



Client Referral/Change

Case #: _____

TO: Dept. of Children & Families

Local Fax #: _____

Date: _____

FROM: _____
(Facility Name or Managed Care Plan)

Contact Name: _____

Telephone #: _____

Nursing

Facility

Address: _____

Section A: Resident's Information

Resident's

Name: _____

SSN: _____

Date of Birth: _____

Medicaid ID #: _____

Section A.1: Representative's Information

Representative: _____

Address: _____

Telephone #: _____

Relationship: _____

Section B: This section will be completed by the nursing facility or Managed Care Plan to refer a resident who does not have Institutional Care (MI) Medicaid in FLMMIS.

Is the individual an SSI Direct Enrollee? Yes Active Aid Category/Coverage Group: _____

The resident was admitted to the above referenced facility on: _____

From: Hospital Home ALF

Prior Residential Address: _____

Section C: This section will be completed by the nursing facility or Managed Care Plan to report a resident enrolled in a Long-Term Care (LTC) Managed Care Plan was discharged from a nursing facility.

RESIDENT DISCHARGED/TRANSFERRED FROM THE FACILITY ON (date): _____

TO: ALF Home Hospital Nursing Home Other (specify): _____

Address: _____

Due to Death on (date of death): _____

Section D: This section will be completed by the Managed Care Plan to notify DCF when a nursing home resident has enrolled in the Long Term Care Managed Care Plan.

The above named resident has enrolled in a managed care plan. Effective date: _____

The above named resident has changed managed care plans. Effective date: _____

Managed Care Plan: _____

MCP Contact Person Information:

Name: _____

Address: _____

Telephone #: _____

Email Address: _____