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.

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 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.**

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

☐ Physicians Orders ☐ Treatment Orders
☐ Discharge Summary ☐ Includes Wound Care
☐ Medication Reconciliation ☐ Lab reports
☐ Discharge Medication List ☐ X-ray ☐ EKG
☐ PASRR Forms ☐ CT Scan ☐ MRI
☐ 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: Sp02:

*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:*

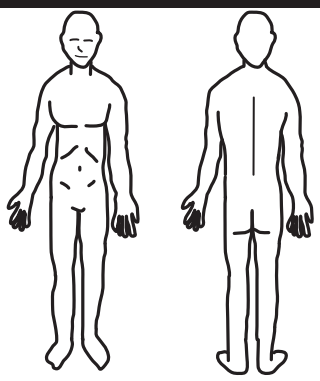
☐ Speech - *Frequency:*

☐ Dialysis - *Frequency:*

*S. PHYSICAL FUNCTION

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

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:_____

*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) ☐ Good ☐ Fair ☐ Poor

*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: _____