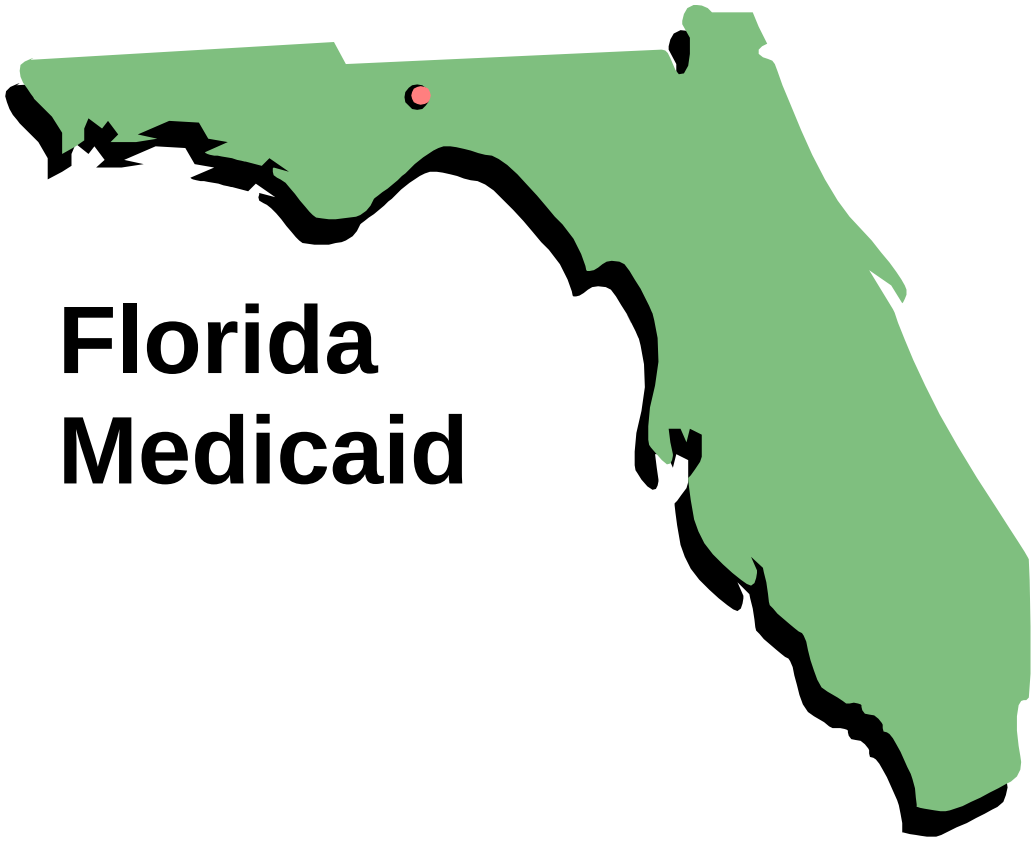

DEVELOPMENTAL DISABILITIES INDIVIDUAL BUDGETING MEDICAID WAIVER COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

UPDATE LOG
DEVELOPMENTAL DISABILITIES INDIVIDUAL BUDGETING MEDICAID WAIVER COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update will be issued as a completely revised handbook.

It is very important that the provider read the updated material in the handbook. It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

Providers can use the update log to determine if they have received all the updates to the handbook.

Update describes the change that was made.

Effective Date is the date that the update is effective.

Instructions

When a handbook is updated, the provider will be notified by a notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

Providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 1-800-289-7799.

UPDATE	EFFECTIVE DATE
NEW HANDBOOK	2011

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DEVELOPMENTAL DISABILITIES INDIVIDUAL BUDGETING MEDICAID WAIVER COVERAGE AND LIMITATIONS HANDBOOK

Table of Contents

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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- *Provider General Handbook* describes the Florida Medicaid Program.
- *Coverage and Limitations Handbooks* explain covered services, their limits, who is eligible to receive them, and the fee schedules.
- *Reimbursement Handbooks* describe how to complete and file claims for reimbursement from Medicaid.

All Florida Medicaid Handbooks may be accessed via the internet at: www.mymedicaid-florida.com/. Select *Public Information for Providers*, then *Provider Support* and then *Handbooks*.

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act;
- Title 42 of the Code of Federal Regulations;
- Chapter 409, Florida Statutes;
- Chapter 59G, Florida Administrative Code.

In This Chapter

This chapter contains:

Handbook Use and Format

Purpose	The purpose of the Medicaid handbooks is to provide the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.
Provider	The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.
Recipient	The term “recipient” is used to describe an individual who is eligible for Medicaid.
General Handbook	General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who provides more than one type of service will have more than one coverage and limitations handbook.
Reimbursement Handbook	Each reimbursement handbook is named for the claim form that it describes.
Chapter Numbers	The chapter number appears as the first digit before the page number at the bottom of each page.
Page Numbers	Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Characteristics of the Handbook

Format	The format styles used in the handbooks represent a short and regular way of displaying difficult, technical material.
Information Block	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines. Each block is identified or named with a label.
Label	Labels or names are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.
Note	Note is used most frequently to refer the user to important material located elsewhere in the handbook. Note also refers the user to other documents or policies contained in other handbooks.
Topic Roster	Each chapter contains a list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log	The first page of each handbook will contain the update log. Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received. Each update will be designated by an “Update” and the “Effective Date.”
How Changes Are Updated	The Medicaid handbooks will be updated as needed. Changes may be: 1. Replacement handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout and it will be a clean copy. 2. Revised handbook – Changes will be highlighted in yellow and will be incorporated within the appropriate chapter. These revisions will have an effective date that corresponds to the effective date of the revised handbook.

Handbook Updates, continued

Effective Date of New Material	The month and year that the new material is effective will appear at the bottom of each page. The provider can check this date to ensure that the material being used is the most current and up to date.
Identifying New Information	New material will be identified by yellow highlighting. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.
New Label and New Information Block	A new label and a new information block will be identified with yellow highlight to the entire section.
New Material in an Existing Information Block or Paragraph	New or changed material within an existing information block or paragraph will be identified by yellow highlighting to the sentence and/or paragraph affected by the change.

CHAPTER 1
DEVELOPMENTAL DISABILITIES INDIVIDUAL BUDGETING MEDICAID WAIVER COVERAGE AND LIMITATIONS HANDBOOK

Overview

Introduction

This chapter describes the Developmental Disabilities Individual Budgeting Medicaid Waiver Program, specifies the authority regulating waiver services, and the purpose of the program.

Purpose of the Handbook

This handbook is for providers who furnish Developmental Disabilities Individual Budgeting Medicaid Waiver services to individuals enrolled in that waiver. It must be used together with the Florida Medicaid Provider General Handbook, which contains information about the Medicaid program, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains procedures for submitting claims for payment.

Legal Authority

Home and Community Based Services (HCBS) waiver programs are authorized under section 1915(c) of the Social Security Act and governed by Title 42, Code of Federal Regulations (C.F.R.), Parts 440 and 441.

Sections 393.0662 and 409.906, Florida Statutes (F.S.) and Chapter 59G, Florida Administrative Code (F.A.C.), authorize the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver.

The iBudget Florida program is referenced in Chapter 393, Florida Statutes, and 65G-4.0021-0025, F.A.C.

Specific statutory authority for the promulgation of the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Handbook into rule is found in sections 393.0662, 408.302, and 409.919, F.S.

The Agency for Health Care Administration (AHCA) has final authority on all policies, procedures, rules, regulations, manuals, and handbooks pertaining to the waiver. The Agency for Persons with Disabilities (APD) is authorized by AHCA to operate and oversee the waiver in accordance with the Interagency Agreement between AHCA and APD regarding the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver.

Overview

Exceptions To Service Limits For Children

According to 42 USC 1396d(r)(5) Medicaid is required to cover for children "such other necessary healthcare, diagnostic services, treatment, and other measures described in section 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan." There are no limitations of amount, duration, and scope on medically necessary services for Medicaid-eligible children.

Note: See the Provider General Handbook for the process to request a service that is not covered or to exceed service limits, for a child under 21.

In This Chapter

This chapter contains:

Description and Purpose

Purpose

The iBudget Florida program, as referenced in Chapter 393, Florida Statutes, and 65G-4.0021-0025, F.A.C., is a Medicaid program that provides home and community-based supports and services to eligible persons with developmental disabilities living at home or in a home-like setting. The iBudget Florida program is funded by the federal Centers for Medicare and Medicaid Services (CMS) and matching state dollars.

This waiver reflects use of an individual budgeting approach and enhanced opportunities for self-determination. The purpose of the waiver is to promote and maintain the health of eligible individuals with developmental disabilities; to provide needed supports and services to delay or prevent institutionalization, and to foster the principles of self-determination as a foundation for services and supports. The intent of the waiver is to provide an array of services from which eligible individuals may choose that allow them to live as independently as possible in their own home or in the community and to achieve productive lives. Eligible individuals may choose between the iBudget Florida waiver or residing in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) or other institutional setting.

The waiver embraces the principles of self-determination, which include freedom for the individual to exercise the same rights as all citizens; authority to exercise control over authorized funds needed for one's own support, including the re-prioritization of these funds when necessary; responsibility for the wise use of public funds; and self-advocacy to speak and advocate for oneself and others who cannot do so in order to gain independence and ensure that all individuals with a developmental disability are treated equally.

Description and Purpose, continued

Purpose, continued

This waiver enhances individuals' opportunities for participant direction by providing greater choice among services within the limits of an individual budget. To facilitate this, similar services will be grouped in service families. Individuals will often have opportunity to shift funds between services within a service family and between service families, enabling them to respond to their changing needs. Prior service review processes will be tailored to maximize an individual's flexibility while assuring health and safety. Individuals and their families will be supported in exercising greater participant direction by receiving training about managing their individual budgets and making informed choices. This training will be provided by waiver support coordinators, through paid waiver services, and through other means. Individuals and families will also be provided relevant information on the variety of waiver and community supports that are available. iBudget Florida enrollees may use a website which helps them select waiver services and track waiver service use. This website will maximize flexibility while supporting individuals in responsibly managing their individual budgets.

The iBudget Florida program requires using waiver funds as only "one piece of the puzzle" of supporting an individual. Waiver services shall not replace the supports already provided by family, friends and other agencies or programs. The waiver is the payer of last resort. Individuals, families, waiver support coordinators, and providers are responsible for finding non-waiver supports to augment and even replace waiver-paid services. State and federal funds are to be used only when a family or community support is unavailable or while a support is being developed.

The individual, the waiver support coordinator, and service providers shall work together to accommodate the needs of the individual within the individual's waiver budget allocation. Individuals will know their budget amounts at the outset of the planning process so that cost plans can be based on the individual's priorities. iBudget Florida provides control and flexibility in spending waiver funds; however, iBudget Florida also requires accountability on the part of all participants in the system.

- Individuals and families are responsible for identifying their needs, prioritizing services for waiver funding, and working with waiver support coordinators to find non-waiver resources to meet their needs. The amount of an individual's budget allocation is determined by an algorithm and depends in large part on the amount of funding for waiver services that is appropriated by the Legislature. Individuals may not have enough funding in their budget allocations to be able to obtain all services through the waiver. They will have to work with their families, circles of support, and waiver support coordinators to obtain from other sources those services that their budget allocation is not able to fund.

Description and Purpose, continued

Purpose, continued

- Waiver support coordinators are responsible for supporting individuals' self-direction, working creatively to meet their needs, and for monitoring individuals' health and safety. The iBudget Florida system places a special emphasis on waiver support coordinators' working with individuals and families to locate and develop natural and community supports. This will require a higher level of creativity and dedication to engage community resources. Waiver support coordinators will need to work with individuals and families to identify and develop resources, such as help from family friends, colleagues, churches, businesses, etc. who might be approached directly with requests to support an individual outside of a formal organizational program of assistance. Waiver support coordinators will have a key role in promoting individuals to be competitively employed based on the individual's interests, talents, and abilities.

Providers are responsible for respecting individuals' choices, working with others who support the individual to deliver high-quality services to that individual, and providing necessary information in a timely manner to facilitate individuals' budget management. In addition, providers must recognize that the iBudget Florida system empowers individuals to make rapid changes in their cost plans to tailor services to their unique needs.

Enrollment

Individual Eligibility Requirements for Enrollment into the iBudget Florida Program

Participants in the iBudget Florida waiver must meet the eligibility requirements of the Agency for Persons with Disabilities, in accordance with Chapter 393, F.S. In addition, the individual must meet the level of care criteria for placement in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) and must be eligible for Medicaid under one of a variety of categories described in the Florida Medicaid Provider General Handbook.

Enrollment, continued

Level of Care Requirements / iBudget Florida Waiver Eligibility Requirements

Individuals who are eligible for Medicaid benefits must also meet all of the following conditions to be eligible for enrollment in the waiver:

Applicants must be determined to meet eligibility requirements for APD services. For applicants who have not yet been determined eligible for APD services, the determination of waiver eligibility shall be pended until eligibility for APD services has first been determined. The qualifying definitions for Developmental Disabilities and the conditions included in that definition are found in section 393.063, F.S.

Eligibility for the waiver is limited to the following qualifying disabilities:

The individual's intelligence quotient (IQ) is 59 or less; OR

The individual's IQ is 60-69 inclusive and the individual has a secondary handicapping condition that includes Down syndrome, cerebral palsy, spina bifida, Prader-Willi Syndrome, epilepsy, autism; OR ambulation, sensory, chronic health, and behavioral problems; OR the individual's IQ is 60-69 inclusive and the individual has severe functional limitations in at least three major life activities including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living; OR

The individual is eligible under a primary disability of Down syndrome, autism, cerebral palsy, spina bifida, or Prader-Willi Syndrome. In addition, the condition must result in substantial functional limitations in three or more major life activities, including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living.

The individual must choose to receive services in community instead of receiving services in an Intermediate Care Facility.

Eligibility

Medicaid Eligibility

Individuals who are not already eligible for Medicaid benefits through Supplemental Security Income (SSI), (MEDS-AD), or Temporary Assistance to Needy Families (TANF) at the time of application for the iBudget Florida waiver must apply or have a designated representative apply for Medicaid benefits through the Department of Children and Families. Eligibility can be applied for online at: http://www.myflorida.com/accessflorida/.

Note: Refer to the Florida Medicaid Provider General Handbook for information on verifying individual eligibility for Medicaid state plan services.

Once APD, Medicaid, and the waiver eligibility requirements are met, APD shall review the individual's request for home and community-based supports and services and shall determine if:

1) A waiver vacancy is available;
2) Sufficient funding is available to meet the individual's needs; and
3) The individual can be safely maintained in the community

The Central APD Office maintains the statewide wait list of applicants awaiting waiver services. Enrollment in the waiver is available only when the Agency has determined it has sufficient funding to offer an enrollment to an individual.

Eligibility, continued

Conditions under which an individual is ineligible for the waiver

When an individual is enrolled on the waiver, he or she remains enrolled allocated to him or her until disenrolled due to one of the following conditions:

- The individual or guardian chooses to terminate participation in the program;
- The individual moves out of state;
- The individual becomes ineligible for the waiver because of a loss of eligibility for Medicaid benefits and this loss is expected to extend for a lengthy period;
- The individual no longer needs waiver services;
- The individual no longer meets level of care for admission to an Intermediate Care Facility for the Developmentally Disabled (ICF/DD)
- The individual no longer resides in a community based setting but moves to a correctional facility, detention facilities, defendant program, nursing home or resides in a residential facility not defined as a licensed residential setting as specified in this handbook; or
- Is not cooperative with the provision of waiver services as specified in this handbook, including but not limited to refusal to develop a cost plan.
- The individual is no longer able to be appropriately maintained safely in the community.
- The individual becomes enrolled on another HCBS waiver.

However, an individual may return to eligible waiver status and resume receiving waiver services providing he or she has been dis-enrolled for 365 days or less.

If waiver eligibility cannot be re-established or if the individual who has chosen to dis-enroll has exceeded this time period, the individual may not return to the waiver until a new waiver vacancy and funding is available. In this instance, the individual is added to the waitlist of persons requesting waiver participation. The new effective date is the date eligibility is re-established or the person requests re-enrollment for waiver participation.

A provider is responsible for notifying the individual's waiver support coordinator and APD if the provider becomes aware that one of these conditions exists.

Necessity

Medical Necessity

APD shall determine whether a service requested to be provided with waiver funding is medically necessary. Once medical necessity is determined, APD shall make the final decision whether an approved service may be authorized.

Medical Necessity Determinations

For some services, a medical necessity determination by a qualified professional shall be required to determine that the standards for medical necessity are met and that the requested item meets the service definition, as contained in the approved iBudget Florida waiver and in this handbook.

If sufficient information is not available to determine that the service or item is medically necessary, a written request for more information will be sent to the waiver support coordinator and the individual, family or guardian. If it is determined that the service is not medically necessary and/or does not meet other requirements for it to be a paid waiver service, a written denial of the service and notice of due process will be sent to the individual, family or guardian and copied to the waiver support coordinator. An individual receiving Medicaid may appeal decisions made by APD by requesting a hearing, in accordance with federal and state laws and regulations. A request for hearing shall be made to the agency, in writing, within 30 days of the individual's receipt of the notice.

A prescription for a service or item may not in itself establish a medical necessity determination.

Freedom of Choice

The iBudget Florida waiver is designed around individual choice. Accordingly, individuals served through the waiver may select among enrolled, qualified service providers and may change providers at any time. Within the funds allocated in individuals' budget allocations, individuals are free to change enrolled, qualified providers as desired to meet the goals and objectives set out in their support plans. Freedom of choice includes individual responsibility for selection of the most cost beneficial residential environment and combination of services and supports to accomplish the individual's goals.

Requirements

Services and the Hierarchy of Reimbursement

Services shall not be authorized under the waiver if they are available from another source. The waiver support coordinator shall determine whether the same type of service offered through the waiver is also available through other funding sources, including Medicaid state plan, and if so, the waiver support coordinator shall coordinate the service through the alternate funding source.

Items and services inappropriately billed and paid through the waiver prior to accessing Medicaid state plan, other payer services, private insurance or available natural supports will be considered as overpayments and subject to recoupment from the service provider.

Funding sources shall be accessed in this order:

1. Natural and community supports
2. Third Party Payer, such as private insurance
3. Medicare
4. Other Medicaid programs
5. iBudget Florida, which is the payer of last resort.

For example, the Medicaid Durable Medical Equipment and Medical Supplies Program services must be accessed before using waiver consumable medical supplies or specialized medical equipment.

If an individual is dually-eligible under Medicare and Medicaid, the waiver support coordinator must secure services from those providers that are enrolled as Medicare and Medicaid providers so that any services that are covered by Medicare can be billed to Medicare first before billing to Medicaid. For example, Medicaid cannot reimburse a non-Medicare home health agency for Medicare reimbursable services provided to a dual-eligible individual.

To obtain specific information about Medicaid state plan coverage, refer to the Medicaid Coverage and Limitations Handbook for the particular service. Handbooks can be downloaded from the Medicaid fiscal agent Web site. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The Medicaid Coverage and Limitations handbooks for the particular services are incorporated by reference in the service-specific rules in 59G-4, F.A.C.

CHAPTER 2
iBudget Definitions and Acronyms

Overview

Introduction	This chapter defines terms and acronyms for the Medicaid Waiver Individual Budget (iBudget).

General Definitions and Acronyms

Agency for Health Care Administration (AHCA)	The single state Medicaid agency in Florida.
Agency for Persons with Disabilities (APD)	The state agency responsible for operation of the iBudget Florida waiver.
Agency Provider	A business or organization enrolled to provide a waiver service(s) that has one or more staff employed to carry out the enrolled service(s). An agency or group provider for rate purposes is a provider that hires staff to perform the waiver services.
Algorithm	Refer to APD Definition
Annual Report	A written report by the provider documenting the individual's progress toward his or her support plan goal(s) for the year, as required in section 393.0651, F.S.
Approved Services	Waiver services which are approved by APD or its contracted reviewers as able to be purchased using waiver funds for a specific individual and are identified on the individual's approved cost plan.
Area Office	APD's local office responsible for managing a specific geographical area.

General Definitions and Acronyms, continued

Billing Agent	An entity that offers claims submission services to providers. Providers may submit claims themselves or choose to have a billing agent. Billing agents must be enrolled in the Medicaid program and have passed the required background screening.
Budget Allocation	The waiver funding approved by APD for an individual to expend on medically necessary iBudget Florida waiver services during the dates of service on the approved cost plan. Central Record of an Individual A file, or a series of continuation files, in paper or electronic format as required by APD, kept by the waiver support coordinator in which the following documentation must be recorded, stored and made available for review: • Individual demographic data including emergency contact information, parental or guardian contact information, releases of information; and results of assessments, eligibility determination, evaluations, as well as medical and medication information; • Legal data such as guardianship papers, court orders and release forms; and • Service delivery information including the current support plan, cost plan or written authorization of services, and implementation plans, as required. The central record is the property of APD and follows the individual if the individual's waiver support coordinator changes. It is the responsibility of the waiver support coordinator to maintain the central record. If the support coordinator is using an electronic system for record keeping beyond the Client Central Record system, the information must be maintained on a disk for backup documentation that is available to APD upon request. The documents on the disk must be clearly named so that their contents are identifiable.
Claim Form	The CMS 1500 paper claim form. Claim forms must be complete and legible when submitted to the Medicaid fiscal agent for reimbursement for services rendered Instructions for completing the CMS-1500 claim form are in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500. Alternatively, the provider may also submit claims to the Medicaid fiscal agent electronically by using the free software supplied by the Medicaid fiscal agent. Note: See Chapter 5 for additional billing and reimbursement information.
Community Integrated Settings	Local settings, resources, and locations. These allow direct personal interaction between persons with and without disabilities.

General Definitions and Acronyms, continued

Community Supports	Services that are available to all community members, often at little or no cost.
Cost Beneficial	Economical in terms of the value of the goods or services received in relation to the money spent.
Cost Plan	The cost plan is the document that lists all approved waiver services for an individual and the maximum cost of each waiver service. The cost plan is maintained online in the online iBudget Florida system or other APD system.
Cost Plan Year	The cost plan year spans the state fiscal year, which begins July 1st and ends June 30th of the following year.
Daily Attendance Log	The daily attendance log is a listing of the individuals who participated in the service and the days in the month the individual participated in the service.
Direct Provider Billing	This is the standard billing process for Developmental Disabilities Individual Budgeting Waiver service providers. All claims for Developmental Disabilities Individual Budgeting Waiver services must be submitted online or by submitting CMS-1500 claim form.
Direct Service Provider	As defined in section 393.063, F.S., a "direct service provider" means a person 18 years of age or older who has direct face-to-face contact with an individual or has access to an individual's living areas or to an individual's funds or personal property.
Florida Medicaid Management Information System (FMMIS)	The information system managed by AHCA that providers use to bill for services rendered under the iBudget Florida program.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996 (HIPAA) makes health insurance more "portable" so that workers may take their health insurance with them when they move from one job to another, without losing health coverage. This federal legislation also requires the health care industry to adopt uniform codes and forms, streamlining the processing and use of health data and claims which will serve to better protect the privacy of people's health care information and give them greater access to that information.

General Definitions and Acronyms, continued

Home	The primary residence occupied by the individual.
iBudget Florida waiver, or iBudget Florida	The program through which the Developmental Disabilities Individual Budgeting Home and Community-Based Services waiver is operated.
Implementation Plan	A plan developed by the provider detailing the support plan goals that the service will address, the methods employed to assist the individual in meeting the support plan goal(s), and the system to be used for data collection and assessing the individual's progress in achieving the support plan goal(s). It is developed and updated with direction from the individual. Refer to service specific documentation matrix requirements.
Individual	A person with a developmental disability enrolled in the iBudget Florida Waiver.
Individually Determined Goal	The major aspirations that an individual has for his or her life as reflected in the support plan. The individual's expectations for the services and supports he receives are defined by these goals, which may also be referred to as personal goals.
Licensed Residential Facility	Facilities providing room and board and other services in accordance with the licensing requirements for the facility type, which include: Group homes and foster care facilities licensed in accordance with Chapter 393, F.S. and Chapter 409, F.S. • Comprehensive Transitional Education Programs (CTEPs) licensed in accordance with Chapter 393, F.S. • Assisted Living Facilities, and Transitional Living Facilities, licensed in accordance with Chapters 400 and 429, F.S. • Residential Habilitation Centers, licensed in accordance with Chapter 393, F.S., and any other type of licensed facility not mentioned above, having a capacity of 16 or more persons, if the individual has continuously resided at the facility since August 8, 2001 or prior to this date.
Medicaid Provider Agreement	The contractual agreement between the provider and the Agency for Health Care Administration which establishes the provider's eligibility to render services under the Medicaid program and designates responsibilities for the provider.

General Definitions and Acronyms, continued

Medicaid State Plan	The Medicaid State Plan is Florida Medicaid's contract with the Centers for Medicare and Medicaid that specifies the eligibility categories of low income people and the medical services that Florida Medicaid provides. In Florida, the Agency for Health Care Administration (AHCA) develops and carries out policies related to the Medicaid program. Florida's state plan services are authorized by s.409.905 and 409.906, F.S.
Medicaid Waiver Services Agreement	The contract between the Agency for Persons with Disabilities and providers of waiver services. All providers of developmental disability waiver services must complete this agreement prior to providing services to individuals enrolled in the iBudget Florida waiver and comply with the terms and conditions of the agreement. An example of the Medicaid Waiver Services Agreement is included as Appendix G.
Medical Case Management Team (MCMT)	The health and safety oversight team for an APD Area Office.
Monitoring	A review, audit, inspection or investigation of the provider's administrative and programmatic service delivery systems by the Agency for Health Care Administration, the Agency for Persons with Disabilities, or their authorized agent(s).
Monthly Summary	A written summary of the month's activities indicating the individual's progress toward achieving support plan goals for the services billed in that month.
Natural Supports	Support that is provided to individuals by family members, guardians or friends without cost. The use of these supports must be exhausted before seeking funding from the iBudget Florida waiver.
iBudget Florida Website	The information technology system used in conjunction with the ABC system and FMMIS system by APD staff, waiver support coordinators, providers, and, at their choice, individuals and families, to administer the iBudget Florida waiver.

General Definitions and Acronyms, continued

Person Centered Planning Process	A planning approach based on the individual's perspective rather than that of a program or resource used to identify the services and supports necessary to meet the individual's needs. The person centered planning process shall involve the individual and significant people in his or her life, identifying the goals and outcome he or she considers most important and the supports necessary to achieve them.
Prescription	Instructions written by a physician on an official physician prescription pad.
Provider	A person or agency enrolled to provide Home and Community Based Non-Institutional services as outlined in the Florida Medicaid Provider General Handbook. Note: The handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Handbooks. The Florida Medicaid Provider General Handbook is incorporated by reference in 59G-5.020, F.A.C. The Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-13.001 and 59G-4.001, F.A.C. Note: Refer to the Florida Medicaid Provider General Handbook for information on verifying provider enrollment, requirements, certifications, provider agreements, terminations, and provider records rights and responsibilities.
Provider File	Documentation maintained by the provider regarding the individual either in electronic and hard copy format as required by APD which includes the authorization for services, release forms, and service delivery documentation as specified in this handbook, which are related to the service and support activities identified in the support plan.
Quarterly Summary	A written summary by provider of the activities in that quarter indicating the individual's progress toward achieving support plan goals for the services billed in that quarter. Refer to Appendix A, (documentation chart) for list of services required to submit quarterly summaries.
Remediation Plan	A plan of proposed corrective actions developed by the provider that address the improvements needed for services cited as below standard or non-compliant by APD or its authorized agent.
Service Authorization	An APD document that authorizes the provision of specific services or supports to an individual and includes at a minimum the provider's name and the specific amount, duration, scope, frequency and intensity of the approved service. The service authorization must be received by a provider before it may provide a service.

General Definitions and Acronyms, continued

Service Families	Categories that group services related to: Life Skills Development, Environmental and Adaptive Equipment, Personal Supports, Residential Services, Support Coordination, Therapeutic Supports and Wellness Management, Transportation and Dental Services. Refer to the chart in Chapter 3 for the specific services grouped in service families.
Service Log	A form used to document service delivery. The service log is completed in the Client Central Records electronic system and is submitted electronically. Refer to Appendix H and I, for list of services for which service logs are required.
Solo Provider	A solo or independent provider who personally renders waiver services directly to recipients and does not employ others to render waiver services for which the rate is being paid.
Support Plan	An individualized plan of supports and services designed to meet the needs of an individual enrolled in the waiver. The plan should include detailed information regarding the individual's current needs, current available resources and natural supports, the individual's goals and the need for the supports and services requested. The document described in s. 393.0651, F.S.
Duration, Frequency, Intensity and Scope	• **Duration –** Length of time a service authorization is approved. May be found as the beginning and ending dates on the service authorization; • **Frequency -** Number of times the service is provided in a given time period; • **Intensity** – The number of units to be provided in a session and may also denote the level (basic, moderate, intensive or 1:1, 1:2, 1:6-10, or Standard, Moderate, Intensive. • **Scope** – The service and any limitations to or instructions for activities to be provided.

CHAPTER 3
GENERAL PROVIDER REQUIREMENTS

Compliance & Requirements

Compliance with Federal Laws and Regulations

The provider shall comply with the relevant provisions of the following federal laws and regulations:

1. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., prohibiting discrimination on the basis of race, color or national origin in programs and activities that receive or benefit from federal financial assistance.
2. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. s.794(a), et. seq., in regard to employees or applicants for employment.
3. The Age Discrimination Act of 1975, as amended, 42 U.S.C. s.12101 et. seq., which prohibits discrimination on the basis of age, in programs or activities that receive or benefit from federal financial assistance.
4. The Omnibus Budget Reconciliation Act of 1981, PL 97-35, prohibiting discrimination on the basis of sex or religion in programs and activities that receive or benefit from federal financial assistance.
5. The Americans with Disabilities Act of 1990, PL 101-336, prohibiting discrimination based on disability in employment, public accommodations, transportation, state and local government services and telecommunications.
6. The Title 42, Code of Federal Regulations (CFR) 431.51, which states that each individual served by the provider will be provided freedom of choice within the scope of available funding levels. Freedom of choice includes:
    a. Opportunities for the individual to select non-waiver funded supports available to the general community from among those activities or experiences that meet the individual's needs and preferences;
    b. Opportunities for the individual to select providers of Medicaid State Plan services from among those providers enrolled in the Medicaid waiver program, and that also meet the individual's needs and expectations;
    c. Opportunities for the individual to select providers of waiver services from those eligible to provide waiver services and enrolled in the Medicaid program, meeting the individual's needs and expectations;
    d. Opportunities for the individual to change providers of supports and services;
    e. Opportunities for the individual to work with a provider to identify mutually agreeable times and settings for the provision of supports or services; and

The opportunity for the individual to end his participation in the waiver.

Compliance & Requirements, continued

Compliance with Federal Laws and Regulations, continued

7. The Health Insurance and Portability Accountability Act, Title 45 CFR Part 164. This includes provider staff, contracted staff and volunteers, Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA privacy requirements. The Florida Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA. Providers who utilize a billing agent are responsible for ensuring the billing agent fully complies with HIPAA regulations and must also obtain a copy of the billing agents' background screening results. This documentation must be maintained by the provider.

Compliance with State Law and Regulations

1. The provider will comply with Chapters 393 and 409, Florida Statutes, Chapters 65G and 59G, Florida Administrative Code, and with all procedures pertaining to the implementation of the waiver, including all rates and fee schedules developed under such laws, rules, and regulations.

2. The provider will uphold the rights and privileges of individuals with developmental disabilities, as specified in Chapter 393.13, F.S., and "The Bill of Rights of Persons Who Are Developmentally Disabled."

Provider General Requirements

1. The provider shall not disclose or use any information concerning an individual who is receiving services under the waiver without the written consent of the individual or the individual's legal guardian, in accordance with Chapter 393.13, F.S., and federal regulations.

2. If all or part of the business is closed, sold, or transferred, the provider shall maintain and make available to APD and the Agency for Health Care Administration all records required to be kept for at least five years from the date of service. If the provider enters into an agreement with a third party to maintain records, they must furnish APD with a copy of such agreement. Any such agreement will require the holder or custodian of the records to comply with the terms set forth in this document for retention and access to said records.

Compliance & Requirements, continued

Provider General Requirements, continued

3. The provider shall agree that APD through AHCA is responsible for the expenditure of all funds appropriated to APD by the Florida Legislature for individuals receiving services from APD and the iBudget Florida waiver. APD and/or its authorized agents shall determine the appropriateness or medical necessity of services purchased, in accordance with 59G 1.010 F.A.C.,65G, F.A.C., Chapter 393, F.S., and the amount of APD funds available to purchase services and goods.

4. The provider shall, within the mission and scope of the services offered, to safeguard the health, safety and well-being of all individuals receiving services from the provider and to assist individuals in the achievement of personal goals, choice, rights, dignity and respect, security and satisfaction.

5. The provider shall participate in and support the person-centered planning and implementation process for each individual. The provider will also use the recommendations from the person-centered planning process to: (1) implement person-centered supports and services; (2) support development of informed choices through education, exposure and experiences in activities of interest to the person served; (3) enhance service delivery in a manner that supports the achievement of individually determined goals; and (4) make improvements in the provider's service delivery system.

6. The provider shall, with the individual's or legal guardian's permission, participate in the discussion of the individual's record, the individual's progress, the extent to which the individual's needs are being met or any need for modifications to their support plan, implementation plan, or other documents, as applicable. This discussion could involve APD or its authorized representatives, other service providers, the individual, the guardian, family and friends.

7. The provider shall, with the individual's or legal guardian's permission, provide information about the individual to assist in the development of the support plan, and to attend the support planning meeting when invited by the individual, family member or guardian.

8. Providers and their employees who transport individuals, either as a specific part of their service delivery or as incidental transportation, shall show, at time of enrollment, proof of a valid Florida driver's license, vehicle registration and sufficient automobile insurance to use the provider's vehicle or their own vehicle when providing transportation. Subsequent to enrollment, the provider is responsible for keeping this documentation up to date.

Compliance & Requirements, continued

Provider General Requirements, continued

9. The provider shall provide and bill only for those services that have been authorized and approved by APD on the individual's cost plan. These supports and services shall be provided within the amount, frequency, scope, intensity and duration specified on the individual's support plan, approved cost plan, and service authorizations. The provider agrees not to bill for services until rendered as authorized.

10. The provider shall immediately notify AHCA using the required form and the APD area office of any change in contact information including email address, mailing address or telephone number. The provider shall also notify AHCA and APD area office if they plan to close the business or have a change in ownership.]

11. All enrolled Medicaid waiver providers shall have access to a computer with internet access, which allows for secure transmission to and from APD, and a valid active email address. The computer must be used exclusively by the provider and stored in a secure manner. Waiver support coordination providers must also have internet access through Internet Explorer, emulation software and a State of Florida VPN account to facilitate access to non-public APD networks. All providers must ensure any computer used for business purposes is capable of performing security functions that promote and maintain confidentiality of information. These security functions include, but are not limited to, password protected logins, virus detection, and secure (encrypted) network communications. Information stored on physical media (for example, a computer hard-drive or USB drive) which is not encrypted should be physically safeguarded to prevent loss or theft. Providers will comply with APD Information Security policies, and State and Federal regulations and laws, in all use of APD computer systems and data. Providers agree to exercise due diligence in taking precautions to protect confidential information from exposure to or access by unauthorized individuals. Providers acknowledge, as independent business entities, that they are solely responsible for safeguarding confidential and protected information in their possession (regardless of how the information was acquired)
12. All providers shall participate in the direct deposit program for Medicaid payments and must have an active saving or checking account.

13. Providers shall access service authorizations through the online iBudget Florida system or other electronic system providing such access. Providers shall agree to abide by the terms and conditions of use of the online iBudget Florida system or other electronic system providing such access

14. It is the provider's responsibility to determine whether a service authorization has been issued, revised, or cancelled for an individual served by the provider before providing services.

Compliance & Requirements, continued

Provider General Requirements, continued	15. The provider shall attend training sessions specific to the type of services provided, monthly support coordination APD Area meetings and quarterly provider meetings as scheduled by the APD Area Office. 16. Providers required to submit service logs shall at a minimum do so via the client central record system as follows; For services that are billed at the daily or quarter hour rate; Supplies and equipment; and assessments - within 15 calendar days after the date on which services were rendered For monthly rates – within 15 days after the month ends. 17. It is the provider's responsibility to be aware of any announcements or changes in policy or procedure by APD or AHCA communicated through the agencies' websites or directly to providers by APD area offices

Waiver Provider Enrollment

Enrollment

Waiver provider applicants must meet specific qualifications and requirements before becoming eligible to provide waiver services. In addition, provider applicants must have no adverse history with any regulatory agency that causes AHCA or APD to question whether the health, safety and welfare of a waiver participant could be jeopardized during the delivery of an approved waiver service. Individuals have the right to choose providers, and enrollment as a waiver provider does not guarantee selection by an individual.

Prior to enrollment the provider applicant must comply with the following requirements. Forms may be obtained from the APD area office.

A. Be determined eligible by the APD Area Office to enroll as a waiver provider
B. Not be currently suspended from Medicare or Medicaid in any state.
C. Meet provider qualification and responsibility requirements described in Chapter 3 of this handbook
D. Complete a Medicaid Provider Enrollment application, which may be obtained from the APD website http://apd.myflorida.com, through the local APD area office or from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. The application is incorporated by reference in 59G-5.010, F.A.C. This handbook provides detailed information on each service available through the waiver, including provider qualifications, limitations and required documentation. Applicants should carefully review the description of each service for which they want to become enrolled prior to completing the waiver provider application.
E. Complete the APD provider supplemental application, which must be obtained from the APD Area offices.
F. Submit a business plan, if applying to provide services for which it is required.
G. Complete a Level 2 background screening and Affidavit of Good Moral Character with results indicating no disqualifying offenses or receive an exemption from disqualification.
H. Be assigned a Medicaid provider number.
I. Have a current, signed Medicaid Waiver Services Agreement with APD.
J. Maintain all certifications necessary to provide services as specified in this handbook.
K. Be at least 18 years of age.

Waiver Provider Enrollment, continued

Enrollment, continued

Provider may be enrolled as an agency or solo provider.

Waiver support coordinators employed by an agency must have their own individual treating provider numbers.

An agency is a business or organization enrolled to provide Medicaid waiver services and has:

- a table of organization with clearly defined position descriptions for all employees, and
- a business plan (further described below) that outlines the agency's mission statement, policies and procedures, staff training protocol and self-assessment process to ensure that the agency employees will provide services in accordance with this waiver handbook.

A provider agency shall maintain a personnel file for each employee documenting the employee meets the minimum education and experience requirements for the service he/she was hired to provide, has completed all required training as specified in this handbook and has satisfied all background screening requirements

Business Plan

All providers of the following services who become enrolled after the effective date of this handbook must submit a business plan: Life Skills Development Levels I, II, III, Residential Services, Behavior Assistant and Behavior Analysis, Personal Supports, Respite, Support Coordination, and Supported Living Coaching. This plan must include the following elements:

1) Mission Statement that clearly states how services provided will focus on and be directed by the individual receiving services.

2) Statement of Work that describes each Medicaid waiver service to be provided, the specific counties to be served, and a detailed description of how each service is to be delivered in a person-centered manner.

3) Provider Qualifications- Details how the provider meets the minimum requirements for the services in which the provider wishes to enroll. For agency providers, the process the provider will use to ensure all agency employees meet the minimum requirements indicated in this handbook for the services in which the provider agency wishes to enroll.

Waiver Provider Enrollment, continued

Business Plan, continued

4) Table of organization (agency providers only) which includes the organizational structure of the agency, board of directors, supervisors and all support staff, including names and position descriptions.

5) A cash flow assessment that includes a one-year projection of how the business will meet anticipated expenses (payroll, worker's compensation, payroll taxes, liability insurance, transportation related expenses, etc., as applicable).

6) Self- assessment process: A description of how the provider will evaluate the effectiveness of services.

7) Policies and procedures that include at a minimum:
   - How the provider will use a person centered approach to identify individually determined goals and in promoting choice
   - A detailed description of how the provider will protect health, safety and wellbeing of the individuals served
   - How the provider will ensure compliance with background screening and five year rescreening
   - Hours/days of operation and the notification process to be used if the provider is unable to provide services for a specific time/day scheduled, including arrangement of a qualified backup provider
   - How the provider will ensure the individuals' medications are administered and handled safely
   - A description of how the provider will ensure a smooth transition to and from another provider if desired by the individual or their guardian/guardian advocate
   - The process that the provider will go through to address individual complaints and grievances regarding possible service delivery issues
   - How the provider will ensure individual confidentiality and the maintaining and storage of records in a secure manner.

8) A training plan that specifies training topics required in this handbook, how training activities will be carried out, how the provider will ensure full compliance with required training, how frequently training will be provided and how competency of training participants will be measured (agency applicants only.

Agency Providers

An agency provider is a business or organization enrolled to provide a waiver service(s) that has four or more staff employed to carry out the enrolled service(s). An agency or group provider for rate purposes is a provider that hires staff to perform the waiver services.
The agency rate is used for all services that are directly provided by employees of the provider. All employees of an agency or group provider must meet the qualifications and requirements specified in the provider's agreement and those specified for enrolled service(s). The provider shall maintain personnel file documenting qualifications of all employees and their background screening results.

Waiver Provider Enrollment, continued

Use of Subcontractors

A subcontractor is an individual or business that signs a contract to perform part or all of the obligations of another's contract.

Use of subcontractors for the provision of direct services to individuals is prohibited.

Solo/Independent Providers

A solo provider, also referred to as an independent provider, must personally render services directly to the individual and may not subcontract with other persons to render services to individuals. Exceptions are Consumable Medical Supplies, Durable Medical Equipment, Environmental Accessibility Adaptations, and Personal Emergency Response Systems,

If the provider is a solo provider and incorporates, the provider is still considered a solo or independent provider for rate purposes unless the provider hires another person to perform the specific waiver service for which the rate is being established.

If the provider is a solo provider and incorporates but does not meet other criteria for being an agency provider, the provider is still considered a solo or independent provider for rate purposes.

Waiver Provider Background Screening Requirements

Provider applicants must comply with the requirements of a level 2 screening in accordance with section 435.04, F.S. All direct service providers for the provider with access to the individual or the records of the individual must also comply with these requirements.

Compliance with background screening requirements may be accomplished, pursuant to s. 393.0655, F.S., by submitting the following documents to the provider enrollment staff in the APD Area office:

1. Completed Fingerprint card or Live scan, with payment. Providers using Live scan must first establish an OCA code for Live scan participation through the Department of Children and Families. Per Chapter 2010-114, Florida Law, effective July 1, 2012, all fingerprints must be submitted via Live scan.
2. An Affidavit of Good Moral Character, which must be notarized. This document may be obtained from the APD website, www.apdcares.org.
3. Local Law Enforcement check- This local check shall be conducted in the jurisdiction in which the applicant resides and may be conducted by either the local police or county Sheriff's office.
4. Employment References- These checks must cover a minimum two year period preceding the application. Any gaps in employment must be explained.

Waiver Provider Enrollment, continued

Waiver Provider Background Screening Requirements, continued

Screening is performed at the time of enrollment for provider applicants. Employees of Medicaid Waiver enrolled agencies must be screened and results of screening must be obtained prior to the person being hired. Medicaid Waiver providers and employees of Medicaid Waiver providers must also be rescreened every five years. It is the responsibility of the applicant or provider to ensure this request for screening or rescreening is submitted for processing in a timely manner. Rescreening consists of a federal background and name check through the Florida Department of Law Enforcement (FDLE) using the Level II standards found in s. 435.04, F.S. and either ss. 393.0655 or 408.809, F.S., and a local criminal check from the county where the employee resides. Providers are responsible for maintaining official documentation of clearance from the screening agency of Level 2 screening in their administrative records.

Note: The Medicaid Enrollment Application is available from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Enrollment to locate the application. The application is incorporated by reference in 59G-5.010, F.A.C.

Change in Provider Status

If a provider wishes to expand from solo to agency status, provide additional services, and/or wishes to expand services geographically, the provider must notify the APD Area Office serving the geographic area in which expansion is requested. The APD area office must prior approve the expansion. The area office will consider the waiver provider applicant criteria enrollment in this chapter as well as quality assurance and monitoring results, valid complaints and general compliance with waiver provider requirements contained in this handbook.

Providers shall notify the APD area office and individuals served as soon as they become aware of any change, sale or transfer of ownership. Individuals receiving services shall be given an opportunity to receive services from the new owner, purchaser, or transferee, or to select another provider.

If a provider voluntarily terminates services and later desires to return to the waiver in any capacity, they will be considered a new applicant and shall comply with all the requirements of a new applicant

Providers shall notify APD in writing prior to any filing for bankruptcy protection or if the financial solvency of the provider becomes unstable

Waiver Provider Enrollment, continued

Family Members Enrolled as Waiver Providers or Acting as Service Providers

Parents and/or persons related by blood or marriage are considered to be natural supports and as such should be considered for the provision of services without payment.

Under no circumstance may a parent of a minor or step parent of a minor, a spouse of an individual, or a guardian or guardian advocate of an individual receive:

- payment under the waiver for services rendered to their family member;
- indirect payment as an employee of a waiver provider or as a subcontractor of a waiver provider to provide services to their own family member; or
- direct or indirect payment for waiver support coordination to their family member.

Parents not legally responsible or persons related by blood or marriage who are not legally responsible may request an exception only under the following limited circumstances:

- Exceptions may only be requested for personal supports services or transportation services.

- Examples of when an exception might be warranted include the lack of available enrolled Medicaid waiver providers, the inability of providers to meet a specific unique need of the individual or the individual's scheduling needs for which no other provider is available.

The exception request must document thorough efforts to secure alternative providers who are not relatives of the individual including a list of providers who were contacted and the reasons they could not provide the service. Convenience to the individual, caregiver, or family alone is not adequate justification. The relative must be an enrolled waiver provider. Any services that meet these criteria must be pre-approved in writing by the Area office prior to services being authorized. Waiver support coordinators are responsible for submitting draft cost plans meeting these criteria to the area for review prior to processing them through the online iBudget Florida system.

Waiver Provider Enrollment, continued

Incident Reporting

Providers are responsible for reporting incidents to the APD office as they occur within specified timeframes as noted below. Providers must submit incident reports and follow-up reports on the Agency approved incident reporting form. Incident reports are classified as either critical or reportable.

Providers shall report critical incidents to the APD Area office within 1 hour of becoming aware of the incident. If the incident occurs between the hours of 8 P.M. and 8:00 A.M., the incident may be reported no later than 9:00 A.M. the next day. Critical incidents include:

1. Unexpected death
2. Sexual Misconduct
3. Missing child or Adult who has been adjudicated incompetent
4. Circumstance that initiates unfavorable media attention
5. Arrest while under the supervision of a provider

The provider shall report incidents classified as reportable within one business day to the APD Area office. Reportable incidents include:

1. Altercation that results in law enforcement contact
2. Individual injury that requires medical attention in an urgent care center, emergency room or physician office setting.
3. An incident resulting in the arrest of individual receiving services.
4. A missing competent adult
5. Suicide attempt by an individual.
6. Other – any event not listed above that jeopardizes an individual's health, safety or well-being

Waiver Provider Enrollment, continued

Zero Tolerance

1. Abuse, neglect, exploitation, or sexual misconduct by a provider of services shall result in the termination of the provider's Medicaid Waiver Services Agreement in addition to any other legal sanctions available. The failure of a provider to report any incident of abuse, neglect, exploitation, or sexual misconduct may also result in the termination of the provider's Medicaid Waiver Services Agreement.

   Abuse, neglect, exploitation, or sexual misconduct by an employee of a provider or an employee's failure to report an incident of abuse, neglect, exploitation, or sexual misconduct may be imputed to the provider and may result in termination of the provider's waiver services agreement.

2. Mandatory Reporting Requirements: Any person who knows, or has reasonable cause to suspect, that a person with a developmental disability is being abused, neglected, or exploited by a relative, caregiver, or household member or, in the case of self-neglect, by themselves, is required to report such knowledge or suspicion to the Florida Abuse Hotline at 1-800-96-ABUSE or 1-800-962-2873. **Failure to report known or suspected cases of abuse, neglect, or exploitation is a criminal offense.** In addition, service providers who fail to report known or suspected cases of abuse, neglect, exploitation, or sexual misconduct will be subject to termination of their waiver enrollment status. Criminal and administrative penalties will also be pursued.

3. The Sexual Misconduct Law: Sexual activity between a direct service provider and a person with a developmental disability (to whom he or she is rendering services) is not only unethical but may also be a crime, regardless of whether or not consent was first obtained from the victim. Pursuant to s. 393.135, F.S., the term "sexual misconduct" refers to any sexual activity between a covered person (such as a direct service provider) and an individual to whom that covered person renders services, care, or support on behalf of the agency or its providers, or between a covered person and another client who lives in the same home as the individual to whom a covered person is rendering the services, care, or support, regardless of the consent of the client. The crime of sexual misconduct is punishable as a second degree felony.

4. Client-on-Client Sexual Abuse: Known or suspected sexual abuse between two individuals with developmental disabilities must also be reported immediately to the Central Abuse Hotline at 1-800-96-ABUSE (1-800-962-2873), so that an investigation will occur in order to determine whether or not the sexual abuse was the result of inadequate supervision or neglect on the part of a service provider or caregiver. The incident must also be reported immediately to the APD Area Office to ensure the continued health and safety of the individuals involved.

Waiver Provider Enrollment, continued

Zero Tolerance, continued

5. Reporting Abuse, Neglect, Exploitation, or Sexual Misconduct**:** Direct service providers who know or suspect that a person with a developmental disability is being abused, neglected, or exploited by a relative, caregiver, or household member or may be the victim of sexual misconduct, should do all of the following immediately:

Call the Florida Abuse Hotline, which is a nationwide, toll-free telephone number, at 1-800-96-ABUSE (1-800-962-2873), TDD access is gained by dialing 1-800-453-5145.

- Notify their supervisor (if employed by an Agency)
- Notify the Area APD office.
- Notify the local law enforcement agency
- For situations in which the life of a person with a developmental disability is in immediate danger due to abuse, neglect, or exploitation, direct service providers should call 911 before calling anyone else.

Provider agencies may not require their employees to first report such information to them before permitting their employees to call the Florida Abuse Hotline or law enforcement. In fact, any person who knowingly and willfully prevents another person from reporting known or suspected abuse is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, F.S.

Provider Notification Requirements

In addition to the requirements listed under Incident Reporting in this handbook**,** all providers shall notify the individual's waiver support coordinator and other appropriate parties when the following issues occur:

1. The individual's continued eligibility for waiver services is in jeopardy due to loss of Medicaid. Any provider that becomes aware of an individual's loss of Medicaid benefits shall immediately contact the individual's waiver support coordinator.
2. The individual plans to move out of the Area, state, or country.
3. The individual has plans to discontinue receiving services from the provider, waiver or APD.
4. Change in provider contact information including email address, physical address or phone number.
5. Breach of individual's confidential information. Notification shall include details of circumstances and information that was involved.

Waiver Provider Enrollment, continued

General Service Documentation Requirements

Documentation is a written record that supports the fact that a service has been rendered. When a service is rendered, the provider must document the service, submit billing documentation to the waiver support coordinator and file the documentation before billing. Sufficient documentation containing all of the required elements as outlined in this handbook is required in order to receive payment. All documentation must be dated and signed by the person rendering the service.

The specific documentation requirements to bill for each service are contained in the Documentation Matrix. It is the responsibility of each provider to understand and comply with all documentation requirements. Questions about documentation requirements should be directed to the APD Area Office.

Service Authorization Requirements

The services described in this handbook represent all of the services that may be approved and purchased by an individual participating in the iBudget Florida waiver and the only services that may be provided by a service provider. The provider must have an approved service authorization for the service rendered. Providers of iBudget waiver services are limited to the amount, duration and scope of the service described on the individual's service authorization. A waiver support coordinator may not provide a service authorization at a rate or frequency that is higher than that approved by APD or authorize a service that was not approved by APD. Doing so will result in the waiver support coordinator being subject to recoupment of funds for support coordination services and recoupment of service dollars billed without proper authorization.

Waiver Provider Enrollment, continued

Service Authorization Requirements

The services described in this handbook represent all of the services that may be approved and purchased by an individual participating in the iBudget Florida waiver and the only services that may be provided by a service provider. The provider must have an approved service authorization for the service rendered. Providers of iBudget waiver services are limited to the amount, duration and scope of the service described on the individual's service authorization. A waiver support coordinator may not provide a service authorization at a rate or frequency that is higher than that approved by APD or authorize a service that was not approved by APD. Doing so will result in the waiver support coordinator being subject to recoupment of funds for support coordination services and recoupment of service dollars billed without proper authorization.

Records Handling and Storage

The provider will establish and maintain records specific to the individual and services delivered as well as records of revenues and expenditures of funds provided by APD and Medicaid. All records including information stored in electronic media shall be retained for a period of at least seven years after the completion date of the Medicaid Waiver Services Agreement and must be made available to the APD and AHCA upon request. If a state or federal audit has been initiated and audit findings have not been resolved at the end of five years, the records shall be retained until resolution of the audit findings or any litigation; Records shall be established and maintained in accordance with generally accepted accounting procedures and practices.

All non-electronic files pertaining to an individual must be physically secured so that only authorized individuals may access them. Individual records may be scanned and saved into individual computer disks which must be labeled for content and stored securely.

Electronic files stored on a computer or server must be secured with technical access controls so only authorized individuals may access the files.

Should a provider need to dispose of its business computer, all client information must be removed from the hard drive of the old computer prior to its disposal, using a method which permanently destroys the data. (Simple file deletion is not sufficient.)

Waiver Provider Enrollment, continued

Required Training

With the implementation of this handbook, all new providers must complete APD approved provider pre-service training. New providers must complete this required training prior to receiving their enrollment letter from the APD. Existing Agency operators must ensure that employees receive the required training within 90 days of hire.

The pre-service training will consist of the following topics:

1. The iBudget Florida waiver program: The iBudget Florida pre-service training will include brief introductions on subjects including; promoting choice, person centered approaches, incident reporting procedures, HIPAA, recognition of abuse, neglect and exploitation, domestic violence and sexual assault, and health and safety responsibilities
2. CPR/ First Aid (CPR must be taught via classroom setting by a trainer certified by either the American Heart Association or the Red Cross. Online CPR training is not acceptable training to meet this requirement)
3. iBudget Florida Coverage and Limitations Handbook
4. HIV/AIDS and infection control
5. Zero Tolerance (must be received by all agency employees prior to providing direct service and shall be completed at least once three years)
6. Medication Administration: Chapter 65G-7, Florida Administrative Code

It is the responsibility of the provider to ensure that training which carries an expiration date (CPR/First Aid, HIV/ AIDS, Infection Control and HIPAA) is received prior to the expiration date to avoid any lapse in certification.

Providers who are licensed are exempt from training requirements that are covered by their licensing entity.

The provider shall maintain on file for review, adequate and complete documentation to verify its participation, and the participation of its employees, for all required training sessions and certifications.

Providers of consumer medical supplies, durable medical equipment, environmental accessibility adaptations, personal emergency response and dental providers are exempt from the pre-service training requirements.

Refer to Training Matrix for specific training requirements and documentation requirements for each type of service provider. Provider Polices/Procedures and Practices.

Waiver Provider Enrollment, continued

Protection of an Individual's Funds and Benefits

Only supported living and residential services providers shall assist with managing an individual's personal funds and only under limited situations when the individual needs assistance with money management and natural supports are not available to assist. In these limited situations, the provider agrees to assist the individual to maintain a separate checking account or savings account for all personal funds.

If a single trust account is maintained for individuals residing in licensed residential settings, there must be a separate accounting for each individual's funds. There must be a monthly reconciliation to the account's total as noted on the bank statement and shall be retained by the individual, provider for review by APD or Agency for Health Care Administration. The provider further understands and agrees that at no time should any individual's personal funds be co-mingled with any other funds, including those of the provider or any of its employees.

The provider shall maintain on file a written consent to manage personal funds, signed by the individual or his legal guardian. The provider shall maintain on file receipts for individual purchases of $25.00 or more.

Neither the provider, its employees, nor any family members of the employee/provider, may receive any financial benefit as a result of being named the beneficiary of a life insurance policy covering an individual served by the provider nor receive any financial benefit through the will of the individual at the time of his or her death.

Neither the provider, its employees, or family members of the employee/provider may benefit financially by borrowing or otherwise using the personal funds of an individual served by the provider.

Providers who manage any aspect of the individual's personal funds shall regularly review bank statements and bank balances to ensure Medicaid eligibility is maintained and shall immediately notify the waiver support coordinator and APD when they become aware of an issue which could jeopardize the individual's Medicaid eligibility.

Neither the provider, its employees, or family members of the provider shall serve as landlord for individuals served by the provider, nor shall they benefit from the sale of property to an individual for whom they provide services.

Neither the provider, its employees nor family members of the provider will be named representative payee for Social Security benefit checks with the exception of provider who operate licensed residential facilities.

Waiver Provider Enrollment, continued

Marketing Practices

When the provider markets its services, it shall do so in a professional and ethical manner.

A. Neither the provider nor employees of the provider shall possess or use for the purpose of solicitation lists or other information from any source that identifies individuals receiving services from APD.

B. Neither the provider nor employees of the provider shall solicit individuals directly or through an agent, through the use of fraud, intimidation, undue influence, or any form of overreaching or vexatious conduct, including offering discounts or special offers that include prizes, free services, rebate of iBudget Florida funds or other incentives.

C. Neither the provider nor employees of the provider shall unduly influence an individual to request a support or service, select a support or service vendor or participate in an activity, regardless of whether or not the individual request, selection or participation results in any benefit to the provider

CHAPTER 4
iBudget Waiver Services Coverage and Limitations

Overview

Introduction

This chapter describes the services covered under the iBudget Florida system. It also describes the requirements for service provision, service limitations and exclusions. Please refer to the Appendices for all Documentation and Training Requirements.

Service Families

Services and/or their subservices components are organized into service families. This is to help individuals select the service(s) that best meets their needs among similar services. In this chapter we describe the service families and the services/subservices included in them as indicated in the chart below:

Group	Service Family	Services and Subservices
1	**Life Skills Development**	Life Skills Development Level 1, Level 2, and Level 3
		Person Centered Planning
		Family & Guardian Representative Training
2	**Supplies and Equipment**	Consumable Medical Supplies
		Durable Medical Equipment and Supplies
		Environmental Accessibility Adaptations
		Personal Emergency Response Systems (Unit and Services)
3	**Personal Supports**	Personal Supports
		Respite
4	**Residential Services**	Residential Habilitation (Standard)
		Residential Habilitation (Behavior Focused)
		Residential Habilitation (Intensive Behavior)
		Specialized Medical Home Care
		Supported Living Coaching
5	**Support Coordination**	Support Coordination--Limited
		Support Coordination—Full
		Support Coordination--Enhanced
6	**Wellness and Therapeutic Supports**	Behavioral Analysis Services
		Behavioral Assistant Services
		Dietician Services
		Private Duty Nursing
		Residential Nursing
		Skilled Nursing

		Occupational Therapy
		Physical Therapy
		Respiratory Therapy
		Speech Therapy
		Specialized Mental Health Counseling
7	**Transportation**	Transportation
8	**Dental Services**	Adult Dental Services

Introduction, continued

In most cases, an individual may choose to have more than one service from a service family on their cost plan during a given period of time (such as the Life Skills Development service family, where an individual may use Life Skills Development Level III (ADT) services on some days and Life Skills Development Level II (supported employment) on others. An individual may choose to receive only one service from the Residential Services service family during a given period of time unless the individual is transitioning to supported living.

SERVICE FAMILY 1 – LIFE SKILLS DEVELOPMENT

- **Level 1 (Companion)**
- **Level 2 (Supported Employment)**
- **Level 3 (Adult Day Training)**
- **Person Centered Planning**
- **Family and Legal Representative Training**

Life Skills Development – Level I (Companion)

Description

Life Skills Development—Level I (Companion) services consist of non-medical care, supervision and socialization activities provided to adults (21 or older). This service must be provided in direct relation to the achievement of the individual's goals per the individual's support plan. The service provides access to community-based activities that cannot be provided by natural or other unpaid supports, and should be defined as activities most likely to result in increased ability to access community resources without paid support. Life Skills Development—Level I (Companion) services may be scheduled on a regular, long-term basis.

Life Skills Development—Level I (Companion) services are not merely diversional in nature, but are related to a specific outcome or goal(s) of the individual. Activities may be volunteer activities performed by the individual as a pre-work activity or activities that connect an individual to his community.

Life Skills Development – Level I (Companion), continued

Provider Qualifications

Providers of Life Skills Development – Level 1 (Companion) may be home health or hospice agencies, licensed in accordance with Chapter 400, parts III or IV, F.S. Providers may also be solo providers who are not required to be licensed, certified, or registered.

Providers and employees of agencies shall be at least 18 years of age, have a high school diploma or its equivalent, and have at least one year of hands on experience working in a medical, psychiatric, nursing or childcare setting or working with individuals who have a developmental disability.

An agency using more than one employee to provide services and billing for their services, shall be registered as a companion provider in accordance with section 400.509, F.S.

Limitations of duration, frequency, intensity and scope:

Level I (Companion) services are limited to the amount, frequency, duration, and intensity of the services described on the individual's support plan and current approved cost plan. The Life Skills Development—Level I (Companion) rate shall be based on a maximum of three individuals. Level I services are limited to adults only (age 21 or older).

This service cannot be provided at the same time with Life Skills Development—Level II (Supported Employment), Life Skills Development—Level III (Adult Day Training), personal supports services or residential habilitation services. An individual shall receive no more than six (6) hours or 24 quarter hour units of these services per day. A unit is defined as a 15 minute time period or a portion thereof.

Place of Service

Life Skills Development—Level I (Companion) services may be provided in the individual's own home or family home, or while an individual who lives in his own home, family home or licensed facility is engaged in a community activity. Life Skills Development—Level I (Companion) services provided to an individual living in a licensed group or foster home must be performed in the community, not the licensed living environment. This service may not be provided or received in the provider's home.

Special Considerations

Life Skills Development — Level I (Companion) service providers are not reimbursed separately for transportation and travel costs. These costs are integral components of Life Skills Development—Level I (Companion) services and are included in the rate.

If the provider plans to transport the individual in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

Life Skills Development – Level II (Supported Employment)

Description

Life Skills Development—Level II (Supported Employment) services provide training and assistance to support individuals in sustaining paid employment at or above minimum wage unless the individual is operating a small business. This service may be performed on a full-time or part-time basis and at a level of benefits paid by the employer for the same or similar work that is performed by trained non-disabled individuals. The provider assists with the acquisition, retention or improvement of skills related to accessing and maintaining such employment or developing and operating a small business. With the assistance of the provider, the individual is assisted in securing employment according to his desired goals or outcomes. This service is conducted in a variety of settings, to include work sites in which individuals, without disabilities, are employed.

Life Skills Development Level II (Supported Employment) providers will focus on the individual's needs as well as provide consultation to the employer on ways to supports the individual in order to sustain paid employment.

There are three models of Life Skills Development Level II (Supported Employment): Individual, Group and Supported Self- Employment:

1) **Individual Model** – The individual model is an approach to obtaining and maintaining competitive employment through the support of a job coach on a one on one basis. This can include intensive training when obtaining or starting a new job and systematic follow-along supports for maintaining a job. The individual model can apply to either employment in the general work force or in development and operation of establishing a business to be operated by the individual. There are two phases under this model:

Phase 1 is defined as time-limited supports needed to obtain a job and reach stabilization. Billable support activities include:

(a) A Situational assessment to determine a person's employment goals, preferences and skills;
(b) Job development for a specific recipient, matching the person with a job that fits personal expectations; and
(c) Intensive, systematic on-the-job training and consultation focused on building skills needed to meet employer productivity requirements, learning behaviors and acceptance in the social environment of the job setting, building job related supports with the employer from those naturally occurring at that work site and other job related supports.

Life Skills Development – Level II (Supported Employment), continued

Description, continued

The number of hours of interventions is intended to diminish over the first few weeks of employment as the supported employee becomes more productive and less dependent on paid supports. Phase 1 ends after demonstration that the supported employee has established job stability. The stabilization period begins when the person has achieved satisfactory job performance as judged by the employer, provider, Vocational Rehabilitation counselor (if applicable) and the supported employee or when the need for paid supports diminishes to fewer than 20 percent of weekly hours of employment. The stabilization period is a minimum of 90 days following the onset of stabilization. If the supported employee continues to perform the job satisfactorily the services move into extended, ongoing support services (phase 2).

Staff is expected to provide varying intensities of services to each supported employee, beginning with high intensity and fading to achieve stabilization. Given the nature of the is wide variation in level of support intensity and duration needed per person, usual and typical staff to service recipient ratios demonstrate that one staff person can support up to two to three supported employees who are in Phase 1 at any given point in time. Phase 1 services typically average 6-8 hours a day per recipient during the first week of services. Average hours of service should fade to 1-2 hours a week in preparation for transition to Phase 2. The average time period for Phase 1 is 24 to 25 weeks, but is different for each recipient depending upon need.

Phase 2 is defined as long-term, ongoing supports needed to maintain employment indefinitely. These billable support activities include:

(a) Ongoing, systematic contacts with supported employees to determine the need, intensity and frequency of supports needed to maintain productivity, social inclusion and maintain employment;
(b) Remedial on-the-job training to meet productivity expectations, consultation and refinement of natural supports or other elements important to maintaining employment, and
(c) Related work supports such as accessing transportation and other supports necessary for the recipient to maintain a job, or consultation to family members or other members of a recipient's support network including employers and co-workers.

Life Skills Development – Level II (Supported Employment), continued

Description, continued

Phase 2 supports assume periodic life changes and personal tensions that will cause job instability. Supports and services are designed to be dynamic and to change in intensity and duration consistent with the needs of each supported employee during periods of job instability and possibly during job loss and re-employment activities. When supports needed to maintain employment for a given person become too great in intensity or duration, it may be necessary to move back to Phase 1 services to access a better job match or seek employment alternatives. Moving to Phase 1 supports must include a referral to Vocational Rehabilitation or the local school system (as applicable) to seek required funding. Medicaid waiver funding shall be used only if these alternative resources are not available.

During Phase 2 the service levels needed per supported employee vary according to individual needs but typically average 1-2 hours a week per recipient. Usual and typical demonstration of Phase 2 services asset an expectation of a staff to service recipient ratio of one staff person supporting up to twenty supported employees.

2) **Group Models are defined as the following:**

a) Enclave - A group approach to employment where up to eight individuals with disabilities work either as a group or dispersed individually throughout an integrated work setting with supervision by the provider.

b) Mobile Crew - A group approach to employment where a crew, such as lawn maintenance or janitorial, of up to eight individuals with disabilities are in the community in businesses or other community settings with supervision by the provider.

c) Entrepreneurial - A group approach to employment where up to eight individuals with disabilities work in a small business created specifically by or for the individuals.

Life Skills Development – Level II (Supported Employment), continued

Description, continued

3) **Supported Self- Employment Model**

Supported self- employment is defined as working for oneself with direct control over work and services undertaken and can include microenterprise arrangements. This includes proprietorships, partnerships and corporations. Those individuals that select supported self-employment must contribute to the development of a business service product or perform a core function of the business.

Any individual expressing an interest in supported self-employment will be referred by their waiver support coordinator to the Division of Vocational Rehabilitation (DVR). The Waiver Support Coordinator will be responsible for providing the information required to DVR to determine eligibility and vocational goals. Any individual determined eligible by DVR will generally be provided funding and supports.

Prior to using an individual's budget allocation to fund waiver services for Life Skills Development—Level II (Supported Employment), a person seeking employment supports must first enroll with Vocational Rehabilitation and if the individual is under the age of 22, they must exhaust available resources through the public school system. The waiver will only pay for job development and stabilization in those limited circumstances when DVR documents service denial to the individual.

Life Skills Development – Level II providers will immediately notify the individuals' waiver support coordinator of any changes affecting the individuals' income. The supported employment provider will work with the individual and the respective waiver support coordinator to maintain eligibility under the iBudget Florida waiver as well as health and income benefits through the Social Security Administration and other resources.

Additionally the provider will provide the Agency for Persons with Disabilities with information regarding the persons' job, benefits and pay as requested.

Limits on the Amount, Frequency, Duration and Scope

Overview

Life Skills Development Level II (Supported Employment) services are limited to 8 hours or 32 quarter units per recipient per day.

Transportation of individuals to and from their job is not a component of supported employment services but may be funded under transportation services when no other community, natural, or generic support is available. Separate payment for transportation services furnished by the supported employment provider will not be made when rendered as a component of this service.

Note: Refer to the transportation section description in this handbook for additional information.

Provider Qualifications

Providers of Life Skills Development—Level II (Supported Employment) services may be either solo providers or agency providers who are enrolled to provide supported employment.

Employees rendering Life Skills Development—Level II (Supported Employment) services shall have a bachelor's degree from an accredited college or university with a major in education; or rehabilitative science or business or related degree. In lieu of a bachelor's degree, a person rendering this service shall have an associate's degree from an accredited college or university and two years of hands on experience with individuals with developmental disabilities.

Place of Service

Life Skills Development—Level II (Supported Employment) services are provided in the individual's place of employment in the community or in a setting mutually agreed to by the supported employee, the provider and the employer.

Should the employment location of an individual change, the provider shall notify the individual's Waiver Support Coordinator within five working days.

Limits on the Amount, Frequency, Duration and Scope, continued

Special Considerations

Life Skills Development—Level II (Supported Employment) services furnished under the waiver are not available through programs funded by the Rehabilitation Act of 1973 or Public Law 94-142. Documentation to this effect shall be maintained in the file of each individual receiving this service.

Providers of Life Skills Development—Level II (Supported Employment) – group model services will bill for each individual based on the published stepped rate for the service. The group rate shall be determined based on from two to eight individuals receiving the service.

Providers of Life Skills Development—Level II (Supported Employment) – individual model services will bill, based on a one to one ratio, the rate established for the service in the published Medicaid rate system.

Payment will not be made for incentives, subsidies, or unrelated vocational training. The supported employment vendor will not bill for supports provided by the employer.

Supported self- employment services may be provided to individuals who own their own businesses and need supports and on-going assistance in the day- to-day running of the business.

Life Skills Development – Level III Adult Day Training (ADT)

Description

Life Skills Development Level III (ADT) for adults are training services intended to support the participation of individuals in valued routines of the community including volunteering, job exploration, accessing community resources and self- advocacy in work-like settings that are age and culturally appropriate.

The service expectation is to achieve individually determined goals and support participation in less restrictive settings. The training activities and routine established by the adult day training program shall be meaningful to the individual and provide a developmentally appropriate level of variation and interest. Activities should focus on employability factors including opportunities for job exploration, volunteer work, job development and other employment options. This training shall be provided in accordance with a formal implementation plan, developed under the direction of the individual, reflecting goal(s) from the individual's current support plan.

Whenever possible, services should be offered in community integrated settings but may be offered at the Life Skills Development Level III (ADT) center. Documentation of services rendered is not considered a billable activity. Life Skills Development Level III (ADT) services may be provided as an adjunct to other services included in the life skills development family on an individual's support and cost plan. For example: an individual may receive other life skills development services for part of a day or week and Level III (ADT) services at a different time of the day or week. Life Skills Development Level III (ADT) services will only be billable for the prorated share of the day or week that the individual actually attends that service.

Mobile crews, enclaves and entrepreneurial models that do not meet the standards for supported employment and that are provided in groups of four or more individuals are included as Life Skills Development Level III (ADT) off site services.

Any individual receiving the Life Skills Development Level III (ADT) who are performing productive work either onsite or offsite, must be financially compensated commensurate with members of the general work force doing similar work per wage and hour regulations of the U.S. Department of Labor.

Life Skills Development Level III (ADT) off site models include services that teach specific job skills and other services directed at meeting specific employment objectives.

1. Enclave - A group approach to training where no more than 10 individuals with disabilities work either as a group or are dispersed individually throughout an integrated work setting with supervision by the provider.

2. Mobile Crew - A group approach to training where a crew (lawn maintenance, janitorial) of individuals with disabilities is in a variety of community businesses or other community settings with supervision by the provider.

Life Skills Development – Level III Adult Day Training (ADT), continued

Description, continued

3. Entrepreneurial - A group approach to training with experienced professionals in assisting the individual with disabilities to set up and work in a small business created especially by or for the individuals. Such models include self- employment and micro- enterprise. Any profits earned from this model must be used to pay the individuals per Federal Guidelines and/ or reinvested into the business.

At least annually, providers will conduct an orientation informing recipients of supported employment and other competitive employment opportunities in the community.

Limits on Duration, Frequency, Intensity and Scope

The individual may choose to attend a Life Skills Development Level III (ADT) program in the frequency that is desired within the Budget allocation and as approved on the service authorization. The stepped rate published for Life Skills Development Level III (ADT) is based on one extra hour of staff time to accommodate the variance in individual schedules for attendance. The provider shall render services at a time mutually agreed to by the individual and the provider. This will allow an individual the flexibility to determine when to attend the Life Skills Development Level III (ADT) program for limited hours or only on certain days. Billing may be by the quarter hour for the number of quarter hours attended each day by the individual, or by the day, up to six hours

This service generally begins at the age of 22 when an individual is out of the public school system or when he has graduated from the public school system, receiving a standard diploma. Individuals wanting to attend ADT prior to the age of 22 without a standard diploma must seek funding through alternative sources outside of the waiver.

Life Skills Development Level III (ADT) services are limited to the amount, duration, frequency and intensity of the service described on the individual's support plan and current approved cost plan within the flexibility of the iBudget. The only services that may be provided concurrently with Life Skills Development Level III (ADT) are Behavior Analysis, Physical Therapy, Occupational Therapy, or Speech Therapy at the request or convenient time of the individual. Behavior assistance services may be provided as a discrete service in the Life Skills Development Level III (ADT) facility if it does not duplicate services provided by the Life Skills Development Level III (ADT) facility and only as described in a behavior plan.

Life Skills Development – Level III Adult Day Training (ADT), continued

Provider Qualifications

Providers of Life Skills Development—Level III (ADT) services shall be designated by the APD Area Office as Life Skills Development—Level III (ADT). Unless waived in writing by the Area Office, the provider shall meet the following minimum qualifications for staff and staffing ratio:

- The manager or director will not have full-time responsibility for providing direct services.
- The program director will possess at a minimum a bachelor's degree from an accredited college or university and two years related experience.
- Instructors (supervisors) will possess at least an associate's degree and two years hands on experience in a related field.
- Related experience will substitute on a year-for-year basis for the required college education.
- Direct service staff will work under appropriate supervision.
- The staffing ratio will not exceed 10 individuals per direct service staff for adult day training facility-based programs. Administrative staff and those not providing direct service to the individual are not considered direct service staff.

Direct service staff must be at least 18 years of age and possess at least a high school diploma or equivalent. When determining the equivalency of high school degrees, providers may accept official transcripts, affidavits from educational institutions, and other formal or legal documents that can be reasonably used to determine educational background. This applies to any employees hired after the effective date of this handbook

Diplomas or Degrees earned in other countries shall be accompanied by authentication documentation that the degree is equivalent to the educational requirements for the position.

Place of Service

Life Skills Development Level III (ADT) services shall be provided in the community whenever possible. Life Skills Development Level III (ADT) services may also be provided in a designated Life Skills Development Level III (ADT) center.

Life Skills Development – Level III Adult Day Training (ADT), continued

Special Considerations

Life Skills Development Level III (ADT) providers are paid separately for transportation services only when they are enrolled as a transportation provider and transportation is provided between an individual's place of residence and the training site. Transportation between Life Skills Development Level III (ADT) sites, if the activities provided are a part of Life Skills Development Level III (ADT) services, will be included as a component of the Life Skills Development Level III (ADT) services and included in the rate paid to the provider of the Life Skills Development Level III (ADT) service. Life Skills Development Level III (ADT) staff responsible for transporting individuals must meet the minimum requirements of a transportation provider.

Life Skills Development Level III (ADT) staff is responsible for assisting individuals into and out of facilities when they have been transported in vehicles not owned or operated by the Life Skills Development Level III (ADT) center. Drivers of such vehicles are responsible for ensuring the individual's safe entry into and exit from the vehicle.

Life Skills Development Level III (ADT) services and Life Skills Development Level III (ADT) off-site services will be billed based on the stepped rate for the services that are at the one (1) staff to ten (10) individual ratio rate level.

Life Skills Development Level III (ADT) services shall be billed at the standard rate level for the service. The standard rate is paid when an individual requires minimal assistance, through instructional prompts, cues, and supervision to properly complete the basic personal care areas of eating, bathing, toileting, grooming and personal hygiene.

For the purposes of staffing ratios for ADT the following will apply:

Indicators of a one (1) staff to five (5) individual staffing rate ratio levels include:

A moderate level of support is provided when an individual routinely requires prompts, supervision and physical assistance, to include lifting and transferring, to complete the basic personal care areas of eating, bathing, toileting, grooming, and personal hygiene as identified in the current abilities section of the APD approved assessment.

Life Skills Development – Level III Adult Day Training (ADT), continued

Special Considerations, continued

An individual who is on a behavioral services plan that is implemented by the adult day training provider, and who requires visual supervision during all waking hours and occasional intervention as determined by a Certified Behavioral Analyst. The individual does not have to live in a licensed residential facility.

Indicators of a one (1) staff to three (3) individual staffing rate ratio levels include:

An intense level of support identified is provided when an individual needing assistance with lifting and transferring requires total physical assistance in at least three of the basic personal support areas identified above due to physical, medical or adaptive limitations as identified in the current abilities section of the APD approved assessment.

An individual who is on a behavioral services plan that is implemented by the Life Skills Development Level III (ADT) provider and who exhibits the characteristics required for behavioral focus residential habilitation services as determined by a Certified Behavioral Analyst. The individual does not have to live in a licensed residential facility. The behavioral services plan and its effects on the behavior must be reviewed by the Local Review Committee (LRC) on a regular schedule as determined appropriate by the LRC.

Indicators of a one (1) staff to one (1) individual staffing rate ratio level include:

An individual who is on a behavioral services plan that is implemented by the adult day training provider, and that exhibits the characteristics required for behavioral focus residential habilitation or intensive behavioral residential habilitation services as determined by a Certified Behavior Analyst. The need for this level of supervision must be verified in writing by the APD Area Office Review Committee Chair. The individual does not have to live in a licensed residential facility. The behavioral services plan and its effects on the behavior must be reviewed by the Local Review Committee (LRC) on a regular schedule as determined appropriate by the LRC.

The ADT provider must maintain documentation of the LRC review schedule, the LRC review dates and recommendations made, and the changes made related to these recommendations.

Support provided to groups of 9-10 must be billed as adult day training-off site regardless of the individual's wage. If the support is provided in groups of eight (8) or less and the individuals are paid less than minimum wage, the service shall be billed as adult day training-off site.

Payment shall not be made for any time period the individual is absent from the service.

Providers shall combine each day's service in a month and bill at the end of the month, using the last day of the month as the date of service.

Life Skills Development – Level III Adult Day Training (ADT), continued

Special Considerations, continued	If services terminate before the end of the month, providers shall combine each day's service for the service period and bill at the end of the service period, using the last day of the service period as the date of service.

Person Centered Planning (PCP)

Overview	Person-Centered Planning assists the individual with developing an in-depth, individualized person-centered plan that is unique to that individual. The resulting person-centered plan focuses on the individual's needs, personal preferences, abilities, relationships, and short- and long-term personal life goals. It involves a creative process that includes the individual and those chosen by the individual in planning to meet needs and personal life goals using supports and services from a variety of natural supports, community resources, local, state, and government resources. In developing the plan, the provider spends time getting to know the person and draws upon the life experiences and history of the person including their familial history, social relationships, school and programmatic history. The plan should provide a roadmap to the individual for meeting his or her goals within the limits of the individual's budget allocation, augmented by natural and community supports.
Provider Qualifications	A bachelor's degree in special education, social work, mental health, counseling, or a related health and rehabilitative field and three year's experience if an independent vendor working hands on with individuals with developmental disabilities. Two years experience is required if employed by an agency. Certified providers must have successfully completed Person Centered Planning training offered by the Agency and must develop a person centered plan which should be submitted to the area person centered planning training coordinator for review and approval.

Person Centered Planning (PCP), continued

Limits on Duration, Frequency, Intensity and Scope	The provider cannot be a waiver support coordination provider certified in the State of Florida. Person Centered Planning is limited to the amount, duration, and scope of the service described on the individual's support plan and current approved cost plan to foster health, safety, and welfare of the individual. PCP is provided on a one-on-one basis. If services are provided with two or more individuals present, the amount of time billed must be prorated based on the number of recipients receiving the service. The individual may be provided a maximum of one plan per year with quarterly updates. This service is to complement and enhance the person-centered planning responsibilities of the individual's support coordinator and does not replace those support planning activities required of a support coordinator.
Family and Guardian Representative Training Service	Family and Guardian Representative Training Services provide the information and tools necessary for the individual's family to coordinate service delivery and access supports and services from sources such as the local communities, federal and state government, Medicaid state plan, school services, and waiver services. The purpose of this training is to assist the individual and family to self-direct the individual's services to the greatest extent possible and reduce reliance on the support coordinator to perform all functions of support coordination. It also includes training on the individual budgeting process and how the individual and family will manage and monitor the services provided under this waiver to ensure cost effectiveness and efficient and effective service delivery to meet the goals and needs identified in the individual's support plan and cost plan.
Provider Qualifications	Providers must have a bachelor's degree in special education, social work, mental health, counseling, or a related health and rehabilitative field and three years if an independent vendor and two year's experience if employed by an agency. Providers must have successfully completed training as offered by the Agency and must pass a test of the iBudget system prior to delivering any training services.
Limits on the Amount, Frequency and Duration	Individuals may receive up to eighty (80) hours annually of Family and Guardian Representative Training services. Will be provided on a one-to-one basis and is billed at a quarter hour unit.

Person Centered Planning (PCP), continued

Special Considerations	A Family and Guardian Representative Training provider may assist individuals in learning how to access the online iBudget Florida system if the provider does not provide other paid waiver services.
Place of Service	Family and Guardian Representative Training may be provided in any location.

SERVICE FAMILY 2 – SUPPLIES AND EQUIPMENT

- **Consumable Medical Supplies**
- **Durable medical Equipment and Supplies**
- **Environmental Accessibility Adaptations**
- **Personal Emergency Response Systems**

Consumable Medical Supplies

Description

Consumable medical supplies are non-durable supplies and items that enable individuals to perform activities of daily living. Consumable medical supplies are of limited usage and must be replaced on a frequent basis. Supplies covered under the iBudget Florida program must meet all of the following conditions:

a) be related to an individual's specific medical condition/developmental disability
b) not be provided by any other program;
c) be the most cost-beneficial means of meeting the individual's need; and
d) not primarily for the convenience of the individual, caregiver, or family.

All items shall meet applicable standards of manufacturer, design and installation.

This service also includes devices, controls or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment for the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items, which are not of direct medical or remedial benefit to the individual."

Consumable Medical Supplies,, continued

Provider Qualifications	Providers of consumable medical supplies include home health or hospice agencies, pharmacies, medical supply companies, durable medical equipment suppliers and vendors such as discount stores and department stores. Independent vendors may also provide these services Home health agencies and durable medical equipment companies must provide a bond, letter of credit or other collateral at the time of application, unless the agency has been a Medicaid enrolled provider for at least one year prior to the date it applies to become a waiver provider and has had no sanctions imposed by Medicaid or any regulatory body. Home health and hospices shall be licensed in accordance with Chapter 400, parts III and IV F.S. Pharmacies shall hold a permit to operate, issued in accordance with Chapter 465, F.S. Medical supply companies and durable medical equipment suppliers shall hold local occupational licenses or permits, in accordance with Chapter 205, F.S., and shall be currently licensed in accordance with Chapter 400, part VII, F.S. Assistive technology suppliers and practitioners shall be certified through the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). Retail stores shall hold local occupational licenses or permits, in accordance with Chapter 205, F.S. If a county does not require a permit or license, evidence must be provided and FEID number made available.
Limits on the Duration, Frequency, Intensity and Scope	Consumable medical supplies cannot duplicate supplies provided by other sources. Refer to the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for additional information on Medicaid state plan coverage.

Consumable Medical Supplies,, continued

Limits on the Duration, Frequency, Intensity and Scope, continued

If multiple vendors are enrolled to provide this service, the individual shall be encouraged to select from among the eligible vendors based on an item's availability, quality and best price. No more than ten (10) items per day may be purchased. Some items have additional limitations.

1. Diapers, including pull-ups and disposable briefs, for individuals 21 or over
2. Wipes, for individuals 21 or over, if the individual requires incontinent supplies.
3. Disposable gloves, when an individual requires personal care that exposes the caregiver to body fluids. Latex-free gloves will be authorized when the individual's or the caregiver's physician certifies that the individual or caregiver has a latex allergy or that there is a probable expectation that the individual or caregiver may have a latex allergy (i.e., individuals with spina bifida). Disposable gloves are only available for purchase through the waiver when Medicaid DME and Medical Supplies Program state plan services allowable units are exhausted and additional gloves are determined to be medically necessary.
4. Surgical masks, when prescribed by a physician and are:
    a. Worn by an individual with a compromised immune system as a protection from infectious disease; or
    b. Worn by a caregiver who must provide a treatment that requires strict, sterile procedure in which they are trained to provide care to an individual who has a compromised immune system and who must be protected at all cost from exposure to any airborne organisms or substances.
    c. The physician must renew the prescription quarterly.
5. Disposable or washable bed or chair pads and adult sized bibs.
6. Ensure or other food supplements, not covered by the Medicaid DME and Medical Supplies Program state plan services, when determined necessary by a licensed dietitian. Individuals that require nutritional supplements must have a dietitian's assessment documenting such need. The assessment shall include documentation of weight fluctuation.
7. Feeding tubes and supplies not covered by Medicaid State Plan and prescribed by a physician. This excludes supplies for an individual who qualifies for food supplements under the Florida Medicaid Durable Medical Equipment and Medical Supplies Program or the Medicare Program.
8. Dressings not covered by the Medicaid DME and Medical Supplies Program state plan services that are required for a caregiver to change wet to dry dressing over surgical wounds or pressure ulcers, and prescribed by a physician.
9. Hearing aid batteries, cords and routine maintenance and cleaning prescribed by an audiologist.
10. Bowel management supplies purchased under the waiver are limited to $150.00 every 3 months. These supplies include laxatives, suppositories and enemas determined necessary for bowel management by the individual's physician.

Consumable Medical Supplies,, continued

Limits on the Duration, Frequency, Intensity and Scope, continued

Items not contained on this list that meet the definition of consumable medical supplies may be approved through exception by APD. To request an exception, a physician must prescribe the item. The statement from the physician must delineate how the item is medically necessary, how it is directly related to the individual's developmental disability, and without which the individual cannot continue to reside in the community or in his current placement. Items specifically excluded in this handbook will not be approved through exception.

The request will be reviewed by the APD to determine compliance with the standards for medical necessity set forth in 59G-1.010(166), F.A.C., and to determine whether the requested item fairly meets the service definition. Consumable medical supplies must be directly and specifically related to the individual's disability. Items of general use such as: toothbrushes, toothpaste, toothpicks, floss, deodorant, feminine hygiene supplies, bath soap, lotions, razors, shaving cream, mouthwash, shampoo, cream rinse, tissues, aspirin, Tylenol, Benadryl, nasal spray, creams, ointments, vapor rub, powder, over-the-counter antihistamines, decongestants and cough syrups, clothing, etc., are not covered. Supplies for investigational or experimental use are not covered.

A prescription submitted for supplies, diets, over-the-counter medications, vitamins, herbs, etc., which has general utility or is generally available to the general population without a prescription, does not change the character of the item for purposes of coverage in this category. For example, a physical therapist, occupational therapist or physician recommending or prescribing items like Tylenol, Ginkgo Biloba, vitamins, gluten-free foods, cotton balls or Q-tips, does not convert that item from general utility items to consumable medical supplies covered under the DD waiver. Items covered in this category generally include only those items that are specifically designed for a medical purpose, and are not used by the general public or other general utility uses. It is the general character and not specific use of the item that governs for purposes of coverage under this category.

Consumable medical supplies are approved for a year at a time. The waiver does not allow for payment or reimbursement of copayments for consumable medical supplies covered by third party insurance.

The waiver does not allow for payment or reimbursement of copayments for consumable medical supplies covered by a private/third party insurance.

Note: The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The handbook is incorporated by reference in 59G-4.070. F.A.C.

Consumable Medical Supplies,, continued

Special Considerations	Educational supplies are not consumable medical supplies and are not covered by the waiver. These supplies are expected to be furnished by the local school system or the individual/parent. Individuals or their family members shall not be reimbursed for consumable medical supplies they purchase. Supplies available under the Medicaid State Plan may not be purchased using waiver funds. Further, waiver funds cannot be used to purchase additional quantities of consumable supplies that are above the Medicaid State Plan limitation amount.

Durable Medical Equipment and Supplies

Description	Durable medical equipment includes specified, prescriptive equipment required by the individual. Durable medical equipment generally meets all of the following requirements: a) can withstand repeated use; b) is primarily and customarily used to serve a medical purpose; c) is generally not useful to an individual in the absence of a disability; and d) is appropriate for use in the home.

Durable Medical Equipment and Supplies, continued

Provider Qualifications

Providers of durable medical equipment (DME) include home health or hospice agencies, pharmacies, medical supply companies, durable medical equipment suppliers and vendors such as discount stores and department stores. In accordance with 59G-4.070, F.A.C., to enroll as a Medicaid provider, a DME and medical supply entity must comply with all the enrollment requirements outlined in the Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

In accordance with 42 C.F.R. 440.70, parts providers must be in compliance with all applicable laws relating to qualifications or licensure. In accordance with Chapter 205, F.S., independent vendors, Assistive Technology Suppliers and Assistive Technology Practitioners certified by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) may also provide these services.

In accordance with section 409.907, F.S., home health agencies and durable medical equipment companies must provide a bond, letter of credit or other collateral at the time of application, unless the agency has been a Medicaid-enrolled provider for at least one year prior to the date it applies to become a waiver provider and has had no sanctions imposed by Medicaid, or any other regulatory body.

Home health and hospice agencies shall be licensed in accordance with Chapter 400, parts III or IV, F.S.

Pharmacies shall hold a permit to operate issued in accordance with Chapter 465, F.S. Medical supply companies and durable medical equipment suppliers shall hold local occupational licenses or permits, in accordance with Chapter 205, F.S., and be currently licensed in accordance with Chapter 400, part VII, F.S.

Retail stores shall hold local occupational licenses or permits, in accordance with Chapter 205, F.S.

Durable Medical Equipment and Supplies, continued

Limits on the Duration, Frequency, Intensity and Scope

All equipment shall have direct medical or remedial benefit to the individual, shall be related to the individual's developmental disability, and shall be necessary to prevent institutionalization. Assessment and recommendation of appropriateness by a licensed physician, physical therapist or occupational therapist is required.

Durable medical equipment and supplies cannot duplicate DME and supplies provided through the Medicaid Durable Medical Equipment (DME) and Medical Supplies Program state plan services or other sources. Equipment and supplies available under the Medicaid State Plan may not be purchased using waiver funds. Further, waiver funds cannot be used to purchase additional quantities of supplies that are above the Medicaid State Plan limitation amount.
Refer to the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for additional information on Medicaid state plan coverage.

1. Van adaptations, including lifts, tie downs, raised roof or doors in a family-owned or individually owned full-size van. The conversion of mini-vans is limited to the same modifications, but exclude the cost to modify the frame (e.g., lower the floor) to accommodate a lift. Van modifications must be necessary to ensure accessibility of the individual with mobility impairments and when the vehicle is the individual's primary mode of transportation. Only one set of modifications per vehicle is allowed, and only one modification will be approved in a five-year period. No adaptations will be approved for an additional vehicle if the Department has paid for adaptations to another vehicle during the preceding five-year period.

   The vehicle modified must also have a life expectancy of at least five years. This is to be documented with an inspection by an Automotive Service Excellence (ASE) certified mechanic. The lift approved cannot then exceed 2 ½ times the NADA (blue book) value for the make, model and mileage on the van. Purchase of a vehicle and any repairs or routine maintenance to the vehicle is the responsibility of the individual or family. Payments for repair to adaptations after the warranty expires may be approved by APD. Many automobile manufacturers offer a rebate of up to $1,000 to individuals purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the individual or family is required to submit documented expenditures of modifications to the manufacturer. If the rebate is available it must be applied to the cost of the modifications. If an individual or a family purchases a used vehicle with adaptive equipment already installed, the waiver may not be used to fund the vehicle purchase or any portion of the purchase related to the adaptive equipment already installed.

   A rehabilitation engineer or other certified professional may be reimbursed under home accessibility assessment to assess the appropriateness of any van conversion including identification of an appropriate lift system.

Durable Medical Equipment and Supplies, continued

Limits on the Duration, Frequency, Intensity and Scope, continued

2. Wheelchair carrier for the back of the car is limited to one carrier for a five-year period.
3. Wheelchairs, to the extent that they are medically necessary and not covered by the Medicaid DME and Medical Supplies Program state plan services. A physician must prescribe the specific item. Coverage in this category will typically only be provided when the following criteria are met:
    a. The individual has a customized power wheelchair funded through Medicare or Medicaid, which is used as his primary mode of ambulation; or the individual is ambulatory, but has a documented medical condition that prevents walking for sufficient lengths of time to go about his daily activities, for example cardiac insufficiency or emphysema. This condition must be documented by a physician and include a statement addressing how the individual is limited in normal daily activities by the condition;
    b. The individual needs a manual wheelchair to facilitate movement within his own home, and to enable the individual to be safely transported in an automobile. It must be documented that the vehicle does not have a lift or that the individual's primary chair, if applicable, cannot be collapsed to fit into a trunk or on a wheelchair carrier;
    c. The requested wheelchair is the most cost-beneficial device that meets the needs of the individual;
    d. The wheelchair covered by this service is a standard (manual) wheelchair and not intended for an individual who cannot use a standard chair for any length of time without adaptation.

If the individual usually uses a customized wheelchair but needs a standard wheelchair to transfer to an automobile that does not have a lift or for around the home to avoid the need for accessibility adaptations, an additional second (standard) wheelchair should be considered. Any adaptive wheelchair, including a customized power wheelchair, is covered through the Medicaid DME and Medical Supplies Program state plan services.

Payments for repair to wheelchairs after the warranty expires may be approved by APD (if not covered by Medicare or Medicaid). Only one manual wheelchair may be purchased in a five-year period. The waiver will not fund the purchase of both a manual wheelchair and a stroller in a five-year period. Excluded from coverage are wheelchairs requested to facilitate recreational activities such as beach wheelchairs, sports wheelchairs, or wheelchairs that are not the most cost-beneficial way to meet the needs of the individual. Waiver services are not used to cover any copayments, with the exception of patient responsibility for Medicare-funded wheelchairs.

Durable Medical Equipment and Supplies, continued

Limits on the Duration, Frequency, Intensity and Scope, continued

4. Strollers, subject to the same criteria and limitations for wheelchairs, as stated above, except reimbursement for a stroller will be limited to $1,200. Only one stroller or manual wheelchair can be purchased in any five-year period. As a cost-effective alternative the base unit for an adaptive car seat could be covered in lieu of a stand-alone stroller unit. Payments for repair to strollers after the warranty expires may be approved by APD, if not covered by Medicare or Medicaid DME and Medical Supplies Program state plan services. APD will respond to requests for repairs to strollers within 10 working days of receipt of such requests.
5. Portable ramps when the individual requires access to more than one non-accessible structure. . If more cost effective, a vertical lift or wheelchair lift can be purchased.
6. Patient lift, hydraulic or electric with seat or sling, when the individual requires the assistance of more than one person to transfer between a bed, a chair, wheelchair or commode are limited to adults and limited to one lift every eight years,. Cost not to exceed $2,000. Payments for repair to lifts after the warranty expires may be approved by APD, if not covered by Medicare or Medicaid DME and Medical Supplies Program state plan services.

Durable Medical Equipment and Supplies, continued

Limits on the Duration, Frequency, Intensity and Scope, continued

7. Patient lifts are available through DME and Medical Supplies Program state plan services. The DD waiver will fund ceiling lifts only when the lift systems available through the Medicaid DME and Medical Supplies Program will not meet the individual's need. A ceiling lift requires a home accessibility assessment by a rehabilitation engineer or appropriate professional to insure the structural integrity of the home to support the ceiling lift and track system. When this system is requested, it must be documented that it is the most cost-effective means of meeting the individual's need and that the specific item selected does not exceed the medically necessary needs of the individual. Medical necessity is usually limited to necessary access to an individual bedroom and bath. Only one system will be allowed for any individual. If after at least five years the individual moves, it will be determined if the most cost-efficient means to meet the individual's need is by moving the current system or purchasing a new system if still required by the individual. A new assessment and determination must be made. The cost may not exceed $10,000. Payments for repair to ceiling lifts after the warranty expires may be approved by APD, if not covered by Medicare or Medicaid DME and Medical Supplies Program state plan services.
8. Adaptive car seat, for individuals being transported in the family vehicle and who cannot use the standard restraint system or can no longer fit into a standard child's car seat. The seat must be prescribed by a physical therapist that will determine that the individual cannot use standard restraint devices or car seats. The physical therapist will identify appropriate equipment for the individual. Adaptive car seats are limited to one per individual every three years and cost no more than $1,000.
9. Bidet, limited to individuals who are able to transfer onto commodes independently, but whose physical disability limits or prevents thorough cleaning. This item requires a prescription by a physician and assessment by a physical or occupational therapist to determine that the individual can use the item independently. The bidet and installation must cost no more than $1,000.
10. Single room air conditioner, when there is a documented medical reason for the individual's need to maintain a constant external temperature. Conditions for which a single room air conditioner may be appropriate include congestive heart failure, severe cardiac disease, COPD (emphysema), or damage or disease of the hypothalamus. Only one single room air conditioner with a maximum of 250 square feet capacity will be approved per individual for a five-year period. The air conditioning unit must cost no more than $300.
11. Single room air purifier, when there is a documented medical reason for the equipment. The documentation necessary for this equipment would be a prescription from a pulmonologist along with a medical statement explaining the medical diagnosis, the reason why the equipment is necessary and the expected outcome of the treatment. Conditions for which a single room air purifier may be appropriate include severe asthma with documented sensitivity to indoor airborne particles, chronic obstructive pulmonary disease, emphysema or pulmonary dysplasia. The air purifier unit must cost no more than $250. Only one air purifier unit will be approved per individual for a five-year period.

Durable Medical Equipment and Supplies, continued

Limits on the Duration, Frequency, Intensity and Scope, continued

12. Adaptive switches and buttons to operate equipment, communication devices, environmental controls, such as heat, air conditioning, and lights, for an individual living alone or who is alone without a caregiver for a major portion of the day. Excluded are adaptive switches or buttons to control devices intended for entertainment, employment, or education.
13. Adaptive door openers and locks for individuals living alone or who are alone substantial portions of the day or night and have a need to be able to open, close or lock the door and cannot do so without special adaptation.
14. Environmental safety devices limited to door alarms, anti-scald device, and grab bars for the bathroom. . If the items are being installed as part of an Environmental Accessibility Adaptation, they may be billed under the procedure code for the adaptation rather than DME
15. Bath or shower chair when medically indicated and not covered through Medicaid DME and Medical Supplies Program state plan services. Coverage is limited to the most cost-beneficial item necessary to meet the individual's need for bathing. Items that exceed the basic needs of the individual are not covered.
16. Adaptive eating devices, including adaptive plates, bowls, cups, drinking glasses, and eating utensils, that are prescribed by a physical therapist, occupational therapist or Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certified provider. Adaptive bathing aids, to facilitate independence, as prescribed by a physical, occupational therapist, or RESNA certified provider.
17. Picture communication boards and pocket charts, selected and prescribed by a speech therapist.
18. Gait belts for safety during transfers and ambulation, and transfer boards.
19. Egg crate padding for a bed, when medically indicated and prescribed by a physician.
20. Hypoallergenic covers for mattress and pillows, ordered by a physician, who documents necessity based upon severe allergic reaction to airborne irritants.
21. Generators may be covered for an individual when:
    a. The individual is ventilator-dependent;
    b. The individual requires daily use of oxygen via a concentrator;
    c. The individual requires continuous, 24-hour total parenteral nutrition via an electric pump;
    d. The individual requires continuous, 24-hour infusion of total nutritional formula through a jejunostomy or gastrostomy tube via an electric pump;
    e. The individual requires continuous, 24-hour infusion of medication via an electric pump; or
    f. The individual meets the medical need for a single room air-conditioner.

Durable Medical Equipment and Supplies, continued

Limits on the Duration, Frequency, Intensity and Scope, continued

22. The size of the generator is limited to the wattage necessary to provide power to the essential life-sustaining equipment. When a generator is requested, it must be documented that the specific model identified is the most cost-beneficial that meets but does not exceed the individual's need. One generator per individual per household may be purchased per 10-year period. Payments for repair to generators after the warranty expires may be approved by APD, if no other funding is available.
23. Bolsters, pillows, or wedges, necessary for positioning that are prescribed by a physical or occupational therapist.
24. Therapy mat prescribed by a physical therapist when an individual is involved in a home-therapy program designed by a therapist and carried out by the family or caregiver in the individual's own or family home.
25. Pulse oximeters may be purchased for individuals with respiratory or cardiac disease, who use supplemental oxygen on a continuous or intermitted basis. This equipment must be prescribed by the individual's pulmonologist, cardiologist or primary care physician.

Items not contained on this list that meet the definition of durable medical equipment may be approved through exception by APD. To request an exception, a physician must prescribe the item. The statement from the physician must delineate how the item is medically necessary, how it is directly related to the individual's developmental disability, without which the individual cannot continue to reside in the community or in his current placement. The request will be reviewed by the APD to determine compliance with the standards for medical necessity set forth in 59G-1.010(166), F.A.C., and to determine whether the requested item fairly meets the service definition. Items specifically excluded in this handbook will not be approved through exception.

If multiple vendors are enrolled to provide this service, the individual shall select from among all eligible vendors based on the item's availability, quality and best price.

A prescription submitted for a piece of equipment, which has general utility or is generally used for physical fitness or personal recreational choice, does not change the character of the equipment for purposes of coverage in this category. For example, a physical therapist, occupational therapist or physician recommending or prescribing a stationary bicycle or hot tub, does not covert that item from personal fitness or recreational choice equipment to durable medical equipment covered under the iBudget Florida Waiver. Items covered in this category generally include those specifically designed for a medical purpose, and are not used by the general public for physical fitness purposes, recreational purposes, or other general utility uses. It is the general character and not the specific use of the equipment that determines its purpose, for coverage under this category.

Durable Medical Equipment and Supplies, continued

Limits on the Duration, Frequency, Intensity and Scope, continued

Items usually found or used in a physician's office, therapist's office, hospitals, rehabilitation centers, clinics or treatment centers, or items designed for use by a physician or trained medical personnel are not covered. This includes items such as prone or supine standers, gait trainers, activity streamers, vestibular equipment, paraffin machines or baths, therapy balls, etc.

Also excluded are experimental equipment, weighted vests and other weighted items used for the treatment of autism, facilitated communication, hearing and vision systems, institutional type equipment, investigational equipment, items used for cosmetic purposes, personal comfort, convenience or general sanitation items, or routine and first aid items.

All supplies shall have direct medical or remedial benefit to the individual and are related to the individual's disability.

Excluded Services

Items usually found or used in a physician's office, therapist's office, hospitals, rehabilitation centers, clinics or treatment centers, or items designed for use by a physician or trained medical personnel are not covered. This includes items such as prone or supine standers, gait trainers, activity streamers, vestibular equipment, paraffin machines or baths, and therapy balls.

Also excluded are experimental equipment, weighted vests and other weighted items used for the treatment of autism, facilitated communication, hearing and vision systems, institutional type equipment, investigational equipment, items used for cosmetic purposes, personal comfort, convenience or general sanitation items, or routine and first aid items.

Items for diversional or entertainment purposes are not covered. Items that would normally be available to any child or adult, and would ordinarily be provided by families are also excluded. Examples of excluded items are toys, such as crayons, coloring books, other books, and games; electronic devices such as MP3 players, cell phones, televisions,, cameras, film, computers and software etc; exercise equipment, such as treadmills and exercise bikes; indoor and outdoor play equipment, such as swing sets, slides, bicycles, tricycles (including adaptive types), trampolines, play houses, and merry-go-rounds; and furniture or appliances. Items that are considered family recreational choices are also not covered (i.e., air conditioning for campers, swimming pools, decks, spas, patios, hot tubs, etc.).

In accordance with section 393.13, F.S., totally enclosed cribs and barred enclosures are considered restraints and are not covered under the waiver. Strollers and wheelchairs, when used for restraint, are also not covered.

Durable Medical Equipment and Supplies, continued

Special Considerations

Individuals and their family members shall not be reimbursed for equipment they purchase. Any durable medical equipment must be determined to be cost-beneficial. Once the most reasonable alternative has been identified and specifications developed, three competitive bids must be obtained for all items $1,000 and over to determine the most economical option. If three bids cannot be obtained, it must be documented to show what efforts were made to secure the three bids and explain if less than three bids were obtained. For items under $1,000, only one bid is required as long as it can be demonstrated that the bid is consistent with local market value.

The iBudget Florida program shall not provide durable medical equipment that is available for purchase through Medicaid State Plan DME and Medical Supplies Program state plan services. Medicaid State Plan often covers like equipment, but not the specific brand requested. When this occurs, the individual is limited to the Medicaid State Plan covered device. The lack of coverage for a specific brand name is not a medically necessary justification for waiver purchase.

All equipment shall have direct medical or remedial benefit to the recipient, shall be related to the recipient's developmental disability and shall be necessary to prevent institutionalization. Assessment and recommendation of appropriateness by a licensed physician, physical therapist or occupational therapist is required.

Environmental Accessibility Adaptations

Description

Environmental accessibility adaptations (EAA) are those physical adaptations to the home that are required by the individual's support plan and are medically necessary to avoid institutional placement of the individual and enable him to function with greater independence in the home.

A **Home Accessibility Assessment** is an independent assessment by a professional rehabilitation engineer or other specially trained and certified professional to determine the most cost-beneficial and appropriate accessibility adaptations for an individual's home. Home accessibility assessments may also include pre-inspection of up to three houses an individual or family is considering for purchase, review of ceiling lift and track systems, van conversions, and oversight and final inspection of any approved EAA.

If the construction is not completed by the independent assessor, the assessor can still provide construction oversight and a final inspection.

Environmental Accessibility Adaptations, continued

Provider Qualifications

Providers of environmental accessibility adaptation (EAA) services include licensed general or independent licensed contractors, electricians, plumbers, carpenters, architects and engineers.

Any enrolled EAA provider who provides construction work must present a qualified business number, as required in section 489.119, F.S. In accordance with section 489.113, F.S., subcontractors of a qualified business shall hold the required state certificate or registration in that trade category.

Engineers shall be licensed in accordance with Chapter 471, F.S., and must have one year of experience in environmental adaptation assessment and remodeling or be Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certified.

Architects shall be licensed in accordance with Chapter 481, F.S., and must have at least one year of experience in environmental adaptation assessment and remodeling or be Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certified.

Contractors and electricians shall be licensed in accordance with Chapter 489, F.S.

Plumbers shall be licensed in accordance with Chapter 489 F.S.
Certified Environmental Access Consultant (CEAC) certified through the U.S. Rehabilitation Association, Certified Aging in Place Consultant Administered through the National Home Builder's Association.

Carpenters and other vendors shall hold local occupational licenses or permits, in accordance with Chapter 205, F.S. Other professionals who may provide environmental accessibility adaptations assessments include providers with experience in the field of environmental accessibility adaptation assessment, with Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certification, and an occupational license.

Environmental Accessibility Adaptations, continued

Limits on the Duration, Frequency, Intensity and Scope

Environmental accessibility adaptation services are limited to the amount, duration and scope of the adaptation project described on the individual's support plan and current approved cost plan. If multiple vendors are enrolled to provide this service, the individual shall be encouraged to select from among the eligible vendors based on availability, quality of workmanship, and best price.

Excluded are those adaptations or improvements to the home, which are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.

Environmental accessibility adaptations (EAA) are approved when they are medically necessary. APD must approve exceptions. To submit an exception request, the appropriate professional must complete an assessment documenting how the specific EAA is medically necessary and is a critical health and safety need, how it is directly related to the individual's developmental disability, how it is directly related to accessibility issues within the home; and how without the selected EAA, the individual cannot continue to reside in his current residence. The request will be reviewed by an appropriate, qualified professional to determine whether the standards for medical necessity are met and to determine whether the requested item fairly meets the service definition.

Adaptations specifically excluded in this handbook will not be approved through exception.

Environmental accessibility adaptations include only adaptations to an existing structure, and must be provided in accordance with applicable state or local building codes. Adaptations that add to the total square footage of the home are excluded from this benefit.

Environmental accessibility adaptations shall be made only to a recipient's family home or recipient's own home, including rented houses or apartments. Recipients living in foster homes, group homes, assisted living facilities, or homes for special services (any licensed residential facility) are not eligible to receive this service. The responsibility for EAA rests with the facility owner or operator.

Environmental Accessibility Adaptations, continued

Place of Service

Environmental accessibility adaptations shall be made only to an individual's family home or individual's own home, including rented houses or apartments. Individuals living in foster homes, group homes, assisted living facilities, or homes for special services (any licensed residential facility) are not eligible to receive this service; the responsibility for EAA rests with the facility owner or operator.

Special Considerations

Environmental accessibility adaptations shall be determined "medically necessary" and a critical health and safety need before approval. This determination includes the following considerations:

a) There are no less costly or conservative means to meet the individual's need for accessibility within the home;
b) The environmental accessibility adaptation is individualized, specific and consistent with the individual's needs and not in excess of his needs; and,
c) The environmental accessibility adaptation enables the individual to function with greater independence in the home and without which, the individual would require institutionalization.

Environmental accessibility adaptations that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for the safe operation of the specified equipment and not intended to correct existing code violations in the individual's home.

Environmental accessibility adaptations shall be approved for an individual's own home or family home whether owned or leased, as needed, to make the home accessible to the individual. Once adaptations are made to an individual's residence, adaptation to another residence cannot be made until five years after the last adaptation to the first residence except for extenuating circumstances, such as total loss of residence. The waiver program does not cover routine repairs to the existing EAA or general repairs to the home or residence. The waiver program cannot be used to fund corrections to any existing code violation(s) to the home.

If an individual or family builds a home while the individual is receiving waiver services, major or structural changes will not be covered. Environmental accessibility adaptations covered under these circumstances are the difference in the cost, if any, between a handicapped-accessible bathroom and a standard bathroom. However, the cost difference for each item and adaptation must be documented, with total cost not exceeding $3,500.

Environmental Accessibility Adaptations, continued

Special Considerations, continued

Rental property is limited to minor adaptations as defined below. Prior to any adaptation to a rental property, a determination should be made as to what, if anything, the landlord will cover. The landlord, prior to service, shall approve all proposed environmental accessibility adaptations in writing. The written agreement between the individual or family and the landlord must specify any requirements for restoration of the property to its original condition if the occupants move and must indicate that APD and waiver funding are not obligated for any restoration costs. Waiver funds cannot be placed in escrow to undo any accessibility adaptations when the individual moves out. Individuals or families requesting EAA are expected to apply for all other assistance that may be available to assist in meeting the individual's needs. This includes local housing authorities, county, and local and community funding, etc.

Environmental accessibility adaptations shall be separated into two categories. Minor adaptations shall be defined as those EAA costing under $3,500 for all adaptations in the home. Major adaptations shall include those adaptations to a home when the total cost is $3,500 and over. Total EAA cannot exceed $20,000 during a five-year period. Major environmental accessibility adaptations require the assessment of a rehabilitation engineer or other professional qualified to make a home accessibility assessment. This home accessibility assessment shall include evaluation of the current home and describe the most cost-beneficial manner to permit accessibility of the home for the individual on the waiver.

The report must demonstrate that the environmental accessibility adaptation recommended is a "prudent purchase." Prudent purchase is a combination of quality and cost, where quality is measured by the ability to meet the individual's accessibility need and cost is measured by being the most reasonable and economical approach necessary to meet that need. Each environmental accessibility adaptation must be the most reasonable alternative based on the results of the review of all options, including a change in the use of rooms within the home or alternative housing.

Environmental accessibility adaptations must be cost-beneficial. Once the most reasonable alternative has been identified and specifications been developed, three competitive bids must be obtained for all EAA to a home costing $3,500 and over to determine the most economical option.

Environmental Accessibility Adaptations, continued

Special Considerations, continued

If three bids cannot be obtained, it must be documented to show what efforts were made to secure the three bids and explain why less was obtained. For EAA to a home costing between $1,000 and $3,499 at least two competitive bids must be obtained. If two bids cannot be obtained, it must be documented to show what efforts were made to secure the two bids and explain why only two were obtained. For EAA to a home costing under $1,000 only one bid is required, as long as it can be demonstrated that the bid is consistent with local market value. Environmental accessibility adaptations do not include those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of the owner or tenant, are considered to be experimental, or are not of direct medical or remedial benefit to the individual on the waiver. Routine maintenance of the adaptations and general repair and maintenance to the home is the responsibility of the owner or landlord and not a covered waiver service.

Examples of items not covered include replacement of carpeting and other floor coverings(unless removed to achieve the installation of the adaptation); roof repair; driveways; decks; patios; fences; swimming pools; spas or hot tubs; sheds; sidewalks (unless this is the person's only means of access into the home) ; central heating and air conditioning; raised garage doors; storage (i.e., cabinets, shelving, closets); standard home fixtures (i.e., sinks, commodes, tub, stove, refrigerator, microwave, dishwasher, clothes washer and dryer, wall, window and door coverings, etc.); furnishings (i.e., furniture, appliances, bedding); and other non-custom items which may routinely be found in a home. Also, specifically excluded are any adaptations that will add square footage to the home.

Personal Emergency Response Systems

Description	A personal emergency response system is an electronic communication system that enables an individual to secure help in the event of an emergency. The individual may also wear a portable "help" button that allows for mobility while at home or in the community. The system is connected to the person's phone and programmed to signal a response center. When the "help" button is activated, qualified personnel are dispatched to the individual's location.
Limits on the Duration, Frequency, Intensity and Scope	A personal emergency response system is limited to those individuals who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time, and otherwise require extensive routine supervision. Individuals living in licensed residential facilities are not eligible to receive this service. A cell phone does not meet the definition of a personal emergency response system. This service does not include the cost for the telephone or telephone line but does include the cost of the monthly service fee
Provider Qualifications	Providers shall be licensed electrical contractors, alarm system contractors, contract agencies for Community Care for the Elderly (CCE) must be authorized by Chapter 430, F.S., Community Care for Disabled Adults (CCDA) Programs must authorized by Chapter 410, F.S., or hospitals. Freestanding equipment may also be purchased from independent vendors, such as discount or home improvement stores, but these vendors may not provide monitoring. Electrical or alarm system contractors shall be licensed in accordance with Chapter 489, part II, F.S. Hospitals shall be licensed in accordance with Chapter 395, F.S. Independent vendors shall hold local occupational licenses or permits, in accordance with Chapter 205, F.S.
Place of Service	A personal emergency response system shall be provided in the individual's own home or apartment or the family's home or apartment. A mobile "help button" is also available for the individual to wear while engaged in a community activity.
Special Considerations	A personal emergency response system is available only for at-risk individuals who require a limited degree of supervision but live alone or are alone for periods of time without a caregiver.

Personal Emergency Response Systems, continued

SERVICE FAMILY 3 – PERSONAL SUPPORTS SERVICES

- **Personal Supports**
- **Respite**

Personal Supports

Description

Personal supports services provide assistance and training to the individual in activities of daily living to include the areas of eating, bathing, dressing, personal hygiene, preparation of meals and other activities of daily living. When specified in the support plan, this service may also include housekeeping chores such as bed making, dusting and vacuuming and assistance to do laundry, shopping and cooking which are incidental to the care furnished, or which are essential to the health and welfare of the individual rather than the individual's family. The support worker, to the extent properly qualified and licensed, assists in maintaining an individual's own home and property as a clean, sanitary and safe environment. These services may include heavy household chores to make the home safer, such as washing floors, windows and walls; tacking down loose rugs and tiles; or moving heavy items or furniture. Services also include non-medical care, supervision and socialization. This service may provide access to community-based activities that cannot be provided by natural or unpaid community supports and are likely to result in an increased ability to access community resources without paid support. This service is provided in support of a goal in the support plan and is not purely diversional in nature.

Assistance is provided on a one to one basis to individuals who live in their family homes unless they are engaged in a community based activity. Community-based activities may be provided to individuals living in their family home or in their own homes in groups not to exceed three.

Limits on the Duration, Frequency, Intensity and Scope

Personal supports are limited to adults only (21 and older). Personal supports are provided on a one on one basis. If services are provided with two or more individuals present, the amount of time billed must be prorated based on the number of recipients receiving the service (up to three people in the same time period.

The support plan shall explain the duties that a personal support provider will perform. In addition, personal support services may not be provided while an individual is attending an adult day training program.

Personal Supports, continued

Limits on the Duration, Frequency, Intensity and Scope, continued	Individuals in supported living arrangements receiving personal supports and supported living coaching must coordinate their activities to avoid duplication. Personal support services are billed by the quarter hour, hour, or by the day if the individual is receiving more than 8 hours per day For individuals under the age of 21, refer to the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage. The handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks.
Provider Qualifications	Providers of personal supports may be home health or hospice agencies, licensed in accordance with Chapter 400, parts III or IV, F.S. Providers may also be solo and are . not required to be licensed, certified, or registered. Solo providers and employees of agencies shall be at least 18 years of age, have a high school diploma or its equivalent, and have at least one year of hands on experience working in a medical, psychiatric, nursing or childcare setting or working with individuals who have a developmental disability or 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school. Solo providers, who are not nurses, are not required to be licensed, certified, or registered if they bill for and are reimbursed only for services personally rendered. An agency using more than one employee to provide services and billing for their services, shall be registered as a homemaker, sitter, or companion provider in accordance with section 400.509, F.S.
Place of Service	Personal supports shall be provided in the individual's own home or family home or while the individual who lives in one of those settings is engaged in a community activity. Personal supports may also be provided at the individual's place of employment. No service may be provided or received in the provider's home, a hospital, an ICF/DD or other institutional environment. Personal support services are provided in the recipient's own home or if authorized by the APD Area office in a licensed foster or group home where three or less recipients reside in the home. The personal support services worker may also accompany the recipient to activities in the community.

Personal Supports, continued

Special Considerations	Individuals living in foster or group homes are not eligible to receive personal supports, except: During an overnight visit with family or friends away from the foster or group home to facilitate the visit; or When a group home resident recovering from surgery or a major illness does not require the care of a nurse, and the group home operator is unable to provide the personal attention required to insure the individual's personal care needs are being met. Under these circumstances, it would be considered reasonable to provide this service to a group home resident only on a time-limited basis. Once the individual has recovered, the service must be discontinued. When an individual living in a licensed home is employed and needs personal support services at the employment site Reimbursement for nursing oversight of services provided by home health agencies and nurse registries is not a separate reimbursable service. The cost must be included in the personal support service. Personal support providers are not reimbursed separately for transportation and travel cost. These costs are included in the rate.

Respite Care

Description	Respite care is a service that provides supportive care and supervision to individuals when the primary caregiver is unable to perform the duties of a caregiver. This service is generally used due to a brief planned or emergency absence, or when the primary caregiver is available, but temporarily physically unable to care for or supervise the individual for a brief period of time.
Limits on the Duration, Frequency, Intensity and Scope	Respite care service providers are not reimbursed separately for transportation and travel cost as these costs are integral components of the service and are included in the basic rate. Respite care services are limited to the amount, duration, intensity and frequency of the service described on the individual's support plan and current approved cost plan

Respite Care, continued

Provider Qualifications	Providers of respite care services may be licensed residential facilities, licensed home health or hospice agencies, licensed nurse registries, or agencies that specialize in services for individuals with developmental disabilities. Providers who are not nurses are not required to be licensed, certified, or registered if they bill for and are reimbursed only for services personally rendered. An agency using more than one employee to provide services and billing for their services, shall be registered as a homemaker, sitter, or companion provider in accordance with section 400.509, F.S. Nurses who render respite care services as solo providers shall be licensed in accordance with Chapter 464, F.S. An independent vendor, or homemaker, sitter or companion employed by an agency, must be at least 18 years of age or older with one year experience in a medical, psychiatric, nursing or childcare setting or working with individuals with developmental disabilities or 30 semester hours, 45 quarter hours, or 720 classroom hours of college or vocational school.
Place of Service	Respite may be provided in the person's own home, family home, while involved with activities in the community, in a licensed group/foster home or assisted living facility (ALF).
Special Considerations	Individuals living in licensed group homes are not eligible to receive respite care services. Providers of respite services must use the published stepped quarter hour rate for the service or the daily rate if respite services are provided for more than ten hours a day. The provider must bill for only those hours of direct contact with the individual(s). Relatives who live outside the recipient's home and are enrolled as Medicaid waiver providers may provide respite care services and be reimbursed for the services. The relative must meet the same qualifications as other providers of the same service. With regard to relatives providing this service, safeguards must be taken to ensure that the payment is made to the relative as a provider, only in return for specific services rendered, and there is adequate justification as to why the relative is the provider of care. An example of a valid reason may be a general lack of enrolled providers due to the rural setting.

Respite Care, continued

Special Considerations, continued

Most recipients who require respite care services do not need the services of a registered or licensed practical nurse. Nurses should only be employed to perform this service when the recipient has a complex medical condition. If a nurse provides this service, a prescription will be necessary.

A relative is defined as someone other than a legally responsible family member, who is required to provide care for the recipient such as a parent of a minor child or a family member who is also a plenary guardian of an adult. With regard to relatives providing this service, controls must be in place make sure that the payment is made to the relative as a provider only in return for specific services rendered; and there is adequate justification as to why the relative is the provider of care. An example of viable reason may be lack of providers in a rural area.

Service Family 4 – Residential Services

SERVICE FAMILY 4 – RESIDENTIAL SERVICES

- **Residential Habilitation (Standard)**
- **Residential Habilitation (Behavioral Focused)**
- **Residential Habilitation (Intensive Behavior)**
- **Specialized Medical Home Care**
- **Supported Living Coaching**

Residential Habilitation

Description

Residential habilitation provides supervision and specific training activities that assist the individual to acquire, maintain or improve skills related to activities of daily living. The service focuses on personal hygiene skills such as bathing and oral hygiene; homemaking skills such as food preparation, vacuuming and laundry; and on social and adaptive skills that enable the individual to reside in the community. This training is provided in accordance with a formal implementation plan, developed with direction from the individual and reflects the individual's goals from the current support plan.

Individuals with challenging behaviors may require more intense levels of residential habilitation services described as behavior focus residential habilitation or intensive behavioral residential habilitation. The necessity for these services is determined by specific individual behavioral characteristics that impact the immediate safety, health, progress and quality of life for the individual, and the determination that less intensive services have not been sufficient to alter these behaviors. The need for increased levels of residential habilitation, behavior focus residential or intensive behavioral residential habilitation must be verified by APD.

Residential Habilitation, continued

Description, continued

Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirement of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which payment is made by a source other than Medicaid.

There are five agency provider types approved to perform this service. They are:

1. Certified Behavior Analysts (CBA) licensed in accordance with Chapter 393, F.S.,
2. Assisted Living Facilities (ALFs), licensed in accordance with Chapter 400, F.S.,
3. Licensed group homes in accordance with Chapter 393, F.S.,
4. Transitional Living Facilities, licensed in accordance with Chapter 393, F.S., and Chapter 400, F.S. and
5. Licensed Foster Homes, licensed in accordance with Chapter 393, F.S.

Agencies may hire direct care providers who must have a high school diploma or equivalent and one year experience working in a medical, psychiatric, nursing, or child care setting or working with individuals with developmental disabilities or 30 semester hours, 45 quarter hours or 720 classroom hours of college or vocational school.

There are three different approved rate components for the iBudget Waiver. They are:

- Day,
- Live-in, and
- Month

Residential habilitation services are provided in licensed facilities. Limitations, provider qualifications, and other information are provided for each type of residential habilitation home below.

(1) Standard residential habilitation
(2) Behavior focus residential habilitation
(3) Intensive behavior residential habilitation.

Residential Habilitation (Standard)

Limits on the Frequency, Duration, Intensity and Scope	Individuals may not receive residential habilitation services and supported living coaching services at the same time, except when the individual lives in a licensed residential facility and has a personal goal or outcome for supported living on his support plan. In this case, the individual may receive both services for a maximum of ninety days prior to their move to the supported living setting. The APD Area Office may approve the use of residential habilitation, live-in services at the appropriate live-in rate for the service for individuals who are in need of support and who reside in a licensed foster or group home, limited to no more than three individuals living in the home. Residential habilitation live-in services may be billed up to 365 days a year when the individual is present. A provider or an employee of a provider does not have to "live-in" the licensed home for the live-in rate to be applied for the service. The live-in daily rate provides from 8 to 24 hours of supports Residential habilitation provided in a licensed home must bill at the monthly rate if the person resides in the home for a minimum of 24 days in the month. Individuals who are in the home less than 24 days for the month must bill at the daily rate. If billing by the month, do not bill on a date the person was not present. Use the last date the person was present as the date of service.
Provider Qualifications	Agency staff providing direct care residential habilitation services in a licensed residential facility must have a high school diploma or equivalent and 1 year experience working in a medical, psychiatric, nursing or child care setting or working with individuals with developmental disabilities or 30 semester hours, 45 quarter hours or 720 classroom hours of college or vocational school.
Place of Service	This service can be provided primarily in a licensed residential facility as defined in Chapter One of this handbook. However, some activities associated with daily living that generally take place in the community such as grocery shopping, banking or working on social and adaptive skills are included in the scope of this service.

Residential Habilitation (Standard), continued

Special Considerations

Residential habilitation providers are paid separately for transportation services if they are currently enrolled as an iBudget Florida waiver transportation provider, only when transportation is provided between an individual's place of residence and another waiver service. Incidental transportation or transportation provided as a component of residential habilitation services is included in the residential habilitation rate paid to the provider. Residential Habilitation providers are not reimbursed separately for time spent documenting services as these costs are integral components of the services and are included in the basic rate.

Residential habilitation training services shall not take the place of a job or another meaningful day service, but must be scheduled around such events. For example, if an individual works a Monday through Friday, 9 a.m. - 4 p.m. schedule, residential habilitation training services must be scheduled in the evening hours and on weekends.

Providers shall provide a minimum level of staffing consistent with the minimum Direct Care Staff Hours per Person per 24 Hour Day identified in the table below. Staffing ratios shall be established by the provider using the available total minimum Direct Care Staff Hours per Person per 24 Hour Day consistent with the support and training needs of individuals receiving residential habilitation services for functional, behavioral or physical needs. The provider will meet the minimum staffing levels on a per day basis for each home, or shall provide the required staffing over a seven day period for each home to accommodate for absences from the home and to establish optimal coverage on weekends. Providers of residential habilitation services and their employees shall provide sufficient staffing and staff ratios while delivering these services to meet individual needs and provide appropriate levels of training and supervision for individuals of the service.

Direct Care Staff Hours per Person per 24 Hour Day

Level of Disability	**Level of Staffing**	
	Hours per Day	**Hours per Week**
Basic Level	**2**	**14**
Minimal Level	**4**	**28**
Moderate Level	**6**	**42**
Extensive 1 Level	**8**	**56**
Extensive 2 Level	**11**	**77**

Residential Habilitation (Standard), continued

Special Considerations, continued

Hours counted must be provided by direct care staff or by other staff, who are providing direct care or direct time spent on client training, intervention or supervision. Provider compliance with direct care staffing levels for residential habilitation services substantiates Medicaid billing requirements only; other provisions of this Handbook remain fully applicable to all providers.

To determine minimum required staffing for each level of support for residential habilitation services, the minimum direct care staff hours per person per 24 hour day authorized for individuals receiving residential habilitation services are multiplied by the number of individuals receiving the service at that level in the home setting. All available staff hours per level are totaled to obtain a daily minimum total number of staff hours. The resulting total is then divided by 8 hours of staff work time to produce an FTE level per day. The number of all available staff hours is multiplied by seven to establish a weekly minimum total. For example: The calculation below is for six individuals receiving the service and living in the same home, all authorized at the Moderate Level of Supports. The minimum number of direct care staff hours per person per 24 hour day for the moderate level is 6 hours. The calculation is as follows:

6 individuals X 6 direct care staff hours per person per 24 hour day = 36 available direct care staff hours per day, or 252 available direct care staff hours per week. 36 direct care staff hours per day divided by an 8 hour staff working day = 4.5 Full Time Equivalents (FTEs) per day for minimum residential habilitation direct care staffing purposes.

Minimum staffing requirements for Intensive Behavioral Residential Habilitation services shall be determined at the time the rate for the service is established. Minimum staffing for Live-In Residential Habilitation services is determined by the rate ratio authorized for the home.

Example of the application of 4.5 staff FTEs at the Moderate Level as calculated above: The 4.5 FTEs generated using the calculation above may be used to establish a staffing pattern for standard or behavior focus residential habilitation providers and their employees of 1.5 staff per 8 hour shift over a 24 hour period. If individuals are engaged in the receipt of other services during a period of time during the day, the residential habilitation provider may modify the staffing pattern to maximize staff during the time that individuals are in the home and receiving the service, and to optimize coverage on the weekends and holidays.

Residential Habilitation (Behavioral Focus)

Limits on the Duration, Frequency, Intensity and Scope

In order for the provider to receive a residential habilitation with a behavioral focus rate for an individual, the provider must meet the specified staff qualifications for the service, and the individual must exhibit the characteristics listed below. This level of service shall be approved for an individual only when it has been determined through use of the APD-approved instrument by the Area Behavior Analyst or designee, and the support planning process that an individual requires residential habilitation services with a behavioral focus services.

At least annually thereafter, the Area Behavior Analyst or designee will re-evaluate the individual through use of the APD-approved instrument to confirm that the individual continues to meet service eligibility criteria.

The need for residential habilitation with a behavioral focus and the rate for the service shall be identified on the individual's support and cost plan and on the authorization for service submitted to the provider by the individual's support coordinator. Service authorization shall be based on established need and re-evaluated at least annually while the individual is receiving the services. The provider must document evidence of continued need as well as evidence that the services are assisting the service provider in meeting the needs of the individual so that transition to less restrictive services may be possible.

Residential habilitation services with a behavioral focus are appropriate for individuals exhibiting at least one of the following behavioral problems, as documented in their appropriately referenced central record:

a) Self-inflicted, detectable, external or internal damage requiring medical attention or the behavior is expected to increase in frequency, duration, or intensity resulting in self-inflicted, external or internal damage requiring medical attention. These types of behaviors include head banging, hand biting, and regurgitation.
b) External or internal damage to other persons that requires medical attention or the behavior is expected to increase in frequency, duration or intensity resulting in external or internal damage to other persons that requires medical attention. These types of behavior include hitting others, biting others and throwing dangerous objects at others.
c) Arrest and confinement by law enforcement personnel.
d) Major property damage or destruction in excess of $500 for any one intentional incident.
e) A life-threatening situation. Examples of these types of behaviors are excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, or severe insomnia.
f) Has led to the use of restraint or emergency medications within the past year.

Residential Habilitation (Behavioral Focus), continued

Provider Qualifications

A Board Certified Behavior Analyst or Board Certified Assistant Behavior Analyst, or Florida Certified Behavior Analyst with a bachelor's degree, or a person licensed under Chapter 490 or Chapter 491, F.S., provides on-site oversight for residential services with a minimum of 30 minutes of on-sight oversight each week for each individual.

Direct care staff providing residential habilitation services in a licensed residential facility must:

1. Be at least 18 years of age
2. Have a high school diploma or equivalent, and
3. Have one year of experience working in a medical, psychiatric, nursing or child care setting or working with persons who have a developmental disability.
4. Receive training in an Agency Approved Emergency Procedure Curriculum consistent with 65G-8.002, F.A.C., where providers will be working with individuals with significant behavioral challenges...

No fewer than 75 percent of the provider's direct service staff working with the individual(s) for whom the behavioral focus residential habilitation rate applies have completed at least 20 contact hours of face-to-face instruction. The 20 hours of training may be obtained by completing an in-service training program offered privately or through a college or university. Proof of training must be maintained on file for review and verification in the following content areas to include:

a) Introduction to applied behavior analysis – basics and functions of behavior;

b) Providing positive consequences, planned ignoring, and stop-redirect-reinforce techniques; and

c) Data collection, recording and documentation.

Place of Service

Group and foster homes licensed as behavior focused by the Agency for Persons with Disabilities.

Residential Habilitation (Behavioral Focus), continued

Special Considerations

Providers of residential habilitation and behavior focus residential habilitation in a licensed facility shall bill for services only when the individual is present, using the monthly or daily rate authorized based on the published rate for the service.

Behavior focused residential habilitation is intended to be a temporary placement and as such once the person's challenging behaviors can be shown to respond to effective treatment, the person should be transitioned to the next lowest effective level of treatment service. The transition criteria for behavior focused residential habilitation serves as a guideline for conditions under which the treatment team must recommend a less structured, more open environment, including levels of involvement from direct care staff, staff supervisors and professional care providers. The goal of behavior focused residential habilitation service is to prepare the person for full or partial reintegration into the community, with established behavioral repertoires, such as developing a healthy lifestyle, filled with engaging and productive activities.

Transition criteria for an individual may include:

1. Living in a communal setting without harmful or dangerous behavior or significant conflict.
2. Interacting safely in a wide range of social settings.
3. Exhibiting stable work behavior.
4. Participating appropriately in a high level of social activities.
5. Identifying the set of services and supports, including minimal supervision, necessary to maintain performance and health.

Conditions to be considered for transition include:

1. The behavioral excesses that made treatment necessary occur at reduced rates and with reduced severity.
2. The behaviors do not typically occur as a function of new environmental conditions.
3. The behaviors intended to replace the problem behavior now often occur in the presence of the environmental conditions that previously evoked behavioral excesses.
4. Level of supervision has been reduced or the person functions with less supervision. Supervision is the same as that which is likely to be provided in the residential setting to which the person is most likely to move, and those settings in which the individual is likely to have access.
5. The provider has determined an effective means of managing the person's behavior to offer recommendations for transition to new levels of staff and the physical environment requirements needed to maintain or to continue the individual's improvement.

Residential Habilitation (Behavioral Focus), continued

Special Considerations, continued

When any of the conditions identified above apply, the individual should be considered for transition from behavior focused residential habilitation treatment. However, treatment would continue with the focus shifting to ensuring that the gains made are maintained or continued.

Providers of behavior focus residential habilitation services shall provide a minimum level of staffing consistent with the minimum Direct Care Staff Hours per Person per 24 Hour Day identified in the table below. Staffing ratios shall be established by the provider using the available total minimum Direct Care Staff Hours per Person per 24 Hour Day consistent with the support and training needs of individuals receiving residential habilitation services for functional, behavioral or physical needs. The provider will meet the minimum staffing levels on a per day basis for each home, or shall provide the required staffing over a seven day period for each home to accommodate for absences from the home and to establish optimal coverage on weekends. Providers of residential habilitation services and their employees shall provide sufficient staffing and staff ratios while delivering these services to meet individual needs and provide appropriate levels of training and supervision for individuals of the service.

Direct Care Staff Hours per Person per 24 Hour Day:

Level of Disability	**Level of Staffing**	
	Hours per Day	**Hours per Week**
Basic Level	**2**	**14**
Minimal Level	**4**	**28**
Moderate Level	**6**	**42**
Extensive 1 Level	**8**	**56**
Extensive 2 Level	**11**	**77**

Hours counted must be provided by direct care staff or by other staff, who are providing direct care or direct time spent on client training, intervention or supervision. Provider compliance with direct care staffing levels for residential habilitation services substantiates Medicaid billing requirements only; other provisions of this Handbook remain fully applicable to all providers.

Residential Habilitation (Behavioral Focus), continued

Special Considerations, continued

To determine minimum required staffing for each level of support for residential habilitation services, the minimum direct care staff hours per person per 24 hour day authorized for individuals receiving residential habilitation services are multiplied by the number of individuals receiving the service at that level in the home setting. All available staff hours per level are totaled to obtain a daily minimum total number of staff hours. The resulting total is then divided by 8 hours of staff work time to produce an FTE level per day. The number of all available staff hours is multiplied by seven to establish a weekly minimum total. For example: The calculation below is for six individuals receiving the service and living in the same home, all authorized at the Moderate Level of Supports. The minimum number of direct care staff hours per person per 24 hour day for the moderate level is 6 hours. The calculation is as follows:

6 individuals X 6 direct care staff hours per person per 24 hour day = 36 available direct care staff hours per day, or 252 available direct care staff hours per week. 36 direct care staff hours per day divided by an 8 hour staff working day = 4.5 Full Time Equivalents (FTEs) per day for minimum residential habilitation direct care staffing purposes.

Example of the application of 4.5 staff FTEs at the Moderate Level as calculated above: The 4.5 FTEs generated using the calculation above may be used to establish a staffing pattern for standard or behavior focus residential habilitation providers and their employees of 1.5 staff per 8 hour shift over a 24 hour period. If individuals are engaged in the receipt of other services during a period of time during the day, the residential habilitation provider may modify the staffing pattern to maximize staff during the time that individuals are in the home and receiving the service, and to optimize coverage on the weekends and holidays.

The service provides for comprehensive monitoring of staff skills and their implementation of required procedures. Monitoring for competence must occur at least once per month for 50 percent of direct service staff that have completed the training described above. Staff must be recertified in the training requirements yearly. The provider also has a system that demonstrates and measures continuing staff competencies on the use of procedures that are included in each individual's behavior analysis services plan.

Residential Habilitation (Intensive Behavioral)

Limits on the Duration, Frequency, Intensity and Scope

Intensive behavioral residential habilitation is for individuals who present problems with behavior that are exceptional in intensity, duration, and frequency, that meet one or more of the following conditions and whose needs cannot be met in a behavior focus or standard residential habilitation setting.

1. Within the past 6-months the individual:

a. Engaged in behavior that caused injury requiring emergency room or other inpatient care from a physician or other health care professional to self or others.

b. Engaged in a behavior that creates a life-threatening situation. Examples of these types of behavior are excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, and severe insomnia.

c. Set a fire in or about a residence or other facility in an unauthorized receptacle or other inappropriate location.

d. Attempted suicide.

e. Intentionally caused damage to property in excess of $1,000 in value for one incident.

f. Engaged in behavior that was unable to be controlled via less restrictive means and necessitated the use of restraints, mechanically, manually or by commitment to a crisis stabilization unit, three or more times in a month or six times across the applicable six-month period.

g. Engaged in behavior that resulted in arrest and confinement.

h. Requires visual supervision during all waking hours and intervention as determined by a certified behavior analyst or licensed behavior analysis professional to prevent behaviors previously described above that were likely, given past behavior in similar situations, without such supervision.

i. Engaged in sexual behavior with any person who did not consent or is considered unable to consent to such behavior, or engaged in public displays of sexual behavior (e.g. masturbation, exposure, peeping Tom, etc.)

j. If the supervision and environment is such that the person lacks opportunity for engaging in the serious behaviors the behavior analyst providing oversight must determine that the behavior would be likely to occur at least every six months if the person is without the supervision or environment provided and document in the individual's records.

Residential Habilitation (Intensive Behavioral), continued

Limits on the Duration, Frequency, Intensity and Scope, continued

Intensive behavioral residential habilitation shall provide aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward: (1) the acquisition of the behaviors necessary for the individual to function with as much self determination and independence as possible; and (2) the reduction or replacement of high risk, problems with behavior. Treatment within Intensive Behavioral Residential Habilitation also includes medical oversight by psychiatric and nursing services when individuals served have specific concerns related to routine use of psychotropic medications or emergency medications for the management of behavior, mood or thought process.

Individual goals must relate to the assessment, management, and replacement of problems with behavior. As treatment progresses and is effective, goals should also include generalization and maintenance of new behavior and behavior reductions in settings that are increasingly similar to less intensive treatment settings, but within which continued treatment and maintenance services are included.

The problems with behavior and any related medical conditions are the central focus of treatment for these individuals. This means that all behavior change targets included in the treatment plan are linked to the initial problem statement. For example, if a problem with behavior was described as self-injury that occurs when the person is in the presence of aversive stimuli of a specific nature, then the targets for change would include alternatives to self-injury that would be controlled by the same stimuli. In addition, the individual's assessment might identify socially-skilled behavior deficits in social skills that make self injury more likely. These deficits might include communication, social skills and basic self care skills necessary to independently function in other settings where they will serve to replace or reduce the occurrence of problem behaviors.

Individuals in intensive residential habilitation programs are not initially able to function independently without continuous training, supervision, and support by the staff. Over time with effective intervention a noticeable reduction in the severity of behavior should occur. However, even though there may be substantial improvement in behavior, the goal is to ensure that gains made are maintained in settings other than the treatment setting alone and services should remain comprehensive and continuous, so that the individual can effectively transition to less intensive services. .

Intensive behavioral residential habilitation rates for an individual must be approved and authorized through the prior service authorization process performed by the APD or an agent of the APD. Authorization for this rate shall be approved for an individual only when it has been determined through use of the APD approved assessment by the Area Behavior Analyst or designee that the individual characteristics have been met for Intensive Behavioral Residential Habilitation. At least annually thereafter, the Area Behavior Analyst or designee will re-evaluate the individual through use of the APD approved assessment to confirm that the individual continues to meet service eligibility criteria.

Residential Habilitation (Intensive Behavioral), continued

Limits on the Duration, Frequency, Intensity and Scope, continued

The review process shall include evaluation of the level of need of the individual and the effectiveness of services being provided. Authorized rates for this service may vary across providers and individuals based on the specific service needs of the individual. Service authorization shall occur prior to service delivery, for new services, within 30-days of the adoption of this rule for existing services and at least annually through prior service authorization while the individual is receiving the service. The provider must meet provider qualifications for this level of service. Further, the following individual characteristics and service characteristics must be met in order to receive an intense behavioral residential habilitation rate. Service authorization shall be based on established need and re-evaluated at least annually while the individual is receiving the services. The provider must document evidence of continued need as well as evidence that the service is assisting in meeting the needs so that transition to a lower level or less intense services may be possible.

Behavioral Assistant Services shall not be provided in conjunction with intensive behavioral residential habilitation.

Provider Qualifications

Providers of intensive behavioral residential habilitation services shall meet the behavioral focus provider and staff qualifications identified above, and in addition shall ensure:

1. All adjunct services (behavioral, psychiatric, counseling, nursing) are included in the service, or billed to independent insurance policies or sources of reimbursement other than the Medicaid waiver program or APD;
2. All direct care service needs are met without an addition to the approved rate;
3. The Program or Clinical Services Director meets the qualifications of a Level 1 Behavior Analyst, including a Doctorate Level Board Certified Behavior Analyst or a Masters Level Board Certified Behavior Analyst, , or a practitioner licensed under Chapter 490 and 491, F.S. The Program or Clinical Services Director must be in place at the time of designation of the organization as an intensive behavioral residential habilitation program;
4. Staff responsible for developing behavior analysis services will meet at a minimum the requirements for a Florida Certified Behavior Analyst or Board Certified Assistant Behavior Analyst under Chapter 393, F.S. or a practitioner licensed under Chapter 490 and 491, F.S.;
5. The ratio of behavior analysts to individuals is no more than one full-time analyst to 20 individuals; and

Residential Habilitation (Intensive Behavioral), continued

Provider Qualifications, continued	6. All direct service staff will complete at least 20 contact hours of face-to-face competency-based instruction with performance-based validation, and comply with staff monitoring and the re-certification system as described for behavioral focused residential habilitation above; and 7. All direct service staff will receive training in an Agency Approved Emergency Procedure Curriculum consistent with 65G-8.002, F.A.C., where staff will be working with individuals with significant behavioral challenges
Place of Service	Group/foster homes licensed as intensive behavioral by the Agency for Persons with Disabilities
Special Considerations	Treatment must also include the arrangement of contingencies designed to improve or maintain performance of activities of daily living. This would occur when an individual, for example, does not bathe regularly and this is resulting in the person being socially isolated. The objective in this case would typically be to establish acceptable bathing routines in the absence of highly engineered contingencies. In these cases, incidental training is provided. For example, a person is provided instruction while getting dressed in order to assist the person in learning to select appropriate clothing for a specific job site. In this way, training on basic skills is provided as one component of active treatment. Individual service plans for individuals receiving intensive behavioral residential habilitation will include a written plan to decrease services through improved behavior and when applicable, medical condition. Environmental changes or adjustments that are made as the person's behavior and medical condition improves are tracked, measured and graphed.

Residential Habilitation (Intensive Behavioral), continued

Special Considerations, continued

The transition criteria for intensive residential habilitation define the conditions under which the treatment team must recommend a less structured, more open environment, including levels of involvement from direct care staff, staff supervisors and professional care providers. The goal of an intensive residential habilitation service is to prepare the person for full or partial reintegration into the community, with established behavioral repertoires, such as developing a healthy lifestyle, filled with engaging and productive activities.

Evaluation criteria for the individual include:

1. Living in a communal setting without harmful or dangerous behavior or significant conflict.
2. Interacting safely in a wide range of social settings.
3. Exhibiting stable work behavior.
4. Participating appropriately in a high level of social activities.
5. Identifying the set of services and supports, including minimal supervision, necessary to maintain performance and health.

Conditions for transition include:

1. The behavioral excesses that made treatment necessary no longer occur in the presence of the environmental conditions that previously evoked those behaviors.
2. The behaviors do not occur as a function of new environmental conditions.
3. The behaviors intended to replace the problem behavior now reliably occur in the presence of the environmental conditions that previously evoked those behaviors that previously controlled the behavioral excesses.
4. Caregivers reliably carry out the medical and behavioral strategies necessary to maintain or continue improvements in health and behavior without direct supervision from a nurse, behavior analyst or other professional care provider. The direct care providers and individual no longer require the levels of oversight established within the exceptional services program for professional care providers including physicians, nurses, and behavior analysts.
5. Direct care providers no longer require the levels established within the exceptional services program for direct supervision. Supervision is the same as that which is typically provided in the residential setting to which the person is most likely to move.
6. The provider has determined the recommended transition levels of staff across all categories and the physical environment requirements needed for the individual to maintain or to continue improvements.

Residential Habilitation (Intensive Behavioral), continued

Special Considerations, continued	When the conditions identified above are met, the individual would no longer require intensive residential habilitation treatment. However, treatment would continue with the focus shifting to ensuring that the gains made maintain or continue to improve in settings that have more variability in the prevailing contingencies and afford greater access to unplanned, everyday encounters with untrained people.

Special Medical Home Care

Description	Special medical home care services are provided in licensed foster or group homes serving individuals with complex medical conditions, requiring an intensive level of nursing care. This may include individuals who are ventilator dependent, require tracheostomy care or have a need for deep suctioning. This does not include individuals whose only need is for gastrostomy tube feedings/medications or insulin injections without other intensive needs. The service may be provided for a period of up to 24-hours-a-day nursing services and medical supervision for all the individuals residing in the home. The group home must have APD Central Office authorization and maintain appropriate and sufficient staffing at all times to meet the intensive needs of all individuals residing in the home.
Limits on the Duration, Frequency, Intensity and Scope	Only those individuals with complex medical conditions, requiring an intense level of nursing care, and who reside in licensed homes with the designation of special medical home care are eligible for this service. Rates for this service must be approved and authorized through the APD Central Office. Authorization for each individual in the home requires review by the Central Office Nursing staff. Authorized rates for service may vary based on the specific service needs of the individual. Service authorization shall occur prior to service delivery and at least every six months by the APD Central Office Nursing staff while the individual is receiving the service. The APD may establish a level of nursing staff based on individual support needs at the time of the review required to authorize the service and rate.

Special Medical Home Care, continued

Provider Qualifications	Providers of special medical home care shall be group homes that employ registered nurses, licensed practical nurses and certified nurse assistant licensed or certified in accordance with Chapter 464, F.S. Certified nurse assistant must work under the supervision of a registered or licensed practical nurse. Group homes shall be licensed in accordance with Chapter 393, F.S. Nurses and certified nurse assistants must perform services within the scope of their license or certification.
Placed of Service	Special medical home care services shall be provided at a licensed foster or group home that has been approved by APD Central Office to provide this level of care.
Special Considerations	Special medical home care services and the rate require approval through a prior authorization by the APD Central Office or a representative of the APD. Most licensed group homes do not provide this level of nursing care, nor do most individuals require such close medical supervision. APD shall determine when a group home qualifies to be a provider of this service and which individuals require this level of nursing support. All individuals residing in a Special Medical Home must be eligible for the level of nursing care provided in the home. When special medical home care is provided, the provider may not receive reimbursement for residential habilitation or residential nursing services. Special medical home care services can only be billed for days the individual was present and received services, up to 365 days a year. The provider may not bill for days the individual is hospitalized or is participating in a home visit.

Supported Living Coaching

Description	Supported living coaching services provide training and assistance, in a variety of activities, to support individuals who live in their own homes or apartments. These services are provided by qualified supported living coaches to an individual residing in a living setting meeting the requirements set forth in rule 65G-5.004, F.A.C., and may include assistance with locating appropriate housing; the acquisition, retention or improvement of skills related to activities of daily living such as personal hygiene and grooming; household chores; meal preparation; shopping; personal finances and the social and adaptive skills necessary to enable individuals to reside on their own.

Supported Living Coaching, continued

Description, continued	In order to identify the types of training, assistance and intensity of support needed for the individual, the provider shall complete a Functional Community Assessment. This document is designed to assist the provider in becoming familiar with the individual and his capacities and needs. This assessment addresses all aspects of daily life including relationships, medical and health concerns, personal care needs, household and money management, community mobility, and community interests. The supported living provider is responsible for completing the community assessment prior to the person's move into a supported living arrangement or within 45 days of service implementation for an individual already in a supported living arrangement. The Functional Community Assessment is updated at least annually To ensure the individuals' housing selection meets housing standards, the supported living provider must complete an initial Housing Survey for each person. The supported living coach must complete the housing survey prior to the lease being signed. Upon final onsite inspection of the home by the supported living provider and the waiver support coordinator, the waiver support coordinator approval of the housing survey is required. The housing survey is also reviewed quarterly as part of the quarterly home visit. The Supported Living Coach shall complete a Financial Profile for each individual. The profile is an analysis of the household costs and revenue sources associated with maintaining a balanced monthly budget for the individual. In addition to substantiating the need for a monthly subsidy or initial start-up costs, the profile will serve as a source of information for determining strategies for assisting the person in money management. The supported living coaching provider is to assist the individual in completing the financial profile and submitting it to the support coordinator no more than ten days following the selection of housing by the individual. If the financial profile indicates a need for a one time or recurring subsidy, the profile must be submitted to the waiver support coordinator and approved by the APD Area Office before the individual signs a lease. Providers of supported living services shall comply with requirements found in the Medicaid Waiver Services Agreement, Chapter 65G-5, F.A.C., and those specified in this handbook
Limits on the Duration, Frequency, Intensity and Scope	Supported living coaching services are limited to the amount, intensity, frequency and duration and of the services described on the individual's support plan and current approved cost plan.

Supported Living Coaching, continued

Limits on the Amount, Frequency, Duration and Scope, continued

The provider shall render supported living coaching services at the time and place mutually agreed to by the individual and provider. The provider shall have an on-call system in place that allows individual's access to services for emergency assistance 24 hours-per-day, 7 days-per-week. The provider must specify a backup person to provide supports in the event he is unavailable. The specified backup provider must be a certified, enrolled Medicaid provider and certified as a supported living coaching provider, pursuant to Chapter 65G-5, F.A.C. Telephone access to the provider or the backup provider shall be available, without toll charges to the individual.

Supported living coaching services are limited to adults (age 18 or over.) Neither the supported living coaching provider nor the provider's immediate family shall be the individual's landlord or have any interest in the ownership of the housing unit, as stated in rule 65G-5.004, F.A.C. A provider is defined as a solo provider or a corporation including all board members and any paid employees and staff of the provider agency, its subsidiaries or subcontractors. If renting, the name of the individual receiving supported living coaching services must appear on the lease either singularly, with a roommate, or a guarantor.

Supported living coaching encourages maximum physical integration into the community. The homes of individuals receiving supported living coaching services shall meet requirements set forth in rule 65G-5.004, F.A.C.

Individuals who live in family homes, foster homes or group homes are not eligible for these services unless the individuals have an individually identified goal to move into their own homes or apartments. Within 90 days from moving, supported living coaching services may be made available to individuals who are in the process of looking for a place of their own, even though they will reside in a family, foster or group home during the search process and may be receiving residential habilitation services. Supported living services may not be paid for a person who chooses a home that does not meet acceptable housing standards. Supported living coaching services are provided on a one-on-one basis. The provider will bill for supported living coaching services in accordance with the published rate structure for individual supports for the individual. If services are provided with two or more individuals present, the amount of time billed must be prorated based on the number of individuals receiving the service.

Supported Living Coaching, continued

Provider Qualifications

Providers of supported living coaching services may be solo providers or employees of agencies.

Employees of providers shall have a bachelor's degree from an accredited college or university with a major in nursing; education; or a social, behavioral or rehabilitative science and two years of hands on experience working with individuals with developmental disabilities

In lieu of a bachelor's degree, employees must have an Associate of Arts degree or two years of college and three years of hands on experience working with individuals with developmental disabilities.

Place of Service

Supported living coaching services are provided in the individual's home, apartment or in the community. In order to be considered a supported living arrangement, the home must be available for lease by anyone in the community and may not be co-located on the same property as the family home.

Special Considerations

Providers of supported living coaching services must participate in monitoring reviews conducted by the APD or its authorized representatives.

When an individual receives personal supports and/or life skills development services in addition to supported living coaching, the providers must work together to avoid duplication of activities with coordination by the waiver support coordinator.

If the supported living coach and the personal supports provider are the same person, the personal supports may not be billed at the live in rate. Separation of the personal supports and supported living activities must be reflected in documentation.

Supported living coaching services are not to be provided concurrently with residential habilitation services, except for the 90 days prior to the recipient moving into the supported living setting.

SERVICE FAMILY 5 – SUPPORT COORDINATION

- **Limited**
- **Full**
- **Enhanced**

Supported Coordination

Description

Support coordination is the service of advocating for the individual and identifying, developing, coordinating and accessing supports and services on his or her behalf, regardless of funding source. Support coordination may also involve assisting the individual or family to access supports and services on their own.

Such supports and services may be provided through a variety of funding sources, including but not limited to the iBudget Florida program, Medicaid State Plan services, third party payers, and natural supports. They also include generic resources through other state, federal, and local government and community programs and supports, available to all residents to support people where they live and work to find meaningful relationships and community membership.

The iBudget Florida program is structured to strongly encourage the use of waiver funds to supplement and not replace the supports already provided by family; friends; neighbors, other vocational and educational programs; and the community. Waiver services are only one element of the supports for an individual; in fact, the waiver is to be the payer of last resort. Individuals, families, waiver support coordinators, and providers are responsible for finding non-waiver supports to augment and even replace waiver-paid services.

In an individual budgeting system like iBudget Florida, the individual, the WSC, and the service providers work together to accommodate the needs of the individual within the individual's waiver budget allocation. With individual budgeting, the individual learns what his or her budget is prospectively, at the outset of the planning process. By knowing the amount of resources the state will provide, the individual, his or her family, and his or her waiver support coordinator can plan based on their priorities.
Waiver support coordinators shall use a person-centered approach to identify an individual's goals and plan and implement supports and services to achieve them. Examples of sources of information about the individual and his or her unique goals, needs, and preferences include conversations with the individual and those who know him or her best, information obtained from the APD approved assessment, and service providers.

Supported Coordination, continued

Description, continued

The amount of an individual's budget allocation will depend in large part on the amount of funding for waiver services that is appropriated by the Legislature. Individuals may not have enough funding in their budget allocations to be able to obtain all desired services through the waiver. They will have to work with their families and waiver support coordinators to obtain from other sources those services that their budget allocation is not able to fund. Waiver support coordinators are responsible for supporting individuals' self-direction, working creatively to meet their needs, and being vigilant about monitoring individuals' health and safety. The iBudget Florida system places a special emphasis on waiver support coordinators' working with individuals and families to locate and develop natural and community supports. This will require a higher level of creativity and dedication to go beyond the generic resources available from established non-profits. Instead, waiver support coordinators will need to work with individuals and families to identify and develop "hidden" resources, such as the help of family friends, colleagues, churches, businesses, etc. who might be approached directly with requests to support an individual outside of a formal organizational program of assistance.

All levels of support coordination shall help the individual monitor and manage the individual's budget allocation.

Support coordinators promote the health, safety and well-being of individuals. They also promote the dignity and privacy of and respect for each individual, including when sharing personal information and decisions.

Three levels of support coordination are available: limited, full, and enhanced. These are described below. If Individuals are eligible for more than one level of support coordination, they may choose the level that best meets their needs within the limits of their budget allocation.

Supported Coordination, continued

Qualifications

Providers of support coordination may be organized as either solo or agency providers.
All waiver support coordinators, including solo providers or support coordinators employed by an agency, shall be determined eligible by the APD area office and individually enrolled in the Medicaid program as individual treating providers prior to providing support coordination services and billing for Medicaid waiver services they render.

The experience requirements for providers and support coordination supervisors employed by an agency are:

a) A bachelor's degree from an accredited college or university
b) Three years of experience working directly with individuals with developmental disabilities. A master's degree in a related field can substitute for one year of the required experience.

The experience requirements for support coordinators employed by agencies are:

a) A bachelor's degree from an accredited college or university
b) Two years of experience working directly with individuals with developmental disabilities. A master's degree in a related field can substitute for one year of the required experience.

The support coordinator may not perform any support coordination activities (such as face to face visits, unsupervised contact with an individual, review of the individual's central records or receiving confidential information) until he has received Level 2 background screening results which indicate no disqualifiers.

Supported Coordination, continued

Dual Employment

Basic to the service of support coordination is the requirement that the support coordinator is available and accessible to the individuals receiving their service on a 24 hour per day, 7 day per week basis. This means that support coordination must take precedence over any other form of employment or business holdings.

For support coordinator applicants who are employed at the time of making application as a Medicaid waiver provider and who intend to remain in the current employment, the Medicaid waiver application must include a plan for dual employment. The plan should address the type of employment held at the time of the application, the number of hours worked on a weekly basis, description of how the support coordinator will be contacted by individuals served during hours employed at the other job and how conflicting priorities, emergencies and meetings will be handled. The plan shall also address long-range plans for reducing or terminating employment should the support coordinator begin serving a full caseload.

The APD Area Office shall approve the applicant's plan for dual employment as part of the enrollment process. If it is determined that the applicant cannot be available to meet the needs of individuals served, the application may be denied.

If a support coordinator is employed by a support coordination agency and is dually employed, it will be the responsibility of the agency manager or support coordination supervisor to provide oversight for their employees related to their plan for addressing dual employment. If the Agency determines that the dually-employed support coordinator is not available or accessible to individuals served or cannot carry out other duties and responsibilities required of a support coordinator, the support coordinator must either terminate other employment or request to be terminated as a waiver provider.

Should an enrolled waiver support coordinator, provider or agency manager or supervisor, who is dual employed choose to expand the caseload size, an update to the dual employment plan shall be submitted to the APD Area Office that specifically addresses the manner in which contact will be maintain and competing priorities addressed. As a part of quality assurance/improvement, the APD Area Office may request an update to the plan at any time to address any deficiencies or need for improvement based on trends, complaints received or billing issues.

If an enrolled support coordinator is seeking dual employment while already performing support coordination responsibilities, the support coordinator must submit a plan for dual employment to the APD Area Office for review and approval.

Under no circumstances may dual employment include the provision of services to individuals who are clients of APD other than a case management or support coordination function.

Supported Coordination, continued

Selection of and Access to Support Coordinators by Individuals

Unless an exception is granted by the area office, the support coordinator does not have the option to decline to serve individuals who choose his services if the individuals are within the geographic boundaries approved by the area office and the support coordinator has the capacity to serve them. Exceptions made by the area office must be approved by the central APD office. The support coordinator must also make himself available to individuals who want to interview support coordinators at a location that is convenient to the individual to include the individual's home or other location in the community. The individual is free to choose a support coordinator of their choice.

The provider must be available to meet the individual's needs and to perform the duties and responsibilities required by this handbook. The provider must have an on-call system in place that allows individuals to contact him or her 24 hours per day, 7 days per week. While there is an expectation that emergency calls will be returned immediately, for non-emergency calls, the provider must respond by the end of the next consecutive calendar day. The on-call system must be approved by the Area Office as a part of the application process. Each support coordinator is required to identify a back-up to provide ongoing services during absences of the primary support coordinator. This back-up provider must be a certified and enrolled waiver support coordinator. The name and contact information for the back-up person must be clearly communicated to individuals and to the Area Office.

Access to the support coordinator or back-up support coordinator shall be available to individuals on their caseload without toll charges.

The provider and all its employees who supervise staff, train staff or conduct support coordination activities shall remain free from influences that interfere with the individual's choice of support and services.

Supported Coordination, continued

Prohibited Activities

The provider, its board members and its employees shall be legally and financially independent from and free-standing of persons or organizations providing direct services within the state of Florida, other than support coordination and related administrative activities to individuals who receive services from APD.

The provider and its employees shall not:

- Provide Person Centered Planning services or Family and Legal representative Training services as separate waiver services.
- Be a subsidiary of, or function under the direct or indirect control of, persons or organizations providing direct services within the state of Florida, other than support coordination and related administrative activities to individuals who receive services from APD.
- At the time of certification and at any time thereafter, provide direct services within the state of Florida other than support coordination or work for a company that provides direct services or related administrative activities to individuals who receive services from APD.
- Be the legal representative or legal representative advocate, apply to be the legal representative or legal representative advocate, or be affiliated with an organization or person who is the legal representative or legal representative advocate of an individual served by the provider.
- Be the legal representative or representative payee for any benefits received by an individual served by the provider.
- Render support coordination services to an individual who is a family member of the provider or any employee of the provider, unless the individual receives services in an APD service area where the family member is not certified to provide support coordination.
- Secure paid services on behalf of an individual from a service provider who is a family member of the provider or any employee of the provider.
- Assume control of an individual's finances or assume possession of an individual's checkbook, investments or cash.

Supported Coordination, continued

Support Coordination Caseload Size

Standard Caseload Size

The caseload size for waiver support coordinators is established by the Florida Legislature at 43 full time individuals per support coordinator. An individual who receives limited support coordination is considered a half-time individual on the caseload. Waiver support coordinators who provide limited support coordination may have a caseload greater than 43 individuals, not to exceed the equivalent of 43 full time individuals.

Supervisors of support coordination within an agency shall limit their caseload to fewer than the equivalent of 43 full time individuals and must ensure that all support coordinators employed by the agency receive adequate supervision.

Vacancies and Leaves of Absence

Providers
Within five (5) days of a vacancy occurring or leave of absence granted to a support coordinator employed by a support coordination agency, the support coordination agency must notify the Area office in writing, including a list of individuals affected. If a vacancy is due to the termination, resignation of a support coordinator, or a written request by a waiver support coordinator for leave based on the intent of the Family and Medical Leave Act, agency caseloads may temporarily exceed the maximum 43 full time individuals for a maximum period of 60 consecutive calendar days from the date the vacancy occurred. Failure of the agency to notify the Area office of the vacancy within the required timeframes will result in recoupment of funds received by the provider.

If a support coordination agency cannot fill a reported vacant position within the time period allotted, the Area office must be notified prior to the 60th consecutive calendar day. Upon receipt of this notification, the Area Office will provide 14 consecutive calendar days notice to the affected individuals and the agency of the need to select a different waiver support coordination provider. This notification will allow sufficient time for the individual to choose an available provider from within or outside the current agency and the provider to complete the necessary paperwork or take other necessary action on behalf of the individual.

Vacancies resulting in caseloads exceeding the maximum of 43 full time individuals for more than the above stated number of days may subject the provider to recoupment of funds and may result in the individuals served to transition to another enrolled provider.

Supported Coordination, continued

Support Coordination Caseload Size, continued

Penalties and Processes for Temporarily Exceeding Caseload Limits

Vacancies resulting in caseloads exceeding the maximum of 43 full time individuals for more than the above stated number of days may subject the provider to recoupment of funds and may result in the individuals served to transition to another enrolled provider.

All caseload transfers will be accomplished by the Area Office working with the provider to identify those individuals affected by the vacancy and who will cause the temporary support coordinator to exceed the maximum caseload of 43 full time individuals.

Expansion of Services

Expansion of services includes increasing the number of individuals served by a solo or agency provider, as well as a solo provider changing his or her status to an agency provider. To expand services, a provider must have no alerts, no verified legally sufficient complaints within the past 12 months, no documentation cites indicating recoupment that have not been sufficiently resolved, have attained a satisfactory overall score on their last quality assurance monitoring conducted by the APD, AHCA or their authorized representative, and be approved by the Area Office to expand services. The area office may review a sample of files prior to granting the expansion request.

Support Coordination Quality Assurance

Owners, directors, or heads of agency support coordination providers shall have a comprehensive internal quality assurance management plan to actively monitor and supervise treating coordinators employed by that agency. This plan should include a systematic method of inspecting and reviewing all required documentation and activities. The agency director, owner, manager or support coordination supervisor shall provide ongoing technical assistance and training to its employees in order to assure that they are fulfilling all requirements as effectively and professionally as possible. This includes but is not limited to processing of all documentation related to support and cost planning, issuing service authorizations to providers in a timely manner, actively monitoring any contracted services, meeting required submission deadlines or any other activities required by this handbook.

If there is a pattern of deficiencies or problems within a support coordination agency that continues to occur, the Area Office may request and recommend the agency status be terminated. At that time, any coordinators that are determined to be fulfilling their requirements under the waiver shall be enrolled as solo providers. In addition, any coordinators that have failed to fulfill waiver requirements satisfactorily may be subject to adverse actions outlined in their waiver service agreement.

Supported Coordination, continued

Access to Agency Electronic Systems

The provider is responsible for the cost of the electronic access to the APD's intranet site as well as entering, updating and assuring the accuracy of all demographic and client related information pertinent to the individual in the ABC and iBudget Florida systems. This information includes but is not limited to individual address, county of residence, program component, legal representative name and address, if applicable, and type of benefits received. Failure of the waiver support coordinator to enter, update and assure the accuracy of information within three consecutive calendar days of becoming aware of a change, could result in recoupment of funds paid to the provider.

The support coordinator is also responsible for the cost to access any APD or ACHA required management, claim submission information or data collection systems

Transition of Individuals between Support Coordinators

Changes in support coordination provider shall occur at the beginning of a month unless otherwise approved by the Area APD.

If while serving an individual, the individual chooses another support coordinator provider, the current provider shall render quality services for the individual until the end of the month, when the transfer to the new support coordinator takes place unless otherwise instructed by the APD. Additionally, the current provider shall assist the individual in making a smooth transition to the new provider.

When a support coordination provider ceases to provide service to an individual, a new support coordinator is selected by the individual, the support coordination agency is downsized, or the support coordination services are terminated, either voluntarily or involuntarily, the waiver support coordinator shall assure that all appropriate central record information is transferred to the new provider or to the Area Office, as directed, within one week of the effective date of the action. Once notified, any activity necessary for the maintenance of the central record must be completed by the support coordinator who has possession of the record.

Central Record

The provider shall maintain each individual's central record in accordance with Chapter 393, F.S., and APD procedures. The central records shall be the property of the APD and must be relinquished to APD immediately upon request. APD retains the right to review, retrieve or take possession of an individual's record at any time.

When a new support coordinator is selected by the individual, the support coordination agency is downsized; or the support coordination service is terminated, either voluntarily or involuntarily, the waiver support coordinator shall assure that all appropriate central record information is transferred to the new provider or to the Area Office, as directed, within one week of the effective date of the action.

Supported Coordination g, continued

Billing Requirements

For reimbursement purposes, the provider must meet certain basic billing requirements. These include:

- Support coordination notes which document the support coordination services rendered. These notes must be specific to the individual. Notes must clearly demonstrate and accurately reflect the support coordination services being rendered to the individual and verify that purchased support coordination services are being received and rendered as specified in the service authorization. Services must meet all requirements specified herein.
- A valid service authorization.

Contact Requirements and Allowable Activities for Billing

Contact Requirements

The requirements by level are:

- Full support coordination: at a minimum, two contacts with or activities on behalf of an individual each month in order to bill Medicaid.
- Limited support coordination, the provider must have a minimum of one contact with or activity on behalf of an individual each month in order to bill.
- Enhanced support coordination: at least weekly face to face contact.

The requirements for face-to-face visits in a specific location are:

- For individuals in supported living, the provider must conduct monthly face to face visits in the individual's home and conduct one other billable activity on behalf of the individual. Individuals receiving supported living services must receive full support coordination.
- For individuals living in an ALF, support coordinators must conduct monthly face to face visits, with every other month face to face contact at the facility. Individuals residing in ALF's must receive full support coordination.
- For individuals residing in their own home or residing in a licensed residential facility, a face to face visit with the individual in his or her place of residence is required every three months.
- If the individual lives with his or her family, the face to face contact with the individual in the residence is required every six months for full support coordination and once a year for limited support coordination. The individual's family may not waive the required visit in the home. The need for more frequent face to face visits may be determined by the individual, family or primary caregiver. The waiver support coordinator shall document this preference in the individual's support plan; however, if this results in a number of contacts beyond the minimum for limited, the individual may need to move to full support coordination.

Supported Coordination, continued

Contact Requirements and Allowable Activities for Billing, continue

The purpose of the face to face visit is to discuss progress/changes to the individual's goals, status of any resolved issues and satisfaction with current supports received. Each visit should be viewed as an opportunity to give or receive meaningful information that can be used to more effectively assist the individual with achieving goals. Face to face contacts shall relate to or accomplish one or more of the following:

1. Assist the individual to reach individually determined goals on the support plan, including gathering information to identify outcomes;
2. Monitor the health and well-being of the individual
3. Obtain, develop and maintain resources needed or requested by the individual to include natural supports, generic community supports and other types of resources.
4. Increase the individual's involvement in the community;
5. Promote advocacy or informed choice for the individual and/or;
6. Follow up on unresolved concerns or conflicts.

Allowable Activities for Billing

Support coordinators must conduct at least one other contact or activity on behalf of the individual each month. These contacts or activities are not merely incidental, but are planned and shall related to or accomplish those items listed above in 1-6 above. These contacts may be with the individual or with persons important to his or her life including family members, legal representatives, service providers, community members, etc. and can be via telephone, letter writing or email transmission. Any contact or activity on behalf of the individual must be documented in the support coordination notes. The contacts must be individualized and related to services and benefits specific to the person receiving services. Administrative activities such as typing letters, filing, mailing or leaving messages shall not qualify as contacts or activities; nor do calls to schedule meetings, setting up face to face visits or scheduling meetings with the individual's employer, family, providers, etc. Any activity or contact requested by APD on behalf of the individual is counted as a billable activity and should be documented in the support coordination notes.

Supported Coordination, continued

General Support and Service Requirements

At least once annually, the support coordinator will:

1. Develop or update the tools necessary to assist the individual in identifying personal goals, needs and services prior to the development of the support plan with input from the individual
2. Complete the support plan, at a time and place selected by the individual. Once completed, the plan must contain signatures of the individual, legal representative and others the individual invited to participate in his support plan meeting. . At a minimum, it shall involve a person-centered planning process which creatively considers all supports that may be available to an individual, whether waiver-funded or funded by other sources or provided on an informal, direct volunteer basis.
3. Complete the cost plan in sufficient time so it will be effective July 1 of each year.
4. Ensuring that the online iBudget Florida system has accurately generated service authorizations.
5. Complete the waiver eligibility worksheet regarding eligibility for Medicaid and Medicaid Home and Community-Based waiver services and assure that Medicaid eligibility is maintained by providing all necessary assistance to the individual to maintain Medicaid benefits.
6. In accordance with 393.0651, F.S., the provider shall complete an annual report of the supports and service received throughout the year, description of progress toward meeting individually determined goals and any pertinent information about significant events that have happened in the life of the individual for the previous year.
7. Provide information to individuals currently in sheltered workshops or segregated work environments to apprise them of the options available for, work activities, volunteer activities and training. The support coordinator shall request a Benefits Planning Query (BPQY) from the Social Security Administration for each individual, indicating an interest in options, for the purpose of monitoring income and assets to determine impact upon Medicaid eligibility. The BPQY will be discussed with the individual/family or legal representative and will be placed in the individual's central record. This documentation can be in the form of a casenote. Provide information to individuals about residential options available including owning or renting a home with supports. This shall occur not only annually but at any point it is anticipated there will be a change in the individual residential situation and shall be documented in case notes for the individual
8. For individuals in a supported living arrangement or licensed residential facility who are taking any psychiatric or anti-epileptic medications, the support coordinator will document in the support coordination notes attempts and efforts to assure a review is completed annually by a licensed psychiatrist, neurologist, or an advance registered nurse practitioner who acts pursuant to a protocol with the psychiatrist or neurologist.
9. The support coordinator will also document in the support coordination notes efforts to assure a medication review by a licensed consultant pharmacist in conducted annually

Support Coordination, continued

Individuals Newly Enrolled on a Waiver

When an individual is newly enrolled to receive waiver services, the waiver support coordinator shall provide a copy of the notice of privacy practices required by HIPAA regulations to the individual or legal representative upon initial contact with the individual and at any time there is a significant change that necessitates the protection of an individual's personal health information.

For new waiver enrollees, the support coordinator will provide the individual with information about the concepts of the iBudget Florida program, basic budget management, and information on services available. Once the individual's budget allocation has been established, the support coordinator will use information from the individual, the APD approved assessment and other available assessments as a basis for working with the individual to develop the individual's initial support and cost plan. The support coordinator must complete and submit the support plan and cost plan through the online iBudget Florida system, along with any required supporting documentation, within 30 consecutive days of the individual's selection of the support coordinator. Copies of the support plan will be given to the individual within 10 consecutive calendar days of the date of the individual's signature on the plan.

If an individual is in a crisis situation, the support and cost plan shall be submitted through the online iBudget Florida system within 30 consecutive calendar days. Updates to the plan shall be submitted as soon as additional information becomes available.

Individuals Who Have Been Receiving Waiver Services during the Past Year

For individuals who have been receiving waiver services, the support coordinator is responsible for assisting APD staff in scheduling and completing the APD approved assessment. When requests for assistance in scheduling the assessment or requests for access to central records are received from the Area Office, the support coordinator will comply within three consecutive calendar days.

For all Individuals

The support coordinator shall work with the individual to develop a cost plan implementing the support plan on at least an annual basis, typically with an effective date of July 1 of each year addressing the subsequent 12 month period. At the individual's choice, the individual or his or her authorized representative may develop all or part of the plan based on the decisions of the individual and submit it for the support coordinator to amend or complete, if necessary, and review; alternatively, the support coordinator shall develop the plan based on the choices and preferences of the individual and submit it through the online iBudget Florida system ensuring all required documentation for service review is included.

Support Coordination, continued

Individuals Newly Enrolled on a Waiver, continued

The support coordinator shall work with the individual to revise the cost plan as necessary using the process described immediately above. The updated plan should be submitted to the Area Office within five consecutive calendar days from the date the support coordinator became aware of the need for a change.
A description of these changes should be noted in the casenotes. If the change is related to a crisis or significant change in circumstances, then the assessment and support plan should be updated.

To ensure that individuals and/or legal representatives are aware of and agree to a cost plan developed or revised by a waiver support coordinator, the waiver support coordinator shall obtain verbal, electronic, or written approval of the plan from the individual and/or his or her legal representative prior to submitting the cost plan to review through the online system. The support coordinator shall record any verbal approvals in a case note. In addition, the WSC must certify that the individual and/or his legal representative have approved the change verbally or in writing by completing the corresponding check box in the online iBudget Florida system. This box should only be checked when the above activities have occurred.

The service authorization is to be generated by the online iBudget Florida system, but the support coordinator is responsible for confirming that service authorizations have been generated as required.

An approved cost plan shall be provided to the individual or his or her legal representative at any time it is requested, but at a minimum, within ten consecutive calendar days of the effective date of the new support plan.

The support coordinator shall provide any documentation requested by APD to determine whether requested changes to cost plans are approvable. The Area Office will respond within 10 business days of their receipt of the updated plan and complete documentation. If necessary, within three (3) consecutive calendar days of receiving a notice of APD's decision, the support coordinator shall submit a cost plan conforming to the APD decision.

For emergency requests involving situations that may not be addressed by revising the individual's plan on a temporary basis, the waiver support coordinator shall notify the Area Office of the emergency situation. The support coordinator shall provide the updated support and cost plan and any supporting documentation within three consecutive calendar days of becoming aware of the emergency.

Support Coordination, continued

Access to Online iBudget Florida System by Individuals and Others Accessing on their Behalf

All levels of support coordination shall provide assistance to individuals wishing to access the iBudget Florida system and to family members or authorized persons accessing the system on their behalf:

Waiver support coordinators shall verify that individuals and the iBudget Florida representatives seeking access to the online iBudget Florida system on individuals' behalf meet the requirements for such access. This verification shall include reviewing and maintaining in the central record copies of the following documentation confirming the proposed iBudget Florida representative's identity and relationship to the individual, as appropriate:

a. Parent of individual under age 18—birth certificate or other official court document indicating parental relationship
b. Designated representative—signed copy of a current designated representative form, hereby incorporated by reference.
c. Legal representative-- copies of official court documents confirming legal representatives

Waiver support coordinators shall provide basic training and technical assistance to individuals wishing to access the iBudget Florida system and to family members or authorized persons accessing the system on their behalf on use of the online iBudget Florida system as required.

The waiver support coordinator will be responsible for completing and updating the iBudget Florida system for all individuals who either choose not to use or are unable to use the system.

Responsibilities for Individuals in Supported Living Arrangements

For individuals who wish to move into a supported living arrangement, supported living coaching services may be approved for a period not to exceed 90 days to assist the individual in finding a home. It is the responsibility of the WSC to review activities occurring during this time period to ensure that the supported living goal may be achieved within this timeframe. The 90 day timeframe is intended to be a onetime approval. As a result, if it is evident that the goal will not be achieved before the 90 day timeframe expires, the service should be reviewed to determine whether the service should be extended to the 90 day maximum or a more appropriate service should be requested. .For individuals in supported living, the support coordinator shall coordinate and monitor services provided by the supported living provider and personal supports provider, if applicable, to assure each is assisting the individual in achieving individually determined goals and to avoid or eliminate duplication of services. The support coordinator will assure that the goals, roles and responsibilities of each provider are clearly delineated and that authorized services are being rendered in accordance with the individual's wishes. Prior to an individual's move to his own home, it is the support coordinator's responsibility to visit the proposed home to assure health and safety standards are met and that the home meets acceptable standards. The support coordinator, along with the individual and supported living provider will review the health and safety checklist, financial profile and the supported living provider's implementation plan to assure a smooth transition to the individual's new home.

Support Coordination, continued

Responsibilities for Individuals in Supported Living Arrangements, continued

Additionally, for individuals in supported living, it is the waiver support coordinator's responsibility to schedule a quarterly meeting and attend the meeting with the individual in his or her home. Unless specifically declined by the individual the supported living coach, and Personal Supports provider should also be invited. During this meeting the following activities will occur:

1. The support coordinator will review the individual's progress toward achieving goals and determine if services are being provided in a satisfactory manner, consistent with the individual's wishes.
2. The support coordinator review the health and safety checklist, housing survey and determine if there is a need for follow up with unresolved issues or changes are needed.
3. For individuals who are receiving assistance with financial management from the provider, the support coordinator will review the bank statements' checkbook, and other public benefits such as Social Security benefits and health care coverage needed to maintain waiver eligibility at the time of the quarterly meeting.
4. For individuals receiving a supported living subsidy, the support coordinator will review the financial profile to verify that it accurately reflects all sources of income and monthly expenses of the individual.
5. The support coordinator will document the results of this meeting in the support coordination notes.

Criteria for Allowable Support Coordination Levels

The following individuals will be required to receive the following levels of waiver support coordination:

1. Full: All individuals age 21 and over during the first 180 calendar days after their transition to the iBudget Florida waiver.
2. Enhanced:
   a. Individuals transitioning from a public or private Intermediate Care Facility for the Developmentally Disabled, a nursing facility, the Mentally Retarded Defendant Program, or jail, during the three months prior to their anticipated date of transfer and the three months after their actual date of transfer
   b. Individuals who are crisis enrollees, up to three months after their enrollment on the waiver.
   c. Individuals in the foster care system, up to three months after their transfer out of that system.

Support Coordination, continued

Criteria for Allowable Support Coordination Levels, continued

To enhance self-direction, some individuals may select the level of waiver support coordination they prefer if they meet the following criteria and they use funds in their budget allocation to fund the difference, if they are selecting a higher level of waiver support coordination than that for which they are funded:

i. If they are not required to receive a different level of support coordination, Individuals age 21 or over may choose
   a. limited support coordination after they have been receiving services through the iBudget Florida waiver for at least six months if they or their designated representative is documented to have received approved training on iBudget Florida.
   b. Full waiver support coordination
   c. Enhanced waiver support coordination.

ii. If they are not required to receive a different level of support coordination, Individuals under age 21 may:
   a. Choose limited support coordination during the first six months after enrolling on the iBudget Florida program.
   b. After six months after transitioning to the iBudget Florida waiver, select limited support coordination if they or their designated representative is documented to have received approved training on iBudget Florida.
   c. Select full or enhanced waiver support coordination.

Full Support Coordination

Full support coordination provides significant support to an individual. The support coordinator is on call on a 24 hours, 7 day a week basis. The support coordinator may share tasks with the individual and his or family or other support persons as they desire, but ultimately the support coordinator shall be responsible for performing all tasks required to locate, select, and coordinate services and supports, whether paid with waiver funds or through other resources. The following are provided in Full Support Coordination level in addition to the other tasks generally described herein:

- Be on call after hours on 24 hour/7 day a week basis
- Provide detailed information to individuals about iBudget Florida and the waiver system and referrals to where they can get more additional training
- Identifying, interviewing, selecting, and coordinating service providers.
- Through conversations with the individual, those who know the individual well and through review of service providers' documentation, monitor the individual's involvement in and satisfaction with services to determine if the activities meet the individual's expectations.
- Attend medical appointments, IEP meetings, social security meetings, and similar appointments at the individual's request.

Support Coordination, continued

Limited Support Coordination

Limited Support Coordination services are services that are intended to be less intense than full support coordination. Limited support coordination services are billed at a reduced rate and have reduced contact requirements. Limited support coordinators are not on-call 24 hours per day, 7 days per week. Support Coordination occurs during times and dates prearranged by the individual and the support coordinator. In the event that the individual experiences emergencies that require a more intensive level of support coordination, a change to full support coordination should be initiated through the online iBudget Florida system using funding presently in the individual's budget allocation

In addition to the general requirements provided elsewhere in this section, the support coordinator providing limited support coordination shall:

- Be on call after hours on an emergency basis only
- Provide basic information to individuals about iBudget Florida and the waiver system, and referrals to the Area office where they can get more detailed training.
- Provide information and referrals on locating, selecting, and coordinating waiver providers, Medicaid State Plan, community, natural, and other supports. The individual, his or her family, and other persons supporting the individual shall themselves locate, select, and coordinate the supports and services, notifying the support coordinator of their decisions.

Eligibility

Adults receiving limited support coordination may request to return to full support coordination due to an increased need for assistance, but must remain in full support coordination for a minimum of 3 months after this return to full support coordination services. The additional funding required for a move to full support coordination must come from the individual's budget allocation.

Support Coordination, continued

Enhanced Support Coordination

This service consists of activities that assist the individual in transitioning from a nursing facility, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) or an ICF/DD unit of Developmental Disabilities Center to the community or for assisting individuals who have a circumstance that necessitates a more intensive level of support coordination. Examples for this enhanced level of support coordination include individuals who are enrolling on the waiver through crisis enrollment, individuals returning to their community upon release from jail or prison or individuals who are experiencing mental health issues that require ongoing Baker Act or short term crisis evaluation in mental health unit. When a transition is involved, enhanced support coordination is intended to be time-limited for three months prior to a discharge from the above named facilities and three months after the move occurs or for a total of no more than six months for situations that are related to a change in the individuals situation as described above. As the person's iBudget allocation allows, the individual may select to receive enhanced support coordination for a longer period of time.

If an individual is moving from an institutional placement into the community, the support coordinator providing enhanced support coordination shall work directly with the individual, institutional staff, and the selected waiver providers prior to the move to assure a smooth transition to community services, including those funded through the waiver and other services and supports necessary to ensure the health and safety of the individual. The support coordinator will coordinate their activities with the facility's discharge planning process.

The support coordinator shall develop an initial person centered support plan. In addition to information typically used to develop a person centered plan, the plan shall consider information from the facility's summary of the individual's development, behavioral, social, health and nutritional status and a discharge plan designed to assist the individual in adjusting to their new living environment.

Waiver support coordinators may bill at the enhanced support coordination level for the three months prior to an individual's move, but only after the individual has been discharged, providing all activities required for a move have been completed. The support coordinator shall pay particular attention to ongoing evaluation of proposed support system to assure a smooth transition, including oversight and coordination with all service providers to assure services are being delivered consistent with the individual's needs

The support coordinator shall have at a minimum weekly face to face contact with the individual for the first 30 days following discharge into the community.

In the case of a transition, the support coordinator shall update the support plan at the end of 30 consecutive calendar days to identify progress made with the transition to community services and possible changes in supports and services, follow up on unresolved issues

Support Coordination, continued

Place of Service

Support coordination may be provided in the individual's home or anywhere in the community. In order to develop relationships with the individual and those important to him or her, the support coordinator is encouraged to interact with and observe the individual in a variety of settings and at different times of the day, different days of the week.

Special Considerations

Support coordination may be provided while an individual is temporarily a patient in a hospital or nursing facility. The waiver support coordinator may not duplicate the services of the hospital discharge planner or facility case manager and may not bill for support coordination services until after the individual is discharged.

SERVICE FAMILY 6 – WELLNESS AND THERAPEUTIC SUPPORTS

- **BehaviorAnalysis Services**
- **Behavior Assistant Services**
- **Dietician Services**
- **Nursing**
  - **Private Duty Nursing**
  - **Residential Nursing**
  - **Skilled Nursing**
- **Occupational Therapy**
- **Physical Therapy**
- **Respiratory Therapy**
- **Speech Therapy**
- **Specialized Mental Health Counseling**

Behavior Analysis Services

Description

Behavior analysis services are provided to assist individuals to learn new functionally equivalent replacement skills for identified challenging behaviors or to learn other behaviors that are directly related to existing challenging behaviors. Services may also be provided to increase existing behavior, to reduce existing behavior, and to help the individual to learn to engage in a behavior in the appropriate situations. The term "behavior analysis services" includes the terms "behavior programming" and "behavioral programs." Behavior analysis includes the design, implementation and evaluation of systematic environmental modifications to understand behavior and change it in socially significant ways. It uses direct observation and measurement of behavior and environment.

Behavior Analysis Services, continued

Description, continued

In order to determine when and in what situations challenging behavior occurs, behavior is assessed to identify the functional relationships between a behavior and the environment. A variety of techniques including positive reinforcement and other consequences, the manipulation of antecedent stimuli and contextual factors and the use of establishing operations are used in order to produce practical behavior change. .

Behavioral services must include procedures to insure generalization and maintenance of behaviors. The services are designed to facilitate ongoing changes in the individual's environment, the interactional styles of caregivers and the contingencies for the individual's behavior provided by other people in order to make lasting improvements in the individual's behavior. Training for parents, caregivers and staff is also an element of the services to ensure maximum effectiveness of the services and because these persons are integral to the implementation or monitoring of a behavior analysis services plan. Services should be provided for a limited time, faded, incrementally reduced, or discontinued as the significant others gain skills and abilities to assist the individual to function in more independent and less challenging ways.

Delivery of behavioral services is a complex process that includes provision of services directly to the individual, at times, or others supporting the individual in his or her presence, as well as services required to assess, plan and train others without the individual present. Examples of services provided to the individual to caregivers, staff or other providers while the individual is present include: analog functional analysis, observation of the individual for descriptive functional assessment, observations of and feedback regarding interactions of caregivers, staff or other providers with the individual, modeling procedures with the individual for caregiver/staff/other providers, training staff, caregivers or other providers, evaluating new procedures with the individual, and direct training to the individual (typically with caregivers/staff/other providers present). In addition, services required to support behavior analysis services, may include: behavior plan development, graphing and analysis of data, behavior plan revision, training staff, caregivers or other providers in consultation to other professionals, presentation of an individual's behavior plan to the Local Review Committee, and meetings. The latter support services may not be reimbursed in excess of 25% of the total units for the cost plan year.

Behavior analysis does not rely on cognitive therapies and expressly excludes psychological testing, neuropsychology, psychotherapy, sex therapy, psychoanalysis, hypnotherapy and long-term counseling as treatment modalities. Provision of behavioral services must comply with rule 65G-4.009 and 65G-4.010, F.A.C. Services provided by behavior analysts with limited experience in the problem area should receive supervision from a Board Certified Behavior Analyst with experience in that problem area.

Behavior Analysis Services, continued

Limits on the Duration, Frequency, Intensity and Scope	An individual shall receive no more than 16 units of this service per day. A unit is defined as a 15-minute time period or portion thereof. This service may be provided concurrently (at the same time and date) with another service. . These services are not to be provided in the school system or take the place of services required under provisions of the Individuals with Disabilities Education Act (IDEA).
Provider Qualifications	Providers of behavior analysis must have licensure or certification on active status at the time services are provided. Providers of this service must have one or more of the following credentials: Level 1 Board Certified Behavior Analyst; Doctoral level, Board Certified Behavior Analyst or a person licensed under Chapter 490 or 491, F.S., (Psychologist, School Psychologist, Clinical Social Worker, Marriage and Family Therapist or Mental Health Counselor), with evidence (e.g. work samples) of at least three years of experience in the application of Applied Behavior Analysis procedures to persons with exceptional needs post certification or licensure. Level 2 Board Certified Behavior Analyst; Doctoral level, Board Certified Behavior Analyst, Florida Certified Behavior Analyst with a Master's degree or higher or a person licensed under Chapter 490 or 491, F.S., (Psychologist, School Psychologist, Clinical Social Worker, Marriage and Family Therapist or Mental Health Counselor), with experience (e.g. work samples) of at least one year supervised experience in the application of Applied Behavior Analysis procedures to persons with exceptional needs. Level 3 Florida Certified Behavior Analyst with Bachelors or high school diploma or Board Certified Assistant Behavior Analyst. Level 3 providers are required to evidence at least one hour per month of supervision from a professional who meets the requirements of a Level 1 or Level 2 Board Certified Behavior Analyst. Diplomas or Degrees earned in other countries shall be accompanied by authentication documentation that the degree is equivalent to the educational requirements for the position
Place of Service	These services may be provided in the individual's place of residence, during Life Skills Development except Level III, or anywhere in the community. However, in all cases, behavior analysis services must also be provided in the setting(s) relevant to the behavior problems being addressed.

Behavior Analysis Services, continued

Special Considerations

Behavior analysis and assessment services are described more fully in Chapter 65G, F.A.C., which is available online at https://www.flrules.org. As stated in rule 65G-4.010, F.A.C., approval for behavior analysis services interventions and behaviors meeting the characteristics described in the rule must be obtained from certified behavior analysts meeting educational and experience requirements or persons licensed pursuant to Chapter 490 or 491, F.S., prior to implementation of the services, with submission for review to the LRC chairperson within five working days of implementation.

Behavior Assistant Services (BAS)

Description

The primary role of the BAS provider is to assist the Behavior Analyst or provider licensed under Chapter 490 or 491, F.S. in training paid and unpaid caregivers for the service recipient in the consistent and accurate implementation of the BASP and recording of related data. Unlike other services, the BAS provider's focus is more on working with the caregivers to provide them with the skills to execute the procedures as detailed in the BASP, rather than, the BAS provider intervening directly with the service recipient.

In the initial stages of treatment, the BAS provider may provide direct intervention with the service recipient to help bring the problem behavior under control within a short period of time. However, thereafter, any direct intervention performed by the BAS provider must be performed in the presence of caregivers and used as a training vehicle or a method of evaluating a caregiver's maintenance of skills.

Behavior assistant services should be time limited. Once paid or unpaid support persons gain skills and abilities to assist the individual to function more independently and in less challenging ways, the behavior assistant services should be faded out and discontinued.

All Behavior Assistant Services provided must be authorized in a Behavior Assistant plan contained within the Behavior Analysis Services Plan developed by a supervising behavior analyst or provider licensed under chapter 490 or 491, F.S., reviewed and approved by the Local Review Committee and the Area Behavior Analyst or designee. The Behavior Analysis Services Plan should include methods for demonstrating competency of caregivers in behavior plan implementation, and a time-based fading plan in which there is an incremental reduction in service by the behavior assistant as well as the supervising behavior analyst, as the long-term caregivers become competent in the procedures and assume more of the responsibilities for implementing the plan.. The Behavior Analysis Services Plan must be designed, implemented or monitored and approved in accordance with 65G-4.009 and 65G-4.010, F.A.C. In those cases where Behavior Assistant services are provided but there is a consistent trend of no progress or targeted behaviors are getting worse then these services may be terminated or aggressively faded upon recommendation of the Local Review Committee Chairperson.

Behavior Assistant Services (BAS), continued

Description, continued

In addition to training and systematically transferring the implementation of procedures to the caregivers, behavior assistant services include monitoring of caregivers implementing the behavior plan, data collection, copying of materials for data collection and implementation of procedures, as well as communicating with the supervising behavioral services provider, in order to assist the Behavior Analyst or provider licensed under Chapter 490 or 491, F.S.

Behavior Assistant services are designed for individuals under one or more of the following conditions:

1. Health and safety needs that are a direct result of the individual's challenging behaviors that pose a documented risk to the individual or the community and may result in a loss of current living environment and a more restrictive setting. Documentation may include, but is not limited to police reports, hospitalization reports, medical reports, incident reports or other records that will substantiate the severity and frequency of the behavior.
2. Other paid or unpaid services requiring time limited supports to demonstrate their efficacy.
3. For a time limited period during transitional residential changes, such as movement from Intensive Behavioral Residential Habilitation to Behavior Focus Residential Habilitation, or other significant life changes where challenging behaviors are likely to increase and new caregivers need to be trained to ensure a successful move.

These services are supplementary to those offered through the school system with a focus in transferring instructional control to caregivers in naturally occurring situations.
These services are not to be provided in the school system or take the place of services required under provisions of the Individuals with Disabilities Education Act (IDEA).

Limits on the Duration, Frequency, Intensity and Scope

Behavior Assistant Services are limited to a maximum of 32 quarter hours per day. Individuals requiring over 24 quarter hours per day must have monthly reviews by the Local Review Committee. Behavior Assistants must receive at least two hours of supervision per month by the supervising behavior analyst or licensed provider, or as deemed appropriate by the LRC.

Behavior Assistant Services (BAS), continued

Provider Qualifications

Providers of this service must have at least:

1. A high school diploma and be at least 18 years of age;
2. Two years of experience providing direct services to individuals with developmental disabilities or
   a. at least 120 hours of direct services to individuals with complex behavior problems, as defined in rule 65G-4.010(2), F.A.C., or
   b. 90 classroom hours of instruction in applied behavior analysis from non-university non-college classes or university and college courses; and
3. 20 contact hours of instruction in a curriculum meeting the requirements specified by the APD and approved by the APD-designated behavior analyst. Instruction must be provided by a person meeting the qualifications of any category of behavior analysis provider as described in this handbook. At least half of the 20 hours of instruction must include real time visual and auditory contact (face-to-face or via electronic means) for initial certification.
   a. Either a certificate of completion or a college or university transcript and a course content description, verifying the applicant completed the required instruction, will be accepted as proof of instruction.
   b The 90 classroom hours of instruction specified under number 2b. above shall also count as meeting the requirements of the 20 contact hours specified in this section.
4. And, successful completion of training based upon an approved emergency procedures curriculum, as defined in 65G-8.002, F.A.C.
5. And, at least 8 hours of supplemental training for annual recertification, determined by the local Area Behavior Analyst
6. And training in an Agency Approved Emergency Procedure Curriculum consistent with 65G-8.002, F.A.C., where providers will be working with individuals with significant behavioral challenges.

Diplomas or Degrees earned in other countries shall be accompanied by authentication documentation that the degree is equivalent to the educational requirements for the position.

Place of Service

These services may be provided in the individual's place of residence or anywhere in the community. However, in all cases, behavior assistant services must also be provided in the setting(s) relevant to the behavior problems being addressed and with the primary caregivers present.

Behavior Assistant Services (BAS), continued

Special Considerations	The services of a Behavior Assistant must be approved by the responsible Behavior Analysis Services Local Review Committee Chairperson, as defined in rule 65G-4.008, F.A.C., and monitored by a person who is certified in behavior analysis or licensed under Chapters 490 or 491, F.S., in accordance with rule 65G-4.009 and 65G-4.010, F.A.C.

Dietitian Services

Description	Dietitian services are those services prescribed by a physician that are necessary to maintain or improve the overall physical health of an individual. The services include assessing the nutritional status and needs of an individual; recommending an appropriate dietary regimen, nutrition support and nutrient intake; and providing counseling and education to the individual, family, direct service staff and food service staff. The services may also include the development and oversight of nutritional care systems that promote an individual's optimal health.
Limitations	An individual shall receive no more than 12 units of these services per day. A unit is defined as a 15-minute time period or portion thereof.
Provider Qualifications	Providers of dietitian services shall be dietitians or nutritionists licensed in accordance with Chapter 468, part X, F.S.
Place of Service	This service may be provided in the provider's office, in the home, or anywhere in the community.
Special Considerations	Dietitian services require an annual physician's order and shall be limited only to individuals who require specialized oversight of their nutritional status in order to prevent deterioration of general health that could result in an institutional placement. Individuals requiring nutritional supplements must have a dietitian's assessment documenting such need. Nutritional supplements are available through the Medicaid DME and Medical Supplies Program state plan services, under specific circumstances. For additional information on Medicaid state plan coverage requirements, refer to the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook. Note: The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The handbook is incorporated by reference in 59G-4.070. F.A.C.

Private Duty Nursing

Description

Private duty nursing services are prescribed by a physician and consist of individual, continuous nursing care provided by registered or licensed practical nurses. Nurses must provide private duty nursing services, in accordance with Chapter 464, F.S.

Limits on the Duration, Frequency, Intensity and Scope

Private duty nursing services are available through the Medicaid Home Health Program state plan services to children under the age of 21 with complex medical needs. Licensed nursing is available to children and adults when determined medically necessary by the Medicaid Home Health State Plan Program and related to the care of a medical condition.

To be eligible for this service, an individual must require active nursing interventions on an ongoing basis. This service is provided on a one-to-one basis to eligible individuals. If the service is provided with two or more individuals present, the amount of time billed must be prorated between the numbers of individuals receiving the service. This service may be provided concurrently (at the same date and time) with another service. A nursing assessment must be performed to determine the need for the service or to evaluate the individual for care plan development. Reimbursement for a nursing assessment is considered two hours of service at the registered nurse rate. Only registered nurses may perform an assessment. Nursing assessments should be updated annually and as needed if there is a significant change in the individual's health status.

A registered nurse is required to monitor the service provision of an LPN who is a solo provider.

The waiver may pay only for those medically-necessary services not covered by the Medicaid State Plan Home Health Program. An individual shall receive no more than 96 units of this service per day. A unit is defined as a 15-minute time period or portion thereof.

Note: Refer to the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information on Medicaid state plan coverage. The handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. It is incorporated by reference in 59G-4.130, F.A.C.

Provider Qualifications

Providers of private duty nursing services shall be nurses registered or licensed in accordance with Chapter 464, F.S.

Nurses may provide this service as employees of licensed home health, hospice agencies or nurse registries licensed in accordance with Chapter 400, parts III or IV, F.S. They may also be enrolled as independent vendors providing services under their own name and license.

Private Duty Nursing, continued

Place of Service	Private duty nursing services shall be provided in the individual's own home or family home.
Special Considerations	Private duty nursing services shall not be used for ongoing medical services and oversight in a licensed residential facility.

Residential Nursing Services

Description	Residential nursing services are services prescribed by a physician and consist of individual continuous nursing care provided by registered or licensed practical nurses, in accordance with Chapter 464, F.S., and within the scope of Florida's Nurse Practice Act, for individuals who require ongoing nursing intervention in a licensed residential facility, group or foster home. A nursing assessment must be performed to determine the need for the service or to evaluate the individual for care plan development. Reimbursement for a nursing assessment is considered two hours of service at the registered nurse rate. Only registered nurses may perform an assessment. Nursing assessments should be updated annually and as needed, if there is a significant change in the individual's health status.
Limits on the Duration, Frequency, Intensity and Scope	This service supplements nursing services available through the Medicaid State Plan Home Health Program. Private duty nursing services are available to children under the age of 21 with complex medical needs. Licensed nursing is available to children and adults when determined medically necessary by the Medicaid State Plan Program and related to the care of a medical condition. Nursing services not available to adults under the Medicaid State Plan Home Health Program may be paid for by the DD waiver, if determined medically necessary by the APD. An individual may receive up to 96 units (24 hours) of nursing services a day. A unit is defined as a 15-minute time period or a portion thereof Note: Refer to the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information on Medicaid state plan coverage. The handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. It is incorporated by reference in 59G-4.130, F.A.C.
Provider Qualifications	Providers of residential nursing services shall be nurses registered or licensed in accordance with Chapter 464, F.S. Nurses may provide these services as independent vendors or as employees of licensed residential facilities

Residential Nursing Services, continued

Place of Service	Residential nursing services must be provided at a licensed group or foster home considered to be the individual's place of a residence.

Skilled Nursing

Description	Skilled nursing is a service prescribed by a physician and consists of part-time or intermittent nursing care provided by registered or licensed practical nurses or vocational nurse under the supervision of a registered nurse licensed to practice within the State of Florida, within the scope of Florida's Nurse Practice Act , in accordance with Chapter 464, F.S. A nursing assessment must be performed to determine the need for the service, or to evaluate the individual for care plan development. Reimbursement for a nursing assessment is considered two hours of service at the registered nurse rate. Only registered nurses may perform an assessment. Nursing assessments should be updated annually and as needed if there is a significant change in the individual's health status.
Limits on the Frequency, Duration, Intensity and Scope	Skilled nursing services are available under Medicaid State Plan to children under the age of 21 with complex medical needs. Licensed nursing is available to children and adults when determined medically-necessary by the Medicaid State Plan Program and related to the care of a medical condition. Nursing services not available to individuals over 21 under the Medicaid State Plan may be paid for by the iBudget Florida waiver. The iBudget waiver may pay only for those medically necessary services not covered by the Medicaid State Plan Home Health Program. Nursing services available under the Medicaid State Plan may not be purchased using waiver funds. Further, waiver funds cannot be used to purchase additional hours of nursing services that are above the Medicaid State Plan limitation amount. The individual shall receive no more than 32 units of this service per day. A unit is defined as a 15-minute time period or portion thereof. This service may be provided concurrently (at the same time and date) with another service being furnished by another provider. Skilled nursing services do not include time spent completing the OASIS assessment. Note: Refer to the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage. The handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The handbook is incorporated by reference in rule 59G-4.130, F.A.C.

Skilled Nursing**,** continued

Provider Qualifications	Providers of skilled nursing services shall be nurses registered or licensed in accordance with Chapter 464, F.S. Nurses may provide this service as solo vendors or as employees of home health, hospice agencies or nurse registries licensed in accordance with Chapter 400, parts III or IV, F.S. Home health agencies must also be enrolled in the Medicaid home health program and meet Federal Conditions of Participation in accordance with 42 CFR Part 484.
Place of Service	Skilled nursing services shall be provided at the individual's place of residence and other waiver service sites, such as an adult day training program.
Special Considerations	Skilled nursing services shall not be used for the ongoing medical oversight and monitoring of direct care staff or caregivers in a licensed residential facility or in the individual's own or family home.

Occupational Therapy

Description	Occupational therapy is a service prescribed by a physician that is necessary to produce specific functional outcomes in self-help, adaptive, and sensory motor skill areas, and assist the individual to control and maneuver within the environment. The service includes an occupational therapy assessment, which does not require a physician's prescription. In addition, the occupational therapist shall train direct care staff and caregivers and monitor those individuals to ensure they are carrying out therapy goals correctly.

Occupational Therapy, continued

Limits on the Frequency, Duration, Intensity and Scope	Occupational therapy and assessment services are available through the Medicaid Therapy Services Program state plan services to individuals under the age of 21. Services for these individuals may not be purchased under the waiver. Refer to the Florida Medicaid Therapy Services Coverage and Limitations Handbook for additional information on Medicaid state plan coverage. Children who receive this service through a school health program may still be eligible for additional Medicaid state plan occupational therapy services. As a general guideline, an individual should receive no more than eight units of these services per day. A unit is defined as a 15 minute time period or portion thereof. The occupational therapy assessment is limited to one per year. Note: The Florida Medicaid Therapy Services Coverage and Limitations Handbook are available on the Medicaid fiscal agent's Web site at www,mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The handbook is incorporated by reference in 59G-4.320, F.A.C.
Provider Qualifications	Providers of occupational therapy and assessment services shall be licensed as occupational therapists, occupational therapy aides, or occupational therapy assistants, in accordance with Chapter 468, part III, F.S. They may also provide and bill for the services of a licensed occupational therapy assistant. The licensed occupational therapy assistant is not qualified to perform occupational therapy assessments. Assessments can only be performed by a licensed occupational therapist. Occupational therapists, aides and assistants may provide services as independent vendors or an employee of an agency. Occupational therapy aides and assistants must be supervised by an occupational therapist in accordance with the requirements of their professional licenses.
Place of Service	These services may be provided in the therapist's office, in the individual's residence, or anywhere in the community

Physical Therapy

Description

Physical therapy is a service prescribed by a physician that is necessary to produce specific functional outcomes in ambulation, muscle control, and postural development and to prevent or reduce further physical disability.

The service may also include a physical therapy assessment, which does not require a physician's prescription. In addition, the physical therapist must train and monitor direct care staff and caregivers to ensure they are carrying out therapy goals correctly.

Limits on the Duration, Frequency, Intensity and Scope

Physical therapy and assessment services are available through the Medicaid Therapy Services Program state plan services to individuals under the age of 21. Services for these individuals may not be purchased under the waiver.

Children who receive this service through a school health program are still eligible for medically-necessary services funded by the Medicaid Therapy Services Program state plan coverage. When additional therapy is necessary, families must seek Medicaid Therapy Program state plan services. Refer to the Florida Medicaid Therapy Services Coverage and Limitations Handbook for additional information on Medicaid state plan coverage.

Adults may receive up to $1,500 annually in outpatient services under the Medicaid Hospital Program state plan services, including physical therapy. If the individual is able to use a hospital outpatient facility for physical therapy and the setting is appropriate to meet the individual's needs, it may be possible to receive limited services funded by the Medicaid Hospital Program state plan services.

The waiver should only be used to fund physical therapy services for adults either when the outpatient dollar limits are reached or when physical therapy must be provided in a location other than a hospital outpatient facility.

As a guideline, an individual should receive no more than eight units of therapy service per day. A unit is defined as a 15-minute time period or portion thereof. The physical therapy assessment is limited to one per year.

Note: The Florida Medicaid Therapy Services Coverage and Limitations Handbook and the Florida Medicaid Hospital Services Handbook are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The Therapy Handbook is incorporated by reference in 59G-4.320, F.A.C. and the Hospital Handbook in 59G-4.160, F.A.C.

Physical Therapy, continued

Provider Qualifications	Providers of physical therapy and assessment services shall be licensed as physical therapists and physical therapist assistants in accordance with Chapter 486, F.S. Physical therapists may provide this service as independent vendors or as an employee of an agency. They may also employ and bill for the services of a licensed physical therapy assistant. The licensed physical therapy assistant is not qualified to perform physical therapy assessments. Assessments can only be performed by a licensed physical therapist. Physical therapy assistants must be supervised by a physical therapist in accordance with the requirements of their professional licenses.
Place of Service	This service may be provided in the therapist's office, individual's residence, or anywhere in the community.

Respiratory Therapy

Description	Respiratory therapy is a service prescribed by a physician and relates to impairment of respiratory function and other deficiencies of the cardiopulmonary system. Treatment activities include ventilator support, therapeutic and diagnostic use of medical gases, respiratory rehabilitation, management of life support systems, bronchopulmonary drainage, breathing exercises and chest physiotherapy. The provider determines and monitors the appropriate respiratory regimen and maintains sufficient supplies to implement the regimen. The provider must also provide training to direct care staff to ensure adequate and consistent care is provided. Respiratory therapy services may also include a respiratory assessment.

Respiratory Therapy, continued

Limits on the Frequency, Duration, Intensity and Scope	Respiratory therapy and assessment services are available through the Medicaid Therapy Services Program state plan services for individuals under the age of 21. Services for these individuals may not be purchased under the waiver. Children receiving this service through a school health program are still eligible for medically-necessary services funded by the Medicaid State Plan. When additional therapy is necessary, families must seek the Medicaid State Plan services for funding. The Medicaid Durable Medical Equipment (DME) and Medical Supplies Program state plan services covers respiratory equipment and supplies for adults and children. The waiver cannot reimburse for respiratory supplies and equipment. An individual shall receive no more than eight units of this service per day. A unit is defined as a 15-minute time period or portion thereof. Two assessments per year are allowed. Note: Refer to the Florida Medicaid Therapy Services Coverage and Limitations Handbook and the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for additional information on Medicaid state plan coverage. The handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The Florida Medicaid Therapy Services Coverage and Limitations Handbook is incorporated by reference in rule 59G-4.320, F.A.C.; and the Florida Medicaid Durable Medical Equipment and Medical Supply Services is incorporated by reference in rule 59G-4.070, F.A.C.
Provider Qualifications	Providers of respiratory therapy and assessment services shall be respiratory therapists licensed in accordance with Chapter 468, Part V, F.S. Respiratory therapists may be either independent vendors or an employee of an agency.
Place of Service	This service is provided in the individual's place of residence.
Special Considerations	Respiratory therapy services shall be provided under a physician's prescription.

Speech Therapy

Description	Speech therapy is a service prescribed by a physician and is necessary to produce specific functional outcomes in the communication skills of an individual with a speech, hearing or language disability. The service may also include a speech therapy assessment, which does not require a physician's prescription. In addition, this service must include training and monitoring of direct care staff and caregivers, to ensure they are carrying out therapy goals correctly.

Speech Therapy, continued

Limits on the Frequency, Duration. Intensity and Scope	Speech therapy and assessment services are available through the Medicaid Therapy Services Program state plan services for individuals under the age of 21. Services for these individuals may not be purchased under the waiver. Children receiving this service through a school health program are still eligible for medically necessary services funded by Medicaid state plan coverage. When additional therapy is necessary, families must seek Medicaid state plan services coverage. Assessments for augmentative communication devices and assessments for training are covered by the Medicaid Therapy Services Program state plan services for all Medicaid individuals. As a guideline, an individual shall receive no more than eight units of this service per day. A unit is defined as a 15-minute time period or portion thereof. The speech therapy assessment is limited to one per year.
Provider Qualifications	Providers of speech therapy and assessment services shall be speech-language pathologists and speech-language pathology assistants licensed by the Department of Health, in accordance with Chapter 468, Part I, F.S., and may perform services within the scope of their licenses. Speech-language pathologists and assistants may provide this service as an independent vendor or as an employee of an agency. Speech therapists may also provide and bill for the services of a licensed or certified speech therapy assistant. Only licensed speech therapists can perform assessments. Speech-language pathologists with a master's degree in speech language pathology who are in their final clinical year of training may also provide this service. Speech-language assistants must be supervised by a speech-language pathologist in accordance with the requirements of their professional licenses, per Chapter 468, Part I, F.S.
Place of Service	This service may be provided in the therapist's office, in the individual's place of residence, or anywhere in the community.

Specialized Mental Health Counseling

Description

Specialized mental health services for persons with developmental disabilities are services provided to maximize the reduction of an individual's mental illness and restoration to the best possible functional level. Specialized mental health services focus on the unique treatment of psychiatric disorders and rehabilitation for impairments for persons with developmental disabilities and mental illness. These services include specialized individual, group and family therapy provided to individuals using techniques appropriate to this population.

Specialized mental health services include information gathering and assessment, diagnosis, development of a plan of care (treatment plan) in coordination with the individual's support plan, mental health interventions designed to help the individual meet the goals identified on the support plan, medication management and discharge planning. This specialized treatment will integrate the mental health interventions with the overall service and supports to enhance emotional and behavioral functions.

Limits on the Duration, Frequency, Intensity and Scope

This service supplements mental health services available under the Medicaid Community Behavioral Health Program state plan services. Mental health services are available to individuals with diagnosed mental illnesses who can benefit from and participate in therapeutic services provided under the Medicaid Community Behavioral Health Program. Refer to the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage.

This service excludes hippo therapy, equine therapy, horseback riding therapy, music therapy, recreation therapy, etc.

This service is provided one to two times weekly for one hour.

Note: The Florida Medicaid Community Behavioral Health Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web Portal at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support and then Provider Handbooks. The handbook is incorporated by reference in rule 59G-4.050, F.A.C.

Provider Qualifications

Providers of specialized mental health services shall be:

- Psychiatrists licensed in accordance with Chapter 458 or 459, F.S.;
- Psychologists licensed in accordance with Chapter 490, F.S.; or
- Clinical social workers, marriage and family therapists or mental health counselors licensed in accordance with Chapter 491, F.S.

Providers of specialized mental health services shall have two year's experience working with individuals dually diagnosed with mental illness and developmental disabilities.

Specialized Mental Health Counseling, continued

Place of Service	These services may be provided in the provider's office, the individual's place of residence, or anywhere in the community
Special Considerations	For purposes of this service, "family" is defined as the persons who live with or provide care to an individual served on the waiver, and may include a parent, spouse, children, relative, foster family, or in-laws. "Family" does not include individuals who are employed to care for the individual. Community mental health centers are not eligible to enroll to provide this service. If they are able to meet the needs of an individual, their services are billed to the Medicaid Community Behavioral Health Program.

Transportation Services

SERVICE FAMILY 7 – TRANSPORTATION SERVICE

- **Transportation**

Transportation services are the provision of rides to and from the individual's home and community-based waiver services, enabling the individual to receive the supports and services identified on both the support plan and approved cost plan, when such services cannot be accessed through natural (i.e., unpaid) supports.

Transportation services funded through the iBudget Florida program shall be used only for individuals who have no other means to get to a service identified on the support plan and approved cost plan. Family members, neighbors or friends who already transport the individual, or who are capable of transporting the individual at no cost to the APD, shall be encouraged to continue their support of the individual. Individuals who are capable of using the fixed route public transit system to access services on their support plan shall be encouraged to use that method of transportation. Transportation services should be negotiated at the most cost effective rate from a provider which meets or exceeds the transportation disadvantaged system safety standards.

This service is not available for transporting an individual to school through 12th grade and/or age 22 while still eligible to receive a free and public education. Transportation to and from school is the responsibility of the public school system. For other transportation needs not identified on the individual's support plan and approved cost plan, the individual should be directed to the local Community Transportation Coordinator or, if available, the local area's fixed route fixed schedule public transit (bus system).

Transportation Services, continued

Vehicles shall not carry more passengers than the vehicle's registered seating capacity. Driver and driver's assistant(s) are considered passengers.

Fifteen passenger vehicles that are not lift-equipped shall not carry more than ten passengers at any given time, and shall follow the National Highway Transportation Safety Board guidelines for loading such vehicles.

Boarding assistance shall be provided as necessary or as requested by the individual being transported. Such assistance shall include opening the vehicle door, fastening the seat belt, securing a wheelchair, storage of mobility assistance devices, and closing the vehicle door. Individuals shall not be carried. Drivers and drivers' assistants shall not assist passengers in wheelchairs up or down more than one step, unless it can be performed safely as agreed by the individual, individual's legal representative, or individual's representative. Drivers and drivers' assistants shall not provide any assistance that is unsafe for the driver, the driver's assistant, or the individual.

In accordance with section 316.613, F.S., children five years of age or younger must be transported in a federally-approved child restraint device. The provider must have the installation of the child restraint device and the positioning of the child checked at a local authorized child safety seat fitting station or by a certified child seat safety technician. For children from birth through three years of age, such restraint device must be a separate carrier or a vehicle manufacturer's integrated child seat. For children from four through eight years of age, a separate carrier, an integrated child seat, or a booster seat with appropriately positioned safety belt, as appropriate for the child's size and age, may be used. In Florida, every county sheriff's office and city police station serves as a fitting station and every traffic law enforcement officer has been trained to provide assistance.

In vehicles with passenger-side air bags turned on, children under the age of 12 and any adult or child less than 100 pounds must be transported in the back seat. In vehicles that also have side-impact air bags, children and adults less than 100 pounds must be transported as close to the middle of the back as possible.

A first aid kit equivalent to Red Cross Family Pak #4001 and an A-B-C fire extinguisher shall be carried on board the vehicle at all times when transporting individuals.

When the vehicle is in motion, all mobility devices (wheelchairs, scooters, etc.) shall be secured with appropriate tie-downs, regardless of whether or not a person is physically positioned in the mobility device; and cell phone, fire extinguisher, first aid kit, and any other such items that could become airborne in the event of a sudden stop or accident must be secured.

Drivers, drivers' assistants or escorts provided by the provider to accompany the individual shall be trained in the Health and Safety Module and the use of the on-board first aid kit. CPR must be provided in a classroom setting by an instructor certified by either the American Heart Association or Red Cross.

Transportation Services, continued

Limits on the Frequency, Duration, Intensity and Scope

Providers of Life Skills Development, personal supports, residential habilitation, respite care, specialized mental health services, support coordination and supported living coaching may not bill separately for transportation that is an integral part of the provision of their primary service with the following exceptions:

- If the provider of one of these indicated services is enrolled as a transportation provider
- If the individual is being transported between his place of residence and the site of a distinct waiver service or
- If the individual being transported between two waiver service sites and the service at each site is delivered by a different provider

Transportation between service sites operated by the same provider or transportation that is an integral part of the service being received by the individual is included in the rate paid to the providers of the appropriate types of waiver services.

Transportation services are available through the Medicaid Non-Emergency Transportation Program state plan services to transport individuals to Medicaid-eligible medical appointments and services. DD waiver funds shall not be used when the individual's trip is for a Medicaid State Plan service.

When a transportation provider is paid by the Medicaid State Plan to transport a Medicaid individual to an eligible service, the individual will be charged a copayment, for which the individual is responsible. DD waiver funds cannot be used to pay any copayment for Medicaid funded transportation services.

When the individual uses a DD waiver provider for transportation to a service listed on the support plan and current approved cost plan and the provider is paid with DD waiver funds, the provider shall not charge the individual a copayment.

Providers may bill for their service by the mile, by the one-way trip, or by the month. Regardless of how services are billed, all providers, except limited service providers, must during the rate-setting process define the charges for their services in terms of cost per vehicle mile. Providers must ensure group trips, ride sharing and multi-loading to the greatest extent possible. If more than one individual is being transported, the mileage charge will be shared among the number of waiver individuals transported. When a provider is reimbursed by the trip, an individual shall receive no more than four one-way trips per day, or 80 per month of this service. Only providers that want to bill for actual expenses incurred may bill by the month. Limited transportation providers, i.e., family members, friends or neighbors, will be reimbursed at the state mileage rate.

Transportation Services, continued

Provider Qualifications

All providers must comply with reporting requirements of Chapter 427, F.S., in order to provide and be reimbursed for transportation under the Medicaid DD Waiver, transportation providers may be Community Transportation Coordinators (CTC) for the Transportation Disadvantaged; limited transportation providers; Public Transit Authorities that run the community's fixed-route, fixed-schedule public bus system; group homes and other residential facilities in which the individuals being transported live; adult day training programs to which the individuals are being transported; and other public, private for-profit and private not-for-profit transportation entities. The manner in which each of these types of providers may be used is specified in Chapter 427, F.S., and described below. All providers must have a valid Florida driver's license.

Pursuant to Chapter 427, part I, F.S., transportation services shall be purchased from Community Transportation Coordinators utilizing the public, private for-profit, or private not-for-profit transportation operators within each county's coordinated transportation system.

Limited transportation providers are relatives, friends and neighbors. They are not "for hire" entities. They are reimbursed at the state mileage rate. The Area is not required to contact or obtain authorization from the CTC in order to use the services of a limited transportation provider. The CTC has no responsibility for overseeing service delivery of such providers. The Area is responsible for this oversight.

When transportation providers are also relatives, controls must be in place to ensure that the payment is made to the relative only in return for specific services rendered, and that there is adequate justification as to why the relative is being paid for the service, rather than being a natural support.

Public Transit Authorities that operate the community's fixed-route, fixed-schedule public bus system may enroll in the DD Waiver to facilitate the purchase of monthly or other frequency bus passes. If natural supports are unavailable, this transportation option is to be used for individuals who can use the fixed-route, fixed-schedule public bus system to go to some or all of their waiver services. Bus passes are to be purchased for individuals who can utilize the bus system to go to their waiver service sites whenever the cost of the trips to be taken during the month, if taken by Para transit, would exceed the cost of the monthly bus pass. Public Transit Authorities are required to adhere to minimum safety standards set forth in Chapter 14-90, F.A.C.

Transportation Services, continued

Provider Qualifications, continued

The Area is not required to contact or obtain authorization from the CTC in order to use the services of the fixed-route fixed-schedule bus system. Drivers of fixed-route, fixed-schedule buses are not considered direct service providers within the context of Chapter 393, F.S. Therefore, they are not required to be level 2 background screened. The CTC has no responsibility for overseeing service delivery of such providers. Group homes or other residential facilities in which individuals live may enroll as transportation providers to transport the individuals to and from their waiver services. Adult day training agencies that individuals regularly attend may enroll as transportation providers to transport the individuals to and from the agencies' programs. In order to use group homes, residential facilities, or adult day training (ADT) agencies as transportation providers, the Area must obtain written authorization from the CTC. The authorization will result in a written agreement that sets forth the roles and responsibilities of the CTC, the group home, residential facility or Life Skills Development agency and the Area for complying with vehicle and passenger safety standards, adhering to, monitoring and overseeing service delivery and any necessary reporting to ensure compliance with Chapter 427, F.S. This arrangement will benefit the providers by enabling them to purchase new or replacement vehicles on state contract through the Department of Transportation.

Transportation providers that are not part of the coordinated transportation system may transport waiver individuals under the following circumstances:

- If the CTC determines it is unable to provide or arrange the required transportation for an individual, transportation providers who operate outside the coordinated transportation system (e.g., taxi companies, private for-profit or not-for-profit transportation companies) may be used to transport the individual to and from their waiver services.

The CTC has no responsibility for monitoring adherence to driver, vehicle and passenger safety standards or overseeing service delivery of such providers. The provider and Area are responsible for complying with reporting requirements of Chapter 427, F.S., through the APD Director's designee on the Commission for the Transportation Disadvantaged.

If the Area Office wishes to utilize a transportation provider that is not a part of the coordinated transportation system, the Area must contact the CTC in the individual's county of residence and follow their procedures for use of alternative providers, as required by the Florida Commission for the Transportation Disadvantaged. This authorization will be issued to the Area. These providers must meet the driver, vehicle and passenger safety standards of overseeing service delivery of such providers. The provider and Area are responsible for complying with reporting requirements of Chapter 427, F.S., through the APD Director's designee on the Commission for the Transportation Disadvantaged.

Transportation Services, continued

Place of Service	This service is provided anywhere in the community.
Special Considerations	When an individual must have an escort to provide assistance, the transportation provider may be paid for transporting both the individual and the escort, unless it is the policy of the transportation provider to allow an escort to ride free of charge. Some county coordinated transportation systems do not charge for an escort to ride with an individual with a disability. When paid vendors are also family members, controls must be in place to ensure that the payment is made to the relative only in return for specific services rendered; and there is adequate justification as to why the relative is the paid vendor of the service, rather than a natural support.

Dental Services

SERVICES FAMILY 8- DENTAL SERVICES

- **Adult Dental Services**

Adult dental services cover dental treatments and procedures that are not otherwise covered by the Medicaid Dental Services Program state plan services.

Adult dental services include diagnostic, preventive and restorative treatment; extractions; endodontic, periodontal and surgical procedures. The services strive to prevent or remedy dental problems that if left untreated could compromise an individual's health, by increasing the risk of infection or disease, or reducing food options, resulting in restrictive nutritional intake.

Emergency dental procedures to alleviate pain and or infection and full and partial dentures are covered by Medicaid state plan dental services.

Dental Services, continued

Limits on the Duration, Frequency, Intensity and Scope	Adult dental services are limited to individuals 21 years of age or older. Adult dental services will not duplicate dental services provided to adults by the Medicaid Dental Services covered by the Medicaid state plan. The Medicaid Dental Services also provide dental services for individuals under the age of 21. Adult cleanings are limited to two per year. There is no limit in the number of emergency episodes per year or the number of teeth that may be extracted per emergency episode. Refer to the Florida Medicaid Dental Services Coverage and Limitations Handbook for additional information regarding Medicaid state plan coverage. An individual shall receive no more than ten units of this service per day. Note: The Florida Medicaid Dental Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The handbook is incorporated by reference in 59G-4.060.
Provider Qualifications	License: Providers of adult dental services shall be dentists licensed in accordance with Chapter 466, F.S. Unlicensed dental interns and dental students of university based dental programs may provide services under the general supervision of a licensed dentist but cannot act as a treating provider or bill Medicaid for covered services**.**
Place of Service	Adult dental services shall be provided in the provider's office or other setting, determined appropriate by the provider.
Special Considerations	Adult dental services are to be authorized only to prevent or remedy problems that could lead to a deterioration of the individual's health, thus placing the individual at risk of an institutional placement. Second opinions are covered when extensive dental work is planned or there is a question about medical necessity of all the work planned. Providers of adult dental services are paid for each date of service and shall prepare their bills accordingly. The provider will submit an invoice listing each procedure and negotiated cost. All procedures or treatments rendered on one day shall be totaled into one bill for payment on that day.

CHAPTER 5

iBudget Waiver Services

Reimbursement Information

Overview

Introduction

This chapter provides and describes reimbursement information regarding the iBudget Waiver Program.

In This Chapter

This chapter contains:

Reimbursement Information Procedure Codes

Medicaid reimburses home and community-based waiver procedure codes based on the Healthcare Common Procedure Coding System (HCPCS) codes, Level I and Level II. Level 1 procedure codes (CPT) are a systematic listing and coding of procedures and services performed by providers. Each procedure or service is identified by a five digit numeric code. The codes are part of the standard code set described in the Physician's Current Procedure Terminology (CPT) book. Please refer to the CPT book for complete descriptions of the standard codes. CPT codes and descriptions are copyright by the American Medical Association. All rights reserved. Level 2 procedure codes are national codes used to describe medical services and supplies. They are distinguished from Level 1 codes by beginning with a single letter (A through V) followed by four numeric digits. The codes are part of the standard code set described in HCPCS Level II Expert code book. Please refer to the HCPCS Level II Expert code book for complete descriptions of the standard codes. The HCPCS Level II Expert code book is copyright by Ingenix, Inc. All rights reserved. The procedure codes and maximum units of service that Medicaid reimburses for DD waiver services are listed on the iBudget Home and Community- Based Services Waiver Procedure Codes and Maximum Units of Service Table.

Note: The iBudget Home and Community-Based Services Waiver Procedure Codes and Maximum Units of Service Table are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Fee Schedules. The procedure code table is incorporated by reference in 59G-13.081, F.A.C.

Overview, continued

Billing Procedures

Each provider is required to submit all claims (paper or electronic) for waiver services directly to Medicaid's fiscal agent. Effective July 1, 2008, the 081 claim form is being replaced by the CMS-1500 claim form. Billing for services that use a quarter hour unit must be billed according to the following schedule:

- Services provided from 1 -15 minutes are billed for one quarter hour.
- Services provided from 16 - 30 minutes are billed as two quarter hours.
- Services provided from 31 - 45 minutes are billed as three quarter hours.
- Services provided from 46 - 60 minutes are billed as four quarter hours.

When billing for services by the quarter hour the provider should total at the end of each billing period actual time spent with the recipient and round the total to the nearest quarter hour as described above. Rounding for the specific service provided should occur only once at the time of billing. Specific billing instructions and procedures for submitting claims can be found in the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 08. Billing instructions will be in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500. The Medicaid fiscal agent provides billing training for providers of DD Waiver services. The Medicaid fiscal agent may be contacted at 800-829-0218 to request this training.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at www.mymedciaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The Florida Medicaid. Provider Reimbursement Handbook, Non-Institutional 081, is incorporated by reference in 59G-13.001, F.A.C.; Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C.

iBudget Florida Waiver Service Rate

Effective July 1, 2003, all rates are determined by the operating agency, which is the Agency for Persons with Disabilities, based on the availability of appropriated funding from the Florida. The provider and the individual may negotiate for a lower rate.

Note: The iBudget Waiver Provider Rate Table is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Fee Schedules. It is incorporated by reference in 59G-13.081, F.A.C

Overview, continued

Recoupment of Funds

Providers of waiver services must provide these services in a manner that meets the definition and requirements found in this handbook and in the Medicaid Waiver Services Agreement. If the provider fails to meet service standards, to properly document the delivery of services or to receive reimbursement for services not properly authorized or delivered, these payments are considered overpayments and can result in a recoupment of funds by the Agency for Persons with Disabilities (APD) or the Agency for Health Care Administration (AHCA), in accordance with 409.913 and 59G-9.070, F.A.C. In addition, providers of services that require the development of implementation plans are subject to the recoupment policies specific to the development and implementation of their services for each recipient they serve. These services are: adult day training, non-residential support services, residential habilitation, supported employment and supported living coaching.

- An amount equal to the daily rate or a pro-rated daily portion of a monthly rate shall be paid back to APD by the provider for each day that the daily service log does not document that the service was provided as billed and after the 30-calendar day time frame that a final implementation plan was not available.
- An amount equal to a monthly rate shall be paid back to APD for each month that a quarterly summary was not available describing the recipient's progress for the quarter toward attaining the support plan goal(s). Support coordinators are subject to the recoupment policies specific to the performance of identified, essential support coordination activities.
- An amount equal to the daily rate, or a pro-rated daily portion of each monthly rate shall be paid back to APD by the provider for each day after the effective date of a recipient's support plan, that a plan is not available and after the effective date of the recipient's cost plan, that a cost plan is not available and sent to the APD Area Office for approval.
- An amount equal to the monthly rate shall be paid back to APD for each month that services were billed, without supporting documentation. Face-to-face contact for a recipient, quarterly, semi-annual or annual visit to the recipient's place of residence as defined above, and no documentation to support a family's desire to postpone the visit; the monthly payback is applicable to the month when the visit was scheduled to occur.

All other providers are subject to the recoupment policies specific to the service requirements specified in this handbook.

Note: Refer to Chapters 1, 2 and 3 for additional information and requirements pertaining to waiver support coordination as well as other services.

Overview, continued

Limitation	Providers may not bill for service when a recipient is not in attendance, except as noted in the description section of that service. A provider shall not render a claim or bill for more than one service to the same recipient at the same time and date unless authorized to do so. Services authorized to bill concurrently with another service include behavior analysis, private duty nursing, skilled nursing and residential nursing.
Procedure Code Modifiers / Definition of Modifiers	For certain types of services, a two two-digit modifier must be entered on the claim form. Modifiers more fully describe the procedure performed so that accurate payment may be determined. Waiver services providers must use the modifiers with the procedure codes listed on the iBudget Home and Community-Based Services Waiver Procedure Codes and Maximum Units of Service Table when billing for the specific services in the procedure code descriptions. The modifiers listed on table can only be used with the procedure codes listed. Use of modifiers with any other procedure codes will cause the claim to deny or pay incorrectly.

APPENDIX A

BILLING AND DOCUMENTATION REQUIREMENTS

DOCUMENTATION REQUIREMENTS

The following documentation shall be maintained by providers. It may be maintained electronically at the provider's facility or office and must be maintained in the APD Web site, when available, and shall be provided to waiver support coordinators promptly upon request.

	Billing and Reimbursement Requirements
Adult Dental Services	• Copy of claim(s) submitted for payment. • All treatment records
• Life Skills Development	**Life Skills Development I (companion)** • Copy of claim(s) submitted for payment; • Service Log **Life Skills Development II (supported employment)** • Copy of claim(s) submitted for payment; • Service Log • Individual's implementation plan and supporting data. The implementation plan will be developed, at a minimum, within 30 days of the initiation of the new service, or within 30 calendar days of the service authorization effective date for continuation of services and annually thereafter. A copy of the implementation plan, approved by the individual, shall be furnished to the individual, guardian and to the waiver support coordinator at the end of this 30-day period. The progress toward achieving the goal(s) identified on the implementation plan shall be documented in notes or quarterly summaries, as specified in each service • Quarterly summary of each quarter of the support plan year. The fourth quarterly summary also serves as the annual report and must include a summary of the previous three quarters (not required for) • Documentation, in the form of a letter from Vocational Rehabilitation (VR) Services or a case note detailing contact with a named VR representative, the date, summary of conversation, etc., indicating a lack of available VR funding for supported employment; • Individualized plan for employment (IPE) must be completed at the time of first claim submission and annually thereafter at the time of support plan update, and at any time updates and changes are made before they are implemented; and must include: • Documentation that supported self- employment services are not available from Vocational Rehabilitation may be either in the form of: • A letter from VR • Case note detailing contact with a named VR representative to include the date, summary of conversation. • Claims for services are to be made upon completion of each individual benchmark

	Life Skills Development III (ADT) • Copy of claim(s) submitted for payment; • A copy of service log monthly • Quarterly summary of each quarter of the support plan year. The fourth quarterly summary also serves as the annual report and must include a summary of the previous three quarters • Staffing documentation such as staffing schedules, payroll records indicating identified support staff and hours worked, and any other supplemental support staffing schedules that document required staffing ratios. • If the provider plans to transport individuals in his private vehicle, at the time of enrollment, the provider must be able to show proof of: 1) a valid driver's license, 2) car registration, and, 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date. An implementation plan the implementation plan will be developed, at a minimum, within 30 days of the initiation of the new service, or within 30 calendar days of the service authorization effective date for continuation of services and annually thereafter. A copy of the implementation plan, approved by the individual, shall be furnished to the individual, guardian and to the waiver support coordinator at the end of this 30-day period. The progress toward achieving the goal(s) identified on the implementation plan shall be documented in notes or quarterly summaries, as specified in each service.
Family and Guardian Training	Copy of log, signed by the individual/family or legal representative, with dates the training was provided Copy of curriculum and information provided to individual, family or legal representative that details the methodology used for the training and the materials covered.
Person Centered Planning	The provider will submit a completed person centered plan with signatures of all individuals participating in the development of the plan. The individual's support coordinator shall be provided a copy of the person-centered plan and any updates developed through this service.
Personal Supports	• Copy of claim(s) submitted for payment; and • Copy of monthly service log • Monthly summary notes at the time of claims submission for service formerly known as in-home supports • Staffing documentation such as in-staffing schedules, payroll records indicating identified in-home support staff and hours worked, and other supplemental in-home support staffing schedules which document required staffing ratios. If the provider plans to transport the individual in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date at all times without any lapse in coverage, licensure or registration and must provide proof of such documentation upon request.
Respite--children in family home only	• Copy of claim submitted for payment • Service Log

Residential Habilitation (Standard)	• Copy of claim(s) submitted for payment; • Daily attendance log; • An implementation plan will be developed, at a minimum, within 30 days of the initiation of the new service, or within 30 calendar days of the service authorization effective date for continuation of services and annually thereafter. A copy of the implementation plan, approved by the individual, shall be furnished to the individual, guardian and to the waiver support coordinator at the end of this 30-day period. The progress toward achieving the goal(s) identified on the implementation plan shall be documented in notes or quarterly summaries, as specified in each service Quarterly summary of each quarter of the support plan year. The fourth quarterly summary also serves as the annual report and must include a summary of the previous three quarters • Staffing documentation such as direct care staffing schedules, payroll records indicating identified direct care support staff and hours worked and any other supplemental support staffing schedules which document staffing ratios and direct contact hours worked. If the provider plans to transport individuals in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license; 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.
Residential Habilitation (Behavior Focused)	• Copy of claim(s) submitted for payment; • Daily attendance log • Copy of the individual implementation plan to be developed within 30 days of the initiation of a new service or within 30 days of the support plan effective date for continuation of services and annually thereafter • Quarterly summary of each quarter of the support plan year. The fourth quarterly summary also serves as the annual report and must include a summary of the previous three quarters LRC review dates and recommendations made specific to the plan and review schedules for the plan as indicated in rule 65G-4.009, F.A.C. • Staffing documentation such as direct care staffing schedules, payroll records indicating identified direct care support staff and hours worked and any other supplemental support staffing schedules which document staffing ratios and direct contact hours worked. If the provider plans to transport individuals in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license; 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

Residential Habilitation (Intensive Behavior)	• Copy of claim(s) submitted for payment; • Daily attendance log • Copy of the individual implementation plan to be developed within 30 days of the initiation of a new service or within 30 days of the support plan effective date for continuation of services and annually thereafter • Quarterly summary of each quarter of the support plan year. The fourth quarterly summary also serves as the annual report and must include a summary of the previous three quarters • LRC review dates and recommendations made specific to the plan and review schedules for the plan as indicated in rule 65G-4.009, F.A.C. • Staffing documentation such as direct care staffing schedules, payroll records indicating identified direct care support staff and hours worked and any other supplemental support staffing schedules which document staffing ratios and direct contact hours worked. If the provider plans to transport individuals in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license; 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.
Specialized Medical Home Care	• Copy of claim(s) submitted for payment; • Nursing Care Plan and revisions • Service logs; • Nursing Assessment (must be completed at the time of the first claim submission and annually thereafter) • Daily progress notes on days service was rendered, for the period being reviewed. There notes should be directly related to the recipient's plan of care and treatment • Prescription for service and • List of duties to be performed by the nurse.

Supported Living Coaching	• Copy of claim(s) submitted for payment; • Service log, which includes documentation of activities, supports and contacts with the individual, other providers and agencies with dates and times, and a summary of support provided during the contact, any follow up needed and progress toward achievement of support plan goals. This service log and progress notes shall be placed in the individual's record prior to claim submission: and • Individual implementation plan, or in the case of transition, a transition plan, must be completed within 30 days of the initiation of the new service, or within 30 calendar days of the service authorization effective date for continuation of services and annually thereafter. A copy of the implementation plan, approved by the individual, shall be furnished to the individual, guardian and to the waiver support coordinator at the end of this 30-day period. • In addition to the minimum required components of the individual implementation plan described in the definitions section of this handbook, the individual implementation plan for supported living coaching service must also contain the following ✓ The frequency of the supported living service; ✓ How home, health and community safety needs will be addressed and the supports needed to meet these needs to include a personal emergency disaster plan. ; ✓ The method for accessing the provider 24-hours per-day, 7-days per-week for emergency assistance; and ✓ A description of how natural and generic supports will be used to assist in supporting the individual • A financial profile that includes strategies for assisting the person in money management when requested by the individual or guardian and to evaluate the need for a supported living subsidy. The financial profile is critical in determining whether or not the housing selected by the individual is within his financial means and will identify the need for monthly subsidy which must be approved by the APD area office.; Up to date information regarding the demographic, health, medical and emergency information, and a complete copy of the current support plan. • If the provider plans to transport the individual in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.
Consumable Medical Supplies	• Copy of claim(s) submitted for payment; • Copy of service log, listing supplies purchased; and • Original prescription for the supply (if prescribed).
Durable Medical Equipment and Supplies	Prior to the provider submitting the claim for payment, the individual's waiver support coordinator must document that the equipment was received and it works according to the manufacturer's description, either by conducting a site visit or obtaining verbal verification from the individual or family. • Copy of pre-approved claim(s) form submitted for payment. • Original prescription for the medical equipment, if prescribed by a physician. • Service log listing equipment provided and documenting waiver support coordinator verification that equipment was received and works, per manufacturer's description, prior to submission of claim for payment

Environmental Accessibility Adaptations	Prior to the provider submitting the claim for payment, the individual's waiver support coordinator must document that the services were completed in accordance with the contract or agreement, either by conducting a site visit or by obtaining written verification from the individual or family. . Environmental accessibility adaptations may be billed across two cost plans if the work is completed in phases. For each phase of work, the Waiver Support Coordinator must obtain the written verification from the individual or family or conduct a site visit • Copy of claims submitted for payment; • Copy of service log; including documentation of waiver support coordinator's verification that services were completed in accordance with the contract or agreement, prior to submission of claim for payment and • Original prescription for medical equipment.
Personal Emergency Response Systems (Unit and Services)	• Copy of claims(s) submitted for payment, and • Service log, detailing services provided
Support Coordination--Limited	Providers of support coordination services must participate in monitoring review conducted by APD, AHCA or an authorized representative of the state. Support coordination providers are expected to meet the needs of individuals receiving services, regardless of the number of contacts it takes to meet those needs. Waiver support coordinators should not assume that meeting the basic billing requirements will necessarily result in a successful monitoring review and approval to continue services. For monitoring purposes, the provider must have on file the following, for the period reviewed or for the period billed: • Documentation in the support coordination notes and the support plan of activities and contacts that assisted the support coordinator in meeting individually determined goals and outcomes provided opportunities to full participate in community life and addressed the individual and families concerns. The notes should clearly and adequately detail services provided in sufficient detail. • A copy of all of the individual's support plans and approved cost plans, filed in the individual's central record • Documentation, in the central record, that the basic billing requirements were met for the months in which the provider was reimbursed for services • Documentation in the central records that a face to face visit with the individual was conducted in their place of residence as required by this handbook • Documentation that service authorizations were provided to all service providers within three consecutive calendar days of the support coordinator receiving approval of the service. Failure of the support coordinator to provide service authorizations within established timeframes will result in recoupment. • Current and correct demographic information for the individual including current health and medical information and emergency contact information.

Support Coordination--Full	Providers of support coordination services must participate in monitoring review conducted by APD, AHCA or an authorized representative of the state. Support coordination providers are expected to meet the needs of individuals receiving services, regardless of the number of contacts it takes to meet those needs. Waiver support coordinators should not assume that meeting the basic billing requirements will necessarily result in a successful monitoring review and approval to continue services. For monitoring purposes, the provider must have on file the following, for the period reviewed or for the period billed: • Documentation in the support coordination notes and the support plan of activities and contacts that assisted the support coordinator in meeting individually determined goals and outcomes provided opportunities to full participate in community life and addressed the individual and families concerns. The notes should clearly and adequately detail services provided in sufficient detail. • A copy of all of the individual's support plans and approved cost plans, filed in the individual's central record • Documentation, in the central record, that the basic billing requirements were met for the months in which the provider was reimbursed for services • Documentation in the central records that a face to face visit with the individual was conducted in their place of residence as required by this handbook • Documentation that service authorizations were provided to all service providers within three consecutive calendar days of the support coordinator receiving approval of the service. Failure of the support coordinator to provide service authorizations within established timeframes will result in recoupment. • Current and correct demographic information for the individual including current health and medical information and emergency contact information.

Support Coordination--Enhanced	Providers of support coordination services must participate in monitoring review conducted by APD, AHCA or an authorized representative of the state. Support coordination providers are expected to meet the needs of individuals receiving services, regardless of the number of contacts it takes to meet those needs. Waiver support coordinators should not assume that meeting the basic billing requirements will necessarily result in a successful monitoring review and approval to continue services. For monitoring purposes, the provider must have on file the following, for the period reviewed or for the period billed: • Documentation in the support coordination notes and the support plan of activities and contacts that assisted the support coordinator in meeting individually determined goals and outcomes provided opportunities to full participate in community life and addressed the individual and families concerns. The notes should clearly and adequately detail services provided in sufficient detail. • A copy of all of the individual's support plans and approved cost plans, filed in the individual's central record • Documentation, in the central record, that the basic billing requirements were met for the months in which the provider was reimbursed for services • Documentation in the central records that a face to face visit with the individual was conducted in their place of residence as required by this handbook • Documentation that service authorizations were provided to all service providers within three consecutive calendar days of the support coordinator receiving approval of the service. Failure of the support coordinator to provide service authorizations within established timeframes will result in recoupment. • Current and correct demographic information for the individual including current health and medical information and emergency contact information.
Transportation	1. Copy of claim(s) submitted for payment; and 2. Trip logs.
Behavior Analysis Services	Documentation of services must comply with rule 65G-4.009, F.A.C. Reimbursement* and monitoring documentation to be maintained by the provider includes: • Copy of claim(s) submitted for payment; • Copy of service log; • Copy of assessment report, when as assessment report has been requested • Quarterly summary of monitoring including who, what, when and where of the monitoring events; or other content as required by the Agency. • Quarterly summary of each quarter of the support plan year. The fourth quarterly summary also serves as the annual report and must include a summary of the previous three quarters • . • Behavior analysis service plan and services provided including graphic display of acquisition and reduction behaviors related to implementation of the behavior analysis service plan, and • Dated evidence of LRC reviews, approval and recommendations specific to target behaviors and the behavior plan, as required and consistent with 65G-4.010, F.A.C.,

Behavior Assistant Services	1. Copy of claim(s) submitted for payment; 2. Copy of service log; 3. Quarterly summary of monitoring of program implementation including the who, what, when, and where of the monitoring events; 4. Quarterly summary of each quarter of the support plan year. The fourth quarterly summary also serves as the annual report and must include a summary of the previous three quarters 5. Copy of the behavior analysis service plan must be in the recipient's file prior to claim submission. 5. Monthly data displays; 6. A record of the LRC review of the behavior services plan and data displays must be provided if the targeted reduction behaviors meet the requirements identified in 65G-4.009, F.A.C.; and 7. A record of the LRC review of the behavior services plan and data displays must be provided if more than 65 quarter hours of behavior assistant services are approved daily.
Dietician Services	• Copy of claim(s) submitted for payment; • Copy of service log; • Monthly nutritional status report; • Dietician assessment; • Individual Dietary Management Plan; • Daily progress notes (on days service was rendered); • Annual report; and • Original prescription for the service, and annual thereafter.
Occupational Therapy	• Copy of claim(s) submitted for payment; • Copy of service log; • Monthly summary note; • Assessment report (if requesting reimbursement for assessment); • Annual report; and • Original prescription for the service, and annual thereafter.
Personal Response System	• Copy of claim(s) submitted for payment; and • Service log detailing services provided
Physical Therapy	• Copy of claim(s) submitted for payment; • Copy of service log; • Monthly summary note; • Assessment report (if requesting reimbursement for assessment). • Annual report; and • Original prescription for the service

Private Duty Nursing	• Copy of claim(s) submitted for payment; • Copy of the Nursing Care Plan • Copy of service log; • Individual Nursing Assessment and annually thereafter; • Daily progress notes; • Original prescription for the service; and • List of duties to be performed by the nurse. Nurses delivering this service as independent providers must provide proof of meeting the educational requirements specified in Chapter 464.008(1), F.S., for licensure as a registered professional nurse or a licensed practical nurse, whichever is applicable. Nursing Assessments and Care Plans should be updated annually, if there is a significant change in the individual's health status or following a prolonged hospitalization. They are required at the time of first claim submission and annually thereafter.
Residential Nursing	• Copy of claim(s) submitted for payment; • Service log; • Monthly summary of service log and progress notes(must include details, such as health risk indicators, information about medication, treatments, medical appointments, and other relevant information); • Nursing Assessment, must be completed at the time of the initial claim submission and annually thereafter or as needed, should the recipient's condition change • Nursing Care Plan with annual updates; • Original prescription for the service; and annual thereafter, and • List of duties to be performed by the nurse. * Note: Nursing Assessments and Care Plans should be updated annually, if there is a significant change in the individual's health status or following a prolonged hospitalization. They are required at the time of first claim submission and annually thereafter.
Respiratory Therapy	• Copy of claim(s) submitted for payment; • Original prescription for service • *Service log; • *Monthly summary note; • Assessment report, if a claim is submitted for an assessment;

Skilled Nursing	• Copy of claim(s) submitted for payment; • Nursing care plans and revisions; • Service log; • *Nursing assessment (must be completed at time of first claim submission and annually thereafter); • Daily progress notes; • Prescription for service; and List of duties to be performed by the nurse. • • Nurses delivering this service as independent providers must provide proof of meeting the educational requirements specified in Chapter 464.008(1), F.S., for licensure as a registered professional nurse or a licensed practical nurse, whichever is applicable.
Speech Therapy	• Copy of claim(s) submitted for payment; • Service Logs • Monthly summary note; • Assessment report, if requesting reimbursement for assessment • Original prescription for the service, and • Annual report If the provider plans to transport the individual in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.
Specialized Mental Health Counseling	• Copy of claim(s) submitted for payment; • Monthly summary note; • Assessment and treatment plan, even if preliminary, or plan for further action, must be completed at time of first claim submission and a final treatment plan at the subsequent claim submission; and • Service log. If the provider plans to transport the individual in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

APPENDIX B

GENERAL TRAINING REQUIREMENTS

Courses	Course Description	Timeframe	Trainer Qualification	Documentation	Frequency
Core Competencies	Modules entitled as follows and developed by APD's central office training unit: 1. Defining Developmental Disabilities 2. Roles and Responsibilities of Direct Care Professionals 3. Teaching Skills 4. Maintaining Health, Safety and Wellbeing of APD Customers 5. Food Safety 6. Disaster/Emergency Preparedness 7. Individual Choices, Rights and Responsibilities 8. Use of Person-Centered Approach to Service Delivery	Prior to providing services	No classroon training - only available from APD as web based course	APD web-based course certificate noting the course title, name of the course taker, date course successfully completed	Once - refresher courses recommended when course content changes
HIPAA	Regulations related to Public Law 104-191	Prior to providing services	No classroon training - only available from APD as web based course	APD web-based course certificate noting the course title, name of the course taker, date course successfully completed	Annually

Overview of Medicaid Waivers	Modules entitled as follows and developed by APD's central office training unit: 1. Development and Implementation of the Required Documentation of each Waiver Service2. Medicaid Waiver Services Agreement & its Attachments 3. Coverage and Limitation Handbook and its appendices	Prior to providing services	No classroom training - only available from APD as web based course	APD web-based course certificate noting the course title, name of the course taker, date course successfully completed	once - refresher courses recommended when course content changes
Zero Tolerance	Modules entitled as follows and developed by APD's central office training unit: 1. Defining and Recognizing Abuse, Neglect and Exploitation 2. DCF Hotline Abuse Reporting Requirements & Procedures 3. APD Incident Reporting Requirements & Procedures 4. Prevention and Safety Planning	Prior to providing services	No classroom training - only available from APD as web based course	APD web-based course certificate noting the course title, name of the course taker, date course successfully completed	At initial employment and every 3 years thereafter

Medication Administration Training and Certification pursuant to 65G-7, F.A.C. (Both training and successful validation must be completed by any provider staff who assists with or administers medication.)	pursuant to 65G-7, F.A.C.	prior to providing services	Medication Administration training - onlinewithValidation by APD approved individuals	APD web-based certificate noting the course title, name of the course taker, date course was successfully completed. ANDFor validation documentation must include title of "Medication Administration Certification," as well as the name of the individual certified, name and signature of certified validater (with a copy of the validater's certificate on the back). Validater is responsible for retaining sign in sheet with original signatures of attendees, as well as copies of certificates provided and any other documentation as noted in 65G-7.	As defined by 65G-7

Reactive Strategies Training and Validation (Both training and successful validation must be completed by any provider staff who work with a person who has a behavior plan containing reactive strategies or is expected to implement approved reactive strategies.)	Pursuant to 65G-8, F.A.C.	Prior to providing services	Reactive Strategies training - onlinewithValidation by APD approved individuals	APD certificate noting the course title, name of the course taker, date course successfully completed. For validation documentation must include title of "Reactive Strategies Certification," as well as the name of the individual certified, name and signature of certified validater (with a copy of the validater's certificate on the back). Validater is responsible for retaining sign in sheet with original signatures of attendees, as well as copies of certificates provided and any other documentation as noted in 65G-8.	As defined by 65G-8

AIDS/HIV/Infection Control	Red Cross or FL DOH course that meets 381.0035, F. S. requirements - no on line course	Prior to providing services	certified by Red Cross or by FL DOH	As defined by Red Cross or FL DOH. However, at a minimum certificates must clearly indicate the length of time the certification is valid - 1 yr., 2 yrs., 3 yrs., etc., the title of the course, the date course was completed, the typed name and signature of the trainer with a copy of the trainer's certification on the back.	As defined by certificate
CPR	Red Cross or American Heart Association - no online course	Prior to providing services	certified by Red Cross or American Heart Association	As defined by Red Cross or American Heart Association. However, at a minimum certificates must clearly indicate the length of time the certification is valid - 1 yr., 2 yrs., 3 yrs., etc., the title of the course, the date course was completed, the typed name and signature of the trainer with a copy of the trainer's certification on the back.	As defined by certificate

First Aid	Red Cross - no online course	Prior to providing services	certified by Red Cross	As defined by Red Cross or American Heart Association. However, at a minimum certificates must clearly indicate the length of time the certification is valid - 1 yr., 2 yrs., 3 yrs., etc., the title of the course, the date course was completed, the typed name and signature of the trainer with a copy of the trainer's certification on the back.	As defined by certificate

APPENDIX C

SERVICE SPECIFIC TRAINING REQUIREMENTS

Service	Service Specific Training Requirements
Behavior Analysis Services	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration may need to be completed prior to service provision as well. Providers of behavior analysis services must comply with all training requirements noted in 65G-8, F.A.C. related to reactive strategies. Note: Refer to the training matrix for general training requirements in Appendix __ for provider basic training requirements. **Additional Training Requirements** Behavior Analysis providers must also comply with required training and continuing education credits related to their certification or licensure as behavior analyst in order to maintain current active status as referenced in Florida Statutes and Florida Administrative Rules.
Behavior Assistant Services	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration may need to be completed prior to service provision as well. Providers of behavior assistant services must comply with all training requirements noted in 65G-8, F.A.C. related to reactive strategies. Trainers must be approved by APD and in accordance with 65G-8, F.A.C. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements. **Additional Training Requirements** Behavior Assistant providers must also comply with required training and continuing education credits related to their certification or licensure as a behavior assistant in order to maintain current active status as referenced in Florida Statutes and Florida Administrative Rules.
Consumable Medical Supplies	Because no direct care is provided, providers of this service are exempt from required handbook training but must comply with training required by Florida law or federal law.

Dietician Services	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements. **Additional Training Requirements** Dietician providers must also comply with required training and continuing education credits related to their certification or licensure in order to maintain current active status as a dietician referenced in Florida Statutes and Florida Administrative Rules.
Durable Medical Equipment and Supplies	Because no direct care is provided, providers of this service are exempt from required handbook training but must comply with training required by Florida law or federal law.
Environmental Accessibility Adaptation	Because no direct care is provided, providers of this service are exempt from required handbook training but must comply with training required by Florida law or federal law.

Family and Guardian Training	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements. **Pre-service Training** Providers of family & guardian training must also complete standardized, pre-service requirements developed and defined by APD's central office prior to providing these services. Pre-service training consists of successfully completing APD's web-based course titled How to Manage Resources, and APD's related face-to-face validation. Documentation of the successful completion of the web-based course will consist of an APD generated certificate. A validation certificate will be standardized by APD and contain at a minimum the course title, name of the attendee, date of the validation, typed name and original signature of the validater, with a copy of the validater's certificate as a validater of this course either copied on the back of or stapled to each trainee's certificate. Validaters are responsible for retaining original sign in sheets and copies of all certificates provided. All validaters must be certified by APD's central office. **Continuing Education** Eight hours of annual in-service training must be completed and be related to APD's waivers, community resources or person-centered planning. Certificates documenting the completion of in-service hours shall meet the following criteria: at a minimum the course title, typed name of the attendee, date of the training, typed name and original signature of the trainer, and number of hours for which training was provided. Trainers are responsible for retaining originally signed attendance sheets and copies of all certificates provided. Re-taking basic APD training courses may not be counted toward this requirement. Proof of annual or required updated training shall be maintained on file for review.

Life Skills Development I, II, III	**Life Skills Development I** (formerly Companion) Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements. **Continuing Education** Life Skills Development I providers must completed eight hours of annual in-service training related to affordable housing options, asset development, money managemen1t, specific health needs of person they are currently serving, accessing governmental benefits other than those provided by APD (such as food stamps, legal services, etc.), or employment. Certificates documenting the completion of in-service hours shall meet the following criteria: at a minimum the course title, typed name of the attendee, date of the training, typed name and original signature of the trainer, and number of hours for which training was provided. Trainers are responsible for retaining originally signed attendance sheets and copies of all certificates provided. Re-taking basic APD training courses may not be counted toward this requirement. Proof of annual or required updated training shall be maintained on file for review. **Life Skills Development II (**formerly Supported Employment**)** Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements **Pre-service Training** Providers of Life Skills Development II services must also complete standardized, pre-service requirements developed and defined by APD's central office prior to providing these services. Pre-service training consists of successfully completing APD's web-based courses titled Best Practices in Supported Employment and Introduction to Social Security Work Incentives, as well as APD's related face-to-face validation.

Life Skills Development I, II, III, continued	Documentation of the successful completion of the web-based course will consist of an APD generated certificate. A validation certificate will be standardized by APD and contain at a minimum the course title, name of the attendee, date of the validation, typed name and original signature of the validater, with a copy of the validater's certificate as a validater of this course either copied on the back of or stapled to each trainee's certificate. Validaters are responsible for retaining original sign in sheets and copies of all certificates provided. All validaters must be certified by APD's central office. If a Life Skills Development II provider wants to support persons who are self-employed, the provider must also be certified as a Certified Business Technical Assistance and Consultation (CBTAC) by the Florida Department of Education, Division of Vocational Rehabilitation. ***Continuing Education*** Eight hours of annual in-service training related to employment must be completed by all Life Skills Development II providers. Certificates documenting the completion of in-service hours shall meet the following criteria: at a minimum the course title, typed name of the attendee, date of the training, typed name and original signature of the trainer, and number of hours for which training was provided. Trainers are responsible for retaining originally signed attendance sheets and copies of all certificates provided. Re-taking basic APD training courses may not be counted toward this requirement. Proof of annual or required updated training shall be maintained on file for review. **<u>Life Skills Development III (formerly Adult Day Training)</u>** Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. <u>Note</u>: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements At all times when individuals are present, a minimum of a least one staff member or 50 percent of all staff at the facility (whichever is greater), must have been trained on Reactive Strategies and Medication Administration.

Occupational Therapy	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements. **Additional Training Requirements** Occupational therapy providers must also comply with required training and continuing education credits related to their certification or licensure as an occupational therapist in order to maintain current active status as referenced in Florida Statutes and Florida Administrative Rules.
Person Centered Planning	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements. **Pre-service Training** Providers of person centered planning services must also complete standardized, pre-service requirements developed and defined by APD's central office prior to providing these services. Pre-service training consists of successfully completing APD's web-based course titled Advanced Person Centered Training, as well as APD's related face-to-face validation. Documentation of the successful completion of the web-based course will consist of an APD generated certificate. A validation certificate will be standardized by APD and contain at a minimum the course title, name of the attendee, date of the validation, typed name and original signature of the validater, with a copy of the validater's certificate as a validater of this course either copied on the back of or stapled to each trainee's certificate. Validaters are responsible for retaining original sign in sheets and copies of all certificates provided. All validaters must be certified by APD's central office.

Person Centered Planning, continued	***Continuing Education*** Eight hours of annual in-service training related to person-centered planning and accessing community resources must be completed. Certificates documenting the completion of in-service hours shall meet the following criteria: at a minimum the course title, typed name of the attendee, date of the training, typed name and original signature of the trainer, and number of hours for which training was provided. Trainers are responsible for retaining originally signed attendance sheets and copies of all certificates provided. Re-taking basic APD training courses may not be counted toward this requirement. Proof of annual or required updated training shall be maintained on file for review.
Personal Emergency Response System	Because no direct care is provided, providers of this service are exempt from required handbook training but must comply with training required by Florida law or federal law.
Personal Supports (formerly companion, in-home supports, personal care assistance and respite – adult)	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Continuing Education: Personal Supports providers must completed eight hours of annual in-service training related to affordable housing options, asset development, money managemen1t, specific health needs of person they are currently serving, accessing governmental benefits other than those provided by APD (such as food stamps, legal services, etc.), or employment. Certificates documenting the completion of in-service hours shall meet the following criteria: at a minimum the course title, typed name of the attendee, date of the training, typed name and original signature of the trainer, and number of hours for which training was provided. Trainers are responsible for retaining originally signed attendance sheets and copies of all certificates provided. Re-taking basic APD training courses may not be counted toward this requirement. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements. Proof of annual or required updated training shall be maintained on file for review.
Physical Therapy	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements.

Physical Therapy, continued	**Additional Training Requirements** Physical Therapy providers must also comply with required training and continuing education credits related to their certification or licensure as a physical therapist in order to maintain current active status as referenced in Florida Statutes and Florida Administrative Rules.
Private Duty Nursing	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements. **Additional Training Requirements** Private Duty Nursing providers must also comply with required training and continuing education credits related to their certification or licensure as a Licensed Practical Nurse or Registered Nurse in order to maintain current active status as referenced in Florida Statutes and Florida Administrative Rules.
Residential Habilitation (Behavior Focused)	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Because of the Behavior Focus of this service, Reactive Strategies must also be completed. Depending on the specific people to be served Medication Administration may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements. ***Continuing Education*** Eight hours of annual in-service training related to behavior modification must be completed. Certificates documenting the completion of in-service hours shall meet the following criteria: at a minimum the course title, typed name of the attendee, date of the training, typed name and original signature of the trainer, and number of hours for which training was provided. Trainers are responsible for retaining originally signed attendance sheets and copies of all certificates provided. Re-taking basic APD training courses may not be counted toward this requirement. Proof of annual or required updated training shall be maintained on file for review.

Residential Habilitation (Intensive Behavior)	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Because of the Intensive Behavior component of this service, Reactive Strategies must also be completed. Depending on the specific people to be served Medication Administration may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements. ***Continuing Education*** Eight hours of annual in-service training related to behavior modification. Certificates documenting the completion of in-service hours shall meet the following criteria: at a minimum the course title, typed name of the attendee, date of the training, typed name and original signature of the trainer, and number of hours for which training was provided. Trainers are responsible for retaining originally signed attendance sheets and copies of all certificates provided. Re-taking basic APD training courses may not be counted toward this requirement. Proof of annual or required updated training shall be maintained on file for review.
Residential Habilitation (Standard)	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements.
Residential Nursing	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements. **Additional Training Requirements** Private Duty Nursing providers must also comply with required training and continuing education credits related to their certification or licensure as a Licensed Practical Nurse or Registered Nurse in order to maintain current active status as referenced in Florida Statutes and Florida Administrative Rules.

Respiratory Therapy	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements. **Additional Training Requirements** Respiratory Therapy providers must also comply with required training and continuing education credits related to their certification or licensure as a respiratory therapist in order to maintain current active status as referenced in Florida Statutes and Florida Administrative Rules.
Respite--children in family home only	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements.
Skilled Nursing	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements. **Additional Training Requirements** Private Duty Nursing providers must also comply with required training and continuing education credits related to their certification or licensure as a Licensed Practical Nurse or Registered Nurse in order to maintain current active status as referenced in Florida Statutes and Florida Administrative Rules.
Specialized Medical Home Care	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements.

Specialized Mental Health Counseling	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements.
Speech Therapy	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements. **Additional Training Requirements** Speech Therapy providers must also comply with required training and continuing education credits related to their certification or licensure as a speech therapist in order to maintain current active status as referenced in Florida Statutes and Florida Administrative Rules.
Support Coordination— Limited, Full or Enhanced	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements. **Pre-Service Training** Providers of support coordination services must also complete standardized, pre-service requirements developed and defined by APD's central office prior to providing these services. All providers of Support Coordination services must complete pre-service requirements prior to providing these services. Pre-service training has 3 components all of which must be successfully completed: 1. APD's web-based course titled Best Practices in Support Coordination, 2. APD's related face-to-face validation component and 3. APD's web-based or classroom course titled Introduction to APD's Area Staff.

Support Coordination—Limited, Full or Enhanced, continued	Documentation of the successful completion of Best Practices in Support Coordination will consist of an APD computer generated certificate. A validation certificate will be standardized by APD and contain at a minimum the course title, name of the attendee, date of the validation, typed name and original signature of the validater, with a copy of the validater's certificate as a validater of this course either copied on the back of or stapled to each trainee's certificate. Validaters are responsible for retaining original sign in sheets and copies of all certificates provided. All validaters must be certified by APD's central office. Each new support coordinator must assume a caseload within six months of successfully completing Best Practices in Support Coordination and being validated or she/he must retake the course and be re-validated. If a support coordinator discontinues providing support coordination services for more than 1 year and wants to return as a provider, both the web-based course and the validation must be re-completed. At the discretion of the APD Area Office based on unsatisfactory monitoring results, any support coordinator may be required to re-take both the Best Practices course and become re-validated. **Continuing Education** All waiver support coordinators and agency supervisors, directors or managers shall attend a minimum of 24 hours of job-related in–service training annually. At least six hours of this in-service training shall relate to the purpose of APD waivers and the necessity for waiver support coordinators to assist individuals they support using a person centered approach to services, work and community life. In addition, at least four of the six hours will focus on employment-related services or benefits planning and management, as well as opportunities such as customized employment options, information and referral to vocational rehabilitation services, public school transition planning processes, and asset development. All support coordinators shall successfully complete APD's web-based course entitled ***Introduction to Social Security Work Incentives*** within one year of receiving their certificate of enrollment. Waiver support coordinators who are certified and enrolled at the time this handbook becomes effective must complete this required training within one year of the handbook's effective date. Internal management meetings conducted by support coordination agencies for their staff shall not apply toward the continuing education annual requirement. For support coordination agency employees and supervisors, one half of the in-service requirement must be provided by trainers who are not employed by support coordination agency. Up to 12 hours per year for attendance at the monthly support coordination meetings conducted by the Area Offices can count toward the annual 24 hour in service requirement. Certificates documenting the completion of in-service hours shall meet the following criteria: at a minimum the course title, typed name of the attendee, date of the training, typed name and original signature of the trainer, and

Support Coordination—Limited, Full or Enhanced, continued	number of hours for which training was provided. Trainers are responsible for retaining originally signed attendance sheets and copies of all certificates provided. Re-taking basic APD training courses may not be counted toward this requirement. Proof of annual or required updated training shall be maintained on file for review.
Supported Living Coaching	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements. **Pre-Service Training** Providers of supported living coaching services must also complete standardized, pre-service requirements developed and defined by APD's central office prior to providing these services. Pre-service training consists of successfully completing APD's web-based course, Best Practices in Supported Living, as well as APD's related face-to-face validation. Documentation of the successful completion of the web-based course will consist of an APD generated certificate. A validation certificate will be standardized by APD and contain at a minimum the course title, name of the attendee, date of the validation, typed name and original signature of the validater, with a copy of the validater's certificate as a validater of this course either copied on the back of or stapled to each trainee's certificate. Validaters are responsible for retaining original sign in sheets and copies of all certificates provided. All validaters must be certified by APD central office. **Continuing Education** Supported Living providers must completed eight hours of annual in-service training related to affordable housing options, asset development, money managemen1t, specific health needs of person they are currently serving, accessing governmental benefits other than those provided by APD (such as food stamps, legal services, etc.), or employment. Certificates documenting the completion of in-service hours shall meet the following criteria: at a minimum the course title, typed name of the attendee, date of the training, typed name and original signature of the trainer, and number of hours for which training was provided. Trainers are responsible for retaining originally signed attendance sheets and copies of all certificates provided. Re-taking basic APD training courses may not be counted toward this requirement. Proof of annual or required updated training shall be maintained on file for review.

Transportation	Providers of this service must complete all basic courses prior to providing services: Core Competencies, HIPAA, Overview of Medicaid Waivers, Zero Tolerance, AIDS/HIV, CPR, First Aid. Depending on the specific people to be served Medication Administration and Reactive Strategies may need to be completed prior to service provision as well. Note: Refer to the training matrix for general training requirements in Appendix __ for the provider basic training requirements. All agency drivers hired after the effective date of this handbook and solo providers enrolled after the effective date of this handbook shall comply with these training requirements.

APPENDIX – D

iBUDGET PROVIDER TRAINING MATRIX

	BASIC COURSES									ADDITIONAL	
Course	**Core Compe-tencies**	**HIPAA**	**Overview of Medicaid Waivers**	**Zero Toler-ance**	**Medica-tion Admini-stration**	**Reactive Strategies**	**AIDS/ HIV**	**CPR**	**First Aid**	**Pre-Service Training**	**Continuing Education**
Beh. Analy.	X	X	X	X	X	X	X	X	X		
Beh. Asst.	X	X	X	X	X	X	X	X	X		
Cons.Med. Supl											
Dietician	X	X	X	X	X	X	X	X	X		
DME & Supp											
Env. Acc. Ada.											
Family & Guardian Training	X	X	X	X	X	X	X	X	X	X	X
Life Skills I (Companion)	X	X	X	X	X	X	X	X	X		X
Life Skills II (Supported Employment)	X	X	X	X	X	X	X	X	X	X	X
Life Skills III (Adult Day Training)	X	X	X	X	X	X	X	X	X		
Occupational Therapy	X	X	X	X	X	X	X	X	X		
Person Centered Planning	X	X	X	X	X	X	X	X	X	X	X
Personal Emergency Response											
Personal Supports	X	X	X	X	X	X	X	X	X		X

Physical Therapy	X	X	X	X	X	X	X	X	X		
Private Duty Nursing	X	X	X	X	X	X	X	X	X		
Res, Hab. - Behavioral Focus	X	X	X	X	X	X	X	X	X		X
Res, Hab. - Intensive Behavioral	X	X	X	X	X	X	X	X	X		X
Res, Hab. - Standard	X	X	X	X	X	X	X	X	X		
Residential Nursing	X	X	X	X	X	X	X	X	X		
Respiratory Therapy	X	X	X	X	X	X	X	X	X		
Respite	X	X	X	X	X	X	X	X	X		
Skilled Nursing	X	X	X	X	X	X	X	X	X		
Spec. Med. Home Care	X	X	X	X	X	X	X	X	X		
Specialized Mental Health Counseling	X	X	X	X	X	X	X	X	X		
Speech Therapy	X	X	X	X	X	X	X	X	X		
Support Coord.	X	X	X	X	X	X	X	X	X	X	X
Supported Living Coaching	X	X	X	X	X	X	X	X	X	X	X
Transp	X	X	X	X		X	X	X	X		

APPENDIX E

AREA OFFICE FOR THE AGENCY FOR PERSONS WITH DISABILITIES

AREA OFFICES FOR THE AGENCY FOR PERSONS WITH DISABILITIES

Area and Telephone Number	*Counties in the Area*
1 (850) 595-8351	***Escambia, Okaloosa, Santa Rosa, Walton***
2 (850) 487-1992	***Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Liberty, Leon, Madison, Taylor, Wakulla, Washington***
3 (352) 955-5793	***Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, Union***
4 (904) 992-2440	***Baker, Clay, Duval, Nassau, St. Johns***
7 (407) 245-0440	***Brevard, Orange, Osceola, Seminole***
8 (239) 338-1572	***Charlotte, Collier, Glades, Hendry, Lee***
9 (561) 837-5564	***Palm Beach***
10 (954) 467-4218	***Broward***
11 (305) 349-1478	***Dade, Monroe***
12 (386) 947-4026	***Flagler, Volusia***
13 (352) 330-2749	***Citrus, Hernando, Lake, Marion Sumter***
14 (863) 413-3360	***Hardee, Highlands, Polk***
15 (772) 468-4080	***Indian River, Martin, Okeechobee, St. Lucie***
23 (813) 233-4300	***DeSoto, Hillsborough, Manatee, Pasco, Pinellas, Sarasota***

Visit the APD Web site for current contact information www.apd.myflorida.com***.***

Visit the AHCA Web site at www.ahca.myflorida.com ***for the AHCA Area Offices contact information. The AHCA Area Offices contact information is also in Appendix A of the Florida Medicaid Provider General Handbook.***

APPENDIX F

WAIVER ELIGIBILITY DETERMINATION

WAIVER ELIGIBILITY DETERMINATION

1. Waiver Eligibility Determination

A. The procedure and criteria for determining waiver eligibility are as follows:

(1) For applicants who are not APD clients, the determination of waiver eligibility shall be pended until eligibility for APD services has first been determined. The qualifying definitions for developmental disability and the conditions included in that definition are found in section 393.063, F.S.

(2) For applicants who are APD clients, eligibility for the waiver is limited to the following qualifying disabilities:

(a) The individual's intelligence quotient (IQ) is 59 or less; or the individual's IQ is 60-69 inclusive and the individual has a secondary handicapping condition, that includes Down Syndrome, cerebral palsy, spina bifida, Prader-Willi syndrome, epilepsy, autism, ambulation, sensory, chronic health, or behavior, or the individual's IQ is 60-69 inclusive and the individual has severe functional limitations in at least three of the major life activities, including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living; or

(b) The individual is eligible under a primary disability of Down Syndrome, autism, cerebral palsy, spina bifida, or Prader-Willi syndrome. In addition, the condition must result in substantial functional limitations in three or more major life activities, including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living.

B. Upon a preliminary determination that the applicant is eligible or ineligible for a waiver based on disability criteria, the following action shall be taken:

(1) Eligibility is denied: If an applicant is determined to not meet the disability criteria, the applicant shall be promptly notified of the denial, and such notification shall include notice that the applicant has a right to an administrative hearing to contest APD's decision.

(2) Eligibility is approved: If an applicant is determined to meet the disability criteria the APD Area Office shall consult with the APD Central Office to determine whether funding is available.

(a) If funding is available, the procedures relating to waiver enrollment outlined in the Section 3 of this Appendix shall be followed.

(b) If funding is not available and the applicant's situation does not to require immediate ICF/DD placement, or if ICF/DD placement is not requested, the applicant shall be placed on the wait list, as described in Section 2 of this Appendix.

2. Wait List

The APD Central Office shall maintain the statewide wait list of all applicants requesting and waiting for waiver services.

A. Only applicants who are eligible for APD services and who have a qualifying disability can be added to the wait list.

B. If a preliminary determination of eligibility for the waiver is made, but no funding is available, the applicant will receive prompt written notification of his placement on the wait list for the waiver. The effective date for placement on the wait list shall be the date the applicant is preliminarily determined waiver eligible in accordance with Section 1.

C. Applicants will be listed in date order, with the earliest effective dates at the top of the wait list.

D. A preliminary determination of waiver eligibility and placement on the wait list for waiver enrollment is not an entitlement to waiver services. The final determination of the applicant's eligibility must also include a determination of Medicaid eligibility and shall be made at the time that funding is available and prior to enrolling the applicant on the waiver.

3. Waiver Enrollment

A. When the level of funding annually appropriated by the Florida Legislature provides funding for additional enrollment, recipients will be added to the waiver in the following order, unless otherwise specified in the Appropriations Act:

(1) Individuals determined, pursuant to Chapter 65G-1, F.A.C., to be in crisis shall have first priority for services.

(2) Children on the wait list who are from the child welfare system with an open case in the Department of Children and Family Services' statewide automated child welfare information system.

(3) All other individuals shall be considered for enrollment on the waiver in the date order in which they are listed on the statewide wait list, beginning with the earliest dates.

B. Should sufficient funding be available to serve some but not all of the applicants having the same effective date on the wait list, current information relating to the applicant's intensity of service needs, as determined by the APD approved assessment, will be used to prioritize the applicants. Circumstances for applicants on the wait list may change over time. Accordingly, when the APD Area Office is notified that funding is available to serve applicants through a particular eligibility date, the information necessary to determine priority will be requested for affected applicants.

C. The following enrollment activities shall be taken as part of the enrollment process once funding becomes available to serve additional applicants:

(1) The APD Area Office where the applicant resides will be notified to complete an initial assessment to finalize waiver eligibility, begin the enrollment process, and determine service.

(2) If the applicant is not enrolled in Medicaid, the APD Area Office shall make the appropriate referrals for the determination of Medicaid eligibility.

(3) Once Medicaid eligibility has been determined, waiver enrollment can be completed. The APD Area Office will notify the Central Office, that the Central Office will add the person as enrolled to the automated Allocation, Budget & Contract Control (ABC) system. Once the individual is enrolled on ABC, the individual is officially on the waiver.

D. When a recipient is enrolled on the waiver, the waiver position allocated to the recipient is his until he becomes ineligible or chooses to discontinue waiver services. If the recipient looses his eligibility or chooses to discontinue waiver services, he may return to the same waiver position allocated and resume receiving waiver services provided that he has been disenrolled for less than one year.
If waiver eligibility cannot be re-established, or the individual who has chosen to disenroll has been continuously disenrolled for one year or longer, he is no longer eligible to return to the waiver until a new waiver vacancy and funding is available. In this instance, the individual is added to the wait list of individuals requesting waiver participation. Their new effective date is the date eligibility is re-established or the individual requests re-enrollment for waiver participation.

APPENDIX G

MEDICAID WAIVER SERVICES AGREEMENT

MEDICAID WAIVER SERVICES AGREEMENT

This Agreement is entered into between the Florida Agency for Persons with Disabilities, hereinafter referred to as "APD", and _____, hereinafter referred to as the "Provider". Pursuant to the terms and conditions of this Agreement, APD authorizes the Provider to furnish _____ Home and Community-Based Services (HCBS) Medicaid waiver services to eligible APD clients, and to receive payment for such services. The services that may be provided in any one APD service area are limited to the services that the APD area office, pursuant to the standards specified in Florida's HCBS waivers, authorizes the Provider to furnish in that service area.

I. *AGREEMENT DOCUMENTS*:

A. The Medicaid Waiver Services Agreement consists of the terms and conditions specified in this Agreement, any attachments, and the following documents, which are incorporated by reference:

1. ***The Developmental Disabilities Waiver Services Coverage and Limitations Handbook***, dated July 2007, and any updates or replacements thereto. The Handbook can be found at the Medicaid fiscal agent's Web site: www.mymedicaid-florida.com. Select Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The Handbook lists the requirements for specific services as well as the Core Assurances, which provide the terms and conditions by which the provider of Developmental Disabilities HCBS waiver services agrees to be bound.
2. ***Attachment _____,*** providing individually negotiated unit rates of payment for services not already established and available on APD's website: www.apd.myflorida.com/providers, as referenced in II.E., and any other service or data requirements, as applicable.

B. Prior to executing this Agreement and furnishing any waiver services, the Provider must have executed a Medicaid Provider Agreement with the Agency for Health Care Administration (AHCA), and be issued a Medicaid provider number by AHCA. The Provider must at all times during the term of this Agreement, maintain a current and valid Medicaid Provider Agreement with AHCA, and comply with the terms and conditions of the Medicaid Provider Agreement.

II. *THE PROVIDER AGREES*:

To comply with all of the terms and conditions contained within this Agreement, including all documents incorporated by reference and any attachments.

A. Monitoring, Audits, Inspections, and Investigations

To permit persons duly authorized by APD, the Agency for Health Care Administration (AHCA), or representatives of either, to monitor, audit, inspect, and investigate any recipient records, payroll and expenditure records (including electronic storage media), papers, documents, facilities, goods and services of the Provider which are relevant to this Agreement, and to interview any recipients receiving services and employees of the Provider to assure APD of the satisfactory performance of the terms and conditions of this Agreement.

1. Following such monitoring, audit, inspection, or investigation, APD or its authorized representative, will furnish to the Provider a written report of its findings and, if deficiencies are found, request for development, by the Provider, a Quality Improvement Plan (QIP) for needed corrections. The Provider hereby agrees to correct all noted deficiencies identified by APD, AHCA, or their authorized representatives within the specified period of time identified within the report documentation. Failure to correct noted deficiencies within stated time frames may result in termination of this Agreement.

2. Upon demand, and at no additional cost to the APD, AHCA, or their authorized representatives, the Provider will facilitate the duplication and transfer of any records or documents (including electronic storage media), during the required retention period of six years after termination of the Agreement, or if an audit has been initiated and audit

findings have not been resolved at the end of six years, the records shall be retained until resolution of the audit findings or any litigation which may be based on the terms of this Agreement, at no additional cost to APD.

3. To comply and cooperate immediately with APD requests for information, records, reports, and documents deemed necessary to review the rate setting process to ensure that provider rates are based on accurate information and reflect the existing operational requirements of each service. Any individual who knowingly misrepresents the information required in rate setting commits a felony of the third degree, punishable as provided in sections 775.082 and 775.083, F.S.

4. To comply and cooperate immediately with any inspections, reviews, investigations or audits deemed necessary by APD's Office of the Inspector General pursuant to section 20.055, F.S.

5. To include the aforementioned audit, inspections, investigations and record keeping requirements in all subcontracts and assignments.

B. Confidentiality of Client Information

Not to use or disclose any information concerning a client receiving services under this Agreement for any purpose prohibited by state or federal law or regulation, except with the written consent of a person legally authorized to give that consent or when authorized by law. This includes compliance with: the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d, and all applicable regulations provided in 45 CFR Parts 160, 162, and 164; and 42 CFR, Part 431, Subpart F, relating to the disclosure of information concerning Medicaid applicants and recipients.

C. Indemnification

1. To be liable for and indemnify, defend, and hold APD, AHCA and all of their officers, agents, and employees harmless from all claims, suits, judgments, or damages, including attorneys' fees and costs, arising out of any act, actions, neglect, or omissions by the Provider, its agents, employees, or subcontractors during the performance or operation of this Agreement or any subsequent modifications thereof, whether direct or indirect, and whether to any person or tangible or intangible property. The Provider shall not be liable for that portion of any loss or damages proximately caused by the negligent act or omission of APD or AHCA.

2. That its inability to evaluate its liability or its evaluation of liability shall not excuse the Provider's duty to defend and to indemnify within 7 days after notice by APD or AHCA by certified mail. After the highest appeal taken is exhausted, only an adjudication or judgment specifically finding the Provider not liable shall excuse performance of this provision. The Provider shall pay all costs and fees, including attorneys' fees related to these obligations and their enforcement by APD or AHCA. APD or AHCA's failure to notify the Provider of a claim shall not release the Provider of these duties.

D. Insurance

To obtain and maintain at all times continuous and adequate liability insurance coverage during the term of this Agreement. The Provider accepts full responsibility for identifying and determining the type and extent of liability insurance necessary to provide reasonable financial protection for the Provider and APD clients served by the Provider. All insurance policies shall be through insurers authorized or eligible to write policies in Florida. Such coverage may be provided by a self-insurance program established and operating under Florida law.

E. Payment

To accept payment for goods and services at rates periodically established by AHCA and APD. The most current rates are available on APD Web site: www.apd.myflorida.com/providers. The signatories recognize that APD is limited by appropriation and acknowledge that Florida law requires AHCA and APD to make any adjustment necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, including

but not limited to adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or limiting enrollment. [See sections 393.0661, 409.906, 409.908, F.S.]

F. Return of Funds

To be responsible for the timely correction of all billing or reimbursement errors resulting in an overpayment, including reimbursement for services not properly authorized or documented. Reimbursement will be made pursuant to the Florida Medicaid Provider Reimbursement Handbook, CMS-1500. Federal regulations, 42 CFR § 433.312, require refund of overpayments within 60 days of discovery. AHCA will be the final authority regarding the timeliness of the reimbursement process.

G. Independent Status

That the Provider acts at all times in the capacity of an independent service provider and not as an officer, employee, or agent of APD, AHCA, or the State of Florida. The Provider shall not represent to others that it has the authority to bind the APD or AHCA unless specifically authorized in writing to do so. In addition to the Provider, this is also applicable to the Provider's officers, agents, employees, or subcontractors in performance of this Agreement.

III. *TERMINATION*:

A. This Agreement may be terminated by either party without cause, upon no less than 30 calendar days notice in writing to the other party unless a lesser time is mutually agreed upon in writing by both parties. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

B. This Agreement may be terminated for the Provider's unacceptable performance, non-performance or misconduct upon no less than 24 hours notice in writing to the Provider. Waiver by either party of any breach of any term or condition of this Agreement shall not be construed as a waiver of any subsequent breach of any term or condition of this Agreement. If APD determines that the Provider is not performing in accordance with any term or condition in this Agreement, APD may, at its exclusive option, allow the Provider a period of time to achieve compliance. The provisions herein do not limit APD's right to any other remedies at law or in equity.

IV. *GOVERNING LAW*:

This Agreement shall be construed, performed, and enforced in all respects in accordance with all the laws and rules of the State of Florida, and any applicable federal laws and regulations.

V. *AGREEMENT DURATION*:

This Agreement shall be effective _____ or the date on which it has been signed by both parties, whichever is later, and shall terminate on _____ which is no later than three years from the effective date.

VI. *OFFICIAL REPRESENTATIVES* (Names, Address, Telephone Number, and E-mail Address):

1. The Provider's contact person and street address where financial and administrative records are maintained is:

Name: _____
Telephone Number: _____
Address: _____
E-mail Address: _____

2. The representative of the Provider responsible for administration of the services under this Agreement is:

Name: _____
Telephone Number: _____
Address: _____
E-mail Address: _____

3. The Agency for Persons with Disabilities contact person for this Agreement is:

Name: _____
Telephone Number: _____

Address:
E-mail Address: _____

4. Upon change of the representative's names, addresses, telephone numbers, and e-mail addresses, by either party, notice shall be provided in writing to the other party and the notification attached to the originals of this Agreement.

VII. *INTEGRATED AGREEMENT*:

Only this Agreement, any attachments referenced, the Medicaid Provider Agreement, the *Developmental Disabilities Waiver Services Coverage and Limitations Handbook*, and the *Family and Supported Living Waiver Services Directory*, which are incorporated into this Agreement by reference, contain all the terms and conditions agreed upon by the parties.

There are no provisions, terms, conditions, or obligations other than those contained herein, and this Agreement shall supersede all previous communications, representations, or agreements, either verbal or written between the parties. If any term or provision of the Agreement is found to be illegal or unenforceable, the remainder of the Agreement shall remain in full force and effect and such term or provision shall be stricken.

The Provider, by signing below, attests that the Provider has received and read the entire Agreement, inclusive of its attachment's and documents as referenced in Section I, A., including the service-specific requirements and Core Assurances for enrolled providers, contained in the *Developmental Disabilities Waiver Services Coverage and Limitations Handbook* and the *Family and Supported Living Waiver Services Directory*, and understands each section and paragraph.

IN WITNESS THEREOF, the parties hereto have caused this ___ page Agreement to be executed by their undersigned officials as duly authorized.

PROVIDER:	**STATE OF FLORIDA, AGENCY FOR PERSONS WITH DISABILITIES**
SIGNED BY:	**SIGNED BY:**
NAME:	**NAME:**
TITLE:	**TITLE:**
DATE:	**DATE:**

Medicaid Provider #: _____ (DD Waiver) **and/or** _____ (FSL Waiver)

APPENDIX H

PERSONAL CARE ASSISTANT

SERVICE LOG

Personal Care Assistant Service Log

Area: : <text box> **Date: : <text box>**

Service: Select... **Procedure Code: : <text box>**

Client Last Name: : <text box> **Client First Name: : <text box>**

Client Medicaid Number: : <text box>

Provider Name: : <text box>

Provider Address: : <text box>

Provider City: : <text box> **Provider State: : <text box>** **Provider Zip: : <text box>**

Provider Medicaid Waiver Number: : <text box>

Unit Type: Select...

Date: <date picker>

Time In: <text box> Time Out: <text box> Duration: <text box>

Total Number Of Units: <text box>

(repeating section) You click this button to add additional box for the next day's information

List of specific activities rendered: : <expandable text box>

Changes Observed/Concerns Noted: Select...

If yes, explain:
<expandable text box>

I hereby certify that I have reviewed and/or personally prepared this form and that it represents a true and correct documentation of services rendered.

Enter Approval Password: <text box – password verification>

The areas "Bolded" (at the top of form) is pre-populated with information from our ABC system.

APPENDIX I

DETAILED SERVICE LOG

Service Log

Area: **<text box>** **Date: <text box>**

Service: Procedure Code:

Client Last Name: **<text box>** Client First Name: **<text box>**

Client Medicaid Number: **<text box>**

Provider Name: **<text box>**

Provider Address: **<text box>**

Provider City: **<text box>** Provider State: **<text box>** Provider Zip: **<text box>**

Provider Medicaid Waiver Number: **<text box>**

Unit Type:

Date: <text box>

Time In: <text box> Time Out: <text box> Duration: <text box>

Total Number of Units: <text box>

List of specific activities rendered: expandable text box>

(repeating section) You click this button to add additional box for the next day's information

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Changes Observed/Concerns Noted:

If yes, explain: <expandable text box>

I hereby certify that I have reviewed and/or personally prepared this form and that it represents a true and correct documentation of services rendered.

Enter Approval Password: <text box – password verification>

The areas "Bolded" (at the top of form) is pre-populated with information from our ABC system.