AHCA Med-Serv 3008 Referral Cover Sheet

TO: CARES PSA _____

_____

_____

Phone: _____

Fax: _____

FROM:

_____

_____

Phone: _____

Fax: _____

This form is being submitted to CARES to request a Level of Care for the specified individual below who is applying for 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 Med-Serv 3008 Medical Certification for Nursing Facility/Home and Community Based Services Form (MCNF/HCBS)* form*/related medical documentation is attachments***

❑ **Yes** ❑ **No** ***AHCA Med-Serv 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: _____

Total Number of Pages Submitted (Including this cover sheet): _____

(FOR ONLINE APPLICANTS) PLEASE INCLUDE DCF ACCESS CONFIRMATION NUMBER BELOW:

_____

Applicant SSN: _____

Name of Applicant (First, MI, Last): _____

Address: _____

Phone: _____ **Marital Status:** _____

DOB: _____ **Sex:** _____ **Race:** _____

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