



# Florida Medicaid

## Developmental Disabilities Waiver Services Coverage and Limitations Handbook

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Agency for Health Care Administration





# FLORIDA MEDICAID

JEB BUSH, GOVERNOR

ALAN LEVINE, SECRETARY

June 14, 2005

Dear Developmental Disabilities Waiver Services Provider:

Enclosed you will find the revised Florida Medicaid Developmental Disabilities Waiver Services Coverage and Limitations Handbook, Updated October 2003 with an implementation date of June 23, 2005. This handbook replaces the October 2002 version, which is now obsolete. Included in the handbook are the Developmental Disabilities Procedure Codes and Units of Service.

The current fee schedule may be found at <http://floridamedicaid.acs-inc.com>, the Medicaid fiscal agent's website. To locate the schedule, click on Provider Support; click on Handbooks and scroll down to Developmental Services Provider Rate Table. In addition, the website contains all of the Medicaid handbooks and other information about Florida Medicaid.

If you have any questions, please contact your Medicaid Area Office. The area office telephone numbers may be found in Appendix C of the Florida Medicaid Provider General Handbook.

We appreciate the services that you provide to Florida's Medicaid recipients.

Sincerely,



Thomas W. Arnold  
Deputy Secretary for Medicaid





# UPDATE LOG

## DEVELOPMENTAL DISABILITIES WAIVER SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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### *How to Use the Update Log*

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#### **Introduction**

Changes to the handbook will be sent out as handbook updates. An update can be a change, addition, or correction to policy. It may be either a pen and ink change to the existing handbook pages or replacement pages.

It is very important that the provider read the updated material and then file it in the handbook, because it is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

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#### **Explanation of the Update Log**

The provider can use the update log to determine if all the updates to the handbook have been received.

Update No. is the month and year that the update was issued.  
Effective Date is the date that the update is effective.

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#### **Instructions**

1. Make the pen and ink changes and file new or replacement pages.
2. File the cover page and pen and ink instructions from the update in numerical order after the log.

If an update is missed, write or call the Medicaid fiscal agent at the address given in Appendix C of the Florida Medicaid Provider General Handbook.

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<b>UPDATE NO.</b>	<b>EFFECTIVE DATE</b>
July 2002 – New Handbook	July 2002
Oct2002 – Promulgated Handbook	October 2002
Oct2003 – Revised Handbook	June 23, 2005



# DEVELOPMENTAL DISABILITIES WAIVER SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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## INTRODUCTION TO THE HANDBOOK

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### Overview

#### Introduction

This chapter introduces the format used to prepare the Florida Medicaid handbooks and tells the provider 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.

Exceptions: For Prescribed Drugs and Transportation Services, the coverage and limitations handbook and the reimbursement handbook are combined into one.

#### 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, and
- Chapter 59G, Florida Administrative Code.
- Specific statutory authority for the promulgation of the Developmental Disabilities Waiver Services Handbook into rule 59G-8.200 is found in Chapters 408.301, 408.302, and 409.919, F.S.

The specific Federal Regulations, Florida Statutes, and the Florida Administrative Code, for each Medicaid service are cited for reference in each service-specific coverage and limitations handbook.

The Agency for Health Care Administration (AHCA) has final authority on all policies, procedures, rules, regulations, manuals, and handbooks pertaining to the waiver. The Department of Children and Families (DCF) is authorized by AHCA to operate and oversee the waiver in accordance with the Interagency Agreement for Medicaid between AHCA and DCF regarding the Developmental Disabilities Home and Community-Based Services Waiver.

#### In This Chapter

This chapter contains:

TOPIC	PAGE
Handbook Use and Format	ii
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**Handbook Use and Format**

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**Purpose**

The purpose of the Medicaid handbooks is to furnish 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.

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**“Provider”**

The term “provider” is used to describe any, facility, person or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.

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**“Recipient”**

The term “recipient” is used to describe an individual who is eligible for Medicaid.

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**General Handbook**

General information regarding the Florida Medicaid program, recipient eligibility, provider enrollment, fraud and abuse policy and important resources for providers is included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.

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**Coverage and Limitations Handbook**

Each coverage and limitations handbook is named for the service it describes. A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.

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**Reimbursement Handbook**

Each reimbursement handbook is named for the claim form that it describes. A provider who bills on more than one type of claim form will have more than one reimbursement handbook.

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**Chapter Numbers**

The chapter number appears as the first digit before the page number at the bottom of each page.

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**Page Numbers**

Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number found at the bottom of each page.

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**White Space**

The "white space" found throughout a handbook enhances readability and allows space for writing notes.

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***Characteristics of the Handbook***

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<b>Format</b>	The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.
<b>Information Block</b>	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of a subject. Horizontal lines separate blocks. Each block is identified or named with a label.
<b>Label</b>	Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.
<b>Note</b>	<p><u>Note</u>: is used most frequently to refer the user to pertinent material located elsewhere in the handbook.</p> <p><u>Note</u>: also refers the user to other documents or policies contained in other handbooks.</p>
<b>Topic Roster</b>	Each chapter contains a topic roster 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.
<b>Forms</b>	Copies of all the forms discussed in the handbook appear in the section of the handbook that describes and discusses the particular document.

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***Handbook Updates***

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<b>Update Log</b>	<p>The first page of each handbook will contain the update log.</p> <p>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.</p> <p>Each update will be designated by an "Update No." and the "Effective Date."</p>
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**Handbook Updates**, continued

**How Changes Are Updated**

The Medicaid handbooks will be updated as needed. Changes may consist of any one of the following:

- Pen and ink updates – Brief changes will be sent as pen and ink updates. The changes will be incorporated on replacement pages the next time replacement pages are produced.
- Replacement pages – Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages. Replacement pages will contain an effective date that corresponds to the effective date of the update.
- Revised handbook – Major changes will result in the entire handbook being replaced with a new effective date throughout.

**Numbering Update Pages**

Replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the preceding replacement page with a numeric character in ascending order. For example: page 1-3 may be followed by page 1-3.1 to avoid reprinting the entire chapter.

**Effective Date of New Material**

The month and year that the new material is effective will appear in the corner of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

If an information block has an effective date that is different from the effective date on the bottom of the page, the effective date will be included in the label.

**Identifying New Information**

New material will be indicated by vertical lines. 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**

A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.

**New Label and New Information Block**

A new label and a new information block will be identified by a vertical line to the left of the label and to the right of the information block.

**New Material in an Existing Information Block**

New or changed material within an existing information block will be indicated by a vertical line to the left and right of the information block.

**New or Changed Paragraph**

A paragraph within an information block that has new or changed material will be indicated by a vertical line to the left and right of the paragraph.

|Paragraph with new material. |

# CHAPTER 1

## DEVELOPMENTAL DISABILITIES WAIVER SERVICES

### PURPOSE, BACKGROUND, AND PROGRAM SPECIFIC INFORMATION

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**Overview**

**Introduction**

This chapter describes the Medicaid Developmental Disabilities (DD) Waiver Program, specifies the authority regulating DD waiver services, the purpose of the program, provider qualifications and responsibilities.

**Legal Authority**

Medicaid 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.), Part 441.300.

Chapter 409, Florida Statutes (F.S.) and the Florida Administrative Code (F.A.C.), Chapter 59G-8.200 authorize the Florida Medicaid DD waiver.

Specific statutory authority for the promulgation of the Florida Medicaid Developmental Disabilities Waiver Services Handbook into rule is found in the following provisions of law: Chapters 408.301, F.S., 408.302, F.S., 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 Department of Children and Families (DCF), is authorized by AHCA, to operate and oversee the waiver in accordance with the Interagency Agreement for Medicaid between AHCA and DCF regarding the Developmental Disabilities Home and Community-Based Services Waiver.

**In This Chapter**

This chapter contains:

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**General Definitions**

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**Agency** The Agency for Health Care Administration (AHCA).

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**Agency or Group 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. 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 a personnel file documenting qualifications of all employees and their background screening results.

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**Core Assurances** The document that specifies administrative and programmatic requirements for DD waiver providers. The Core Assurances and the specific service requirements published in this handbook are incorporated into the Medicaid Waiver Services Agreement by reference, and provide the terms and conditions by which the provider of waiver services to recipients with developmental disabilities served by the Department agrees to be bound.

Note: See Appendix C for additional information on Core Assurances.

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**Department** The Department of Children and Families (DCF), which includes the Developmental Disabilities (DD) Program Office (Central Office), located in Tallahassee and its Developmental Disabilities District/Region Offices (District Office), located throughout the state.

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**Direct Provider Billing** This is a standard billing process for Developmental Disabilities Home and Community-Based Services (DD/HCBS) Medicaid Waiver service providers that will replace the current system of submitting claims to Waiver Support Coordinators for processing.

Effective March 3, 2003, the Allocation, Budget and Control (ABC) system will no longer be used for submission of claims for DD/HCBS services rendered. From March 3, 2003 forward, all claims for DD/HCBS services will be submitted either by mail, using the 081-claim form, or electronically using the WINASAP2000 software, directly to the Medicaid fiscal agent.

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**Direct Service Provider** As referenced in Chapter 393.063(15), Florida Statutes, a "direct service provider," also known as "caregiver" in Chapters 393 and 415, F.S., or "caretaker" in provisions relating to employment security checks, means a person 18 years of age or older who has direct contact with individuals with developmental disabilities and is unrelated to the individuals with developmental disabilities.

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**General Definitions**, continued

<b>District Developmental Disabilities Program Administrator</b>	The person in charge of the Developmental Disabilities Program in each district or region of the state.
<b>District or Region</b>	A service district or region of the Florida Department of Children and Families.  <i>Note:</i> See Appendix E for additional information.
<b>FMMIS</b>	Florida Medicaid Management Information System (FMMIS).
<b>Health Insurance Portability and Accountability Act of 1996 (HIPAA)</b>	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 moved 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.
<b>Independent Vendor</b>	A service provider who meets specified qualifications or holds local occupational licenses.
<b>Job Development</b>	Means the process of developing employer relations and linking recipients with private and public sector labor needs. This process involves exploring job skills and job preferences with the recipient with a disability, as well as networking with the recipient with a disability, the job developer or job coach, other people who know the recipient seeking employment, and local employers.
<b>Licensed Residential Facility</b>	Facilities providing room and board, and other services in accordance with the licensing requirements for the facility type. Community-based recipients with developmental disabilities may receive DD waiver services while residing in: <ul style="list-style-type: none"> <li>• Group and foster homes licensed by the Department of Children and Families in accordance with Chapter 393, F.S., and Chapter 409, F.S.</li> </ul>

**General Definitions**, continued

**Licensed Residential Facility**, continued

- Comprehensive, Transitional Education Program Facilities, licensed by the Department of Children and Families in accordance with Chapter 393, F.S.
- Assisted Living Facilities, and Transitional Living Facilities, licensed by the Agency for Health Care Administration in accordance with Chapter 400, F.S.
- Residential Habilitation Centers and any other type of licensed facility not mentioned above, having a capacity of 16 or more persons, if the recipient has continuously resided at the facility since August 8, 2001, or prior to this date.

**Meaningful Day Activities**

Choices made by recipients of how to use their time in order to provide direction, purpose and quality to the individual recipient's daily life. The recipient's choice of meaningful day activities must be based on his interests, skills and talents. Meaningful day activities may involve choices that are not paid for by the waiver, including paid employment, volunteer work and school. Meaningful day activities that are paid for under the waiver are limited to 35 hours per week, and include supported employment, adult day training and non-residential support services. A recipient may choose a mix of meaningful day activities, but under no circumstances will the waiver pay for more than 35 hours a week of meaningful day activities for each recipient. Chosen activities must directly address identified goals in the recipient's support plan.

**Medicaid State Plan Services**

The Medicaid State Plan is the state and federal partnership that provides health coverage for selected categories of people with low incomes. Its purpose is to improve the health of people who might go without medical care for themselves and their children. Medicaid is different in every state. In Florida, the Agency for Health Care Administration (AHCA) develops and carries out policies related to the Medicaid program. A brief description of the services offered by the Florida Medicaid Program can be found in the Medicaid Summary of Services booklet available from the AHCA website at: <http://www.fdhc.fl.us/Medicaid/>.

Printed copies may be obtained from the Medicaid area offices and from Medicaid Contract Management, 2308 Killearn Center Blvd., Suite 200, Tallahassee, Florida 32309, (850) 922-2726.

Note: Refer to Appendix D for contact information.

**General Definitions**, continued

**Medicaid Waiver Services Agreement**

The Developmental Disabilities Program Medicaid Waiver Services Agreement means the agreement between the DCF Developmental Disabilities Program and providers of waiver services, which consists of Form CF-DD 3064 (Medicaid Waiver Services Agreement), and the Core Assurances for providers of Medicaid Home and Community-Based Waiver Services Programs. Specific service requirements, as defined in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, and rate methodology information that is incorporated into the agreement by reference. All providers must complete this agreement to provide services to recipients enrolled in the Developmental Disabilities Home and Community-Based Services Waiver Program and comply with the terms and conditions of the agreement.

Note: Refer to Appendices A, B and C for additional information.

**Medical Case Management Team**

The health and safety oversight team designated by the District Developmental Disabilities Program Office as the District/Regional Medical Case Management Team (DMCMT). At a minimum, the DMCMT will have one full time or full time equivalency Registered Nurse who will be the Medical Case Manager. Tasks of the DMCMT include:

- Review of recipient needs;
- Review of health related supports and services that a recipient is receiving and the recipient's response to them;
- Follow-up concerning an illness, injury, or accident; and
- Consultation, technical assistance and training with support coordinators, service providers, and medical specialists regarding a recipient's care.

**Medical Necessity or Medically Necessary**

A set of conditions established by the Agency for Health Care Administration (AHCA), for determining the need for and appropriateness of Medicaid funded services for an enrolled recipient.

As defined in Chapter 59G-1.010(166)(a), F.A.C., as it relates to medical necessity or medically necessary, the medical or allied care, goods, or services furnished or ordered as defined as meeting the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

**General Definitions**, continued

**Medical Necessity or Medically Necessary,**  
continued

- Be consistent with generally accepted professional medical standards as defined by the Medicaid program, according to Chapter 42 of the Code of Federal Regulations, and not be experimental or investigational;
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide; and
- Be furnished in a manner not primarily intended for the “convenience” of the recipient, the recipient’s caretaker, or the provider.

**Pre-Service Training for Waiver Support Coordinators**

Consists of 60 hours of training provided by the Department. Attendance and completion is mandatory for all waiver support coordinators.

Note: Refer to Chapter 1, Waiver Support Coordination training requirements for additional information.

**Projected Service Outcomes**

Goals used to determine, through monitoring and review, the accomplishments of providers and the effectiveness of service provision.

**Provider of Limited Transportation Service**

Family member, friend, or neighbor who provides occasional transportation service to a specific DD waiver recipient.

**Provider Service Agreement**

Prior to providing any services the provider must, in order to be compensated by the Developmental Disabilities Home and Community-Based Waiver Program, execute a Medicaid Provider Agreement with the Agency for Health Care Administration (Agency), and be issued a Medicaid provider number by the Agency. The provider must, at all times, maintain a current and valid Medicaid Provider Agreement with the Agency and a current Medicaid Waiver Services Agreement with the Department. The provider must comply with the terms and conditions of the Medicaid Provider Agreement as fully set forth within this agreement. The provider agrees to comply with all the terms and conditions contained within the Agreement documents and those contained in the Florida Medicaid Developmental Disabilities Waiver Services Coverage and Limitations Handbook.

Note: See Appendix B for additional information.

**Residence**

The place in which a recipient resides for an extended or a permanent period of time and is considered his home.

**General Definitions**, continued

**Service Authorization Form**

A Department approved form sent to a waiver provider from the waiver support coordinator authorizing the provision of specific services or supports to a recipient. Without this service authorization form the provider is not authorized to provide the service and cannot submit a claim nor be reimbursed for the service. For the purposes of direct provider billing, the service authorization form must contain the waiver support coordinator's 9-digit treating provider number. Services provided without authorization may be subject to recoupment of funds from the service provider. Support coordinators must ensure service authorizations are provided in writing using the service authorization form.

Authorizing a service at a rate or frequency that is higher than that approved by the Department may 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. This authorization is contingent upon the enrolled recipient remaining eligible, for Medicaid during the month of service. Upon a recipient's loss of Medicaid eligibility the service authorization is null and void. In this instance, the provider must contact the waiver support coordinator or Department to ascertain if alternative funding is available for the services.

**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. For example: If the provider is a solo provider and incorporates, the provider is still considered a solo or independent provider for rate purposes unless they hire another person to perform the specific waiver service for which the rate is being established. If the provider is a solo provider and incorporates and the board hires them to perform the service, they are still considered an independent provider for rate purposes for those services that they directly perform or personally deliver.

**Support Plan**

An individualized plan of supports and services designed to meet the needs of a recipient enrolled in the waiver. The plan is based on the preferences, interests, talents, attributes and needs of a recipient. The recipient or parent, legal guardian or guardian advocate, shall be consulted in the development of the plan and shall receive a copy of the plan and any revisions made to the plan. Each plan shall include the least restrictive, and most cost-beneficial environment for accomplishment of the objectives for individual progress and a specification of all services authorized. The plan shall include provisions for the most appropriate level of care for the recipient. The ultimate goal of each plan shall be to enable the recipient to live a dignified life in the least restrictive setting, appropriate to the recipient's needs. The support plan must be completed in a format provided by the Department and according to the instructions provided by the Department.

**General Definitions**, continued

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**Trip Log**

Transportation provided through the DD waiver is billed by the trip, month and mile. All trip logs associated with this service will contain the individual's name(s), date of service, destination and actual mileage for each vehicle trip. If more than one recipient is being transported, the mileage charge will be shared among the number of recipients transported. When compiling trip and mileage information, to facilitate billing by the month, include the dates of service for each individual in the trip log.

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**Waiver Support Coordinator**

An enrolled waiver provider of support coordination services that is selected by the recipient enrolled in the waiver (or their guardian) to assist the recipient who receives waiver services in gaining access to needed waiver and Medicaid State Plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. In the absence of a selection by the recipient or guardian, waiver support coordinators may be assigned by the District, subject to the recipient or guardian making a different selection at a later date. The waiver support coordinators are responsible for ongoing monitoring of supports and services to ensure they are provided to meet the recipients' needs. They also initiate and oversee the process of assessment and reassessment of the recipients' level of care and the review of support plans at such intervals as described in the support coordination section of this handbook. Each support coordinator must enroll as a provider, whether a solo or individual provider, or whether employed by an agency or group provider.

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**Description and Purpose**

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**Developmental Disabilities Waiver Description**

The Developmental Disabilities (DD) Waiver 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 DD waiver is funded by the federal Centers for Medicare and Medicaid Services (CMS), and matching state dollars. The waiver is operated by the Florida Department of Children and Families' Developmental Disabilities Program, under the authorization of the Agency for Health Care Administration's Division of Medicaid.

**Description and Purpose**, continued

**Purpose of the DD Waiver**

The purpose of the DD waiver is to promote, maintain and restore the health of eligible recipients with developmental disabilities; to minimize the effects of illness and disabilities through the provision of needed supports and services in order 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 a viable choice of services that allow eligible recipients to live as independently as possible in their own home or in the community and to achieve productive lives as close to normal as possible as opposed to residing in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) or other institutional settings. The goal of such waiver programs shall be to allow recipients to live as independently as possible in their own home, and to achieve productive lives as close to normal as possible, in accordance with Chapter 393.066, F.S.

The DD waiver embraces the principles of self-determination, which include for the recipient, the freedom 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, 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.

Recipients enrolled in the DD waiver receive services that enable them to:

- Have a safe place to live.
- Have a meaningful day activity.
- Receive medically necessary medical and dental services.
- Receive medically necessary supplies and equipment.
- Receive transportation required to access necessary services.

See the definitions section of this chapter for explanation of a meaningful day activity. The selected activity or activities will usually occupy four to six hours of the person's day. Activities may occur during the day or evening.

Waiver services are not used to cover any co-payments, with the exception of patient responsibility for Medicare-funded wheelchairs.

**Purpose of This Handbook**

This handbook is intended for use by eligible providers who furnish DD waiver services to recipients enrolled in the waiver. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, which contains information about the Medicaid program in general, as well as specific procedures for record keeping and submitting claims for payment.

Note: Refer to Chapter 3 for Direct Provider Billing information, Appendix A for Rate Methodology, and Appendix D for contact information.

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**Provider Qualifications and Responsibilities**

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**DD Waiver Provider Applicant Enrollment**

DD waiver provider applicants must meet specific qualifications and requirements before becoming eligible to provide DD waiver services. In addition, provider applicants must possess a high degree of ethical principles and have no adverse history with the Department of Children and Families, the Agency for Health Care Administration, or any other regulatory agency that causes the Agency or the Department to question whether the health, safety and welfare of a waiver participant would be jeopardized during the delivery of an approved waiver service.

Medicaid DD waiver providers must:

- Be certified as eligible, by the Department of Children and Families, Developmental Disabilities District Office, to enroll as a DD waiver provider;
- Not be currently suspended from Medicare or Medicaid in any state;
- Meet provider qualification and responsibility requirements described in Chapter 1 of this handbook;
- Be enrolled with the Medicaid fiscal agent as a DD waiver provider;
- Have a current, signed DD Waiver Services Agreement with the Department; and
- Be at least 18 years of age.

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**DD Waiver Provider Background Screening Requirements**

Direct service provider applicants, as defined in Chapter 393.063(15), F.S., must comply with the requirements of a level 2 screening in accordance with section 435.04, F.S. Compliance with this requirement may be accomplished through one of two ways:

- Background screenings pursuant to Chapter 393.0655, F.S. or  
Applicants must submit the DCF fingerprinting card, an affidavit of good moral character, a caretaker information sheet and a check for \$39.00, made payable to DCF, to the Department for processing. If the applicant had a screening within 12 months of the time of application and can provide a copy of the report, then the applicant does not need to repeat the screening. The results of this screening will be submitted with the Medicaid enrollment application in lieu of the Medicaid fingerprint card and check for \$39.00. As of July 1, 2004, this fee will be \$47.00.
- Background screenings pursuant to Chapter 409.907, F.S.  
Applicants must submit the Medicaid fingerprint card, the enrollment application and a check for \$39.00, made payable to the Medicaid fiscal agent for processing. As of July 1, 2004, this fee will be \$47.00.

Screening is performed at the time of enrollment and every five years thereafter. It is the responsibility of the applicant or provider to ensure this request for screening or re-screening is submitted for processing in a timely manner.

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***Provider Qualifications and Responsibilities***, continued

**Determination of Eligibility for Certification**

The District Office determines if the provider applicant meets the qualifications and requirements for enrollment as a waiver provider. This determination includes a review of previous employment history and other relevant information. The District shall notify the provider in writing if they are denied enrollment as a provider of waiver services. Any individual or agency desiring to enroll in Medicaid as a DD waiver provider shall submit an application for enrollment to the District Office. This handbook provides detailed information on each service available through the waiver, including provider qualifications, limitations, and required documentation. If you are considering becoming a provider, please carefully review each service you wish to provide before completing a waiver provider application. The application for enrollment consists of a Florida Medicaid Provider Enrollment Application and a DD Waiver Provider Application.

The DD Waiver Provider Application includes a Medicaid Waiver Services Agreement, Core Assurances and Developmental Disabilities Waiver Services Coverage and Limitations Handbook. All DD waiver provider applicants must agree to comply with requirements found in the Developmental Disabilities Medicaid Waiver Services Agreement and attached Core Assurances, as well as service-specific requirements specified in this handbook, incorporated by reference into the Core Assurances, as a condition of enrollment.

The Medicaid forms in the application packet and payment for the background screening if required (i.e., if not completed under Chapter 393, F.S., requirements) from the provider applicant along with a certificate of eligibility, are then forwarded to the DCF Developmental Disabilities Program Central Office for further processing. The Medicaid fiscal agent completes final processing and enrollment.

The District Office receives verification from the DCF Developmental Disabilities Program Central Office when the provider applicant is enrolled in Medicaid as a waiver provider. The District Office then sends the provider a certificate indicating their status as a Medicaid enrolled DD waiver provider.

Prior to July 1, 2001, agency and solo provider applicants may have received certificates from the District Office prior to completion of Medicaid enrollment. Effective July 1, 2001, eligibility for agency and solo providers to provide services will be established when the Medicaid enrollment is completed. When an applicant for enrollment in the waiver has been determined eligible, passed necessary background screening requirements, and is enrolled in Medicaid, the Department will issue a certificate of eligibility. This certificate will list the waiver services the applicant is eligible to provide and the effective date of Medicaid enrollment with the assigned Medicaid provider number. Once the certificate of eligibility is received, the provider may render waiver services and receive reimbursement for those services from Medicaid. No waiver-reimbursed service may be rendered until the provider receives notification of his enrollment in Medicaid.

***Provider Qualifications and Responsibilities***, continued

**Determination of Eligibility for Certification,**  
continued

Providers wishing to expand their status from a solo provider to an agency provider, or a provider desiring to obtain certification in additional waiver services, must be approved by the District in order to expand. A provider must have attained an overall score of at least 85 percent on their last quality assurance monitoring conducted by the Agency, the Department or an authorized agent of the Agency or the Department in order to be considered for expansion.

For information regarding how to become a waiver service provider, contact the DCF District Office in your area.

All providers are required to participate in the direct deposit program for Medicaid payments and must have an active savings or checking account.

Note: Refer to the Florida Medicaid Provider Reimbursement Handbook Non-Institutional 081, for information concerning general Medicaid provider qualifications and refer to Appendices B, C, D and E for additional information.

**Agencies Wishing to Provide Multiple Services**

Agency providers that specialize in services to recipients who have a developmental disability may apply and be approved eligible to provide additional services if they employ staff who meet the qualifications for that service. For example, an agency that serves recipients with a developmental disability that is certified to provide supported living coaching services may also provide non-residential support services.

**Special Requirements for Support Coordination Providers**

All waiver support coordinators, including solo providers or support coordinators employed by agency providers, shall be determined eligible by a District Office and individually enrolled in the Medicaid program as individual treating providers, prior to providing waiver services and billing Medicaid.

Support coordinators will have their eligibility date established on the date the District Office receives a completed application and the background screening from the Florida Department of Law Enforcement (FDLE) is returned with no record or no disqualifying offense.

When the individual waiver support coordinator completes and submits an application with fingerprint card to the District and a local level background screening has been completed by FDLE and returned with no record or disqualifying offense, the District will determine the applicant eligible to conduct an unsupervised face-to-face visit or to have unsupervised contact with a recipient, pending the results of a level 2 background screening. If the local background screening is returned and indicates a record or disqualifying offense, the applicant may not provide services until the level 2 background screening is completed, returned and eligibility is approved.

**Provider Qualifications and Responsibilities**, continued

**Special Requirements for Support Coordination Providers**, continued

However, if the applicant's certificate of eligibility is denied for any reason the applicant cannot perform any waiver services with or without the supervision of an enrolled waiver support coordinator.

For applicants who are employed at the time of application and intend to remain in the current employment, the application must include a statement addressing a plan for dual employment. The plan should address the type of employment held at the time of the application, the total number of hours involved in that employment on a weekly basis, a plan for the manner in which the applicant may be contacted by recipients receiving services during the hours employed in the other job, and how conflicting priorities, emergencies and meetings will be handled. The plan shall also address any long-range plan for reducing or terminating the other employment, should he assume a full waiver caseload.

The District Office shall approve the applicant's dual employment plan as part of the waiver enrollment process. If it is determined that the applicant cannot be available to meet the needs of recipients on their caseload, the application may be denied. In no instance may dual employment include the provision of services to recipients with developmental disabilities, other than within a case management or support coordination function.

Specific support coordination responsibilities are specified in the Core Assurances and must be signed by the provider prior to receiving a certificate of eligibility from the District Office.

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**Family Members Enrolled as DD Waiver Providers**

Parents of minors, spouses, guardians and guardian advocates of waiver participants are specifically excluded from payment for any services provided to their child, spouse or recipient served.

Under no circumstances may a relative provide support coordination to their family member. However, relatives not legally responsible for the care of the recipient may provide respite care, personal care, or transportation. In those limited situations, the relative must meet the same qualifications as other providers of the same waiver service.

Reasons for using a relative not legally responsible for the care of the recipient must be documented, and include lack of available providers or the ability to meet specific scheduling needs of a recipient that other providers can't meet. Convenience to the recipient, caregiver or family alone is not adequate justification.

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**Provider Qualifications and Responsibilities**, continued

**Statewide Enrollment**

All DD waiver providers are enrolled on a statewide basis unless they indicate a geographic preference on the DD waiver application or the District Office restricts enrollment to specified geographic areas. DD waiver providers may be restricted to the provision of services within specific geographic areas based on a lack of provider capacity sufficient to meet projected service needs, concerns regarding the provider's quality of care or other issues that may negatively impact recipients, as determined by the District Office.

Note: Refer to Appendix E for contact information.

**Freedom of Choice**

The waiver is designed around recipient choice. Accordingly, recipients served through the waiver may select among enrolled, qualified service providers and may change providers at any time. Once a recipient has an approved cost plan, the funds allocated to that support plan follow the recipient. Within the funds allocated in the support plan, the recipient is free to change enrolled, qualified providers as desired to meet the goals and objectives set out in the support plan. Freedom of choice includes recipient responsibility for selection of the most cost beneficial residential environment and combination of services and supports to accomplish the recipient's goals.

**Provider Responsibility Regarding HIPAA Requirements**

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements effective April 14, 2003. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements effective October 16, 2003. This coverage and limitations handbook contains information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid see the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA requirements, see the current version of the Florida Medicaid Provider Reimbursement handbook, Non-Institutional 081.

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA requirements, contact the Medicaid fiscal agent EDI help desk at 800-829-0218.

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## **Adult Day Training Provider Requirements**

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### **Provider Qualifications**

Providers of adult day training services shall be designated, by the District Office, as adult day training centers. Unless waived in writing by the District, 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 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 recipients per direct service staff for adult day training facility-based programs. Administrative staff and those not providing direct service to the recipient 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 and two years of related experience.

Note: See the definition of Direct Service Provider in Chapter 1.

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### **Training Requirements**

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), AIDS and infection control is required for all staff within 30 days of initially providing adult day training services. Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances. Staff is required to attend eight hours of annual in-service training related to implementation of individually tailored services.

Note: Refer to Appendix C for provider training requirements.

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### **Projected Service Outcomes**

Projected services outcomes are goals used to determine, through monitoring and review, the accomplishments of providers and the effectiveness of service provision.

- Recipients receiving services demonstrate an increase in abilities, consistent with their support plan.
- Recipients served who have a stated support plan goal to be employed in the community, have been provided with specific information, opportunities for exploration, and the necessary support to make progress toward this goal on supported employment or other competitive employment opportunities.

**Adult Day Training Provider Requirements**, continued

**Projected Service Outcomes**, continued

- Recipients served who have a stated support plan goal to be involved in the community in another type of arrangement such as volunteer work have been provided with specific information, opportunities for exploration, and necessary support to make progress towards the goal.
- All recipients served who have responded to the annual satisfaction survey, are satisfied with the services based on the results or that the provider has addressed any concerns raised during the survey.
- Recipients achieve goals on their support plan throughout the year.
- Recipients demonstrate freedom of choice, including being informed about rights and service options (e.g., more inclusive programs, supported employment).

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**Adult Dental Services Provider Requirements**

**Provider Qualifications**

Providers of adult dental services shall be dentists licensed by the Department of Health in accordance with Chapter 466, F.S.

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**Behavior Analysis Provider Requirements**

**Provider Qualifications**

Licensure or certification must be 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; Florida Certified Behavior Analyst with expanded privileges; 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 more than three years of experience post certification or licensure.

Level 2 Board Certified Behavior Analyst; Florida Certified Behavior Analyst with expanded privileges; 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 less than three years of experience; or a Florida Certified Behavior Analyst with a Masters or Doctorate, regardless of experience.

Level 3 Board or Florida Certified Associate Behavior Analyst or a Florida Certified Behavior Analyst with bachelors or high school diploma, regardless of experience.

***Behavior Analysis Provider Requirements***, continued

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**Training Requirements**

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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***Behavior Assistant Services Provider Requirements***

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**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 recipients with developmental disabilities or at least 120 hours of direct services to recipients with complex behavior problems, as defined in Chapter 65B-4.031(2), F.A.C., or 90 classroom hours of instruction in applied behavior analysis from non-university non-college classes or university or college courses; and
3. 20 contact hours of instruction in the following content areas:
  - a. Introduction to applied behavior analysis basic principles and functions of behavior;
  - b. Providing positive consequences, planned ignoring, and stop-redirect-reinforce techniques;
  - c. Data collection and charting; and
  - d. 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.

The 20 contact hours of instruction required under number three above may be obtained within the 90 classroom hours of instruction used to meet requirements under number two above.

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**Training Requirements**

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), AIDS and infection control is required within 30 days of initially providing behavior assistant services. Proof of annual or required updated training shall be maintained on file for review. The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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### ***Chore Service Provider Requirements***

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#### **Provider Qualifications**

Providers of chore services may be licensed home health or hospice agencies. Providers may also be independent vendors.

Independent vendors and staff of agencies must be at least 18 years of age and have at least one year of experience working in a medical, psychiatric, nursing or childcare setting or working with developmentally disabled recipients. College, vocational or technical training equal to 30 semester hours, 45 quarter hours or 720 classroom hours may substitute for the required experience. Independent vendors are not required to be licensed or registered.

Home health and hospice agencies shall be licensed by the Agency for Health Care Administration in accordance with Chapter 400, Part IV or Part VI, F.S.

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### ***Companion Provider Requirements***

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#### **Provider Qualifications**

Providers of companion services may be licensed home health or hospice agencies. Providers may also be independent vendors who are individuals or employees of agencies licensed by the Agency for Health Care Administration. Home health agencies, hospice agencies and all agencies and organizations providing this service shall be licensed by the Agency for Health Care Administration in accordance with Chapter 400.464, F.S.

Independent vendors are not required to be licensed or registered if they bill for and are reimbursed only for services personally rendered.

If operating as an agency, as defined on page 1-2 under agency or group provider, using more than one employee to provide services and billing for their services, it shall be registered as a sitter or companion provider in accordance with Chapter 400, F.S.

Minimum qualifications for a companion include: be at least 18 years of age and have one year of experience working in a medical, psychiatric, nursing or child care setting, or in working with recipients having developmental disabilities; college, vocational or technical training from an accredited institution can substitute at the rate of 30 semester, 45 quarter or 720 classroom hours for the required experience.

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**Companion Provider Requirements**, continued

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**Training Requirements**

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), AIDS and infection control is required within 30 days of initially providing companion services. Proof of annual or required updated training shall be maintained on file for review. The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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**Consumable Medical Supplies Provider Requirements**

**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 by the Agency for Health Care Administration in accordance with Chapter 400, Part IV or Part VI, F.S. Pharmacies shall hold a permit to operate, issued by the Department of Health, 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 by the Agency for Health Care Administration.

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.

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### ***Dietitian Provider Requirements***

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<b>Provider Qualifications</b>	Providers of dietitian services shall be dietitians or nutritionists licensed by the Department of Health, in accordance with Chapter 468, F.S.
<b>Training Requirements</b>	The provider is responsible for all training requirements outlined in the Core Assurances.  <u>Note:</u> Refer to Appendix C for provider training requirements.

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### ***Durable Medical Equipment Provider Requirements***

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<b>Provider Qualifications</b>	<p>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 meet the following criteria:</p> <ul style="list-style-type: none"><li>• Be licensed by the local government as a business or merchant or provide documentation from the city or county authority that no licensure is required; and</li><li>• Be licensed by the Department of Health Medical Quality Assurance, Board of Orthotics and Prosthetics, if providing orthotics and prosthetic devices.</li></ul> <p>In accordance with Code of Federal Regulations (C.F.R.) Part 440.70, 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.</p> <p>In accordance with Chapter 400.935, F.S., and Chapter 409.919, 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.</p>
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***Durable Medical Equipment Provider Requirements***, continued

**Provider Qualifications**,  
continued

Home health and hospice agencies shall be licensed by the Agency for Health Care Administration, in accordance with Chapter 400, Part IV or Part VI, F.S.

Pharmacies shall hold a permit to operate issued by the Department of Health, in accordance with Chapter 400, 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 by the Agency for Health Care Administration.

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

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***Environmental Accessibility Adaptation Provider Requirements***

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**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 Chapter 489.119, F.S. In accordance with Chapter 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 by the Department of Business and Professional Regulation, 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 by the Department of Business and Professional Regulation in accordance with Chapter 481, 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.

Contractors and electricians shall be licensed by the Department of Business and Professional Regulation, in accordance with Chapter 489, F.S.

Plumbers shall be licensed by the Department of Business and Professional Regulation, in accordance with Chapter 553, F.S.

***Environmental Accessibility Adaptation Provider Requirements***, continued

**Provider Qualifications**,  
continued

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.

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***Homemaker Services Provider Requirements***

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**Provider Qualifications**

Providers of homemaker services may be licensed home health or hospice agencies. Providers may also be independent vendors, who are individuals or employees of agencies that are licensed by the Agency for Health Care Administration.

Home health and hospice agencies shall be licensed by AHCA, in accordance with Chapter 400.464, F.S.

Independent vendors are not required to be licensed or registered if they bill for and are reimbursed only for services personally rendered. If operating as an agency, using more than one employee to provide services and billing for their services, the agency shall be registered as a homemaker provider in accordance with Chapter 400, F.S.

Minimum qualifications for a homemaker include being at least 18 years of age, having one year of experience working in a medical, psychiatric, nursing or childcare setting, or in working with recipients having developmental disabilities. College, vocational or technical training from an accredited institution can substitute at the rate of 30 semester, 45 quarter or 720 classroom hours for the required experience.

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***In-Home Support Services Provider Requirements***

**Provider Qualifications**

Providers of in-home support services are independent vendors, who are either individuals or employees of agencies, must be at least 18 years of age and have at least a high school diploma or equivalent and one year of experience working in a medical, psychiatric, nursing or childcare setting or working with recipients who have a developmental disability. College, vocational or technical training equal to 30 semester hours, 45 quarter hours or 720 classroom hours may substitute for the required experience. Licensure or registration is not required.

**Training Requirements**

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), AIDS and infection control is required within 30 days of initially providing in-home supports. Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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***Medication Review Provider Requirements***

**Provider Qualifications**

Medication review providers shall be consultant pharmacists licensed by the Department of Health and certified, in accordance with Chapter 465, F.S.

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***Non-Residential Support Services Provider Requirements***

**Provider Qualifications**

Providers of non-residential support services may be independent vendors with at least a high school diploma or equivalent and one year of experience working in a medical, psychiatric, nursing or childcare setting or working with recipients with developmental disabilities. College, vocational or technical training equal to 30 semester hours, 45 quarter hours, or 720 classroom hours may substitute for the required experience.

Agencies may also provide this service if the agency employee who actually performs the services meets the same qualifications as an independent vendor described previously. Providers of these services are selected based on their unique abilities to provide the specific services described on the recipients support plan and current approved cost plan.

Licensure or registration is not required.

***Non-Residential Support Services Provider Requirements***, continued

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**Training Requirements**

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), AIDS and infection control is required within 30 days of initially providing non-residential support services. Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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**Projected Service Outcomes**

Projected service outcomes are goals used to determine, through monitoring and review, the accomplishments of providers and the effectiveness of service provision.

- Recipients achieve goals on their support plan during the year.
  - All recipients served, who have responded to their annual satisfaction survey are satisfied with the services based on the results or that the provider has addressed any concerns raised during the survey.
  - Recipients who use the supports and services of the provider demonstrate an increase in abilities, consistent with their support plan.
  - Recipients who use the supports and services of the provider are supported in integrated community settings of their choice to increase their level of participation or independence.
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***Occupational Therapy Provider Requirements***

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**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, F.S.

Occupational therapists, aides and assistants may provide services as independent vendors or as employees of licensed home health or hospice agencies.

Occupational therapy aides and assistants must be supervised by an occupational therapist in accordance with the requirements of their professional licenses. Occupational therapy assistants are not eligible to perform occupational assessments. Assessments can only be provided by the occupational therapist.

Occupational therapists, occupational therapy aides, and occupational therapy assistants shall be licensed by the Department of Health, in accordance with Chapter 468, Part III, F.S., and may provide services within the scope of their licenses.

**Occupational Therapy Provider Requirements**, continued

**Provider Qualifications**, continued

Home health and hospice agencies shall be licensed by the Agency for Health Care Administration, in accordance with Chapter 400, Part IV or Part VI, F.S.

Note: Refer to General Definitions for additional information about agency or group providers and independent vendors.

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**Training Requirements**

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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**Personal Care Assistance Provider Requirements**

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**Provider Qualifications**

Providers of personal care assistance may be home health or hospice agencies. Providers may also be independent vendors. These services are provided pursuant to the requirements in Chapter 393, F.S.

Independent vendors and employees of agencies shall be at least 18 years of age and have at least one year of experience working in a medical, psychiatric, nursing or childcare setting or working with recipients who have a developmental disability. College, vocational or technical training equal to 30 semester hours, 45 quarter hours or 720 classroom hours may substitute for the required experience.

Home health agencies and hospice agencies shall be licensed by the Agency for Health Care Administration, in accordance with Chapter 400, Part IV or Part VI, F.S.

Independent vendors are not required to be licensed or registered.

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**Training Requirements**

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), AIDS and infection control is required within 30 days of initially providing personal care assistance. Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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### ***Personal Emergency Response (PERS) Provider Requirements***

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**Provider  
Qualifications**

Providers shall be licensed electrical contractors, alarm system contractors, contract agencies for Community Care for the Elderly (CCE), Community Care for Disabled Adults (CCDA) Programs, 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 by the Department of Business and Professional Regulation, in accordance with Chapter 489, Part II, F.S.

Hospitals shall be licensed by the Agency for Health Care Administration, in accordance with Chapters 395, 410 and 430, F.S.

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

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### ***Physical Therapy Provider Requirements***

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**Provider  
Qualifications**

Providers of physical therapy and assessment services shall be licensed as physical therapists and physical therapist assistants. Physical therapists may provide this service as independent vendors or as employees of licensed home health or hospice agencies. 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.

Physical therapists and physical therapist assistants shall be licensed by the Department of Health in accordance with Chapter 486, F.S., and may perform services within the scope of their licenses.

Home health and hospice agencies shall be licensed by the Agency for Health Care Administration, in accordance with Chapter 400, Part IV or Part VI, F.S.

Note: Refer to General Definitions for additional information about agency or group providers and independent vendors.

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***Physical Therapy Provider Requirements***, continued

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**Training Requirements**

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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***Private Duty Nursing Provider Qualifications***

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**Provider Qualifications**

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

Nurses may provide this service as employees of licensed home health, hospice agencies or nurse registries. They may also be enrolled as independent vendors providing services under their own name and license.

Home health agencies, hospice agencies and nurse registries shall be licensed by the Agency for Health Care Administration, in accordance with Chapter 400, Part IV or Part VI, F.S.

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**Training Requirements**

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), AIDS and infection control is required within 30 days of initially providing private duty nursing services. Proof of annual or required updated training shall be maintained on file for review. The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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***Psychological Assessment Provider Requirements***

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**Provider Qualifications**

Providers of psychological assessments shall be psychologists licensed by the Department of Health, in accordance with Chapter 490, F.S.

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**Training Requirements**

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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## ***Residential Habilitation Provider Requirements***

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### **Provider Qualifications**

Providers of residential habilitation services shall be transitional living facilities or residential facilities licensed under Chapter 393 or 400, F.S. Staff providing residential habilitation services in a licensed setting must comply with the required licensure qualifications.

Direct care staff providing residential habilitation services must be at least 18 years of age and have a high school diploma or equivalent and one year of experience working in a medical, psychiatric, nursing or child care setting or in working with persons who have a developmental disability. College, vocational or technical training equal to 30 semester hours, 45 quarter hours, or 720 classroom hours can substitute for the required experience.

These services may also be provided by a qualified independent vendor for which licensure or registration is not required.

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

A Board Certified Behavior Analyst or Associate Analyst, or Florida Certified Behavior Analyst with a bachelor's degree, or a person licensed under Chapter 490 or Chapter 491, F.S., who provides on-site oversight for residential services.

No fewer than 75 percent of the provider's direct service staff working with the recipient(s) for whom the behavioral residential habilitation rate applies have completed the following training.

At least 20 contact hours of face-to-face instruction in the following content areas to include:

- Introduction to applied behavior analysis – basic principles and functions of behavior;
- Providing positive consequences, planned ignoring, and stop-redirect-reinforce techniques; and
- Data collection and charting.

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.

Other staff training can and should be provided in addition to the minimum hours and content areas described in the above training as appropriate for the setting or services provided.

**Residential Habilitation Provider Requirements**, continued

**Provider Qualifications**, continued

There is a staff monitoring system that verifies direct service staff continue to be competent in the use of the techniques listed in the training requirement above. Monitoring for competence must occur at least once per month for 50% of direct service staff that have completed the training. Staff must be re-certified in the training requirements yearly.

The provider has a system that demonstrates and measures continuing staff competencies on the use of procedures that are included in each person's behavior analysis services plan.

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

- 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 Developmental Disabilities Program;
- All direct care service needs are met without an addition to the approved rate;
- The Program or Clinical Services Director meets the qualifications of a Doctorate Level Board Certified Behavior Analyst or Masters Level Board Certified Behavior Analyst, or Florida Certified Behavior Analyst, under Chapter 393, F.S., with expanded privileges or 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;
- Staff responsible for developing behavior analysis services will meet at a minimum the requirements for a Florida Certified Behavior Analyst or Board Certified Associate Behavior Analyst under Chapter 393, F.S. or licensed under Chapter 490 and 491, F.S.;
- The ratio of behavior analysts to recipients is no more than one full-time analyst to 20 recipients; and
- 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 residential habilitation above.

**Residential Habilitation Provider Requirements**, continued

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**Training Requirements**

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), AIDS and infection control is required within 30 days of initially providing residential habilitation services. Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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**Projected Service Outcomes**

Projected service outcomes are goals used to determine, through monitoring and review, the accomplishments of providers and the effectiveness of service provision.

- Recipients receiving residential habilitation services achieve goals on their support plan throughout the year.
  - All recipients served who have responded to an annual satisfaction survey, are satisfied with their residential habilitation services based on the results or that the provider has addressed any concerns raised during the survey.
  - Recipients who use the supports and services of the provider are assisted in being healthy and free from injury, abuse or neglect.
  - Recipients using the supports and services of the provider demonstrate an increase in abilities, self-sufficiency, and changes in their lives, consistent with their support plan.
  - Recipients demonstrate freedom of choice, including being informed about rights, service options, and making all possible decisions with regard to the conduct of their lives.
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**Residential Nursing Services Provider Requirements**

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**Provider Qualifications**

Providers of residential nursing services shall be nurses registered or licensed by the Department of Health, in accordance with Chapter 464, F.S. Nurses may provide these services as independent vendors or as employees of licensed residential facilities.

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**Training Requirements**

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), AIDS and infection control is required within 30 days of initially providing residential nursing services. Proof of annual or required updated training shall be maintained on file for review. The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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***Respiratory Therapy Provider Requirements***

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**Provider  
Qualifications**

Providers of respiratory therapy and assessment services shall be respiratory therapists licensed by the Department of Health, in accordance with Chapter 468, Part V, F.S. Respiratory therapists may be either independent vendors or employees of licensed residential facilities, home health agencies or hospice agencies.

Home health agencies and hospice agencies shall be licensed by the Agency for Health Care Administration, in accordance with Chapter 400, Part IV or Part VI, F.S.

Note: Refer to General Definitions for additional information about agency or group providers and independent vendors.

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**Training  
Requirements**

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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***Respite Care Services Provider Requirements***

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**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 recipients with developmental disabilities.

Independent vendors may also provide this service. Independent vendors and employees of agencies may be registered or licensed practical nurses or persons at least 18 years of age with one year of experience working in a medical, psychiatric, nursing or child care setting or working with recipients with developmental disabilities. College, vocational or technical training equal to 30 semester hours, 45 quarter hours or 720 classroom hours may substitute for the required experience.

Home health agencies, hospice agencies and nurse registries shall be licensed by the Agency for Health Care Administration, in accordance with Chapter 400, Part IV or Part VI, F.S.

**Respite Care Services Provider Requirements**, continued

**Provider Qualifications**, continued

Independent vendors, who are not nurses, are not required to be licensed 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 Chapter 400, F.S.

Nurses who render respite care services as independent vendors shall be licensed or registered by the Department of Health, in accordance with Chapter 464, F.S.

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**Training Requirements**

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), AIDS and infection control is required within 30 days of initially providing respite care services. Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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**Skilled Nursing Services Provider Requirements**

**Provider Qualifications**

Providers of skilled nursing services shall be nurses registered or licensed by the Department of Health, in accordance with Chapter 464, F.S.

Nurses may provide this service as independent vendors or as employees of licensed home health, hospice agencies or nurse registries.

Home health, hospice agencies and nurse registries shall be licensed by the Agency for Health Care Administration, in accordance with Chapter 400, Part IV or Part VI, 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 484.

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***Skilled Nursing Services Provider Requirements***, continued

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**Training Requirements**

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), AIDS and infection control is required within 30 days of initially providing skilled nursing services. Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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***Special Medical Home Care Provider Requirements***

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**Provider Qualifications**

Providers of special medical home care shall be group homes that employ registered nurses, licensed practical nurses and certified nurse aides. Certified nurse aides must work under the supervision of a registered or licensed practical nurse.

Group homes shall be licensed by the Developmental Disabilities Program, in accordance with Chapter 393, F.S.

Nurses shall be registered or licensed by the Department of Health, in accordance with Chapter 464, F.S., and may perform services within the scope of their license or registration.

Nurses aides shall be certified, in accordance with Chapter 464, Part II, F.S.

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**Training Requirements**

Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), AIDS and infection control is required within 30 days of initially providing special medical home care. Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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### ***Specialized Mental Health Services Provider Requirements***

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**Provider  
Qualifications**

Providers of specialized mental health services shall be:

- Psychiatrists licensed by the Florida Board of Medicine or Osteopathic Medicine, in accordance with Chapter 458 or 459, F.S.;
- Psychologists licensed by the Department of Health, in accordance with Chapter 490, F.S.; or
- Clinical social workers, marriage and family therapists or mental health counselors licensed by the Department of Health, in accordance with Chapter 491, F.S.

Providers of specialized mental health services shall have two years experience working with recipients dually diagnosed with mental illness and developmental disabilities.

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**Training  
Requirements**

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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### ***Speech Therapy Provider Requirements***

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**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 independent vendors or as employees of licensed home health or hospice agencies. 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, F.S.

**Speech Therapy Provider Requirements**, continued

**Provider Qualifications**, continued

Home health and hospice agencies shall be licensed by the Agency for Health Care Administration, in accordance with Chapter 400, Part IV or Part VI, F.S.

Note: Refer to General Definitions for additional information about agency or group providers and independent vendors.

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**Training Requirements**

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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**Support Coordination Provider Requirements**

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**Provider Qualifications**

Providers of support coordination services may be either single (solo) providers or agency providers.

Training and Experience

- Solo providers and waiver support coordination supervisors employed by agencies shall meet the minimum qualifications. Minimum qualifications include a bachelor's degree from an accredited college or university and three years of professional experience in developmental disabilities, special education, mental health, counseling, guidance, social work or health and rehabilitative services. A master's degree can substitute for one year of the required experience.
- Support coordinators employed by agencies shall meet minimum qualifications. Minimum qualifications include a bachelor's degree from an accredited college or university and two years of professional experience in developmental disabilities, special education, mental health, counseling, guidance, social work or health and rehabilitative services. A master's degree can substitute for one year of the required experience.

**Support Coordination Provider Requirements**, continued

**Provider Qualifications**, continued

- For applicants who have other employment at the time of application to become a waiver provider and intend to remain in the current employment, the application must include a statement addressing a plan for dual employment. The plan should address the type of employment held at the time of the application, the total number of hours involved in that employment on a weekly basis, a plan for the manner in which the applicant may be contacted by recipients receiving services during the hours employed in the other job, and how conflicting priorities, emergencies and meetings will be handled. The plan shall also address any long-range plan for reducing or terminating the other employment should a full waiver caseload be assumed. The District Office shall approve the dual employment plan as a part of the waiver enrollment process. If it is determined that the applicant cannot be available to meet the needs of recipients on applicant's caseload, the application may be denied. In no instance may the dual employment include providing services to recipients with developmental disabilities, unless services are provided within the role of case manager or support coordination.

**Pre-Service Training Requirements**

A minimum of 60 hours of pre-service training is required for solo providers and for the director or managers and the waiver support coordinator supervisor of provider agencies. This pre-service training shall consist of 34 hours of statewide pre-service training that is conducted by the Department of Children and Families, or by a trainer certified by the Department, and 26 hours of District training. The District training shall include orientation to the District staff and responsibilities, District resources, ABC training regarding entry and maintenance of recipient's demographic information, and general District operational procedures. The District training content must be approved by the DCF Developmental Disabilities Program Central Office to ensure statewide uniformity and must be provided by the District within 90 days of the completion of the statewide pre-service training.

The District will also be responsible for training and certifying each support coordinator in the proper administration of the Department approved assessment tool for ascertaining the recipient's level of need. This training is separate from, and in addition to, the 26 hours of District training identified for pre-service requirements. A support coordinator must be certified in the administration of the Department approved assessment within 90 days of completion of the statewide pre-service training.

**Support Coordination Provider Requirements**, continued

**Pre-Service  
Training  
Requirements,**  
continued

Support coordinators employed by agencies are required to receive the same number of training hours and are to be trained on the same topics covered in the statewide training, District training and training in the proper administration of the Department approved assessment. This training may be conducted by the support coordination agency once approved by the Department. Agency trainers must attend a train-the-trainer session conducted by the Department and mandatory refresher courses, as required by the Department.

Agency trainers, and the agency training plan, must be prior approved by the Central and District Office. Agency trainers cannot certify a support coordinator in administration of the Department approved assessment. Support coordinators trained by their agency in the administration of the Department approved assessment must undergo certification by the District.

Waiver support coordinators currently enrolled as Developmental Disabilities Home and Community-Based Services support coordination providers must become certified in the administration of the Department approved assessment within 90 days of the effective date of the implementation of this rule. Failure to become certified in the use of the Department approved assessment will result in termination as a Developmental Disabilities Home and Community-Based Services support coordination provider.

Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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**Support Coordination Provider Requirements**, continued

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**Continuing Training Requirements**

All waiver support coordinators and agency supervisors, directors or managers shall attend 24 hours of job-related in-service training annually. Internal management meetings, held by agency providers, shall not apply toward the 24 hours requirement unless approved by the District. For support coordination supervisors and employees of agency providers, 12 hours of the 24 hours in-service requirement must be provided by trainers outside of the agency.

All waiver support coordinators shall attend Personal Outcome Measures training conducted by the Department or a Department's certified trainer within 90 days of receiving a certificate of enrollment from the District. This training shall satisfy the annually required 24 hours of job related training for that year. Support coordinators who have not completed the Personal Outcome Measures training must have a trained waiver support coordinator in attendance when conducting the Personal Outcome Measures interview, as part of the annual support planning process.

In order to remain eligible to provide support coordination services under the Medicaid waiver, support coordinators shall maintain certification on the Department approved assessment. Re-certification shall occur every two years. Certification includes the capability to access and finalize the assessment on the Department's intranet site.

Documentation of all training will be maintained on file by the solo provider or the agency provider and be available for monitoring and review.

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**Projected Service Outcomes**

Projected service outcomes are goals used to determine, through monitoring and review, the accomplishments of providers and the effectiveness of service provision.

- Recipients receiving support coordination services have freedom of choice in all areas of their lives, including setting personal goals, being fully informed about service options and making all possible decisions with regard to the conduct of their lives.
  - Recipients receiving services demonstrate an increase in abilities, self-sufficiency and changes in their lives consistent with their support plan.
  - There is evidence that the provider advocates for the individual on an ongoing basis to achieve a personally identified goal.
  - All recipients served, who have responded to the annual satisfaction survey, are satisfied with the services based on the results or that the provider has addressed any concerns raised during the survey.
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**Supported Employment Services Provider Requirements**

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**Provider Qualifications**

Providers of supported employment services may be either independent vendors, solo providers or agency vendors.

Independent vendors, solo providers and employees of agencies who render this service shall have a bachelor's degree from an accredited college or university with a major in business, nursing, education or a social, behavioral or rehabilitative science. In lieu of a bachelor's degree, a person rendering this service shall have an associate's degree from an accredited college or university with a major in business, nursing, education or a social, behavioral or rehabilitative science and two years of experience. Experience in one of the previously mentioned fields shall substitute on a year-for-year basis for the required college education.

Licensure and registration is not required.

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**Training Requirements**

Agency providers are required to attend twelve hours of pre-service training and eight hours of annual in-service training related to supported employment. Agency employees and independent vendors and solo providers enrolled after March 01, 2004 are required to attend 18 hours of pre-service training prior to assuming job responsibilities and eight hours of annual in-service training. Training will include the approved curriculum entitled, "Supported Employment and Natural Supports, A Florida Training Curriculum, 2001 Edition", or an equivalent training curriculum, as approved by the Department.

Individual vendors must attend at least one supported employment related conference or workshop prior to certification and eight hours of annual in-service training related to supported employment. Proof of annual or required updated training shall be maintained on file for review.

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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**Projected Service Outcomes**

Projected service outcomes are goals used to determine, through monitoring and review, the accomplishments of providers and the effectiveness of service provision.

- Provider assists individuals in securing employment according to their desired outcomes, including type of work environment, activities, hours of work, level of pay and supports needed.
- Recipients in the individual model, during follow along (phase 2) do not need paid job coaching in excess of an average of 20% of the recipient's average work hours.

**Supported Employment Services Provider Requirements**, continued

**Projected Service Outcomes,**  
continued

- Recipients receiving supported employment services achieve goals on their support plan throughout the year.
- Recipients receiving this service are assisted in progressing on their chosen career path.
- All recipients served, who have responded to the annual satisfaction survey, are satisfied with their services based on the results or that the provider has addressed any concerns raised during the survey.

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**Supported Living Coaching Services Provider Requirements**

**Provider Qualifications**

Providers of supported living coaching services may be either independent vendors, solo providers or employees of agencies.

Independent vendors, employees of agencies and solo providers who render these services 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. In lieu of a bachelor's degree, a person rendering these services shall have an associate'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 experience. Experience in one of the previously mentioned fields shall substitute on a year-for-year basis for the required college education.

**Training Requirements**

Agency employees, independent providers and solo providers are required to attend twelve hours of pre-service training prior to assuming job responsibilities, and eight hours of annual in-service training. Agency employees and independent providers enrolled after October 2003 are required to attend eighteen hours of pre-service training prior to assuming job responsibilities, and eight hours of annual in-service training. Training will consist at a minimum of a detailed review of the most recent publication of "A Guide to Supported Living in Florida", an overview of affordable housing options and home modifications and Chapter 65B-11, F.A.C. The pre-service training content must be approved by the DCF Developmental Disabilities Program Central Office to ensure statewide uniformity.

Providers of supported living coaching services must, at a minimum, also complete training covering CPR, Infection Control, AIDS and HIV, maintaining current certification.

Proof of annual or required updated training shall be maintained on file for review. The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

**Supported Living Coaching Services Provider Requirements**, continued

**Projected Service Outcomes**

Projected service outcomes are goals used to determine, through monitoring and review, the accomplishments of providers and the effectiveness of service provision.

- Recipients in supported living are the lessee or owner of the home in which they reside.
- All recipients served, who have responded to the annual satisfaction survey, are satisfied with the services based on the results or that the provider has addressed any concerns raised during the survey.
- Recipients in supported living live in homes occupied by no more than two other recipients with developmental disabilities and in areas in which persons with disabilities account for no more than 10% of the houses or 10% of the units in an apartment complex, unless otherwise waived by the Department.
- Recipients are supported to live in their own homes.
- Recipients who use the supports increase their level of participation or independence in the community.
- Recipients demonstrate freedom of choice in all areas of their lives as evidenced by setting personal goals, being fully informed about service options and making all possible decisions with regard to the conduct of their lives.
- Recipients achieve goals on their support plan.

Note: Refer to Chapter 2, Supported Living Coaching, under Limitations.

**Therapeutic Massage Provider Requirements**

**Provider Qualifications**

Providers of therapeutic massage and assessment services shall be licensed by the Department of Health, in accordance with Chapter 480, F.S., and may perform services within the scope of their massage therapy license.

Massage therapists may provide this service as independent providers or as employees of licensed home health or hospice agencies.

Home health and hospice agencies shall be licensed by the Agency for Health Care Administration, in accordance with Chapter 400, Part IV or Part VI, F.S. The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to General Definitions for additional information about agency, group providers, and independent providers.

**Training Requirements**

The provider is responsible for all training requirements outlined in the Core Assurances.

Note: Refer to Appendix C for provider training requirements.

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## ***Transportation Services Provider Requirements***

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### **Provider Qualifications**

In order to provide and be reimbursed for transportation under the Medicaid Home and Community-Based Services 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 recipients being transported live, adult day training programs to which the recipients 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 is described below.

Pursuant to Chapter 427, 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. Chapter 427, F.S., allows for the use of other providers, the circumstances for the use of which are specified in Chapter 41-2, F.A.C., and are described herein specifically for the Home and Community Based Services Waiver.

With the exception of limited transportation providers and Public Transit Authorities that run the community's fixed-route fixed-schedule public bus system, as described below, all transportation providers are required to adhere to the driver, vehicle and passenger safety standards set forth in Chapter 41-2, F.A.C. All providers must adhere to the requirements of this handbook.

Drivers shall be at least 18 years of age and possess a current, valid commercial or non-commercial driver's license appropriate to the vehicle and for the purpose it is being used, in accordance with Chapter 316, F.S. Transportation providers shall hold applicable licenses issued by the Department of Highway Safety and Motor Vehicles, in accordance with Chapter 322, F.S.

When it is better suited to the unique and diverse needs of a recipient, either limited transportation providers or the local fixed-route fixed-schedule public bus system may be used to transport recipients. These options are to be used prior to obtaining transportation services from the CTC.

Limited transportation providers are relatives, friends and neighbors. They are not "for hire" entities. They are reimbursed at the state mileage rate. They are encouraged to adhere to the specific driver, vehicle and passenger safety standard in Chapter 41-2, F.A.C. The District 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 District 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 there is adequate justification as to why the relative is being paid for the service, rather than being a natural support.

**Transportation Services Provider Requirements**, continued

**Provider Qualifications**, continued

Public Transit Authorities that operate the community's fixed-route fixed-schedule public bus system may enroll in the HCBS 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 recipients 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 recipients 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 not required to meet the standards set forth in Chapter 41-2, F.A.C., however, they are required to adhere to minimum safety standards set forth in Chapter 14-90, F.A.C. The District 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 caretakers 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 recipients live may enroll as transportation providers to transport the recipients to and from their waiver services. Adult day training agencies that recipients regularly attend may enroll as transportation providers to transport the recipients to and from the agencies' programs. In order to use group homes, residential facilities, or adult day training (ADT) agencies as transportation providers, the District 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 ADT agency and the District 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 recipients; however, the reason the District needs to use them as a provider determines what the Developmental Disabilities Program must go through in order to use the provider and the roles and responsibilities of the District Developmental Disabilities Program and the CTC, as follows.

If the CTC determines it is unable to provide or arrange the required transportation for a recipient, 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 recipient to and from their waiver services. These providers must meet the driver, vehicle and passenger safety standards specified in Chapter 41-2, F.A.C.

**Transportation Services Provider Requirements**, continued

**Provider Qualifications**, continued

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

If the District Developmental Disabilities Program Office wishes to utilize a transportation provider that is not a part of the coordinated transportation system, the District must contact the CTC in the recipient'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 District. These providers must meet the driver, vehicle and passenger safety standards of overseeing service delivery of such providers. The provider and District are responsible for complying with reporting requirements of Chapter 427, F.S., through the Department Secretary's designee on the Commission for the Transportation Disadvantaged.

## **CHAPTER 2**

# **DEVELOPMENTAL DISABILITIES WAIVER SERVICES COVERED SERVICES, LIMITATIONS AND EXCLUSIONS**

**Overview**

**Introduction**

This chapter describes the services covered under the Medicaid Developmental Disabilities (DD) Waiver Program. It also describes the requirements for service provision, service limitations and exclusions.

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**Requirements to Receive Services**

**Who Can Receive Services?**

Participants in the waiver must meet the eligibility requirements of the Developmental Disabilities Program, in accordance with Chapter 393, F.S., 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 Reimbursement Handbook, Non-Institutional 081. Recipients of DD waiver services must need and receive support coordination services.

Note: Refer to Appendix D for contact information and Appendix F for recipient application and eligibility determination.

**Medicaid Eligibility**

Recipients who are not already eligible for Medicaid benefits through Supplemental Security Income (SSI), MEDS-AD, or TANF at the time they apply for DD waiver services must complete, or have a designated representative complete, and submit a Request for Assistance (RFA) to the local Department of Children and Families.

Note: Refer to the Florida Medicaid Provider General Handbook for information on verifying recipient eligibility. Refer to Appendix D for contact information.

**Requirements to Receive Services**, continued

**Level of Care Requirements**

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

The recipient must meet one of the following Developmental Disabilities Program eligibility requirements, in accordance with Chapter 393, F.S.

- The recipient's intelligence quotient (IQ) is 59 or less; OR
- The recipient's IQ is 60-69 inclusive and the recipient has a secondary handicapping condition that includes cerebral palsy, spina bifida, Prader-Willi syndrome, epilepsy, autism, OR ambulation, sensory, chronic health, and behavioral problems, OR the recipient's IQ is 60-69 inclusive and the recipient 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 recipient is eligible under a primary disability of 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 DD program determines that DD waiver services are medically necessary. The recipient or the legal guardian must choose to receive home and community-based supports and services.

DD waiver services shall not be reimbursed when the date of service is prior to the recipient's enrollment into the DD Waiver.

**Recipient Enrollment Into the DD Waiver**

Once Medicaid and the waiver eligibility requirements are met, the Department's District Office reviews the recipient's request for home and community-based supports and services. That office will determine if: 1) a waiver vacancy is available; 2) sufficient funding is available to meet the recipient's needs; and, 3) the recipient can be safely maintained in the community. The determination will be made in accordance with legislatively appropriated funding and established annual priorities.

The Central Office maintains the statewide list of all recipients determined eligible and waiting for waiver services.

**Requirements to Receive Services**, continued

**Recipient Enrollment Into the DD Waiver**, continued

A recipient's enrollment in the waiver continues indefinitely unless one of the following conditions exist:

- The recipient or guardian chooses to terminate participation in the program;
- The recipient moves out of state or country;
- The recipient 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 recipient no longer needs waiver services;
- The recipient does not meet level of care for admission to an Intermediate Care Facility for the Developmentally Disabled (ICF/DD); or
- The recipient dies.

Note: Refer to Appendix F for complete recipient application and eligibility determination, waiting list information, crisis information, and enrollment into the DD Waiver.

**Medical Necessity**

Waiver services shall only be provided when the service or item is medically necessary. Chapter 59G-1.010(166)(a)(c) of the F.A.C. defines medical necessity as:

(a) "Medically necessary" or "medical necessity" means that medical or allied care, goods or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
- Be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide; and,
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, or a medical necessity, or a covered service.

**Requirements to Receive Services**, continued

**Medical Necessity Determinations**

An appropriate, qualified professional shall make the determination that the standards for medical necessity set forth in 59G-1.010 (166)(a)(c), F.A.C., are met, and that the requested item meets the service definition, as contained in the approved DD waiver. When a requested service or item is determined to be medically necessary, it shall be approved. 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, recipient, family or guardian. If it is determined that the service is not medically necessary (i.e., the request does not conform to the standards set forth in 59G-1.010 (166)(a), and (c) F.A.C.), a written denial of the service and notice of due process will be sent to the recipient, family or guardian and copied to the waiver support coordinator. A Medicaid recipient may appeal decisions by the District Office by requesting a Medicaid Fair Hearing, in accordance with Chapter 42, 431.221(d) of the Code of Federal Regulations. The recipient has 90 days from the date that notice of due process was mailed to file an appeal. A prescription for a service or item, which has general utility or that is generally available to the public does not change the character of the item for coverage purposes under the waiver. It is the general use and not the specific use that governs coverage.

**Service Authorization Requirements**

The services described in this handbook represent all approved services that may be purchased for a recipient participating in the DD waiver who needs the service to reach an outcome described on the support plan. In order for a recipient to receive a service it must be identified on a recipient's support plan and cost plan, also known as the plan of care, and be approved by the District Office before the service may be provided. Providers of DD Waiver services are limited to the amount, duration and scope of the services described on the recipient's support plan and current approved cost plan.

**Availability of Other Coverage Sources**

Supports and services are developed and delivered in natural community settings. Additionally, the supports and services authorized under the waiver should be used to supplement the supports already provided by family, friends, neighbors, and the community. Replacement of such natural and free supports with government-funded services, including educational and vocational services, is contrary to the intent of the waiver program. State and federal funds are the means of last resort and only utilized when a family or community support is unavailable or while a support is being developed. Only by involving the recipient in community inclusive supports and experiences, can full integration into community life be accomplished.

**Requirements to Receive Services**, continued

**Availability of Other Coverage Sources,**  
continued

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When a service must be purchased, those available under the Medicaid State Plan must be utilized before accessing services through the waiver. The waiver cannot supplant or replace a benefit available through Medicaid State Plan services. It is a federal requirement to access state plan coverage before the provision of waiver services. As stated in section 4442.3, State Medicaid Manual:

“No service may be provided under the waiver if it is already provided under the State plan unless the nature or the amount of the service, when provided under the waiver, would not be covered if provided under the State plan. For example, if the waiver provides for coverage of home health aide services, the maximum number of visits allowed under the waiver could be greater than the limit contained under the State plan. The amount chargeable for waiver services is that amount incurred after any limits in State plan services have been reached. Similarly, if the State proposed to provide home health aide services, which were defined more broadly than those available under the State plan, these could be included as waiver services.”

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 website <http://floridamedicaid.acs-inc.com>, select Provider Support, and select handbooks.

Note: Refer to Appendix D for contact information.

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**Service Delivery Timelines**

Recipients currently enrolled in the waiver will be provided with those services that have been determined to be medically necessary with reasonable promptness. The Developmental Disabilities Program will make reasonable efforts to provide those waiver services for which a determination of medical necessity has been made within 90 days of the date of the recipient's enrollment in the waiver or request, to the extent that sufficient provider capacity exists.

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## **Documentation Requirements**

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### **Introduction**

DD waiver services are based on recipient needs that are documented in an approved plan of care. The plan of care includes the support plan and approved cost plan. A person cannot receive Medicaid waiver services until he is determined eligible and is enrolled in the appropriate waiver program.

Medicaid will only reimburse for waiver services, at an approved rate, that are specifically identified in the approved plan of care by service type, frequency and duration and for which there is sufficient documentation supporting the provision of a service to the recipient.

Note: See Appendix A for rate methodology information.

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### **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 and file the documentation appropriately before requesting reimbursement. Appropriate documentation is required in order to receive payment. All documentation must be dated and signed by the individual rendering the service. Progress notes that are co-signed by support coordinator supervisors are acceptable for waiver support coordinators whose application has been submitted to the District Office and approved for enrollment while they are waiting for enrollment notification from the Department. An updated support plan and cost plan are submitted, at a minimum, annually to the District Office.

A list of the documentation that is required for each service is included in each service description. Please refer to the 'Documentation Requirements' section of each service for a detailed listing of documentation that must be submitted for reimbursement, and documentation that must be kept on file by the provider for monitoring and review purposes.

Please refer to the 'Documentation Definitions' contained in this section of this handbook for a description of each type of documentation. For the purpose of efficiency, the required elements of the following documentation may be combined on one form:

- Bi-Weekly Contact Log
- Daily Attendance Log
- Daily Progress Note
- Invoice
- Monthly Summary
- Service Log
- Supported Living Log

**Documentation Requirements**, continued

**General Service Documentation Requirements**, continued

It is the responsibility of each service provider to understand and comply with all documentation requirements. Questions regarding further clarification about these requirements should be directed to the DCF District Office.

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**Definitions**

**Annual Report**

A written report documenting the recipient's progress toward his support plan goal(s) for the year, as required in Chapter 393, F.S. This report must be submitted to the waiver support coordinator no later than 30 days prior to the support plan year-end date.

**Annual Satisfaction Survey**

A survey of recipients that addresses their satisfaction with service delivery and the extent to which the recipients' desired outcomes have been achieved, as specified in the Core Assurances and as described in Chapter 65B-11.008, F.A.C., for providers of supported living coaching services.

**Behavior Analysis Services Plan**

A written plan that includes a description of the specific behaviors to be changed, intervention procedures to be used, data to be collected, training for caregivers, and a monitoring schedule to be followed by the behavior analysis services provider. This plan should be clearly written in language that is easily understood by other service providers.

**Bi-weekly Contact Log**

Every two weeks a recording of contacts completed for recipients receiving Supported Employment. Contacts may be either at the job site or another setting.

**Central Record of a Recipient**

A file, or a series of continuation files, kept by the provider in which the following documentation must be recorded, stored and made available for review:

- Recipient demographic data including emergency contact information, parental or guardian contact data, permission forms, and results of assessments, evaluations, and 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.

**Definitions**, continued

**Community Integrated Settings**

Local settings that are not limited to, or segregated settings for, recipient's with developmental disabilities, and that possess the following characteristics: generic local community resources utilized by other people without disabilities and settings which promote direct personal interaction with others with or without developmental disabilities.

**Cost Plan**

The form used by the waiver support coordinator listing all services requested by the recipient on the support plan, regardless of funding source, and the anticipated cost of each waiver service. The Department's District Office must approve the cost plan prior to service provision. Each time a recipient makes a request to increase or add services the cost plan too must be amended and approved, as described above, in order for the service to be initiated. A support plan and cost plan must be updated for each recipient enrolled on the waiver at least annually, during the annual support planning process to reflect current needs and situations. Cost plan forms are available from the District Office.

Note: Refer to Appendix E for contact information.

**Daily Attendance Log**

A listing of the recipient's and the days of the month. For each day the recipient participated in the service, the date is checked (√) or marked with an "X".

**Daily Progress Note**

Daily, on days service was rendered, notes of the recipient's progress towards achieving his support plan goals for the period being billed or the summary describing the treatment or training provided to the recipient or task accomplished. For example: November 11, 2000, John prepared macaroni and cheese in the microwave successfully for his housemates. This activity supports a goal on his support plan to learn how to cook.

**Data Displays**

Graphed data of target and replacement behaviors, including planned environmental interventions, medication changes, unplanned environmental changes or events, for the time period displayed.

**Definitions**, continued

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**Dietary Management Plan**

A nutritional plan based on an assessment that includes current weight, height, usual weight, body measurements, results of laboratory tests useful in establishing current nutritional status, possible symptoms of or contributors to malnutrition, appetite, dysphasia (difficulty swallowing), odynophagia (pain on swallowing), correlation between drug therapy and appetite, chronic digestive conditions, current dietary practices, vitamins, herbal supplements, food preferences, and hydration status. The plan should address problems based on the assessment and establish targets for weight, nutritional intake, food texture and consistency, fluid and caloric intake.

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**Department Approved Assessment**

The Department approved assessment, entitled Individual Cost Guidelines (ICG), is a tool designed to determine the recipients' resource allocations of waiver(s) funds for recipients receiving supports from the State of Florida, Department of Children and Families, Developmental Disabilities Program (DDP). The ICG is a validated tool that provides a rational basis for the allocation of the waiver funds to individuals with developmental disabilities. Waiver(s) funds are funds allocated through the Developmental Disabilities HCBS waiver, the Supported Living Waiver, and the Consumer-Directed Care Plus waiver (CDC+). The instructions for the completion of this assessment is provided by the Department and is completed at least every three years or as determined necessary by the recipient and the waiver support coordinator, due to changing needs of the recipient.

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**Family Home**

The primary residence occupied by the recipient and member(s) of his immediate family, which include spouse, children, parents, siblings, stepchildren, stepparents, stepsiblings and in-laws.

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**Home**

With respect to the home of a recipient receiving supported living services, means a house or apartment, or comparable living dwelling space meeting community housing standards and 65B-11.005 F.A.C. requirements, which is neither a community care facility, health facility, nor a family home, and in which no parent, guardian, or guardian advocate of the recipient resides, and which a recipient chooses, owns or rents, controls and occupies as a principle place of residence.

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**Home Accessibility Assessment**

An assessment conducted by a Rehabilitation Engineer or other certified professional that determines the medically necessary physical adaptations to a recipient's home to permit accessibility when adaptations are in excess of \$3,500. This assessment must also be used to determine appropriateness of ceiling tracking systems and may be used for determination of appropriate van modifications.

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**Definitions**, continued

**Implementation Plan**

A plan developed with direction from the recipient, which includes information from the recipient's current support plan, and other pertinent sources. The specific areas of training and strategies to meet support plan goal(s) for each recipient will be addressed in the recipient's implementation plan. Training objectives appropriate to the recipient's programs and services may also be included in the implementation plan. At a minimum, the implementation plan will include:

- The name, address, and contact information of the recipient served.
- The goal(s) from the support plan that the service will address.
- The strategies employed to assist the recipient in meeting the support plan goal(s).
- The system to be used for data collection and assessing the recipient's progress in achieving the support plan goal(s). The information from this assessment will be used to update and modify the plan, as needed, to ensure that progress toward goal achievement is attained.

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 recipient, shall be furnished to the recipient, 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 daily progress notes or monthly summaries, as specified in each service description. Data supporting the recipient's progress, or lack thereof, summarized in the monthly summary shall be available for review.

**Recipient Nursing Assessment**

A detailed assessment that includes height, weight, blood pressure, allergies, medications, a comprehensive evaluation of mental status, physical status, neurological, respiratory, cardiovascular, gastro-intestinal, reproductive and musculoskeletal systems, nursing diagnosis, and recommendations for nursing interventions.

**Definitions**, continued

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**081 Claim Form**

Effective March 3, 2003, the 081 claim form is the standard claim form to be used when submitting claims for reimbursement for DD/HCBS services provided. This form contains the provider's name, address, provider number, name of recipient of services, recipient's Medicaid ID number, date of birth, etc., and lists service dates, description of service(s) received, approved procedure code(s), and fees, etc. Claim forms must be complete and legible when submitted to the Medicaid fiscal agent for reimbursement for services rendered. The provider may submit the 081-claim and information to the Medicaid fiscal agent, either in paper form or electronically by using the free software, WINASAP supplied by the Medicaid fiscal agent.

Note: See Chapter 3 for additional billing and reimbursement information.

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**Medicaid Waiver Services Agreement**

The Developmental Disabilities Program Medicaid Waiver Services Agreement means the agreement between DCF Developmental Disabilities Program and providers of waiver services, which consists of form CF-DD 3064, and the Core Assurances for providers of Medicaid Home and Community-Based Waiver Services Programs. Specific service requirements, as defined in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, and rate methodology information are incorporated into the agreement by reference. All providers must complete this agreement to provide services to recipients enrolled in the Developmental Disabilities Home and Community-Based Services Waiver Program.

Note: Refer to Appendices A, B and C for additional information.

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**Medication Review**

A review that contains recommendations for changes in medications, and is provided by the consultant pharmacist to the recipient, or family or legal guardian, and the prescribing physician. Follow-up by the consultant pharmacist with the prescribing physician shall be provided. In addition, the consultant pharmacist shall provide written guidelines and information for use by the recipient and their caregivers, about medication administration and other interventions specific to the recipient's needs designed to improve the therapeutic outcome of currently prescribed medications.

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**Monthly Nutritional Status Report**

A report that reflects the recipient's progress toward meeting targets in his Dietary Management Plan. Weight gains or losses should be reported as well as any recommended dietary adjustments.

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**Definitions**, continued

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**Monthly Summary**

A summary note of the month's activities indicating the recipient's progress toward achieving support plan goals for the services billed in that month.

For example: November 2000, during the past month John cooked a dinner item three times each week (12 times). His most successful item was macaroni and cheese, which he chose to prepare at least once a week. He is able to set the timer, but still needs some assistance with over-cooking because he tends to get distracted by the television or his housemates. Next month, we will try to increase the variety of items cooked successfully and work on paying attention to cooking times. This activity supports a goal on his support plan to learn how to cook because he wants to move into his own apartment.

For residential nursing services, the monthly summary must include details such as health risk indicators, information about medication, treatments, doctor's appointments and anything else of significance regarding the recipient's health.

For any behavioral services provided the monthly summary must include a graphic display and brief description of events affecting the data displayed. In addition, changes made to the intervention plan, as a result of the analysis of the data and monitoring of the implementation of the plan and behavior of the recipient, should be described as well as anything of significance regarding the recipient's behavior.

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**Prescription**

Instructions written by a physician. A copy of the prescription is needed prior to requesting funding for medical services or certain medical equipment or supplies and is kept in the recipient's central file. The original prescription for an individual medical service is maintained in the medical service provider's file with a copy maintained in the recipient's central file.

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**Provider File**

Service delivery documentation, in the form of service logs, implementation plans and progress reports or as specified in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, that are related to the service and support activities identified in the implementation plan.

The provider file maintained by the support coordinator is designated as the recipient's central record, but remains the property of the Department.

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**Definitions**, continued

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<b>Service Log</b>	The service log shall include documentation that includes the recipient's name, social security number, recipient's Medicaid ID number, the description of the service, activities, supplies or equipment provided and corresponding procedure code, times and dates service was rendered, amount billed for each service, provider's name and provider Medicaid ID number.
<b>Solo Provider</b>	An enrolled provider who personally renders waiver services directly to recipients and does not employ others to render waiver services.
<b>Supported Living Log</b>	Written documentation of the dates, times and summary of the supports provided during contact with the recipient, as described in Chapter 65B-11.014, F.A.C.
<b>Treatment Plan</b>	A written plan developed by a provider of specialized mental health services. The initial treatment plan must be provided to the waiver support coordinator with an updated plan submitted every six months thereafter.

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**Adult Day Training**

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<b>Description</b>	<p>Day training programs for adults are training services intended to support the participation of recipients in daily, meaningful, valued routines of the community, which for adults may include work-like settings that do not meet the definition of supported employment.</p> <p>Adult day training services stress training in the activities of daily living, self-advocacy, adaptive and social skills and are age and culturally appropriate. The service expectation is to achieve the outcomes (goals) defined by each recipient; and, to attain and support participation in less restrictive settings. The training, activities and routine established by the adult day training program shall be meaningful to the recipient and provide an appropriate level of variation and interest. This training is provided in accordance with a formal implementation plan, developed under the direction of the recipient, reflecting their goal(s) from the current support plan.</p>
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**Adult Day Training**, continued

**Description,**  
continued

Services are typically facility-based and are usually furnished at a minimum of six hours per day on a regularly scheduled basis, for one or more days per week. Four of the six hours must be spent in training and program activities. Services may also be provided in the community if the activity is reflected in the individual's support plan and included in the implementation plan. Adult day training services may be provided as an adjunct to other services included on a recipient's support and cost plan. For example: a recipient may receive supported employment or other services for part of a day or week and adult day training services at a different time of the day or week. Adult day training services will only be billable for the prorated share of the day or week that the recipient actually attended that service.

Mobile crews, enclaves and entrepreneurial models that do not meet the standards for supported employment and provided in groups of four or more recipient's are included as ADT-off site services.

Any recipient receiving adult day training or ADT-off site services who is performing productive work that benefits the organization, or would have to be performed by someone else if not performed by the recipient, must be paid. Recipient's who are working must be paid commensurate with members of the general work force doing similar work per wage and hour regulations of the U.S. Department of Labor.

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

ADT-off site models include the following services that teach specific job skills and other services directed at meeting specific employment objectives:

1. Enclave - A group approach to training where recipients 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 recipients with disabilities are in a variety of community businesses or other community settings with supervision by the provider.
3. Entrepreneurial - A group approach to training where recipients with disabilities work in a small business created specifically by or for the recipient's.

Note: Refer to Appendix A for rate Methodology information.

**Adult Day Training**, continued

**Limitations**

Adult day training services are usually provided five days a week, for up to six structured hours per day of operation, and up to 240 days a year. The stepped rate published for ADT and ADT off-site services is based on seven hours of staff time to accommodate the variance in recipient schedules for attendance. The provider shall render services at a time mutually agreed to by the recipient and the provider. This will allow a recipient the flexibility to determine when to attend the ADT program for limited hours or only on certain days. Billing will be by the quarter hour for the number of quarter hours attended each day the recipient is present.

Recipients attending full time, six hours, will be billed at the quarter hour rate for each full day the recipient is present. This service generally begins at the age of 22 when a recipient is out of the public school system or when they have graduated from the public school system, receiving a standard diploma. However, a recipient can begin at the age of 16 without a standard diploma if the public school system is willing to provide funding for this service throughout the person's legal age of eligibility. Recipients over the age of 22 who have not graduated shall also be eligible.

Adult day training services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan. The staffing ratio shall not exceed ten recipients per direct care staff. This service cannot be provided concurrently with PCA, NRSS, or companion services.

A recipient may not receive a combination of ADT, NRSS or supported employment services that exceeds 35 hours per week. A recipient may not receive more than a total of 35 hours a week of a paid support, or a combination of paid supports designed to be used as a meaningful day activity.

**Adult Day Training**, continued

**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Service log;
3. \*Recipient's implementation plan and supporting data;
4. Staffing documentation such as staffing schedules, payroll records indicating identified support staff and hours worked, and any other supplemental support staffing schedules which document required staffing ratios.

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 adult day training service must contain the following: a description of methods that the provider will use to ensure the recipient makes an informed choice concerning types of work and meaningful day activities (type of activities). This information is to be discussed with recipients and documented at least annually.

5. \*Monthly summaries for the period being reviewed;
6. An annual report;
7. Results of the annual satisfaction survey;
8. Performance data on the selected service outcomes for this service; and

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly;
2. Copy of recipient's implementation plan at the time of first claim submission, and at least annually thereafter at the time of the support plan update and, any time updates and changes are made before they are implemented; and
3. Annual report prior to the annual support plan update.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information regarding specific documents required.

**Adult Day Training**, continued

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**Place of Service**

Adult day training services must be provided in a designated adult day training center or other training sites in the community as agreed to by the recipient and provider.

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**Special Considerations**

Adult day training providers are paid separately for transportation services only when they are enrolled as a transportation provider and transportation is provided between a recipient's place of residence and the training site. Transportation between day training sites, if the activities provided are a part of day training services, will be included as a component part of the adult day training services and included in the rate paid to the provider of the adult day training service.

ADT staff is responsible for assisting recipients into and out of facilities when they have been transported in vehicles not owned or operated by the ADT. Drivers of such vehicles are responsible for ensuring the recipient's safe entry of and exit from the vehicle.

When the supervisor of a mobile crew or enclave does not meet the qualifications for a supported employment coach, even when the recipient meets the criteria for supported employment, the support must be billed as adult day training-off site.

Adult Day Training Services and ADT Off-Site Services, will be billed based on the published stepped rate for the services at the 1 staff to 10 recipient ratio rate level. Exceptions to this rate level shall be made only when it has been determined through use of the Department approved assessment and the support planning process that a recipient requires a different support staffing ratio. The rate and staffing ratio shall be identified in the individual's support plan and cost plan, and on the authorization for service submitted to the provider by the recipient's support coordinator. The rate ratio is determined by what is the usual and customary service delivery pattern and does not fluctuate with incidental absences of one or more recipients included in the rate ratio.

**Adult Day Training**, continued

**Special Considerations**, continued

Personal care assistance services shall be billed at the standard rate level for the service based on the published rate system. The standard rate is paid when a recipient 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. A rate other than the standard rate level for this service shall only be authorized when it has been determined through use of the Department approved assessment and the support planning process that an individual requires an enhanced level of supports.

Indicators of a one staff to five recipient staffing rate ratio level include:

- Recipients who have a moderate level of support for personal care services on the Department approved assessment may receive the rate level identified as moderate for the service. The moderate rate is paid when a recipient routinely requires prompts, supervision and physical assistance to complete the basic personal care areas of eating, bathing, toileting, grooming, and personal hygiene; or
- A recipient 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 recipient does not have to live in a licensed residential facility.

Indicators of a one staff to three recipient staffing rate ratio level include:

- An intense level of personal care support services as indicated on a Department approved assessment;
- Recipients who have an intense level of support identified in the current abilities section of the Department approved assessment may receive the rate level identified as intense for the service. The intensive rate is paid when a recipient requires total physical assistance, to include lifting and transferring, in at least three of the basic personal care areas of eating, bathing, toileting, grooming, and personal hygiene, due to physical, cognitive or behavioral limitations;
- A recipient who is on a behavioral services plan that is implemented by the adult day training provider, and who exhibits the characteristics required for behavioral residential habilitation services as determined by a Certified Behavioral Analyst. The recipient 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.

**Adult Day Training**, continued

**Special Considerations**, continued

Indicators of a one staff to one recipient staffing rate ratio level include:

- A recipient who is on a behavioral services plan that is implemented by the adult day training provider, and that exhibits the characteristics required for behavioral 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 District Local Review Committee Chair. The recipient 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.

If the support is provided to groups larger than eight recipients', regardless of the wage, the service will be billed as adult day training-off site. If the support is provided in groups of eight or less and the recipient's 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 recipient 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. 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.

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**Adult Dental Services**

**Description**

Adult dental services cover dental treatments and procedures that are not otherwise covered by Medicaid State Plan services.

Adult dental services include diagnostic, preventive and restorative treatment, extractions; and endodontics, periodontal and surgical procedures. Adult dental benefits also include medically necessary emergency dental procedures to alleviate pain and or infection. Emergency dental care consists of oral examinations, necessary radiographs, extractions, and the incision and drainage of an abscess. The services strive to prevent or remedy dental problems that, if left untreated, could compromise a recipient's health, by increasing the risk of infection or disease, or reducing food options, resulting in restrictive nutritional intake.

**Adult Dental Services**, continued

**Limitations**

Adult dental services are limited to recipient's 21 years of age or older. Adult dental services will not duplicate dental services provided to adults by the Medicaid State Plan. Adult dentures and denture related procedures for adults are now funded through the DD waiver for any enrolled DD waiver adult. The Medicaid State Plan provides dental services for recipients 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.

A recipient shall receive no more than ten units of this service per day.

|Note: Refer to Appendix A for rate methodology information. |

**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment.
2. All treatment records.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of claims submitted at time of claim submission; and
2. Copy of treatment plan.

|Note: \* Indicates reimbursement documentation. |

Note: Refer to the definitions section for additional information.

**Place of Service**

Adult dental services shall be provided in the provider's office or other setting, determined appropriate by the provider.

**Adult Dental Services**, continued

**Special Considerations**

Adult dental services are to be authorized only to prevent or remedy problems that could lead to a deterioration of the recipient's health, thus placing the recipient 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.

**Behavior Analysis Services**

**Description**

Behavior analysis services are provided to assist a person or persons to learn new behavior that are directly related to existing challenging behaviors or functionally equivalent replacement behaviors for identified challenging behaviors. Services may also be provided to increase existing behavior, to reduce existing behavior, and to emit behavior under precise environmental conditions. 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 for the purposes of producing socially significant improvements in and understanding of human behavior based on the principles of behavior identified through the experimental analysis of behavior. It includes the identification of functional relationships between behavior and environment. It uses direct observation and measurement of behavior and environment. Contextual factors, establishing operations, antecedent stimuli, positive reinforcement and other consequences are used, based on identified functional relationships between behavior and environment, in order to produce practical behavior change.

Behavioral services must include procedures to insure generalization and maintenance of behaviors. The services are designed to engineer environmental modifications including ongoing styles of interactions, and contingencies maintained by significant others in the recipient's life. Training for parents, caregivers and staff is also part of the services when these persons are integral to the implementation or monitoring of a behavior analysis services plan. Services should be provided for a limited time and discontinued as the significant others gain skills and abilities to assist the recipient to function in more independent and less challenging ways.

**Behavior Analysis Services, continued**

<p><b>Description,</b> continued</p>	<p>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 Chapter 65B-4.030(9)(10), F.A.C. Services provided by behavior analysts with limited experience in the problem area or by behavior analysts who are not Board Certified Behavior Analysts with three years of experience or licensure under Chapter 490 or 491, F.S., should receive oversight and approval of services with a more experienced behavior analyst or with the above described highest level of certification.</p>
<p><b>Limitations</b></p>	<p>A recipient 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.</p> <p><u>Note:</u> Refer to Appendix A for rate methodology information.</p>
<p><b>Documentation Requirements</b></p>	<p>Documentation of services must comply with Chapter 65B-4.030(9) and (10), F.A.C. Reimbursement* and monitoring documentation to be maintained by the provider includes:</p> <ol style="list-style-type: none"> <li>1. *Copy of claim(s) submitted for payment;</li> <li>2. *Copy of service log;</li> <li>3. *Copy of assessment report;</li> <li>4. *Monthly summary of monitoring including the who, what, when and where of the monitoring events;</li> <li>5. *Behavior analysis service plan and services provided including graphic display of acquisition and reduction behaviors related to implementation of the service plan;</li> <li>6. *Annual report; and</li> <li>7. *If the targeted reduction behaviors meet the requirements identified in Chapter 65B-4.030(9)(10), F.A.C., the LRC review date and recommendations made specific to the plan, a review schedule for the plan must be included.</li> </ol>

**Behavior Analysis Services, continued**

**Documentation Requirements, continued**

Documentation to be submitted to the waiver support coordinator by the provider:

1. \*Copy of service log, monthly;
2. \*Copy of assessment report within 30 days of initially providing services;
3. \*A copy of the provider's behavior analysis service plan within 90 days of initially providing services;
4. \*Monthly updates of the intervention plan as it is modified;
5. \*Graphic displays of acquisition and reduction behaviors related to implementation of the service updated monthly, with baseline data to allow evaluation of progress; and
6. Annual report prior to the annual support plan update.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

**Place of Service**

These services may be provided in the provider's office, the recipient's place of residence 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.

**Special Considerations**

Behavior analysis and assessment services are described more fully in Chapter 65B-4, F.A.C., which is available through the District Office. As stated in 65B-4.031, F.A.C., approval for behavior analysis services for behaviors meeting the characteristics described in 65B-4.031, F.A.C., will 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.

Note: Refer to Appendix E for contact information.

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**Behavior Assistant Services**

**Description**

Behavior assistant services are one-on-one activities related to the delivery of behavior analysis services, as defined under Behavior Analysis Services and Assessment, and are designated in and required by a behavior analysis service plan. Activities include monitoring of behavior analysis services, the implementation of behavioral procedures for acquisition of replacement skills and reduction of problematic behaviors, data collection and display (e.g., graphics) as authorized by a recipient's behavior analysis service plan and assist the person certified as a behavior analyst or licensed under Chapter 490 or 491, F.S., in training of caregivers. The behavior analysis service plan must be designed, implemented and monitored in accordance with Chapter 65B-4.030, F.A.C., and approved in accordance with Chapter 65B-4.029, F.A.C.

Behavior assistant services are designed for recipients for whom traditional residential habilitation services have been documented unsuccessful or are considered to be inappropriate for health or safety reasons and for children who require behavioral services but for whom providing services in the family home will likely be more effective and least restrictive. Services should be provided for a limited time and discontinued as the support persons gain skills and abilities to assist the recipient to function in more independent and less challenging ways. Behavioral assistant services for children should supplement and support, transfer stimulus control and generalize behavior change, the acquisition and reduction plans designed and implemented by the primary source of services for children, the education system.

Note: Refer to Appendix A for rate methodology information.

**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Copy of service log;
3. \*Monthly summary notes and graphic display of effects of behavioral service plan;
4. \*Copy of the behavior analysis service plan must be in the recipient's file prior to claim submission.
5. \*Documentation of approval for services by the LRC chairperson or designee; and
6. \*Documentation of monitoring by the responsible person certified in behavior analysis or licensed under Chapters 490 or 491, F.S., of data and implementation of plan. Documentation will include date, time, observations and changes made related to the monitoring event.

**Behavior Assistant Services**, continued

**Documentation Requirements**, continued

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly; and
2. Monthly summary note at the time of claims submission.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

**Place of Service**

These services may be provided in the provider's office, the recipient'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.

**Special Considerations**

The services of a Behavior Assistant must be approved by the responsible Behavior Analysis Services Local Review Committee Chairperson, as defined in Chapter 65B-4.029, 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 Chapter 65B-4.030(10), F.A.C.

**Chore Services**

**Description**

Chore services are provided to maintain the recipient's home and property as a clean, sanitary and safe environment. These services include heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, replacing a broken window, or moving heavy items of furniture to make the home safer.

**Limitations**

Chore services may be provided only when there is no one else capable of or responsible to accomplish the household tasks. A recipient 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.

Note: Refer to Appendix A for rate methodology information.

**Chore Services**, continued

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<b>Documentation Requirements</b>	Reimbursement* and monitoring documentation to be maintained by the provider: <ol style="list-style-type: none"><li>1. *Copy of claim(s) submitted for payment;</li><li>2. *Copy of service log.</li></ol> Documentation to be submitted to the waiver support coordinator by the provider: <ol style="list-style-type: none"><li>1. Copy of service log, monthly.</li></ol> <p><u>Note:</u> * Indicates reimbursement documentation.</p> <p><u>Note:</u> Refer to the definitions section for additional information.</p>
<b>Place of Service</b>	Chore services shall be provided in the recipient's own home or family home. This service is available in the family home only when there is documentation as to why the family cannot provide the support. Examples of reasonable justification would include the advanced age or physical disability of the caregiver. If approved, chore activities will be limited to the recipient's primary living areas such as a bedroom and bathroom. It may include the kitchen and a common area, if regularly utilized by the recipient. Recipient's living in licensed residential settings, are not eligible to receive chore services.
<b>Special Considerations</b>	For recipient's living in rented homes or apartments, the lease and the landlord's responsibility to the property shall be examined prior to the authorization of any chore services.

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**Companion Services**

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<b>Description</b>	Companion services consist of non-medical care, supervision and socialization activities provided to an adult on a one-on-one basis. This service must be provided in direct relation to the achievement of the recipient's goals per his support plan. A companion provider may also assist the recipient with such tasks as meal preparation, laundry and shopping; however, these activities shall not be performed as discrete services. This service does not entail hands-on medical care. Providers may also perform light housekeeping tasks, incidental to the care and supervision of the recipient. Companion services may be scheduled on a regular, long-term basis.  Companion services are not merely diversional in nature but are related to a specific outcome or goal of the recipient. An acceptable companion activity could include going to the library, getting a library card, learning how to use the library and checking out books or videos for personal use, shopping for groceries, or going to an animal shelter to learn about animals, perhaps volunteering or assisting at the animal shelter.
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**Companion Services**, continued

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**Limitations**

Providers of companion services are limited to the amount, duration, and scope of the services described on the recipient's support plan and current approved cost plan. A recipient shall receive no more than ten hours or 40-quarter hour units of these services per day. A unit is defined as a 15-minute time period or a portion thereof.

Companion services are limited to adults only (18 or older). Recipient's living in licensed residential settings, excluding foster homes, are not eligible to receive these services. Recipients may not receive this service in the provider's home. This service cannot be provided concurrently (at the same time) with adult day training, PCA and NRSS services.

Note: Refer to Appendix A for rate methodology information.

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**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Copy of service log.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly.

If the provider plans to transport the recipient 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.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

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**Place of Service**

Companion services may be provided in the recipient's own home, foster home or family home, or while the recipient who lives in one of those settings is engaged in a community activity. No service may be provided or received in the provider's home.

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**Companion Services**, continued

**Special Considerations**

Companion services are provided in accordance with an outcome on the recipient's support plan and are not merely a diversion.

If the provider plans to transport the recipient 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.

Companion services providers are not reimbursed separately for transportation and travel costs. These costs are integral components of companion services and are included in the basic rate.

Companion services do not replace a more cost-beneficial day activity like supported employment or adult day training.

**Consumable Medical Supplies**

**Description**

Consumable medical supplies are those non-durable supplies and items that enable recipients to increase their ability 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 Developmental Disabilities Home and Community-Based Services waiver must meet all of the following conditions: a) be related to a recipient's specific medical condition, b) not be provided by any other program, c) be the most cost-beneficial means of meeting the recipient's need, and d) not primarily for the convenience of the recipient, caregiver, or family. Consumable medical supplies covered by the DD waiver are listed under Limitations.

**Limitations**

Consumable medical supplies will not duplicate supplies provided by the Medicaid State Plan. Refer to the Florida Medicaid Durable Medical Equipment-Medical Supplies Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage. Supplies not available under the Medicaid State Plan, or available in insufficient quantity to meet the needs of the recipient, may be purchased by the waiver. All supplies shall have direct medical or remedial benefit to the recipient and are related to the recipient's developmental disability.

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

**Consumable Medical Supplies**, continued

**Limitations,**  
continued

Consumable medical supplies covered by the DD waiver are listed below. Some items have specific requirements or limitations.

1. Diapers, including pull-ups, adult diapers or adult disposable briefs.
2. Wipes.
3. Disposable gloves, when a recipient requires personal care that exposes the caregiver to body fluids. Latex-free gloves will be authorized when the recipient's or the caregiver's physician certifies that the recipient or caregiver has a latex allergy or that there is a probable expectation that the recipient or caregiver may have a latex allergy (i.e., recipient's with spina-bifida).
4. Surgical masks, when prescribed by a physician and are:
  - a. Worn by a recipient 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 a recipient 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, when determined necessary by a licensed dietitian. Recipients that require nutritional supplements must have a dietitian's assessment documenting such need. The assessment shall include documentation of weight fluctuation. Total parenteral nutrition (TPN) is available through the Medicaid Prescribed Drug Services Program.
7. Feeding tubes and supplies, not covered by Medicaid State Plan and prescribed by a physician. Excludes supplies for a recipient who qualifies for food supplements under the Florida Medicaid Prescribed Drug Services or Medicare program.
8. Dressings, not covered by Medicaid, 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 recipient's physician.

**Consumable Medical Supplies**, continued

**Limitations,**  
continued

Items not contained on this list, that meet the definition of consumable medical supplies, may be approved through exception by the Department. 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's directly related to the recipient's developmental disability, and without which the recipient can not continue to reside in the community or in his current placement.

The request will be reviewed by the District's physician or nurse 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. The Developmental Disabilities Medical Director shall also review the request for the same purpose. This additional review will typically only be necessary if the District does not have an appropriate physician available to review the request. A recommendation will be made to the District for approval or denial. Consumable medical supplies must be directly and specifically related to the recipient'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 HCBS 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. Supplies may be ordered for 3 months at a time. The waiver does not allow for payment or reimbursement of co-payments for consumable medical supplies covered by third party insurance.

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**Consumable Medical Supplies**, continued

**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Copy of service log, listing supplies purchased; and
3. Original prescription for the supply (if prescribed).

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log listing supplies purchased prior to or at the time of claim submission; and
2. Copy of original prescription for the supply (if prescribed).

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

**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. Recipients or their family members shall not be reimbursed for consumable medical supplies they purchase.

**Dietitian Services**

**Description**

Dietitian services are those services prescribed by a physician that are necessary to maintain or improve the overall physical health of a recipient. The services include assessing the nutritional status and needs of a recipient; recommending an appropriate dietary regimen, nutrition support and nutrient intake; and providing counseling and education to the recipient, family, direct service staff and food service staff. The services may also include the development and oversight of nutritional care systems that promote a person's optimal health.

**Limitations**

A recipient 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.

Note: Refer to Appendix A for rate methodology information.

**Dietitian Services**, continued

**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Copy of service log;
3. \*Monthly nutritional status report;
4. \*An assessment;
5. Individual Dietary Management Plan;
6. Daily progress notes (on days service was rendered);
7. Annual Report; and
8. Original prescription for the service.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly;
2. Copy of assessment at time of initial claim submission and at time of reassessments;
3. Copy of individual dietary management plan at time initial claim submission and at least annually thereafter at the time of the support plan update;
4. Copy of annual report prior to the annual support plan update; and
5. Copy of original prescription for service.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

**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 persons who require specialized oversight of their nutritional status in order to prevent deterioration of general health that could result in an institutional placement. Recipient's requiring nutritional supplements must have a dietitian's assessment documenting such need. Nutritional supplements are available through the Medicaid State Plan, under specific circumstances. For additional information on Medicaid State Plan Coverage requirements, refer to the Florida Medicaid Prescribed Drug Coverage and Limitations Handbook.

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## **Durable Medical Equipment and Supplies**

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### **Description**

Durable medical equipment includes specified, prescriptive equipment required by the recipient. 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 a recipient in the absence of a disability; and d) is appropriate for use in the home. Examples of durable medical equipment covered by the DD waiver are listed in the Limitations segment of this section.

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### **Limitations**

Durable medical equipment and supplies will not duplicate DME and supplies provided through the Medicaid State Plan. Refer to the Florida Medicaid Durable Medical Equipment-Medical Supplies Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage. Supplies not available under the Medicaid State Plan, or available in insufficient quantity to meet the needs of the recipient, may be purchased by the waiver. All supplies shall have direct medical or remedial benefit to the recipient and are related to the recipient's disability. The following is a list of equipment that the DD waiver will cover under the category of durable medical equipment. Some items have specific requirements or limitations.

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 recipient with mobility impairments and when the vehicle is the recipient'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 are the responsibility of the recipient or family. Payments for repair to adaptations after the warranty expires may be approved by the District. The District will respond to requests for repairs to van adaptations within 10 working days of receipt of such requests. Many automobile manufacturers offer a rebate of up to \$1,000 to recipients purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the recipient or family is required to submit documented expenditures of modifications to the manufacturer. If the rebate is available it must be applied to the

***Durable Medical Equipment and Supplies***, continued

**Limitations,**  
continued

cost of the modifications. If a recipient 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.

2. Wheelchair carrier, for the back of the car. 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 State Plan. A physician must prescribe the specific item. Coverage in this category will typically only be provided when the following criteria are met:
  - a. The recipient has a customized power wheelchair funded through Medicare or Medicaid, which is used as his primary mode of ambulation, or the recipient 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 recipient is limited in normal daily activities by the condition;
  - b. The recipient needs a manual wheelchair to facilitate movement within his own home, and to enable the recipient to be safely transported in an automobile. It must be documented that the vehicle does not have a lift or that the recipient'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, meeting the needs of the recipient;
  - d. The wheelchair covered by this service is a standard (manual) wheelchair and not intended for a recipient who cannot use a standard chair for any length of time without adaptation.

If the recipient usually uses a customized wheelchair, but needs a standard wheelchair to transfer to an automobile that does not have a lift or 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 State Plan.

**Durable Medical Equipment and Supplies**, continued

**Limitations,**  
continued

Payments for repair to wheelchairs after the warranty expires may be approved by the District (if not covered by Medicare or Medicaid). The District will respond to requests for repairs to wheelchairs within ten working days of receipt of such requests. 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 recipient. Waiver services are not used to cover any co-payments, with the exception of patient responsibility for Medicare-funded wheelchairs.

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 the District, if not covered by Medicare or the Medicaid State Plan. The District will respond to requests for repairs to strollers within 10 working days of receipt of such requests.
5. Portable ramps, when the recipient requires access to more than one non-accessible structure.
6. Patient lift, hydraulic or electric with seat or sling, when the recipient requires the assistance of more than one person to transfer between a bed, a chair, wheelchair or commode. One lift every eight years, limited to adults. Cost not to exceed \$2,000. Payments for repair to lifts after the warranty expires may be approved by the District, if not covered by Medicare or the Medicaid State Plan. The District will respond to requests for repairs to lifts within 10 working days of receipt of such requests.

**Durable Medical Equipment and Supplies, continued**

**Limitations,  
continued**

7. 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 recipient's need and 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. Cost may not exceed \$10,000. Payments for repair to ceiling lifts after the warranty expires may be approved by the District, if not covered by Medicare or the Medicaid State Plan. The District will respond to requests for repairs to ceiling lifts within 10 working days of receipt of such requests.
  
8. Adaptive car seat, for recipient's 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 recipient cannot use standard restraint devices or car seats. The physical therapist will identify appropriate equipment for the recipient. Adaptive car seats are limited to one per recipient every three years and cost no more than \$1,000.
  
9. Bidet, limited to recipient's 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 recipient 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 recipient'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, maximum of 250 square feet capacity, will be approved per recipient for a five-year period. The air conditioning unit must cost no more than \$300.

***Durable Medical Equipment and Supplies***, continued

**Limitations,**  
continued

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 recipient for a five-year period.
12. Adaptive switches and buttons to operate equipment, communication devices, environmental controls, such as heat, air conditioning, and lights, for a recipient 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 recipient's 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.
15. Bath or shower chair when medically indicated and not covered through the Medicaid State Plan. Coverage is limited to the most cost-beneficial item necessary to meet the recipient's need for bathing. Items that exceed the basic needs of the recipient 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.

**Durable Medical Equipment and Supplies**, continued

**Limitations,**  
continued

21. Generators, may be covered for a recipient when:
  - a. The recipient is ventilator-dependent;
  - b. The recipient requires daily use of oxygen via a concentrator;
  - c. The recipient requires continuous, 24-hour total parenteral nutrition via an electric pump;
  - d. The recipient requires continuous, 24-hour infusion of total nutritional formula through a jejunostomy or gastrostomy tube via an electric pump; or,
  - e. The recipient requires continuous, 24-hour infusion of medication via an electric pump.

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 and meets, but does not exceed the recipient's need. One generator per recipient may be purchased per 10-year period. Payments for repair to generators after the warranty expires may be approved by the District, if no other funding is available. The District will respond to requests for repairs to generators within 10 working days of receipt of such requests.

22. Bolsters, pillows, or wedges, necessary for positioning, prescribed by a physical or occupational therapist.
23. Therapy mat, prescribed by a physical therapist when a recipient is involved in a home-therapy program designed by a therapist and carried out by the family or caregiver in the person's own or family home.
24. Pulse oximeters may be purchased for recipients with respiratory or cardiac disease, who use supplemental oxygen on a continuous or intermitted basis. This equipment must be prescribed by the recipient's pulmonologist, cardiologist or primary care physician.

Items not contained on this list, meeting the definition of durable medical equipment, may be approved through exception by the Department. 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 recipient's developmental disability, without which the recipient can not continue to reside in the community or in his current placement. The request will be reviewed by an appropriate, qualified professional to determine whether the standards for medical necessity set forth in Chapter 59G-1.010(166), F.A.C., are met, and to determine whether the requested item fairly meets the service definition. The Developmental Disabilities Medical Director shall also review the request, for the same purpose. This additional review will typically only be necessary if the District does not have an appropriate physician available to review the request. A recommendation will be made to the District for approval or denial.

***Durable Medical Equipment and Supplies***, continued

**Limitations,**  
continued

If multiple vendors are enrolled to provide this service, the recipient shall select from among all eligible vendors based on the item's availability, quality and best price. No more than five items per day may be purchased.

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 convert that item from personal fitness or recreational choice equipment to durable medical equipment covered under the HCBS 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.

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.

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**Documentation  
Requirements**

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. Such items include, but are not limited to, crayons, coloring books, other books, games, toys, videotapes, CD players, radios, cassette players, tape recorders, television, VCRs, cameras, film, computers and software, exercise equipment (i.e., treadmill, exercise bike), indoor and outdoor play equipment (i.e., swing sets, slides, bicycles, tricycles (including adaptive types), trampolines, play houses, merry-go-rounds, etc., 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.). The above examples do not represent an exhaustive list of all items not covered through the waiver.

***Durable Medical Equipment and Supplies***, continued

**Documentation Requirements,**  
continued

Prior to the provider submitting the claim for payment, the recipient'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 recipient or family.

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of the pre-approved claim(s) form submitted for payment.
2. Original prescription for the medical equipment, if prescribed by a physician.

Documentation to be submitted to the waiver support coordinator by the provider:

1. 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; and
2. Copy of original prescription, if prescribed by physician.

Note: \*Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

**Special Considerations**

Recipients 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 why less were obtained. For items under \$1,000, one bid is required as long as it can be demonstrated that the bid is consistent with local market value.

The DD waiver shall not provide durable medical equipment that is available for purchase through the Medicaid State Plan. Medicaid often covers like equipment, but not the specific brand requested. When this occurs, the recipient is limited to the Medicaid covered device. The lack of coverage for a specific brand name is not a medically necessary justification for waiver purchase. Only the equipment that is not covered through the Medicaid State Plan, or in a sufficient quantity to meet the

***Durable Medical Equipment and Supplies***, continued

**Special Considerations,**  
continued

needs of the recipient, may be purchased through the DD waiver, and then only consistent with what is described above. 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 may be required.

In accordance with Chapter 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.

Note: Refer to the definitions section for additional information regarding prescriptions.

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***Environmental Accessibility Adaptations***

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**Description**

Environmental accessibility adaptations (EAA) are those physical adaptations to the home, required by the recipient's support plan, which are "medically necessary" to avoid institutional placement of the recipient 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 a recipient's home.

Home accessibility assessments may also include pre-inspection of up to three houses a recipient 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. The assessment may also include pre-purchase inspection of up to three homes identified by a recipient or family to determine the best design to meet the recipient's needs and any potential adaptations that may be required to make the home accessible.

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***Environmental Accessibility Adaptations***, continued

**Limitations**

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

Environmental accessibility adaptations covered under this waiver includes the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities or installation of specialized electric and plumbing systems required to accommodate the medical equipment and supplies, which are necessary for the welfare of the recipient.

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 recipient, such as carpeting, roof repair, central air conditioning, etc.

Environmental accessibility adaptations (EAA) are approved when they are medically necessary. The Department must approve exceptions. To submit an exception request, the appropriate professional must complete an assessment documenting how the specific EAA is medically necessary, how it's directly related to the recipient's developmental disability, how it's directly related to accessibility issues within the home, and how, without the selected EAA, the recipient can not 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 set forth in Chapter 59G-1.010 (166), F.A.C., are met and to determine whether the requested item fairly meets the service definition. The Developmental Disabilities Medical Director shall also review the request, for the same purpose. This additional review will typically only be necessary if the District does not have an appropriate physician available to review the request. A recommendation will be made to the District for approval or denial.

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

**Documentation Requirements**

Prior to the provider submitting the claim for payment, the recipient'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 verbal verification from the recipient or family.

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claims submitted for payment;
2. \*Copy of service log; and
3. Original prescription for medical equipment.

**Environmental Accessibility Adaptations**, continued

**Documentation Requirements**, continued

Documentation to be submitted to the waiver support coordinator by the provider:

1. Service log monthly, 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
2. Copy of original prescription for medical equipment.

Note: \*Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

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**Place of Service**

Environmental accessibility adaptations shall be made only to a recipient's family home or recipients 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.

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**Special Considerations**

Environmental accessibility adaptations shall be determined "medically necessary" before approved. This determination includes the following considerations:

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

***Environmental Accessibility Adaptations***, continued

**Special Considerations**, continued

Environmental accessibility adaptations shall be approved for a recipient's own home or family home whether owned or leased, as needed, to make the home accessible to the recipient. No more than five units shall be billed per day. Once adaptations are made to a recipient'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 a recipient or family builds a home while the recipient is receiving waiver services, major or structural changes will not be covered. Environmental accessibility adaptations covered under these circumstances: 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 will have to be documented, with total cost not exceeding \$3,500.

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 recipient 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 the Department of Children and Families and waiver funding are not obligated for any restoration costs. Waiver funds cannot be placed in escrow to undo any accessibility adaptations when the recipient moves out. Recipient's or families requesting EAA are expected to apply for all other assistance that may be available to assist in meeting the recipient'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 recipient on the waiver.

***Environmental Accessibility Adaptations***, continued

**Special Considerations**, continued

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 recipient’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. 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 were 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 less 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 recipient 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, roof repair, driveways, decks, patios, fences, swimming pools, spas or hot tubs, sheds, sidewalks, 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.

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**Homemaker Services**

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**Description**

Homemaker services are those general household activities such as meal preparation, laundry, vacuuming and routine household cleaning provided by a trained homemaker, when the person who usually handles these tasks is unable to perform them. The intent of this service is to ensure that the recipient's home environment remains clean, safe, and sanitary.

**Limitations**

Homemaker services are provided only when there is no one else capable of accomplishing the household tasks. A recipient shall receive no more than 40 units of this service per day. A unit is defined as a 15 minute time period or portion thereof. This service is normally provided one or two days a week for two to four hours at a time. Homemaker services cannot be used for supervision or personal care of a recipient.

Note: Refer to Appendix A for rate methodology information.

**Documentation Requirements**

Reimbursement\* and monitoring documentation to be submitted by the provider:

1. \*Copy of claims submitted for payment; and
2. \*Copy of service log.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly.

Note: \*Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

**Place of Service**

Homemaker services shall be provided in the recipient's own home or family home. This service is available in the family home only when there is documentation as to why the family cannot provide the support. Examples of justification would include the advanced age or physical disability of the caregiver. If approved, homemaker services will be limited to the recipient's primary living areas such as bedroom and bathroom. This includes the kitchen and a common area, if regularly utilized by the recipient.

Recipient's living in licensed residential facilities are not eligible to receive homemaker services.

**Special Considerations**

Homemaker services are rendered only when the recipient is unable to manage the home, or the person who usually performs these tasks is absent for an extended period of time or unable to manage the home. A homemaker cannot provide hands-on care to a recipient.

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## ***In-Home Support Services***

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### **Description**

In-home supports are services that provide a recipient in a supported living situation with four to 24-hours-a-day assistance from a support worker or support workers. The support worker may live in the recipient's home or apartment and share living expenses (rent, utilities, phone, etc.) with the recipient. The support worker provides companionship and personal care, and may assist with or perform activities of daily living and other duties necessary to maintain the recipient in supported living. The in-home support services are separate and not a replacement for the services performed by a supported living coach. Some recipient's in supported living may need only the services of an in-home support worker, or only the services of a supported living coach. Other recipient's may need both services. When both services are used, the providers must coordinate their activities to avoid duplication.

### **Limitations**

In-home support services are available only to recipients residing in their own homes, excluding family home or sharing of a home with family members. The District Developmental Disabilities Program may also approve the use of in-home live-in and hourly live-in services, and the appropriate live-in rate for the service, for recipients who are in need of support, and who reside in a licensed foster or group home, limited to no more than three recipients living in the home. A recipient receiving in-home support services is not eligible to receive personal care, companion or residential habilitation services. In-home support services may be billed up to 365 days a year when the recipient is present.

Note: Refer to Appendix A for rate methodology information.

### **Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claims submitted for payment;
2. \*Copy of service log;
3. Monthly summary notes; and
4. Staffing documentation such as in-home 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.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly; and
2. Monthly summary notes at the time of claims submission.

***In-Home Support Services***, continued

**Documentation Requirements,**  
continued

If the provider plans to transport the recipient 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.

Note: \*Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

**Place of Service**

In-home support services are provided in the recipient's own home or if authorized by the District, in a licensed foster or group home where three or less recipients reside in the home. The in-home support services worker may also accompany the recipient to activities in the community.

**Special Considerations**

The in-home support provider or the provider's immediate family shall not be the recipient's landlord or have any interest in the ownership of the housing unit, as stated in Chapter 65B-11.005(2)(c), F.A.C. If renting, the name of the recipient receiving In-home support services must appear on the lease either singularly, with a roommate or a guarantor.

In-home supports provided by a provider or an employee of a provider who is living in a recipient's home must be billed at the live-in published stepped rate for the service. The live-in rate shall be determined based on from one to three recipients in the home receiving the service. The live-in rate includes a relief factor for primary staff performing the support. Additional in-home supports above the live-in rate may be approved by the District with concurrence from the Developmental Disabilities Central Office based on the support needs of the recipient. Additional supports above the live-in rate shall be billed by the quarter hour. A provider or employees of a provider do not have to "live-in" a recipient's home for the live-in rate to be applied for the service.

When the in-home support worker lives in the recipient's home, and the home is considered the support worker's primary residence, the support worker or provider will pay an equal share of the room and board for the home. The equal share determination shall be made prior to any stipend calculation for the recipient(s).

***In-Home Support Services***, continued

**Special Considerations,**  
continued

The recipient has the option to negotiate with the support worker for a share of the household expenses during the time that the support worker shares the living arrangement when it is not the primary residence.

In-home support services that are provided on an hourly basis instead of live-in shall be billed by the quarter hour in accordance with the published stepped rate for in-home supports awake staff for up to eight hours a day. If in-home hourly supports are required in excess of eight hours a day, or 32 quarter hour units, the service must be billed at the in-home live in daily rate. When periodic additional staff assistance is required for in-home live in services, an in-home hourly support service may be billed for up to eight hours a day in addition to the live in support if approved by the District with concurrence from the developmental disabilities central office. The rate for the service will be determined based on from one to three recipients in the home receiving the service. The rate ratio is determined by what is the usual and customary service delivery pattern and does not fluctuate with incidental absences of one or more recipients included in the rate ratio.

The in-home support services worker is prohibited from paying rent or the cost of other living expenses directly to the recipient, since such financial transactions could jeopardize the recipient's eligibility status as a Medicaid recipient. The support worker should instead, pay their portion of the rent directly to the landlord and their portion of other living expenses (utilities, phone, etc.) directly to the service companies. If the recipient owns the home, the waiver support coordinator or District staff must assist the recipient in negotiating the provider's fee, then negotiate offsetting the fee by the amount the provider owes the recipient for rent and other living expenses.

When a recipient receives supported living coaching and in-home support services, the providers must work together and with the waiver support coordinator to avoid duplication of services.

In-home support providers are not reimbursed separately for transportation and travel costs. These costs are integral components of in-home support services and are included in the basic rate.

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**Medication Review**

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**Description**

Medication review is an independent review and assessment of all prescription and over-the-counter medications taken by a recipient. The purpose of the drug regimen review is to assess, among other clinical considerations, whether drug therapy is needed, accurate, valid, non-duplicative and correct for the indication (diagnosis); that therapeutic doses and administration are at an optimum level; that there is appropriate monitoring (laboratory or clinical testing); and that drug interactions, allergies and contraindications are assessed and prevented. This service is provided by consultant pharmacists to recipient's who meet any of the following criteria and is medically indicated:

- Have a prescription for, and are receiving or will be receiving within the next 30 days, any psychotropic medication including atypical antipsychotics such as Risperdal (Risperidone), Zyprexa (Olanzapine), Clozaril (Clozapine), Seroquel (Quetiapine), or Gedone (Ziprasidone);
  - Have a prescription for, and are receiving or will be receiving within the next 30 days, any medication associated with tardive dyskinesia;
  - Have a prescription for, and are receiving or will be receiving within the next 30 days, any of the following medications: Digoxin (Lanoxin), Lithium, Carbamazepine (Tegretol), Phenytoin (Dilantin), Valproic Acid/Valproate (Depakene/Depakote), Primidone (Mysoline, Phenobarbital, or Theophylline);
  - Have a prescription for, and are receiving or will be receiving within the next 30 days, any neuroleptic medication;
  - Have a seizure disorder which: (a) is not controlled by medication as evidenced by documentation of seizure activity within the last twelve months or (b) requires the use of 2 or more anti-epileptic drugs (AED's);
  - Receive routine monitoring for any of the following: potassium, sugar, thyroid and drug levels;
  - Have a chronic disease associated with the blood, brain, lungs, heart, liver, skin, kidney and circulation, including diabetes;
  - Have been hospitalized or visited the emergency room in the past 18 months for a medication-related problem; and
  - Have a prescription for, and are taking two or more anti-epileptic medications or is taking one anti-epileptic medication and any other medication.
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**Medication Review**, continued

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<b>Limitations</b>	Medication review services are limited to two reviews per year unless the prescribing physician writes an order and determines it is medically necessary for additional reviews based on the criteria provided under the description section of this service.
<b>Documentation Requirements</b>	<p>Reimbursement* and monitoring documentation to be maintained by the provider:</p> <ol style="list-style-type: none"><li>1. *Copy of claims submitted for payment; and</li><li>2. *Report summarizing the medication review.</li></ol> <p>Such review shall contain recommendations for changes in medications and shall also be provided by the consultant pharmacist to the recipient, family or legal guardian, and the prescribing physician.</p> <p>Follow-up by the consultant pharmacist with the prescribing physician shall be provided. The consultant pharmacist will provide written guidelines and information for use by the recipient and their caregivers, about medication administration and other interventions specific to the recipient's needs designed to improve the therapeutic outcome of currently prescribed medications. For monitoring purposes, the provider must have all of the above-mentioned documents available.</p> <p>Documentation to be submitted to the waiver support coordinator by the provider:</p> <ol style="list-style-type: none"><li>1. Copy of claim submitted for payment; and</li><li>2. Copy of report summarizing the medication review prior to or at the time of claim submission.</li></ol> <p><u>Note:</u> *Indicates reimbursement documentation.</p>
<b>Place of Service</b>	This service is performed at the recipient's place of residence, or the provider's office.

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## ***Non-Residential Support Services***

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**Description**

Non-residential support services (NRSS) are individualized training activities provided to an adult or child in integrated, non-residential settings. This service offers individualized training and is provided for the express purpose of providing access to community-based activities that cannot be provided by natural or other unpaid supports, and are defined as activities most likely to result in increased ability to access community resources without paid supports. These training activities are age-appropriate and geared to enhancing the acceptable individual behaviors, increasing the recipient's ability to control the environment and emphasizing those qualities, which are integrative and normative in nature. Implementation of a behavioral services plan may be part of this service if the recipient has behaviors that result in restricted access to community resources. In this case the development of the behavior analysis services plan and implementation of the plan by the NRSS provider must be completed by a person who is certified in behavior analysis or licensed under Chapters 490 or 491, F.S., in accordance with Chapter 65B-4.030(10).

Service models include both an individual approach of training specific to the person and setting that gradually fades to a minimum support level, and group approaches that offer a constant level of support. Group service recipients should choose to participate together. For adults, support services, which may be provided in a work-like setting, are a process used to attain the necessary skills to control the environment, increase acceptable behaviors and provide integrative opportunities. These services are intended to support the participation of recipients in daily valued routines in the community. This service is covered when necessary to prevent institutionalization. These services are reduced over time, as the recipient becomes more of an integral part of the community with less reliance on paid staff.

The primary functions of non-residential support services are:

- Development of communication and social skills to assist the recipient to function with maximum independence in the community;
- Development of skills needed to increase independent living in the community setting; and
- To assist the recipient to develop the skills required to maintain a living environment, use community resources and conduct activities of daily living.

Examples include: volunteering, job exploration and shadowing; developing control and choice over valued daily routines; accessing generic public resources; participation and membership in places of worship and other social organizations; developing acquaintances, friendships and other social supports; and supporting connections with family members and other social supports that promote health, safety and well being.

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**Non-Residential Support Services**, continued

**Limitations**

A recipient is limited to no more than 35 hours a week of non-residential support services. The unit value is 15 minutes. When NRSS services are used to provide a meaningful day activity for a recipient, the service is limited to up to five days a week. Non-residential support services are based on the published stepped rate for the service. The NRSS rate shall be determined based on one to three recipients receiving the service during the same time interval. This service cannot be provided concurrently (at the same time) with PCA or companion services. Excluded are services directed at teaching specific job skills or meeting employment objectives of non-supportive, competitive, paid or unpaid employment, or during any educational programs that is the responsibility of the Department of Education to provide.

Non-residential support services are limited to the amount, duration and scope of the services described in the recipient's support plan and current approved cost plan.

Recipient's receiving this support may not receive the support in groups of individuals larger than three, except as noted under special considerations.

Non-residential support service providers are not reimbursed separately for transportation and travel costs that are a part of the service. These costs are integral components of non-residential support services and are included in the basic rate. Transportation may be billed separately by an enrolled transportation provider to allow recipients to be transported to a central community-based location, from which the recipients would then travel to appropriate and approved training locations with the NRSS provider. For example, in a rural area, recipients may be transported by a transportation provider to a central, in-town location in order for NRSS services to begin at a single community-based site. This does not preclude the recipient from paying for his own bus tokens if his goal, as identified on the support plan, is to learn to use his own money and the bus system. The cost of the non-residential support service provider to ride the bus is included in his service and cannot be paid by the recipient or through separate transportation reimbursement.

Non-residential support services cannot be provided during the time that another provider is scheduled to provide services.

When residential habilitation and NRSS are used as part of a meaningful day activity for a recipient, the recipient may not receive a combination of ADT, NRSS or supported employment services that exceeds 35 hours a week. A recipient may not receive more than 35 hours a week of a paid support, or a combination of paid supports, as a meaningful day activity.

Note: Refer to Appendix A for rate methodology information.

**Non-Residential Support Services**, continued

**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Monthly summary;
3. \*Annual report;
4. Copy of individual implementation plan and or behavior analysis services plan with supporting data if warranted as described above. In addition to those requirements for an implementation plan found in the definition, the implementation plan for this service shall contain strategies to reduce the reliance on paid supports, to include the transfer of the support to a more cost effective service, or unpaid supports. The strategies to reduce the reliance on paid supports should be measurable and addressed in the monthly summary of progress and the annual report;
5. Daily progress notes for each day services were provided;
6. Results of the annual satisfaction survey;
7. Performance data on the projected service outcomes for this service with graphic display of behaviors targeted in the behavior analysis services plan; and
8. Copy of service log to include paid and unpaid supports, a daily schedule and location for days the service was provided.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly;
2. Copy of annual report;
3. A description of the provider's behavior analysis services plan covering the foreseeable future, but not less than 90 days of initially providing services; and
4. Copy of recipient's implementation plan prior to first claim submission and at least annually thereafter at the time of the support plan update and any time updates and changes are made before they are implemented.

If the provider plans to transport the recipient 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.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

***Non-Residential Support Services***, continued

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**Place of Service** Non-residential support services must be provided in integrated settings in the community other than the recipient's or the provider's place of residence.

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**Special Considerations** Non-residential support services are training activities provided in accordance with a specific outcome on the support plan and are not merely recreation or a diversion.

Exception: Recipients receiving supports through community senior citizen programs or licensed adult day care centers may be exempted from the group size limitation by the District Office. Providers serving recipients in remote areas where it is cost-beneficial to have slightly larger groups, four to six, shall negotiate the limit with their District Office. The rate for the extended service ratio from four to six recipients will be billed based on the published step rate for the service.

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***Occupational Therapy***

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**Description** Occupational therapy services are services prescribed by a physician that are necessary to produce specific functional outcomes in self-help, adaptive, and sensory motor skill areas, and assist the recipient to control and maneuver within the environment. The services may also include an occupational therapy assessment, which does not require a physician's prescription. In addition, this service may include training direct care staff and caregivers and monitoring those individuals to ensure they are carrying out therapy goals correctly.

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**Limitations** Occupational therapy and assessment services are available through the Medicaid State Plan services to recipients under the age of 21. Services for these recipient's 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.

A recipient shall 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: Refer to Appendix A for rate methodology information.

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**Occupational Therapy**, continued

**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Copy of service log;
3. \*Monthly summary note;
4. \*Assessment report (if requesting reimbursement for assessment);
5. Annual report; and
6. The original prescription for the service.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of the assessment report;
2. Copy of annual report prior to the annual support plan update;
3. Copy of original prescription for the service; and
4. Copy of service log, monthly.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

**Place of Service**

These services may be provided in the therapist's office, in the recipient's residence, or anywhere in the community.

**Personal Care Assistance**

**Description**

Personal care assistance is a service that assists a recipient with eating and meal preparation, bathing, dressing, personal hygiene, and other self care activities of daily living. The service also includes activities such as assistance with meal preparation, bed making and vacuuming when these activities are essential to the health, safety and welfare of the recipient and when no one else is available to perform them. This service is provided on a one-on-one basis. Personal care assistance may not be used solely for supervision.

**Limitations**

Personal care assistance is limited to the amount, duration and scope of the services described in the recipient's support plan and current approved cost plan. A recipient shall receive no more than 64 units of this service per day, when the quarter-hour unit pays the provider. Should the recipient need more than 64 units of this service a day, the additional units shall be approved by the Department's prior service authorization process.

**Personal Care Assistance**, continued

**Limitations**,  
continued

Personal care assistance services shall be billed at the standard rate level for the service based on the published rate system. The standard rate is paid when a recipient requires minimal support, through instructional prompts, cues, and supervision to properly complete the basic personal support areas of eating, bathing, toileting, grooming and personal hygiene. A rate other than the standard rate level for this service shall only be authorized when it has been determined through use of the Department approved assessment and the support planning process that an individual requires an enhanced level of supports.

The need for an enhanced rate and the approved rate level shall be identified in the recipient's support and cost plan and on the authorization for service submitted to the provider by the recipient's support coordinator. Recipients with the following needs may require enhanced services:

- Recipients who have a moderate level of support identified in the current abilities section of the Department approved assessment may receive the rate level identified as moderate for the service. The moderate rate is paid when a recipient 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.
- Recipients who have an intense level of support identified in the current abilities section of the Department approved assessment may receive the rate level identified as intense for the service. The intensive rate is paid when a recipient requires total physical assistance, to include lifting and transferring, in at least three of the basic personal care areas identified above due to physical, cognitive or behavioral limitations.

A personal care worker with specific, identifiable skills over and above those identified in the qualifications for the service may be required in order to effectively provide the personal care assistance service. The personal care assistant meeting the specific skill requirement may bill at the approved rate level of standard, moderate or intense, and may also be authorized to receive a rate modifier as specified in the published rate for the service. The specific skill(s) and the justification for the skill(s) shall be identified in the recipient's support plan. The approved rate shall be identified on the recipient's cost plan and the authorization for service submitted to the provider by the recipient's support coordinator. Key skills for which a modifier to one of the three rate levels may be approved include:

- Recipients who have difficulty swallowing or eating, or who have multiple physical handicaps, or who have severe spasticity may require staff with skills in physical and nutritional management.
- Recipients who exhibit intense problems with behavior and who have a written behavior service plan may require behavioral assistant services in place of personal care assistance to correctly and safely implement behavior service plans.

**Personal Care Assistance**, continued

**Limitations**,  
continued

- Recipients may need staff with skills in American Sign Language, or other recognized communication specialties in order for the personal care worker to communicate with the recipient using the recipient's primary form of communication.

This service cannot be provided concurrently (at the same time) with NRSS, companion services, ADT services, or in-home support services.

Note: Refer to the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage. Refer to Appendix D for contact information.

Note: Refer to Appendix A for rate methodology information.

**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment; and
2. \*Copy of service log.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly.

If the provider plans to transport the recipient 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.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

**Place of Service**

Personal care assistance shall be provided in the recipient's own home or family home or while the recipient who lives in one of those arrangements is engaged in a community activity. No service may be provided or received in the provider's home or in a hospital, ICF/DD or other institutional environment.

**Personal Care Assistance**, continued

**Special Considerations**

Personal care assistance in the family home should be provided only to assist the parent or primary caregiver of children in meeting the personal care needs of the child. Recipient's who live in their own home or adults that live in a family home may require personal care assistance to assist them with meeting their own personal care needs.

Things to consider when approving this service for children include: 1) physical limitations or abilities of the parent or caregiver; 2) number of other recipient's the parent or caregiver is attempting to provide assistance to; 3) gender of recipient, compared to that of the parent or caregiver; and 4) complexity of the recipient's personal care routine.

For recipient's living in their own home, consider their own physical limitations or abilities to meet their own daily personal care assistance needs.

Recipient's living in foster or group homes are not eligible to receive this service, 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 is recovering from surgery, does not require the care of a nurse and the group home operator is unable to provide the personal attention required to insure the recipient'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 recipient has recovered, the service must be discontinued.

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 to 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 a viable reason may be lack of providers in a rural area.

Personal care assistance is monitored through the waiver support coordinator's contact with the recipient and provider. The recipient or family member contacts the waiver support coordinator when concerns arise or if needs change. The waiver support coordinator will request changes to the care plan to increase or decrease services, and will submit the changes to the District Office for approval.

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 care service.

Personal care assistance providers are not reimbursed separately for transportation and travel cost. These costs are included in the rate.

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**Personal Emergency Response Systems**

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**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 person's location.

Note: See Appendix A for rate methodology information.

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**Limitations**

A personal emergency response system is limited to those recipient's 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. Recipient's 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.

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**Documentation Requirements**

Reimbursement\* documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment; and
2. \*Service log, detailing services provided.

For monitoring review purposes, the equipment installation provider and the emergency monitoring provider must have a copy of the invoices for the period being reviewed. The equipment itself is generally free of charge. The cost of this service involves installation, testing and monitoring.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly, to include waiver support coordinator's verification for receipt of equipment prior to submission of claim for payment.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

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**Place of Service**

A personal emergency response system shall be provided in the recipient's own home or apartment or the family's home or apartment. A mobile "help button" is also available for the recipient to wear while engaged in a community activity.

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**Special Considerations**

A personal emergency response system is available only for at-risk recipient's who require a limited degree of supervision, but live alone or are alone for periods of time without a caregiver.

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## **Physical Therapy**

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### **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, this service may include training and monitoring direct care staff and caregivers to ensure they are carrying out therapy goals correctly.

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### **Limitations**

Physical therapy and assessment services are available through Medicaid State Plan services to recipients under the age of 21. Services for these recipient's 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 State Plan. When additional therapy is necessary, families will seek Medicaid State Plan service coverage. 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 State Plan, including physical therapy. If the recipient is able to use an outpatient facility for physical therapy and the setting is appropriate to meet the recipient's needs, it may be possible to receive limited services funded by the Medicaid State Plan.

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 an outpatient facility.

A recipient 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 physical therapy assessment is limited to one per year.

Note: Refer to Appendix A and D for rate methodology and contact information.

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### **Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Copy of service log;
3. \*Monthly summary note;
4. \*Assessment report (if requesting reimbursement for assessment).
5. Annual report; and
6. Original prescription for the service.

**Physical Therapy**, continued

**Documentation Requirements**, continued

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly;
2. Copy of assessment report;
3. Copy of annual report prior to the annual support plan update; and
4. Copy of original prescription for the service.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

**Place of Service**

This service may be provided in the therapist's office, recipient's residence, or anywhere in the community.

**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 will provide private duty nursing services, in accordance with Chapter 464, F.S. and within the scope of their nursing license.

**Limitations**

Private duty nursing services are available through the 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 program and related to the care of a medical condition.

To be eligible for this service, a recipient must require active nursing interventions on an ongoing basis. This service is provided on a one-to-one basis to eligible recipients. If the service is provided with two or more recipients present, the amount of time billed must be prorated between the numbers of recipients receiving the service. This service may be provided concurrently (at the same date and time) with another service.

Nursing services not available to recipients under the Medicaid State Plan, or which are insufficient in quantity to meet recipient needs, may be paid for by the DD waiver, if the appropriate, qualified professional determines, on behalf of the Department, that the standards for medical necessity set forth in Chapter 59G-1.010(166)(a), F.A.C., are met. The DD waiver may pay only for those medically necessary services not covered by the Medicaid State Plan. A recipient 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.

**Private Duty Nursing**, continued

**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Copy of nursing care plan;
3. \*Copy of service log;
4. \*Individual nursing assessment (must be completed at the time of the first claim submission and annually thereafter);
5. Daily progress notes; and
6. Original prescription for the service.

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. Nurses will also demonstrate either verbally or in writing their knowledge, skills and ability to provide the specific care required by the recipient, as well as a plan for the care that they provide. This documentation must be provided to the waiver support coordinator before rendering services.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly;
2. Copy of nursing care plan at time of first claim submission and annually thereafter;
3. Individual nursing assessment, at time of first claim submission and annually thereafter; and
4. Copy of original prescription for the service.

Note: \* Indicates reimbursement documentation.

**Place of Service**

Private duty nursing services shall be provided in the recipient'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.

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**Psychological Assessment**

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**Description**

Psychological assessment is the evaluation and interpretation of intelligence, aptitudes, interests, academic achievement, adjustment and motivations, or any other attributes in a recipient that relate to learning, educational or adjustment needs.

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**Limitations**

A recipient shall receive no more than one psychological assessment per year. Psychological assessment services shall include only the assessment services provided by a licensed psychologist.

Note: See Appendix A for rate methodology information.

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**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Copy of the evaluation report(s).

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of the evaluation report(s) prior to or at the time of claim submission.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

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**Place of Service** This service is usually performed in the psychologist's office, but may also be performed in the recipient's place of residence or other location conducive to the service.

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**Special Considerations** Psychological counseling services are available through the waiver under the Specialized Mental Health Service, through the Medicaid State Plan's Physician Services Program when performed by a psychiatrist or from the community mental health program when performed by a psychologist or clinical social worker.

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### **Residential Habilitation Services**

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**Description** Residential habilitation provides supervision and specific training activities that assist the recipient 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 recipient to reside in the community. This training is provided in accordance with a formal implementation plan, developed with direction from the recipient and reflects the recipient's goal(s) from their current support plan.

Recipients with challenging behavioral disorders may require more intense levels of residential habilitation services described as behavioral residential habilitation, or intensive behavioral residential habilitation. The necessity for these services is determined by specific recipient behavioral characteristics that impact the immediate safety, health, progress and quality of life for the recipient, and the determination that less intensive services have not been sufficient to alter these behaviors. The need for more intense levels of residential habilitation, behavioral residential or intensive behavioral residential habilitation will be verified by the Developmental Disabilities Program Office.

Note: Refer to special considerations under behavioral analysis and behavioral assistant services for additional requirements.

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**Limitations** Residential habilitation services are provided to adults, 18 years of age and older, living in their own home or family home, or living in a licensed facility. A child may receive residential habilitation services as follows:

1. Residential habilitation services may be provided in the family home for children ages 16-18 with a focus on developing independent living skills.
2. Residential habilitation services may be provided for children up to age 18 in licensed rehabilitation facilities with an emphasis on generalization, maintenance and transfer of skill taught in the school.

Children or adults whose primary problem is behavioral in nature, should receive services through the behavior assistant services.

**Residential Habilitation Services**, continued

**Limitations**,  
continued

Residential habilitation services may be provided to children residing in a licensed facility or children with severe behavioral issues living in their family home. The child must have a written behavior analysis services plan that is written and monitored by a certified behavior analyst, in order for services by a behavior assistant to be reimbursed under residential habilitation. The focus of the service is to assist the parents in training and implementing the behavior analysis services plan.

Recipients may not receive residential habilitation services and supported living coaching services at the same time, except when the recipient's live in a licensed residential facility and has a personal goal or outcome for supported living on their support plan. In this case, the recipient may receive both services for a maximum of ninety days prior to their move to the supported living setting.

A recipient who receives residential habilitation services that are billed by the quarter hour is limited to no more than eight hours, or 32-quarter hour units, of the service in a calendar day. When daily residential habilitation services are used to provide a meaningful day activity for a recipient, the service is limited to 35 hours a week. The recipient may not receive a combination of ADT, NRSS or residential habilitation services that exceeds 35 hours a week. A recipient may not receive more than 35 hours a week of a paid support, or a combination of paid supports, as a meaningful day activity.

When this service is provided in a recipient's own home or family home, the service must be directly related to a training goal(s) on the recipient's support plan and cannot be used for the supervision of the recipient. If a recipient is receiving residential habilitation services and has a goal on the support plan to move to their own home, supported living coaching services may also be provided for up to 90 days prior to the person moving to his own home.

Note: See Appendix A for rate methodology information.

**Residential Habilitation Services**, continued

**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Service log;
3. \*Annual report(s);
4. \*Copy of the individual implementation plan (completed at time of initial claim submission and monthly updates to reflect adjustments to the plan);
5. \*Monthly summary including graphic display of acquisition and reduction behaviors related to the implementation plan;
6. LRC review dates and recommendations made specific to the plan and review schedules for the plan as indicated in Chapter 65B-4.030(9)(10);
7. 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;
8. Results of the annual satisfaction survey; and
9. Performance data on the selected service outcomes projected in this document.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly;
2. Copy of individual implementation plan, at time of initial claim submission and annually thereafter;
3. Copy of annual report prior to the annual support plan update;

**Residential Habilitation Services**, continued

**Documentation Requirements**, continued

4. Monthly summary including graphic display of acquisition and reduction behaviors related to the implementation plan;
5. LRC review dates and recommendations made specific to the plan and review schedules for the plan as indicated in Chapter 65B-4.030(9)(10); and
6. If the provider plans to transport recipients 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.

Note: \* Indicates reimbursement documentation.

**Place of Service**

This service shall be provided primarily at the recipient's place of residence, which must be the recipient's own home, family home, a foster home or a licensed residential facility. 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.

**Special Considerations**

Residential habilitation providers are paid separately for transportation services if they are currently enrolled as a DD Waiver transportation provider, only when transportation is provided between a recipient's place of residence and another waiver service training site. Incidental transportation or transportation provided as a component of residential habilitation services is included in the rate paid to the provider.

Residential habilitation training services shall not take the place of a job, a day training service, or a non-residential support service, but must be scheduled around such events. For example, if a recipient 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.

Employees of licensed residential facilities that provide residential habilitation are usually direct care staff; however, in certain situations it may be appropriate to include other staff as residential habilitation direct care providers.

Providers of residential habilitation services provided in a recipient's own home or family home will bill for services by the quarter-hour based on the published rate for the service. Up to three recipients may receive this service during the same time period, if approved by the District. If more than one recipient receives the service during the same time period, the service will be billed at the published stepped rate ratio for the service.

**Residential Habilitation Services**, continued

**Special Considerations**, continued

When residential habilitation is provided in a recipient's own home, the provider shall not be the recipient's landlord or have any interest in the ownership of the housing unit, as stated in Chapter 65B-11.005(2)(c), F.A.C. If renting, the name of the recipient receiving residential habilitation services must appear on the lease either singularly, with a roommate or a guarantor.

Providers of residential habilitation and behavioral residential habilitation in a licensed facility shall bill for services only when the recipient is present, up to 350 days a year, using the daily rate authorized based on the published rate for the service.

Residential Habilitation with a Behavioral Focus

Service characteristics for residential habilitation with a behavioral focus include:

- A Board Certified Behavior Analyst or Associate Analyst, or Florida Certified Behavior Analyst with a bachelor's degree, or a person licensed under Chapter 490 or 491, F.S., provides on-site-oversight for residential services,
- Integration of behavioral services throughout residential and community programs,
- No fewer than 75% of the provider's direct service staff who work with the recipient(s) for whom the residential habilitation with a behavioral focus rate applies have completed at least 20 contact hours of face-to-face competency-based instruction with performance-based validation in the following content areas;
  - ❖ Introduction to applied behavior analysis – basic principles and functions of behavior.
  - ❖ Providing positive consequences, planned ignoring, and stop-redirect-reinforce techniques.
  - ❖ Data collection and charting.
- 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% of direct service staff that have completed the training described above. Staff must be recertified in the training requirements yearly. The provider has a system that demonstrates and measures continuing staff competencies on the use of procedures that are included in each recipient's behavior analysis services plan.
- Provides for the eventual transitioning of behavioral improvement of the recipient, to a less intense service alternative, through formalized procedures incorporated into implementation plans.

**Residential Habilitation Services**, continued

**Special Considerations**, continued

In order for the provider to receive a residential habilitation with a behavioral focus rate for a recipient based on the published rate matrix, the provider must meet the specified staff qualifications for the service, and the recipient must exhibit the characteristics listed below. This rate level shall be approved only when it has been determined through use of the Department approved assessment by a certified behavior analyst, and the support planning process that an individual requires residential habilitation with a behavioral focus services. 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 every six months while the recipient 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 recipient so that transition to less restrictive services may be possible.

Recipients exhibiting one of the following characteristics may need residential habilitation with a behavioral focus services. Recipients receiving the service have behavioral challenges that fit one or both of the following two categories of behavioral problems, labeled A and B:

- A. The person does not engage in an adaptive behavior that, if not performed by the person or taught by a caregiver, would result in a real and present threat of substantial harm to the person's health or safety. This includes not engaging in adaptive behaviors such as following safety rules, responding in acceptable ways to conflict, performing daily living activities safely and maintaining basic health.
- B. The person has exhibited a problem with behavior during the past year or currently exhibits a problem with behavior that meets one of the criteria below:
  - Requires visual supervision during all waking hours and intervention as determined by a certified behavior analyst or licensed behavior analysis professional.
  - Is being addressed through the use of behavior analysis services and reviewed by the Local Review Committee (LRC).
  - Has lead to the use of restraint or emergency medications within the past year.

**Residential Habilitation Services**, continued

**Special Considerations**, continued

- Has resulted in one or more of the following:
  1. 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.
  2. 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.
  3. Arrest and confinement by law enforcement personnel.
  4. Major property damage or destruction in excess of \$500 for any one intentional incident.
  5. A life-threatening situation. These types of behaviors include but are not limited to excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, or severe insomnia.

Intensive Behavioral Residential Habilitation

Intensive behavioral residential habilitation rates for a recipient shall be approved and authorized through the prior service authorization process performed by the Department or an agent of the Department. Authorization shall require review by at least one board certified behavior analyst or a Florida certified behavior analyst with expanded privileges who holds a master's degree with a primary emphasis in applied behavior analysis. The review process shall include evaluation of the proposed rates for the service being sought. Authorized rates for this service may vary across providers and recipients based on the specific service needs of the recipient. 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 once every six months while the recipient is receiving the service. The provider must meet provider qualifications for this level of service. Further, the following recipient 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 every six months while the recipient 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 less restrictive services may be possible.

**Residential Habilitation Services**, continued

**Special Considerations**, continued

Recipient Characteristics

This service is for persons who present problems with behavior that are exceptional in intensity, duration, or frequency and that meet one or more of the following conditions.

Within the past 6-months the recipient:

1. 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.
2. Engaged in a behavior that creates a life-threatening situation. These types of behavior include but are not limited to excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, and severe insomnia.
3. Set a fire in or about a residence or other facility in an unauthorized receptacle or other inappropriate location.
4. Attempted suicide.
5. Intentionally caused damage to property in excess of \$1,000 in value for one incident.
6. 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.
7. Engaged in behavior that resulted in arrest and confinement.
8. 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.
9. 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.)
10. 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 recipient's records.

**Residential Habilitation Services**, continued

**Special Considerations**, continued

Service Characteristics

The service 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 recipient to function with as much self determination and independence as possible; and (2) the reduction or replacement of high risk, problems with behavior. Treatment may also include intensive medical oversight when warranted by the person's specific concerns.

Individual goals relate to the assessment, management, and replacement of problems with behavior. Goals also include, especially as treatment progresses and is effective, 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 were 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 person's assessment might identify socially skilled behavior deficits that make more likely the self-injury. These deficits might include communication and social skills necessary to independently function in other settings or basic self care skills.

Individuals in intensive residential habilitation programs are not able to function independently without continuous training, supervision, and support by the staff. Only near the end of treatment will a noticeable reduction in intensity occur. However, even at this stage, because the goal is to ensure that gains made are maintained in settings other than the treatment setting, services remain comprehensive and continuous.

**Residential Habilitation Services**, continued

**Special Considerations**, continued

Treatment will also include the arrangement of contingencies designed to improve or maintain performance of activities of daily living. This would occur when a person, 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 recipients 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.

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 recipient 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.

**Residential Habilitation Services**, continued

**Special Considerations**, continued

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 client 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 client to maintain or to continue improvements.

When the conditions identified above are met, the recipient 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.

Note: Refer to the definitions section and Appendix A for additional information.

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**Residential Nursing Services**

**Description**

Residential nursing services are services prescribed by a physician and consist of 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 recipients who require ongoing nursing intervention in a licensed residential facility, group or foster home.

**Limitations**

This service supplements nursing services available through the Medicaid State Plan. 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 program and related to the care of a medical condition. Nursing services not available to individuals under the Medicaid State Plan, or which are insufficient in quantity to meet their needs, may be paid for by the DD waiver, if determined medically necessary by the Department. Refer to the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage.

**Residential Nursing Services**, continued

**Limitations,**  
continued

A recipient shall 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. The ratio of nurses to recipients residing in a licensed residential facility shall not exceed one nurse for every eight recipients. This service may be provided concurrently (at the same date and time) with another service being furnished by another provider.

The ratio of nurses to recipients residing in a group or foster home shall not exceed one nurse for every three recipients.

Note: See Appendix A for rate methodology information and Appendix D for contact information.

**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Service log;
3. \*Monthly summary (must include details, such as health risk indicators, information about medication, treatments, medical appointments, and other relevant information);
4. \*Nursing assessment, must be completed at the time of initial claim submission and annually thereafter or as needed, should the recipient's condition change; and
5. \*Nursing care plan.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of nursing assessment at time of initial claim submission and annually thereafter;
2. Copy of monthly summary at time of claim submission;
3. Copy of service log, monthly; and
4. Nursing care plan.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

**Place of Service**

Residential nursing services shall be provided at a licensed residential facility, group or foster home considered to be the recipient's place of residence.

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## **Respiratory Therapy**

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### **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 may also provide training to direct care staff to ensure adequate and consistent care is provided. Respiratory therapy services may also include a respiratory assessment.

### **Limitations**

Respiratory therapy and assessment services are available through the Medicaid State Plan service for recipients under the age of 21. Services for these recipients 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 will seek the Medicaid State Plan services for funding. The Medicaid State Plan covers respiratory equipment and supplies for adults and children. The waiver cannot reimburse for respiratory supplies and equipment. Refer to the Florida Medicaid Therapy Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage. A recipient 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 Appendix D for contact information and Appendix A for rate methodology information.

### **Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Service log;
3. \*Monthly summary note;
4. Assessment report, if a claim is submitted for an assessment; and
5. Original prescription for service.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log prior to or at time of claim submission;
2. Copy of monthly summary note;
3. Copy of assessment prior to or at time of claim submission; and
4. Copy of original prescription for service.

Note: \* Indicates reimbursement documentation.

**Respiratory Therapy**, continued

**Place of Service**

This service is usually provided in the recipient's place of residence.

**Special Considerations**

Respiratory therapy services shall be medically necessary and provided under a physician's prescription.

**Respite Care**

**Description**

Respite care is a service that provides supportive care and supervision to a recipient when the primary caregiver is unable to perform these duties due to a planned brief absence, an emergency absence or when the caregiver is available, but temporarily physically unable to care for or supervise the recipient for a brief period.

**Limitations**

Respite care service providers are not reimbursed separately for transportation and travel cost. These costs are integral components of respite care services, and are included in the basic fee.

Respite care services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan. The amount of respite services are determined individually and limited to no more than thirty days per year, (720 hours) per recipient.

Note: See Appendix A for rate methodology information.

**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment; and
2. \*Service log.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly.

If the provider plans to transport the recipient 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.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

**Respite Care**, continued

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**Place of Service**

This service may be provided in the recipient's own home, family home or foster home. The recipient may also go to a licensed group, foster home, or assisted living facility to receive the service. Overnight respite care can be provided only in the recipient's own home, family home, licensed foster home, group home or ALF.

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**Special Considerations**

Recipient's, living in licensed group homes, are not eligible to receive respite care services.

Relatives living outside the recipient's home and enrolled as a Medicaid waiver provider 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.

Most recipient's 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.

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 ten or more hours a day. The provider shall bill for only those hours of direct contact with the recipient(s). The respite rate shall be determined based on from one to three recipients in the home receiving the service. Respite services provided in a licensed residential facility will be billed at the ratio of 1:1 in the stepped rate for the service.

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**Skilled Nursing**

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**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, within the scope of Florida's Nurse Practice Act.

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**Limitations**

This service supplements nursing services available through the Medicaid State Plan. Skilled 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 program and related to the care of a medical condition. Refer to the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information on Medicaid State Plan coverage.

**Skilled Nursing**, continued

**Limitations**,  
continued

Nursing services not available to recipient's under the Medicaid State Plan, or which are insufficient in quantity to meet their needs, may be paid for by the DD Waiver, if the appropriate, qualified professional determines, on behalf of the Department, that the standards for medical necessity set forth in Chapter 59G-1.010(166)(a), F.A.C., are met. The DD Waiver may pay only for those medically necessary services not covered by the Medicaid State Plan.

The recipient 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 Appendix D for contact information and Appendix A for rate methodology information.

**Documentation  
Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Nursing care plans and revisions;
3. \*Service log;
4. \*Nursing assessment (must be completed at time of first claim submission and annually thereafter);
5. Daily progress notes; and
6. Original prescription for service.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service logs, monthly;
2. Nursing care plan at time of initial claim submission and annually thereafter;
3. Nursing assessment, prior to or at time of claim submission; and
4. Copy of original prescription for service.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

**Skilled Nursing**, continued

**Place of Service**

Skilled nursing services shall be provided at the recipient'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 recipient's own or family home.

**Special Medical Home Care**

**Description**

Special medical home care services are for a period of up to 24-hours-a-day nursing services and medical supervision provided to residents of a licensed foster or group home that serves recipients with complex medical conditions. The group home must maintain a staffing ratio of one nurse to every three recipient's in the home who require close nursing supervision.

**Limitations**

Only those recipients with complex medical conditions, requiring an intense level of nursing care, and who reside in licensed foster or group homes shall be eligible for this service. The Department may establish a level of nursing staff based on individual recipient support needs at the time of the prior service authorization review required to authorize the service and rate.

Note: See Appendix A for rate methodology information.

**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Nursing care plans and revisions;
3. \*Service log;
4. \*Nursing assessment (must be completed at the time of the first claim submission and annually thereafter);
5. Daily progress notes on days service was rendered, for the period being reviewed: these notes should be directly related to the recipient's plan of care and treatment; and
6. Original prescription for service.

**Special Medical Home Care**, continued

**Documentation Requirements,**  
continued

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service logs, monthly;
2. Nursing care plan at time of initial claim submission and annually thereafter;
3. Nursing assessment, prior to or at time of claim submission; and
4. Copy of original prescription for service.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

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**Place of Service**

Special medical home care services shall be provided at the recipient's licensed group home.

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**Special Considerations**

Special medical home care services and the rate for the service requires approval through a prior authorization process performed by the Department, or a representative of the Department.

Most licensed group homes do not provide this level of nursing care, nor do most recipient's require such close medical supervision. The Department shall determine when a group home qualifies to be a provider of this service and which recipient's require this level of nursing support.

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 recipient was present and received services up to 365 days a year. The provider may not bill for days the recipient is hospitalized or is participating in a home visit.

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## ***Specialized Mental Health Services***

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### **Description**

Specialized Mental Health Services for persons with developmental disabilities are services provided to maximize the reduction of a recipient'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 recipients 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 recipient's support plan, mental health interventions designed to help the recipient 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.

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### **Limitations**

This service supplements mental health services available under the Medicaid State Plan. Mental health services are available to recipients with diagnosed mental illnesses who can benefit from and participate in therapeutic services provided under the Medicaid Community Mental Health Program. Refer to the Florida Medicaid Community Mental 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 1-2 times weekly for 1 hour.

Note: Refer to Appendix D for contact information.

Note: See Appendix A for rate methodology information. |

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**Specialized Mental Health Services**, continued

**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Monthly summary note;
3. \*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
4. \*Service log.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly;
2. Copy of assessment and treatment plan prior to or at time of claim submission;
3. Monthly progress notes including training, instructions or assistance provided to caretakers to provide consistent carryover in the home setting; and
4. Treatment plan updates, every 6 months.

If the provider plans to transport the recipient 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.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

**Place of Service**

These services may be provided in the provider's office, the recipient'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 a recipient 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 recipient.

Community Mental Health Centers are not eligible to enroll to provide this service. If they are able to meet the needs of a recipient, their services are billed to the Medicaid Community Mental Health Program.

## Speech Therapy

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### Description

Speech therapy is a service prescribed by a physician and is necessary to produce specific functional outcomes in the communication skills of a recipient 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 may include training and monitoring of direct care staff and caregivers, to ensure they are carrying out therapy goals correctly.

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### Limitations

Speech therapy and assessment services are available through the Medicaid State Plan services for recipients under the age of 21. Services for these recipient's 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 will seek Medicaid State Plan services coverage.

Assessments for augmentative communication devices and assessments for training are covered by the Medicaid State Plan for all Medicaid recipients.

A recipient 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.

Note: Refer to Appendix D for contact information.

Note: See Appendix A for rate methodology information.

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### Documentation Requirements

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Copy of service log;
3. \*Monthly summary note;
4. \*Assessment report, if requesting reimbursement for assessment;
5. Original prescription for the service; and
6. Annual report.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly;
2. Copy of assessment report prior to or at time of initial claim submission;
3. Copy of annual report prior to the annual support plan update; and
4. Copy of original prescription for the service.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

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### Place of Service

This service may be provided in the therapist's office, in the recipient's place of residence or anywhere in the community.

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## ***Support Coordination***

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### **Description**

Support coordination is the service of advocating, identifying, developing, coordinating and accessing supports and services on behalf of a recipient, or assisting the recipient or family to access supports and services on their own. These services may be provided through waiver and Medicaid State Plan services, as well as needed medical, social, educational, other appropriate services, and community resources regardless of the funding source through which access is gained. The waiver support coordinator is responsible for assessing a recipient's needs, preferences and future goals (outcomes). From that information, the waiver support coordinator assists the recipient in developing a support plan and cost plan.

Once a recipient's support plan is developed and the cost plan is approved by the District, the waiver support coordinator assists the recipient to meet their support plan outcomes or personal goals by linking the recipient with natural and generic supports and services available through family, friends and community resources. When natural or generic supports are unavailable, or are in the process of development, the waiver support coordinator assists the recipient in locating services available through local, state or federal sources, including Medicaid, the DD Waiver and the Developmental Disabilities Program, as authorized.

Waiver support coordinators promote the dignity and respect for each recipient with regard to the recipient's personal privacy, sharing personal information and making decisions.

Support coordinators promote the health, safety and well-being of the recipient; assist the recipient to identify and access formal and informal support systems; assist the recipient to increase or maintain the capacity to direct formal and informal resources; promote advocacy or informed choice for the recipient; provide information regarding the Medicaid fair hearing process; increase the recipient's involvement in the community; and assist the recipient to achieve personal goals.

**Support Coordination**, continued

**Description**, continued

Transitional support coordination also consists of activities that assist the recipient in transitioning from a Nursing Facility (NF), Intermediate Care Facility for the Developmentally Disabled (ICF/DD), State Mental Health Hospital or forensic facility to a community-based setting. These activities include working with the recipient to arrange for the provision of community-based services and supports upon discharge, including those available under this waiver and other services and supports, regardless of funding source, necessary to ensure the health and welfare of the recipient.

Waiver support coordinators are responsible for working with the institutional provider and staff and coordinating their activities with the facility's discharge planning process. The waiver support coordinator will develop an initial support plan based on current assessments including the facility's summary of the recipient's developmental, behavioral, social, health and nutritional status and discharge plan designed to assist the recipient in adjusting to their new living environment. The support plan will identify the community supports and services required to meet these identified needs. Waiver support coordinators can bill for up to 90 days (three months) for services rendered prior to the recipient's discharge. These services can be billed only after the recipient is discharged.

The waiver support coordinator will maintain, at a minimum, weekly contact with the recipient for the first 30 days following discharge to ensure that community supports and services are meeting the recipient's needs. The waiver support coordinator will update the support plan at the end of the 30-day period, identifying progress made with the transition to community-based living and changes in supports and services. At the end of each month following discharge, if the waiver support coordinator has provided all necessary services, including the weekly face-to-face visits for the first 30 days following discharge, they may bill for up to 90 days at the enhanced waiver support coordination rate.

Note: See Appendix A for rate methodology information. |

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**Support Coordination**, continued

**Limitations**

The provider must accept all recipient's who select the provider for waiver support coordination services and not reject any recipient referred to them or who selects them from within the geographic boundaries previously approved by the District. The Department may grant exceptions to this requirement in writing.

Each waiver support coordinator shall maintain a caseload of no more than 36 recipient's, or as specified in statute, even when that total includes recipient's who are not participants in the waiver or are not recipient's of the Developmental Disabilities Program. Support coordination services are rendered in a ratio that does not exceed one certified full-time equivalent (FTE) waiver support coordinator position to every 36 persons. "Full Time Equivalent" (FTE) means a person who is providing support coordination services for 30-36 recipients. Supervisors of waiver support coordinators within group providers shall limit their caseloads to less than 36 persons and must ensure that adequate supervision is also provided for support coordination employees. When a provider is planning to expand services, providers may temporarily exceed the above ratios for a period not to exceed 60 consecutive days.

The support coordination provider must notify the District in writing of any vacancies or leave of absences granted with a list of recipient's affected by this vacancy, within 5 days of each occurrence. Vacancies, due to the termination or resignation of a waiver support coordinator, resulting in caseloads temporarily exceeding the maximum of 36, may be for a period of no more than 60 consecutive days, per vacancy. The 60 consecutive days begin with the date the vacancy actually occurs. Failure of the provider to notify the District of the vacancy within the required timeframe could result in recoupment of funds received by the provider.

Vacancies, due to a waiver support coordinator submitting a written request to the District for leave based on the intent of the Family and Medical Leave Act, resulting in caseloads temporarily exceeding the maximum of 36, may be for a period of no more than 60 working days, per vacancy.

**Support Coordination**, continued

**Limitations**,  
continued

If the support coordination provider cannot fill a reported vacant position within the time allotted, the District must be notified prior to the 60<sup>th</sup> consecutive or 60<sup>th</sup> working day, whichever is applicable to the situation. Upon receipt of this notification the District will provide 14 calendar days notice to the affected recipient's and agency of the need to select a different waiver support coordination provider. This notification will enable the District to inform the affected recipient's of the impending change in their support coordination provider. This notification will allow sufficient time for the recipient to choose an available provider from within or outside the current agency and the provider to complete needed paperwork and take any other necessary actions. It will also allow the recipient time to adjust to the anticipated changes. Vacancies resulting in caseloads exceeding the maximum of 36 for more than the above stated number of days, may subject the provider to recoupment of funds and the recipient's served to transition to another enrolled support coordination provider, chosen by the recipient. All caseload transfers will be accomplished by the District working with the provider to identify those recipient's affected by the vacancy and who will cause the temporary support coordinator to exceed the maximum caseload of 36.

Expansion of services includes increasing the number of recipient's served by a solo practitioner or an agency, as well as a solo practitioner changing or expanding their status from solo practitioner to an agency. A provider must have attained a score of at least 85% on the last quality assurance monitoring conducted by the Department, Agency or their authorized representative, and be approved by the District in order to expand services.

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 recipient's choice of supports and services. This includes, but is not limited to, the following:

- The provider and its employees do not currently, and shall not while certified to render support coordination services, provide direct services within the state of Florida, other than support coordination or related administrative activities, to recipient's who receive services from the Developmental Disabilities Program;
- 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 recipient's who receive services from the Developmental Disabilities Program;
- The provider and its employees shall not 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 recipient's who receive services from the Developmental Disabilities Program;

**Support Coordination**, continued

**Limitations**,  
continued

- The provider shall not, nor shall employees of the provider, be the guardian, apply to be the guardian, or be affiliated with an organization or person who is the guardian of a recipient served by the provider;
- The provider shall not, nor shall employees of the provider, render support coordination services to a recipient who is a family member of the provider or any employee of the provider, unless the recipient receives services in a district where the family member is not certified to provide support coordination;
- The provider shall not, nor shall employees of the provider, secure paid services on behalf of a recipient from a service vendor who is a family member of the provider or any employee of the provider. Exceptions to this prohibition may be made in writing by the Department; and
- The provider and its employees shall not assume control of recipient's finances or assume possession of a recipient's checkbook or cash, nor shall they become representative payee for recipient benefits.

**Support and  
Service Planning  
Requirements**

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The provider must be available to meet the recipient's needs and to perform the responsibilities for support coordination. The provider shall have an on-call system in place that allows recipients to access support coordination services 24-hours per day, 7 days per week. The District must approve this on-call system.

Any time a back-up support coordinator is used during the provider's absence, the back-up support coordinator shall be a certified and an enrolled waiver support coordinator. The name and contact information for the back-up waiver support coordinator shall be clearly communicated to the recipient and to the District. Access to the provider or back-up provider shall be available, without toll charges to the recipient.

Waiver support coordinators should assist ADT recipients with information or referral to rehabilitation, vocational habilitation, and other employment services and employment opportunities available in their community. On an annual basis, waiver support coordinators shall provide service counseling for recipients currently in sheltered workshops or segregated work environments to apprise them of the options available to them for meaningful work activities and training. The support coordinator shall provide information to recipients on residential options available to them including owning or renting their own home, with supports. This shall occur at a minimum of once a year during support planning but should also occur when anticipating a change in the residential situation.

**Support Coordination**, continued

**Support and Service Planning Requirements**, continued

The waiver support coordinator will complete activities that assist the recipient in determining their own future. At least once annually the provider will assist the recipient, primary caregiver, or legal guardian to:

- Complete or update tools, including the Personal Outcome Measures and the Department approved assessment, necessary to assist in identifying personal goals, needs and services prior to the development of the support plan; make decisions and informed choices. The support coordinator is responsible for administering the Department approved assessment to all recipients on their caseload;
- Complete the support plan, including required signature(s) of recipient or legal guardian;
- Complete the cost plan; and
- Complete the Developmental Disabilities Home and Community-Based Services Waiver Eligibility Work Sheet.

In accordance with Chapter 393.0651(7), F.S., the provider shall complete an annual report of progress.

The waiver support coordinator shall provide a copy of the notice of privacy practices required by HIPAA regulations to the recipient or legal guardian upon initial contact with the recipient, and at any time there is a significant change that necessitates the protection of a recipient's health care information.

The waiver support coordinator will submit to the District, no later than twenty calendar days prior to the support plan effective date, a new annual support plan and cost plan with supporting documentation. The District will in turn respond no later than ten working days of its receipt of the cost plan, with a statement of approval or denial. Copies of the support plan and cost plan will be provided to the recipient or his guardian at any time they are requested, but at a minimum, within ten calendar days of the effective date of the support and cost plan. If changes to the support plan's effective date must be made by the support coordinator for purposes of case load management, the support coordinator shall notify providers 60 days in advance of the change. As part of the annual support planning process, the waiver support coordinator will complete a needs assessment, which shall include, among other things, an assessment of the need for an alternative residential placement.

A copy of support plan information, pertinent to the provider, and an approved service authorization will also be provided to other providers of services to authorize and initiate service delivery by the effective date of the approved support and cost plans. Through conversations with the recipient, those who know the recipient well, and through review of the service vendor's documentation, the waiver support coordinator monitors the recipient's involvement in purchased services to determine if the activities meet the recipient's expectations, as identified through use of the personal outcome measures. Along with other planning sources, the waiver support coordinator will determine that these services are age and culturally appropriate, address the need for which they are intended, provide appropriate challenges, motivation and experiences, to meet the recipient's identified goals.

**Support Coordination**, continued

**Support and Service Planning Requirements**, continued

If a recipient's cost plan, amendment or addendum to the cost plan, results in the total cost of the plan exceeding the average ICF/DD cost for services, the waiver support coordinator will submit an exceptional cost review package in accordance with prior authorization procedures to the funding District, within 90 calendar days prior to the effective date of the cost plan. If additional information is needed to consider an exceptional request, the waiver support coordinator will provide the additional information to the District, within five calendar days of notification. For emergency requests, the waiver support coordinator will notify the District of the crisis situation and provide the updated support plan, cost plan and supporting documentation, within three working days.

Throughout the year a recipient's service and support needs may change, necessitating an update in the cost plan. While it is not necessary to update the support plan, a comprehensive description of these changes and sufficient information concerning the change in service needs should be thoroughly documented in the waiver support coordinator's progress notes. Updates to the cost plan shall be initiated when the waiver support coordinator becomes aware of the need for change. The updated cost plan is submitted to the District, for review and approval within five working days of the date the waiver support coordinator becomes aware of the need for change. The District may request copies of the waiver support coordinator's progress notes, which support and describe the need for an updated cost plan. The District will in turn respond within ten days of their receipt of the updated cost plan, with a statement of approval or denial. Within five working days of receiving the District's response, the waiver support coordinator will notify the service provider of the updated changes to the cost plan.

The information relating to the change in condition, need, or revised supports should be incorporated into the support plan at the time of the annual update. The service authorizations must be revised by the support coordinator to reflect the needs of the person and the services that are to be provided. The provider shall assist the recipient in using family, neighborhood and community supports and services funded by private, city and county sources prior to seeking services funded by federal and state sources. The provider shall assist the recipient in using Medicaid State Plan services prior to seeking services funded by the Developmental Disabilities Home and Community-Based Services Waiver. When services must be purchased by a source other than the Developmental Disabilities Home and Community-Based Services Waiver, the provider shall work cooperatively with the District in locating service vendors who meet the needs of the recipient in the most cost-beneficial manner possible.

**Support Coordination**, continued

**Support and Service Planning Requirements**, continued

When services must be purchased by the Florida Medicaid Developmental Disabilities Home and Community-Based Services Waiver, the provider shall locate potential service vendors who are qualified to meet the needs of the recipient in the most cost-beneficial manner possible. The provider shall recruit qualified vendors, acceptable to the recipient, and assist them with waiver enrollment procedures. The waiver support coordinator assures that purchased supports and services do not exceed the annual limits of the current approved cost plan(s) for recipients served. The waiver support coordinator shall use the ABC system to regularly monitor service utilization and expenditures. If the support coordinator becomes aware that supports and services are in excess of the annual limits of the approved cost plan they will notify the District and provider as soon as the excess is known to them.

If paid services are used, the provider shall review with service vendors the goals to be achieved for the recipient and note these discussions in the recipient's progress notes. The agreed upon goal(s) shall be reflected on the service authorization form for that provider.

The provider shall maintain each recipient's central record in accordance with Department procedures. The central records remain the property of the Department. The Department retains the right to review, retrieve, or take possession of a recipient's central record at any time.

The provider shall assist the recipient in maintaining their Medicaid eligibility. The provider shall also notify other waiver service providers and the Department when it is determined that a recipient receiving services is ineligible for Medicaid. The waiver support coordinator will work with providers and the Department to plan for alternative funding sources.

The provider is responsible for the cost of the electronic access to the Department's intranet site as well as entering, updating and assuring the accuracy of demographic information pertinent to the recipient in the ABC system. Failure of the waiver support coordinator to enter, update and assure the accuracy of this information could result in recoupment of funds paid to the waiver support coordinator.

The provider shall comply with all written procedures established by the Department regarding the transition of recipient's from developmental disabilities support coordinators or other waiver support coordinators to the provider.

For recipient's residing in supported living arrangements or licensed residential facilities and who are taking any psychiatric or anti-epileptic medications, the support coordinator will document in the progress notes attempts and efforts to assure:

- A comprehensive psychiatric medication review is completed annually by a licensed psychiatrist or neurologist or an A.R.N.P., who acts pursuant to a protocol with the psychiatrist or neurologist.
- A medication review by a licensed consultant pharmacist is conducted at least annually.

**Support Coordination**, continued

**Support and Service Planning Requirements**, continued

The recipient receives follow-up reviews by the psychiatrist, neurologist or A.R.N.P. at a frequency established by these practitioners. If the frequency of review established by the psychiatrist, neurologist or A.R.N.P. is less frequent than every ninety days, documentation for their rationale will be provided. This documentation will be maintained in the recipient's central record.

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

When a new support coordination provider is selected by the recipient, or the support coordination services 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 District, as directed, within two weeks of the effective date of the action.

Note: Refer to the medication review service section for additional information.

**Documentation Requirements**

For reimbursement\* purposes, the provider must meet certain basic billing requirements. These include progress notes, which adequately document the support coordination services rendered. Exceptions granted by the Department to any requirements set forth in the assurances or policy must also be documented. All documentation must be filed in the recipient's central record prior to billing. The provider must have, at a minimum, two contacts with or activities on behalf of recipients each month in order to bill to Medicaid. Prior to submitting a claim for payment of support coordination services for a recipient, the provider shall complete the following:

1. \*Have on file in the recipient's central record, the recipient's current support planning information to include the personal outcome measures information and outcome notes, the Department approved assessment, a current waiver eligibility worksheet, a current support plan and current approved cost plan; and
2. \*Have at least one face-to-face contact monthly with recipient's living in a licensed residential facility or supported living situation. Have at least one face-to-face contact every three months for recipient's living in their family home, and two of those contacts per year, will be held in the recipient's residence at six-month intervals. Face-to-face contacts shall relate to or accomplish one or more of the following:
  - (a) Assist the recipient to reach outcomes on the support plan, including gathering information to identify outcomes;
  - (b) Monitor the health and well-being of the recipient;
  - (c) Obtain, develop and maintain resources needed or requested by the recipient to include natural supports, generic community supports and other types of resources;
  - (d) Increase the recipient's involvement in the community;
  - (e) Promote advocacy or informed choice for the recipient; or
  - (f) Follow-up on the recipient's or family's concerns.

**Support Coordination**, continued

**Documentation Requirements,**  
continued

\*For recipients in supported living, residing in their own home or residing in licensed facilities, a face-to-face visit with the recipient in the recipient's place of residence is required every three months. If the recipient lives with his family, the face-to-face contact with the recipient in the residence is required every six months. The recipient or family may not waive the six-month visit in the home. The need for more frequent face-to-face-visits may be determined by the recipient, family or primary caregiver. The waiver support coordinator shall document this preference in the support plan.

\*For recipients receiving supported living coaching services, it is the waiver support coordinator's responsibility to schedule a quarterly meeting with the recipient and the supported living coach. The purpose of this meeting is to review supported living needs with the recipient and the coach to determine if services are being provided at a satisfactory level, and to assure that housing, health, safety and financial support are adequate. The waiver support coordinator shall document the results of each meeting in the progress notes. This quarterly meeting with the recipient and the supported living coach, unless the supported living coach is excluded at the request of the recipient, may satisfy the quarterly face-to-face meeting requirement above, provided the meeting takes place in the recipient's home.

\*Conduct at least one other contact or activity per month. These contacts or activities are not merely incidental, but are planned and shall relate to or accomplish those items, previously identified in 2 (a-f). These contacts or activities may be either with the recipient or with other persons, such as family members, service vendors, community members and others, and may be conducted face-to-face or by phone. Administrative activities such as typing, filing, mailing, or leaving messages shall not qualify as contacts or activities.

\*Letter writing would qualify as another contact if related to services and benefits specific to a recipient's needs. This would exclude form letters to confirm meetings, etc. Additionally, scheduling time to develop the support plan, setting up the face-to-face contact, setting up meetings with other persons, and meeting with one's supervisor or co-workers shall not qualify as contacts or activities.

Upon receipt of a determination that terminates or reduces the level of services, the support coordinator will, within ten business days of receipt of the determination, inform the recipient of the decision and submit a revised service authorization to the service provider. If the determination affects the provider immediately, the support coordinator must contact the provider by phone call, fax or other method to inform them of the need to immediately revise the services being provided with notification that the service authorization will be sent to the provider to document the change. If the support coordinator does not follow these procedures and this results in the provider not being notified of the service change, the support coordinator may be subject to recoupment of the services that were provided when the service provider was unaware of the need to change the level of service provision. Upon receipt of a determination of approval of a new service, the support coordinator must issue a service authorization within ten business days of receipt of the determination.

**Support Coordination**, continued

**Documentation Requirements**, continued

For monitoring review purposes the provider must have on file, for the period being reviewed:

1. A copy of all of the recipient's support plans and approved cost plans in their central records;
2. Documentation in the central records that the basic billing requirements were met, for the months in which the provider was reimbursed for services;
3. Progress notes which adequately detail support coordination provided to the recipient and his family or guardian;
4. Documentation in the central records that a face-to-face visit with the recipient was conducted in their place of residence, including those recipient's in supported living, quarterly meetings with the recipient and their supported living coach;
5. Copies of the annual reports and individual implementation plans submitted by other providers, as required and appropriate to each service;
6. Current and correct demographic information for each recipient, including current health and medical information and emergency contacts;
7. Results of the annual satisfaction survey; and
8. Performance data on the selected service outcomes projected in this document.

In addition, the provider is expected to document in all recipient central records all other support coordination services, activities or contacts that assisted him in meeting support plan outcomes or personal goals, become more integrated into communities and address each recipient's or family's concerns. Progress notes should adequately and clearly document all support coordination services provided to a recipient.

If the provider plans to transport the recipient 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.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

**Place of Service**

This service may be provided in the recipient's residence, or anywhere in the community.

**Special Considerations**

Support coordination services may be rendered in any community location conducive to the contact or activity being provided, including the waiver support coordinator's office, the recipient's residence, a library, a park, or any other community location. In order to get to know each recipient well, waiver support coordinators are encouraged to interact with and observe each recipient in a variety of settings, during different times of the day and on different days of the week.

**Support Coordination**, continued

**Special Considerations**, continued

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

Providers of support coordination services must participate in monitoring reviews conducted by the Department, Agency or an authorized representative of the state. Support coordinators are expected to meet the needs of the recipient's 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.

The provider will be responsible for the cost to access any Departmental or Agency required management, claim submission information or data collection systems.

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**Supported Employment**

**Description**

Supported employment services provide training and assistance in a variety of activities to support recipients in sustaining paid employment at or above minimum wage unless the recipient is operating a small business. The supported employment 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 supported employment provider, the recipient is assisted in securing employment according to their desired outcomes, including the type of work environment, activities, hours of work, level of pay and supports needed. Supported employment is conducted in a variety of settings, to include work sites in which individuals, without disabilities, are employed.

Supported employment includes activities needed to sustain paid work at or above minimum wage for recipients receiving waiver services, including supervision and training. This training can focus on both the recipient's needs, as well as providing consultation to the employer to enhance supports natural to the workplace rather than imposing paid supports. Supported employment providers will immediately notify the recipient's waiver support coordinator of any changes affecting the recipient's income. The service provider shall work with both the recipient and the respective support coordinator to maintain eligibility under the HCBS waiver, as well as health and income benefits through the Social Security Administration and other resources.

**Supported Employment, continued**

**Description,**  
continued

Models of supported employment services shall include:

Individual Model - One person at a time approach to obtaining competitive employment through the support of a job coach, employment specialist, or consultant for job development, intensive training (Phase I) and systematic follow-along supports (Phase 2). 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 recipient.

Phase I is defined as time-limited supports needed to obtain a job and reach stabilization. These 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.

The number of hours of intervention 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 I 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 service moves 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 this 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 I at any given point in time. Phase I 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 I is 24 to 25 weeks, but is different for each recipient depending upon need.

**Supported Employment**, continued

**Description**,  
continued

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.

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 I services to access a better job match or seek employment alternatives. Moving to Phase I 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 assert an expectation of a staff to service recipient ratio of one staff person supporting up to twenty supported employees.

Group Models – Including:

- 1. Enclave - A group approach to employment where up to eight recipients with disabilities work either as a group or dispersed individually throughout an integrated work setting with supervision by the provider.
- 2. Mobile Crew - A group approach to employment where a crew, such as lawn maintenance, janitorial, of up to eight recipients with disabilities are in the community in businesses or other community settings with supervision by the provider.
- 3. Entrepreneurial - A group approach to employment where up to eight recipients with disabilities work in a small business created specifically by or for the recipients.

Providers of supported employment services shall comply with requirements found in the Developmental Disabilities Waiver Services Agreement, attached Core Assurances, and those specified in this handbook.

**Supported Employment**, continued

**Limitations**

Supported employment services are limited to the amount, duration and scope of the services described in the recipient's support plan and current approved cost plan. The provider shall render services at a time mutually agreed to by the recipient and the provider. Off-hours support may occur as an alternative or supplement to the on-the-job contacts.

Decisions to change the duration or intensity of the service to less than twice monthly contacts, in the individual model of service delivery, or to terminate supported employment services, shall only be made through consensus between the recipient receiving services and his guardian, the Vocational Rehabilitation counselor, if applicable, the District or waiver support coordinator, and the provider. If for any reason a recipient has terminated services and requests reinstatement, due to the need for ongoing supports, he will be given priority for restoration of services.

Recipients working an average of less than 20 hours per week must have at least a quarterly review. Documented attempts to increase work hours or secure an appropriate job must be summarized quarterly, in the monthly summary notes. Recipients should not remain in job development status for more than a two month period. For recipients who remain in job development status for more than two months, the supported employment coach will justify monthly the reason(s) why employment has not been obtained, and the strategies planned for securing employment.

Phase I supported employment services are limited to eight hours, or 32-quarter hour units per recipient a day. Phase 2 supported employment services are limited to eight hours, or 32-quarter hour units per recipient per week. Group model services are limited to eight hours, or 32-quarter hour units per recipient a day.

Transportation of recipient's 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.

Note: See Appendix A for rate methodology information.

**Supported Employment**, continued

**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Service log
3. \*Monthly summary;
4. 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;
5. \*Implementation, employment plan 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
6. Annual report.

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 employment service must also contain the following:

Documented review by the provider to furnish information and supports for the recipient to make an informed choice in the type of work preferred, job changes or career advancement opportunities.

For recipient's receiving services in the individual model there must be documented bi-weekly contacts, either on the job site or in another setting, to monitor the needs and provide supports for retraining, adequacy of workplace supports and relationships, and job satisfaction or desires for job change should be noted. The monthly summary must clearly reference these contacts and the specific supports provided.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log, monthly;
2. Implementation and employment plan at the time of first claim submission and annually thereafter;
3. Performance data on the selected service outcomes projected in this document; and
4. Copy of annual report prior to annual support plan update.

If the provider plans to transport recipients 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.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

**Supported Employment**, continued

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**Place of Service**

Supported employment services are provided in the recipient's place of employment in the community or in a setting mutually agreed to by the supported employee, the employment coach or consultant and the employer.

Should the employment location of a recipient change, the provider shall notify the recipient's waiver support coordinator within five working days.

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**Special Considerations**

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 will be maintained in the file of each recipient receiving this service.

When the supervisor of a mobile crew or enclave does not meet the qualifications for a supported employment coach, although the recipient meets the criteria for supported employment, the support service must be billed as adult day training off-site, rather than supported employment.

Supported employment services are defined as competitive employment, which may be performed on a full-time or part-time basis, in an integrated setting, for which an individual is compensated at or above minimum wage but not less than the customary wage, and at a level of benefits paid by the employer for the same or similar work that is performed by trained, non-disabled individuals.

Providers of supported employment – group model services will bill for each recipient based on the published stepped rate for the service. The group rate shall be determined based on from two to eight recipients receiving the service.

Providers of supported employment – individual model services will bill, based on a one to one ratio, the rate established for the service in the published 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.

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## ***Supported Living Coaching***

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### **Description**

Supported living coaching services provide training and assistance, in a variety of activities, to support recipient's who live in their own homes or apartments. These services 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 recipient's to reside on their own.

Supported living services mean the provision of supports necessary for an adult who has a developmental disability to establish, live in and maintain a household of his choosing in the community. This includes supported living coaching and other supports.

**Functional Community Assessment:** The basis for identifying the types of training, assistance and the intensity of support rendered by the provider. It is a tool designed to assist the provider in becoming familiar with the recipient and his capabilities and needs. This assessment addresses all areas of daily life including relationships, medical and health concerns, personal care, household and money management, community mobility, recreation and leisure. The supported living provider is responsible for helping the recipient complete a functional community assessment prior to his move to a supported living arrangement. This assessment shall be updated annually.

**The Housing Survey:** The basis for surveying a prospective home to ensure that it is safe. The supported living coach must forward a copy of the completed survey of the housing that was selected by the recipient, to the recipient's support coordinator within ten working days of the selection. This survey must be updated quarterly and made available for review by the support coordinator at the time of the support coordinator's quarterly home visit. These updates shall include a review of the recipient's overall health, safety and well-being status.

**Financial Profile:** An analysis of the household costs and revenue sources associated with maintaining a balanced monthly budget for the recipient. The analysis will substantiate the need for a monthly subsidy or initial start-up costs, and should be a source of information for determining strategies for assisting the person in money management. The supported living coaching provider is to assist the recipient in completing the financial profile and submitting it to the support coordinator no more than ten days following the selection of housing by the recipient. 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 District before the recipient signs a lease.

Providers of supported living services shall comply with requirements found in the Florida Medicaid Developmental Disabilities Waiver Services Agreement, attached Core Assurances, and those specified in this handbook.

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**Supported Living Coaching**, continued

**Limitations**

Each supported living coach shall maintain a caseload of no more than ten individuals who are receiving supported living coaching services.

Supported living coaching services are limited to the amount, duration and scope of the services described on the recipient's support plan and current approved cost plan, not to exceed 40 quarter hour units per day.

The provider shall render supported living coaching services at the time and place mutually agreed to by the recipient and provider. The provider shall have an on-call system in place that allows recipient's access to services for emergency assistance 24 hours-per-day, 7 days-per-week. If an individual vendor, 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 65B-11, F.A.C. Telephone access to the provider or the backup provider shall be available, without toll charges to the recipient.

Supported living coaching services are limited to adults (age 18 or over) who rent or own their own homes or apartments in the community. The supported living coaching provider or the provider's immediate family shall not be the recipient's landlord or have any interest in the ownership of the housing unit, as stated in Chapter 65B-11.005(2)(c), F.A.C. If renting, the name of the recipient 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 recipient's receiving supported living services shall account for no more than ten percent of the housing in the smallest identifiable geographical area in which the homes are located, which may be a city block, subdivision, neighborhood, apartment complex or mobile home park. The recipient's home shall be scattered, noncontiguous, and dispersed throughout that area. Waiver requests, regarding the density requirements can be submitted in writing, to the Department.

Recipient's receiving supported living coaching services shall live where and with whom they choose. Recipient's receiving supported living coaching services shall live with no more than two other people who have developmental disabilities and shall have control over the household and its daily routines.

Recipient's who live in family homes, foster homes or group homes are not eligible for these services unless the recipient's have an outcome (goal) to move into their own homes or apartments. Within 90 days from moving, supported living coaching services may be made available to recipient's 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 receive residential habilitation services.

**Supported Living Coaching**, continued

**Limitations,**  
continued

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 coaching supports for the recipient. If services are provided with two or more individuals present, the amount of time billed must be prorated based on the number of recipient's receiving the service.

Note: See Appendix A and E for rate methodology and contact information.

**Documentation**  
**Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Service log or time intervention log, which shall be supported by progress notes including documentation of activities, supports and contacts with the recipient, other providers and agencies with dates and times, and a summary of support provided during the contact, any follow up needed and progress toward achieving support plan goals. This service log and progress notes shall be placed in the recipient's record prior to claim submission; and
3. \*Individual implementation plan, or in the case of transition, a transition plan, must be completed at the time of the first claim submission and annually thereafter at the time of the support plan update, and at any time updates and changes are made before they are implemented.

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;
- 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 recipient; and a financial profile that includes strategies for assisting the person in money management, when requested by the recipient or guardian, and the amount approved for the supported living subsidy, the financial profile is critical in determining whether or not the housing selected by the recipient is within his financial means and will identify the need for monthly subsidy which must be approved by the District;

**Supported Living Coaching**, continued

**Documentation Requirements**, continued

4. An annual written report, summarizing the recipient's progress toward achieving the goal(s) from the support plan. The annual report shall include objective, fact-based, information reflecting the results of training and supports provided to the recipient over the course of the year, as well as subjective information (opinions) and recommendations. The annual report shall be submitted to the recipient or guardian and the support coordinator 30 days prior to the end of the support plan year;
5. An annual satisfaction survey as described in Chapter 65B-11.008, F.A.C. At least annually, recipient's receiving supported living coaching services will be asked to complete a survey that addresses satisfaction with supported living services. While it is the provider's responsibility to assure the recipient has the opportunity to complete the survey, staff providing direct supported living services to the recipient may not assist in the survey activity for that recipient. The results of the survey will be maintained in the recipient's record and a copy forwarded to the waiver support coordinator for review;
6. The recipient's waiver support coordinator is responsible for arranging, scheduling and documenting a quarterly meeting in which the recipient, the waiver support coordinator and the provider of services review the current supported living services. The purpose of this visit is to update the housing survey to assure that the home continues to meet basic health and safety standards and to determine if supported living coaching services are being carried out as identified on the support plan. The supported living coach and the waiver support coordinator are to review the recipient's bank statements and other financial records at the time of the quarterly visit. This review will be documented, unless the supported living provider is excluded from the meeting at the request of the recipient, in the progress notes contained in the provider's service log;
7. An initial housing survey containing quarterly updates of the recipient's health and safety status. The housing survey will be updated quarterly and made available to the waiver support coordinator at or prior to the quarterly meeting. Documentation of the meeting and subsequent recommendations will be made in the recipient's record;
8. Up-to-date information regarding the demographic, health, medical and emergency information, and a complete copy of the current support plan, if approved by the recipient or guardian, for each recipient served; and
9. Performance data on the selected service outcomes projected in this document.

**Supported Living Coaching**, continued

**Documentation Requirements**, continued

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log or time intervention log, monthly
2. Copy of individual implementation plan or transition plan (must be completed at the time of first claim submission and annually thereafter at the time of the support plan update, and at any time updates and changes are needed and before they are implemented;
3. Annual report prior to annual support plan update.

If the provider plans to transport the recipient 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.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

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**Place of Service**

Supported living coaching services are provided in the recipient's place of residence or in the community.

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**Special Considerations**

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

When a recipient receives supported living coaching, in-home supports, personal care assistance or companion services, the providers must work together to avoid duplication of activities with coordination by the waiver support coordinator.

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.

Supported living coaching services may not duplicate services available from programs funded by the Rehabilitation Act of 1973 or Public Law 94-142 or their subsequent updates.

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## ***Therapeutic Massage***

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### **Description**

Therapeutic massage and assessment means the manipulation of the superficial tissues of the human body with the hand, foot, arm or elbow, whether or not such manipulation is aided by hydrotherapy, including colonic irrigation or thermal therapy; any electrical or mechanical device; or the application to the human body of a chemical or herbal preparation.

Indications for this service include the need to increase the blood flow through applied pressure and stretching; deep muscle relaxation to promote more functional joint movement, which assists in the range of motion and prevention of deterioration due to contractures; to assist in keeping muscles supple and free from fibrous adhesions; and to loosen shortened, contracted muscles and the stimulation of weak and flaccid muscles to promote efficient movement and improved posture.

Additionally, this service may prevent or relieve constipation and bowel impaction thereby reducing the need for alternative bowel management strategies. Respiratory benefits may also be achieved by including the promotion of deep breathing through stretching techniques. Therapeutic massage softens tough inflexible skin making it suppler, which promotes comfort and skin integrity.

Therapeutic massage is indicated for medical conditions that are characterized by poor circulation, dysfunction or pain including conditions related to: peripheral vascular insufficiency, in the absence of blood clot; lymph edema; arthritis; spastic colon or bowel disease; muscle dysfunction including conditions characterized by muscle rigidity and flaccidity.

This therapy shall be prescribed by a physician, physician's assistant, or nurse practitioner and is limited to recipients with specific medical conditions listed above. This service may be complementary to physical therapy or rendered as a less intrusive alternative. Assessment to determine the specific therapeutic activities to be utilized and the need for continued services is also an included service.

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### **Limitations**

A recipient shall receive no more than four units of this service per day. A unit is defined as a 15 minute time period or portion thereof. The therapeutic massage assessment is limited to two occurrences per year, each billed to a maximum of four units.

Note: See Appendix A for rate methodology information. |

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**Therapeutic Massage**, continued

**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment;
2. \*Copy of service log;
3. \*Monthly summary note;
4. \*Assessment report, if requesting reimbursement for assessment;
5. Original prescription for the service; and
6. Annual report.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of service log;
2. Copy of assessment report, at the time of initial claim submission and every six months thereafter;
3. Copy of annual report prior to annual support plan update; and
4. Copy of current prescription for the service.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information.

**Place of Service**

This service may be provided in the therapist's office or in the recipient's home.

**Special Considerations**

Therapeutic massage and assessment is limited to recipients with specific medical conditions.

Therapeutic massage may be prescribed for six months at a time. After six months, the therapist and prescribing physician, physician's assistant or nurse practitioner must make an assessment as to the benefit to the recipient. Anytime it is determined that the service is not benefiting the recipient, the service must be discontinued.

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## ***Transportation***

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### **Description**

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

Transportation services funded through the DD waiver shall be used only for recipients 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 recipient, or who are capable of transporting the recipient at no cost to the Department, shall be encouraged to continue their support of the recipient. Recipients 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.

This service is not available for transporting a recipient to school, through 12<sup>th</sup> grade. Transportation to and from school is the responsibility of the public school system. For other transportation needs not identified on the recipient's support plan and approved cost plan, the recipient should be directed to the local Community Transportation Coordinator or, if available, the local area's fixed route fixed schedule public transit (bus system).

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 but not be limited to opening the vehicle door, fastening the seat belt, securing a wheelchair, storage of mobility assistance devices, and closing the vehicle door. Recipients 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 recipient, recipient's guardian, or recipient's representative. Drivers and drivers' assistants shall not provide any assistance that a prudent person would consider unsafe for either the driver, the driver's assistant or the recipient.

**Transportation**, continued

**Description**,  
continued

Drivers, drivers' assistants or escorts provided by the provider to accompany the recipient shall be trained in CPR, disease transmission, and use of the on-board first aid kit.

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 under 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 recipients.

When the vehicle is in motion, all mobility devices (wheelchairs, scooters, etc.) shall be secured with appropriate tie-downs, regardless of whether a person is physically positioned in the mobility device or not, 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, shall be secured.

**Limitations**

Providers of adult day training, companion services, in-home support services, non-residential support services, personal care assistance, 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.

In order for providers of adult day training, companion services, in-home support services, non-residential support services, personal care assistance, residential habilitation, respite care, specialized mental health services, support coordination and supported living coaching to bill separately for transportation provided between a recipient's place of residence and the site of a distinct waiver service, or between waiver service sites when the service at each site is provided by a different provider, they must qualify for and enroll as a transportation provider.

**Transportation**, continued

**Limitations**,  
continued

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

Transportation services are available through the Medicaid State Plan to transport recipients to Medicaid-eligible medical appointments and services. DD waiver funds shall not be used when the recipient's trip is for a Medicaid State Plan service.

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

When the recipient 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 recipient a co-payment.

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 recipient is being transported, the mileage charge will be shared among the number of waiver recipients transported. When a provider is reimbursed by the trip, a recipient 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.

Note: See Appendix A for rate methodology information.

**Documentation Requirements**

Reimbursement\* and monitoring documentation to be maintained by the provider:

1. \*Copy of claim(s) submitted for payment; and
2. \*Trip logs.

Documentation to be submitted to the waiver support coordinator by the provider:

1. Copy of trip logs, monthly.

**Transportation**, continued

**Documentation Requirements**, continued

Districts must maintain a database for each enrolled provider to include:

- The names of the recipients being transported by that provider;
- The beginning and ending date of each recipient's service;
- The destination and distance of each recipient's authorized trip;
- The cost per vehicle mile; and
- The amount authorized to be billed monthly for each recipient.

This information may be obtained from the recipient's service authorizations and verified by trip logs and quarterly operating or service reports submitted by providers.

A Community Transportation Coordinator (CTC) must be able to show, at the time of enrollment, a copy of its current Memorandum of Agreement with the Commission for the Transportation Disadvantaged (CTD), or a copy of the CTD's letter of intent to issue a Memorandum of Agreement for the enrollment period. The CTC must notify the District at least 30 days in advance of a change in its status as CTC.

Transportation providers that are neither CTCs, public fixed route fixed scheduled bus systems, nor limited transportation providers must, at the time of enrollment, be able to show proof of current Florida driver's licenses for all drivers who will be transporting recipients, vehicle registration for all vehicles to be used in the provision of this service and 100/300 vehicle liability insurance coverage, in accordance with Chapter 768.28, F.S.

Fixed route fixed schedule bus systems shall, at the time of enrollment, provide the District office with proof of their status as the local Public Transit Authority.

Limited transportation providers shall, at the time of enrollment, provide the District office with proof of a current Florida driver's license, vehicle registration, possess a vehicle that is in safe operating condition and maintain at least minimum vehicle liability insurance coverage as required by Florida law (PIP).

Subsequent to enrollment, all providers are responsible for keeping drivers' licenses, vehicle registrations, and insurance up-to-date. Drivers shall be at least 18 years of age and possess a current, valid commercial or non-commercial driver's license appropriate to the vehicle and for the purpose it is being used, in accordance with Chapter 316, F.S.

Note: \* Indicates reimbursement documentation.

Note: Refer to the definitions section for additional information regarding trip log contents.

**Transportation**, continued

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**Place of Service**

This service is provided anywhere in the community.

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**Special Considerations**

When a recipient must have an escort to provide assistance, the transportation provider may be paid for transporting both the recipient 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 a recipient with a disability.

Providers shall not be paid separately for transportation services provided as an integral part of performing the following services: adult day training, companion services, in-home support services, non-residential support services, personal care assistance, residential habilitation, respite care, specialized mental health services, support coordination and supported living coaching. Group and foster homes that provide transportation, as a component of their long-term residential care services, shall not be paid separately for the transportation service.

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.

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**CHAPTER 3**  
**DEVELOPMENTAL DISABILITIES WAIVER SERVICES**  
**PROCEDURE CODES AND REIMBURSEMENT INFORMATION**

**Overview**

**Introduction**

This chapter provides and describes reimbursement information regarding the DD/HCBS waiver, the procedure codes, maximum units of service, rate methodology, an example of the Medicaid Waiver Services Agreement, Core Assurances for the Developmental Disabilities waiver services, contact directories for the District DD offices and the Medicaid area offices, recipient application and eligibility determination information, waiting list information, crisis information, waiver enrollment, example of application for participation, crisis identification tool and example of wait list form.

**In This Chapter**

This chapter contains:

TOPIC	PAGE
Reimbursement Information	3-2
Appendix A: Procedure Codes, Maximum Units of Service, Rate Methodology	A-1
Appendix B: Developmental Disabilities Program Example of Medicaid Waiver Services Agreement	B-1
Appendix C: Core Assurances for Providers of Developmental Disabilities Home and Community-Based Waiver Services Program	C-1
Appendix D: Contact Directory Area Offices for the Agency for Health Care Administration	D-1
Appendix E: Contact Directory District Offices for the Department of Children and Families, Developmental Disabilities	E-1
Appendix F: Recipient Wait List	F-1

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## Reimbursement Information

### Introduction

Medicaid reimburses home and community-based waiver procedure codes based on the Healthcare Common Procedure Coding System (HCPCS) codes. The codes are part of the standard code set described in HCPCS Level I Expert codebook. Please refer to the HCPCS Level I Expert codebook for complete descriptions of the standard codes. The HCPCS Level I Expert codebook is copyright 2002 by Ingenix, Inc. All rights reserved.

Effective October 16, 2003, in compliance with the federal requirements found in the Health Insurance Portability and Accountability Act (HIPAA), Florida Medicaid will process claims for only the standard procedure code sets allowed in the federal legislation.

All previously used "W" or local procedure codes will no longer be processed by the Florida Medicaid claims processing system for Medicaid payment for dates of service on or after October 16, 2003. For dates of service prior to October 16, 2003, the provider must use procedure codes that were payable at that time. Please refer to Appendix A of this handbook for the valid codes for Florida Medicaid services effective October 16, 2003.

Note: See Appendix A Procedure Codes and Maximum Units of Service for "W" Code information.

### Billing Procedures

Each provider is required to submit all claims (paper or electronic) for DD/HCBS waiver services directly to Medicaid's fiscal agent. 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 at the following Florida Medicaid website address:  
[www.fdhc.state.fl.us/Medicaid/dev\\_serv/index.shtml](http://www.fdhc.state.fl.us/Medicaid/dev_serv/index.shtml).

The Medicaid fiscal agent provides direct billing training for providers of DD Waiver services. The Medicaid fiscal agent may be contacted at 1-800-829-0218 to request this training.

**Reimbursement Information**, continued

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**Direct Provider Billing**

This is a standard billing process for Developmental Disabilities Home and Community-Based (DD/HCBS) Medicaid Waiver service providers that will replace the current system of submitting claims to waiver support coordinators for processing. As of March 3, 2003, the ABC system is no longer used for submission of claims for DD/HCBS services rendered. All claims for DD/HCBS services will be submitted either by mail, using the 081 claim form, or electronically using the WINASAP2000 software, directly to the Medicaid fiscal agent.

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**DD Waiver Service Rates**

Effective March 3, 2003, direct billing was implemented for all DD waiver providers. Effective July 1, 2003, all rates are determined by the operating agency, which is the Department of Children and Families Developmental Disabilities Program Office, based on the Home and Community-Based Services Waiver Final Published Rate structure, and subject to the availability of appropriated funding from the Florida Legislature.

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**Consolidated Billing**

Through March 2, 2003, providers of services paid by the day, shall combine each day's service into a monthly bill and submit it at the end of the month for payment, using the last day of the month as the date of service. 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. Payment shall not be requested or made for any day the recipient is absent from the service.

Transportation providers that are paid by the trip may combine all services during a month and bill at the end of the month, using the last day of the month as the date of service and the actual number of trips as the unit of service. However, the provider shall still maintain the trip log documenting the recipients transported, specific dates and destinations. If services terminate before the end of the month, providers that are paid by the trip may combine all services during a service period and bill at the end of the service period, using the last day of the service period as the date of service.

Transportation providers that are paid by the mile are paid for each date of service and shall prepare their bills accordingly. Providers that bill by the mile may also compile their mileage and bill once a month. When two or more recipients are transported at the same time, the provider must divide the cost among the recipients being transported. The trip log will document the recipient's name(s), date of service, destination and actual mileage. The provider shall submit documentation of actual mileage billed.

Transportation providers that are reimbursed actual expenses by the month shall bill at the end of the month, using the last day of the month as the date of service. If services terminate before the end of the month, providers that are paid by the month shall calculate each day's service and bill at the end of the service period, using the last day of the service period as the date of service. Actual cost per recipient cannot exceed \$721 per month.

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**Reimbursement Information**, continued

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**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 Florida Medicaid Developmental Disabilities Waiver Services Agreement with attached Core Assurances. 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 may result in a recoupment of funds by the Department of Children and Families (DCF) or the Agency for Health Care Administration (AHCA).

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.

1. An amount equal to the daily rate, or a pro-rated daily portion of a monthly rate shall be paid back to the Department by the provider for each day that the daily service log or progress note 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.
2. An amount equal to a monthly rate shall be paid back to the Department for each month that a monthly summary was not available describing the recipient's progress for the month 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.

1. An amount equal to the daily rate, or a pro-rated daily portion of each monthly rate shall be paid back to the Department 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 District for approval.
2. An amount equal to the monthly rate shall be paid back to the Department 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 Appendices B and C and Chapter's 1 and 2 for additional information and requirements pertaining to waiver support coordination as well as other services.

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**Reimbursement Information**, continued

**Limitations**

Providers may not bill for service when a recipient is not in attendance. 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.

**Timely Submission of Claims**

Through March 2, 2003, all invoices for DD/HCBS waiver services were submitted through Developmental Disabilities Allocation, Budget and Contract Control System (ABC) in a timely manner.

Effective with claims submitted on March 3, 2003, all claims for reimbursement of DD/HCBS services must be submitted to the Medicaid fiscal agent, regardless of the date of service. Claims must be submitted to the fiscal agent within 12 months of the date of service provision. From March 3, 2003, forward, any problems with claim submission can be corrected and the claim resubmitted to the Medicaid fiscal agent, prior to the 12-month deadline.

All claims shall be correct, complete, legible and in accordance with the approved service authorization. All claim adjustment requests must be filed on the "081" paper claim form or electronically through the WINASAP, software after March 3, 2003. Adjustments must be received by Medicaid's fiscal agent within twelve months from the date of service provision.

Medicaid's fiscal agent must receive all requests for payment within 12 months of service provision or the provider will not be paid for the service. It is the provider's responsibility to track waiver receivables. Failure to track claims, may result in non-payment for services.

Any problem with the receipt of payment for an authorized service must be evaluated and resolved within 12 months of the service provision.

For further instructions on claims submission, adjustments, and exceptions to the 12-month filing rule, consult the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081 available from the Medicaid fiscal agent.

Detailed information on recipient eligibility, service reimbursement or service limitations may be found in the Florida Medicaid Provider General Handbook, the Coverage and Limitations handbooks and the Provider Reimbursement handbooks, which are available from the Medicaid fiscal agent or on the fiscal agent's website at <http://floridamedicaid.acs-inc.com>. For additional information about Florida's Medicaid program, log on to the AHCA website at [www.fdhc.state.fl.us/Medicaid](http://www.fdhc.state.fl.us/Medicaid). A complete training package on direct provider billing is available at the following website: [www.fdhc.state.fl.us/Medicaid/dev\\_serv/index](http://www.fdhc.state.fl.us/Medicaid/dev_serv/index).

**Note:** Refer to Appendices A for rate methodology information, D and E for contact information.

**Reimbursement Information**, continued

**Correspondence  
Regarding Claims**

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Any time there is a change of address or bank account, it is the provider's responsibility to notify Medicaid's fiscal agent and the District Office, otherwise payment may be delayed. Any time correspondence is returned to Medicaid's fiscal agent, the processing of future claims ceases. It is critical that both Medicaid's fiscal agent and the District Office are notified of any change. Any correspondence from Medicaid or Medicaid's fiscal agent requesting information or clarification from the provider requires a prompt response.

It is best to maintain a copy of all correspondence and a return receipt for any information requested or sent by certified mail. If Medicaid or Medicaid's fiscal agent does not receive the information sent, you will have documentation of your response, which will facilitate correction at a later date.

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**Procedure Codes**

Effective October 16, 2003, in compliance with the federal requirements found in the Health Insurance Portability and Accountability Act (HIPAA), Florida Medicaid will process claims for only the standard procedure code sets allowed by the federal legislation.

All previously used "W" or local procedure codes will no longer be processed by the Florida Medicaid claims processing system for Medicaid payment for dates of service on or after October 16, 2003. For dates of service prior to October 16, 2003, the provider must use the "W" or local procedure codes that were payable at that time, which may be submitted either electronically or on a paper claim form. Please refer to Appendix A of this handbook for the valid codes, effective October 16, 2003.

The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) codes. 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 2002 by the American Medical Association. All rights reserved.

Note: Refer to Appendix A procedure code table and maximum units of service for "W" code information.

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**Procedure Codes  
and Maximum Units  
of Service**

Each procedure code found in Appendix A, Procedure Codes and Maximum Units of Service, corresponds to a service described in Chapter 2 of this handbook. The table gives the description of the service, waiver "W" procedure code, standard procedure code, modifiers, units of service, and maximum limits.

Note: See Appendix A for additional information.

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Developmental Disabilities Waiver Services Coverage and Limitations Handbook

**APPENDIX A  
PROCEDURE CODES, MAXIMUM UNITS OF SERVICE**

DESCRIPTION OF SERVICE	CURRENT CODE	MODIFIER 1	MODIFIER 2	PRE – HIPAA CODE	UNIT OF SERVICE	MAXIMUM LIMITS
Adult Day Training	S5102	U6		W9535	Quarter hour	240 days per year, up to 5 days per week, 24 units per day
Adult Dental Services	D0160	U6		W9561	Procedure	10 per day
Behavior Assessment	H2020	U6		W9545	Assessment	1 per year
Behavior Assistant Services	H2019	U6	HM	W9568	Quarter hour	64 units per day
Behavior Therapy – Bachelors Degree	H2019	U6	HN	W9530	Quarter hour	16 units per day
Behavior Therapy – Masters Degree	H2019	U6	HO	NONE	Quarter hour	16 units per day
Behavior Therapy – Doctorate Degree	H2019	U6	HP	NONE	Quarter hour	16 units per day
Chore Services	S5120	U6		W9547	Quarter hour	16 units per day
Companion Services	S5135	U6		W9548	Quarter hour	40 units per day
Consumable Medical Supplies	S5199	U6		W9537	Each	10 units per day
Dietitian Services	97802	U6		W9562	Quarter hour	12 units per day
Durable Medical Equipment	E1399	U6		W9536	Item	5 per day
Environmental Accessibility Adaptations	S5165	U6		W9549	Each	5 per day
Environmental Accessibility Assessment	S5165	U6	SC	W9549	Assessment	1 per year
Homemaker Services	S5130	U6		W9550	Quarter hour	40 units per day
In-Home Support Services	97537	U6		W9513	Quarter hour	32 units per day
In-Home Support Services	97537	U6	SC	W9513	Day	365 days per year
Medication Review	99499	U6		W9749	Review	2 reviews per year
Non-Residential Support Services	H2015	U6		W9551	Quarter hour	28 units per day, up to 5 days per week
Occupational Therapy Assessment	97003	U6		W9539	Assessment	1 per year
Occupational Therapy	97530	U6		W9531	Quarter hour	8 units per day
Personal Care Assistance	T1019	U6		W9538	Quarter hour	96 units per day
Personal Emergency Response Installation and Testing	S5160	U6		W9594	Unit	1 per year
Personal Emergency Response - Service	S5161	U6		W9553	Month	12 months per year
Physical Therapy – Assessment	97001	U6		W9540	Assessment	1 per year
Physical Therapy	97110	U6		W9529	Quarter hour	8 units per day
Private Duty Nursing	T1000	U6		W9554	Quarter hour	96 units per day

Developmental Disabilities Waiver Services Coverage and Limitations Handbook

**APPENDIX A  
PROCEDURE CODES, MAXIMUM UNITS OF SERVICE**

DESCRIPTION OF SERVICE	CURRENT CODE	MODIFIER 1	MODIFIER 2	PRE - HIPAA CODE	UNIT OF SERVICE	MAXIMUM LIMITS
Psychological Assessment	H0031	U6	SC	W9541	Assessment	1 per year
Residential Habilitation Services	H0043	U6	SC	W9533	Day	350 days per year
Residential Habilitation Services	H0043	U6		W9512	Quarter hour	32 units per day
Residential Nursing Services	T1001	U6		W9560	Quarter hour	96 units per day
Respiratory Therapy - Assessment	S5180	U6		W9564	Assessment	2 per year
Respiratory Therapy	S5181	U6		W9563	Quarter hour	8 units per day
Respite Care	S5151	U6		W9527	Quarter hour	96 units per day
Respite Care	S5151	U6	SC	W9528	Day	30 days per year
Skilled Nursing - RN	T1001	U6	HN	W9555	Quarter hour	32 units per day
Skilled Nursing - LPN	T1001	U6	HM	W9556	Quarter hour	32 units per day
Special Medical Home Care	S9122	U6		W9557	Day	Refer to chapter 2, SMHC
Specialized Mental Health Services Assessment	H0031	U6		W9569	Assessment	1 per year
Specialized Mental Health Services Therapy	H0046	U6		W9570	Quarter hour	8 units per day
Speech Therapy - Assessment	92506	U6		W9542	Assessment	1 per year
Speech Therapy	92507	U6		W9532	Quarter hour	8 units per day
Support Coordination	G9012	U6		W9588	Month	12 units per year
Support Coordination - Transitional	G9012	U6	SC	W9571	Month	3 months per year
Supported Employment *	H2023	U6		W9565	Quarter hour	32 units per day not to exceed 160 units per week
Supported Living Coaching	97535	U6		W9558	Quarter hour	40 units per day
Therapeutic Massage – Assessment	97124	U6	SC	W9567	Assessment	2 per year
Therapeutic Massage	97124	U6		W9566	Quarter hour	4 units per day
Transportation – Mile	A0425	U6		W9526	Mile	200 per day
Transportation – Trip	T2003	U6		W9522	Trip	4 one-way trips per day
Transportation – Month	T2002	U6		W9559	Month	Actual expenses
* January 1, 2004, this code changed from H2024U6 to H2023U6						

## **APPENDIX A**

### **RATE METHODOLOGY**

#### ***Rate Setting Methodology***

The following section describes key aspects of the Developmental Disabilities (DD) Home and Community Based Services (HCBS) rate reimbursement structure. Specifically, the cost items for each rate component are listed, agency and independent contract status is defined, and the rate structure for various services is described.

Mercer Incorporated calculated provider reimbursement rates for all HCBS programs, with the exception of the following service categories:

- Physical therapy
- Occupational therapy
- Speech therapy
- Respiratory therapy
- Behavioral analysis services assessment
- Physical therapy assessment
- Occupational therapy assessment
- Speech therapy assessment
- Psychological assessment
- Respiratory therapy assessment
- Therapeutic massage assessment
- Specialized mental health therapy assessment
- Special medical home care

Rates for these therapy services are referenced to the HCBS Maximum Allowable Rates published by the Florida Developmental Disabilities Program. Rates for assessments are based upon the hourly therapy rates and cannot exceed the HCBS Maximum Allowable Rate.

#### ***RATE COMPONENTS***

The cost centers used in construction of each of the HCBS service categories fall into four components:

1. Direct Care Staff Wage
2. Employment Related Expenditures
3. Program Related Expenditures
4. General and Administrative Expenditures

These cost categories are derived in the following fashion:

**Direct Care Staff Wage:** The Direct care staff wage is selected from national Mercer compensation and wage studies and is determined according to the classification of direct care staff duties. Direct care staff is defined to be those individuals whose primary responsibility is the day-to-day support of people with disabilities, training and instruction, and assistance with and management of activities of daily living. Direct care workers can be either employees of an agency, or may be self-employed, so long as 90% of their work activities include daily supports to people with disabilities. For the purposes of this study, direct care staff job descriptions were benchmarked to six primary job classifications:

- **Homemakers:** Workers who primarily performed housekeeping, cooking, and environmental cleaning duties for people with long-term care needs.
- **Personal Care Workers:** Workers who possessed high school degrees and were able to perform such duties as physical support, lifting, assistance with personal hygiene and activities of daily living, and transportation and mobility support.
- **Habilitation Workers:** Workers who possessed some advanced training beyond high school and were skilled in teaching and training, behavior supports, administration of select health-related treatments, and community inclusion.

## **APPENDIX A**

### **RATE METHODOLOGY**

- Licensed Practical Nurses: Workers who possessed LPN licenses and who had work experience in long-term care.
- Registered Nurses: Workers who possessed RN licenses and who had work experience in long-term care.
- Behavioral Analysts: Workers who were specially trained in behavior management and analysis; education requirements varied from bachelor, masters, and doctoral levels.

Employment Related Expenditures: Employment related expenditures refer to the benefits package that is offered to all employees who are involved in the care and services provided to the person with disabilities. These costs can be categorized into two groups:

1. Discretionary Costs: Discretionary costs are those associated with benefits provided at the discretion of the employer and are not mandated by local, state, or federal governments. Such benefits may include (but are not limited to) health insurance, profit sharing, and retirement benefits or stock options.
2. Non-Discretionary: Non-discretionary costs are those related to employment expenditures that are mandated by local, State, and Federal governments and are not optional to the employer. Such expenditures include (but are not limited to) FICA, FUTA, SUTA and Workers' Compensation Insurance. Employee-related expenses vary for people who are self-employed and agency employees. Employer agencies bear the financial responsibility for workers' compensation, while self-employed workers are required to pay all federal income taxes.

Program Related Expenditures: Program related expenditures are those that are part of the operation of the setting in which residential habilitation occurs and related to the programs which occur within the setting, but are not directly tied to the direct care staff. They include the following:

- Program Support Services such as staff trainers and clinical supervisors;
- Supervision of Direct Care Staff;
- Qualified Mental Retardation Professionals, Registered Records Technicians;
- Program related supplies;
- Social Services involving family counseling, estate and guardianship support;
- Evening Activities including recreation and community-inclusion opportunities; and
- Program Associated Transportation.

General and Administrative Costs: General and Administrative costs are those associated with operating the organization's business and administration and are not directly related to the clients or the programs that serve the clients. They include the following:

- Administrative Salaries to include agency director and secretarial support;
- Professional Services to include management of payroll and accounts receivable;
- Insurance to include liability;
- Travel and Entertainment not related to direct care activities;
- Office Expenses such as supplies, equipment, and telephone;
- Program Development and fund raising;
- Occupational and Health Safety costs;
- Depreciation and Amortization on capital assets;
- Interest on Capital Debt;
- Real Estate Taxes;
- Property Insurance; and
- Other Interests, Miscellaneous, Equipment Rental.

General and administrative expenses are calculated as a percentage of the total costs of direct care, employee related expenses, and program-related expenses. The percentage is not multiplied by the

## **APPENDIX A**

### **RATE METHODOLOGY**

direct care staff hourly wage totals as is done for employment related expenditures and program related expenditures, but rather is considered a percentage of the total costs. General and administrative costs are calculated by adding the other components together; direct care staff costs, employment related expenditures and program related expenditures, and then dividing that total by the factor calculated as the number one minus the general and administrative expense percentage. The product of this calculation represents the total of these four cost categories, direct care staff, employment related expenses, program related expenses, and general and administrative expenses.

Source Information of Each Component: Each of the four cost components has been individually calculated for each HCBS service category. The four rate component dollar amounts and percentages were taken from the following sources.

1. **Direct Care Staff Wage:** Direct care staff wage was calculated using compensation and wage data from three sources: e.g. Hayes Compensation studies, Health and Hospital compensation studies, and Mercer Human Services consulting wage and benefit surveys. These surveys specifically focused on the state of Florida, states in the southern United States, and states with similar size and program demographics. Data from these surveys were aged forward at a rate of 0.95% per quarter based upon SFY 02 experience of 3.8% per year.
2. **Employment Related Expenditures:** Employment related expenditures were calculated using current federal and state tax requirements, workers' compensation history, and health benefits data from the Atlanta and Tampa Mercer offices. Employment related expenditures are expressed as a percentage, which is applied to (added to) the direct care staff wage.
3. **Program Related Expenditures:** Program related expenditures were calculated based upon a cost survey of sample agencies conducted by Mercer for the purpose of this study. Findings from the cost survey provided the basis for determining the program-related factor. Program related expenditures are expressed as a percentage, which is applied to (added to) the total cost of care.
4. **General and Administrative Expenditures:** General and administrative expenditure levels are set at a percentage rate that is considered acceptable to the state of Florida, Department of Children and Families (DCF). General and administrative expenditures are expressed as a percentage that is applied to (added to) the total cost of care.

#### ***GEOGRAPHICAL FACTORS***

Mercer developed geographical factors based upon Mercer's survey of a sample of provider costs, audited financial reports, and a market analysis of the following Bureau of Labor statistics:

- Wages and Compensation practices
- Housing rent and lease costs
- Uninsured workers
- Crime statistics
- Cost of Living indices

Based upon this analysis, Mercer factored a 12% adjustment for providers who delivered services in the US Department of Census Metropolitan Areas (MSA) of Fort Lauderdale, Palm Beach, Miami, and the Florida Keys.



## APPENDIX B

### Medicaid Waiver Service Agreement



#### DEVELOPMENTAL DISABILITIES PROGRAM

## MEDICAID WAIVER SERVICES AGREEMENT

### GENERAL TERMS AND CONDITIONS

Provider agrees to provide (list enrolled services) under the Florida Medicaid Developmental Disabilities Home and Community-Based Waiver Program to eligible recipients.

#### I. AGREEMENT DOCUMENTS

A. The Medicaid Waiver Services Agreement consists of the General Terms and Conditions and the following documents:

Core Assurances

Rate Structure documents

The Developmental Disabilities Waiver Services Coverage and Limitations Handbook, listing requirements for specific services, including rate methodology information, is incorporated into this Agreement, by reference.

B. Prior to providing any services the provider must, in order to be compensated by the Developmental Disabilities Home and Community-Based Waiver Program, execute a Medicaid Provider Agreement with the Agency for Health Care Administration (Agency), and be issued a Medicaid provider number by the Agency. The provider must at all times maintain a current and valid Medicaid Provider Agreement with the Agency. The provider must 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 the Agreement documents attached and those contained in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook for specific services rendered by the provider.

#### A. Department Monitoring, Audits, Inspections, and Investigations

1. To permit persons duly authorized by the Department or the Agency for Health Care Administration, or agents of either, to monitor, audit, investigate and inspect 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 contract, and to interview any recipients receiving services and employees of the provider to assure the Department of the satisfactory performance of the terms and conditions of this contract.
2. Following such evaluation, the Department or its authorized representative will furnish to the provider a written report of its findings and request for development, by the provider, of a Quality Improvement Plan (QIP) for needed corrections. The provider hereby agrees to correct all noted deficiencies identified by the Department, Agency 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.
3. Upon demand, at no additional cost to the Agency or the Department, or an authorized agent of either, the provider will facilitate the duplication and transfer of any records or documents (including electronic storage media), during the required retention period of five years after termination of the Agreement, or if an 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 which may be based on the terms of this Agreement, at no additional cost to the Department.

4. To comply and cooperate immediately with Departmental requests for information, records, reports, and documents deemed necessary to establish methods 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 Chapters 775.082-083, 775.044, F.S.
5. To comply and cooperate immediately with any inspections by the Department of Children and Families, reviews, investigations or audits deemed necessary by the Office of the Inspector General (Section 20.055, F.S.).
6. To include the aforementioned audit, inspections, investigations and record keeping requirements in all subcontracts and assignments.

#### **B. Indemnification**

1. To be liable for and indemnify, defend, and hold the Department, Agency 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, or employees during the performance or operation of this contract or any subsequent modifications thereof, whether direct or indirect, and whether to any person or tangible or intangible property.
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 seven days after notice by the Department 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 the Department. The Department's failure to notify the provider of a claim shall not release the provider of these duties. The provider shall not be liable for negligence, which is solely that of the Department.

#### **C. Insurance**

To obtain and maintain at all times liability insurance coverage, as required by state or federal law or by this Agreement.

#### **D. 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 Non-Institutional 081. Federal regulations, 42 CFR 433.312, require refund of overpayments within 60 days of discovery. The Agency will be the final authority regarding the timeliness of the reimbursement process.

### **III. TERMINATION**

**A.** This Agreement may be terminated by either party without cause, upon no less than thirty 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 non-performance or misconduct upon no less than twenty-four 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 the Department determines that the provider is not performing in accordance with any term or condition in this agreement, the Department may, at its exclusive option, allow the provider a period of time to achieve compliance. The provisions herein do not limit the Department'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, rules, and regulations of the State of Florida, and any applicable federal laws, rules, and regulations.

**V. RENEGOTIATION OR MODIFICATION**

Modifications of the provisions of this Agreement shall be valid only when reduced to writing and duly signed by both parties with the same formality as this document.

**VI. AGREEMENT DURATION**

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

**VII. INDEPENDENT STATUS**

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

**VIII. OFFICIAL REPRESENTATIVES (Names, Addresses, and Telephone Numbers):**

- 1. The name and telephone number of the provider's contact person and street address where financial and administrative records are maintained is:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 2. The name, address, and telephone number of the representative of the provider responsible for administration of the service(s) under this Agreement is:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 3. The name, address, and telephone number of the department's contact person for this Agreement is:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

**IX. INTEGRATED AGREEMENT**

Only these General Terms and Conditions, the Core Assurances, attachment as referenced, the Medicaid Provider Agreement and the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, which is 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 attachments, and document as referenced, listed in Section 1, A., the service-specific requirements for enrolled providers, contained in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, 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,  
DEPARTMENT OF CHILDREN AND FAMILIES

SIGNED

BY:

NAME:

\_\_\_\_\_

TITLE:

\_\_\_\_\_

\_\_\_\_\_

DATE:

\_\_\_\_\_

\_\_\_\_\_

SIGNED

BY:

NAME:

\_\_\_\_\_

TITLE:

\_\_\_\_\_

\_\_\_\_\_

DATE:

\_\_\_\_\_

\_\_\_\_\_

Example  
For Review Only

## APPENDIX C

### Core Assurances for Providers of Developmental Disabilities Home and Community-Based Waiver Services Program

Chapter 393, Florida Statutes, charges the Department of Children and Families (Department/DCF) with providing the services, particularly community-based services, to ensure the well being and improve the quality of life of recipients with developmental disabilities. Section 393.066, Florida Statutes, specifically directs the Department to purchase these services through contracts with private businesses, not-for-profit corporations, units of local government and other organizations capable of providing the services in a cost-beneficial manner. The Department, as the operating agency and the Agency for Health Care Administration (Agency/AHCA) the single state Medicaid agency, has agreed to jointly purchase necessary services for recipients with developmental disabilities through the Developmental Disabilities Home and Community-Based Services Waiver. This waiver is a federally approved Medicaid waiver services program, authorized by Title XIX of the Social Security Act. The Department and AHCA are required to establish contractual performance standards for all contracted recipient services and service provision quality in the delivery of contracted Medicaid waiver services. The Department expressly requires that the contractual performance standards assure financial integrity.

These Core Assurances and the specific service requirements published in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, incorporated into this Agreement by reference, provides the terms and conditions by which the provider of waiver services to recipients with developmental disabilities served by the Department agree to be bound. Breach of the terms and conditions set forth in these Assurances shall be considered indicative of the provider's failure to comply with the terms and conditions set forth in this document and the Developmental Disabilities Program Medicaid Waiver Services Agreement.

#### Programmatic Definition of Terms

**Agency or AHCA** means the Agency for Health Care Administration.

**Agency or Group Provider** means 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). All employees of an agency or group provider must meet the qualifications and requirements specified in this Agreement and those specified for enrolled service(s). The provider shall maintain a personnel file, documenting qualifications of all employees and their background screening results.

**Central Record or Provider File of a Recipient** means a file (or a series of continuation files) kept by the provider. The provider file maintained by the support coordinator is designated as the recipient's Central Record. These files contain the following documentation that must be recorded, stored and made available for monitoring and review: (1) recipient's demographic data including emergency contact information, parental or guardian contact data, permission forms, results of assessments and evaluations, and medical and medication information; (2) legal data such as guardianship papers, court orders and release forms; (3) service delivery information including the current support plan, cost plan or written authorization of services, and implementation plans; and, (4) service delivery documentation in the form of progress reports or as specified in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, that are related to the service and support activities identified in the recipient's implementation plan.

**Community Integrated Settings** means those local, non-segregated, settings for recipients with developmental disabilities, which possess the following characteristics: (1) generic local community resources, utilized by other people without disabilities; and (2) settings which promote direct personal interaction with others, with or without developmental disabilities.

**Core Assurances** means the document that specifies administrative and programmatic requirements for the Developmental Disabilities Home and Community-Based Services Waiver and Developmental Disability Program waiver(s) providers.

**Cost-Beneficial** means economical in terms of the goods or services received and the money spent.

**Cost Plan** is the form used by the waiver support coordinator listing all services requested by the recipient on the support plan, regardless of funding source, and the anticipated cost of each waiver service and approval. The District Office must approve the cost plan prior to service provision. Each time a recipient's support plan is amended to increase or add services the cost plan too must be amended and approved, in order for the service to be initiated. A support plan and cost plan must be updated for each recipient enrolled in the waiver at least annually, during the annual support planning process to reflect current needs and situations. Department approved cost plan forms are available from the District Office.

**Cost Plan Year** means the 365 or 366 days that correspond to the span of time, covered by the recipient's support plan.

**Department** means the Department of Children and Families (DCF), which includes the Developmental Disabilities Program Office (Central Office), located in Tallahassee, and the Developmental Disabilities District or Regional Offices (District), located throughout the state.

**Developmental Disabilities Waiver Services Coverage and Limitations Handbook** is a rule promulgated by the Agency for Health Care Administration (AHCA), used by waiver providers as a reference guide. The handbook lists all waiver services offered under the Developmental Disabilities Home and Community-Based Services Waiver. Provider qualifications and training requirements, projected service outcomes, service descriptions, service limitations, documentation requirements, place of service and special considerations are included in this document. The handbook also contains procedure codes and maximum units of service used for billing, rate structure methodology, an example of the Waiver services agreement, the core assurances, contact directories for AHCA area and DCF district offices, an example of recipient application and eligibility determination and wait list information. Compliance with handbook requirements will assure the provider is delivering successful waiver services while meeting program guidelines established by state and federal authorities.

**District or Region** means a service district or region of the Florida Department of Children and Families.

The current **Department Approved Assessment**, entitled Individual Cost Guidelines (ICG), is a tool designed to determine the recipients' resource allocations of waiver(s) funds for recipients receiving supports from the State of Florida, Department of Children and Families, Developmental Disabilities Program (DDP). The ICG is a validated tool that provides a rational basis for the allocation of the waiver funds to individuals with developmental disabilities. Waiver funds are funds allocated through the Developmental Disabilities HCBS Waiver, the Supported Living Waiver, and the Consumer-Directed Care Plus Waiver (CDC+). The instruction for the completion of this assessment is provided by the Department and is completed at least every three years or as determined necessary by the recipient and the waiver support coordinator, due to changing needs of the recipients.

**Implementation Plan** is an individualized document, developed by the provider with direction from the recipient that specifies how the recipient will be assisted by the provider(s) to achieve or maintain specific support plan goal(s). This plan also includes any training objective(s) to be met by the recipient. At a minimum, the plan will include the actions and tasks (strategies) to be employed by the provider to achieve the recipient's identified goal(s) or objectives. The system of data assessment used for measuring the progress of programs and services, is the Developmental Disabilities Waiver Services Coverage and Limitations Handbook for implementation plan adding more detailed requirements regarding specific services.

**Recipient(s)** is any person receiving services through the Developmental Disabilities Home and Community-Based Services Waiver.

**Medicaid Home and Community-Based Services Waiver Programs** means federally approved Medicaid programs, authorized by Title XIX of the Social Security Act, for the Developmental Disabilities Home and Community-Based Services Waiver (DD/HCBS). Chapter 393, F.S., specifies Medicaid funded services for an enrolled recipient.

**Medicaid Provider Agreement** is 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.

**Medicaid Waiver Services Agreement** is the contractual agreement between the Developmental Disabilities Program and providers of waiver services that consists of the Medicaid Waiver Services Agreement (form CF-DD 3064), and the Core Assurances for providers of Medicaid Home and Community-Based Waiver Services Programs, and Rate Structure documents. Specific service requirements, as defined in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, including rate methodology information, are incorporated into the Agreement by reference. All providers must complete and submit this agreement to the Department for its approval, before providing services to recipients enrolled in the Developmental Disabilities Home and Community-Based Services Waiver.

**Medical Necessity or Medically Necessary** means a set of conditions established by the Agency for Health Care Administration (AHCA) in section 59G-1.010(166)(a)(c), F.A.C., and Chapter 393, F.S., for determining the need for and appropriateness of Medicaid funded services for an enrolled recipient.

**Monitoring** is a review by the Department, the Agency for Health Care Administration, or an authorized agent of either, of the provider's administrative and programmatic service delivery systems.

**Non-Reimbursed Transportation** means any transportation that is provided as a component to one or more primary waiver service(s) for recipients on the waiver. This transportation service is not reimbursed separately from the primary waiver service.

**Person-Centered** is an approach, developed from the recipient's perspective rather than that of the program or resource, used to provide the services and supports necessary to meet the recipient's needs.

**Personal Outcome** means the major expectation(s) that a recipient has during his life. The recipient's expectations for the services and supports he receives are defined by these outcomes, which may also be referred to as their personal goals.

**Personal Outcome Process** is the process used, with the recipient, to assess how to obtain the outcomes he considers most important in his life. This process includes getting to know the recipient and the significant people in his life, determining the presence or absence of personal outcomes, and the supports necessary to achieve the outcomes desired. The process may also involve record review, on-site visits to service providers and additional interviews with the provider's staff. All providers are expected to assist in the outcome process. With the use of the personal outcome measures tool and the information gathered during the personal outcome process, the waiver support coordinator is responsible for compiling and reporting information and planning for needed supports and services.

**Provider** means an individual, group or agency vendor that is also an approved Medicaid waiver provider which has entered into a contractual agreement with the Department, that is eligible to provide one or more of the DD/HCBS waiver services listed in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook.

**Provider Self-Assessment** is an evaluation completed by the provider reviewing its organizational capabilities for meeting the recipient's outcomes or goals and the service requirements identified in the Medicaid Waiver Services Agreement, the Services Waiver Services Coverage and Limitations Handbook. This self-assessment also reviews the provider's policies and procedures by identifying the extent to which

they are consistent with their daily practices and the objectives stated in the Medicaid Waiver Service Agreement.

**Quality Improvement Plan** means a plan of proposed, corrective actions developed by the provider that address the improvements needed for services cited below standard by the Department or its authorized agent. Those providers deemed non-compliant with these Assurances and requirements found in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, will submit written Quality Improvement Plans (QIPs) as required in their written monitoring report. The provider may also develop a Quality Improvement Plan, addressing needed program improvements identified through a self-assessment.

**Reportable Events** are any of the following events, which must be reported to the District:

- a. **Altercation:** A physical confrontation occurring between a recipient and employee or two or more recipient's at the time services are being rendered, or when a recipient is in the physical custody of the Department, which results in one or more recipient's or employees receiving medical treatment by a licensed health care professional.
- b. **Recipient Death:** A person whose life ends due to or allegedly due to an accident, act of abuse, neglect or other incident occurring while in the presence of an employee, in a Department of Children and Families operated or contracted facility or service center; while in the physical custody of the Department; or when a death review is required.
- c. **Recipient Injury or Illness:** A medical condition of a recipient requiring medical treatment by a licensed health care professional sustained or allegedly sustained due to an accident, act of abuse, neglect or other incident occurring while in the presence of an employee, in a Department of Children and Families or contracted facility or service center, or who is in the physical custody of the Department.
- d. **Elopement:** The unauthorized absence beyond eight hours, or other time frames as defined by a specific program operating procedure or manual, of a child or adult who is in the physical custody of the Department.
- e. **Escape:** The unauthorized absence as defined by statute, departmental operating procedure or manual, of a recipient committed to, or securely detained in, a Department of Children and Families mental health or Developmental Disabilities forensic facility authorized by Chapters 393, 394 or 916, F.S.
- f. **Other Incident:** An unusual occurrence or circumstance initiated by something other than natural causes or out of the ordinary such as a tornado, kidnapping, riot or hostage situation, which jeopardizes the health, safety and welfare of recipient's who are in the physical custody of the Department.
- g. **Sexual Battery:** An allegation of sexual battery by a recipient on a recipient, employee on a recipient, or recipient on an employee as indicated by medical evidence or law enforcement involvement.
- h. **Suicide Attempt:** An act which clearly reflects the physical attempt by a recipient to cause his own death while in the physical custody of the Department or a Departmental contracted or certified provider and which results in bodily injury requiring medical treatment by a licensed health care professional.

These reporting procedures do not replace the abuse, neglect and exploitation reporting system. Regardless of their status as an event in recipient risk prevention, allegations of abuse, neglect or exploitation must always be reported immediately to the Florida Abuse Hotline and appropriate district human rights advocacy committees as required by law. TTY access is gained by dialing 1-800-96ABUSE. Access by others is gained by dialing 1-800-453-5145.

## Zero Tolerance

- a. **Penalties for Sexual Abuse:** Confirmed cases of sexual abuse by service providers will result in immediate termination of the waiver enrollment status of the individual who committed the abuse as well as the imposition of legal penalties. If it is determined that administrators, owners, or operators of a provider agency are considered to be culpable for the abuse through negligence or failure to report the incident(s), their waiver enrollment status will be terminated. Criminal and administrative penalties will be pursued.
- b. **Mandatory Reporting Requirements:** A person with knowledge of, or having reasonable cause to suspect that a child is being sexually abused by a parent, legal custodian, caregiver, or other person responsible for the child's welfare, as defined in Section 39.201, F.S., is required to report such knowledge or suspicion to the Department's Central Abuse Hotline at 1-800-96-ABUSE (1-800-962-2873).

Pursuant to Section 415.1034, F.S., any service provider with knowledge of, or having reasonable cause to suspect that a vulnerable adult has been or is being abused, neglected or exploited shall immediately report such knowledge or suspicion to the Department's Central Abuse Hotline at 1-800-96-ABUSE (1-800-962-2873).

Failure to report known or suspected cases of sexual abuse represents an offense that will be cause for termination of waiver enrollment status. Criminal and administrative penalties will be pursued.

- c. **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 District or Regional Developmental Disabilities Program Office to ensure the continued health and safety of the individuals involved.

**Retail Outlet** means any provider that derives fifty percent or more of its revenue from the sale of goods to the general public and not engaged in any business that is specifically targeting recipient's receiving waiver services. Retail outlets are certified only for the purpose of delivering commodities.

**Solo Provider** is an eligible provider who personally renders waiver services directly to recipients and does not employ others to render waiver services.

**Support Coordination** is the service of advocating, identifying, developing, coordinating and accessing supports and services on behalf of a recipient, or assisting the recipient or family to access supports and services on their own. These services may be provided through waiver and Medicaid State Plan services, as well as other needed medical, social, educational and other appropriate services, regardless of the funding source through which access is gained.

**Support Plan** is an individualized plan of supports and services designed to meet the needs of an enrolled recipient. This plan is based upon the preferences, interests, talents, attributes and needs of a recipient. The recipient or parent, legal guardian advocate, as appropriate, shall be consulted in the development of the plan and shall receive a copy of the plan and any revisions made to the plan. Each plan shall include the most appropriate, least restrictive, and most cost-beneficial environment for accomplishment of the objectives and a specification of all services authorized. The plan shall include provisions for the most appropriate level of care for the recipient. The ultimate goal of each plan, whenever possible, shall be to enable the recipient to live a dignified life in the least restrictive setting, appropriate to the recipient's needs. The support plan must be completed according to the instructions provided by the Department.

**Valued Social Roles** means those activities that are recognized by the general public, defining the recipient in the context of their relationships with others. Typical valued social roles include but are not

limited to: co-worker, employee, neighbor, volunteer, student, friend, family member, athlete, theatergoer, church member, taxpayer, citizen, etc.

**Waiver Support Coordinator** is an enrolled waiver provider of support coordination services that is selected by the recipient enrolled in the waiver (or guardian) to assist recipient's who receive waiver services in gaining access to needed waiver and Medicaid State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Each support coordinator must enroll as a provider, whether a solo or individual provider or employed by an agency or group provider.

## **THE ASSURANCES**

The provider assures compliance with the following stipulations:

### **1.0 COMPLIANCE WITH LAWS AND REGULATIONS**

#### **A. Compliance with State Law and Regulations**

1. The provider will comply with state statutes and rules of the operating agency, which is the Department of Children and Families, including Chapters 393 and 409, F.S., Chapters 65B-4, 65B-8, 65B-11, and 59G-8 F.A.C., 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 recipient's with developmental disabilities, as specified in Chapter 393.13, F.S., "The Bill of Rights of Persons Who Are Developmentally Disabled."

#### **B. Compliance with Federal Laws and Regulation**

1. The provider will comply with 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. The provider will comply with Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 2000e, et seq., in regard to employees or applicants for employment.
3. The provider will comply with the Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age, in programs or activities that receive or benefit from federal financial assistance.
4. The provider will comply with 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 provider will comply with 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 provider will comply with Title 42, Code of Federal Regulations (CFR) 431.51, which states that each recipient served by the provider will be provided freedom of choice within the scope of available funding levels. Freedom of choice includes, but is not limited to:
  - (a) Opportunities for the recipient to select non-waiver funded supports available to the general community from among those activities or experiences that meet the recipient's needs and preferences;

- (b) Opportunities for the recipient to select providers of Medicaid State Plan services from among those providers enrolled in the Medicaid waiver program, and that also meet the recipient's needs and expectations;
- (c) Opportunities for the recipient to select providers of waiver services from those eligible to provide waiver services and enrolled in the Medicaid program, meeting the recipient's needs and expectations;
- (d) Opportunities for the recipient to change providers of supports and services;
- (e) Opportunities for the recipient to work with a provider to identify mutually agreeable times and settings for the provision of supports or services; and
- (f) The opportunity for the recipient to end his participation in the waiver.

## **2.0 PROGRAM REQUIREMENTS**

- A. The provider will not disclose or use any information concerning a recipient who is receiving services under the waiver, without the written consent of the recipient or the recipient's legal guardian, in accordance with Chapter 393.13, F.S., and federal regulations.
- B. In accordance with Chapter 415.1034, F.S., the provider or any employee of the provider who knows, or has reasonable cause to suspect, that a recipient receiving services from Developmental Disabilities is being or has been abused, neglected or exploited, will immediately report such knowledge or suspicion to the central abuse registry and tracking system of the Department, using the statewide toll-free telephone number (1-800-96ABUSE). TTY users call 1-800-453-5145.
- C. The provider understands and agrees that the Department and Medicaid is responsible for the expenditure of all funds appropriated to the Department by the Florida Legislature for recipient's receiving services from Developmental Disabilities and Developmental Disabilities Home and Community-Based Services Waiver Programs. The Department is ultimately responsible for determining the appropriateness or medical necessity of services purchased, in accordance with 59G 1.010 F.A.C., Chapter 393, F.S., and the amount of Developmental Disabilities funds available to purchase services and goods.
- D. The provider agrees, within the mission and scope of the service(s) offered, to safeguard the health, safety and well being of all recipients receiving services from the provider.
- E. The provider agrees, within the mission and scope of the service(s) offered, to assist people in their achievement of personal outcomes in the areas of personal goals, choice, social inclusion, relationships, rights, dignity and respect, health, environment, security and satisfaction.
- F. The provider agrees to participate in and support the personal outcome process for each recipient. The provider will also use the recommendations from the person-centered review report that is part of the statewide quality assurance system to: (1) implement person-centered supports and services; (2) enhance service delivery in a manner that supports the achievement of personal outcomes; and (3) make improvements in the provider's service delivery system.
- G. The provider agrees, with the recipient's permission, to participate in the discussion of the recipient's record, the recipient's progress, the extent to which the recipient'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 the Department or its authorized representatives, other service providers, the recipient, the guardian, family and friends.

- H. The provider agrees, with the recipient's permission, to provide information about the recipient to assist in the development of the support plan, and to attend the support planning meeting when invited by the recipient, family member or guardian.
- I. The provider agrees to provide the recipient with opportunities for relevant training, achieve his personal goals, and to expand his life experiences within the community through the provision of person-centered supports and services. These services and supports will be provided within the scope, intensity and duration specified on the recipient's support plan and approved cost plan.
- J. It is the responsibility of the Developmental Disabilities Home and Community-Based Services Waiver providers, and employees of waiver providers who furnish non-reimbursed transportation services to recipient's as part of one or more primary waiver service(s) and that are not reimbursed for such transportation, to meet the following requirements. The provider must be able to show, at time of enrollment, proof of a valid driver's license, car registration and insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.
- K. The provider understands and agrees to provide and bill for those services that have been authorized and approved by the District on the recipient's cost plan. The provider agrees not to bill for services until rendered, as authorized.
- L. The provider shall attend training sessions specific to the type of services provided, monthly support coordination district meetings and quarterly provider meetings as scheduled by the District.

## 2.1 Required Training

The provider and its employees will ensure they receive the specific training required to successfully serve each recipient including the following topics:

1. Emphasis on individual choice and rights;
2. The responsibilities of and procedures for maintaining the health, safety, and well being of recipient's served;
3. Recognition of abuse and neglect and required reporting procedures, to include domestic violence and sexual assault;
4. Development and implementation of the required documentation for each waiver service;
5. The Medicaid Waiver Services Agreement and its Attachments. The Developmental Disabilities Waiver Services Coverage and Limitations Handbook and its appendices, and the use of personal outcomes to establish a person-centered approach to service delivery;
6. Other training specific and appropriate to the needs of the recipient's served by the provider and required for specific services listed in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, for which the provider is enrolled and eligible to provide; and
7. All direct service providers are required to complete training in the Department's Direct Care Core Competencies Training, or an equivalent curriculum approved by the Department within 120 days from the effective date of this rule. Said training may be completed using the Department's web-based instruction, self-paced instruction or classroom-led instruction.

The provider shall maintain on file for review, adequate and complete documentation to verify its participation, and the participation of its employees, in the required training sessions. This documentation shall, at a minimum, include the training topic(s), length of training session, date and location of training, name and signature of trainer, name and signature of person(s) in attendance.

## **2.2 Department Notification**

The provider will share responsibility and assist the Department and others in the notification and resolution of the following issues and concerns for, or on behalf of, each recipient served by the provider:

- A. Notifying the District and other providers of issues concerning:
  1. The recipient's continued eligibility for waiver services. Any provider that becomes aware of a recipient's loss of Medicaid benefits shall immediately contact the recipient's waiver support coordinator.
  2. The possibility of losing Medicaid eligibility. Any provider that becomes aware of a recipient's pending loss of Medicaid benefits shall immediately contact the recipient's waiver support coordinator.
  3. Plans to move out of the district or state; and
  4. Plans to discontinue receiving services from the provider, waiver or the Department.
- B. Immediate notification to the District of an emergency or of an unusual occurrence or circumstance. Said notification of an unusual occurrence or circumstance includes, but is not limited to:
  1. Hospitalization of the recipient;
  2. Involvement of law enforcement agencies;
  3. Concerns about abuse, neglect, or exploitation and reporting of abuse, and reportable events; and
  4. Death of a recipient.

## **3.0 ADMINISTRATIVE POLICIES, PROCEDURES, AND PRACTICES**

Pursuant to Section 393.062, Florida Statutes, the Department is charged with ensuring the most cost-beneficial and effective community-based services for recipients with developmental disabilities. In order to accomplish this objective the Department requires that each provider type and those providing the services listed below develop written policies and procedures for the provision of services to recipients under the Medicaid waiver:

- All agency or group providers;
  - Solo practitioners providing the following services: adult day training, non-residential support services, residential habilitation services, support coordination, supported employment, and supported living coaching.
- A. The provider's practices shall be consistent with its written policies and procedures. Revisions to the provider's policies and procedures shall be made in a timely manner if modifications in provider practices deviate from the policies as written.
  - B. The provider's policies shall address, at a minimum, the following:
    1. Procedures on the use of the personal outcome process, and how individual outcome information will be incorporated into service delivery planning;

2. Procedures governing how a person-centered approach to services will be provided in order to meet the needs of the recipient's served and to achieve the personal goals on the support plan;
  3. Policies and procedures that will promote the health and safety of every recipient who receives services from the provider;
  4. Policies and procedures, which detail the safe administration and handling of medication in order to assure the health and safety of recipients served; if it is the policy of the provider that the provider or the provider's staff should not administer or assist in administration of medication, this should be clearly stated;
  5. Policies and procedures to ensure the smooth transition of the recipient between providers and other supports and services;
  6. Policies and procedures that address the provider's staff training plan and that specify how pre-service and in-service activities will be carried out including HIV/AIDS training pursuant to Chapter 381.0035, F.S., CPR, and all other mandated training;
  7. The provider's grievance procedures, as outlined in section 3.10 of this document; and
  8. The provider's procedures for conducting provider self-assessments.
- C. Each agency or group provider will maintain a current table of organization, including board of directors (when applicable), directors, supervisors, support staff, and all other employees.

### **3.1 Self-Assessment**

Each agency or group provider, or solo or individual provider furnishing specific services referenced in 3.0 above shall perform an annual self-assessment to determine the effectiveness of services being offered and the provider's compliance with requirements identified in this agreement and the Developmental Disabilities Waiver Services Coverage and Limitations Handbook. This annual assessment will assist the provider to determine, within the realm and scope of the service(s) that is provided, the extent to which the provider is developing and maintaining person-centered processes that will assist recipient's in the achievement of personal outcomes, particularly in the areas of personal goals, choice, social inclusion, relationships, rights, dignity and respect, health, environment, security and satisfaction. At a minimum, the provider's self-assessment survey will include a combination of: a) records review; b) interviews to determine the extent to which provider actions support the achievement of personal goals identified by recipient's receiving services; and c) annual recipient satisfaction surveys. The provider, as part of the self-assessment process develops a Quality Improvement Plan, addressing the areas in need of improvement.

### **3.2 Screening Requirement**

Each provider will maintain on file, and make available upon request, documentation that:

- A. Level Two background screening requirements are met for all direct service providers that are unrelated to their recipients, in accordance with Chapter 393.0655, F.S.
- B. State and national criminal and history background checks are performed for any officer, director, billing agent, managing employee and any affiliated person, partner, or shareholder having ownership interest of five percent or greater in the agency, in accordance with section 409.907, F.S.

- C. All employees meet qualifications as specified in this document and the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, including copies of licenses, certificates, high school and college diplomas and certified college transcripts as required.

### 3.3 Changes in Provider Status

- A. The provider understands and agrees that the Department and recipient's served will be notified of any change, sale or transfer of ownership. Recipient's receiving services will be given an opportunity to receive services from the new owner, purchaser, or transferee, or to select another provider.
- B. The provider understands and agrees that the Department shall be notified, prior to any change in provider status from a solo or individual provider to an agency or group provider. Such change shall be subject to Department review and approval.
- C. The provider understands and agrees that if they voluntarily terminate services, experiencing a break in service of ninety (90) days or more, and desire to return to the waiver in any capacity, that they will be considered a new applicant and shall comply with all the requirements of a new applicant.

### 3.4 Records Retention

- A. The provider will establish and maintain for review records pertinent to this Agreement that sufficiently and properly reflect all services provided and revenues and expenditures of funds provided by the Department and Medicaid under this Agreement. All records pertinent to this Agreement, including information stored in electronic media, shall be retained for a period of at least five years after the completion date of the Agreement. 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, which may be based on the terms of this Agreement. Records shall be established and maintained in accordance with generally accepted accounting procedures and practices.
- B. The provider agrees that if all or part of the business is sold or transferred, the provider will maintain and make available to the Department and the Agency, those Medicaid-related records required to be kept unless the provider enters into an agreement with a third party to do so and furnishes the Department 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.

### 3.5 Financial Requirements

- A. The provider agrees to notify the Department in writing prior to any filing for bankruptcy protection.
- B. Appropriate to the type and scope of services rendered, the provider agrees to maintain a separate checking account for any personal funds of any and all recipients in the care of, or receiving services from, the provider. If a single trust account is maintained for all recipients' personal funds, a separate accounting must be maintained for each recipient's funds, which reconciles monthly to the account's total as noted on the bank statement and is retained by the provider for review by the Department or Agency. The provider further understands and agrees that at no time should any recipient's personal funds be commingled 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 recipient or his legal guardian. The provider shall maintain on file receipts for individual purchases of \$25.00 or more.
- C. Neither the provider nor its employees, in their official capacity, will receive any financial benefit as a result of being named the beneficiary of a life insurance policy covering a recipient served by the provider.
- D. Neither the provider nor its employees, in their official capacity, will benefit financially by borrowing or otherwise using the personal funds of a recipient served by the provider.

### 3.6 Marketing Practices

The provider will market its services in a professional and ethical manner.

- A. The provider shall not, nor shall employees of the provider, possess or use for the purpose of solicitation, lists or other information from any source that identifies recipient's receiving services from the Department.
- B. The provider shall not, nor shall employees of the provider, solicit recipient's 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, or other incentives.
- C. The provider shall not, nor shall employees of the provider, unduly influence a recipient to request a support or service, select a support or service vendor or participate in an activity, regardless of whether or not the recipient request, selection or participation results in any benefit to the provider.

### 3.7 Goods and Services Provided

- A. The provider will conduct or be responsible for the following duties, for or on the behalf of each recipient served by the provider. The provider will:
  - 1. Document all service provision clearly and legibly, in accordance with the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, in a manner that will describe the limits of service, units of service, payment of service, location of service, and any other special consideration that will clearly document the rationale for the provision of the service;
  - 2. File all required documentation in the recipient's record prior to submitting a claim for services rendered;
  - 3. Maintain documentation in accordance with procedures specified in these Agreement documents, including the specific service requirements identified in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, for each participant being served, as well as for each waiver service being provided. The Department, Agency or their authorized representatives retain the right to review a recipient's record(s) at any time.
  - 4. Bill for only those services for which an approved service authorization has been received. Services shall be billed only at the approved rate, frequency and duration. Copies of service authorizations shall be kept on file by the provider and shall be made available to Department, Agency or their authorized representatives for monitoring purposes.
- B. The provider understands and agrees that the Department and Agency has the final authority on all matters pertaining to paid services or goods purchased with funds appropriated to the Department for recipient's who receive services through the waiver.

### 3.8 Payment Provisions

- A. The provider understands and agrees that all claims for duly authorized and rendered services will be submitted directly through the Medicaid FMMS system. Claims submitted for payment and the corresponding support documentation must be correct and legible.

- B. The provider understands and agrees that the Medicaid fiscal agent or the Office of the Comptroller will not pay a different Medicaid waiver payment rate for the same level of service for the same provider-type and will only pay for those services authorized and directly related to the recipient's goals as identified in his current support plan and that are authorized on the recipient's current and approved cost plan.
- C. The provider understands and agrees that payment from the Medicaid fiscal agent is made to a provider that is determined eligible by a District Office and has executed a Medicaid Waiver Services Agreement. The provider further understands that payment is contingent upon its enrollment in Medicaid as a waiver provider of Developmental Disabilities Home and Community-Based Services Waiver services.
- D. The provider understands that Medicaid payment will be payment in full for the services provided. The provider understands that it may not bill the recipient or family for any service that is authorized for reimbursement by Medicaid.
- E. The provider understands and agrees that payment from the Medicaid fiscal agent will be made only after services are rendered.
- F. Payment shall not be made for services not rendered.
- G. The provider understands and agrees that the Department is under no obligation to fund or fill vacancies created, under any circumstance.
- H. The provider understands and agrees that submission of a claim for a service that is not authorized on the service authorization form is grounds for termination of the Medicaid provider agreement.

### 3.9 Recoupment of Funds

- A. The provider understands and agrees that the Department or Agency will recoup funds paid to the provider for any reimbursed service for which the provider cannot produce the required documentation that fully supports the service as being rendered.
- B. The provider understands that payment for services that are not authorized, appropriately documented, or not billed appropriately through the Medicaid FMMIS system, or are billed in excess of the maximum units authorized, will result in recoupment of funds by the Department or Agency.

### 3.10 Grievance Procedures

The provider understands and agrees to establish and maintain written grievance procedures that will be used to resolve conflicts that may arise between the recipient, family, or guardian and the provider. These procedures do not preclude appropriate requests for a hearing, nor do they preempt the recipient, family, and guardian's right to request a change in services and/or provider.

- A. These procedures will specify:
  - 1. That grievance procedures will be reviewed and signed by the recipient, family or guardian within 30 days of beginning services and annually thereafter.
  - 2. Those grievance procedures will be communicated in clear, understandable language to the recipient, his family or guardian. Responses to grievances will be provided verbally and in writing at the recipient's level of comprehension and in the language understood by the recipient.
  - 3. That a log of all grievances filed by recipients, families or guardians will be maintained for review and will include the following information:

- (a) The name of the person making the complaint and his relationship to the recipient receiving services;
  - (b) The date the complaint is received;
  - (c) A clear description of the complaint. Oral complaints will be documented in writing. All complaints should be retained in the recipient's file and a copy retained with the grievance log; and
  - (d) The date of and the final disposition of each logged complaint.
4. The established procedures should provide for prompt resolution of any conflict.

## APPENDIX D

### CONTACT DIRECTORY

#### Area Offices Agency for Health Care Administration Medicaid

For information or assistance regarding other Medicaid/Waiver Handbooks

**Area 1**  
*Suncom*

**(850) 595-5700**  
695-5700

Serving: Escambia, Okaloosa,  
Santa Rosa, and Walton counties

**Area 2A**  
*Suncom*

**(850) 872-7690**  
777-7690

Serving: Bay, Franklin, Gulf, Holmes,  
Jackson, and Washington counties

**Area 2B**  
*Suncom*

**(850) 921-8474**  
291-8474

Serving: Calhoun, Gadsden, Jefferson,  
Leon, Liberty, Madison, Taylor, and  
Wakulla counties

**Area 3A**  
*Suncom*

**(386) 418-5350**  
NONE

Serving: Alachua, Bradford, Columbia,  
Dixie, Gilchrist, Hamilton, Lafayette,  
Levy, Putnam, Union, and Suwannee  
counties

**Area 3B**  
*Suncom*

**(352) 732-1349**  
667-1349

Serving: Citrus, Hernando, Lake,  
Marion, and Sumter counties

**Area 4**  
*Suncom*

**(904) 353-2100**  
826-2100

Serving: Baker, Clay, Duval, Nassau,  
St. Johns, Flagler, and Volusia counties

**Area Offices**  
**Agency for Health Care Administration**  
**Medicaid**

For information or assistance regarding other Medicaid/Waiver Handbooks

<b><u>Area 5</u></b> <i>Suncom</i>	<b>(727) 552-1191</b> 513-2659	<u>Serving:</u> Pasco and Pinellas counties
<b><u>Area 6</u></b> <i>Suncom</i>	<b>(813) 871-7600</b> 512-8290	<u>Serving:</u> Hardee, Highlands, Hillsborough, Manatee, and Polk counties
<b><u>Area 7</u></b> <i>Suncom</i>	<b>(407) 317-7851</b> 344-7851	<u>Serving:</u> Brevard, Orange, Osceola, and Seminole counties
<b><u>Area 8</u></b> <i>Suncom</i>	<b>(239) 338-2620</b> 748-2620	<u>Serving:</u> Charlotte, Collier, DeSota, Glades, Hendry, Sarasota, and Lee counties
<b><u>Area 9</u></b> <i>Suncom</i>	<b>(561) 881-5080</b> 264-5080	<u>Serving:</u> Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie counties
<b><u>Area 10</u></b> <i>Suncom</i>	<b>(954) 202-3200</b> 423-3200	<u>Serving:</u> Broward County
<b><u>Area 11</u></b> <i>Suncom</i>	<b>(305) 499-2000</b> 429-2000	<u>Serving:</u> Dade and Monroe counties

## Appendix E

### Contact Directory

**District Offices  
Department of Children and Families  
Developmental Disabilities**

For information or assistance, ask for the staff person assigned to the Developmental Disabilities Home and Community-Based Waiver.

<b><u>District 1</u></b> <i>Suncom</i>	<b>(850) 595-8344</b> 695-8344	<b><u>District 9</u></b> <i>Suncom</i>	<b>(561) 837-5564</b> 252-5564
<b><u>District 2</u></b> <i>Suncom</i>	<b>(850) 487-1992</b> 277-1992	<b><u>District 10</u></b> <i>Suncom</i>	<b>(954) 467-4218</b> 453-4218
<b><u>District 3</u></b> <i>Suncom</i>	<b>(352) 955-5793</b> 625-5793	<b><u>District 11</u></b> <i>Suncom</i>	<b>(305) 377-5029</b> 452-5029
<b><u>District 4</u></b> <i>Suncom</i>	<b>(904) 992-2440</b> 876-2440	<b><u>District 12</u></b> <i>Suncom</i>	<b>(386) 238-4718</b> 380-4026
<b><u>Suncoast Region</u></b> <i>Suncom</i>	<b>(813) 558-5540</b> 514-5540	<b><u>District 13</u></b> <i>Suncom</i>	<b>(352) 330-2162</b> 895-2177
<b><u>District 7</u></b> <i>Suncom</i>	<b>(407) 245-0440</b> 344-0440	<b><u>District 14</u></b> <i>Suncom</i>	<b>(863) 619-4100</b> 561-4100
<b><u>District 8</u></b> <i>Suncom</i>	<b>(239) 338-1572</b> 722-1572	<b><u>District 15</u></b> <i>Suncom</i>	<b>(772) 468-4080</b> 240-4080



## APPENDIX F

### RECIPIENT WAIT LIST

#### 1. Recipient Application and Eligibility Determination

Individuals shall be considered for determination of eligibility for the Developmental Disabilities Home and Community-Based Services Waiver upon the Department's receipt of a completed application for the waiver from the individual or legal guardian using the application for participation form approved by the Department. The application shall be furnished by mail or in person at the request of the individual or legal guardian. When an individual, family or legal guardian requests special accommodations to complete or submit an application, reasonable accommodations shall be made.

- A. The waiver application shall be reviewed for completeness within five working days of receipt by the District. If the application is incomplete, the District will promptly notify the individual or legal guardian in writing.
- B. The determination of eligibility for the waiver must be completed as follows:
  - (1) For individuals who are Medicaid recipients and, at the time of application, are also Developmental Disabilities (DD) recipients: the eligibility determination shall be made within ten working days of receipt of the completed application by the District.
  - (2) For those who are not DD recipients but are Medicaid recipients: an application for the Developmental Disabilities Program will be provided with instructions regarding documentation needed to complete the application process. Upon issuance of such written notification to the applicant, the time for processing the waiver application shall be tolled (placed on hold or pended) and remain in a tolled status until the results of the DD eligibility determination are known to the District.
    - (a) Eligibility for Developmental Disabilities is found in Chapter 393.063, F.S.
    - (b) Eligibility for the waiver is limited to the following qualifying disabilities:
      - i. The individual's intelligence quotient (IQ) is 59 or less; or
      - ii. The individual's IQ is 60-69 inclusive and the individual has a secondary handicapping condition, that includes 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
      - iii. The individual is eligible under a primary disability of 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.
  - (3) For individuals who are DD recipients but are not Medicaid recipients: a notice shall also be promptly sent to the applicants advising them that a determination of their eligibility for the waiver cannot be made until their eligibility for Medicaid has been confirmed. Upon issuance of such written notification to the applicant, the time for processing the waiver application shall be tolled and remain in a tolled status until the results of the eligibility determination(s) are provided to the District.
  - (4) For those who are neither DD recipients nor Medicaid recipients: a notice shall be promptly sent to the applicants advising that a determination of eligibility for the waiver cannot be made until eligibility for DD services is determined and Medicaid eligibility has been confirmed. Upon issuance of such written notification to the applicant, the time for processing the waiver application shall be tolled and remain in a tolled status until the results of the eligibility determination(s) are provided to the District.
- C. Upon determination of eligibility, (eligible or ineligible), the following action shall be taken:
  - (1) If Eligibility is Denied: When an individual is not eligible for waiver services, notification of ineligibility must be provided to the applicant within ten working days of receipt of the application, except when tolled as described in Section 1.

- (2) If the Individual is Determined Eligible: When an individual is determined to be eligible for waiver services, the District should consult with the Central Office to determine whether a vacancy and funding are available to serve the individual.
    - (i) If vacancy and funding are available to serve the individual, the procedures outlined in the section on "Waiver Enrollment" shall be followed.
    - (ii) If no vacancy or funding are available to serve the individual:
      - I. The District will assess whether an assessment for crisis, using the Crisis Identification Tool (page 3 of this appendix) is needed. The District will complete the Crisis Identification Tool when it appears that the individual requires immediate placement into an Intermediate Care Facility for Developmental Disabilities (ICF/DD), absent the provision of waiver services or the individual, family or legal guardian makes a request for a crisis determination. If the Crisis Identification Tool is to be completed, the procedures outlined in Section 3 (page 3 of this appendix) shall be followed.
      - II. If the individual's situation does not appear to require immediate ICF/DD placement or no request for a crisis determination is made, the individual shall be placed on the waiting list, as described in Section 2 (page 2 of this appendix). The date used to establish placement on the waiting list shall be the date the person was determined eligible for waiver services, which shall be known as the effective date.
2. **Waiting List.** The Central Office shall maintain the statewide list of all individuals requesting and waiting for waiver services.
    - A. Only individuals with a qualifying disability and who are eligible for or presumed to be eligible for Medicaid through Medicaid waiver assistance (Institutional Care Program income and asset limits) can be added to the wait list. Should a qualifying disability or Medicaid eligibility be established at a subsequent time, the later date will become the effective date the individual can be added to the wait list.
    - B. The waiting list is composed of two tiers with those in crisis at the top of the list. Once the preliminary determination of eligibility for the waiver is made but no vacancy or funding is available to serve the applicant, the applicant will receive prompt written notification of his placement on the waiting list for the waiver. Notification should be provided within ten working days after receipt of the application, except when tolled as described in Section 1 of this appendix. The effective date used when an individual is placed on the wait list shall be the date the individual is determined waiver eligible in accordance with Section 1.

Placement of any individual on a waiting list for services is not entitlement to waiver services. The final determination of the applicant eligibility for the waiver shall be made at the time that a vacancy and funding are available, and prior to enrolling the individual on the waiver. Placement on the waiting list shall proceed as follows:

- (1) For individuals determined to be in crisis, see Section 3 on "Crisis".
- (2) For individuals who have not been determined to be in crisis, who have completed an application for waiver services, submitted it to the District, and have been determined eligible for and in need of waiver services, the District shall complete the Wait List Form. When completed, the District Office will submit the form to the Central Office. Individuals will be listed in date order (beginning with the earliest date), based on the date eligibility for the waiver was determined by the District or the date that a qualifying disability was established, whichever is later. The earlier dates will be listed at the top of the waiting list, immediately following those individuals determined to be in crisis. Individuals will be listed in order of their effective date, as determined by the Department.

### 3. Crisis

- A. **Crisis Identification Tool:** District staff will complete the Crisis Identification Tool when it appears the individual requires immediate ICF/DD placement, absent the provision of waiver services or the individual, family or a legal guardian makes a request for a crisis determination. The assessment for crisis should be completed within five working days of the Department's receipt of the waiver application or the individual, family, or legal guardian's request, unless additional information is required. The Crisis Identification Tool should be completed as soon as all necessary information is available. The crisis identification process is not applicable for individuals seeking general revenue funded services.

The District will conduct a preliminary review of the documentation to determine whether sufficient information exists to recommend review by the Central Office. The District program administrator will complete the initial crisis assessment, sign the request and transmit the assessment to the Central Office for final determination. The Crisis Identification Tool, along with relevant documentation to support the crisis request, and a copy of the Wait List Form shall be submitted to the Central Office. It is the Central Office's responsibility to determine whether or not an individual's situation constitutes a crisis. This determination shall be made on all tools received by the 20<sup>th</sup> of the month to be reviewed for determination of crisis and inclusion in the next month's wait list review.

B. After Completion and Review of the Crisis Identification Tool:

- (1) Determined in Crisis: If it is determined that an individual who appears to be eligible for the waiver is in crisis, then the procedures set forth below should be followed.
- (2) Determined Not to be in Crisis: If the individual appears to be eligible for the waiver but is determined not to be in crisis by either the District or the Central Office, then the individual should be placed on the waiting list, using the procedures set forth in Section 2 above and shall receive written notification from the District. In the future, should the individual experience a change in his situation, which may affect his status for crisis determination, he or she may reapply.

C. Enrollment or Wait Listing of Individuals in Crisis: If an individual determined eligible for waiver services and determined by the Department to be in crisis, then a determination must be made as to whether there is an existing vacancy and funding for the individual.

- (1) If a vacancy and funding exist to serve the individual, the Central Office will notify the District that the individual can be promptly enrolled in the waiver. The enrollment process described in this section and in the Section 4 "Enrollment on the Waiver" should be followed.
- (2) If a vacancy and funding do not exist, the Central Office will place the individual on the crisis waiting list; the District shall notify the individual of his placement on the crisis waiting list. Individuals determined to be in crisis who are waiting for services will be considered each month for vacancies and funding available.

D. Prioritization on the Crisis Waiting List: Individuals determined to be in crisis will be listed in order of severity of crisis. Severity will be determined by the risk experienced by the individual relative to that experienced by other individuals in crisis, as indicated by the number of criteria listed below which are documented to be met by that individual's situation. If a number of individuals are experiencing crises of similar severity, they will be prioritized by the type of crisis they are experiencing including the consideration of the intensity and scope of the services required. Priority for consideration is listed below. If an individual is experiencing more than one type of crisis, that individual will be prioritized based upon the crisis experienced that has highest priority. If necessary, after prioritization by severity and type of crisis, individuals shall be further prioritized based on the intensity and scope of the services required, and in date order the Central Office determined the individual to be in crisis, with earliest dates having highest priority.

- (a) First Priority: The individual does not have a place to live and is homeless, requires emergency placement, or while living with family or relatives is in an unsafe environment. There must be evidence that the individual's safety (or the safety of those with whom he or she is presently living) is in immediate peril if waiver services are not provided immediately.
  - (i) Without immediate provision of waiver services, this individual's health and safety are at risk.
  - (ii) The individual requires emergency placement by the Department or another state agency.
  - (iii) Alternative funding is not available for placement and services to the individual.
  - (iv) The individual is currently staying with friends or relatives but the situation is temporary and not expected to last beyond the month.
  - (v) The caregiver has no legal obligation to provide shelter to the individual.
  - (vi) The commitment of the caregiver to shelter the individual is low.

- (vii) There are risk factors for the individual remaining in the current temporary setting; for instance, the individual is not receiving sufficient supervision and support or the individual's behavior places other vulnerable individuals living in the home at risk.
  - (viii) Given the presence of others in the home and the size and configuration of the home, there is insufficient room to provide shelter to the individual, or the individual is sharing a room with another in a situation inappropriate based on the ages, sex and conditions of the individuals.
  - (ix) The individual desires placement and is expected to be cooperative with placement.
  - (x) The individual's health status has been or is in jeopardy because of his living situation.
  - (xi) There has been law enforcement involvement.
  - (xii) Protective Services has been involved.
  - (xiii) The individual is currently homeless or living in a homeless shelter.
  - (xiv) Individual requires services of greater intensity. Service intensity will be ranked as follows, from greatest to least: (1) residential placement and residential habilitation, nursing or behavioral services, including supported living with required supports; (2) residential placement without need for residential habilitation, nursing or behavioral services, includes supported living with some support; (3) behavioral intervention; (4) other therapies to avoid or reduce disability; (5) need for a meaningful day activity; (6) durable medical equipment; (7) environmental accessibility adaptations; (8) consumable medical supplies.
- (b) Second Priority: Presently, the individual is either in danger because of confirmed abuse or neglect, or is exhibiting behaviors that:
- Result in harm to the person or others that, in turn, creates a life-threatening situation for the person or others, or
  - Will result in bodily harm to the person or others that will require emergency medical care from a physician if waiver services are not provided immediately.

The following criteria shall be considered to determine whether an individual in this situation is in crisis:

- (i) Without immediate provision of waiver services, the health and safety of this individual or others in the household are at risk.
- (ii) The frequency and intensity of the injury to self or others is high.
- (iii) It appears the individual or others are at high risk for serious injury, or permanent damage.
- (iv) There is reasonable possibility for fatal or life threatening injury.
- (v) No other supports or services are available to assist in addressing the behaviors.
- (vi) Other reasonable behavioral assessments and interventions have been attempted but have proven ineffective.
- (vii) The relative ages, sexes, and sizes of the aggressor and the individuals subject to his aggression place the individuals subject to the aggression at great risk.
- (viii) The caregiver has insufficient ability or capabilities to handle the individual.
- (ix) The age or disability of the individual or caregiver exacerbates the problem.
- (x) There has been law enforcement involvement.
- (xi) Protective Services has been involved.
- (xii) There has been documented injury to self or others requiring medical treatment.
- (xiii) Individual requires services of greater intensity. Service intensity will be ranked as follows, from greatest to least: (1) residential placement and residential habilitation, nursing or behavioral services, including supported living with required supports; (2)

residential placement without need for residential habilitation, nursing or behavioral services, includes supported living with some support; (3) behavioral intervention; (4) other therapies to avoid or reduce disability; (5) need for a meaningful day activity; (6) durable medical equipment; (7) environmental accessibility adaptations; (8) consumable medical supplies.

- (c) Third Priority: The individual's current caregiver is in extreme duress, is no longer safely able to provide care for the individual due to advanced age, illness or injury and the individual is in immediate need of waiver services in order to remain living with the caregiver or to locate an alternative living arrangement. This would include situations where abuse or neglect is present. The following criteria shall be considered to determine whether an individual in this situation is in crisis:
- (i) Without immediate provision of waiver services, this individual's health and safety are at dire risk.
  - (ii) Other caregivers, such as another parent, stepparent, brother, sister or other relative or person willing and able to assume care, are not available.
  - (iii) The physical and mental condition of the caregiver prevents rendering necessary care.
  - (iv) The disability of the caregiver is permanent.
  - (v) The caregiver is unable to provide sufficient care to the individual due to the caregiver's age, which has resulted in significant impairment of his physical or mental ability to provide care and supervision for the individual.
  - (vi) The caregiver is unable to provide sufficient care due to the age, size or physical, functional, or behavioral capabilities of the individual.
  - (vii) The intensity and scope of services needed by the individual makes him only semi-independent or totally dependent.
  - (viii) The caregiver has an unstable economic situation in part because of the demand of care giving and is unlikely to change.
  - (ix) The caregiver serves other individuals who require care, and due to these other demands the caregiver is unable to provide adequate care to the individual, or the demands of providing care to the individual places others at risk due to insufficient care.
  - (x) There has been law enforcement involvement.
  - (xi) Protective Services has been involved.
  - (xii) The primary caregiver is deceased or about to expire.
  - (xiii) Individual requires services of greater intensity. Service intensity will be ranked as follows, from greatest to least: (1) residential placement and residential habilitation, nursing or behavioral services, including supported living with required supports; (2) residential placement without need for residential habilitation, nursing or behavioral services, includes supported living with some support; (3) behavioral intervention; (4) other therapies to avoid or reduce disability; (5) need for a meaningful day activity; (6) durable medical equipment; (7) environmental accessibility adaptations; (8) consumable medical supplies.
- E. If the situation of an individual determined to be in crisis changes in any way that might affect his prioritization as an individual in crisis, updated documentation reflecting the changes shall be submitted by the District to the Central Office as soon as possible.
- F. Once the Central Office notifies the District that a vacancy and funding exist to serve an individual in crisis, the District shall, if necessary, refer the individual for a determination of Medicaid eligibility within five working days. In this case, promptly upon referring the individual for the determination of Medicaid eligibility, a letter shall be sent to the applicant advising a determination of eligibility for the waiver cannot be made until eligibility for Medicaid has been confirmed.

- (1) Upon notification that a determination has been made regarding an individual's Medicaid eligibility, the tolling of the time for consideration of the waiver application ceases, and five working days remain in which to act upon the completed application.
- (2) If the District is notified that a determination has been made to deny Medicaid eligibility, then written notice should be provided to the applicant that their application for waiver services has been denied.

**4. Waiver Enrollment:**

- A. When the level of funding appropriated by the Florida Legislature provides funding for additional vacancies on the waiver, individuals shall be added to the waiver in the following order unless otherwise specified in the Appropriations Act for the current state fiscal year.
  - (1) Individuals determined by assessment using the Crisis Identification Tool to be in crisis shall have first priority for services. Priority shall be determined according to the severity of the crisis as described in Section 3, by the recommendation of the Central Office,
  - (2) Individuals with valid Court Orders or diversions from programs for persons adjudged incompetent to stand trial, validated by the District Legal Counsel and recommended by the Central Office.
  - (3) All other individuals shall be considered for enrollment on the waiver in the date order in which they are listed on the statewide waiting list, beginning with the earliest dates.
- B. When a waiver vacancy and funding become available to serve an individual, the Central Office will notify the appropriate District office where the individual resides to begin the enrollment process. If the individual is not enrolled in Medicaid but appears to be eligible, the District shall at that time make the appropriate referrals for determination of Medicaid eligibility.
- C. Should sufficient vacancies and funding is available to serve some but not all individuals having the same eligibility date on the waiting list, current information (at the time of proposed enrollment) will be used to prioritize individuals with the same waiting list date. Intensity of service needs and the individual's level of need shall be used to determine which individuals with the same date shall be enrolled on the waiver. Circumstances for individuals on the waiting list may change over time. Accordingly, when the District is notified that vacancies and funding are available to serve individuals through a particular eligibility date, the information necessary to determine prioritization will be requested for affected individuals.
  - (1) Priority will be given in the following order to individuals for whom the following waiver services are medically necessary:
    - (a) Residential placement and residential habilitation, nursing or behavioral services, including supported living with required supports.
    - (b) Residential placement without need for residential habilitation, nursing or behavioral services, including supported living with some support.
    - (c) Behavioral intervention.
    - (d) Other therapies to avoid or reduce disability.
    - (e) Need for Meaningful Day Activity.
    - (f) Durable Medical Equipment.
    - (g) Environmental Accessibility Adaptations.
    - (h) Consumable Medical Supplies.
  - (2) After individuals are prioritized by considering the intensity of service needs, further prioritization within each category is necessary; level of need will be used to determine priority, with highest levels of need having greatest priority. Level of need sub scores shall be considered if necessary.
- D. Enrollment Activities Required: The following steps shall be taken as part of the enrollment process once a vacancy and funding potentially become available to serve an individual:
  - (1) The District where the individual resides will be notified to complete an initial assessment to determine service needs and the estimated cost to serve the individual.

- (2) The District will notify the Central Office regarding the amount of anticipated funding required. If sufficient funding exists to meet the identified needs and the District has determined the individual can be safely served in the community, the District will be notified to enroll the recipient on the waiver and of the funding allocated to serve the recipient.
  - (3) The recipient or legal guardian must complete and sign the Developmental Disabilities Waiver Eligibility Worksheet.
  - (4) The recipient, family or legal guardian will select a waiver support coordinator to assist the recipient.
- E. When a recipient is enrolled on the waiver, the waiver position allocated to the recipient is theirs until they become ineligible or choose to discontinue waiver services. If the recipient loses their eligibility or chooses to discontinue their waiver services during a waiver year (July 1 thru June 30), and later chooses to re-establish their eligibility, prior to the end of the same waiver year (before June 30), the individual may return to the same waiver position allocated and resume receiving waiver services.

If waiver eligibility cannot be re-established or the individual chooses to resume their waiver services after the beginning of the next waiver year (July 1), they are 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.

**Developmental Disabilities  
Home and Community-Based Services Waiver  
Application for Participation**

For myself or on behalf of the individual named below, I am requesting participation in the DD/HCBS waiver program. This individual is or is not a current recipient of Developmental Disabilities.

Applicant Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Medicaid yes #: \_\_\_\_\_  
(Medicaid #, if known)

Street Address: \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Street Address: \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number: (home) \_\_\_\_\_ (work) \_\_\_\_\_

(self/parent/guardian phone 1)

Phone Number: (home) \_\_\_\_\_ (work) \_\_\_\_\_

(self/parent/guardian phone 2)

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I believe the services or supports identified below are required by the person named above to allow them to remain in the community and avoid the need for institutional placement.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My signature below indicates that I have received the following pamphlets explaining the Developmental Disabilities Home and Community-Based Services Waiver.

DD/HCBS Waiver Eligibility (CI/PI 160-35, 7/2000)

Due Process Rights (CI/PI 160-32, 4/2002)

Medicaid Funded Services (CI/PI 160-36, 8/2000)

DD/HCBS Waiver Services (CI/PI 160-34, 6/2000)

The information included on this application is true and accurate to the best of my knowledge.

\_\_\_\_\_  
Signature of Requestor \_\_\_\_\_ Date of Request

Date stamp date received by District \_\_\_\_\_ Return application to:



**DEVELOPMENTAL DISABILITIES PROGRAM**  
**Crisis Identification Tool**

The purpose of the crisis determination tool is to assess whether or not the individual requires immediate placement in an ICF/DD absent the provision of DD/HCBS waiver services.

**District** \_\_\_\_\_

**Recipient Name:** \_\_\_\_\_ **Age** \_\_\_\_\_ **SSN:** \_\_\_\_\_

Check those categories that apply and provide a comprehensive description of the situation and the types of supports or services that are needed to alleviate the crisis situation. Attach all supporting documentation to assist in providing accurate picture of current crisis, including court orders, medical reports, psychological or behavioral reports, Department approved assessment scores, IEP, psychosocial, etc.

\_\_\_\_\_ **Danger to self or others:** The individual is currently exhibiting behaviors that:  
a) result in harm to the person or others that, in turn, creates a life-threatening situation for the person or others or  
b) will result in bodily harm to the person or others that will require emergency medical care from a physician if waiver services are not provided immediately.  
Indicate the individual's behavioral level of need on the department approved assessment tool. When this item is checked, the District Sr. Behavior Analyst shall verify whether the individual is highly dangerous to self or others.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ **Homeless:** The individual does not have a place to live and is homeless, requires emergency placement, or while living with family or relatives is in an unsafe environment. There must be evidence that the individual's safety (or the safety of those with whom he or she is presently living) is in immediate peril if waiver services are not provided immediately.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ **Caregiver unable to give care:** The individual's current caregiver is in extreme duress, is no longer safely able to provide care for the individual due to advanced age, illness or injury and the individual is in immediate need of services in order to remain living with the caregiver or to locate an alternative living arrangement. This would include situations where abuse or neglect is present. Specify caregiver age, illness or reason unable to provide care. Indicate the individual's level of need using the department approved assessment tool.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Crisis Identification Tool for: \_\_\_\_\_

Page 2

Name \_\_\_\_\_

**Service Needs:** Include a list of potential services or supports this individual will require, i.e. residential placement, residential habilitation, supported living, behavior analysis, OT, PT, ST, DME, etc. (This section must be completed.)

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\_\_\_\_\_  
Preparer's Signature/Title Date  
(Must be an employee of DCF)

Recommendation Yes No

\_\_\_\_\_  
Reviewing Behavioral Analyst/Title Date

Recommendation Yes No

\_\_\_\_\_  
District Medical Quality Assurance Staff Date

Recommendation Yes No

\_\_\_\_\_  
District Developmental Disabilities Date  
Program Administrator

List Documents Attached:

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**Developmental Disabilities Program  
Wait List Form**

Last Name: \_\_\_\_\_ Name: \_\_\_\_\_ First \_\_\_\_\_  
M.I.: \_\_\_\_\_

District/Region: \_\_\_\_\_ Level \_\_\_\_\_ of \_\_\_\_\_ Need: \_\_\_\_\_  
SSN: \_\_\_\_\_

Date DD/HCBS waiver eligibility established: \* \_\_\_\_\_

The individual meets the following waiver eligibility criteria:

- \_\_\_ The individual's primary disability is mental retardation with an intelligence quotient (IQ) of 59 or less.
- \_\_\_ The individual's primary disability is mental retardation with an intelligence quotient (IQ) of 60-69 inclusive and the individual has at least one of the following handicapping conditions OR individual's primary disability is mental retardation with an intelligence quotient (IQ) of 60-69 inclusive and the individual has severe functional limitations in at least three of the major life activities. Please check all handicapping conditions and major life activities that apply.
- \_\_\_ The individual is eligible under the category of autism, cerebral palsy, spina bifida or Prader-Willi syndrome and the individual has severe functional limitations in at least three of the major life activities. Please check all handicapping conditions and major life activities that apply.

Handicapping Conditions			Major Life Activities	
___ Ambulation Deficits	___ Behavior Problems	___ Epilepsy	___ Self Care	___ Mobility
___ Sensory Deficits	___ Autism	___ Spina Bifida	___ Understanding and use of language	___ Self Direction
___ Chronic Health Problems	___ Cerebral Palsy	___ Prader-Willi Syndrome	___ Learning	___ Capacity for independent living

Medicaid Recipient?  Yes Medicaid #: \_\_\_\_\_  No

If Medicaid Eligibility has been denied, explain \_\_\_\_\_

*For Central Office Use only:* In crisis:  Yes  No Date determined: \_\_\_\_\_

DCF Employee Completing the form: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

District/Region Review by \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

Date Received by Central DD Program Office: \_\_\_\_\_ Date Added to Wait List: \_\_\_\_\_

Staff: \_\_\_\_\_

Date Referred Back to District to Update Assessment: \_\_\_\_\_

Date Sent to District to Enroll into the DD/HCBS Waiver: \_\_\_\_\_

\* This is the date used to identify an individual's order of placement on the waiver wait list.  
CF-DD 3066, Feb 00 (revised)







Jeb Bush  
Governor

Alan Levine  
Secretary

2727 Mahan Drive  
Tallahassee, FL 32308

[www.fdhc.state.fl.us](http://www.fdhc.state.fl.us)