CARES Long-Term Care Transition Referral Form and Instructions
(Minimum requirements to be accepted in red)

For Medicaid recipients eighteen (18), nineteen (19), or twenty (20) years of age requesting priority enrollment into the long-term care managed care program pursuant to s. 409.979(3)(f)1., F.S., a referral must be made to the Comprehensive Assessment and Review for Long-Term Care Services (CARES) program, providing the information below. Either this optional form, or the required information in another format, must be submitted along with AHCA Form 5000-3008.

Enrollee Name: _____

Date of Birth: _____

Medicaid ID: _____

I certify the individual below is (check all the apply and fill in blank): (both boxes checked, and blank filled in with at least one chronic debilitating disease or condition of one or more physiological or organ systems)

- ☐ 18, 19, or 20 years of age
- ☐ with the listed chronic debilitating disease or condition of one or more physiological or organ systems:

  _____

  _____

  which generally make the individual dependent upon 24-hour-per-day:
  (check all that apply and fill in blank to support all checked boxes) (at least one box checked and corresponding blank filled in)
  - ☐ medical supervision: _____
  - ☐ nursing supervision: _____
  - ☐ health supervision: _____
  - ☐ medical intervention: _____
  - ☐ nursing intervention: _____
  - ☐ health intervention: _____

**Additional Comments:**

_____

_____

_____
Name of person completing Form

_____
Physician/APRN/PA Name and Title

_____ _____
Contact number of person completing Form

_____
Physician/APRN/PA Signature

Same requirements as Section Y and Z of AHCA Form 5000-3008

_____
Physician/APRN/PA License #

_____
Date