FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

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) ☐ will not be enrolled in the Medicaid waiver (HCBS):_____.
(**Enter reason**)

c) ☐ will not be enrolled in the Medicaid waiver (HCBS) as no funding/vacancies are available.

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 is enrolled in waiver services, you must report any changes to DCF/Economic Self-Sufficiency Services staff immediately.**

VI. ☐ Certified By:

_____ _____
Case Manager Name (Print) Case Manager Signature

_____
Date

CF-AA 2515, Oct 2002 (Replaces previous editions which may not be used)

CHANGE IN HCBS RECIPIENT'S LIVING ARRANGEMENT
UPDATE INFORMATION

VII. LIVING ARRANGEMENT INFORMATION:

a) Recipient's current address: _____

b) Recipient's 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 district/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 (district/county) eligibility specialist been contacted? ☐ NO ☐ YES (Date): _____

IX. CHANGE IN CASE MANAGER INFORMATION:

a) ☐ Recipient transferred to another Medicaid waiver Case Manager on (date) _____.

b) ☐ New form CF-AA 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): (_____) _____