MODEL WAIVER

PHYSICIAN REFERRAL FOR INDIVIDUALS AT RISK OF HOSPITALIZATION

Incomplete forms will be returned. Please complete all items. If non-applicable, insert N/A. Attach extra sheets or supporting documentation if necessary.

Name: _____ *SSN: _____ Date of Birth: _____

1. Diagnosis: _____
2. Medications (list all prescribed medications): _____
   _____
   _____
3. All body systems (vision and hearing, respiratory, gastrointestinal, genito-urinary, cardiovascular, musculoskeletal, and neurological) have been reviewed and specific physical findings are listed:
   _____
   _____
   _____
4. Medical history: _____
   _____
   _____
5. Mental & physical limitations: _____
   _____
6. Treatment & therapies: _____
   _____
7. Diet: Normal (check if yes): __ Special (describe): _____
8. Activities of daily living impairment: _____
   _____
9. Social services and activities needed: _____
   _____
10. Individual's prognosis: _____

I certify that this individual is disabled based upon their medical history and current condition; and, I also believe there is reasonable indication that this individual will require hospitalization in the absence of home and community-based services.

Physician's signature: _____

Physician's name: _____ Date: _____

Address: _____ Telephone: _____

***WHY ARE WE ASKING FOR YOUR SOCIAL SECURITY NUMBER (SSN)?** Federal law permits the State to use your SSN for screening and referral to programs or services that may be appropriate for you. 42 CFR § 435.910. We use the number to create a unique record for every individual that we serve, and the SSN ensures that every person we serve is identified correctly so that services are provided appropriately. Any information the State collects will remain confidential and protected under penalty of law. We will not use it or give it out for any other reason unless you have signed a separate consent form that releases us to do so or if required by law.

AHCA Form 5000-0025, January 2018 (incorporated by reference in Rule 59G-1.045, F.A.C.)