

Instructions for Completing the AHCA MedServ-3008 Form

This form is a dual-purpose form for physicians to certify Nursing Facility Care or Home- and Community-Based Services (Medicaid Waiver Services)

I. In an effort to assist you in the completion of the AHCA MedServ-3008 form, the following definitions are being provided.

A. Skilled Nursing (ECF): ECF means extended care facility. The definition of skilled nursing is found in the Florida Administrative Code, and can be found in 59G-4.290(b).

[To access this information on the Internet use the following link:

<https://www.flrules.org/gateway/readFile.asp?sid=0&tid=1849225&type=1&file=59G-4.290.doc>]

Skilled Nursing must be:

- Ordered by and remain under the supervision of a physician;
- Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse;
- Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effective performance;
- Required on a daily basis;
- Reasonable and necessary to the treatment of a specific documented illness or injury; and
- Consistent with the nature and severity of the individual's condition or the disease state or stage.

B. Intermediate Care: The definition of intermediate care is also found in the Florida Administrative Code, and can be found in 59G-4.180(3)(b). [To access this information on the Internet use the following link:

<https://www.flrules.org/gateway/readFile.asp?sid=0&tid=1847673&type=1&file=59g-4.180.doc>]

Intermediate Care must be:

- Ordered by and remain under the supervision of a physician;
- Medically necessary and provided to an applicant or recipient whose health status and medical needs are of sufficient seriousness as to require nursing management, periodic assessment, planning or intervention by licensed nursing or other health professionals;
- Required to be performed under the supervision of licensed nursing or other health professionals;
- Necessary to achieve the medically desired results and to ensure the comfort and safety of the applicant or recipient;
- Required on a daily or intermittent basis;
- Reasonable and necessary to the treatment of a specific documented medical disorder, disease or impairment; and
- Consistent with the nature and severity of the individual's condition or the disease state or stage

II. To further assist you in the completion of the AHCA MedServ-3008 form, the following **instructions** are provided: (Additional information is located on the Comprehensive Assessment and Review for Long Term Care Services (CARES) Web site:

<http://elderaffairs.state.fl.us/english/cares.php>

Section A: Facility Information

List where the individual is transferring to and from, along with admission and discharge dates, if appropriate.

Section B: Demographic Information

- Enter individual's demographic information
- List physician's name
- Answer the question regarding the care of the individual in the nursing facility and who the individual will be referred to if you will not be caring for individual
- List the principal diagnosis for which the individual has been hospitalized/admitted
- List all other diagnosis for which the individual has for secondary diagnosis, as well as discharge diagnosis
- Attach Problem List
- Include any surgeries performed, including date of surgery
- List all allergies and drug sensitivities
- If the individual is to be discharged with medication(s) and/or treatment(s), specify them by name, including dosage and method of administration. If you need additional space, you may attach additional pages, but please indicate that you have done so.

Section C: Preadmission Screening

This section contains items numbered one through ten, which meet the mental illness/mental retardation screening required by Omnibus Budget Reconciliation Act (OBRA) '87. Answer each item by checking the appropriate box for Yes or No to indicate the individual's mental illness/mental retardation (MI/MR) status (additional documentation may be attached).

Section D: Additional Orders (Orders may be attached)

Section E: History & Physical and Labs

1. Physical Exam: (History & Physical may be attached)

- Review all body systems of the individual and list specific findings
- Briefly describe the individual's medical history
- Describe the individual's mental and physical functional limitations
- Use additional order space (D) for additional findings if needed

2. Laboratory Findings: (Reports may be attached)

- Check if TB Test has been completed or not; provide date of testing and results
- List date of chest x-ray and results
- Use additional order space (D) for other lab orders or results

Section F: Immunizations Given

- List dates of last Pneumococcal vaccine, Influenza vaccine, Tetanus and Diphtheria vaccine and Herpes Zoster vaccine.

Section G: Physical Therapy (Attach Orders)

- Check if this is a new referral or continuation of therapy
- List frequency of treatment
- Provide instructions for other physical therapy needs (Use additional order (D) if needed)
- Check therapy ordered and precautions if any for individual

Section G: Additional Therapies (Attach Orders)

- List type of therapy ordered and precautions if any for the individual
- Use additional order space (D) for additional therapies not listed
- List instructions for therapy identified

Section H: Treatment and Equipment Needs (Attach Orders)

- Check type of treatment and equipment needs for individual
- Use additional order space (D) for other treatment or equipment needs not listed

Section I: Special Diet Orders (Orders may be attached)

- List individual's dietary restrictions and requirements

Section J: Type of Care Recommended

- Indicate the type of care (skilled nursing ECF or intermediate) recommended for the individual and the duration
- Indicate the individual's rehabilitation potential (good, fair, or poor)
- List admission date to nursing facility
- Indicate certification of individual requiring ECF Nursing Facility Care for the condition for which the individual received care during hospitalization
- Indicate certification of individual in need of Medicaid Waiver Service in lieu of institutional care placement
- List effective date for certification
- Print name, address, and phone number of physician
- MD/DO must sign and date form as mandated by federal law

Section K: The Nursing/Social Work Assessment Form

- Activities of Daily Living (ADLs) are at the time of admission into the nursing facility
- (*) Indicates "Hands on is needed" for this ADL
- Check appropriate box on the Nursing Assessment to indicate the level of assessment of the individual at time of admission
- Add additional nursing assessment information in the Comment Section
- Sign and date form

Section L: The Nursing/Social Work Assessment Form

- Social Work Assessment is to be completed at the time of nursing facility admission
- Sign and date form

The Nursing/Social Work Assessment Form (page 2 of the AHCA MedServ-3008 form) is to be completed for individuals in hospitals and nursing facilities seeking level of care for nursing facility placement.

- Page 2 is not required for individuals in the community seeking nursing facility placement
- Page 2 may be completed and signed by a nurse or social worker

Please note: This form is also located for your convenience at the following link:
<http://elderaffairs.state.fl.us/english/cares.php>

From this link you may download the form, complete as appropriate for each individual, save the .pdf file as needed before printing, signing and returning to CARES.