# CARES Program Policy Handbook

## MEDICAL CERTIFICATION FOR NURSING FACILITY/HOME-AND COMMUNITY-BASED SERVICES FORM

**A) FACILITY INFORMATION**
- Facility From: ______________
- Admission Date: ______________
- Discharge Date: ______________
- Facility To: ______________

**B) DEMOGRAPHIC INFORMATION**
- Individuals’ DSN: ______________
- Sex: ______________
- Race: ______________
- Individuals Last Name: ______________
- First Name: ______________
- Initial: ______________
- Individuals Address: ______________
- Phone Number: ______________
- Nearest Relative/Health Care Surrogate: ______________
- Phone Number: ______________

**PHYSICIAN INFORMATION**
- Name: ______________
- Will you care for individual in NF? Yes ___ No ___
- If no, refer to ______________
- Principal Diagnosis: ______________
- Secondary Diagnosis: ______________
- Discharge Diagnosis: ______________
- Problem List may be attached: ______________
- Surgery Performed: ______________
- Date: ______________
- Allergy/Drug Sensitivity: ______________

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

**C) PRE-ADMISSION SCREENING FOR MENTAL ILLNESS/MENTAL RETARDATION**
(Complete form for application to NF only)
- 1. Is dementia the primary diagnosis? Yes ___ No ___
- 2. Is there an indication of, or diagnosis of mental retardation (MR), or has the individual received MR services within the last 2 years? Yes ___ No ___
- 3. Is there an indication of, or diagnosis of a serious mental illness (MI), such as schizophrenia, panic or severe anxiety disorder, mood disorder, personality disorder, psychotic disorder, or other psychotic or mental disorder leading to chronic disability? Yes ___ No ___
- 4. Has the individual received services within the past two years? Yes ___ No ___
- 5. Is the individual on any medication for the treatment of a serious mental illness or psychiatric disorder? Yes ___ No ___
- 6. Is the individual admitted to the hospital after receiving psychiatric inpatient care? Yes ___ No ___
- 7. Does the individual require nursing facility services for a condition for which he/she received care in the hospital? Yes ___ No ___
- 8. Has the individual received any treatment within the past 30 days of nursing facility services? Yes ___ No ___

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

**E) HISTORY & PHYSICAL AND LABS**
1. PHYSICAL EXAM (History & Physical may be attached):
   - Head & Neck
   - Eyes
   - Ears
   - Nose
   - Throat (HEENT)
   - Neck
   - Cardiopulmonary
   - Abdomen
   - GU
   - Rectal
   - Extremities
   - Neurologic
   - Other
   - Fever from communicable disease: Yes ___ No ___
   - Date: ______________
   - Date: ______________
   - TB Test: Yes ___ No ___
   - Date: ______________
   - Results: ______________
   - Chest X-Ray: Yes ___ No ___
   - Date: ______________
   - Date: ______________

**F) IMMUNIZATIONS GIVEN**
- Pneumococcal Vaccine: Date ______________
- Influenza Vaccine: Date ______________
- Tetanus and Diphtheria vaccine: Date ______________
- Hepatitis A Vaccine: Date ______________

**G) PHYSICAL THERAPY**
(Attach Orders)
- New Referral: Yes ___ No ___
- Continuation of Therapy: Yes ___ No ___

**FREQUENCY OF THERAPY INSTRUCTIONS**
- Stretching: Yes ___ No ___
- Coordinating Activities: Yes ___ No ___
- Progressed bed to wheelchair: Yes ___ No ___
- Recovery to full function: Yes ___ No ___
- Wheelchair independent: Yes ___ No ___
- Active assistive: Yes ___ No ___
- Passive: Yes ___ No ___
- Progressive resistive: Yes ___ No ___
- Sensation Impaired: Yes ___ No ___
- Restricted Activity: Yes ___ No ___

**ADDITIONAL THERAPIES**
(Attach Orders)
- Respiratory Therapy: Yes ___ No ___
- Speech Therapy: Yes ___ No ___
- Occupational Therapy: Yes ___ No ___

**H) TREATMENT AND EQUIPMENT NEEDS**
(Attach Orders)
- Catheter Care: Yes ___ No ___
- Diabetic Care: Yes ___ No ___
- Changing Feeding Tube: Yes ___ No ___
- Monitor Blood Sugar/Frequency: Yes ___ No ___
- Dressing Changes: Yes ___ No ___
- Ostomy Care: Yes ___ No ___
- Tube Feeding: Yes ___ No ___
- Ambulance: Yes ___ No ___
- Suctioning: Yes ___ No ___
- Intravenous: Yes ___ No ___
- ER: Yes ___ No ___
- Continuous Infusion: Yes ___ No ___

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

**J) TYPE OF CARE RECOMMENDED**
(Attach one)
- Skilled Nursing Extended Care Facility (ECF), Duration: ______________
- Intermediate Care: ______________
- Admission Date to Nursing Facility: ______________
- Effective Date of Medical Condition: ______________
- Rehabs Potential: Good ___ Fair ___ Poor ___

Print Physician’s Name: ______________
Address: ______________
Phone Number: ______________
Email Address: ______________
Physician’s Signature and Date Required: ______________

FOR ONLINE APPLICANT USE ONLY
If applying for Medicaid, please include DCF Access Confirmation Number Below:

March 2015
**NURSING/SOCIAL WORK ASSESSMENT**
[Page 2 may be completed by a Nurse or Social Worker]

<table>
<thead>
<tr>
<th>INDIVIDUAL'S NAME</th>
<th>DOB</th>
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<table>
<thead>
<tr>
<th>(K) VISION (w/glasses if used)</th>
<th>AMBULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEARING (w/aid if used)</td>
<td>ENDURANCE</td>
</tr>
<tr>
<td>SPEECH</td>
<td>TRANSFER</td>
</tr>
<tr>
<td>COMMUNICATION</td>
<td>WHEELCHAIR USE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MENTAL AND BEHAVIOR STATUS</th>
<th>TOILETING</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SKIN CONDITION</th>
<th>BLADDER CONTROL</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>DRESSING</th>
<th>PAVILLION CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No assistance 2. Requires assistance* 3. Has to be dressed</td>
<td>1. Continent 2. Occasional incontinence - once a week or less 3. Frequent incontinence - up to once a day 4. Total incontinence 5. Ostomy</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>BATHING</th>
<th>FEEDING</th>
</tr>
</thead>
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<table>
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<tr>
<th>TEACHING NEEDS</th>
<th>DIET</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>HANDS ON NEEDED</th>
<th>Comments:</th>
</tr>
</thead>
</table>

**SIGNATURE AND TITLE**

**DATE**

**SOCIAL WORK ASSESSMENT**

Prior Living Arrangement

Long Range Plan/Agency Referrals

Adjustments to Illness or Disability

Comments

ARCA MEDDIE 3000 form, May 2000 - (Replaces Patient Transfer and Continuity of Care Form 3000 July 2000 - 97 Med 3000)
Instructions for Completing the AHCA MedServ-3008 Form

This form is a dual-purpose form for physicians and ARNPs to certify Nursing Facility Care or Home and Community-Based Services (Medicaid Waiver Services)

To further assist you in the completion of the AHCA MedServ-3008 form, the following instructions are provided: Additional information is located on the Comprehensive Assessment and Review for Long Term Care Services (CARES) Web site: http://elderaffairs.state.fl.us/english/cares.php

For individuals applying for enrollment in a Home and Community-Based Services Medicaid waiver program, only Page 1 of this form is required. It must be signed and dated by an MD, DO, or ARNP. For those sections on the form that allow attachments, if “attached” is indicated, the documentation must be attached in order for the form to be accepted.

Section A: Facility Information

List where the individual is transferring to and from, along with admission and discharge dates, if appropriate.

Section B: Demographic Information

- Enter individual’s demographic information
- List physician’s name
- Answer the question regarding the care of the individual in the nursing facility and who the individual will be referred to if you will not be caring for individual
- List the principal diagnosis for which the individual has been hospitalized/admitted
- List all other diagnosis for which the individual has secondary diagnosis, as well as discharge diagnosis
- Attach Problem List
- Include any surgeries performed, including date of surgery
- List all allergies and drug sensitivities
- List all medication(s) and/or treatment(s) for the individual; specify them by name, including dosage and method of administration. If you need additional space, you may attach additional pages, but please indicate that you have done so.

Section C: Preadmission Screening
(This section is only for those seeking Nursing Facility placement)

This section contains items numbered one through ten, which meet the mental illness/mental retardation screening required by Omnibus Budget Reconciliation Act (OBRA) ’87. Answer each item by checking the appropriate box for Yes or No to indicate the individual’s mental illness/mental retardation (MI/MR) status (additional documentation may be attached).

Section D: Additional Orders (Orders may be attached)

Section E: History & Physical and Labs

1. Physical Exam: (History & Physical may be attached)

- Review all body systems of the individual and list specific findings
- Briefly describe the individual’s medical history
- Describe the individual’s mental and physical functional limitations
- Use additional order space (D) for additional findings if needed
2. **Laboratory Findings:** (Reports may be attached)
   - Check if TB test has been completed or not; provide date of testing and results
   - List date of chest x-ray and results
   - Use additional order space (D) for other lab orders or results

**Section F: Immunizations Given**
- List dates of last Pneumococcal vaccine, Influenza vaccine, Tetanus and Diphtheria vaccine and Herpes Zoster vaccine.

**Section G: Physical Therapy (Attach Orders)**
- Check if this is a new referral or continuation of therapy
- List frequency of treatment
- Provide instructions for other physical therapy needs (Use additional order (D) if needed)
- Check therapy ordered and precautions if any for individual

**Section G: Additional Therapies (Attach Orders)**
- List type of therapy ordered and precautions if any for the individual
- Use additional order space (D) for additional therapies not listed
- List instructions for therapy identified

**Section H: Treatment and Equipment Needs (Attach Orders)**
- Check type of treatment and equipment needs for individual
- Use additional order space (D) for other treatment or equipment needs not listed

**Section I: Special Diet Orders (Orders may be attached)**
- List individual’s dietary restrictions and requirements

**Section I: Type of Care Recommended**
- Indicate the type of care (skilled nursing ECF or intermediate) recommended for the individual and the duration
- Indicate the individual’s rehabilitation potential (good, fair, or poor)
- List admission date to nursing facility
- Indicate certification of individual requiring ECF Nursing Facility Care for the condition for which the individual received care during hospitalization
- Indicate certification of individual in need of Medicaid Waiver Service in lieu of institutional care placement
- List effective date for certification
- Print name, address, and phone number of physician
- MD, DO, or ARNP must sign and date form as mandated by federal law

If applying for Home and Community Based Services, no further information is required. See the following page for instructions regarding individuals applying for Medicaid Nursing Facility services.
Section K: The Nursing/Social Work Assessment Form

- Activities of Daily Living (ADLs) are at the time of admission into the nursing facility
- (*) Indicates "Hands on is needed" for this ADL
- Check appropriate box on the Nursing Assessment to indicate the level of assessment of the individual at time of admission
- Add additional nursing assessment information in the Comment Section
- Sign and date form

Section L: The Nursing/Social Work Assessment Form

- Social Work Assessment is to be completed at the time of nursing facility admission
- Sign and date form

The Nursing/Social Work Assessment Form (page 2 of the AHCA MedServ-3008 form) must also be completed for individuals in hospitals and nursing facilities seeking level of care for nursing facility placement.

- Page 2 is not required for individuals in the community seeking nursing facility placement
- Page 2 may be completed and signed by a nurse or social worker

Please note: This form is also located for your convenience at the following link:
http://elderaffairs.state.fl.us/english/cares.php

From this link you may download the form, complete as appropriate for each individual, save the .pdf file as needed before printing, signing and returning to CARES.