

**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 purposes 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 professional'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 individuals condition or the form appears to be altered.,

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 immunizations provided, PPD 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 Medicare coverage 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 MedServ-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 Forms: 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.

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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 immunizations 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 locations 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.*
- Y. ***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) 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 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.
- 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.**
- Z. **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 N/A.
3. Any section that can be addressed through documents should include the documents with the form and marked "See Attached" for the section.

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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.

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 L R

C. DECISION MAKING CAPACITY (PATIENT)

Capable to make healthcare decisions Requires a surrogate

***D. EMERGENCY CONTACT**

Name: _____ Name: _____
 Phone: _____ Phone: _____

***E. MEDICAL CONDITION**

*Primary diagnosis: _____
 *Other diagnoses: _____
If Hospitalized:
 Primary diagnosis at discharge: _____
 Reason for transfer: _____
 Surgical procedures performed: _____

F. INFECTION CONTROL ISSUES

PPD Status: Positive Negative Not known
 Screening date: _____
 Associated Infections/resistant organisms: _____
 MRSA Site: _____
 VRE Site: _____
 ESBL Site: _____
 MDRO Site: _____
 C-Diff Site: _____
 Other: Site: _____
 Isolation Precautions: None
 Contact Droplet Airborne

***G. PATIENT RISK ALERTS**

*None Known *Harm to self *Difficulty swallowing
 *Elopement *Harm to others *Seizures
 *Pressure Ulcers *Falls *Other: _____

RESTRAINTS: Yes No

Types: _____
 Reasons for use: _____

ALLERGIES: None Known Yes, List below: _____

Latex Allergy: Yes No Dye Allergy/Reaction: Yes No

H. ADVANCE CARE PLANNING

Please ATTACH any relevant documentation:

Advance Directive	Yes	No
Living Will	Yes	No
DO NOT Resuscitate (DNR)	Yes	No
DO NOT Intubate	Yes	No
DO NOT Hospitalize	Yes	No
No Artificial Feeding	Yes	No
Hospice	Yes	No

I. TRANSFERRED FROM

Facility Name: _____
 Date: _____ Unit: _____
 Phone: _____ Fax: _____
 Discharge Nurse: _____ Phone: _____
 Admit Date: _____ Discharge Date: _____
 Admit Time: _____ AM PM Discharge Time: _____ AM PM

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 / list last time administered
 Script sent for controlled substances (attached): Yes No
 Anticoagulants Date: _____ Time: _____ AM PM
 Antibiotics Date: _____ Time: _____ AM PM
 Insulin Date: _____ Time: _____ AM PM
 Other: Date: _____ Time: _____ AM PM

Has CHF diagnosis: Yes No
 If yes; new/worsened CHF present on admission?
 Yes No
 Last echocardiogram: Date: _____ LVEF %

On a proton pump inhibitor? Yes No
 If yes, was it for: In-hospital prophylaxis and can be discontinued
 Specific diagnosis:

On one or more antibiotics? Yes No
 If yes, specify reason(s): _____

Any critical lab or diagnostic test pending at the time of discharge? Yes No
 If yes, please list: _____

M. PAIN ASSESSMENT:

Pain Level (between 0 - 10): _____
 Last administered: Date: _____ Time: _____ AM PM

***N. FOLLOWING REPORTS ATTACHED**

<input type="checkbox"/> Physicians Orders	<input type="checkbox"/> Treatment Orders
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Includes Wound Care
<input type="checkbox"/> Medication Reconciliation	<input type="checkbox"/> Lab reports
<input type="checkbox"/> Discharge Medication List	<input type="checkbox"/> X-ray <input type="checkbox"/> EKG
<input type="checkbox"/> PASRR Forms	<input type="checkbox"/> CT Scan <input type="checkbox"/> MRI
<input type="checkbox"/> Social and Behavioral History	History & Physical

*ALL MEDICATIONS: (MUST ATTACH LIST)

MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM

*Patient Name: _____

*Last 4 SSN: _____

*DOB: _____

O. VITAL SIGNS

Date: _____ Time Taken: _____ AM PM
 HT: FEET INCHES WT: _____
 Temp: _____ BP: _____ / _____
 HR: _____ RR: _____ SpO2: _____

***P. PATIENT HEALTH STATUS**

***Bladder:** Continent Incontinent
 Ostomy Catheter Type: _____ date inserted: _____
 Foley Catheter: Yes No If yes, date inserted: _____
Indications for use:
 Urinary retention due to: _____
 Monitoring intake and output
 Skin Condition: _____
 Other: _____
Attempt to remove catheter made in hospital? Yes No
 Date Removed: _____
***Bowel:** Continent Incontinent Ostomy
 Date of Last BM: _____
Immunization status:
 Influenza: Yes No Date: _____
 Pneumococcal: Yes No Date: _____

***Q. NUTRITION / HYDRATION**

***Dietary Instructions:** _____
 Tube Feeding: G-tube J-tube PEG
 Insertion Date: _____
 Supplements (type): TPN Other Supplements: _____
 Eating: Self Assistance Difficulty Swallowing

R. TREATMENTS AND FREQUENCY

PT - Frequency: _____
 OT - Frequency: _____
 Speech - Frequency: _____
 Dialysis - Frequency: _____

***S. PHYSICAL FUNCTION**

*Ambulation: Not ambulatory Ambulates independently Ambulates with assistance Ambulates with assistive device	*Transfer: Self Assistance 1 Assistant 2 Assistants
Devices: Wheelchair (type): _____ Appliances: _____ Prosthesis: _____ Lifting Device: _____	Weight-bearing: Left: Full Partial None Right: Full Partial None

***Y. PHYSICIAN CERTIFICATION**

*I certify the individual requires nursing facility (NF) services.
 The individual received care for this condition during hospitalization.
 *I certify the individual is in need of Medicaid Waiver Services in lieu of nursing facility placement.

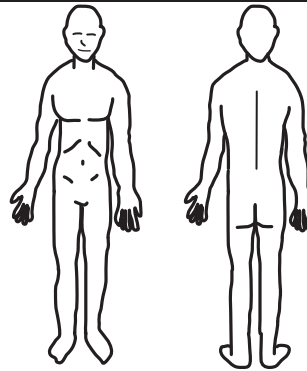
Rehab Potential (check one) <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
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*Effective date of medical condition: _____ *Physician/ARNP/PA License #: _____
 *Physician/ARNP/PA Signature: _____ *Date: _____
 *Printed Physician/ARNP/PA Name & Title: _____ *Phone Number: _____

Z. PERSON COMPLETING FORM

Name: _____ Phone Number: _____ Date: _____

T. SKIN CARE – STAGE & ASSESSMENT



Pressure Ulcers
 (Indicate stage and location(s) of lesions using corresponding number:
 1.
 2.
 3.
 List any other lesions or wounds: _____

***U. MENTAL / COGNITIVE STATUS AT TRANSFER**

Alert, oriented, follows instructions
 Alert, disoriented, but can follow simple instructions
 Alert, disoriented, and cannot follow simple instructions
 Not Alert

V. TREATMENT DEVICES

Heparin Lock - Date changed: _____
 IV / PICC / Portacath Access - Date inserted: _____
 Type: _____
 Internal Cardiac Defibrillator Pacemaker
 Wound Vac
 Other: _____
 Respiratory - Delivery Device: CPAP BiPAP
 Nebulizer Other: _____ Nasal Cannula
 Mask: Type _____
 Oxygen - liters: _____ % PRN Continuous
 Trach Size: _____ Type: _____
 Ventilator Settings: _____
 Suction

W. PERSONAL ITEMS

Artificial Eye Prosthetic Walker
 Contacts Cane Other
 Eyeglasses Crutches
 Dentures Hearing Aids
 U L Partial L R

X. COMMENTS (Optional)

Signature: _____
 Printed Name: _____