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:** Representatives 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.

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

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

Managed Care Plan:

MCP Contact Person Information _____

Name: _____

Address: _____

Telephone #: _____

Email Address: _____