Clear

ALTERNATE CARE CERTIFICATION
OPTIONAL STATE SUPPLEMENTATION

OSS

Please print – Refer to instructions for assistance.

PART 1 CLIENT/FACILITY INFORMATION

Name (Last, First, M.I.)	Date Of Birth	Social Security Number	Date of Placement

OSS Status: ☐ New ☐ Change

Facility Name	Telephone Number	License Number	Expiration Date

Facility Address

Facility Type: ☐ ALF ☐ ALF–LMHL ☐ AFCH ☐ MHRTF ☐ Home of Relative

Certification: The person named above is appropriate for this placement based on one of the following:

☐ DOEA Form 1823, Health Assessment (ALF) ☐ DOEA Form 1110, Health Assessment (AFCH)

☐ Other Physician Certification (ALF or MHRTF); describe:_____

Type of Income:			
Income Amount:	$	$	$

SSI Status: ☐ Application Pending ☐ Recipient ☐ SSI/SSDI Recipient Due to Psychiatric Disorder

☐ Did Not Apply ☐ SSI Denied (check if known at time of application)

AS, APD, MH or AAA / lead agency Signature	Print Name / Title / Agency and Telephone Number	Date

PART 2 AGREEMENT FOR ALTERNATE CARE

Client and provider agree to placement in above facility. Client agrees to pay provider following monthly rate:

☐ Amount of $_____ equal to current recognized standard cost of care as set forth in Chapter 65A-2, F.A.C., OSS. Client will keep personal allowance of $_____ per month.

☐ Amount of $_____ per month, if less than standard cost of care.

☐ Third Party Contribution: $_____ per month for third party payment in accordance with s.409.212, F.S.

Client Signature		Date
Provider Signature	**Print Name / Title**	**Date**
Witness Signature if signed with mark (not DCF, APD or DOEA)	**Print Name / Relationship to Client or Facility**	**Date**

PART 3 (To be completed ONLY for Mental Health Resident residing in ALF–LMHL)

Client is appropriate to reside ALF–LMHL based on one of the following:

☐ State mental hospital discharge evaluation documenting client's appropriateness to reside in ALF–LMHL was completed within 90 days prior to admission to the ALF–LMHL and is on file at the facility.

_____ A. Signature of Mental Health Professional _____ Title/Agency _____ Date

☐ In my professional opinion, this person at this time and based on person's Community Living Support Plan is appropriate to reside in an ALF–LMHL. (Professional signature required below.)

_____ B. Signature of Mental Health Professional* _____ Title/Agency _____ License Number _____ Date

_____ C. Supervisor Name* _____ Title/Agency _____ License Number

*Give supervisor information if professional signing in "B" is unlicensed.

If there is a Mental Health case manager, please specify in space below.

_____ MH Case Manager's Name** _____ Agency / Organization

**For mental health residents, the case manager must be the same person that signed in Part 1.

Distribution of Copies: Original and 1 Copy -- To Economic Self-Sufficiency (ESS)
Copy -- To facility for resident's record; and Copy -- To case manager for case management file