when the client is not taking medications as indicated:  
"Why do you take [name of medication] differently than prescribed?" and explain each below:

Medication and reason: 
Medication and reason: 
Medication and reason: 
Medication and reason: 
Medication and reason: 
Medication and reason: 
Medication and reason: 
Medication and reason: 
Medication and reason: 
Medication and reason: 
Medication and reason: 

### J. MEDICATIONS & SUBSTANCE USE SECTION, CONTINUED

<table>
<thead>
<tr>
<th>101. Please list the doctors you usually go to for treatment and medications:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician name</strong></td>
</tr>
<tr>
<td><img src="image" alt="Table Content" /></td>
</tr>
</tbody>
</table>

*If you have more than ten physicians to record, use the Notes & Summary section or a blank sheet of paper to write the information.*

<table>
<thead>
<tr>
<th>102. What pharmacies or drug stores do you use?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>103. Are you able to tell the difference between your pills (i.e., colors, shapes, print)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>104. ASSESSOR/CM: Are the client's medications managed by a facility/caregiver?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>105. ASSESSOR/CM: In your opinion, are the client's medications managed properly?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>106. ASSESSOR/CM: Should client have a new medication review by a doctor or pharmacist?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>107. How many days in a typical week do you drink alcohol?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Refused (Skip to 108)</td>
</tr>
<tr>
<td>[ ] One to two (Skip to 108)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>108. Have you used any form of tobacco in the last six months?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] No (Skip to 109)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>a. What type(s)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Chewing tobacco</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b. About how many times do you use tobacco each day?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] One to three</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>109. Do you regularly use drugs other than those required for medical reasons (i.e., controlled substances or “street drugs”)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Refused (Skip to 110)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>a. About how often do you use these?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Rarely</td>
</tr>
<tr>
<td>[ ] Less than once a week</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b. How long have you been using that often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Less than a year</td>
</tr>
</tbody>
</table>

---

**Notes & Summary:**

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14  DOE A 701B, April 2013
K. SOCIAL RESOURCES SECTION

110. If needed, is there someone (besides the primary caregiver) who could help you? ☐ No (Skip to 112) ☐ Yes

111. Do I have your permission to contact this person, if you need help? ☐ No (Skip to 112) ☐ Yes

a. Name: ____________________
b. Relationship to client: ____________________
c. Phone: ____________________

About how often do you: Once a Two to a week Once Several Every a month few A few times never times a year

112. Talk to friends, relatives, or others (by phone, computer, or other means)? ☐ ☐ ☐ ☐ ☐ ☐ ☐

113. Spend time with someone who does not live with you? ☐ ☐ ☐ ☐ ☐ ☐ ☐

114. Participate in activities outside the home that interest you? ☐ ☐ ☐ ☐ ☐ ☐ ☐

L. CAREGIVER SECTION

ASSESSOR/CM: If client has no caregiver, stop the assessment here. If client has a caregiver, complete 115-136.

115. ASSESSOR/CM: HCE Caregiver? If yes, check ☐

b. Middle Initial: _________ c. Last: ____________________

117. Caregiver date of birth: (mm/dd/yyyy) ____________________

118. ASSESSOR/CM: Caregiver identification number ____________________

119. Caregiver sex: ☐ Male ☐ Female

120. Caregiver race (Mark all that apply): ☐ White ☐ Black/African American ☐ Asian

☐ American Indian/Alaska Native ☐ Native Hawaiian/ Pacific Islander ☐ Other

121. Caregiver ethnicity: ☐ Hispanic or Latino ☐ Other

122. Caregiver primary language: ☐ English ☐ Spanish ☐ Other ____________________

123. Caregiver relationship to client: ☐ Wife ☐ Husband ☐ Partner ☐ Parent

☐ Son/In-law ☐ Daughter/In-law ☐ Other relative ☐ Other Non-relative

124. Caregiver address:

a. Street: ____________________
b. City: ____________________ c. State: _________ d. ZIP code: ____________________

125. Caregiver phone number: ____________________

126. Do you work outside the home? ☐ No ☐ Yes: ☐ Full-time ☐ Part-time

127. Do you currently have anyone to assist you with providing care? ☐ No (Skip to 129) ☐ Yes
**FLORIDA DEPARTMENT OF ELDER AFFAIRS: 701B COMPREHENSIVE ASSESSMENT**

**1. CAREGIVER SECTION, CONTINUED**

128. Do I have your permission to contact this person if for some reason you are unable to provide care for the client?   [ ] No (Skip to 129) [ ] Yes, please provide the name and relationship to client:

<table>
<thead>
<tr>
<th>a. First name:</th>
<th>b. Last name:</th>
</tr>
</thead>
</table>

| c. Phone: | d. Relationship to client: [ ] Wife [ ] Husband [ ] Partner [ ] Parent [ ] Son/In-law [ ] Daughter/In-law [ ] Other relative [ ] Other Non-relative |

129. How long have you been providing care for this client?

[ ] Less than six months [ ] Six to twelve months [ ] One to two years [ ] Two or more years

130. How many hours per week do you currently spend providing care for the client? #

131. Do you need training or assistance in performing caregiving tasks?   [ ] No [ ] Yes, please describe:

132. How much of a mental or emotional strain is it on you to provide care for the client?

[ ] None [ ] Some strain [ ] A lot of strain

133. Considering other aspects of your life, please rate the level of difficulty in your:

<table>
<thead>
<tr>
<th>No difficulty</th>
<th>Little difficulty</th>
<th>Some difficulty</th>
<th>Moderate difficulty</th>
<th>A lot of difficulty</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Relationship with client</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Relationship with family</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Relationships with friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Physical health</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>e. Finances</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Functional abilities</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>g. Employment</td>
<td></td>
<td></td>
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<tr>
<td>h. Time for yourself to do the things you enjoy</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

134. How confident are you that you will have the ability to continue to provide care?

[ ] Very confident (Skip to 135) [ ] Somewhat confident (Skip to 135) [ ] Not very confident

a. What is the main reason you may be unable to continue to provide care?


135. Assessor/CM: Is the caregiver in crisis?   [ ] No [ ] Yes; check all that apply:

[ ] Financial [ ] Emotional [ ] Physical
Florida Department of Elder Affairs: 701B Comprehensive Assessment

L. CAREGIVER SECTION, CONTINUED

<table>
<thead>
<tr>
<th>136. Ask the caregiver to answer the following about the client. (An answer of “Yes, a change” indicates that there has been a change in the last year caused by thinking and memory problems.)</th>
<th>Yes, a change</th>
<th>No change</th>
<th>Don’t know or N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Problems with judgment (problems making decisions, bad financial decisions, problems with thinking)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. Less interest in hobbies/activities</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>c. Repeats the same things over and over (questions, stories, or statements)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>d. Trouble learning how to use a tool, appliance, or gadget (TV, radio, microwave, remote control)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>e. Forgets the correct month or year</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>f. Trouble handling complicated financial affairs (balancing checkbook, income taxes, paying bills)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>g. Trouble remembering appointments</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>h. Daily problems with thinking or memory</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Adapted from the “Eight-Item Informant Interview to Differentiate Aging and Dementia,” a copyrighted instrument of Washington University, St. Louis, Missouri. Copyright 2003. All rights reserved.

Notes & Summary:
Florida Department of Elder Affairs: 701B Comprehensive Assessment

[This page is intentionally left blank]
WHY ARE WE COLLECTING YOUR SOCIAL SECURITY NUMBER?

We are required to explain that your Social Security number is being collected pursuant to Title 42 Code of Federal Regulations, Section 435.910, to be used for screening and referral to programs or services that may be appropriate for you.

The provision of your Social Security number is voluntary, and your information will remain confidential and protected under penalty of law. We will not use or give out your Social Security number for any other reason unless you have signed a separate consent form that releases us to do so.
(This page intentionally left blank.)
### A. DEMOGRAPHIC SECTION

1. **ASSESSOR: What is the purpose of this assessment?**
   - [ ] Initial
   - [ ] Annual
   - [ ] Health
   - [ ] Living situation
   - [ ] Caregiver
   - [ ] Environment
   - [ ] Income

2. Social Security number: 

3. Name:  
   - a. First: 
   - b. Middle initial: 
   - c. Last: 

4. Medicaid number: 

5. Phone number: 

6. Date of birth (mm/dd/yyyy): 

7. Sex:  
   - [ ] Male
   - [ ] Female

8. Race (Mark all that apply):  
   - [ ] White
   - [ ] Black/African American
   - [ ] Asian
   - [ ] American Indian/Alaska Native
   - [ ] Native Hawaiian/Pacific Islander
   - [ ] Other

9. Ethnicity:  
   - [ ] Hispanic/Latino
   - [ ] Other

10. Primary language:  
    - [ ] English
    - [ ] Spanish
    - [ ] Other

11. Does client have limited ability reading, writing, speaking, or understanding English?  
    - [ ] No
    - [ ] Yes

12. Marital status:  
    - [ ] Married
    - [ ] Partnered
    - [ ] Single
    - [ ] Separated
    - [ ] Divorced
    - [ ] Widowed

13. **ASSESSOR: Current Physical Location Address** (If type is a facility, please enter facility name.)
   - a. Street: 
   - b. City: 
   - c. ZIP code: 
   - d. Type:  
     - [ ] Private residence
     - [ ] Assisted living facility (ALF)
     - [ ] Nursing facility
     - [ ] Hospital
     - [ ] Adult day care
     - [ ] Other
   - e. Name: 

14. Home Address (If different from current physical location)
   - a. Street: 
   - b. City: 
   - c. ZIP code: 

15. Mailing Address (If different from current physical location)
   - a. Street: 
   - b. City: 
   - c. State: 
   - d. ZIP code: 

---

1. **DOEA 701T, April 2013**
Florida Department of Elder Affairs: 701T CARES Mini Assessment

16. **ASSESSOR: Assessment date:** (mm/dd/yyyy)

17. **ASSESSOR: Assessment site:**
   - [ ] Home
   - [ ] ALF
   - [ ] Nursing facility
   - [ ] Hospital
   - [ ] Adult day care
   - [ ] Other

18. **ASSESSOR: Referral date:** (mm/dd/yyyy)

19. **ASSESSOR: Referral source:**
   - [ ] Self/Family
   - [ ] Nursing facility
   - [ ] Case management agency
   - [ ] CARES
   - [ ] Aging out
   - [ ] Hospital
   - [ ] Department of Children and Families
   - [ ] Other

20. **ASSESSOR: Imminent risk of nursing home placement?**
   - [ ] No
   - [ ] Yes

21. **Is there a primary caregiver?**
   - [ ] No
   - [ ] Yes

22. **Living situation:**
   - [ ] With primary caregiver
   - [ ] With other caregiver
   - [ ] With other
   - [ ] Alone

23. **ASSESSOR: Is someone besides the client providing answers to questions?**
   - [ ] No (Skip to 24)
   - [ ] Yes

   a. Relationship: __________________________

B. MEMORY SECTION

24. Has a doctor or other health care professional told you that you suffer from memory loss, cognitive impairment, any type of dementia, or Alzheimer’s disease?  
   - [ ] No
   - [ ] Yes

25. **ASSESSOR: If the client is not answering questions, skip to Question 32 and check:**
   - [ ]

26. “I am going to say three words for you to remember. Please repeat the words after I have said them. The words are: sock (something to wear), blue (a color), and bed (a piece of furniture). Now you tell me the three words.”

   **ASSESSOR: Select the number of words correctly repeated after the first attempt:**
   - [ ] Sock
   - [ ] Blue
   - [ ] Bed

   **Total number of correct words:**
   - [ ] None
   - [ ] One
   - [ ] Two
   - [ ] Three

   “Thank you. I will ask you to repeat these to me again later.”

27. Please tell me what year it is:
   - [ ] Correct
   - [ ] Missed by one year
   - [ ] Missed by two to five years
   - [ ] Missed by five or more years
   - [ ] No answer

28. Please tell me what month it is:
   - [ ] Correct
   - [ ] Missed by one month
   - [ ] Missed by two to five months
   - [ ] Missed by five or more months
   - [ ] No answer

29. Please tell me what day (of the week) it is:
   - [ ] Correct
   - [ ] Incorrect
   - [ ] No answer

30. “Let’s go back to an earlier question. What were those words I asked you to repeat back to me?”
   - [ ] Sock
   - [ ] Blue
   - [ ] Bed

31. **ASSESSOR: Number of words correctly recalled without prompting:**
   - [ ] None
   - [ ] One
   - [ ] Two
   - [ ] Three

32. **ASSESSOR: In your opinion, are cognitive problems present?**
   - [ ] No
   - [ ] Yes
   - [ ] Don’t know

**Notes & Summary**
Florida Department of Elder Affairs: 701T CARES Mini Assessment

C. GENERAL HEALTH SECTION

33. How many times have you fallen in the last six months? #

34. Have you visited the emergency room (ER) or been admitted to the hospital within the last year?
   □ No   □ Yes: How many times? ER #_________ Hospital #_________

D. ACTIVITIES OF DAILY LIVING SECTION

<table>
<thead>
<tr>
<th>Task</th>
<th>No assistance needed</th>
<th>Uses assistive device</th>
<th>Needs supervision or prompt</th>
<th>Needs assistance (but not total help)</th>
<th>Needs total assistance (cannot do at all)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Bathing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Dressing</td>
<td></td>
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<td></td>
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<tr>
<td>c. Eating</td>
<td></td>
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<tr>
<td>d. Using the bathroom</td>
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<tr>
<td>e. Transferring</td>
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<tr>
<td>f. Walking/Mobility</td>
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</tbody>
</table>

E. INSTRUMENTAL ACTIVITIES OF DAILY LIVING SECTION

36. How much assistance do you need with the following tasks?

<table>
<thead>
<tr>
<th>Task</th>
<th>No assistance needed</th>
<th>Uses assistive device</th>
<th>Needs supervision or prompt</th>
<th>Needs assistance (but not total help)</th>
<th>Needs total assistance (cannot do at all)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Heavy chores</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Light housekeeping</td>
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<tr>
<td>c. Using the telephone</td>
<td></td>
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<td></td>
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<tr>
<td>d. Managing money</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>e. Preparing meals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Shopping</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>g. Managing medication</td>
<td></td>
<td></td>
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<tr>
<td>h. Using transportation</td>
<td></td>
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</tbody>
</table>

Notes & Summary
F. HEALTH CONDITIONS & THERAPIES SECTION

37. Have you been told by a physician that you have any of the following health conditions? 

ASESSOR/CM: Indicate whether a problem occurred in the past by marking the first box and when a problem is current by marking the second box. Please mark all that apply.

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Health Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Acid reflux/GERD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allergies, list:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anemia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Arthritis, type:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bed sore(s) (Decubitus), location:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blood pressure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Broken bones/fractures, location:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cancer, site:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cholesterol</td>
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<td></td>
<td></td>
<td>Chlamydia</td>
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<tr>
<td></td>
<td></td>
<td>Dehydration</td>
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<td></td>
<td></td>
<td>Diabetes</td>
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<td></td>
<td></td>
<td>Dizziness</td>
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<tr>
<td></td>
<td></td>
<td>Fibromyalgia</td>
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<td></td>
<td></td>
<td>Gallbladder</td>
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<tr>
<td></td>
<td></td>
<td>Gonorrhea</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Heart problems</td>
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<tr>
<td></td>
<td></td>
<td>Head, brain, or spinal cord trauma</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Herpes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Human Immunodeficiency Virus (HIV)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Human Papillomavirus (HPV)/Genital warts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incontinence, Bladder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incontinence, Bowel</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kidney problems or Renal disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Liver problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lung problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lupus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multiple Sclerosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Muscular Dystrophy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Osteoporosis</td>
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<tr>
<td></td>
<td></td>
<td>Parkinson’s disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paralysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seizure disorder, type &amp; frequency:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shingles</td>
</tr>
</tbody>
</table>

4  DOEА 701T, April 2013
Florida Department of Elder Affairs: 701T CARES Mini Assessment

F. HEALTH CONDITIONS & THERAPIES SECTION, CONTINUED

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Health Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Stroke/CVA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Syphilis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thyroid problems/Graves/Myxedema</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tumor(s), site:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ulcer(s), site:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urinary Tract Infection (UTI)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other(s):</td>
</tr>
</tbody>
</table>

38. Provide information on the frequency of current therapies or specialty care:

<table>
<thead>
<tr>
<th>Treatment type</th>
<th>N/A or None</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Several times a week</th>
<th>Daily</th>
<th>Several times a day</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Bladder/bowel treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Catheter, type:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Dialysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Insulin assistance</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>e. IV Fluids/IV Medications</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>f. Occupational therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Ostomy, site:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Oxygen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Physical therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Radiation/Chemotherapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Respiratory therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Skilled nursing</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>m. Speech therapy</td>
<td></td>
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<td></td>
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<tr>
<td>n. Suctioning</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o. Tube feeding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p. Wound care/Lesion Irrigation</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>q. Other therapy, type:</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Notes & Summary
### G. MENTAL HEALTH SECTION

39. Over the past two weeks, how often have you been bothered by any of the following problems?

(Adapted from the Patient Health Questionnaire PHQ-9, ©PRBC)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Little interest or pleasure in doing things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Feeling down, depressed, or hopeless</td>
<td></td>
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<tr>
<td>c. Trouble falling or staying asleep, or sleeping too much</td>
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<tr>
<td>d. Feeling tired or having little energy</td>
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<tr>
<td>e. Poor appetite or overeating</td>
<td></td>
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<tr>
<td>f. Feeling bad about yourself— or that you are a failure or have let yourself or your family down</td>
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</tr>
<tr>
<td>g. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td></td>
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<tr>
<td>h. Moving or speaking so slowly that other people noticed— Or, the opposite, being so fidgety or restless that you have been moving around a lot more than usual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Thoughts that you would be better off dead or of hurting yourself in some way*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Thoughts of suicide or self-injury, hallucinations, or aggressive behaviors are potentially serious problems that should be reported immediately to a supervisor, primary care physician, emergency care, law enforcement, and/or Adult Protective Services, as appropriate.

---

**ASSESSOR:** If the client answered “Not at all” to a-i above, skip to Question 42.

41. How difficult have these problems made it for you in your daily life activities and interactions with others?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

42. Have you been diagnosed with a mental condition or psychiatric disorder by a health professional?

- No
- Yes; List conditions:

43. **ASSESSOR:** Indicate whether you noticed problem behaviors or any recurring problems have been reported to you by the client, caregiver, in-home worker, family, or staff, and note the frequency of occurrence in the last month. Please provide details in the Notes & Summary section, below.

<table>
<thead>
<tr>
<th>Problem behaviors</th>
<th>Not at all</th>
<th>Once</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Forgetful or easily confused</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>b. Gets lost or wanders off</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>c. Easily agitated or disruptive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Sexually inappropriate</td>
<td></td>
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<td></td>
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<tr>
<td>e. Threatens or is verbally hostile*</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>f. Physically aggressive or violent*</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Intentionally injures or harms him/herself*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Expresses suicidal feelings or plans*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Hallucinates, hears/sees things that are not there*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Thoughts of suicide or self-injury, hallucinations, or aggressive behaviors are potentially serious problems that should be reported immediately to a supervisor, primary care physician, emergency care, law enforcement, and/or Adult Protective Services, as appropriate.

44. **ASSESSOR:** Does client need supervision?

- No
- Yes
Florida Department of Elder Affairs: 701T CARES Mini Assessment

H. NUTRITION SECTION

45. Have you lost or gained weight in the last few months? □ Unsure (Skip to 46) □ No (Skip to 46) □ Yes
   a. How much? □ Less than five pounds □ Five to ten pounds □ Ten pounds or more
   b. Was the weight loss/gain on purpose (i.e., dieting or trying to lose/gain weight)? □ No □ Yes

46. Are you on a special diet(s) for medical reasons? □ No (Skip to 47) □ Yes; check any/all:
   □ Calorie supplement □ Low fat/cholesterol □ Low salt/sodium □ Low sugar/carb □ Other
   a. How long have you been on this diet?
   b. Why are you on this diet?

I. MEDICATIONS SECTION

47. Do you take three or more prescribed or over-the-counter medications a day? □ No □ Yes
48. May I see all the medications you take, both regularly and those taken only as needed? Also, please show me all types of over the counter medications and any supplements that you regularly take.

ASSESSOR: Check the original bottles in the medicine cabinet, nightstand, and refrigerator, as well as non-prescription drugs, over the counter drugs, sleep aids, herbal remedies, vitamins, and supplements.

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Prescribed dose</th>
<th>Prescribed Frequency</th>
<th>Taken as prescribed? Yes/No</th>
<th>Administration method</th>
<th>Prescriber name</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

If you have a printed list of meds managed by a facility, attach sheet. If there are more medications to record, use the Notes & Summary section or a blank sheet of paper to write the information.

49. Please list the doctors you usually go to for treatment and medications:

<table>
<thead>
<tr>
<th>Physician name</th>
<th>Phone number</th>
<th>Approx. date of last visit</th>
<th>Reason for last visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have more than ten physicians to record, use the Notes & Summary section or a blank sheet of paper to write the information.
Florida Department of Elder Affairs: 701T CARES Mini Assessment

[This page is intentionally left blank]
WHY ARE WE COLLECTING YOUR SOCIAL SECURITY NUMBER?

We are required to explain that your Social Security number is being collected pursuant to Title 42 Code of Federal Regulations, Section 435.910, to be used for screening and referral to programs or services that may be appropriate for you.

The provision of your Social Security number is voluntary, and your information will remain confidential and protected under penalty of law. We will not use or give out your Social Security number for any other reason unless you have signed a separate consent form that releases us to do so.
(This page intentionally left blank.)
Dear Mr. /Ms. [INSERT NAME]:

The Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program has not received the completed Medical Certification for Medicaid Long-Term Care Services and Patient Transfer form (AHCA 5000-3008 form) certifying your medical status.

The on-site medical assessment was completed on [INSERT DATE ASSESSMENT WAS COMPLETED]. The Medical Certification for Medicaid Long-Term Care Services and Patient Transfer form (AHCA 5000-3008 form) must be received in the CARES office within 30 days from the date the assessment was completed by the CARES staff.

If the Medical Certification for Medicaid Long-Term Care Services and Patient Transfer form (AHCA 5000-3008 form) is not received in the CARES office by [INSERT DATE — 30 BUSINESS DAYS FROM THE DATE ASSESSMENT WAS COMPLETED], the medical level of care (LOC) cannot be released. If you do not contact our office by this date, your request will be closed.

For your convenience, we have enclosed another copy of the Medical Certification for Medicaid Long-Term Care Services and Patient Transfer form (AHCA 5000-3008 form) for completion by your physician.

Thank you for your prompt attention to this matter.

Sincerely,

[INSERT NAME]
[INSERT TITLE]

CC:

[REFERRAL SOURCE]
NAME, TITLE
ADDRESS
CITY, STATE, ZIP CODE

DOEA CARES FORM 613 — October 2015
AHCA 5000-3008 RETURN FAX COVER

DATE: ____________________________

PLEASE DELIVER TO: ____________________________ FAX #: ____________________________

FROM: DOEA CARES PSA ____________________________ PHONE #: ____________________________ FAX #: ____________________________

An AHCA 5000-3008 form was received on ____________________________

For ____________________________, SSN: ____________________________

It is being returned for the reason(s) indicated below. We will be unable to determine medical eligibility for long-term care services until we receive the completed/corrected AHCA 5000-3008 form.

The following sections of the AHCA 5000-3008 form are incomplete:

Page 1:

☐ Patient Name is missing
☐ Patient DOB is missing
☐ Section A - Patient Information
☐ Section B - Sight and/or Hearing
☐ Section C - Emergency Contact
☐ Section D - Medical Condition/Recent Hospital Stay
☐ Section F - Patient Risk Alerts
☐ Section I - Transferred From

☐ Section J - Transferred To
☐ Section K - Physician Contacts
☐ Section N - Attached Reports

☐ FASRR
☐ Physician Orders
☐ MAR
☐ Discharge Summary

Page 2:

☐ Section P - Patient Health Status

☐ Bladder
☐ Bowel

☐ Section Q - Treatment and Frequency

☐ Section S - Physical Function

☐ Section T - Skin Care

☐ Section U - Mental/Cognitive Status

☐ Section V - Treatment Devices

☐ Section Y - Physician Certification

☐ Type of Care
☐ Rehab Potential

☐ Effective Date of Medical Condition

☐ Physician/ARNP Signature

☐ Signature Date

☐ Printed Physician/ARNP Name and Title

☐ Physician Phone Number

☐ Name of Person Completing Form

☐ Phone Number of Person Completing Form

☐ Form completion date

Other:

________________________________________________________________________

_____________________________ ____________________________ ____________________________

Sponsor Name Title Date

Please FAX the corrected information back to CARES at the number indicated above.
(This page intentionally left blank.)
### CARES Program Policy Handbook

#### MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM

- **Patient Name:**
- **Last 4 SSN:**
- **DOB:**

#### A. PATIENT INFORMATION

- **Gender:** Male, Female
- **Hispanic Ethnicity:** Yes, No
- **Race:** White, Black, Other
- **Language:** English, Other

#### B. SIGHT HEARING

- Normal, Impaired, Deaf, Normal, Impaired
- Blind, Hearing Aid
- Admit Date: 
- Discharge Date: 
- Admit Time: 
- Discharge Time: 
- Nurse: 
- Phone: 

#### C. DECISION MAKING CAPACITY (PATIENT)

- Capable to make healthcare decisions
- Requires a surrogate

#### D. EMERGENCY CONTACT

- Name: 
- Address 1: 
- Address 2: 
- Phone: 
- Fax: 

#### E. MEDICAL CONDITION

- **Primary diagnosis:**
- **Other diagnoses:**

#### F. INFECTION CONTROL ISSUES

- PPD Status: Positive, Negative, Not known
- Associated Infection resistant organisms:
- MRSA: Site: 
- VRE: Site: 
- AESELB: Site: 
- MDRO: Site: 
- C. Diff: Site: 
- Other: Site: 
- Isolation Precautions: None
- **Contact:** 
- **Airborne:** 
- **G. PATIENT RISK ALERTS**

#### G. PATIENT RISK ALERTS

- None Known
- Harm to self
- Difficulty swallowing
- Fall
- Pressure Ulcers
- Falls
- Other

#### H. ADVANCE CARE PLANNING

- **Advance Directive:** Yes, No
- **Living Will:** Yes, No
- **Do Not Resuscitate (DNR):** Yes, No
- **Do Not Intubate:** Yes, No
- **Do Not Hospitilize:** Yes, No
- **No Artificial Feeding:** Yes, No
- **Hospice:** Yes, No

#### I. TRANSFERRED FROM

- Facility Name:
- Date: 
- Unit: 
- Phone: 
- FAX: 

#### J. TRANSFERRED TO

- Facility Name:
- Address 1:
- Address 2:
- Phone:
- Fax:

#### K. PHYSICIAN CONTACTS

- Primary Care Name:
- Phone:
- Hospitalist Name:
- Phone:

#### L. TIME SENSITIVE CONDITION SPECIFIC INFORMATION

- Medication due near time of transfer:
- Last time administered:
- Script sent for controlled substances:
- Anticoagulants
- Antihypertensives
- Insulin
- Other

#### M. PAIN ASSESSMENT

- Pain Level (between 0 - 10):
- Last administered:

#### N. FOLLOWING REPORTS ATTACHED

- Physicians Orders
- Discharge Summary
- Medication Reconciliation
- Discharge Medication List
- PASRR Forms
- Social and Behavioral History

### AHCA Form 3000-3008 (JUN 2016), incorporated by reference in Rule 65G-1.015, F.A.C.

* Data required for Medicaid

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**March 2017**

Form 3008

N-1
### MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM

**O. VITAL SIGNS**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Ht.:** FEET INCHES **Wt.:**

<table>
<thead>
<tr>
<th>Temp.:</th>
<th>BP:</th>
<th>HR:</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

**P. PATIENT HEALTH STATUS**

**Urinary Retention due to:**
- Monitoring intake and output
- Skin Condition:
- Other:

**Attempt to remove catheter made in hospital?**
- Yes
- No

**Date Removed:**

**N. DIETARY INSTRUCTIONS**

**Insertion Date:**

**Supplements (type):**
- TPN
- Other Supplements:

**TREATMENTS AND FREQUENCY**

**PT - Frequency:**
- Self
- Assistance
- 1 Assistant
- 2 Assistants

**SPEECH - FREQUENCY:**

**DIALYSIS - FREQUENCY:**

**AMBULATORY STATUS**

**Transfers**
- Self
- Assistance
- 1 Assistant
- 2 Assistants

**Weight-bearing:**
- Left:
  - Full
  - Partial
  - None
- Right:
  - Full
  - Partial
  - None

**PHYSICAL FUNCTION**

**8. PHYSICAL FUNCTION**

**Transfer:**
- Self
- Assistance
- 1 Assistant
- 2 Assistants

**Weight-bearing:**
- Left:
  - Full
  - Partial
  - None
- Right:
  - Full
  - Partial
  - None

**Rehab Potential (check one):**
- Good
- Fair
- Poor

**PHYSICIAN CERTIFICATION**

**Transfers**
- Self
- Assistance
- 1 Assistant
- 2 Assistants

**Weight-bearing:**
- Left:
  - Full
  - Partial
  - None
- Right:
  - Full
  - Partial
  - None

**Physician/NP/PA Signature:**

**Physician/NP/PA License #:**

**Date:**

**Pharmacist**

**Pharmacy:**

**Medication:**

**Prescription:**

**Signature:**

**Printed Name:**

**2. PERSON COMPLETING FORM**

**Name:**

**Phone Number:**

**Date:**

**Sections required for Medicaid:**

**AHCA form 5000-3008, JUN 2015, incorporated by reference in Rule 023-1045, F.A.C.**
Instructions for Completing the
Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form

1. The AHCA 5000-3008 form must be filled out in a complete and accurate manner.

2. If patient seeks eligibility for the Medicaid Institutional Care Program (ICP) or a Medicaid Home and Community-Based Services (HCBS) Waiver:
   - For the purpose of determining whether an individual meets the medical eligibility criteria, the Comprehensive Assessment and Review for Long-Term Care Services (CARES) program requires all applicable sections of this form be completed; however, for Medicaid eligibility, CARES cannot accept this form if the items or sections marked by an asterisk (*) are not completed.

3. For Medicaid eligibility purposes, this form is good for one year from the date of the health care provider's signature, unless there has been a significant change in the individual's condition since the form was completed. CARES reserves the right to request new 3008's in situations where there has been a significant change in the individual's condition or the form appears to be a template.

NOTE: The AHCA 5000-3008 is an optional patient transfer form.

Page 1: Top of Page: “Patient’s Name”, “Last 4 digits of the SSN” and “DOB (Date of Birth)” (Required Items)

A. **Patient Information**: general demographic information about the patient, including primary language.
B. **Sight/Hearing**: note any visual impairments and any auditory impairments.
C. **Decision Making Capacity (Patient)**: what is the decision-making capacity of the person listed as the patient?
D. **Emergency Contact**: the names and phone numbers of the patient's emergency contacts.
E. **Medical Condition**: “Primary diagnosis: List the diagnosis that is considered to be primary for the individual.” Other diagnoses will include any other medical conditions the individual has been diagnosed with. If the individual is hospitalized at the time of completion, list the primary diagnosis at discharge, reason for transfer, and any surgical procedures performed during the hospital stay. If not enough room, list the primary diagnosis here and list the others on a separate page. Attach a medication reconciliation form and/or medication list that accurately notes medication history and those medications to be continued or stopped. Mandatory discussion of medications must be included in hand-off communication. (See section N.)
F. **Infection Control Issues**: note if immunizations provided, PFID status, whether isolation precautions are required, and whether patient has any underlying infection.
G. **Patient Risk Alerts**: note any areas of risk, use of restraints, and allergies.
H. **Advance Care Planning**: note and attach any relevant documentation regarding patient's health care wishes.
I. **Transferred From**: information on the facility transferring the patient, including facility name, transfer date, unit, the phone and fax numbers for that unit, the name of the discharge nurse and his/her direct contact number. The admit date and time are critical for determining which coverage is in the skilled nursing facility. The discharge date and time are important to the hospital for inpatient billing.
J. **Transferred To**: the name of the skilled nursing facility or other receiving facility where the patient is being transferred to, including the address, phone, and fax numbers.
K. **Physician Contacts**: the name and phone number of the patient's primary care physician and, if applicable, the name and phone number of the hospitalist treating the patient during the recent hospital stay.
L. **Time-Sensitive Condition Specific Information**: note whether patient has any specific critical conditions that require specialized care, or time sensitive medications due near time of transfer, and whether script was sent for controlled substance (if patient requires controlled substance, script must be sent with patient).
M. **Pain Assessment**: note the patient's pain level and when medication was last administered, if applicable.

N. **Following Reports Attached**: any of the following completed or available reports must be indicated, and attached to the AHCA MedSeq-3008 form if appropriate and available: (Medication list is not optional, and must be attached):
   - Physician Orders; Discharge Summary; Medication Reconciliation; Discharge Medication List; PASRR Form: completed PASRR Level I and Level II (if required) — patient may not be admitted to a nursing facility prior to completion and authorization given for nursing facility placement; Social and Behavioral History; Treatment orders (indicate if wound care is included); Lab reports: X-rays; EKG; CT Scan; MRI; History & Physical.
   - *All Medications: If additional space is required to list all medications, attach a medications list to this form.

AHCA Form 5000-3008, (JUN 2016), incorporated by reference in Rule 59G-1.045, F.A.C.
Instructions for Completing the
Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form

Page 2 - Top of Page: "Patient's Name, "Last 4 digits of the SSN and "DOB (Date of Birth) (Required Items)

O. Vital Signs: note vital signs along with the date and time taken.

P. *Patient Health Status: current state of patient as it relates to notation on bladder and bowel, as well as vaccinations provided.

Q. *Nutrition / Hydration: list any special dietary instructions, tube feeding information, supplements, and eating capabilities.

R. Treatments and Frequency: note which treatments are prescribed and the frequency.

S. *Physical Function: check physical capabilities of patient.

T. Skin Care - Stage & Assessment: note by number on the diagram the location of any wounds, and list the corresponding stages for each location. List any other lesions or wounds.

U. *Mental / Cognitive Status at Transfer: indicate the cognitive status of the patient.

V. Treatment Devices: check if other devices are in place, and indicate corresponding dates, types, and settings.

W. Personal Items: check any personal items that are being sent with the patient.

X. Comments: add any comments here, sign, and print name; this is an optional field; may be signed by a nurse or social worker who enters the comments.

*Physician Certification: this section must be completed and signed by a Florida licensed doctor of medicine or osteopathy, who holds a valid and active license pursuant to Chapters 458 and 459, Florida Statutes, and must include the physician's printed name, title, Florida Medical License number, and contact telephone number.

NOTE: If within their scope of practice, this section may be signed by an advanced registered nurse practitioner (ARNP) or a physician assistant (PA) who holds a valid and active license pursuant to Chapter 464, Florida Statutes.

NOTE: If delegated by the supervising physician in accordance with Chapters 458 and 459, Florida Statutes, and applicable Florida Administrative Code rules, this section may be signed by a physician's assistant (PA).

NOTE: If the patient, ARNP, or PA is not licensed by the State of Florida but is similarly and appropriately licensed by the United States Military, Veteran's Affairs (VA), or another state in the United States of America, a copy of the physician, ARNP, or PA's valid and current license must accompany the 3008 form.

NOTE: Any and all items that apply should be checked as appropriate; the physician, ARNP or PA should:

- certify whether nursing facility services are required, and if the individual requires those services for the condition for which he/she received care during the hospitalization;
- indicate whether the individual is in a community setting and is seeking long-term care services through a Medicaid Home and Community-Based Services (HCBS) Waiver, in lieu of certifying the need for nursing facility placement;
- note the rehabilitation potential and;
- include the effective date of the onset of the medical condition which requires nursing facility services. NOTE: If this is left blank, CARES will use the physician/ARNP/PA signature date for medical eligibility purposes for Medicaid programs.

7. Person Completing Form: include the printed name and contact telephone number of the person completing the form. This is only required when the medical professional signing the form did not complete the form. Only individuals working with the medical professional who signed the form are allowed to complete this form.

Additional Notes:

1. Patient Name, last 4 digits of the SSN, and DOB must be completed on both pages.

   WHY ARE WE ASKING FOR YOUR SOCIAL SECURITY NUMBER (SSN)?: Federal law permits the State to use your social security number for screening and referral to programs or services that may be appropriate for you. 42 CFR § 435.910. We use the number to create a unique record for every individual that we serve, and the SSN ensures that every person we serve is identified correctly so that services are provided appropriately. Any information the State collects will remain confidential and protected under penalty of law. We will not use it or give it out for any other reason unless you have signed a separate consent form that releases us to do so or if required by law.

2. If this form is being used as a hospital transfer form, any area that does not pertain to the client's current condition should be marked NA.

3. Any section that can be addressed through documents should include the documents with the form and marked "See Attached" for the section.
Instructions for Completing the
Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form

4. Any changes after the provider has signed the form must be made by either the individual who signed the form (physician, ARNP, or PA) or another physician, PA, or ARNP. If someone other than the physician, ARNP, or PA makes a change, the physician, ARNP, or PA must also initial the change. If a provider other than the original provider makes changes they will initial any changes/additions, add their name, signature, Florida License number, and contact phone information in Section X.
REQUEST FOR ADDITIONAL MEDICAL INFORMATION FOR LOC DETERMINATION

DATE: ______________________

PLEASE DELIVER TO: ______________________ FAX # ______________________

FROM: DOE CARES PSA ______________________ PHONE # ______________________ FAX # ______________________

A referral requesting a Level-of-Care Determination (LOC) was received on ______________________

For: ______________________ SSN: ______________________

This is to notify you that the DOEA Comprehensive Assessment and Review for Long-Term Care Services Program (CARES) is in the process of determining medical eligibility for long-term care services through the issuance of a Level-of-Care Determination on the above referenced individual. We are unable to release a Level-of-Care at this time, as we are waiting for additional medical information in order to determine medical eligibility on this case. Please provide the additional information as soon as possible so that we may provide a timely determination on the individual’s request for assistance. In the absence of this information being provided, the Department of Children and Families’ (DCF) Automated Community Connection to Economic Self Sufficiency (ACCESS) Florida Program will not be able to approve the Institutional Care Program (ICP) application. If this is the case, the client or designated representative will be required to complete a new Request for Financial Assistance application.

The information needed is identified below:

☐ AHCA Form 5000-3008
☐ Admission and Discharge Summary
☐ History & Physical
☐ Psychiatric Evaluation
☐ PASRR Level I Screen
☐ Physician Orders for Skilled Care (e.g., PT, OT, ST, wound care, etc.)
☐ Most recent Medication Administration Record (MAR)
☐ Signed Informed Consent Form
☐ Other medical information: ______________________

As soon as CARES receives the above information, we will determine medical eligibility, and forward the Level-of-Care Determination to DCF or the appropriate agency to complete the eligibility process. Thank you.

______________________________  ______________________  ______________________
Name  Title  Date

Please FAX the additional information back to CARES at the number indicated above.
59G-4.180 Intermediate Care Services, Florida Administrative Code

(1) Purpose. This rule establishes the level of care criteria that must be met in order for nursing and rehabilitation services to qualify as intermediate care services and clarifies the criteria that must be met in order for such services to qualify as an intermediate level I or intermediate level II service under Medicaid.

(2) Definitions as used in this section.

(a) Intermediate care nursing home resident. A Medicaid nursing home applicant or recipient who requires intermediate care services including 24-hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and treatment provided in a hospital or that which meets the criteria for skilled nursing services.

(b) Rehabilitation services. Individualized activities or exercises prescribed by health care professionals that are designed to restore the recipient to self-sufficiency or to maintain the recipient at the highest attainable functional level.

(c) Routine. The administration of medications, treatments, or services in accordance with an established or predetermined schedule and performed for individuals whose medical needs are stabilized or chronic.

(3) Intermediate Services criteria.

(a) To be classified as requiring intermediate care services, level I or level II in the community or in a nursing facility, the applicant or recipient must require the type of medical, nursing or rehabilitation services specified in this subsection.

(b) Intermediate Care Services. To be classified as intermediate care services, the nursing or rehabilitation service must be:

1. Ordered by and remain under the supervision of a physician;

2. Medically necessary and provided to an applicant or recipient whose health status and medical needs are of sufficient seriousness as to require nursing management, periodic assessment, planning or intervention by licensed nursing or other health professionals;

3. Required to be performed under the supervision of licensed nursing or other health professionals;

4. Necessary to achieve the medically desired results and to ensure the comfort and safety of the applicant or recipient;

5. Required on a daily or intermittent basis;

6. Reasonable and necessary to the treatment of a specific documented medical disorder, disease or impairment; and

7. Consistent with the nature and severity of the individual’s condition or the disease state or stage.
(c) When determining whether intermediate care services are required, consideration shall be given to the nature of the services prescribed and to which level of nursing or other health care personnel meets the qualifications necessary to provide such services, the availability and accessibility of community or alternative resources, and how the recipient’s, applicant’s or resident’s needs can be most effectively and efficiently met.

(d) The amount of care required shall not be a primary factor in determining whether or not an applicant or resident requires intermediate care services.

(e) To qualify for placement in a nursing facility, the applicant or recipient must require intermediate care services including 24 hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and services provided in a hospital or that meets the criteria for skilled services.

(4) Intermediate Care Services Level I.

(a) Intermediate care service level I is extensive health related care and service required by an individual who is incapacitated mentally or physically.

(b) Examples of services that qualify as intermediate care services level I:

1. Administration of routine or stabilized dosages of oral medication, eye drops or ointments;

2. Routine administration of intramuscular or subcutaneous medication and observation of the individual’s response and side effects;

3. Administration and adjustment of medication for pain and the monitoring of results and side effects;

4. Routine administration of insulin to a diabetic resident whose condition is stable, but who is unable to self-administer due to physical, mental or medical reasons;

5. Routine oral suctioning;

6. Tracheostomy care when the individual’s condition is stable, but the individual is unable to care for the tracheostomy due to physical, mental or medical reasons;

7. Routine intermittent positive pressure breathing (IPPB) therapy after a regimen of therapy has been established or therapy is performed by the resident with nursing supervision;

8. Routine care of stoma and surrounding skin in the presence of colostomy, gastrostomy or ileostomy, excluding the initial period of training, teaching or intensive care, and special problems, for example, bleeding, severe diarrhea, or stricture;

9. Routine care of a supra-pubic catheter, excluding special care in cases of hemorrhage, frequent obstruction, frequent changes;

10. Routine services to maintain satisfactory functioning of indwelling bladder catheters, including routine insertion of catheter and, excluding special care in cases of infection, hemorrhage, frequent obstruction, frequent changes of the catheter, irrigations more than two times daily, or the use of special medications for irrigation and instillation;
11. Changes of dressings, sterile or aseptic, for noninfected postoperative or chronic conditions;

12. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor and noninfected skin problems;

13. Routine care of the incontinent resident, including the use of diapers and protective sheets;

14. General maintenance care in connection with a plaster cast;

15. Routine care in connection with temporary casts, splints, braces or similar devices, excluding observing for circulatory or skin changes in unstable cases;

16. Decubitus care involving superficial, noninfected lesions and preventive measures when a resident is susceptible to decubitic formation;

17. Bowel and bladder control training and maintenance after a successful program has been established;

18. Care of a resident with an amputation or a fracture requiring routine care of a stabilized condition and reinforcement of an established rehabilitation plan;

19. Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator, including the use of special baths with whirl-type action when not required to be performed by a physical therapist or licensed nurse;

20. Routine administration of medical gases after a regimen of therapy has been established by a physician and is administered by the resident;

21. Assistance or supervision in dressing, eating and toileting;

22. Periodic positioning or repositioning;

23. General supervision of exercises which have been taught to the resident, including the carrying out of a maintenance program, for example, the performance of repetitive exercises required to maintain functions in paralyzed extremities, assisted walking, and similar procedures;

24. Administration of oxygen on an emergency or short-term basis;

25. Rehabilitative restorative care, passive range of motion (ROM) exercise;

26. Routine use of physical restraints or protective devices; and

27. Routine dietary management.

(c) Intermediate care services level II is limited health related care and services required by an individual who is mildly incapacitated or ill to a degree to require medical supervision. Individuals requiring this level of care shall:

1. Be ambulatory, with or without assistive devices,

2. Demonstrate independence in activities of daily living, and
3. Not require the administration of psychotropic drugs on a daily or intermittent basis or exhibit periods of disruptive or disorganized behavior requiring 24-hour nursing supervision.

(d) Examples of services, in addition to medical supervision, that qualify as intermediate care level II:

1. Administration of routine oral medication;

2. Assistance with mobilization, helping a resident maintain balance when transferring from bed to chair and providing necessary help when climbing steps or manipulating wheelchair in difficult places;

3. Assistance with bathing, that is, assembling towels, soap, and other necessary supplies, helping the recipient in and out of the bathtub or shower, turning the water on and off, adjusting water temperature, washing and drying portions of the body which are difficult for the recipient to reach and being available while the recipient is bathing himself;

4. Assistance with dressing, that is, helping the recipient to choose and to put on appropriate clean clothing, and fastening hooks, buttons, zippers and ties;

5. Assistance with meals, that is, helping with cutting up food and pouring beverages;

6. Assistance with grooming, that is, helping the recipient to shave, wash, comb and curl hair, and to clean and file fingernails and toenails. Fingernails or toenails should not be cut by the recipient unless approved by the physician;

7. Provision of social and leisure services which are arranged for and individually designed to reduce isolation and withdrawal and to enhance communication and social skills;

8. Self-administration of medical gases, oral medications, subcutaneous medication after a regimen of therapy has been established and self-administration approved by the physician;

9. Ongoing medical and social evaluations to determine the point when a recipient’s progress has reached the stage at which medical and related needs can be met appropriately outside of the nursing facility or through alternative placement or services;

10. Application of dressings and treatments prescribed by the physician for small or superficial areas requiring a dressing;

11. Application of elastic stockings, when prescribed, if the recipient cannot manage independently;

12. Administration of oxygen or intermittent positive pressure breathing when prescribed by the physician and performed by the recipient;

13. Assistance with colostomy care, that is, helping the recipient care for permanent colostomy which the recipient ordinarily cares for;

14. Routine measurement and recording of vital signs and weights, including being alert to symptoms and readings corresponding to abnormal conditions of the residents;
15. Routine restorative and rehabilitation procedures, that is, the encouragement and incorporation of range of motion exercises in the daily activities schedule.
59G-4.290 Skilled Services, Florida Administrative Code

(1) Purpose. This rule establishes the level of care criteria that must be met in order for nursing and rehabilitative services to qualify as skilled services under Medicaid.

(2) Definitions as used in this section.

(a) Continuous. The need for 24-hour care in a skilled nursing facility with professional nursing services available.

(b) Direct supervision. Performance of a procedure in the presence of professional personnel or their presence in the facility during the time in which the procedure is being performed.

(c) Licensed nursing personnel. Registered professional or licensed practical nurses, currently licensed by the State of Florida to practice as a registered nurse or licensed practical nurse respectively.

(d) Professional personnel. Florida licensed or certified physicians, registered nurses, respiratory care practitioners/therapists, audiologists, physical, occupational or speech therapists.

(e) Rehabilitative services. Individualized services prescribed by a health care professional that are designed to restore a recipient to self-sufficiency or to the highest attainable functional level in the shortest possible time following an illness or injury.

(f) Skilled care recipient. A Medicaid applicant or recipient who requires skilled nursing or skilled rehabilitative services.

(3) Skilled Services Criteria.

(a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require the type of medical, nursing or rehabilitative services specified in this subsection.

(b) Skilled Nursing. To be classified as skilled nursing service, the service must meet all of the following conditions:

1. Ordered by and remain under the supervision of a physician;

2. Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse.

3. Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effective performance;

4. Required on a daily basis;

5. Reasonable and necessary to the treatment of a specific documented illness or injury; and
6. Consistent with the nature and severity of the individual’s condition or the disease state or stage.

(c) Examples of services that qualify as skilled nursing services:

1. Intravenous medication or fluids.

2. Intramuscular or subcutaneous injection and hypodermoclysis when:
   a. Administered by licensed nursing personnel at least 5 times weekly, excluding daily insulin administration, and
   b. Observation is necessary to assess the recipient’s response to treatment or to identify adverse reactions.

3. Management and monitoring medication regime on a daily basis:
   a. For drugs whose dosage requirements may rapidly change;
   b. For drugs prone to cause adverse reactions, severe side effects or unfavorable reactions; and
   c. For residents with unstable conditions.

4. Levin tube and gastrostomy feedings; excluding feedings performed by residents, family members, or friends.

5. Administration of medical gases, aerosolized medication or oxygen which is started, monitored and regulated by professional staff.


7. Insertion, replacement, and sterile irrigation of catheters when:
   a. Medically necessary or required for reasons other than to maintain satisfactory catheter functioning and dryness;
   b. The medical need is documented by the physician;
   c. Continuous irrigation, frequent insertion, special care or observation is required because of bleeding, infection, obstruction, or heavy sediment formations; and
   d. Care of a recently inserted supra-pubic catheter, inserted within 2-4 weeks, is required.

8. Colostomy and ileostomy care:
   a. When medically necessary and required during early postoperative period;
   b. During the period of initial self-care training; or
   c. When complications are present and documented in the medical record.

9. Treatment of decubitus ulcers when:
   a. Deep or wide without necrotic center;
   b. Deep or wide with layers of necrotic tissue; or
c. Infected and draining.

10. Treatment of widespread infected or draining skin disorders.

11. Application of dressings involving prescription medication and aseptic techniques when documented as required on a daily basis. Excludes simple dressings involving non-infected cases, simple skin breaks, and healed postoperative incisions.

12. Heat treatments prescribed by a physician as daily treatment for a specific condition.

13. Rehabilitation nursing procedures required on a daily basis as necessary to restore functioning, including teaching and adaptive aspects of nursing.

(4) Skilled Rehabilitative Services. To be classified as skilled rehabilitative services, the services must meet all of the following conditions:

(a) Ordered by and remain under the supervision of a physician;

(b) Reasonable and necessary to the treatment of a recent or presently existing illness or injury;

(c) Performed by a physical therapist, occupational therapist, certified respiratory care practitioner/therapist;

(d) Required at least 5 days a week; and

(e) Reviewed and reevaluated at least every 30 days by the physician and the physical, occupational therapist or respiratory care practitioner/therapist.

(5) Examples of services that qualify as skilled rehabilitation services:

(a) Daily services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.

(b) Ongoing assessment of rehabilitation potential and needs in accordance with Rule 59G-4.320, F.A.C.

1. Such services must be provided as an integral part of the management of the care plan; and

2. Must include results of tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, physical capacities, perceptual deficits, speech and language or hearing disorders.

(c) Therapeutic exercise or activities that, because of the type of exercise employed or the condition of the recipient, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the recipient and the effectiveness of the treatment.

(d) Gait evaluation and training when furnished in accordance with the treatment plan and designed to restore function to a recipient whose ability to walk has been impaired by neurological, muscular or skeletal abnormalities.

(e) Range of motion exercises that are part of the active treatment for a specific disease state which has resulted in a loss of, or restriction of, mobility as evidenced by a therapist’s notes showing the degree of motion lost and the degree to be restored.
(f) Maintenance therapy, when the specialized knowledge, skills, and judgment of a qualified therapist are required to design and implement a maintenance program based on an initial evaluation and periodic assessment of the recipient’s needs, and consistent with the recipient’s capacity and tolerance. For example, a recipient with Parkinson’s disease who has not been under a rehabilitative program may require the services of a qualified therapist to determine the type of exercise that will contribute the most to the maintenance of his present level of functioning.

(g) Ultrasound, short-wave and microwave therapy by a qualified physical therapist.

(h) Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool in cases in which the recipient’s condition is complicated by circulatory deficiency, areas of desensitization, or complications, and the skills, knowledge and judgment of a qualified physical therapist are required.

(i) Chest physiotherapy or augmentary airway clearance techniques, maintain airway patency and lung volume.

(6) Examples of services that qualify as either skilled nursing or skilled rehabilitative services:

(a) Ongoing involvement of registered nurses or other professional personnel in the evaluation of the total needs of a resident and management of the treatment plan.

(b) Continuous observation and monitoring for complications, adverse reactions, or changes in the status of a recipient’s condition when required to identify and evaluate the individual’s need for modification of the treatment plan or institution of a critical medical procedure.

(c) Ongoing teaching and training activities that are required to teach a recipient or caregiver how to manage the treatment regime or perform self care or treatment skills. This service must be ordered by the physician and evidenced by a recent change in the health status of the resident. Skilled teaching and training services must be documented on at least a daily basis in the progress notes.

(7) Medically fragile. To be classified as medically fragile, the applicant or recipient must be:

(a) Age birth through age 20 years old;

(b) Require skilled nursing in a nursing facility; and

(c) Be technologically dependent on apparatus or procedures to sustain life, or require significantly more intense and continual professional nursing supervision and intervention to sustain life and who, without the provision of such continuous services and observation, is likely to expire.

(8) Services shall be considered skilled in cases in which medically complex condition(s) or medically fragile condition(s) are documented by a physician, or when the instability of the recipient’s condition requires frequent nursing intervention, observation and assessment of the recipient’s status and response to care.

(9) The restorative or recovery potential of the individual shall not be a factor when determining the need for skilled services.
(10) To qualify for placement in a nursing facility, the applicant or recipient must require 24 hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and services provided in a hospital.

(11) When determining whether nursing facility services are required, consideration shall be given to the individual’s physical and mental condition, excluding individuals with functional psychoses, acute psychiatric illness or individuals requiring or receiving active psychiatric treatment, or who require 24-hour care for diagnostic evaluation and psychiatric treatment.
# CARES INDIVIDUAL REVIEW OF NO LEVEL OF CARE RECOMMENDATION

<table>
<thead>
<tr>
<th>CARES Assessor:</th>
<th>PSA:</th>
<th>□ CARES □ Lead Agency</th>
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<tr>
<td>Program:</td>
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<td>□ NF □ Waiver</td>
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<tr>
<td>Client Name:</td>
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<td>□ Initial □ Annual □ Re-Assess</td>
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<th>CARES Supervisor:</th>
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<tbody>
<tr>
<td>Included in this review:</td>
<td>□ Case Notes □ 3008(s) □ Assessment(s)</td>
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<tr>
<td>Other Medical Documentation:</td>
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<tr>
<td>Consultation w/RN:</td>
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<td>Attached RN Comments, if applicable:</td>
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<tr>
<td>Supervisor <strong>does not agree</strong> with No Level of Care, case returned to:</td>
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<td>for appropriate action, case <strong>will not</strong> be forwarded to RPS for further review.</td>
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<td>Supervisor <strong>agrees</strong> with No Level of Care, case forwarded to RPS for further review.</td>
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<td>Justification for Decision:</td>
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<td>RPS <strong>agrees</strong> with No Level of Care, case <strong>will not</strong> be forwarded to CO for further review;</td>
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<td>E-mail justification sent on <strong>/</strong>/__ (provided within 3 business days or review)</td>
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<td>Phone conversation with supervisor <strong>/</strong>/__</td>
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<td>RPS forwarding to CO for consult.</td>
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<td>Other Medical Documentation Requested:</td>
<td></td>
</tr>
<tr>
<td>Consultation w/RN and/or Physician:</td>
<td></td>
</tr>
<tr>
<td>CO <strong>does not agree</strong> with No Level of Care, e-mail notification sent on <strong>/</strong>/__</td>
<td></td>
</tr>
<tr>
<td>CO <strong>agrees</strong> with No Level of Care, E-mail justification sent on <strong>/</strong>/__ (provided within 3 business days or review):</td>
<td></td>
</tr>
<tr>
<td>Phone conversation with RPS on <strong>/</strong>/__</td>
<td></td>
</tr>
<tr>
<td>CO request PSA send notification to certifying M.D. regarding No LOC decision <strong>/</strong>/__</td>
<td></td>
</tr>
</tbody>
</table>

March 2017
Form 610 – Review of NLOC
NOTIFICATION OF LEVEL OF CARE

1. From CARES PSA/Worker: _________________  To DCF Circuit/Region _________________
   Case Mgr: _________________  DCF Case #: _________________
   Case Mgt. Agency: _________________

2. Client Name: _________________  DOB: ______  SSN: _________________
   Current Location/Address: __________________________________________________________________

3. Level of Care:
   □ Skilled  □ Intermediate I  □ Withhold LOC
   □ Risk of Hospital  □ Intermediate II  □ Does Not Meet LOC Criteria

4. Program Recommendation:
   □ Cystic Fibrosis  □ Brain and Spinal Cord Injury  □ PAC
   □ PACE  □ SMMC LTC:
      □ MLTCN (ICP)
      □ Other: ____________________
      □ MLTCC (HCBS)
   □ FD Waiver

5. Placement Recommendation:
   □ Community  □ Nursing Facility  □ Temporary Nursing Facility
   □ Swing Bed  □ State Mental Health Hospital  □ Other: ____________________
      (specify)
   □ Hospital Based Nursing Bed for Rehab Care

6. PASRR Screen:
   □ MI/ID Level I  Date Completed: _________________
   □ MI Level II  Date Completed: _________________  □ ID Level II  Date Completed: _________________

7. LOC Effective Date: _________________

8. Comments:

   ____________________________________________________________________
   ____________________________________________________________________

9. Approval Signature: __________________________  Date: __________________________

DOEA-CARES Form 603 (Revised, July 2014)
Client Discharge/Change Notice

TO: Dept. of Children & Families

FROM: [Facility name]

E.S.S. [location]

Date: [Date]

Contact Name: ____________________________

Telephone #: ____________________________

_Enter extension, if applicable_

Patient: ____________________________

SS#: ____________________________

Date of Birth: ____________________________

Medicaid ID #: ____________________________

THIS IS TO ADVISE YOU OF THE STATUS OF THE ABOVE PATIENT:

I. PATIENT DISCHARGED FROM THE FACILITY ON [Date] TO:
   - [ ] ALF
   - [ ] Home
   - [ ] Hospital
   - [ ] Other (specify): ____________________________

   Address: ____________________________

   [ ] Due to Death on [Date of death]

II. TEMPORARY ABSENCE BEGINNING ON [Date] DUE TO:
   - [ ] Hospital Admission
   - [ ] Therapeutic Home Visit
   - [ ] Other (specify): ____________________________

III. EXPECTED TO RETURN ON [Date]

IV. READMITTED TO FACILITY ON [Date]

V. OTHER STATUS CHANGE:
   - [ ] Medicare coverage began on [Date] and ended on [Date]
   - [ ] Change in income: Type: ____________________________, Amount: ____________________________

TO: [Facility name]

FROM DCF: [Economic Self-Sufficiency Specialist]

ATTENTION: [Facility Contact]

PHONE #: ____________________________

_Enter extension, if applicable_

DATE: ____________________________

COMMENTS: