AHCA 5000-3008 REFERRAL COVER SHEET

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

TO: CARES PSA _____ **FROM:** _____

_____ _____

_____ _____

Phone: _____ **Phone:** _____

FAX: _____ **FAX:** _____

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

Please check Yes or No to each below:

☐ **Yes** ☐ **No** **AHCA Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form – AHCA 5000-3008 (JUN 2016) and related medical documentation is attached**

☐ **Yes** ☐ **No** **2040 Informed Consent for applicant is attached**

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

Please check Yes or No to each below:

☐ **Yes** ☐ **No** **DCF ACCESS online application submitted for applicant**

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

Comments: _____

_____

Applicant's Social Security Number: _____

Applicant's Name: _____
First *MI* *Last*

Address: _____

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

Phone: _____ **Marital Status:** _____

Date of Birth: _____ **Sex:** _____ **Race:** _____

CONFIDENTIALITY NOTICE: This FAX, including attachments, is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. Any unauthorized review, use, disclosure, or distribution is prohibited. If you have received this communication in error, please do not distribute it. Please notify the sender by FAX at the address shown and delete the original message. Thank you.