Institutional Care Program (ICP)

ICP

Supplement to Application Packet

Please Read Carefully

STEP 1: If you are applying for ICP Institution Care Nursing Home Medicaid benefits, please complete this packet in addition to the Application Packet.

The physician should complete the last form in the packet, the Patient Transfer and Continuity of Care form. When you speak with the Intake Specialist today, this will be explained to you.

STEP 2: If you need help completing any forms, please tell the receptionist.

STEP 3: These forms should be turned into the receptionist at the front desk along with the forms from the Application Packet.

CF-ES 2344, PDF 10/2005

Authorization To Release Medical Information

This form will be used to request information related to your health, or health history from your medical provider. Federal law limits how this information may be used. The information the Department of Children and Families is requesting will be used in determining your eligibility for health coverage, determining your state of disability, or to carry out treatment, payment, or health care operations.

By signing this authorization you are allowing persons, or health care providers, in possession of information related to your personal health to release such information to the Department of Children and Families, or their designated agent(s), and to the Department of Health, Division of Disability Determinations to determine your eligibility for health care program benefits.

This release is time limited and is valid for the time period listed on the front of this document. You have the right to revoke or cancel this Authorization to Release Medical Information at any time. To cancel this release you must inform the Department of Children and Families in writing. For more information on how you can cancel this release please call your Department of Children and Families caseworker.

The information the Department of Children and Families receives may be shared with other agencies as allowed by law, only to the extent necessary to determine your eligibility for health coverage, or determining your state of disability, or to carry out treatment, payment, or health care operations, or as required by law.

If you do not agree to have your personal health information (or your child's information) released to the Department of Children and Families it could affect the Department of Children and Families ability to determine your eligibility.

If you do not sign this authorization it will not affect your eligibility for any other program where personal health information is not needed.

Authorization to Release Medical Information

SOURCE OF MEDICAL INFORMATION

Name:	Address:

I hereby authorize the above named entity to disclose the following information to the Department of Children and Families (DCF) or their designated agent(s), and to the Department of Health (DOH), Division of Disability Determinations (DDD) to determine my eligibility for health care program benefits:

☐ Medical records or other information regarding my treatment, hospitalization, and/or care;

☐ Information about how my condition affects my ability to complete tasks and activities of daily living;

☐ Information about how my condition affects my ability to work.

By my signature below, I affirm that I have read and understand the information on page two of this document, and understand my rights under the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2). I authorize you to release to the Department of Children and Families, or their designated agents, any health information you may have in your possession relative to my heath history.

This Authorization for the Release of Medical Information is valid for six months from the date signed.

_____ _____
Applicant's name (print) Applicant's Social Security Number

_____ _____
Signature of Applicant or Legal Representative Date Signed

If applicant or representative signs with a mark ("X"), a witness signature is required below:

_____ _____
Signature of Witness Date Signed

_____
Street Address City State Zip Code

This form must be signed by the applicant or someone with legal authority to sign on the applicant's behalf. If someone other than the applicant signs, please specify the legal authority to sign and complete the information below:

☐ **Power of Attorney** ☐ **Guardianship Papers** ☐ **Parental relationship (if applicant is a child)**

☐ **Other:**_____

_____
Address of person signing for applicant City State Zip Code

(_____)_____
(Area Code) Telephone Number

Name of individual authorized to receive requested health information on behalf of the applicant:

_____ (_____)_____ _____ _____
Name Phone Number Title Agency

Authorization to release the information described above to the entities listed is based on the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d-2, the Veterans Omnibus Health Care Act of 1974, PL 94-581, including the Drug Abuse Office and Treatment Act of 1972, PL 92-255, and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974, PL 93-282, and implementing federal regulations.

A PATIENT TRANSFER AND CONTINUITY OF CARE

Facility To:_____ Facility From:_____ Hospital Admission/ Discharge Dates _____

B

Patient's DOB: _____ Sex:_____ Race:_____

_____
Patient's Last Name First Name Initial

_____
Patient's Address Phone

_____
Nearest Relative Phone

PHYSICIAN INFORMATION:

Name: _____ Phone: _____

Will you care for Patient in NH? ☐ Yes ☐ No If not, referred to: _____

Principle Diagnosis: _____

Secondary Diagnosis: _____

Discharge Diagnosis: _____

Surgery Performed & Date: _____

MEDICATION AND TREATMENT ORDERS (copies may be attached):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

☐ Immunizations Given:

☐ Pneumococcal Vaccine; Date:_____ ☐ Influenza Vaccine; Date:_____

C

1. Is dementia the primary diagnosis? ☐ Yes ☐ No
2. Is there a diagnosis or presenting evidence of mental retardation, or has the client received MR services within the past 2 years? ☐ Yes ☐ No
3. Has the client received MI services within the past two years? ☐ Yes ☐ No
   Is there any presenting evidence of mental illness such as (check all that apply):
   - ____ Schizophrenia
   - ____ Paranoia
   - ____ Mood
   - ____ Panic or severe anxiety disorder
   - ____ Somatoform disorder
   - ____ Personality disorder
   - ____ Other psychotic or mental disorder leading to chronic disability
4. Is the client a danger to self or others? ☐ Yes – please attach explanation ☐ No
5. Is the client on any medication for the treatment of a major illness or psychiatric diagnosis? ☐ Yes ☐ No
6. If yes, is the mental illness or psychiatric diagnosis controlled with medication? ☐ Yes ☐ No

D

☐ **OXYGEN**
L/min:_____
Nasal Cannula
Mask
PRN
Continuous

☐ **SUCTIONING**
Frequency:_____

☐ **TRACH CARE**
Frequency: _____
Size: _____

☐ **OSTOMY CARE**
Frequency: _____

☐ **TUBE FEEDING**
Frequency: _____
Type of feeding: _____

☐ **CHANGE FEEDING TUBE**
Frequency: _____

☐ **CATHETER**
Date last changed: _____
Size: _____
Type: _____

☐ **IRRIGATE CATHETER**
Frequency: _____
Solution: _____

☐ **DRAINING WOUND**
Cultured: _____
Date: _____
Results: _____

☐ **DRESSING**
Type: _____
Frequency: _____

☐ **DECUBITUS CARE**
Site: _____
Size: _____
Stage: _____
Medication/ Solution: _____

E

Social Sec. No.:_____
Health Ins. Claim No.:_____
Medicare Claim No.:_____
Medicaid Claim No.:_____
Language:_____

F

ADVANCED MEDICAL DIRECTIVE:
☐ Yes ☐ No ☐ Copy Attached
Name of Surrogate:_____

G

PHYSICAL EXAM (may attach)
Heent:_____
_____
Neck:_____
Cardiopulmonary:_____
_____
Abdomen:_____
Gu:_____
Rectal:_____
Extremities:_____
Neurological:_____
Allergy/Drug Sensitivity:_____
Free from communicable diseases? ☐ Yes ☐ No

H

BRIEF MEDICAL AND MENTAL HISTORY
(may attach progress notes) _____
_____
_____
_____
_____
_____

MAJOR TESTS AND RESULTS: _____
_____

LABORATORY FINDINGS: (may attach reports)
Chest X-Ray: Date: _____
Results: _____
C B C: Date: _____
Results: _____
Urinalysis: Date: _____
Albumin: _____
Sugar: _____
Acetone: _____
TB Test: ☐ Yes ☐ No Results: _____

I

TYPE OF CARE RECOMMENDED:
☐ Skilled Nursing (ECF): Duration: _____
☐ Intermediate Care: Duration: _____
Rehab Potential (check one): ☐ Good ☐ Fair ☐ Poor
Admission Date to Nursing Home: _____/_____/_____
☐ I certify that this patient requires E.C.F. Nursing Home Care for the condition for which he/she received care during hospitalization.
Effective Date: _____/_____/_____

_____ _____
Physician's Signature (valid for both pages) Date

_____
Print Physician's Name

_____
Address

_____
Phone Number

Federal law mandates the physician's signature; all other signatures on this form are optional.

Patient's Name:_____

J **SIGHT**	☐ 1. Good ☐ 2. Vision adequate – unable to read/see details ☐ 3. Vision limited – gross object differentiation ☐ 4. Blind 5. Glasses: ☐ Yes ☐ No	**AMBULATION**	☐ 1. Independence w/wo assistive device ☐ 2. Walks with supervision ☐ 3. Walks with continuous human suppport ☐ 4. Bed to chair (total help) ☐ 5. Bedfast
HEARING	☐ 1. Good ☐ 2. Hearing slightly impaired ☐ 3. Limited hearing (e.g., must speak loudly) ☐ 4. Virtually/completely deaf	**ENDURANCE**	☐ 1. Tolerates distance (250 feet sustained activity) ☐ 2. Needs intermittent rest ☐ 3. Rarely tolerates short activities ☐ 4. No tolerance
SPEECH	☐ 1. Speaks clearly with other of same language ☐ 2. Some defect – usually gets message across ☐ 3. Unable to speak clearly or not at all	**TRANSFER**	☐ 1. No assistance ☐ 2. Equipment only ☐ 3. Supervision only ☐ 4. Requires human transfer w/wo equipment ☐ 5. Bedfast
COMMUNI-CATION	☐ 1. Transmits messages / receives information ☐ 2. Limited ability ☐ 3. Nearly or totally unable	**WHEELCHAIR USE**	☐ 1. Independent ☐ 2. Assistance in difficult maneuvering ☐ 3. Wheels a few feet ☐ 4. Unable ☐ N/A
MENTAL AND BEHAVIOR STATUS	☐ 1. Alert ☐ 2. Confused ☐ 3. Disoriented ☐ 4. Comatose ☐ 5. Aggressive ☐ 6. Disruptive ☐ 7. Apathetic ☐ 8. Wanders ☐ 9. Safety Restraints Needed ☐ 10. Well Motivated	**TOILETING**	☐ 1. No assistance ☐ A – Bathroom ☐ 2. Assistance to and from and transfer ☐ B – Bedside Commode ☐ 3. Total assistance including personal ☐ 4. Hygiene/help with clothes ☐ C – Bedpan
SKIN CONDITION	☐ 1. Intact ☐ 2. Dry/Fragile ☐ 3. Irritations (rash) Site:_____ ☐ 4. Open Wound Stage:_____ ☐ 5. Decubitus Size:_____	**BLADDER CONTROL**	☐ 1. Continent ☐ 5. Total incontinence ☐ 2. Rarely – e.g., h.s. ☐ 6. Catheter – indwelling ☐ 3. Occasional – once/week or less ☐ 4. Frequent – up to once a day
DRESSING	☐ 1. Dresses self ☐ 2. Minor assistance ☐ 3. Partial help complete half dressing ☐ 4. Has to be dressed	**BOWEL CONTROL**	☐ 1. Continent ☐ 4. Frequent – up to once a day ☐ 2. Rarely – e.g., h.s. ☐ 5. Total incontinence ☐ 3. Occasional – once/week or less ☐ 6. Ostomy
BATHING	☐ 1. No assistance ☐ 2. Supervision only ☐ 3. Assistance ☐ 4. Is bathed ☐ 5. Complete bed bath procedure ☐ A – Tub ☐ B – Shower ☐ C – Sponge Bath	**FEEDING**	☐ 1. No assistance ☐ 2. Minor assistance; needs tray set up only ☐ 3. Help in feeding/encouraging ☐ 4. Is fed ☐ 5. Aspirates
TEACHING NEEDS	☐ 1. Diabetic ☐ 2. Cardiac ☐ 3. Ostomy ☐ 4. Other (specify):	**DIET**	☐ 1. Full ☐ 2. Mechanical Soft ☐ 3. Pureed ☐ 4. Other (specify):

SIGNATURE AND TITLE: DATE:

K PHYSICAL THERAPY: ☐ New Referral ☐ Continuation of Therapy

Frequency of Treatment:_____

Treatment Goals

☐ Stretching ☐ Coordinating Activities ☐ Progress bed to wheelchair
☐ Passive ROM ☐ Non-weight bearing ☐ Recovery to full function
☐ Active assistive ☐ Partial weight bearing ☐ Wheelchair independent
☐ Active ☐ Full weight bearing ☐ Complete ambulation
☐ Progressive resistive

Sensation Impaired: ☐ Yes ☐ No

Restrict Activity: ☐ Yes ☐ No

Precautions:

☐ Cardiac ☐ Other:_____

L ADDITIONAL THERAPIES: ☐ O.T. ☐ Speech ☐ R.T.

Instructions:_____

Signature & Title: Date:

M SOCIAL WORK ASSESSMENT:

Prior Living Arrangement:_____

Long Range Plan/Agency Referrals:_____

Adjustment to Illness or Disability:_____

Signature & Title: Date:

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
DEPARTMENT OF ELDER AFFAIRS

INFORMED CONSENT FORM

CLIENT'S NAME: _____

SOCIAL SECURITY # : _____

An assessment is required for all persons applying for or receiving assistance for long term care. This includes the Institutional Care Program (ICP) and Home and Community Based Services (HCBS) waiver programs.

In order to evaluate my needs, I am giving my consent to the following:

- I agree to an assessment to identify my need for long term care, and to determine if my needs can be met in the community instead of a nursing facility.

- I authorize DC&F and DOEA staff to access my medical records. I understand and agree that DC&F and DOEA may need to talk to my doctor and other health professionals. I also understand that they may need to interview family members, close friends and social services professionals about my situation.

_____
Individual or Representative

_____
Relationship (if representative signs)

_____
Date