DEPARTMENT OF
ELDER AFFAIRS
STATE OF FLORIDA

CARES PSA 11
Long Term Care Community Diversion Program
REFERRAL FORM

Client Name: _____ DOB:_____ Sex:_____ Marital Status:_____

SSN: _____ Medicaid: _____ Medicare: _____

Address: _____ Phone Number: _____
_____
_____

ALF Name: _____ ALF Phone Number: _____ Contact Person: _____

Living Situation: _____

Relative or Legal Guardian: _____ Relationship: _____ Phone:_____
Relative or Legal Guardian: _____ Relationship: _____ Phone:_____

The eligibility requirements for this program requires the applicant be:

- 65 years or age or older
- A current Medicaid recipient or Medicaid
- Medicare eligible (Parts A & B)
- Determined to be at risk of nursing home placement
- Capable of being served safely in the community with services

Please identify reason client is eligible for LTCCD Program: (choose the one that applies):

___ Requires help with 5 Activities of Daily Living (ADL's)
___ Requires help with 4 ADL's plus requiring supervision or administration of medication
___ Requires total help with 2 or more ADL's
___ Have a diagnosis of Alzheimer's disease or another type of dementia and require help with three or more ADL's
___ Have a diagnosis of a degenerative or chronic condition requiring daily nursing services

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_____ _____ _____
Person making referral (print name) Agency Name Phone Number

_____ _____
Signature of Person making referral Date

_____ _____
Client/Relative/Legal guardian signature Date

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