STATE OF FLORIDA
DEPARTMENT OF VETERANS' AFFAIRS

STATE VETERAN NURSING HOME APPLICATION PACKET

INTRODUCTION

GENERAL INFORMATION

Thank you for applying to the Florida Department of Veterans' Affairs State Veterans Nursing Home. We offer rehabilitation services such as: Physical, Occupational & Speech therapy and Restorative Programs, all under the direct supervision of trained qualified therapists. Hospice and Respite Services are also available.

There is a three-step applicant qualifying process that is as follows:

- All documents required by the home must be completed before the application can be processed. These documents include VA, Financial and Medical.
- The completed application will be reviewed by our admission team.
- Whether your application is approved or disapproved, you will be notified by telephone or mail.

ADMISSION CRITERIA

The facility will verify the following of an applicant prior to admission:

- That the applicant is a Veteran as determined under Chapter 1.01 (14), Florida Statutes.
- That the applicant has been Honorably Discharged from the most recent period of active duty.
- That the applicant is a resident of Florida at time of application.
- That the applicant needs skilled nursing home care for a medical condition.
- That the applicant is not currently delinquent on any monies due to the Florida Department of Veterans Affairs for a prior skilled nursing facility stay.
- That the applicant has submitted a completed application for admission, and any additional information requested.
- If there is a share of cost (payment) required from the applicant, that payment is made prior to admission.

APPLICATION PROCESS

(Please note that an incomplete application may result in delays or denial)

For the facility to process an application, the following must occur:

- Application must be completed in its entirety and may be submitted via fax, mail, in-person, or emailed.
- All financial information required must be provided (applicants with a 70%-100% service-connected disability is not required to submit financial information, but proof this disability must be submitted with the application).
- All medical forms required must be completed by a health care practitioner (HCP).
- If the facility requests additional medical, financial, of proof of service or disability information, then all information requested must be provided.
- The Admissions Coordinator will review the potential veteran for placement in a skilled nursing facility.
- The application will be reviewed by the Interdisciplinary Team, and the team before an admission is scheduled.
- If after approval the veteran is placed on our waiting list, a reassessment will be scheduled before actually admission to determine if there is a change in the veteran's condition.
- Whether your application is approved or disapproved, either for direct admission or waiting list, you will be notified by telephone or mail.

APPLICATION CHECKLIST

(To assist with completing the packet, the following checklist is provided)

Forms to be completed/submitted by applicant or representative

☐ A signed and complete application packet must be returned via fax, mail, in-person, or emailed
☐ Form 54 – Application for Admission
☐ Form 10-10 EZ
☐ Medical Information Release From
☐ Activities of Daily Living (ADLs) and Behaviors Questionnaire
☐ Documents showing proof of Veteran status as determined under Chapter 1.01 (14), Florida Statutes.
☐ If applicable, documents showing proof of service-connected disability from the VA
☐ All medical insurance cards for verification of health insurance benefits (copies of front and back)
☐ A government issued identification card (ID) for applicant

Forms to be completed by the Health Care Provider

☐ Form 3008 (signed and dated within 30 days of admission)
☐ AHCA MedServ Form 004 (PASRR)
☐ Most recent History & Physical, or summary of most recent physician visit
☐ Statement that applicant is currently communicable disease status
☐ Current medication list
☐ COVID-19 Card, other proof of vaccination, and included in documentation

These documents must be submitted with application if applicable

☐ Power of Attorney documents
☐ Health Care Surrogate documents
☐ Living Will documents
☐ Guardianship documents
☐ Any court-order documents related to applicant

Financial Information

REQUIRED for all applicants who do not have a service-connected disability, or those with a service-connected disability rating of 60% or below.
NOT REQUIRED by applicants who are have a 70% - 100% service-connected disability rating, (*VA Disability letter required as proof of rating*).

☐ Most recent three months bank statements
☐ Most recent social security statement
☐ Most recent tax return (if applicable)
☐ Proof of all income currently received by applicant

SMOKING STANDARD

The Florida Department of Veterans' Affairs adheres to the Clean Air Act of Florida. The department is moving towards becoming 100% tobacco free. That means no smoking on the facility property at all – not in cars, in the grass, porch, etc. Smoking is NEVER permitted in or near areas where oxygen or other gases are being stored or administered.

For the purpose of this standard, smoking and tobacco include any lighted or unlighted cigarette, cigar, pipe, bidi, clove cigarette, cigarillo, hookah, and any other smoking product, and any smokeless or spitless tobacco also known as dip, chew, snuff, snus, orbs and strips, sticks, or any electronic cigarette in any form. Vapor Producing Devices or Non-Lit smoking devices are all considered smoking in this standard. Residents are not permitted to leave the campus to smoke, and residents are not permitted to smoke while on facility sponsored outings/events.

*** Residents admitted to the Emory L Bennet State Veterans' Nursing Home before 07/01/2019 have been "grandfathered" with smoking privileges. Veterans admitted on or after 07/01/2019 do not have smoking privileges. ****

MONTHLY COST OF CARE

For Veterans who have a 70%-100% service connection, there is NO SHARE OF COST to the facility.

For Veterans required to pay a monthly share of cost (monthly payment to the facility):

- The monthly cost of care = NET MONTHLY INCOME minus $130.00.
- The Veteran gets to keep $130.00 each month as a personal needs allowance.
- Proof of income is required to determine monthly cost of care.
- All Veterans who are required to pay a share of cost must apply for monetary benefits for which they may qualify that will assist in paying for their care at the facility (i.e. Medicaid).
- Should the resident's income exceed the maximum cost per day, other charges may ensue (such as medications).

WHAT IS INCLUDED IN COST OF CARE?

- Room and board
- 24-hour nursing services
- Social services
- Therapeutic activities
- Restorative nursing care
- Daily meals and snacks
- Housekeeping and laundry services
- Prescription medications

Non-routine services, which are not covered in the daily room rate, include but not limited to:

- Dental Care at any level
- Hearing Aide repair / replacements
- X-ray Services
- Laboratory Charges
- Physical, Occupational and Speech Therapy
- Physician visits
- Private Sitters or Personal Care Attendants
- Transportation or non-emergency ambulance travel
- Beauty / Barber charges (Cash or Resident Trust Fund needed)

James S. Hartsell Executive Director	**STATE OF FLORIDA** **DEPARTMENT OF VETERANS' AFFAIRS** **NURSING HOME PROGRAM**	**Ron DeSantis** Governor **Ashley Moody** Attorney General **Jimmy Patronis** Chief Financial Officer **Nikki Fried** Commissioner of Agriculture

APPLICATION FOR ADMISSION (FORM 54)

(to be completed by applicant or representative)

NO INDIVIDUAL WILL, ON THE GROUNDS OF RACE, COLOR, RELIGIOUS BELIEFS, SEX, GENDER IDENTITY, SEXUAL ORIENTATION, OR NATIONAL ORIGIN BE DENIED ADMISSION, CARE OR ANY OTHER BENEFIT PROVIDED BY THE STATE HOME.

INSTRUCTIONS

- Print or type and answer all items.
- Individuals must meet the criteria required by the U.S. Department of Veterans Affairs for veteran status.
- Must be resident of Florida immediately preceding this application, and in need of institutional long-term care.

SECTION A: PERSONAL INFORMATION		
VETERAN'S LAST NAME FIRST NAME MIDDLE NAME *SOCIAL SECURITY # VA CLAIM #		
VETERAN'S DATE OF BIRTH	VETERAN'S BIRTHPLACE	VETERAN'S SEX ☐ Male ☐ Female
VETERANS MEDICARE #	VETERANS MEDICAID #	VETERANS OTHER INSURANCE #
SPOUSE NAME:	SPOUSE'S SSN	SPOUSE'S DATE OF BIRTH
PLACE OF RESIDENCE: ☐ Own Home ☐ Hospital ☐ Nursing Home ☐ Retirement Home ☐ Boarding Home ☐ Other, explain: _____		
PHONE NUMBERS Home: _____ Work: _____ Other: _____		
MAILING ADDRESS: Street, City, State Zip Code		Phone Number:
RESIDENCE ADDRESS: (IF DIFFERENT) Street, City, State Zip Code		Phone Number:
MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Date of Marriage: _____ Date of Divorce: _____		
HAS VETERAN BEEN A PATIENT/RESIDENT IN A HOSPITAL OR NURSING HOME DURING THE PAST YEAR? ☐ YES ☐ NO	Name of Facility: _____ Address of Facility: _____	
HAS VETERAN EVER BEEN CONVICTED OF A FELONY? ☐ YES ☐ NO If yes, in what state? _____		
HAS VETERAN EVER REGISTERED AS A SEX OFFENDER? ☐ YES ☐ NO If yes, in what state? _____		

SECTION B: MILITARY INFORMATION - ATTACH A COPY OF MILITARY DISCHARGE PAPERS (DD-214)

BRANCH OF SERVICE	SERVICE NUMBER	DATE ENTERED	DATE DISCHARGED	CHARACTER OF SERVICE

SECTION C: GROSS MONTHLY INCOME INFORMATION

DO NOT COMPLETE SECTION C FOR VETERANS WITH PROOF OF 70%-100% SERVICE-CONNECTED DISABILITY

MONTHLY INCOME	APPLICANT Gross	APPLICANT Net	SPOUSE Gross	SPOUSE Net
VA Pension/VA Compensation				
Social Security				
U.S. Civil Service				
U.S. Railroad Retirement				
Military Retirement				
Employment				
Other Retirement, or Income Source: Attach extra page if more Space is needed	ASSET VALUE/MONTHLY INCOME		ASSET VALUE/MONTHLY INCOME	

SECTION D: LEGAL REPRESENTATIVE FOR HEALTH CARE AND FINANCIAL AUTHORITY

Designated Authority Name _____ Relationship_____
Designated Authority Address _____
Designated Authority Phone Number _____

SECTION E: THIS SECTION MUST BE SIGNED BY THE VETERAN OR DPOA

The Veteran is applying for admission to the State Veterans Nursing Home. The veteran is a resident of the State of Florida immediately preceding the date of this application. All the statements on this application are true and complete. Veteran agrees to follow the rules of conduct and policies and procedures of the Department of Veterans' Affairs and the State Veterans' Nursing Home. VETERAN AGREES TO APPLY FOR ALL FINANCIAL ASSISTANCE AVAILABLE THAT THEY MAY QUALIFY FOR, TO INCLUDE MEDICAID. I agree to the release of all medical and financial information needed to complete this application process.

_____ _____

Applicant's Signature, or person authorized to sign for applicant Date signed

The State of Florida Department of Veterans' Affairs (FDVA) is asking you to provide your Social Security Number. If you give FDVA your Social Security Number, we will use it to verify honorable Veteran status, for billing purposes or for other purposes as authorized or required by law. The information you supply may be verified through a computer-matching program. FDVA may disclose the information you put on this form as permitted by law. You do not have to provide the information to FDVA, but if you do not, we will be unable to process your application for admission and serve your medical needs.

APPLICATION FOR BENEFITS VA FORM 10-10-EZ

(to be completed by applicant or representative)

OMB Control No. 2900-0091
Estimated Burden Avg. 30 min.
Expiration Date: 06/30/2024

Department of Veterans Affairs

VA DATE STAMP
(For VHA Use Only)

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

TYPE OF BENEFIT(S) APPLYING FOR:

☐ **ENROLLMENT** - VA Medical Benefits Package (Veteran meets and agrees to the enrollment eligibility criteria specified at 38 CFR 17.36)

☐ **REGISTRATION** - VA Health Services (Veterans meets the "Enrollment not required" eligibility criteria specified at 38 CFR 17.37)

1A. VETERAN'S NAME *(Last, First, Middle Name)*	1B. PREFERRED NAME	2. MOTHER'S MAIDEN NAME

3A. BIRTH SEX	3B. SELF-IDENTIFIED GENDER IDENTITY	4. ARE YOU SPANISH, HISPANIC,OR LATINO?	5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)*
☐ MALE ☐ FEMALE	☐ MALE ☐ FEMALE ☐ TRANSMALE/TRANSMAN/FEMALE-TO-MALE ☐ TRANSFEMALE/TRANSWOMAN/MALE-TO-FEMALE ☐ CHOOSE NOT TO ANSWER	☐ YES ☐ NO	☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ CHOOSE NOT TO ANSWER

6. SOCIAL SECURITY NO.	7A. DATE OF BIRTH *(mm/dd/yyyy)*	7B. PLACE OF BIRTH *(City and State)*	8. RELIGION

9A. MAILING ADDRESS *(Street)*	9B. CITY	9C. STATE	9D. ZIP CODE	9E.COUNTY

9F. HOME TELEPHONE NO. *(optional)* *(Include Area Code)*	9G. MOBILE TELEPHONE NO. *(optional)* *(Include Area Code)*	9H. E-MAIL ADDRESS *(optional)*

10A. HOME ADDRESS *(Street)*	10B. CITY	10C. STATE	10D. ZIP CODE	10E.COUNTY

11. CURRENT MARTIAL STATUS

☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

12A. NEXT OF KIN NAME	12B. NEXT OF KIN ADDRESS	12C. NEXT OF KIN RELATIONSHIP

12D. NEXT OF KIN TELEPHONE NO. *(Include Area Code)*	12E. NEXT OF KIN WORK TELEPHONE NO. *(Include Area Code)*	13. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH *(Note: This does not constitute a will or transfer of title)*

14. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/find-locations)*	15. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT? ☐ YES ☐ NO

SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE	1B. LAST ENTRY DATE *(mm/dd/yyyy)*	1C. FUTURE DISCHARGE DATE *(mm/dd/yyyy)*	1D. LAST DISCHARGE DATE *(mm/dd/yyyy)*

1E. DISCHARGE TYPE	1F. MILITARY SERVICE NUMBER

2. MILITARY HISTORY *(Check yes or no)*	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	G. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	IF "YES", WHAT IS YOUR RATED PERCENTAGE _____ %		
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	H. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?	☐	☐
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐	I. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
E. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	☐	☐	J. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
F. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐	K. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?	☐	☐

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION III - INSURANCE INFORMATION *(Use a separate sheet for additional information)*

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(include coverage through spouse or other person)*

2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE

5. ARE YOU ELIGIBLE FOR MEDICAID? *(Federal health insurance for low income adults)*
☐ YES ☐ NO

6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?
☐ YES ☐ NO
6B. EFFECTIVE DATE *(mm/dd/yyyy)*

SECTION IV - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*

1A. SPOUSE'S SOCIAL SECURITY NUMBER

1B. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*

1C. SELF-IDENTIFIED GENDER IDENTITY
☐ MALE ☐ FEMALE
☐ TRANSMALE/TRANSMAN/FEMALE-TO-MALE
☐ TRANSFEMALE/TRANSWOMAN/MALE-TO-FEMALE
☐ CHOOSE NOT TO ANSWER

1D. DATE OF MARRIAGE *(mm/dd/yyyy)*

1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)*

3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT?
☐ YES ☐ NO

2. CHILD'S NAME *(Last, First, Middle Name)*

2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*

2B. CHILD'S SOCIAL SECURITY NO.

2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*

2D. CHILD'S RELATIONSHIP TO YOU *(Check one)*
☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER

2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18?
☐ YES ☐ NO

2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR?
☐ YES ☐ NO

2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*

SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one)*.
☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED

1B. DATE OF RETIREMENT *(mm/dd/yyyy)*

1C. COMPANY NAME. *(Complete if employed or retired)*	1D. COMPANY ADDRESS *(Complete if employed or retired - Street, City, State, ZIP)*	1E. COMPANY PHONE NUMBER *(Complete if employed or retired) (Include area code)*

SECTION VI - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension, interest, dividends)* EXCLUDING WELFARE.	$	$	$

SECTION VII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION VIII - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT *(Sign in ink)* _____ **DATE** *(mm/dd/yyyy)* _____

James S. Hartsell Executive Director	**STATE OF FLORIDA** **DEPARTMENT OF VETERANS' AFFAIRS** **NURSING HOME PROGRAM**	**Ron DeSantis** Governor **Ashley Moody** Attorney General **Jimmy Patronis** Chief Financial Officer **Nikki Fried** Commissioner of Agriculture

MEDICAL RECORDS AND HEALTH INFORMATION RELEASE

(to be completed by applicant or representative)

PATIENT NAME: _____ **DATE OF BIRTH:** _____

I authorize the use or disclosure of the above individual's health information as described below. The following individual or organization is authorized to make the disclosure:

Facility to fill in:

LEAVE BLANK

_____

NAME OF HOSPITAL, PHYSICIAN, OR HEALTHCARE FACILITY

This information may be disclosed to and used by the following individual or organization for the purposes of assisting with placement and providing medical care:

☐ **Emory L Bennett SVNH**
1920 Mason Avenue
Daytona Beach, FL 32117
PH: 386-274-3460
FAX: 386-274-3487

☐ **Douglas Jacobson SVNH**
21281 Grayton Terr.
Pt. Charlotte, FL 33954 PH: 941-613-0919
FAX: 941-613-0935

☐ **Baldomero Lopez SVNH**
6919 Parkway Blvd
Land O Lakes, FL 34689
PH: 813-558-5000
FAX: 813-558-5021

☐ **Clyde E Lassen SVNH**
4650 SR 16
St. Augustine, FL 32092
PH: 904-940-2193
FAX: 904-940-9913

☐ **Sandy Nininger SVNH**
8401 W. Cypress Drive
Pembroke Pines
PH: 954-985-4824
FAX: 954-985-4866

☐ **Ardie R. Copas SVNH**
13000 SW Tradition
Pt. St. Lucie, FL 34987
PH: 772-241-6132

☐ **Chester Sims SVNH**
4419 Tram Road
Panama City, FL 32404
PH: 850-747-5401
FAX: 850-747-5301

☐ **Lake Baldwin SVNH**
5255 Raymond Street
Orlando, FL 32803
PH: 407-741-4614
FAX: 407-741-4631

The purpose of the disclosure is to assist with placement and providing medical care and may be shared with other Florida State Veterans' Homes for placement.

INITIAL BELOW FOR RELEASE OF INFORMATION

_____ 1. The undersigned hereby authorizes the release of copies of all medical records included but not limited to the following: Physician's orders, discharge summary, and History & Physical X-ray/Lab/EKG reports, MDS Physician's progress notes
Nursing notes, Care plans, Medication list
Dietary notes, Activity notes, Social Services assessment
Consultations-specify: _____
Other-specify: _____

_____ 2. I understand and hereby authorize the release of information in my medical record, which may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).

_____ 3. I understand and hereby authorize the release of information in my medical record, which may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

(Note: Release of psychiatric or substance abuse progress notes require a separate authorization.) I understand that I have a right to revoke this authorization at any time. I understand that if I revoke the authorization, I must do so in writing and present my written revocation to the health information management department.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire if my application is denied, or if accepted, upon my permanent transfer or discharge from the facility.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to obtain treatment. I understand the potential for the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by the Federal privacy laws.

_____ _____

Signature of Resident or Legal Representative Date

_____

Relationship of Legal Representative to Resident

_____ _____

Signature of Witness Date

ACTIVITIES OF DAILY LIVING (ADLS) AND BEHAVIORS QUESTIONNAIRE

(to be completed by applicant or representative, CHECK ALL THAT APPLY)

AMBULATION (walking) ☐ Ambulates safely w/no physical help ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist ☐ Does not ambulate	EATING ☐ Can safely eat meals or snacks with no assistance ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist ☐ Does not eat (other modes of nutrition)
WHEELCHAIR ☐ Can safely propel self in wheelchair ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 or 2 people to physical assist	TOILETING ☐ Can safely toilet with no assistance or supervision ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist
BOWEL FUNCTION ☐ Continent ☐ Occasional incontinence – once or twice a week ☐ Frequent incontinence – at least once a day ☐ Total incontinence ☐ Ostomy	BLADDER FUNCTION ☐ Continent ☐ Occasional incontinence – once or twice a week ☐ Frequent incontinence – at least once a day ☐ Total incontinence ☐ Catheter
BED MOBILITY ☐ Can safely position and move in the bed alone ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist	TRANSFERS ☐ Can safely sit to stand or stand to sit with no help ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist
BATHING ☐ Can safely bathe with no assistance or supervision ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist	DRESSING ☐ Can safely dress with no assistance or supervision ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist
PERSONAL HYGIENE / GROOMING ☐ Can safely complete hygiene/ personal grooming with no assistance or supervision ☐ Needs assistance, set-up help, or supervision ☐ Needs 1 person or 2-person physical assist	ALCOHOL USE ☐ Never occurs ☐ Occurs less than daily ☐ Occurs daily or more frequently
TOBACCO USE (CIGARETTES, CIGARS, PIPE) ☐ Never occurs ☐ Occurs less than daily ☐ Occurs daily or more frequently	DRUG USE ☐ Never occurs ☐ Occurs less than daily ☐ Occurs daily or more frequently
BEHAVIORS (circle all that apply) ☐ Has current diagnosis of dementia or Alzheimer's ☐ Sundowns" or wanders ☐ Exit seeking or eloping ☐ Verbally abusive ☐ Physically abusive ☐ Resistant to care ☐ Inappropriate toileting habits ☐ Inappropriate sexual behavior ☐ Hallucinations, Delusions, or Paranoia ☐ Resistant to care (stiffening, rigidity, refusal)	BEHAVIORS (circle all that apply) Hallucinations (hears or sees things not there) Delusions (tells stories that are not fact based) ☐ Current smoker ☐ Former smoker ☐ Can understand others ☐ Can be understood by others ☐ Verbal ☐ Non-verbal ☐ Wandering ☐ Comments about death of self or others ☐ Verbally abusive (curses, screams, threatens) ☐ Physically abusive (strikes out, grabs)

VETERAN'S HISTORY QUESTIONNAIRE

1. What traumatic events has the veteran experienced in the past 10 years (i.e. death of a loved one, diagnosed with terminal illness, etc.) And how did he/she handle this? What coping skills or resources did they utilize (i.e. help from family, friends, community support, spiritual faith, etc.)? What is an effective intervention that our staff might use during difficult times?

2. Identify a pleasant/fun activity for the veteran which could be implemented right now (i.e. singing a favorite song, watching special tv program, listening to hymns, etc.).

3. Were there unpleasant or sensitive life experiences which the veteran still recalls and which staff needs to be aware? Please indicate how to respond.

4. Is there anything else we should know to help us provide individualized care to the veteran?

.

PATIENT TRANSFER FORM

(to be completed by health care provider)

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)

AHCA Form 5000-3008, (JUN 2016), incorporated by reference in Rule 59G-1.045, F.A.C. ***Data required for Medicaid**

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:*

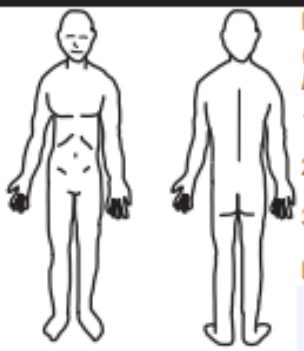
☐ Dialysis - *Frequency:*

*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: _____

AHCA Form 5000-3008, (JUN 2016), incorporated by reference in Rule 59G-1.045, F.A.C.

* Sections **required for Medicaid**

PASRR

(to be completed by health care provider)

State of Florida Agency for Health Care Administration
Preadmission Screening and Resident Review (PASRR)

LEVEL I SCREEN

For Serious Mental Illness (SMI) and/or Intellectual Disability or Related Conditions (ID)

For Medicaid Certified Nursing Facility (NF) Only

Name of Individual Being Evaluated (print) | Social Security Number* | Date of Birth

☐ Male ☐ Female Age | Individual's or Residency Phone Number

Present Location of Individual Being Evaluated | Street Address, City | State, Zip

☐ NF ☐ Hospital ☐ Home ☐ Assisted Living Facility ☐ Group Home ☐ Other

Legal Representative's Name (if applicable) | Street Address, City | State, Zip

Representative's Phone Number

Medicaid Identification Number if Applicable | Other Health Insurance Name and Number if Applicable

☐ Private Pay

Requesting Admission to:
(May document up to three facilities)

NF Name	Street Address	City, State, Zip Code	Phone

*WHY ARE WE ASKING FOR YOUR SOCIAL SECURITY NUMBER (SSN)? Federal law permits the State to use your SSN 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.

AHCA MedServ Form 004 Part A, March 2017 (incorporated by reference in Rule 59G-1.040, F.A.C.)

Name of Individual Being Evaluated _____ Date of Birth _____

Section I:PASRR Screen Decision-Making

A. MI or suspected MI (check all that apply):

- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Depressive Disorder
- ☐ Dissociative Disorder
- ☐ Panic Disorder
- ☐ Personality Disorder
- ☐ Psychotic Disorder
- ☐ Schizoaffective Disorder
- ☐ Schizophrenia
- ☐ Somatic Symptom Disorder
- ☐ Substance Abuse
- ☐ Other (specify): _____

B. ID or suspected ID (check all that apply):

- ☐ Current diagnosis of an ID, mild, moderate, severe or profound.
- ☐ IQ of 70 or less, if available.
- ☐ Onset prior to 18 years of age. Age of onset: _____
- ☐ Impaired adaptive behavior

Related Condition:

- ☐ Onset prior to 22 years of age. Age of onset: _____
- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Down Syndrome
- ☐ Epilepsy
- ☐ Muscular Dystrophy
- ☐ Prader Willi
- ☐ Spina Bifida
- ☐ Traumatic Brain Injury
- ☐ Other (specify): _____

Functional Criteria:

- ☐ Likely to continue indefinitely

Results in substantial functional limitations in three or more major life activities (**check all that apply**):

- ☐ Capacity for independent living
- ☐ Learning
- ☐ Mobility
- ☐ Self care
- ☐ Self direction
- ☐ Understanding and use of language

Services:

- ☐ Currently receiving services for MI.
- ☐ Previously received services for MI.
- ☐ Referred for MI services.
- ☐ Currently receiving services for ID.
- ☐ Previously received services for ID.
- ☐ Referred for ID services.

Additional Information: _____

Finding is based on (check all that apply):

☐ Documented History ☐ Behavioral Observations ☐ Individual, Legal Representative or Family Report

☐ Medications ☐ Other (specify): _____

Name of Individual Being Evaluated | Date of Birth

Section II: Other Indications for PASRR Screen Decision-Making

1. Is there an indication the individual has or may have had a disorder resulting in functional limitations in major life activities that would otherwise be appropriate for the individual's developmental stage? ☐Yes ☐No

2. Does the individual typically have or may have had at least one of the following characteristics on a continuing or intermittent basis?

A. Interpersonal functioning: The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, fear of strangers, avoidance of interpersonal relationships, social isolation, or has been dismissed from employment. ☐Yes ☐No

B. Concentration, persistence, and pace: The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks. ☐Yes ☐No

C. Adaptation to change: The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system. ☐Yes ☐No

3. Is there an indication that the individual has received recent treatment for a mental illness with an indication that the individual has experienced at least one of the following?

A. Psychiatric treatment more intensive than outpatient care. (e.g., partial hospitalization or inpatient hospitalization). ☐Yes ☐No

B. Due to the mental illness, the individual has experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. ☐Yes ☐No

A Level II PASRR evaluation must be completed prior to admission if any box in Section I.A. or I.B. is checked and there is a 'yes' checked in Section II.1, II.2, or II.3, unless the individual meets the definition of a provisional admission or a hospital discharge exemption.

4. Has the individual exhibited actions or behaviors that may make them a danger to themselves or others? ☐Yes ☐No

Name of Individual Being Evaluated _____ Date of Birth _____

Section II: Other Indications for PASRR Screen Decision-Making, Continued:

5. Does the individual have a primary diagnosis of:

Dementia? ☐Yes ☐No
Related Neurocognitive Disorder (including Alzheimer's disease)? ☐Yes ☐No

6. Does the individual have a secondary diagnosis of dementia, related neurocognitive disorder (including Alzheimer's disease) and the primary diagnosis is an SMI or ID?

☐Yes ☐No

7. Does the individual have validating documentation to support the dementia or related neurocognitive disorder (including Alzheimer's disease)?

☐ No
☐ Yes (**Check all that apply.** Send accompanying documentation with completed Level I PASRR screen):
- ☐ Dementia work-up
- ☐ Comprehensive mental status exam
- ☐ Medical/functional history prior to onset
- ☐ Other – Specify: _____

A Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder, and a suspicion or diagnosis of an SMI, ID, or both. A Level II PASRR may only be terminated by the Level II PASRR evaluator in accordance with 42 CFR §483.128(m)(2)(i) or 42 CFR §483.128(m)(2)(ii).

Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption

☐ **Not a provisional admission**
☐ **Provisional admission (choose one)**
☐ **Hospital Discharge Exemption**

If a provisional admission or hospital discharge exemption is indicated, the individual may enter an NF without a Level II PASRR evaluation/determination if the Level I screen indicates a suspicion of SMI, ID or both, and the box in Section II.4 is checked 'no'. A Level II evaluation must be completed, if required, by submitting the documentation for the Level II evaluation to CARES for adults or DOH*** for individuals under the age of 21 years within the time frames indicated in this section.**

☐ The individual being admitted has delirium. The Level II evaluation must be completed within 7 days after the delirium clears.

☐ The individual is being admitted on an emergency basis requiring protective services. The Level II evaluation must be completed within 7 days of admission, on or before (date): _____

☐ The individual is being admitted for caregiver's respite. The Level II evaluation must be completed in advance of the expiration of 14 days if the stay is expected to exceed the 14-day time limit, on or before (date): _____

☐ The individual is being admitted under the 30-day hospital discharge exemption. If the individual's stay is anticipated to exceed 30 days, the NF must notify the Level I screener on the 25th day of stay and the Level II evaluation must be completed no later than the 40th day of admission, on or before (date):

An attending physician's signature is required for those individuals admitted under a 30-day hospital discharge exemption.

_____ _____
ATTENDING PHYSICIAN'S SIGNATURE DATE

Name of Individual Being Evaluated

Date of Birth

Section IV: PASRR Screen Completion

Individual may be admitted to an NF (check one of the following):	**Individual may not be admitted to an NF. Use this form and required documentation to request a Level II PASRR evaluation because there is a diagnosis of or suspicion of (check one of the following):**
☐ No diagnosis or suspicion of SMI or ID indicated. Level II PASRR evaluation not required.	☐ SMI
☐ Provisional admission	☐ ID
☐ Hospital Discharge Exemption	☐ SMI and ID

******Incomplete forms will not be accepted******

By signing this form below, I attest that I have completed the above Level I PASRR screen for the individual to the best of my knowledge.

Screener's Name (Printed)

Signature

Credentials

Date

Phone

Place of Employment

Fax

Completed Level I screen **distributed to (check all that apply):**

☐ Local DOH*** office, for individuals under the age of 21 years

☐ Accompanying documents attached

Date:

☐ Local CARES** office, for adults age 21 years or older

Date:

☐ Accompanying documents attached

☐ Nursing Facility

Date:

☐ Discharging Hospital (if applicable):

Date:

Name: **Date:**

Consent for Level II Evaluation and Determination
In order to assess my needs, by signing above, I consent to an evaluation of my medical, psychological and social history.
I understand and agree that evaluators may need to talk to my doctor, my family, and close friends to talk about my situation.

If the individual requires a Level II PASRR evaluation, submit the completed Level I PASRR screen, documented informed consent, completed AHCA 5000-3008 form, and other relevant medical documentation including case notes, medication administration records, and any available psychiatric evaluation, or supporting documentation to CARES or DOH for facilitation to the state authority for SMI or ID.

If an individual is unwilling, unable, or has no legal representative or health care agent to sign the consent for Level II PASRR evaluation, information regarding the reason for the inability to obtain the signature must be documented here:

**Florida Department of Elder Affair's Comprehensive Assessment and Review for Long-Term Care Services

***Florida Department of Health

DISCHARGE MEDICATION LIST

(written in or list can be attached, must be signed Health Care Provider)

Medication Name	Dose	Instructions for Use	Route

Provider Name (printed): _____
Signature: _____
Office Phone Number: _____
Date of Exam: _____

Place stamp here if available.

James S. Hartsell Executive Director	**STATE OF FLORIDA** **DEPARTMENT OF VETERANS' AFFAIRS** **NURSING HOME PROGRAM**	**Ron DeSantis** Governor **Ashley Moody** Attorney General **Jimmy Patronis** Chief Financial Officer **Nikki Fried** Commissioner of Agriculture

STATEMENT OF HEALTH

(to be completed by health care provider, must be completed 30 days prior to admission)

Patient/Resident Name: _____

DOB: _____

☐ I have examined the individual named above and to the best of my knowledge, he/she is free of any communicable diseases.

☐ I have examined the individual named above and to the best of my knowledge, he/she has a communicable disease (if so, indicate in the space below).

Indicate communicable disease here:

_____

_____

_____

By signing below, I certify that this information above is true and accurate.

Provider Name (printed): _____
Signature: _____
Office Phone Number: _____
Date of Exam: _____

Place stamp here if available.