

UPDATE LOG

DEVELOPMENTAL SERVICES WAIVER SERVICES FLORIDA MEDICAID COVERAGE AND LIMITATIONS

How to Use the Update Log

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 reads the updated material and then files it in the handbook, as it is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

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.

Instructions

Make the pen and ink changes and file new or replacement pages.

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 Reimbursement handbook, Non-Institution 081.

Note: Refer to Appendix D for contact information.

UPDATE NO.	EFFECTIVE DATE
July 2002 – New Handbook	October 2002

Developmental Services Waiver Services Florida Medicaid

Coverage and Limitations Handbook

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Introduction To The Handbook

Overview

Introduction

This chapter introduces the format used to prepare the Medicaid Reimbursement and Coverage and Limitations handbooks and tells the provider how to use the handbooks.

Background

The Coverage and Limitations handbook explains covered services, their limits and who is eligible to receive them. It is to be used with the Reimbursement handbook, which describes how to complete and file claims for reimbursement by Medicaid.

Legal Authority

The Medicaid program is authorized by Title XIX of the Social Security Act and Title 42, Code of Federal Regulations. The Florida Medicaid program is authorized by Chapter 409, Florida Statutes (F.S.) and Chapter 59G, Florida Administrative Code (F.A.C.).

Federal Regulations, Florida Statutes, and the Florida Administrative Code, which deal with the purpose, implementation, and administration of each Medicaid program, are cited for reference in each program Coverage and Limitations handbook.

Specific statutory authority for the promulgation of the Developmental Services Waiver Services handbook into rule (59G-8.200), 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/Agency) has final authority on all policies, procedures, rules, regulations, manuals, and handbooks pertaining to the waiver. The Department of Children and Families (DCF/Department) 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 Services Home and Community-Based Services Waiver.

In This Chapter

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Handbook Use and Format

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.

“Provider”

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

“Beneficiary”

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

Coverage and Limitations Handbook

Each service handbook is named for the service it describes and is referred to as a “Coverage and Limitation handbook.” A provider who furnishes more than one type of Medicaid or waiver service will reference more than one coverage and limitations handbook.

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.

Chapter Numbering System

The first page of each chapter designates the chapter number. The chapter number will appear as the first number of the page number at the bottom of each page in the handbook.

Page Numbering

Pages consecutively numbered, by chapter. Page numbers follow the chapter number found at the bottom of each page.

White Space

The “white space” throughout a handbook is characteristic of the handbook format style. It enhances readability and allows space for writing notes during training and for on-the job reference.

Characteristics of the Handbook

Format	<p>The format used in this handbook represents a concise and consistent way of displaying complex, technical material.</p>
Information Block	<p>One of the major features of the format is the Information Block, which replaces the traditional paragraphs. Blocks are separated by horizontal lines.</p> <p>The block consists of one or more paragraphs or diagrams about a portion of a subject. Each block is identified or named with a label.</p>
Label	<p>Labels or names are located in the left margin of each information block. They describe the content or function of the block.</p> <p>Labels provide key subject matter identification, which facilitates scanning and locating information quickly within a chapter or section within a chapter.</p>
Note	<p>Note: is used most frequently to refer the user to material located elsewhere in a handbook that is pertinent to the subject being addressed within the information block.</p> <p>Note: also refers the user to other documents or policies contained in other handbooks.</p>
Topic Roster	<p>Each chapter contains a topic roster, which lists the major subject areas covered in the chapter and gives the page number where the subject can be found. This topic roster serves as a table of contents for major sections within each chapter.</p>
Forms	<p>Copies of all the forms discussed in the handbook appear in the section of the handbook that describes and discusses the particular document.</p>

Handbook Updates

How Changes Are Updated

The Medicaid handbooks will be updated as needed.

Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages.

Brief changes will be sent as pen and ink updates. The pen and ink updates will be incorporated on replacement pages the next time replacement pages are produced.

Update Log

A page designated, as the log will accompany handbook updates. This log serves as a reference for the provider to be sure that each update has been received.

An "Updated No." will be indicated in the first column on the update log. The second column is titled the "Effective Date" and indicates the date that the update is effective.

Numbering Update Pages

Updated replacement pages will have the same number as the date they are replacing. If additional pages are required, the new pages will carry the same number as the proceeding replacement page with an alphabetic character in ascending order.

CHAPTER 1

Developmental Services Waiver Services Purpose, Background, And Program Specific Information

Overview

Introduction

This chapter describes the Medicaid Developmental Services (DS) waiver program, specifies the authority regulating DS waiver services, the purpose of the program, and 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 DS waiver.

Specific statutory authority for the promulgation of the Developmental Services 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 Services Home and Community-Based Services waiver.

In This Chapter

This chapter contains:

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General Definitions

Agency

The Agency for Health Care Administration (AHCA/Agency)

Agency or Group Provider

A business, organization or entity 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 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.

Core Assurances

The document that specifies administrative and programmatic requirements for DS 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 beneficiaries with developmental disabilities served by the Department agrees to be bound.

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

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.

District Developmental Disabilities Program Administrator

The person in charge of the Developmental Disabilities Program in each district or region.

District or Region

A service district or region (district) of the Florida Department of Children and Families.

Note: See Appendix E for additional information.

General Definitions, continued

Independent Vendor

An agency that employs individuals or an individual who meets specified qualifications of certain career service classification codes or holds local occupational licenses.

Job Development

Means the process of developing employer relations and linking beneficiaries with private and public sector labor needs. This process involves exploring job skills and job preferences with the beneficiary with a disability, as well as networking with the beneficiary with a disability, the job developer or job coach, and other people who know the beneficiary seeking employment, and local employers.

Licensed Residential Facility

Facilities providing room and board, and other services in accordance with the licensing requirements for the facility type. Community-based beneficiaries with developmental disabilities may receive DS waiver services while residing in:

- Group and foster homes licensed by the Department of Children and Families in accordance with Chapter 393, F.S., and Chapter 409, F.S.
 - 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 beneficiary has continuously resided at the facility since August 8, 2001, or prior to this date.
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General Definitions, continued

Medicaid State Plan Services

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.

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-DS 3064 (Medicaid Waiver Services Agreement), the Core Assurances for providers of Medicaid Home and Community-Based Waiver Services Programs, and documents specifying rates. Specific service requirements, as defined in the Developmental Services Waiver Services Coverage and Limitations handbook, are incorporated into the agreement by reference. All providers must complete this agreement to provide services to beneficiaries enrolled in the Developmental Services Home and Community-Based Services Waiver Program.

General Definitions, continued

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 beneficiary needs;
- Review of health related supports and services that a beneficiary is receiving and the beneficiaries 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 beneficiary'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 beneficiary.

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;
 - 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 beneficiary, the beneficiary's caretaker, or the provider.
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General Definitions, continued

Pre-Service Training for Waiver Support Coordinators

Consists of one 34-hour and one 26-hour training session provided by the Department. Attendance and completion is mandatory for all waiver support coordinators.

Note: Refer to Chapter 2, Waiver Support Coordination training requirements for additional information.

Projected Service Outcomes

Goals used to determine, through monitoring and review, the effectiveness of service provision. Outcomes should be measured considering individual skills and circumstances.

Provider Service Agreement

Prior to providing any services the provider must, in order to be compensated by the Developmental Services 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 Developmental Services Waiver Services Coverage and Limitations handbook.

Note: See Appendix B for additional information.

Residence

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

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 beneficiary. Without this form the provider cannot be assured reimbursement. This authorization is contingent upon the enrolled beneficiary remaining eligible, for Medicaid during the month of service. Upon a beneficiaries 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.

General Definitions, continued

Solo Provider

An eligible provider who personally renders waiver services directly to beneficiaries and does not employ others to render waiver services.

Support Plan

An individualized plan of supports and services designed to meet the needs of a beneficiary enrolled in the waiver. The plan is based on the preferences, interests, talents, attributes and needs of a beneficiary. The beneficiary 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 beneficiary. The ultimate goal of each plan, shall be to enable the beneficiary to live a dignified life in the least restrictive setting, appropriate to the beneficiary's needs. The support plan must be completed in a format provided by the Department and according to the instructions provided by the Department.

Waiver Support Coordinator

An enrolled waiver provider of support coordination services that is selected by the beneficiary enrolled in the waiver (or their guardian) to assist the beneficiary 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 beneficiary or guardian, waiver support coordinators may be assigned by the District (subject to the beneficiary 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 beneficiaries' needs. They also initiate and oversee the process of assessment and reassessment of the beneficiaries' 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.

Description and Purpose

Developmental Services Waiver Description

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

Purpose

The purpose of the DS waiver is to promote, maintain and restore the health of eligible beneficiaries with developmental disabilities; and to minimize the effects of illness and disabilities through the provision of needed supports and services in order to delay or prevent institutionalization. The intent of the waiver is to provide a viable choice of services that allow eligible beneficiaries 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 beneficiaries 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.

Beneficiaries enrolled in the DS 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.

For adults, a meaningful day activity includes a choice of paid employment, supported employment, adult day training programs or other DS waiver services, such as non-residential support services. 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.

Description and Purpose, continued

Purpose of This Handbook

This handbook is intended for use by eligible providers who furnish DS waiver services to beneficiaries enrolled in the waiver. It must be used in conjunction with the 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 Appendix D for contact information.

Provider Qualifications and Responsibilities

DS Waiver Provider Applicant Enrollment

DS Waiver provider applicants must meet specific qualifications and requirements before becoming eligible to provide DS 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 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 DS waiver providers must:

- Be certified as eligible, by the Department of Children and Families, Developmental Disabilities District Office, to enroll as a DS 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 DS waiver provider; and
 - Have a current, signed DS Waiver Services Agreement with the Department.
-

Provider Qualifications and Responsibilities, continued

**DS Waiver Provider
Background
Screening
Requirements**

Applicants 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.

Applicants must submit the DCF fingerprinting card, an affidavit of good moral character, a caretaker information sheet and a check for \$32.00 (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.

- Background screenings pursuant to Chapter 409.907, F.S.

Applicants must submit the Medicaid fingerprint card, the enrollment application and a check for \$39 (made payable to the Medicaid fiscal agent, ACS State Healthcare) to ACS for processing.

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

**Determination of
Eligibility for
Certification**

The District Office determines if the provider applicant meets the qualifications and requirements for enrollment as a waiver provider. Any individual or agency desiring to enroll in Medicaid as a DS 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 Medicaid Provider Enrollment Application and a DS Waiver Provider Application.

Provider Qualifications and Responsibilities, continued

Determination of Eligibility for Certification, continued

The DS Waiver Provider Application includes a Medicaid Waiver Services Agreement, Core Assurances and Developmental Services Waiver Services Coverage and Limitations handbook. All DS 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 Central Office for further processing. The Medicaid fiscal agent (ACS) completes final processing and enrollment.

The District Office receives verification from the 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 DS 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 or her enrollment in Medicaid.

For information regarding how to become a waiver service provider, contact the 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 Chapter 2 of the 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.

Provider Qualifications and Responsibilities, continued

Agencies Wishing to Provide Multiple Services

Agency providers that specialize in services to beneficiaries 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 beneficiaries 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 at the date the District Office receives a complete 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 F.D.L.E. and returned with no record or disqualifying offence, the District will determine the applicant eligible to conduct an unsupervised face-to-face visit or to have unsupervised contact with a beneficiary, pending the results of a level two background screening. If the local background screening is returned and indicates a record or disqualifying offence, the applicant may not provide services until the level two background screening is complete, returned and eligibility is approved.

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 beneficiaries 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 or she assume a full waiver caseload.

Provider Qualifications and Responsibilities, continued

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

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 beneficiaries on their caseload, the application may be denied. In no instance may dual employment include the provision of services to beneficiaries 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.

**Family Members
Enrolled as DS Waiver
Providers**

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

Controls must be in place to insure 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. The reason a relative is chosen for the provider shall also be documented.

Reasons for using a relative may include lack of other available providers in a rural area or the ability to meet specific scheduling of a beneficiary that other providers can't meet. Convenience to the beneficiary, caregiver or family alone is not adequate justification. 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 beneficiary served.

Statewide Enrollment

All DS waiver providers are enrolled on a statewide basis unless they indicate a geographic preference on the DS Waiver Application or the District Office restricts enrollment to specified geographic areas. DS 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 beneficiaries, as determined by the District Office.

Note: Refer to Appendix E for contact information.

Provider Qualifications and Responsibilities, continued

Freedom of Choice

The waiver is designed around beneficiary choice. Accordingly, beneficiaries served through the waiver may select among enrolled, qualified service providers and may change providers at any time. Once a beneficiary has an approved cost plan, the funds allocated to that support plan follow the beneficiary. Within the funds allocated in the support plan, the beneficiary is free to change enrolled, qualified providers as desired to meet the goals and objectives set out in the support plan.

Adult Day Training Provider Requirements

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 beneficiaries per direct service staff for adult day training facility-based programs.
 - Direct service staff will possess at least a high school diploma or equivalent. Two years of related experience may substitute for a diploma.
-

Adult Day Training Provider Requirements, continued

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 (8) hours of annual in-service training related to implementation of individually tailored services.

Note: Refer to Appendix C for provider training requirements.

Projected Service Outcomes

Projected Services Outcomes are goals used to determine, through monitoring and review, the effectiveness of service provision.

Outcomes should be measured considering individual skills and circumstances.

Beneficiaries receiving services demonstrate an increase in abilities, self-sufficiency, and changes in their lives consistent with their support plan goal(s).

Beneficiaries served annually who have a stated support plan goal to be employed in the community, access supported employment or other competitive employment opportunities.

Beneficiaries served are satisfied with the services based on the results of the annual satisfaction survey, or are satisfied that their concerns raised during the survey have been addressed.

Beneficiaries achieve or make progress toward the support plan goals(s) assigned to the provider.

Beneficiaries who use the supports and services of the provider are allowed maximum freedom of choice, including being informed about rights and service options (i.e., more inclusive programs, supported employment, etc.).

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.

Behavior Analysis Provider Requirements

Provider Qualifications Providers of this service must have one or more of the following credentials:

1. Certification as a:
 - a. Florida Certified Behavior Analyst with expanded privileges;
 - b. Florida Certified Behavior Analyst;
 - c. Florida Certified Associate Behavior Analyst;
 - d. Board Certified Behavior Analyst;
 - e. Board Certified Associate Behavior Analyst; and
 - f. Provisional Board Certified Behavior Analyst.

2. Licensure as a:
 - a. Psychologist or licensed school psychologist pursuant to Chapter 490, F.S.; and
 - b. Clinical social worker, marriage and family therapist or mental health counselor, pursuant to Chapter 491, F.S.

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

Note: Refer to Appendix C for provider training requirements.

Behavior Assistant Services Provider Requirements

Provider Qualifications

Providers of this service must have at least:

1. A high school diploma;
2. Two years of experience providing direct services to beneficiaries with developmental disabilities or at least 120 hours of direct services to beneficiaries 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/college classes or university 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.
4. The 20 contact hours of instruction required under the 3rd bullet above may be obtained within the 90 classroom hours of instruction used to meet requirements under the 2nd bullet above.

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.

Chore Service Provider Requirements

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 have at least one year of experience working in a medical, psychiatric, nursing or childcare setting or working with developmentally disabled beneficiaries. College or vocational/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.

Companion Provider Requirements

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 400.509, F.S.

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

Minimum qualifications for a companion include: one year of experience working in a medical, psychiatric, nursing or child care setting, or in working with beneficiaries having developmental disabilities; College or vocational/technical training from an accredited institution can substitute at the rate of 30 semester, 45 quarter or 720 classroom hours for the required experience.

Companion Provider Requirements, continued

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.

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 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 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.

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

Dietitian Provider Requirements

Provider Qualifications Providers of **dietitian services** shall be dietitians/nutritionists licensed by the Department of Health, in accordance with Chapter 468, F.S.

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

Note: Refer to Appendix C for provider training requirements.

Durable Medical Equipment Provider Requirements

Provider Qualifications Providers of **durable medical equipment (DME)** include home health or hospice agencies, pharmacies, medical supply companies, durable medical equipment suppliers and vendors such as discount stores and department stores.

In accordance with rule 59G-4.070, F.A.C., to enroll as a Medicaid provider, a DME and medical supply entity must meet the following criteria:

- 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;
- Be licensed by the Department of Health Medical Quality Assurance, Board of Orthotics and Prosthetics, if providing orthotics and prosthetic devices.

In accordance with Code of Federal Regulations (C.F.R.) Part 440.70, providers will 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.

Durable Medical Equipment Provider Requirements, continued

Provider Qualifications,
continued

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.

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.

Environmental Accessibility Adaptation Provider Requirements

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 the construction work must present a Qualified Business number, as required in Chapter 489.119, F.S. In accordance with Chapter 489.113, F.S., sub-contractors of a qualified business shall hold the required state certificate or registration in that trade category.

Environmental Accessibility Adaptation Provider Requirements, continued

Provider Qualifications,
continued

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 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 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.

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 extensive experience in the field of environmental accessibility adaptation assessment, with RESNA certification , and an occupational license.

Homemaker Services Provider Requirements

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 the Agency for Health Care Administration (AHCA), in accordance with Chapter 400.509, F.S.

Homemaker Services Provider Requirements, continued

Provider Qualifications,
continued

Independent vendors are not required to be licensed or registered if they bill for and are reimbursed only for services personally rendered by the provider. 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 one year of experience working in a medical, psychiatric, nursing or childcare setting, or in working with beneficiaries having developmental disabilities. College or vocational/technical training from an accredited institution can substitute at the rate of 30 semester, 45 quarter or 720 classroom hours for the required experience.

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, and must have at least one year of experience working in a medical, psychiatric, nursing or childcare setting or working with beneficiaries who have a developmental disability. College or 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.

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.

Non-Residential Support Services Provider Requirements

Provider Qualifications Providers of **non-residential support services** may be independent vendors with at least one year of experience working in a medical, psychiatric, nursing or childcare setting or working with beneficiaries with developmental disabilities. College or 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 beneficiaries support plan and current approved cost plan.

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 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.

Non-Residential Support Services Provider Requirements, continued

Projected Service Outcomes

Projected Service Outcomes are goals used to determine, through monitoring and review, the effectiveness of service provision. Outcomes should be measured considering individual skills and circumstances.

- Beneficiaries achieve goals on their support plan during the year.
 - Beneficiaries receiving NRSS from the provider are satisfied with the services based on the results of the annual satisfaction survey or are satisfied that their concerns raised during the survey have been addressed.
 - Beneficiaries who use the supports and services of the provider demonstrate an increase in abilities, self-sufficiency, and changes in their lives, consistent with their personal goal(s).
 - Beneficiaries who use the services of the provider achieve an increased level of community inclusion or community involvement. (Indicators may be evidence of building and/or maintaining natural support systems, establishing or increasing community connections, and/or in exercising rights and privileges as fully participating members of the community). Beneficiaries receiving services from the provider will have these services provided in an integrated community setting.
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Occupational Therapy Provider Requirements

Provider Qualifications

Providers of **occupational therapy and assessment services** shall be licensed as occupational therapists, occupational therapy aides, or occupational therapy assistants, in accordance with Chapter 468, Part III, F.S.

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.

Training Requirements

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

Note: Refer to Appendix C for provider training requirements.

Personal Care Assistance Provider Requirements

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 have at least one year of experience working in a medical, psychiatric, nursing or childcare setting or working with beneficiaries who have a developmental disability. College or vocational/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.

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.

Personal Emergency Response (PERS) Provider Requirements

**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 Chapter 395, F.S.

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

Physical Therapy Provider Requirements

**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 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.

Physical Therapy Provider Requirements, continued

Training Requirements

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

Note: Refer to Appendix C for provider training requirements.

Private Duty Nursing Provider Qualifications

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.

Training Requirements

Proof of training in the areas of Cardio Pulmonary 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.

Psychological Assessment Provider Requirements

Provider Qualifications

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

Training Requirements

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

Note: Refer to Appendix C for provider training requirements.

Residential Habilitation Provider Requirements

**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 have at least 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, or vocational/technical training equal to 30 semester hours, 45 quarter hours, or 720 classroom hours can substitute for the required experience.

Staff of an agency providing residential habilitation independent of a licensed facility must have at least one year of experience working in the fields of nursing, education, social, behavioral or rehabilitative sciences. Experience in one of the previously mentioned fields shall substitute on a year-for-year basis for the required education.

Licensure or registration is not required for independent vendors.

**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.

Residential Habilitation Provider Requirements, continued

Projected Service Outcomes

Projected Service Outcomes are goals used to determine, through monitoring and review, the effectiveness of service provision. Outcomes should be measured considering individual skills and circumstances.

- Beneficiaries receiving residential habilitation services achieve or make progress toward the support plan goal(s) assigned by the provider.
 - Beneficiaries served are satisfied with their residential habilitation services based on the results of the annual satisfaction survey, or are satisfied that their concerns raised during the survey have been addressed.
 - Beneficiaries who use the supports and services of the provider remain healthy and free from injury, abuse or neglect.
 - Beneficiaries using the supports and services of the provider demonstrate an increase in abilities, self-sufficiency, and changes in their lives, consistent with their personal goal(s).
 - Beneficiaries who use the supports and services of the provider are allowed maximum 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

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.

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.

Respiratory Therapy Provider Requirements

**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.

**Training
Requirements**

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

Note: Refer to Appendix C for provider training requirements.

Respite Care Services Provider Requirements

**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 beneficiaries 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 with at least one year of experience working in a medical, psychiatric, nursing or child care setting or working with beneficiaries with developmental disabilities. College or 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.

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 by the provider. An agency using more than one employee to provide services and billing for their services, shall be registered as a homemaker/sitter/companion provider in accordance with Chapter 400, F.S.

Respite Care Services Provider Requirements, continued

Provider Qualifications, continued 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.

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.

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 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.

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.

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.

Special Medical Home Care Provider Requirements

**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.

**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.

Specialized Mental Health Services Provider Requirements

**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.; or

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 beneficiaries dually diagnosed with mental illness and developmental disabilities.

Specialized Mental Health Services Provider Requirements, continued

Training Requirements

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

Note: Refer to Appendix C for provider training requirements.

Speech Therapy Provider Requirements

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 therapist 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.

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.

Training Requirements

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

Note: Refer to Appendix C for provider training requirements.

Support Coordination Provider Requirements

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 education qualifications described in the State of Florida Career Service Class Specification for a Senior Human Services Counselor Supervisor, class code 5949, effective 03/06/2000. 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 who are employed by agencies shall meet the minimum education and experience qualifications described in the State of Florida Career Service Class Specification for a Human Services Counselor III, class code 5940, effective 03/06/2000. 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.
 - 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 beneficiaries receiving services during the hours employed in the other job, 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 beneficiaries on their caseload, the application may be denied. In no instance may the dual employment include providing services to beneficiaries with developmental disabilities, unless services are provided within the role of case manager or support coordination.
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Support Coordination Provider Requirements, continued

Pre-Service Training Requirements

A minimum of 60 hours of pre-service training is required for solo providers and for the director/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 and general District operational procedures. The District training content must be approved by the 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.

Support coordinators employed by agencies are required to receive the same number of hours of training and are to be trained on the same topics covered in the statewide training; however, this training may be conducted by the support coordination agency. 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 District Office.

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.

Continuing Training Requirements

All waiver support coordinators and agency supervisors, directors/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 coordinator 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.

Support Coordination Provider Requirements, continued

Continuing Training Requirements, continued

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

Projected Service Outcomes

Projected Service Outcomes are goals used to determine, through monitoring and review, the effectiveness of service provision. Outcomes should be measured considering individual skills and circumstances.

- Beneficiaries receiving services from the support coordinator shall maximize 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.
 - Beneficiaries receiving services demonstrate an increase in abilities, self-sufficiency and changes in their lives consistent with their personal goals.
 - Beneficiaries achieve or make progress toward their personal goals on their support plan.
 - Beneficiaries are satisfied with their support coordination services based on the results of the annual satisfaction survey, or are satisfied that their concerns raised during the survey have been addressed.
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Supported Employment Services Provider Requirements

Provider Qualifications

Providers of **supported employment services** may be either independent vendors or agency vendors.

Independent vendors 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.

Supported Employment Services Provider Requirements, continued

Training Requirements

Agency providers are required to attend twelve (12) hours of pre-service training and eight (8) hours of annual in-service training related to supported employment.

Individual vendors must attend at least one supported employment related conference or workshop prior to certification and eight (8) 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.

Projected Service Outcomes

The following Projected Service Outcomes will be used to set goals for each provider and to determine, through monitoring and review, the effectiveness of service provision. Outcomes should be measured considering individual skills and circumstances.

- Beneficiaries in supported employment do not need paid job coaching in excess of 20% of the beneficiaries' average work hours.
 - Beneficiaries receiving supported employment achieve the goal(s) identified on their support plan for which the provider is responsible.
 - The providers achieve a satisfactory or better rating on the annual beneficiary satisfaction survey.
-

Supported Living Coaching Services Provider Requirements

Provider Qualifications

Providers of **supported living coaching** services may be either independent or agency providers.

Independent providers and employees of agencies 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.

Supported Living Coaching Services Provider Requirements, continued

Training Requirements

Agency employees and independent providers are required to attend twelve (12) hours of pre-service training prior to assuming job responsibilities, and eight (8) 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.

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.

Projected Service Outcomes

Projected Service Outcomes are goals used to determine, through monitoring and review, the effectiveness of service provision. Outcomes should be measured considering individual skills and circumstances.

- Beneficiaries in supported living are the lessee or owner of the home in which they reside.
- The provider achieves a satisfactory or better rating, based upon the results of annual beneficiary satisfaction surveys.
- Beneficiaries in supported living live in homes occupied by no more than two other beneficiaries 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.
- Beneficiaries who use the supports and services of the provider demonstrate an increase in abilities, self-sufficiency, and changes in their lives consistent with their Support Plan goal(s). (Indicators may include achievement of goals on the support plan and Implementation Plan, results of Satisfaction Surveys and Personal Outcome Assessments).

Supported Living Coaching Services Provider Requirements, continued

Projected Service Outcomes, continued

- Beneficiaries who use the services of the provider achieve an increased level of community inclusion or community involvement. (Indicators may be evidence of building and/or maintaining natural support systems, establishing or increasing community connections, and/or in exercising rights and privileges as fully participating members of the community).
- Beneficiaries who use the services of the provider maximize 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.

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.

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.

Transportation Services Provider Requirements

**Provider
Qualifications**

Pursuant to Chapter 427, F.S., **transportation services** shall be purchased from community transportation coordinators utilizing the public, private, or private non-profit transportation operators within each county's coordinated transportation system. Transportation operators that are part of the coordinated system are required to adhere to a comprehensive set of vehicle and passenger safety standards that are set forth in Chapter 41-2, F.A.C.

If a group home, residential facility, or adult day training agency wishes to transport its own beneficiaries, the agency must discuss its transportation plans with the Community Transportation Coordinator before initiating transport services. The purpose of this discussion is to enable the Community Transportation Coordinator and the agency to develop an agreeable coordination contract, pursuant to Chapter 427, F.S. If a coordination contract is executed, the trips the agency provides will be counted as coordinated trips. This count is used in the distribution formula for each county's share of the Transportation Disadvantaged Trust Fund, which is used to subsidize the cost of trips that are not included on a beneficiaries support plan or cost plan.

If the District wishes to use an alternative independent provider, the District must obtain prior authorization from the Community Transportation Coordinator, before any contracts are signed.

Transportation providers shall hold applicable licenses issued by the Department of Highway Safety and Motor Vehicles, in accordance with Chapter 322, F.S.

At time of enrollment the provider must be able to show proof of valid: 1) driver's license; 2) vehicle registration; and 3) maintain minimum vehicle liability insurance coverage, as required by law. Subsequent, to enrollment, the provider is responsible for keeping this documentation up to date and is responsible for notifying the District Office of all traffic violations, with the exception of parking tickets, immediately.

Applicants who are paid providers (family members, friends and neighbors) shall provide the District Office with proof of valid Florida driver's license to operate a private vehicle; possess a vehicle that is in safe operating condition; and maintain minimum vehicle liability insurance coverage required by Florida law.

Chapter 2

Developmental Services Waiver Services Covered Services, Limitations And Exclusions

Overview

Introduction

This chapter describes the services covered under the Medicaid Developmental Services (DS) 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 Medicaid Provider Reimbursement handbook, Non-Institutional 081. In addition, beneficiaries receiving DS waiver services must need and receive support coordination and at least one other waiver service.

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

Requirements to Receive Services, continued

Medicaid Eligibility

Beneficiaries who are not already eligible for Medicaid benefits through Supplemental Security Income (SSI), MEDS-AD, or TANF at the time they apply for DS 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 Chapter 3 of the Medicaid Provider Reimbursement handbook, Non-Institutional 081, for information on verifying beneficiary eligibility. Refer to Appendix D for contact information.

Level of Care Requirements

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

- The beneficiary must meet one of the following Developmental Disabilities Program eligibility requirements, in accordance with Chapter 393, F.S.
- The beneficiaries intelligence quotient (IQ) is 59 or less; or
- The beneficiaries IQ is 60-69 inclusive and the beneficiary 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 beneficiaries IQ is 60-69 inclusive and the beneficiary 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 (Secondary disability = 6 in the ABC system.); or
- The beneficiary 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. (Secondary disability = 6 in the ABC system.)
- The DD program determines that DS waiver services are medically necessary.
- The beneficiary or the legal guardian must choose to receive home and community-based supports and services.

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

Requirements to Receive Services, continued

Beneficiary Enrollment Onto the DS Waiver

Once Medicaid and the waiver eligibility requirements are met, the District Office reviews the beneficiaries 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 beneficiary's needs; and, 3) the beneficiary 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 beneficiaries determined eligible and waiting for waiver services.

- A beneficiaries enrollment in the waiver continues indefinitely unless one of the following conditions exist:
- The beneficiary or guardian chooses to terminate participation in the program;
- The beneficiary moves out of state or country;
- The beneficiary 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 beneficiary no longer needs waiver services;
- The beneficiary does not meet level of care for admission to an Intermediate Care Facility for the Developmentally Disabled (ICF/DD); or
- The beneficiary dies.

Note: Refer to Appendix F for complete beneficiary application and eligibility determination, waiting list information, crisis information, and enrollment into the DS Wavier.

Requirements to Receive Services, continued

Medical Necessity

Waiver services shall only be provided when the service or item is medically necessary. Chapter 59G-1.010(166), (a), and (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 beneficiary, the beneficiary’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.

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) and (c), F.A.C., are met, and that the requested item meets the service definition, as contained in the approved DS waiver. The request shall also be reviewed by the Department’s Medical Director or consulting physician, 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. 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 and beneficiary/family/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 beneficiary/family/guardian and copied to the waiver support coordinator. A Medicaid beneficiary may appeal decisions by the District Office by requesting a Medicaid Fair Hearing, in accordance with Chapter 42, 431.200 of the Code of Federal Regulations.

Requirements to Receive Services, continued

**Medical
Necessity
Determinations,**
continued

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.

Note: Refer to definitions for additional information.

**Service
Authorization
Requirements**

The services described in this handbook represent all approved services that may be purchased for a beneficiary participating in the DS waiver who needs the service to reach an outcome described on the support plan. In order for a beneficiary to receive a service it must be identified on a beneficiaries 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 DS Waiver services are limited to the amount, duration and scope of the services described on the beneficiaries 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 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 beneficiary 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

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 the 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 Limitation handbook for the particular service. Handbooks can be downloaded from the Medicaid fiscal agent web site <http://floridamedicaid.acsinc.com>, select Provider Support, select handbooks.

Note: Refer to Appendix D for contact information.

**Service Delivery
Timelines**

Beneficiaries currently enrolled on 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 beneficiary’s enrollment on the waiver, or request, to the extent that sufficient provider capacity exists.

Documentation Requirements

Introduction

DS waiver services are based on beneficiary 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 or she is determined eligible and is enrolled in the appropriate waiver program.

Medicaid will only reimburse for waiver services 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 beneficiary.

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

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 District Office.

Definitions

Annual Report

A written report documenting the beneficiary's progress toward their support plan goal(s) for the year, as required in Chapter 393, F.S.

Annual Satisfaction Survey

A survey of beneficiaries that addresses his or her satisfaction with service delivery and the extent to which the beneficiaries 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 required for beneficiaries receiving Supported Employment. Contacts may be either at the job site or another setting.

Central Record or Provider File of a Beneficiary

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:

- Beneficiary 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;
- Service delivery information including the current support plan, cost plan or written authorization of services, and implementation plans, as required; and,
- Service delivery documentation, in the form of progress reports or as specified in the Developmental Services 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 beneficiary's Central Record, but remains the property of the Department.

Definitions, continued

Community Integrated Settings

Local settings that are not limited to, or segregated settings for, beneficiaries 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 beneficiary 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 beneficiary's support plan is amended 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 beneficiary 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 beneficiaries and the days of the month. For each day the beneficiary participated in the service, the date is checked (✓) or marked with an "X". This log is called a "trip log" for transportation services.

Daily Progress Note

Daily (on days service was rendered) notes of the beneficiary's progress towards achieving his or her support plan goals for the period being billed or the summary describing the treatment or training provided to the beneficiary 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.

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.

Definitions, continued

Florida Status Tracking Survey (FSTS)

The FSTS is a questionnaire, designed to obtain and provide information about a beneficiary with developmental disabilities, which is used to develop the beneficiary's supports and services. The FSTS aids in the support planning process. Following the instructions provided by the Department, this survey is initially completed and updated annually by the beneficiary's waiver support coordinator.

Home Accessibility Assessment

An assessment conducted by a Rehabilitation Engineer or other certified professional that determines the medically necessary physical adaptations to a beneficiary'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.

Implementation Plan

A plan developed with direction from the beneficiary, which includes information from the beneficiaries current support plan, and other pertinent sources. The specific areas of training and strategies to meet support plan goal(s) for each beneficiary will be addressed in the beneficiaries implementation plan. Training objectives appropriate to the beneficiaries 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 beneficiary served.
- The goal(s) from the support plan that the service will address.
- The strategies employed to assist the beneficiary in meeting the support plan goal(s).
- The system to be used for data collection and assessing the beneficiaries 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 beneficiary, shall be furnished to the beneficiary, 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 beneficiaries progress, or lack thereof, summarized in the monthly summary shall be available for review.

Definitions, continued

Beneficiary 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.

Invoice

A list of the approved service(s) or procedure(s) rendered or item(s) purchased, rate and units. The provider's name, address, provider number and the appropriate service code must appear on the form. When billing for equipment or supplies, include brand name, model number, size, and any attachments needed. The service provider may send a copy of catalog pages.

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-DS 3064, the Core Assurances for providers of Medicaid Home and Community-Based Waiver Services Programs, and documents specifying rates. Specific service requirements, as defined in the Developmental Services Waiver Services Coverage and Limitations handbook, are incorporated into the agreement by reference. All providers must complete this agreement to provide services to beneficiaries enrolled in the Developmental Services Home and Community-Based Services Waiver Program.

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

Medication Review

A review that contains recommendations for changes in medications, and is provided by the consultant pharmacist to the beneficiary (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 beneficiary and their caregivers, about medication administration and other interventions specific to the beneficiary's needs designed to improve the therapeutic outcome of currently prescribed medications.

Monthly Nutritional Status Report

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

Definitions, continued

Monthly Summary

A summary note of the month's activities indicating the beneficiary's progress toward achieving their support plan goals for the month billed.

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 beneficiary's health.

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 beneficiary'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 beneficiary's central file.

Service Log

Includes times and dates service was rendered with a detailed list of the activities performed on each visit.

Solo Provider

An enrolled provider who personally renders waiver services directly to beneficiaries and does not employ others to render waiver services.

Supported Living Log

Written documentation of the dates, times and summary of the supports provided during contact with the beneficiary, as described in Chapter 65B-11.014, F.A.C.

Treatment Plan

A written plan developed by a provider of Specialized Mental Health Services. The treatment plan must be provided to the waiver support coordinator with the first full month's billing and every six months thereafter.

Adult Day Training

Description

Day training programs for adults are training services intended to support the participation of beneficiaries in daily, valued routines of the community. For adults this may include work-like settings that do not meet the definition of supported employment.

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 beneficiary; 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 beneficiary 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 beneficiary, reflecting their goal(s) from the current support plan.

Services shall be 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. Adult day training services may be provided as an adjunct to other services included on a beneficiary's support and cost plan. For example: a beneficiary 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 beneficiary 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 beneficiaries are included as ADT-Off Site services.

Any beneficiary 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 beneficiary, must be paid. Beneficiaries who are working must be paid commensurate with members of the general work force doing similar work per wage and hour regulations of the Department of Labor.

Adult Day Training, continued

Description, continued

At least annually, providers will conduct an orientation informing beneficiaries 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 beneficiaries 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 beneficiaries 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 beneficiaries with disabilities work in a small business created specifically by or for the beneficiaries.

Limitations

Adult day training services are usually limited to a specific number of days per year, for up to six hours per day. The provider shall render services at a time mutually agreed to by the beneficiary and the provider. This will allow a beneficiary the flexibility to determine when to attend the ADT program for limited hours or only on certain days. This service generally begins at the age of 22 when a beneficiary is out of the public school system or when they have graduated from the public school system. However, a beneficiary can begin at the age of 16 if the public school system is willing to provide funding for this service throughout the person's legal age of eligibility. Beneficiaries 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 beneficiary's support plan and current approved cost plan.

The staffing ratio shall not exceed ten beneficiaries per direct care staff.

This service cannot be provided concurrently with PCA, NRSS, or Companion services.

Adult Day Training, continued

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice;
2. A daily attendance log; and,
3. A copy of the beneficiaries implementation plan (when billing for an beneficiary for the first time; at least annually thereafter at the time of the support plan update; and, 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 definition 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 beneficiary makes an informed choice concerning types of work and meaningful day activities (type of activities).

For monitoring purposes, the provider must have, at a minimum:

1. An individual implementation plan and supporting data;
2. A copy of the daily attendance logs for the period being reviewed;
3. Monthly summaries for the period being reviewed;
4. An annual report;
5. Results of the annual satisfaction survey; and
6. Performance data on the selected Service Outcomes projected in this handbook.

Note: Refer to the definition section for additional information.

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 beneficiary and provider.

Special Considerations

Adult day training providers may be paid separately for transportation services only when transportation is provided between a beneficiary's place of residence and the training site. Transportation between day training sites 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.

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

Adult Day Training, continued

Special Considerations, continued

If the support is provided to groups larger than eight beneficiaries, 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 beneficiaries are paid less than minimum wage, the service shall be billed as adult day training-off site.

Payment shall not be made for any day the beneficiary 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.

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 beneficiary's health, by increasing the risk of infection or disease, or reducing food options, resulting in restrictive nutritional intake. Routine preventive cleanings are provided under the waiver.

Limitations

Adult Dental Services are limited to beneficiaries 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 DS waiver for any enrolled DS waiver adult. The Medicaid State Plan provides dental services for beneficiaries under the age of 21.

Adult cleanings are limited to one 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 Medicaid Dental Services Coverage and Limitations handbook for additional information regarding Medicaid State Plan coverage.

A beneficiary shall receive no more than 10 units of this service per day.

Adult Dental Services, continued

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice.

For monitoring review purposes, the provider must have, at a minimum:

1. Copies of all invoices submitted for the period being reviewed, and
2. All treatment records.

Note: Refer to the definition 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.

Special Considerations

Adult dental services are to be authorized only to prevent or remedy problems that could lead to a deterioration of the beneficiary's health, thus placing the beneficiary at risk of an institutional placement. A beneficiary must have teeth in order to receive this service. 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, 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 reinforcers and other consequences are used, based on identified functional relationships between behavior and environment, in order to produce practical behavior change.

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. 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.

Limitations

A beneficiary 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.

Documentation Requirements

Documentation of services must comply with Chapter 65B-4.030(9) and (10), F.A.C.

For reimbursement purposes, the provider must submit:

1. An invoice;
2. A service log;
3. Data displays;
4. A monthly summary of monitoring and;
5. A description of the provider’s behavior analysis services plan covering the foreseeable future but not less than a 30-day period (at the time of the first billing and when an update is made to the behavior analysis services plan); or,

Behavior Analysis Services, continued

Documentation Requirements, continued

If the provider is to be reimbursed for an assessment, the provider must submit:

1. An invoice; and
2. A copy of the assessment report.

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the behavior analysis services plan;
2. Copies of data displays;
3. A copy of the service logs for the period being reviewed;
4. A copy of the monthly summary notes; and
5. A copy of the assessment report, if the provider was reimbursed for such a report.

Note: Refer to the definition section for additional information.

Place of Service

These services may be provided in the provider's office, the beneficiaries place of residence or anywhere in the community.

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.

Note: Refer to Appendix E for contact information.

Behavior Assistant Services

Description

Behavior Assistant Services include the performance of 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, data collection and display (e.g., graphics) as authorized by a beneficiary's behavior analysis service plan and training for 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 beneficiaries for whom traditional residential habilitation services have been documented unsuccessful.

Behavior Assistant Services, continued

Documentation Requirements

For reimbursement purposes, the Behavior Assistant Services provider must submit:

1. An invoice;
2. A service log;
3. A monthly summary note; and
4. A copy of the behavior analysis service plan (must be submitted to the waiver support coordinator at the time of the first billing).

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the behavior analysis service plan;
2. A copy of the service logs for the period being reviewed; and
3. Copies of all monthly summary notes.

Note: Refer to the definition section for additional information.

Place of Service

These services may be provided in the provider's office, the beneficiaries place of residence or anywhere in the community.

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-4.039(10), F.A.C.

Chore Services

Description

Chore services are provided to maintain the beneficiary'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 beneficiary 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.

Chore Services, continued

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice; and
2. A service log.

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of all service logs for the period being reviewed.

Note: Refer to the definition section for additional information.

Place of Service

Chore services shall be provided in the beneficiary'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 beneficiary's primary living areas such as a bedroom and bathroom. It may include the kitchen and a common area, if regularly utilized by the beneficiary.

Beneficiaries living in licensed residential settings are not eligible to receive chore services.

Special Considerations

For beneficiaries 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.

Companion Services

Description

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 beneficiary's goals per his or her support plan. A companion provider may also assist the beneficiary 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 beneficiary. 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 beneficiary. 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.

Companion Services, continued

Limitations

Providers of companion services are limited to the amount, duration, and scope of the services described on the beneficiaries support plan and current approved cost plan. A beneficiary shall receive no more than 40 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).

Beneficiaries living in licensed residential settings, excluding foster homes, are **not** eligible to receive these services.

Beneficiaries 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.

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice; and
2. A service log.

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of all service logs for the period being reviewed.

Note: Refer to the definition section for additional information.

Place of Service

Companion services may be provided in the beneficiary's own home, foster home or family home, or while the beneficiary 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.

Companion Services, continued

Special Considerations

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

If the provider plans to transport the beneficiary in his/her 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 and is responsible for notifying the District Office of all traffic violations, with the exception of parking tickets, immediately.

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 beneficiaries 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 Services Home and Community-Based Services waiver must meet all of the following conditions: a) be related to a beneficiaries specific medical condition, b) not be provided by any other program, c) be the most cost-beneficial means of meeting the beneficiaries need, and d) not primarily for the convenience of the beneficiary, caregiver, or family. Consumable medical supplies covered by the DS waiver are listed under *Limitations*.

Consumable Medical Supplies, continued

Limitations

Consumable Medical Supplies will not duplicate supplies provided by the Medicaid State Plan. Refer to the 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 beneficiary, may be purchased by the waiver. All supplies shall have direct medical or remedial benefit to the beneficiary and are related to the beneficiary's developmental disability.

If multiple vendors are enrolled to provide this service, the beneficiary 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 covered by the DS 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 beneficiary requires personal care that exposes the caregiver to body fluids. Latex-free gloves will be authorized when the beneficiaries or the caregiver's physician certifies that the beneficiary or caregiver has a latex allergy or that there is a probable expectation that the beneficiary or caregiver may have a latex allergy (i.e., beneficiaries with spina-bifida).
4. Surgical masks, when prescribed by a physician and are:
 - a. Worn by a beneficiary 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 beneficiary who has a compromised immune system and who must be protected at all cost from exposure to any airborne organisms or substances. The physician must renew the prescription quarterly.
5. Disposable or washable bed/chair pads and adult sized bibs.
6. Ensure, or other food supplements, when determined necessary by a licensed dietitian. Beneficiaries 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 pharmacy program.
7. Feeding tubes and supplies, not covered by Medicaid and prescribed by a physician. Excludes supplies for a beneficiary who qualifies for food supplements under the Medicaid pharmacy program 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.

Consumable Medical Supplies, continued

Limitations, continued

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 beneficiary's physician.

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 beneficiary's developmental disability, and without which the beneficiary can not continue to reside in the community or in his or her 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 beneficiary'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, Ginko 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.

Consumable Medical Supplies, continued

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice listing the supplies purchased.

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the invoices listing the supplies purchased for the period being reviewed; and
2. The original prescription for the supply (if prescribed).

Note: Refer to the definition 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. Beneficiaries 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 beneficiary. The services include assessing the nutritional status and needs of a beneficiary; recommending an appropriate dietary regimen, nutrition support and nutrient intake; and providing counseling and education to the beneficiary, 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 beneficiary 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.

Dietitian Services, continued

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice;
2. Service log;
3. A monthly nutritional status report;
4. An assessment (at the time of the first billing and any re-assessments thereafter); and
5. A copy of the individual dietary management plan (at the time of the first billing).

For monitoring review purposes, the provider must have, at a minimum:

1. An individual dietary management plan;
2. A copy of the service logs;
3. Daily progress notes (on days service was rendered);
4. Copies of each monthly nutritional status report for the period being reviewed; and
5. The original prescription for the service.

Note: Refer to the definition 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.

Beneficiaries 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 Medicaid Prescribed Drug Coverage and Limitations handbook.

Durable Medical Equipment and Supplies

Description

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

Limitations

Durable Medical Equipment and Supplies will not duplicate DME and supplies provided through the Medicaid State Plan. Refer to the 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 beneficiary, may be purchased by the waiver. All supplies shall have direct medical or remedial benefit to the beneficiary and are related to their disability.

The following is a list of equipment that the DS 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 beneficiary with mobility impairments and when the vehicle is the beneficiary'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 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 beneficiary or family. Repair to adaptations after the warranty expires may be covered. Many automobile manufacturers offer a rebate of up to \$1,000 to beneficiaries purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the beneficiary or family is required to submit documented expenditures of modifications to the manufacturer. If the rebate is available it must be applied to the cost of the modifications. If a beneficiary 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.

Durable Medical Equipment and Supplies, continued

Limitations,
continued

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 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 beneficiary has a customized power wheelchair funded through Medicare or Medicaid, which is used as their primary mode of ambulation, or the beneficiary is ambulatory, but has a documented medical condition that prevents walking for sufficient lengths of time to go about his or her daily activities, for example cardiac insufficiency or emphysema. This condition must be documented by a physician and include a statement addressing how the beneficiary is limited in normal daily activities by the condition;
 - b. The beneficiary needs a manual wheelchair to facilitate movement within their own home, and to enable them to be safely transported in an automobile. It must be documented that the vehicle does not have a lift or that the beneficiaries 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 beneficiary.
 - d. The wheelchair covered by this service is a standard (manual) wheelchair and not intended for a beneficiary who cannot use a standard chair for any length of time without adaptation.

If the beneficiary 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 Medicaid State Plan.

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 beneficiary.

Durable Medical Equipment and Supplies, continued

Limitations,
continued

4. Strollers, subject to the same criteria and limitations for wheelchairs, as stated above, except reimbursement for a stroller will be limited to \$1,200. Only one stroller or manual wheelchair can be purchased in any five-year period. As a cost-effective alternative the base unit for an adaptive car seat, could be covered in lieu of a stand-alone stroller unit.
5. Portable ramps, when the beneficiary requires access to more than one non-accessible structure.
6. Patient Lift, hydraulic or electric with seat or sling, when the beneficiary 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.
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 beneficiary'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 individuals 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.
8. Adaptive car seat, for beneficiaries 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 beneficiary cannot use standard restraint devices or car seats. The physical therapist will identify appropriate equipment for the beneficiary. Adaptive car seats are limited to one per beneficiary every three years and cost no more than \$1,000.
9. Bidet, limited to beneficiaries 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 beneficiary 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 beneficiaries 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 beneficiary 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 beneficiary 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 beneficiary 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 beneficiaries living alone or who are alone for 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 beneficiary's need for bathing. Items that exceed the basic needs of the beneficiary 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 beneficiary when:
- a. The beneficiary is ventilator-dependent;
 - b. The beneficiary requires daily use of oxygen via a concentrator;
 - c. The beneficiary requires continuous, 24-hour total parenteral nutrition via an electric pump;
 - d. The beneficiary requires continuous, 24-hour infusion of total nutritional formula through a jejunostomy or gastrostomy tube via an electric pump;
 - or,
 - e. The beneficiary 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 beneficiary's need. One generator per beneficiary may be purchased per 10-year period.

22. Bolsters/pillows/wedges, necessary for positioning, prescribed by a physical or occupational therapist.
23. Therapy mat, prescribed by a physical therapist when a beneficiary 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 beneficiaries with respiratory or cardiac disease, who use supplemental oxygen on a continuous or intermittent basis. This equipment must be prescribed by the beneficiary'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 beneficiary's developmental disability, without which the beneficiary can not continue to reside in the community or in their 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 beneficiary 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/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.

**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.

For reimbursement purposes, the provider must submit:

1. An invoice (prior to processing the invoice for payment the beneficiaries 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 beneficiary/family).

Durable Medical Equipment and Supplies, continued

Documentation Requirements,
continued

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the invoices listing the equipment provided for the period being reviewed; and
2. The original prescription for the equipment (if prescribed by a physician).

Note: Refer to the definition section for additional information.

Special Considerations

Beneficiaries 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 DS 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 beneficiary 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 needs of the beneficiary, may be purchased by the DS waiver, and then only consistent with what is described above. All equipment shall have direct medical or remedial benefit to the beneficiary, shall be related to the beneficiary'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 Definition Section for additional information regarding prescriptions.

Environmental Accessibility Adaptations

Description

Environmental accessibility adaptations (EAA) are those physical adaptations to the home, required by the beneficiaries support plan, which are “medically necessary” to avoid institutional placement of the beneficiary and enable them to function with greater independence in the home. 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 beneficiary’s home.

Home accessibility assessments may also include pre-inspection of up to 3 houses a beneficiary 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 beneficiary or family to determine the best design to meet the beneficiary’s needs and any potential adaptations that may be required to make the home accessible.

Limitations

Environmental accessibility adaptation services are limited to the amount, duration and scope of the adaptation project described on the beneficiary’s support plan and current approved cost plan. If multiple vendors are enrolled to provide this service, the beneficiary 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 beneficiary.

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

Environmental Accessibility Adaptations, continued

Limitations,
continued

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 beneficiary's developmental disability, how it's directly related to accessibility issues within the home, and how, without the selected EAA, the beneficiary can not continue to reside in their 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**

For reimbursement purposes, the provider must submit:

1. An invoice listing the adaptations completed on the home. (Prior to processing the invoice for payment, the beneficiary'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 beneficiary/family).

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the invoices for the period being reviewed; and
2. The original prescription for the environmental adaptation and/or home accessibility assessment.

Note: Refer to the definition section for additional information.

Environmental Accessibility Adaptations, continued

Place of Service

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

Special Considerations

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

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

Environmental accessibility adaptations shall be approved for a beneficiary's own home or family home (whether owned or leased), as needed, to make the home accessible to the beneficiary. No more than five units shall be billed per day. Once adaptations are made to a beneficiaries 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.

In general, if a beneficiary or family purchases or builds a home while the beneficiary 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.

Environmental Accessibility Adaptations, continued

Special Considerations, continued

Rental property is limited to minor adaptations as defined below. Prior to any adaptation to a rental property, a determination should be made as to what, if anything, the landlord will cover. The landlord, prior to service, shall approve all proposed environmental accessibility adaptations in writing. The written agreement between the beneficiary 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 beneficiary moves out. Beneficiaries or families requesting EAA are expected to apply for all other assistance that may be available to assist in meeting the beneficiary'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 beneficiary on the waiver.

The report must demonstrate that the environmental accessibility adaptation recommended is a "prudent purchase." Prudent purchase is a combination of quality and cost, where quality is measured by the ability to meet the beneficiary'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, continued

Special Considerations, continued

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 beneficiary 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/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.

Homemaker Services

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 beneficiary'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 beneficiary 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 1 or 2 days a week for 2-4 hours at a time.

Homemaker services cannot be used for supervision or personal care of a beneficiary.

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice; and
2. A service log.

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of all the service logs for the period being reviewed.

Note: Refer to the definition section for additional information.

Place of Service

Homemaker services shall be provided in the beneficiary'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 beneficiary's primary living areas such as bedroom and bathroom. This includes the kitchen and a common area, if regularly utilized by the beneficiary.

Beneficiaries living in licensed residential facilities are not eligible to receive homemaker services.

Special Considerations

Homemaker services are rendered only when the beneficiary 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 beneficiary.

In-Home Support Services

Description

In-home supports are services that provide a beneficiary in a supported living situation with 4 to 24-hour-a-day assistance from a support worker or support workers. The support worker may live in the beneficiary's home or apartment and share living expenses (rent, utilities, phone, etc.) with the beneficiary. 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 beneficiary in supported living. The in-home support services are separate and not a replacement for the services performed by a supported living coach. Some beneficiaries in supported living may need only the services of an in-home support worker, or only the services of a supported living coach. Other beneficiaries 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 beneficiaries residing in their own homes (excludes family home or sharing of a home with family members). A beneficiary receiving in-home support services is not eligible to receive personal care, companion or residential habilitation services.

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice; and
2. A service log.

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the service logs; and
2. A copy of the monthly summary notes for the period being reviewed.

Note: Refer to the definition section for additional information.

Place of Service

In-home support services are provided in the beneficiary's own home. The in-home support services worker may also accompany the beneficiary to activities in the community.

In-Home Support Services, continued

Special Considerations

The in-home support services worker is prohibited from paying rent or the cost of other living expenses directly to the beneficiary, since such financial transactions could jeopardize the beneficiary's eligibility status as a Medicaid beneficiary. 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 beneficiary owns the home, the waiver support coordinator or District staff must assist the beneficiary in negotiating the provider's fee, then negotiate offsetting the fee by the amount the provider owes the beneficiary for rent and other living expenses.

When a beneficiary 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.

Medication Review

Description

Medication Review is an independent review and assessment of all prescription and over-the-counter medications taken by a beneficiary. 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 beneficiaries 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*;

Medication Review, continued

Description,
continued

- Have a prescription for, and are receiving or will be receiving within the next 30 days, any neuroleptic medication;
- Receive routine monitoring for any of the following: potassium, sugar, thyroid and/or drug levels;
- Have a chronic disease associated with the blood, brain, lungs, heart, liver, skin, kidney and/or 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.

Limitations

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.

Documentation Requirements

For billing purposes, the provider shall submit to the waiver support coordinator:

1. An invoice; and,
2. A report summarizing the medication review.

Such review shall contain recommendations for changes in medications and shall also be provided by the consultant pharmacist to the beneficiary (or family or legal guardian) and the prescribing physician.

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 beneficiary and their caregivers, about medication administration and other interventions specific to the beneficiary'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.

Note: Refer to the definition section for additional information.

Place of Service

This service is performed at the beneficiary's place of residence, or the provider's office.

Non-Residential Support Services

Description

Non-residential support services are individualized training activities provided to an adult or child in integrated, non-residential settings. These activities are age-appropriate and geared to enhancing the acceptable individual behaviors; increasing the beneficiary's ability to control the environment and emphasizing those qualities, which are integrative and normative in nature. 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 beneficiaries in daily valued routines in the community. This service is covered when necessary to prevent institutionalization.

The primary functions of non-residential support services are:

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

Limitations

A beneficiary is limited to no more than 12 hours of non-residential support services per day. Non-residential support services are billed at an hourly or daily rate. If the provider renders the services for more than 4 hours per day, they must bill at the daily rate if more cost beneficial to the waiver. Daily billing is limited to no more than the total number of days in the month. 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 in the general work force.

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

Beneficiaries receiving this support may not receive the support in groups of individuals larger than 3, except as noted under Special Considerations.

Non-Residential Support Services, continued

Limitations,
continued

Non-residential support service providers are not reimbursed separately for transportation and travel costs. These costs are integral components of non-residential support services and are included in the basic rate. This does not preclude the beneficiary 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 beneficiary or through separate transportation reimbursement. If the provider plans to transport the beneficiary in his/her 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 and is responsible for notifying the District Office of all traffic violations, excluding parking tickets, immediately.

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

**Documentation
Requirements**

For reimbursement purposes, the provider must submit:

1. An invoice;
2. A monthly summary (including the training location) for the days services were provided; and
3. A copy of the individual implementation and or behavior analysis services plan (at the time of the first billing, annually thereafter at the time of the support plan update, and any time updates and changes are made before they are implemented).

For monitoring review purposes, the provider must have, at a minimum:

1. An individual implementation plan and or behavior analysis services plan and data supporting training toward achievement of the support plan goal(s);
2. Daily progress notes for each day services were provided;
3. Monthly summary of progress and activities during the month toward achieving support plan goal(s);
4. An annual report;
5. Results of the annual satisfaction survey; and
6. Performance data on the selected service outcomes projected in this document.

Note: Refer to the definition section for additional information.

Non-Residential Support Services, continued

Place of Service

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

Special Considerations

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

Exception: Beneficiaries 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 beneficiaries in remote areas where it is cost-beneficial to have slightly larger groups (4-6) shall negotiate the limit with their District Office.

Occupational Therapy

Description

Occupational therapy services are services prescribed by a physician that are necessary to produce specific functional outcomes in selfhelp, adaptive, and sensory motor skill areas, and assist the beneficiary 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.

Limitations

Occupational therapy and assessment services are available through the Medicaid State Plan services, to beneficiaries under the age of 21. Services for these beneficiaries may not be purchased under the waiver.

Refer to the Medicaid Therapy Services Coverage and Limitations handbook for additional information on Medicaid State Plan coverage.

Children who receive this service through the certified "school match" program, may still be eligible for additional Medicaid State Plan occupational therapy services.

A beneficiary 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.

Occupational Therapy, continued

Documentation Requirements

For reimbursement purposes, the occupational therapy provider must submit:

1. An invoice;
2. A service log; and
3. A monthly summary note.

For reimbursement of an occupational therapy assessment the provider must submit:

1. An invoice; and
2. A copy of the assessment report.

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the service logs for the period being reviewed;
2. A copy of the monthly summary notes;
3. A copy of the assessment report ; and
4. The original prescription for its service.

Note: Refer to the definition section for additional information.

Place of Service

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

Personal Care Assistance

Description

Personal care assistance is a service that assists a beneficiary with eating and meal preparation, bathing, dressing, personal hygiene, and 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 and welfare of the beneficiary and when no one else is available to perform them. This service is provided on a one-on-one basis.

Personal Care Assistance, continued

Limitations

Personal Care assistance is limited to the amount, duration and scope of the services described in the beneficiaries support plan and current approved cost plan. A beneficiary shall receive no more than 96 units of this service per day, when the provider is paid by the quarter-hour unit.

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 Medicaid Home Health Services Coverage and Limitations handbook for additional information on Medicaid State Plan coverage. Refer to Appendix D for contact information.

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice; and
2. A service log.

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the service logs for the period being reviewed.

If the provider plans to transport the beneficiary in his/her 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 and is responsible for notifying the District Office of all traffic violations, with the exception of parking tickets, immediately.

Note: Refer to the definition section for additional information.

Personal Care Assistance, continued

Place of Service

Personal care assistance shall be provided in the beneficiary's own home or family home or while the beneficiary who lives in one of those arrangements is engaged in a community activity.

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.

Beneficiaries 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 beneficiaries the parent or caregiver is attempting to provide assistance to; 3) gender of beneficiary, compared to that of the parent or caregiver; and 4) complexity of the beneficiary's personal care routine.

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

Beneficiaries 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 beneficiary'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 beneficiary has recovered, the service must be discontinued.

Personal Care Assistance, continued

Special Considerations,
continued

A relative is defined as someone other than a legally responsible family member, who is required to provide care for the beneficiary, 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 beneficiary and provider. The beneficiary 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.

If the provider plans to transport beneficiaries in their 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 and is responsible for notifying the District Office of all traffic violations, with the exception of parking tickets, immediately.

Personal Emergency Response Systems

Description

A **Personal Emergency Response System** is an electronic communication system that enables an individual to secure help in the event of an emergency. The individual may also wear a portable "help" button that allows for mobility while at home or in the community. The system is connected to the person's phone and programmed to signal a response center. When the "help" button is activated; qualified personnel are dispatched to the person's location.

Limitations

A Personal Emergency Response System is limited to those beneficiaries 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 requires extensive routine supervision. Beneficiaries 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.

Documentation Requirements

For reimbursement purposes, the equipment installation provider and the emergency monitoring provider must submit invoices specifying the services rendered. For monitoring review purposes, the equipment installation provider and the emergency monitoring provider must have, at a minimum, 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 and monitoring.

Note: Refer to the definition section for additional information.

Place of Service

A Personal Emergency Response System shall be provided in the beneficiaries own home or apartment or the family's home or apartment. A mobile "help button" is also available for the beneficiary to wear while engaged in a community activity.

Special Considerations

A Personal Emergency Response System is available only for at-risk beneficiaries who require a limited degree of supervision, but live alone or are alone for periods of time without a caregiver.

Physical Therapy

Description

Physical therapy is a service prescribed by a physician that is necessary to produce specific functional outcomes in ambulation, muscle control, and postural development, and to prevent or reduce further physical disability. The service may also include a physical therapy assessment, which does not require a physician's prescription. In addition, this service may include training and monitoring direct care staff and caregivers to ensure they are carrying out therapy goals correctly.

Limitations

Physical therapy and assessment services are available through Medicaid State Plan services to beneficiaries under the age of 21. Services for these beneficiaries may not be purchased under the waiver.

Children, who receive this service through the "school match" 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 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 beneficiary is able to use an outpatient facility for physical therapy and the setting is appropriate to meet the beneficiaries 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 (1) when the outpatient dollar limits are reached; or (2) when physical therapy must be provided in a location other than an outpatient facility.

A beneficiary 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 D for contact information.

Physical Therapy, continued

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice;
2. A service log; and
3. A monthly summary note.

If the provider is to be reimbursed for an assessment, the provider must submit:

1. An invoice; and
2. A copy of the assessment report.

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the service logs, for the period being reviewed;
2. A copy of the monthly summary notes;
3. A copy of the assessment report, if the provider was reimbursed for such a report; and
4. The original prescription for their service.

Note: Refer to the definition section for additional information.

Place of Service

This service may be provided in the therapist's office, beneficiary'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.

To be eligible for this service, a beneficiary must require active nursing interventions on an on-going basis.

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

A beneficiary 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.

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice;
2. A nursing care plan;
3. A service log; and
4. An individual nursing assessment (must be completed at the time of the first billing.)

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the service logs, for the period being reviewed;
2. A copy of the nursing care plan (and all revisions), for the period being reviewed;
3. A copy of all daily progress notes;
4. The original prescription for their service; and
5. An individual nursing assessment, conducted initially and annually thereafter.

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 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 beneficiary, as well as a plan for the care that they provide. This documentation must be provided to the waiver support coordinator before rendering services.

Private Duty Nursing, continued

Place of Service	Private duty nursing services shall be provided at the beneficiaries place of residence.
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Special Considerations	Private duty nursing services shall not be used for ongoing medical oversight in a residential facility.
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Psychological Assessment

Description	Psychological assessment is the evaluation and interpretation of intelligence, aptitudes, interests, academic achievement, adjustment and motivations, or any other attributes in a beneficiary that relate to learning, educational or adjustment needs.
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Limitations	A beneficiary shall receive no more than one psychological assessment per year. Psychological assessment services shall include only the assessment services provided by a licensed psychologist.
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Documentation Requirements	For reimbursement purposes, the provider must submit:
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1. An invoice; and
2. A copy of the evaluation report.

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the evaluation report(s).

Note: Refer to the definition section for additional information.

Place of Service	This service is usually performed in the psychologist's office, but may also be performed in the beneficiary'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

Description

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

A more intensive residential habilitation service may be required for beneficiaries with challenging behavioral disorders. The necessity for these intensive services is determined by the impact of these behavioral disorders on the immediate safety, health, progress and quality of life for the beneficiary, and the determination that less intensive services have not been sufficient to alter these behaviors. These intensive services are marked by the on-site presence of certified behavior analysis professionals, high-levels of integration of behavioral services throughout all aspects of the residential and community programs, progress in reducing challenging behaviors and in acquiring new skills, comprehensive monitoring of implementation, and provisions for the eventual transitioning of behavioral improvement to less intensive, more community-based, residential alternatives.

Note: Refer to Special Considerations under Behavioral Analysis and Behavioral Assistant Services for additional requirements.

Limitations

Residential habilitation services are provided to adults, 18 years of age and older, living in their own home or family home.

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.

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

Residential Habilitation Services, continued

Limitations,
continued

When this service is provided in a beneficiary's own home, the service must be directly related to a training goal(s) on the beneficiaries support plan and cannot be used solely for the supervision of the beneficiary.

When residential habilitation is provided in a beneficiary's family home, the beneficiary shall have an outcome (goal) for supported living on the support plan. Residential habilitation can be provided for up to 90 days prior to the supported living coach assuming responsibilities or 90 days prior to moving into supported living.

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice;
2. A daily attendance log;
3. A monthly summary of progress and activities during the month toward achieving support plan goal(s); and
4. A copy of the individual implementation plan must be submitted to the support coordinator at the time of the first full month's billing when a beneficiary is initially enrolled in the service, and at least annually thereafter at the time of the support plan update.

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the daily attendance logs, for the period being reviewed;
2. An individual implementation plan and supporting data;
3. Monthly summaries of progress and activities during the month(s) toward achieving support plan goal(s), for the period being reviewed;
4. An annual report; and
5. Results of the annual satisfaction survey performance data on the selected Service Outcomes projected in this document.

Place of Service

This service shall be provided primarily at the beneficiaries place of residence, which must be the beneficiaries 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, may also be authorized within the scope of this service.

Residential Habilitation Services, continued

Special Considerations

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 beneficiary 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. For example, a behavior analyst employed by an agency may provide the actual day-to-day residential habilitation service, especially when a beneficiary requires a complicated or very intensive behavioral support plan. The behavior analyst could also perform the ongoing assessments and plan development.

Note: Refer to the Definition Section for additional information.

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, within the scope of Florida's Nurse Practice Act, for beneficiaries who require on-going daily nursing intervention. The provider may also conduct training for direct care staff to ensure adequate and consistent health care is provided.

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 nurse and home health aide visits are 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 DS waiver, if determined medically necessary by the Department. Refer to the Medicaid Home Health Services Coverage and Limitations handbook for additional information on Medicaid State Plan coverage.

Note: Refer to Appendix D for contact information.

A beneficiary shall receive up to 24 hours of nursing services a day, at a nurse to beneficiary ratio not exceeding one nurse for every eight beneficiaries.

Residential Nursing Services, continued

Documentation Requirements	<p>For reimbursement purposes, the provider must submit:</p> <ol style="list-style-type: none">1. An invoice;2. A service log;3. A monthly summary note; and4. A beneficiary Nursing Assessment (must be provided at the time of the first billing). <p>For monitoring review purposes, the provider must have, at a minimum:</p> <ol style="list-style-type: none">1. A beneficiary Nursing Assessment, conducted initially and annually thereafter or as needed should the beneficiaries condition change;2. A copy of the service logs, for the period being reviewed; and3. A copy of the monthly summary notes (the monthly summaries must include details such as health risk indicators, information about medication, treatments, doctor's appointments, etc.); and a copy of the monthly summary notes (the monthly summaries must include details such as health risk indicators, information about medication, treatments, doctor's appointments and other relevant information). <p><u>Note:</u> Refer to the definition section for additional information.</p>
Place of Service	<p>Residential nursing services shall be provided at the beneficiary's place of residence.</p>

Respiratory Therapy

Description	<p>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.</p>
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Respiratory Therapy, continued

Limitations

Respiratory therapy and assessment services are available through the Medicaid State Plan service for beneficiaries under the age of 21. Services for these beneficiaries may not be purchased under the waiver. Children receiving this service through the "school match" 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 Medicaid Therapy Services Coverage and Limitations handbook for additional information on Medicaid State Plan coverage.

A beneficiary 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.

Note: Refer to Appendix D for contact information.

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice;
2. A service log; and
3. A monthly summary note.

If the provider is to be reimbursed for an assessment, the provider must submit:

1. An invoice; and
2. A copy of the assessment report.

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the service logs;
2. A copy of the monthly summary note;
3. A copy of the assessment report, if the provider was reimbursed for such a report; and
4. The original prescription for this service.

Note: Refer to the definition section for additional information.

Place of Service

This service is usually provided in the beneficiary'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 beneficiary 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 beneficiary 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. If the provider plans to transport the beneficiary in his or her 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 and is responsible for notifying the District Office of all traffic violations, with the exception of parking tickets, immediately.

Respite care services are limited to the amount, duration, and scope of the service described on the beneficiaries support plan and current approved cost plan.

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice; and
2. A service log.

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the service logs, for the period being reviewed.

Note: Refer to the definition section for additional information.

Place of Service

This service may be provided in the beneficiary's own home, family home or foster home. The beneficiary 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 beneficiary's own home, family home, licensed foster home, ALF, or Home for Special Services.

Respite Care, continued

Special Considerations

Beneficiaries, living in licensed group homes, are not eligible to receive respite care services.

Relatives living outside the beneficiaries 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 insure 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 beneficiaries 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 beneficiary has a complex medical condition. If a nurse provides this service, a prescription will be necessary.

Skilled Nursing

Description

Skilled nursing is a service prescribed by a physician and consists of part-time or intermittent nursing care provided by registered or licensed practical nurses, within the scope of Florida's Nurse Practice Act.

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 nurse and home health aide visits are 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 Medicaid Home Health Services Coverage and Limitations handbook for additional information on Medicaid State Plan coverage.

Nursing services not available to beneficiaries under the Medicaid State Plan, or which are insufficient in quantity to meet their needs, may be paid for by the DS 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 DS waiver may pay only for those medically necessary services not covered by the Medicaid State Plan.

The beneficiary 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.

Skilled nursing services do not include time spent completing the OASIS assessment.

Note: Refer to Appendix D for contact information.

Skilled Nursing, continued

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice;
2. A nursing care plan;
3. A service log; and
4. A beneficiary nursing assessment (must be completed at the time of the first billing.)

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the service logs, for the period being reviewed;
2. A copy of all nursing care plans (and revisions), for the period being reviewed;
3. Daily progress notes (or case notes), for the period being reviewed;
4. The original prescription for the service; and
5. A beneficiary nursing assessment, conducted initially and annually thereafter.

Note: Refer to the definition section for additional information.

Place of Service

Skilled nursing services shall be provided at the beneficiaries place of residence.

Special Considerations

Skilled nursing services shall not be used for the ongoing medical oversight in a residential facility.

Special Medical Home Care

Description

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

Limitations

Only those beneficiaries with complex medical conditions, requiring an intense level of nursing care, who reside in licensed group homes with a one-to-three nurse to resident ratio shall be eligible for this service.

Special Medical Home Care, continued

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice;
2. A nursing care plan;
3. A service log; and
4. A beneficiary nursing assessment (must be completed at the time of the first billing.)

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the service logs, for the period being reviewed;
2. A copy of the nursing care plan (and all revisions), for the period being reviewed;
3. Daily progress notes (on days service was rendered), for the period being reviewed (these notes should be directly related to the beneficiaries plan of care and treatment); and
4. A beneficiary nursing assessment, conducted initially and annually thereafter.

Note: Refer to the definition section for additional information.

Place of Service

Special medical home care services shall be provided at the beneficiaries licensed group home.

Special Considerations

Most licensed group homes do not provide this level of nursing care, nor do most beneficiaries require such close medical supervision. The District Office shall determine when a group home qualifies to be a provider of this service and which beneficiaries 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 beneficiary actually resided in the licensed group home. The provider may not bill for days the beneficiary is hospitalized or is participating in a home visit.

Specialized Mental Health Services

Description

Specialized Mental Health Services for persons with Developmental Disabilities are services provided to maximize the reduction of a beneficiary'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 beneficiaries 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 beneficiary support plan, mental health interventions designed to help the beneficiary 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.

Limitations

This service supplements mental health services available under the Medicaid State Plan. Mental health services are available to beneficiaries with diagnosed mental illnesses who can benefit from and participate in therapeutic services provided under the Medicaid Community Mental Health program. Refer to the 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, art therapy, recreation therapy, etc.

This service is usually provided 1-2 times weekly for 1 hour.

Note: Refer to Appendix D for contact information.

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice;
2. A monthly summary note; and
3. A copy of the assessment and the treatment plan (even if it's only preliminary) or plan of further action (at the time of first billing) and a final treatment plan at the subsequent billing. Treatment plan updates must be provided to the waiver support coordinator every six months or at the time of billing.

Specialized Mental Health Services, continued

Documentation Requirements,
continued

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the assessment;
2. A copy of the treatment plan; and
3. A copy of the monthly summary notes, for the period being reviewed.

Note: Refer to the definition section for additional information.

Place of Service

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

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

Speech Therapy

Description

Speech therapy is a service prescribed by a physician and is necessary to produce specific functional outcomes in the communication skills of a beneficiary 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.

Limitations

Speech therapy and assessment services are available through the Medicaid State Plan services for beneficiaries, under the age of 21. Services for these beneficiaries may not be purchased under the waiver. Children receiving this service through the "school match" 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. Refer to the Medicaid Therapy Services Coverage and Limitations handbook for additional information on Medicaid State Plan coverage.

Speech Therapy, continued

Limitations,
continued

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

A beneficiary 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.

**Documentation
Requirements**

For reimbursement purposes, the provider must submit:

1. An invoice;
2. A service log; and
3. A monthly summary note.

If the provider is to be reimbursed for an assessment, the provider must submit:

1. An invoice; and
2. A copy of the assessment report.

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the service logs, for the period being reviewed;
2. A copy of the monthly summary notes;
3. A copy of the assessment report (if the provider was reimbursed for such a report); and
4. The original prescription for their service.

Note: Refer to the definition section for additional information.

Place of Service

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

Support Coordination

Description

Support coordination is the service of advocating, identifying, developing, coordinating and accessing supports and services on behalf of a beneficiary, or assisting the beneficiary or family to access supports and services on their own. These services may be provided through waiver and other 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 beneficiaries needs, preferences and future goals (outcomes). From that information, the waiver support coordinator assists the beneficiary in developing a support plan and cost plan.

Once a beneficiaries support plan is developed and the cost plan is approved by the District, the waiver support coordinator assists the beneficiary to meet their support plan outcomes/personal goals by linking the beneficiary 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 beneficiary in locating services available through local, state or federal sources, including Medicaid, the waiver and the Developmental Disabilities Program, as authorized.

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

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

Transitional Support Coordination also consists of activities that assist the beneficiary 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 beneficiary 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 beneficiary.

Support Coordination, continued

Description,
continued

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 beneficiary's developmental, behavioral, social, health and nutritional status and discharge plan designed to assist the beneficiary 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 beneficiary's discharge. These services can be billed only after the beneficiary is discharged. The waiver support coordinator will maintain, at a minimum, weekly contact with the beneficiary for the first 30 days following discharge to ensure that community supports and services are meeting the beneficiary'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.

Limitations

The provider must accept all beneficiaries who select the provider for waiver support coordination services and not reject any beneficiary 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 beneficiaries, or as specified by the Florida Legislature, even when that total includes beneficiaries who are not participants in the waiver or are not beneficiaries 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 beneficiaries. 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.

Support Coordination, continued

Limitations,
continued

The support coordination provider must notify the District in writing of any vacancies or leave of absences granted with a list of beneficiaries 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.

If the support coordination provider cannot fill a reported vacant position within the time allotted, the District must be notified prior to the 60th consecutive or 60th working day, whichever is applicable to the situation. Upon receipt of this notification the District will provide 14 calendar days notice to the affected beneficiaries and agency of the need to select a different waiver support coordination provider. This notification will enable the District to inform the affected beneficiaries of the impending change in their support coordination provider. This notification will allow sufficient time for the beneficiary 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 beneficiary 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 beneficiaries served to transition to another enrolled support coordination provider, chosen by the beneficiary. All caseload transfers will be accomplished by the District working with the provider to identify those beneficiaries 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 beneficiaries 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.

Support Coordination, continued

Limitations,
continued

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 beneficiaries 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 beneficiaries 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 beneficiaries 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 beneficiaries who receive services from the Developmental Disabilities program;
 - 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 beneficiary served by the provider;
 - The provider shall not, nor shall employees of the provider, render Support Coordination services to a beneficiary who is a family member of the provider or any employee of the provider, unless the beneficiary 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 beneficiary 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 ;
 - The provider and its employees shall not assume control of beneficiary's finances or assume possession of a beneficiary's checkbook or cash, nor shall they become representative payee for beneficiary benefits.
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Support Coordination, continued

Support and Service Planning Requirements

The provider must be available to meet the beneficiary's needs and to perform the responsibilities for Support Coordination. The provider shall have an on-call system in place that allows beneficiaries 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 beneficiary and to the District. Access to the provider or back-up provider shall be available, without toll charges to the beneficiary.

Waiver Support Coordinators should assist ADT beneficiaries with information and/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 beneficiaries currently in sheltered workshops or segregated work environments to apprise them of the options available to them for meaningful work activities.

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

- Complete or update tools, including the Personal Outcome Measures and the Florida Status Tracking Survey, necessary to assist in identifying personal goals, needs and services prior to the development of the support plan; make decisions and informed choices;
- Complete the support plan and cost plan, including required signatures; and
- Complete the Developmental Services 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 will submit to the District, no later than twenty calendar days prior to the support plan effective date, an updated support plan and cost plan with supporting documentation. Copies of the support plan and cost plan will be provided to the beneficiary or their 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. 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.

Support Coordination, continued

Support and Service Planning Requirements, continued

The waiver support coordinator will submit to the District, no later than twenty calendar days prior to the support plan effective date, an updated support plan and cost plan with supporting documentation. Copies of the support plan and cost plan will be provided to the beneficiary or their 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. 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 within ten calendar days of the effective date of the support plan. Through conversations with the beneficiary, those who know the beneficiary well, and through review of the service vendor's documentation, the waiver support coordinator monitors the beneficiary's involvement in purchased services to, determine if the activities meet the beneficiary'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 beneficiaries identified goals.

If a beneficiary'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 5 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 3 working days.

Throughout the year a beneficiary's service and support needs may change, necessitating an update in their 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 5 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 10 days of their receipt of the updated cost plan, with a statement of approval or denial. Within 5 working days of receiving the District's response, the waiver support coordinator will notify the service provider of the updated changes to the beneficiaries cost plan.

Support Coordination, continued

Support and Service Planning Requirements, continued

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 beneficiary 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 beneficiary in using Medicaid State Plan services prior to seeking services funded by the Developmental Services Home and Community-Based Services Waiver. When services must be purchased by a source other than the Developmental Services Home and Community-Based Services Waiver, the provider shall work cooperatively with the District in locating service vendors who meet the needs of the beneficiary in the most cost-beneficial manner possible.

When services must be purchased by the Developmental Services Home and Community-Based Services Waiver, the provider shall locate potential service vendors who are qualified to meet the needs of the beneficiary in the most cost-beneficial manner possible. The provider shall recruit qualified vendors, acceptable to the beneficiary, 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 beneficiaries served.

If paid services are used, the provider shall review with service vendors the goals to be achieved for the beneficiary and note these discussions in the beneficiary's progress notes. The agreed upon goal(s) shall be reflected on the service authorization form for that provider. The provider shall conduct rate negotiations with service vendors for the most cost-beneficial services available to the beneficiary.

The provider shall maintain each beneficiary 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 beneficiary's Central Record at any time.

The provider shall assist the beneficiary in maintaining their Medicaid eligibility. The provider shall also notify other waiver service providers and the Department when it is determined that a beneficiary 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 entering, updating and assuring the accuracy of information pertinent to the beneficiary in the ABC system, including demographic information.

Support Coordination, continued

Support and Service Planning Requirements, continued

The provider shall comply with all written procedures established by the Department regarding the transition of beneficiaries from Developmental Disabilities support coordinators or other waiver support coordinators to the provider.

For beneficiaries 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.

The beneficiary 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 90 days, documentation for their rationale will be provided. This documentation will be maintained in the beneficiary's Central Record.

If, while serving a beneficiary, the beneficiary chooses another support coordination provider, the current provider shall render quality services for the beneficiary 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 beneficiary in making a smooth transition to the new support coordination provider.

When a new support coordination provider is selected by the beneficiary, 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.

Support Coordination, continued

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 beneficiary's central record prior to billing. Prior to requesting a monthly payment for support coordination services for a beneficiary, the provider shall complete the following:

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

Support Coordination, continued

Documentation Requirements, continued

For beneficiaries in supported living, residing in their own home or residing in licensed facilities, a face-to-face visit with the beneficiary in the beneficiary's place of residence is required every three months. If the beneficiary lives with their family, the face-to-face contact with the beneficiary in the residence is required every six months. The beneficiary 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 beneficiary, family or primary caregiver. The waiver support coordinator shall document this preference in the support plan.

For beneficiaries receiving supported living coaching services, it is the waiver support coordinator's responsibility to schedule a quarterly meeting with the beneficiary and the supported living coach. The purpose of this meeting is to review supported living needs with the beneficiary and the coach to determine if services are being provided at a satisfactory level, and to assure that housing, health, safety and financial support is adequate. The waiver support coordinator shall document the results of each meeting in the progress notes. This quarterly meeting with the beneficiary and the supported living coach may satisfy the quarterly face-to-face meeting requirement above, provided the meeting takes place in the beneficiary'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 beneficiary or with other persons, such as family members, service vendors, community members and so on, and may be conducted face to face or by phone. Administrative activities such as typing, filing, mailing, data entry for billing, 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 beneficiaries 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.

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 beneficiaries 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 beneficiary and his or her family or guardian;
4. Documentation in the Central Records that a face-to-face visit with the beneficiary was conducted in their place of residence, including those beneficiaries in supported living, quarterly meetings with the beneficiary 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 beneficiary, including current health and medical information and emergency contacts;
7. Results of the annual satisfaction survey; and
8. Performance information on the selected outcomes projected in this document.

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

Note: Refer to the definition section for additional information.

Support Coordination, continued

**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 beneficiary's residence, a library, a park, or any other community location. In order to get to know each beneficiary well, waiver support coordinators are encouraged to interact with and observe each beneficiary in a variety of settings, during different times of the day and on different days of the week.

Support coordination may be provided while a beneficiary 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 beneficiary 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 beneficiaries 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, billing information or data collection systems.

Supported Employment

Description

Supported employment services provide training and assistance in a variety of activities to support beneficiaries in sustaining paid employment. The supported employment provider assists with the acquisition, retention or improvement of skills related to accessing and maintaining such employment. With the assistance of the supported employment provider, the beneficiary 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 beneficiaries receiving waiver services, including supervision and training. This training can focus on both the beneficiary's needs, as well as providing consultation to the employer to enhance supports natural to the workplace rather than imposing paid supports.

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 II). The individual model can apply to either employment in the general work force or in establishing a business to be operated by the beneficiary.

Group Models – Including:

1. Enclave - A group approach to employment where up to eight beneficiaries 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 (lawn maintenance, janitorial) of up to eight beneficiaries 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 beneficiaries with disabilities work in a small business created specifically by or for the beneficiaries.

Providers of supported employment services shall comply with requirements found in the Developmental Disabilities Medicaid 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 on the beneficiaries support plan and current approved cost plan. The provider shall render services at a time mutually agreed to by the beneficiary 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 services, shall only be made through consensus between the beneficiary receiving services and their guardian, their Vocational Rehabilitation counselor (if applicable), the District or waiver support coordinator, and the provider. If for any reason a beneficiary has terminated services and requests reinstatement, due to the need for ongoing supports, they will be given priority for restoration of services.

Beneficiaries working an average of less than 20 hours per week, or who remain in job development status, must have at least a quarterly review. Documented attempts to increase work hours or secure an appropriate job. Attempts will be summarized quarterly, in the monthly summary notes.

Transportation of beneficiaries 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.

If the provider plans to transport beneficiaries in his or her 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 and is responsible for notifying the District Office of all traffic violations, excluding parking tickets, immediately.

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 description in this handbook for additional information.

Supported Employment, continued

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice;
2. A monthly summary; and
3. A copy of the individual implementation/employment plan (at the time of the first full month billing when a beneficiary is initially enrolled in the service, at least annually thereafter at the time of the support plan update, and 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 definition section of this handbook , the Individual Implementation Plan for supported employment service must also contain the following:

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

For the beneficiaries receiving services in the individual model, 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.

For monitoring review purposes, the provider must have, at a minimum:

1. Copies of monthly summaries;
2. An individual implementation and employment plan for each beneficiary;
3. Documentation that services under the waiver are not available by programs funded by the Rehabilitation Act of 1973 or Public Law 94-142;
4. Results of the annual satisfaction survey; and
5. Performance data on the selected projected service outcomes in this document.

Note: Refer to the definition section for additional information.

Supported Employment, continued

Place of Service

Supported employment services are provided in the beneficiary'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 beneficiary change the provider shall notify the beneficiaries waiver support coordinator within five (5) working days.

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 beneficiary receiving this service.

When the supervisor of a mobile crew or enclave does not meet the qualifications for a supported employment coach, although the beneficiary 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.

Payment will not be made for incentives, subsidies, or unrelated vocational training.

Supported Living Coaching

Description

Supported living coaching services provide training and assistance, in a variety of activities, to support beneficiaries 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 beneficiaries 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 their 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 beneficiary and his or her 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 beneficiary complete a functional community assessment prior to his or her 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 beneficiary, to the beneficiaries support coordinator within ten (10) 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 beneficiaries overall health, safety and well-being status.

Supported Living Coaching, continued

Description,
continued

Financial Profile: An analysis of the household costs and revenue sources associated with maintaining a balanced monthly budget for the beneficiary. 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 provider is to assist the beneficiary in completing the Financial Profile and submitting it to the support coordinator no more than 10 days following the selection of housing by the beneficiary. 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 beneficiary signs a lease.

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

Limitations

Supported living coaching services are limited to the amount, duration and scope of the services described on the beneficiaries support plan and current approved cost plan.

The provider shall render supported living coaching services at the time and place mutually agreed to by the beneficiary and provider. The provider shall have an on-call system in place that allows beneficiaries 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 or she is unavailable. The specified backup provider must be a certified, enrolled Medicaid provider and certified as a supported living 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 beneficiary.

Supported Living Coaching, continued

Limitations,
continued

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 provider or the provider's immediate family shall not be the beneficiary'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 beneficiary receiving supported living services must appear on the lease either singularly, with a roommate or a guarantor.

Supported living encourages maximum physical integration into the community. The homes of beneficiaries 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 beneficiaries home shall be scattered, noncontiguous, and dispersed throughout that area. Waiver requests, regarding the density requirements can be submitted in writing, to the Department .

Beneficiaries receiving supported living coaching services shall live where and with whom they choose. Beneficiaries receiving supported living 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.

Beneficiaries who live in family homes, foster homes or group homes are not eligible for these services unless the beneficiaries are in the process of moving into their own homes or apartments. Within 90 days from moving, supported living coaching services may be made available to beneficiaries 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.

Note: Refer to Appendix E for contact information.

Supported Living Coaching, continued

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice;
2. A service log (time intervention log), which shall be supported by progress notes including documentation of activities, supports and contacts with the beneficiary, 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 beneficiaries record prior to billing); and
3. A copy of the Individual Implementation Plan (or in the case of transition, a transition plan) at the time of the first full month billing when a beneficiary is initially enrolled in the service, at least annually thereafter at the time of the support plan update, and 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 definition 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;
- A description of how natural and generic supports will be used to assist in supporting the beneficiary; and a financial profile that includes strategies for assisting the person in money management, when requested by the beneficiary 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 beneficiary is within their financial means and will identify the need for monthly subsidy which must be approved by the District).

Supported Living Coaching, continued

Documentation Requirements,
continued

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the service logs (time intervention log), for the period being reviewed;
2. An individual implementation plan and/or transition plan;
3. An annual written report, summarizing the beneficiary'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 beneficiary over the course of the year, as well as subjective information (opinions) and recommendations. The annual report shall be submitted to the beneficiary or guardian and the support coordinator 30 days prior to the end of the support plan year;
4. An annual satisfaction survey (as described in Chapter 65B-11.008, F.A.C.). At least annually, beneficiaries receiving supported living 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 beneficiary has the opportunity to complete the survey, staff providing direct supported living services to the beneficiary may not assist in the survey activity for that beneficiary. The results of the survey will be maintained in the beneficiaries record and a copy forwarded to the waiver support coordinator for review;
5. Documentation of a quarterly meeting in which the beneficiary, the waiver support coordinator and the provider review the current supported living services. The beneficiary's waiver support coordinator is responsible for arranging and scheduling the quarterly meeting. 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. If the supported living coach is acting as fiscal agent for the beneficiary bank statements and other financial records should be reviewed by the supported living coach and the waiver support coordinator at the time of the quarterly visit. This review will be documented (unless the supported living provider is excluded from the meeting) in the progress notes contained in the provider's service log;
6. An initial housing survey containing quarterly updates of the beneficiary'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 beneficiaries record;
7. 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 beneficiary/guardian, for each beneficiary served; and
8. Performance data on the selected service outcomes projected in this document.

Note: Refer to the definition section for additional information.

Supported Living Coaching, continued

Place of Service	Supported living coaching services are provided in the beneficiaries place of residence or in the community.
Special Considerations	<p>Providers of supported living coaching services must participate in monitoring reviews conducted by the Department, or its authorized representatives.</p> <p>When a beneficiary 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.</p> <p>Supported living coaching services are not to be provided concurrently with residential habilitation services, except for the 90 days prior to the beneficiary moving into the supported living setting.</p> <p>Supported living services may not duplicate services available from programs funded by the Rehabilitation Act of 1973 or Public Law 94-142 or their subsequent updates.</p>

Therapeutic Massage

Description	<p>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.</p> <p>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.</p> <p>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.</p>
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Therapeutic Massage, continued

Description,
continued

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 beneficiaries 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.

Limitations

A beneficiary 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.

**Documentation
Requirements**

For reimbursement purposes, the provider must submit:

1. An invoice;
2. A service log; and
3. A monthly summary note.

If the provider is to be reimbursed for an assessment, the provider must submit:

1. An invoice; and
2. A copy of the assessment report.

For monitoring review purposes, the provider must have, at a minimum:

1. A copy of the service logs, for the period being reviewed;
2. A copy of the monthly summary notes;
3. A copy of the prescription;
4. A copy of the assessment report, if the provider was reimbursed for such a report; and
5. The original prescription for their service.

Note: Refer to the definition section for additional information.

Place of Service

This service may be provided in the therapist's office or in the beneficiary's home.

Therapeutic Massage, continued

Special Considerations

Therapeutic massage and assessment is limited to beneficiaries 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 beneficiary. Anytime it is determined that the service is not benefiting the beneficiary, the service must be discontinued.

Transportation

Description

Transportation services provide rides to and from the beneficiaries home and their community-based waiver services, enabling the beneficiary 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 will be provided between the beneficiary's place of residence and the site of their habilitation service, as a separate transportation service.

Transportation will be provided between habilitation sites (in cases where the beneficiary receives habilitation services at more than one location) as a component part of their habilitation services. The cost of transportation, between habilitation sites, is included in the rate paid to the providers of the appropriate types of habilitation services.

For transportation to and from non-waiver Medicaid services, State Plan transportation service is an available option.

Transportation services funded through the DS waiver shall be used only for beneficiaries who have no other means to get to a service or activity identified on the support plan and approved cost plan. Family members, neighbors or friends who already transport the beneficiary, or who are capable of transporting the beneficiary at no cost to the department, shall be encouraged to continue their support of the beneficiary.

This service is not available for transporting a beneficiary to school (through 12th grade.) Transportation to and from school is the responsibility of the public school system. For other transportation needs not identified on the beneficiaries support plan and approved cost plan, the beneficiary should be directed to the local Community Transportation Coordinator or, if available, the local area's fixed route public transit office.

Transportation, continued

Limitations

Transportation services are available through the Medicaid State Plan to transport beneficiaries to Medicaid-eligible medical appointments and services. DS waiver funds shall not be used when Medicaid State Plan transportation services are available.

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

Providers may charge for their service by the mile, the trip, or the month. When a provider is reimbursed by the mile, a beneficiary shall receive no more than 200 miles per day of this service. When a provider is reimbursed by the trip, a beneficiary shall receive no more than four one-way trips per day, or 80 per month of this service. Monthly billing shall be reserved for reimbursement of actual expenses incurred by a provider.

Documentation Requirements

For reimbursement purposes, the provider must submit:

1. An invoice; and
2. A trip log.

For a monitoring review, the provider must have, at a minimum:

1. A copy of the trip logs, for the period being reviewed.

Providers reimbursed by the month shall provide documentation to demonstrate actual cost of the service. This applies to group home providers that use one van to transport numerous beneficiaries of the Developmental Disabilities Program at any given time. Their documentation must clearly indicate their actual cost itemized by category (i.e., gas, insurance, vehicle costs, repairs and maintenance costs, driver's costs, etc.) and divided equally by the number of beneficiaries served during that billing period. Regardless of how the provider is reimbursed, a record must be kept of the numbers of trips and the related cost, by county, in order to report those figures to the District quarterly.

Note: Refer to the definition section for additional information.

Transportation, continued

Place of Service

This service is provided anywhere in the community.

Special Considerations

When the beneficiary uses a DS waiver provider for transport to a service listed on the support plan and current approved cost plan, and the provider is paid with DS waiver funds, the provider shall not charge the beneficiary a co-payment.

When a beneficiary must have an escort to provide assistance, the transportation provider may be paid for transporting both the beneficiary 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 beneficiary with a disability.)

Providers shall not be paid for transportation services provided as a component of any adult day training, residential habilitation, or other service. 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 insure 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.

CHAPTER 3

Developmental Services Waiver Services Procedure Codes, Maximum Units Of Service, Waiver Services Agreement, Core Assurances, Contact Directories, And Beneficiary Application And Eligibility Determination Information

Overview

Introduction

This chapter provides and describes the procedure codes, maximum units of service, Waiver Services Agreement, Core Assurances for the Developmental Services (DS) waiver services, contact directories for District DD offices and Medicaid area offices, Beneficiary Application and Eligibility Determination Information, Waiting List Information, Crisis Information, Waiver Enrollment, Application for Participation, Crisis Identification Tool and Wait List Form.

In This Chapter

This chapter contains:

TOPIC	PAGE
Reimbursement Information	3-2
Appendix A: Developmental Services Waiver Services— Procedure Code Table and Maximum Units of Service	A-1
Appendix B: Developmental Disabilities Program—Medicaid Waiver Services Agreement	B-1
Appendix C: Core Assurances—Core Assurances for Providers of Developmental Disabilities Medicaid Home and Community-based Waiver Services Program	C-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), Level III procedure codes that are locally assigned codes, approved by Centers for Medicare and Medicaid Services (CMS), and identified by the “W” prefix.

Billing Procedures

Each provider is required to submit all invoices or claims for DS/HCBS waiver services through the ABC system, *in a timely manner*. This will be accomplished by submitting an invoice to a waiver support coordinator, the District office or directly into ABC, as instructed. No provider may file claims directly to Medicaid's fiscal agent.

Specific billing instructions and procedures for submitting invoices through the Developmental Disabilities Allocation, Budget and Contract Control (ABC) system are available through the District Office.

DS Waiver Service Rates

The maximum fee allowable for support coordination services is established by the Florida Legislature, and is uniform statewide.

The rate for payment for all services is determined by the operating agency, which is the Department of Children and Families, and subject to a maximum rate in the Medicaid system. A rate is based on the service being provided and meeting the needs of the beneficiary receiving the service. Once a District has established a rate with a waiver provider for a certain level of service, that rate must apply to all beneficiaries' receiving the same level of service. Providers may not charge different rates based on the beneficiary's home District or other arbitrary criteria, if the beneficiary is receiving the same service.

Once a provider's rate is established, the rate cannot be increased unless specifically provided by an appropriation from the Florida Legislature, or when the provider's service composition experiences significant change to meet the needs of the beneficiaries they serve. All rates shall be determined by the operating agency and subject to the availability of appropriated funding from the Florida Legislature.

Consolidated Billing

Providers of services paid by the day, at a rate negotiated by the waiver support coordinator or District Office, 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 beneficiary is absent from the service.

Reimbursement Information, continued

**Consolidated
Billing**, continued

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 beneficiary's 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 a provider transports two or more beneficiaries at the same time and the provider bills by the mile, the provider must divide the cost among the beneficiary's being transported. Costs will be developed for individual and multi-load trips. The trip log will document the beneficiary's name(s), date of service, destination and actual mileage. If mileage is billed by the month the total miles billed will be multiplied by \$.29 and the total amount billed as a monthly unit as long as the total amount billed for the month unit does not exceed \$721. If the amount billed exceeds \$721, the service shall be billed for each date of service. 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 beneficiary cannot exceed \$721 per month.

**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 Developmental Disabilities Medicaid 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).

Reimbursement Information, continued

Recoupment of Funds, continued

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 beneficiary they serve, as detailed below. 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:
 - a. That the daily attendance log or progress note does not document that the service was provided as billed; and
 - b. 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 beneficiary'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, as follows:

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:
 - a. After the effective date of a beneficiary's support plan, that a plan is not available; and
 - b. After the effective date of the beneficiary'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.
 - a. Face-to-face contact for a beneficiary; and/or
 - b. Quarterly or semi-annual or annual visit to the beneficiary'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.

Reimbursement Information, continued

Recoupment of Funds, continued

3. Except for circumstances not caused by nor under the control of the support coordination provider, an amount equal to the monthly waiver support coordination fee shall be paid back for each beneficiary listed on a delinquent invoice(s) when it has been determined that a trend or pattern exists, indicating a failure to enter invoices of other providers into the ABC system within stated timeframes.

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 for additional information.

Limitations

Providers may not bill for service when a beneficiary is not in attendance or receiving a service. Services that are ordinarily provided in accumulated units (for example, day or month) must be adjusted to reflect actual service provision.

A provider shall not render or bill for more than one service to the same beneficiary at the same time and date.

Timely Submission of Claims

All invoices for DS/HCBS waiver services must be submitted through Developmental Disabilities Allocation, Budget and Contract Control System (ABC) *in a timely manner*. Invoices must be submitted *in a timely manner*, for Medicaid's fiscal agent to receive all Medicaid claims within twelve months of the date of service provision. Once a service is provided and documented, the provider should *promptly* submit all invoices for reimbursement through ABC. Any problems with an invoice can be corrected and the claim resubmitted through ABC and forwarded on to Medicaid, prior to the twelve month filing deadline. All invoices 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 and received by Medicaid's fiscal agent no later than twelve months from the date of the original payment. If a waiver support coordinator processes an invoice for payment, and the provider realizes that they were not paid for a service that was rendered and billed for, it is the provider's responsibility to promptly notify the waiver support coordinator. If the problem is not corrected and the provider is not paid in a timely manner, it is the provider's responsibility to notify the District Office.

Reimbursement Information, continued

Timely Submission of Claims, continued

Medicaid's fiscal agent must receive all requests for payment within 12 months or the provider will not be paid for the service. It is the provider's responsibility to track waiver receivables. Failure to track claims, will result in non-payment for services.

Any problem with the receipt of payment for an authorized service must be elevated and resolved within 12 months of the service provision.

For further instructions on claims submission, adjustments, and exceptions to the twelve-month filing rule, consult the Medicaid Provider Reimbursement handbook, Non-Institutional 081, available through the Area Offices of the Agency for Health Care Administration. Specific billing instructions and procedures for submitting invoices through the Developmental Disabilities Allocation, Budget and Contract Control (ABC) system are available through the District Office.

Each provider is required to submit all invoices or claims through the ABC system. Submitting invoices to a waiver support coordinator, the District office or directly into ABC, as instructed, will accomplish this. No provider may file claims directly to Medicaid's fiscal agent.

Detailed information on beneficiary eligibility, service reimbursement or service limitations may be found in the Florida Medicaid 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.

Note: Refer to Appendices D and E for contact information.

Correspondence Regarding Claims

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.

Reimbursement Information, continued

**Correspondence
Regarding Claims,**
continued

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.

**Procedure Code
Table**

Each procedure code found in Appendix A, "Developmental Services Waiver Services Procedure Code Table and Maximum Units of Service", corresponds to a service described in Chapter 2 of this handbook. The table gives:

- The name of the service;
 - The ABC (DD Data System) codes associated with the service and maximum units; and
 - The FMMIS (Medicaid) codes associated with the service.
-

Appendix A

Procedure Code Table and Maximum Units of Service

SERVICE	ABC CODE	FMMIS CODE
Adult Day Training	1701- Day, ADT-Facility Based 1 unit per day maximum (days may be combined into a monthly bill)	W9535
	1703- Day, ADT-Off Site 1 unit per day maximum (days may be combined into a monthly bill)	
Adult Dental Services	1402 – Unit 10 units per day maximum.	W9561
Behavior Assessment	1504 – (Behavior Assessment) – Unit 1 unit per year maximum	W9545
Behavior Therapy	0701 – (Behavior Analysis) – Quarter Hour 16 units per day maximum	W9530
Behavioral Services Assistant	0702 – Month (Behavior Assistant Services)	W9568
Chore Services	2302 – Quarter Hour 16 units per day maximum	W9547
Companion Services	2304 – Quarter Hour 40 units per day maximum	W9548
Consumable Medical Supplies	2003 – Unit 10 per day maximum	W9537
Dietitian Services	1307 – Quarter hour 12 units per day maximum	W9562
Other Adaptive Equipment (Durable Medical Equipment and Supplies)	2002 – Unit 5 items per day maximum	W9536
Wheelchairs, Related Equipment and Repairs (Durable Medical Equip.)	2001 – Unit 1 unit (manual wheelchairs only)	W9536

Developmental Services Waiver Services Florida Medicaid Coverage and Limitations

SERVICE	ABC CODE	FMMIS CODE
Environmental Modifications (Environmental Accessibility Adaptations)	2004 – Adaptation: 5 units per day maximum 2005 – Home Accessibility Assessment	W9549
Homemaker Services	2301 – Quarter Hour 40 units per day maximum	W9550
In-Home Support Services	2513 – Month 1 unit per month maximum	W9513
Medication Review	1309 – Unit –2 reviews per year	W9749
Non-Residential Support Services, Hour	0801 – Hour 12units per day maximum	W9551
Non-Residential Support Services, Day	0801 – Day, 1 unit per day maximum (Days may be combined into a monthly bill)	W9534
Non-Residential Support Services, Month	0801 – Month 1 unit maximum	W9511
Occupational Therapy, Assessment	1505 (Assessment) – Unit 1 per year maximum	W9539
Occupational Therapy, Therapy	0501 (Therapy) - Quarter Hour 8 units per day maximum	W9531
Personal Care Assistance, Quarter Hour	1910 - Quarter Hour 96 units per day, maximum 1910 – Month 1 unit per month, maximum	W9538 W9552
PERS, Installation	2306 (Installation) – Unit 1 unit maximum	W9594
PERS, Monthly Service	2305 (Monthly Service) – Month 1 unit per month maximum	W9553
Physical Therapy, Assessment	1506 (Assessment) – Unit 1 per year maximum	W9540

Developmental Services Waiver Services Florida Medicaid Coverage and Limitations

SERVICE	ABC CODE	FMMIS CODE
Physical Therapy, Therapy	0601 (Therapy) - Quarter Hour 8 units per day maximum	W9529
Private Duty Nursing	1302 - Quarter Hour 96 units per day maximum	W9554
Psychological Assessment	1503 – Unit 1 per year maximum	W9541
Residential Habilitation Services, Day	0901 - Day, (a maximum of 31 days may be combined into one claim billed on the last day of the month)	W9533
Residential Habilitation Services, Month	0901 – Month 1 unit billed on the last day of the month	W9512
Residential Nursing Services	1306 – Month	W9560
Respiratory Therapy, Assessment	1512 (Assessment) Unit A maximum of 2 assessments per year	W9564
Respiratory Therapy, Therapy	1308 (Therapy) – Quarter Hour 8 units per day maximum	W9563
Respite Care, Hour	0301 – Hour 24 units per day, maximum	W9527
Respite Care, Day	Day 1 per day maximum (Days may be combined into a monthly bill)	W9528
Skilled Nursing, RN	1303 (RN) – Quarter Hour 32 units per day maximum	W9555
Skilled Nursing, LPN	1304 (LPN) – Quarter Hour, 32 units per day maximum	W9556
Special Medical Home Care	1305 – Day 1 unit per day maximum (days may be combined into a monthly bill)	W9557

Developmental Services Waiver Services Florida Medicaid Coverage and Limitations

SERVICE	ABC CODE	FMMIS CODE
Specialized Mental Health Services, Assessment	1514 – Assessment	W9569
Specialized Mental Health Services, Therapy	1002 – Therapy (hour)	W9570
Speech Therapy, Assessment	1507 (Assessment) – Unit 1 per year maximum	W9542
Speech Therapy, Therapy	0401 Therapy – Quarter hr. 8 units per day, maximum	W9532
Support Coordination	0101 – Unit 1 unit per month maximum	W9588
Transitional Support Coordination	0102 – Transitional Support Coordination	W9571
Supported Employment	<u>Individual Model</u> 2201 – Month 1 per month maximum <u>Group Model</u> 2202 – Month 1 per month maximum	W9565
Supported Living Coaching	2502 – Month 1 per month maximum	W9558
Therapeutic Massage Assessment	1513 (Assessment) – Quarter Hour 4 units per day maximum, 2 per year maximum	W9567
Therapeutic Massage	0602 (Therapy) – Quarter Hour 4 units per day maximum	W9566
Transportation, Mile	0201 (Mile) – 200 miles per day maximum	W9526
Transportation, One-way Trip	0201 (Trip) – 4 one-way trips per day max. (trips may be combined into a monthly bill)	W9522
Transportation, Month	0201 (Month) – 1 per month max. (actual expenses only)	W9559

Appendix B

Medicaid Waiver Service Agreement



DEVELOPMENTAL DISABILITIES PROGRAM

MEDICAID WAIVER SERVICES AGREEMENT

GENERAL TERMS AND CONDITIONS

(Provider),

Agrees to provide services under the Developmental Services Home and Community-Based waiver program to eligible beneficiaries of the Department of Children and Families (Department) who select the provider.

(List enrolled services)

I. AGREEMENT DOCUMENTS

A. The Medicaid Waiver Services Agreement consists of the General Terms and Conditions and the following attachments:

- Core Assurances
- Rate Structure documents (Attachment ___)
- Developmental Services Waiver Services Florida Medicaid Coverage and Limitations handbook, listing requirements for specific services, and incorporated into this Agreement, by reference.

B. Prior to providing any services the provider must, in order to be compensated by the Developmental Services 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 as fully set forth within this 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 Services Waiver Services Florida Medicaid Coverage and Limitations handbook for specific services rendered by the provider.

A. Department Monitoring

To permit persons duly authorized by the Department or the Agency for Health Care Administration, or agents of either, to monitor and inspect any records, papers, documents, facilities, goods and services of the provider which are relevant to this contract, and to interview any beneficiaries receiving services and employees of the provider to assure the department of the satisfactory performance of the terms and conditions of this contract. 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 or its authorized representative within the specified period of time identified within the report documentation.

B. Indemnification

1. To be liable for and indemnify, defend, and hold the Department and all of its 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 (7) 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 Medicaid provider Reimbursement Handbook Non-Institutional 081. FEDERAL REGULATIONS (42 CFR 433.312) REQUIRE REFUND OF OVERPAYMENTS WITHIN 60 DAYS OF DISCOVERY. The Department will be the final authority regarding the timeliness of the reimbursement process.

III. DEPARTMENT RESPONSIBILITIES

The Department shall:

- A.** Grant the provider access to the Allocation Budget and Contract Control (ABC) System, which will permit the provider to bill the Medicaid Developmental Services Home and Community-Based waiver services programs for authorized services rendered; or
- B.** Enter provider invoices into the ABC system on behalf of the provider; or
- C.** Allow the support coordinator(s) of the beneficiaries served by the provider to enter the provider's invoices into the ABC system, as mutually determined and agreed upon by the parties.

IV. TERMINATION

- A.** This Agreement may be terminated by either party without cause, upon no less than thirty (30) calendar days notice in writing to the other party unless a lesser time is mutually agreed upon in writing by both parties. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.
- B.** This Agreement may be terminated for the provider's non-performance or misconduct upon no less than twenty-four (24) hours notice in writing to the provider. Waiver by either party of any breach of any term or condition of this Agreement shall not be construed as a waiver of any subsequent breach of any term or condition of this Agreement. If 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.

V. 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.

VI. 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. Temporary or permanent variations in the rate structure described in Attachment _____ are permissible on a beneficiary-specific or service-specific basis but must be executed as provided in this section.

VII. 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.

VIII. 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 or the State of Florida. The provider shall not represent to others that it has the authority to bind the Department 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.

IX. 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 representatives (names, addresses, 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.

X. INTEGRATED AGREEMENT

Only these General Terms and Conditions, the Attachments as referenced, _____ (list attachments), and the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations handbook, which is incorporated into this Agreement by reference, contains 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 all its attachments, as listed in Section 1, A., the service specific requirements for enrolled providers, contained in the Developmental Services Waiver Services Florida Medicaid 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: _____

Appendix C

Core Assurances for Providers of Developmental Disabilities Medicaid Home and Community-based Waiver Services Program

Chapter 393, Florida Statutes, charges the Department of Children and Families (Department/DCF) with providing services, particularly community-based services, to ensure the well being and improve the quality of life of beneficiaries 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) has agreed to jointly purchase necessary services for beneficiaries with developmental disabilities through the Developmental Services 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. Section 20.19, Florida Statutes. The Department and AHCA are required to establish contractual performance standards for all contracted beneficiary 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 Services Waiver Services Florida Medicaid Coverage and Limitations handbook, incorporated into this Agreement by reference, provides the terms and conditions by which the provider of waiver services to beneficiaries 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 Services Medicaid Waiver Services Agreement.

Programmatic Definition of Terms

Agency/AHCA means the Agency for Health Care Administration.

Agency or Group Provider means a business, organization or entity 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 Beneficiary 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 beneficiaries *Central Record*. These files contain the following documentation which must be recorded, stored and made available for monitoring and review: (1) beneficiaries demographic data including emergency contact information, parental or guardian contact data, permission forms, results of assessments and evaluations, 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 Services Waiver Services Florida Medicaid Coverage and Limitations handbook, that are related to the service and support activities identified in the beneficiaries implementation plan.

Community Integrated Settings means those local, non-segregated, settings for beneficiaries with developmental disabilities, that 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 this document that specifies administrative and programmatic requirements for Developmental Services 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 beneficiary on the support plan, regardless of funding source, and the anticipated cost of each waiver service. The District Office must approve the cost plan prior to service provision. Each time a beneficiary'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 beneficiary enrolled on 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 beneficiary'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 Office (District), located throughout the state.

Developmental Services Waiver Services Florida Medicaid 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 Services 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, the Waiver Services Agreement, the Core Assurances, and contact directories for AHCA area and DCF District offices. 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.

Florida Status Tracking Survey (FSTS) is a questionnaire, designed to obtain and provide information about a beneficiary with developmental disabilities, which is used to develop the beneficiary's supports and services.. The FSTS aids in the support planning process. Following the instructions provided by the Department, this survey is initially completed and updated annually by the beneficiary's waiver support coordinator.

Implementation Plan is an individualized document, developed by the provider with direction from the beneficiary that specifies how the beneficiary 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 beneficiary. At a minimum, the plan will include the actions and tasks (strategies) used by the provider, to achieve the beneficiaries identified goal(s) and/or objectives. The system of data assessment used for measuring the progress of programs and services, is also included in the plan. Refer to the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations handbook for Implementation Plan adding more detailed requirements regarding specific services.

Beneficiary(s) is any person receiving services through the Developmental Services 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 Services Home and Community-Based Services Waiver (DS/HCBS). Chapter 393, F.S., determines the need for and appropriateness of Medicaid funded services for an enrolled beneficiary.

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-DS 3064), 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 Services Waiver Services Florida Medicaid Coverage and Limitations handbook, 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 beneficiary's enrolled in the Developmental Services 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)and (c), F.A.C., and Chapter 393, F.S., for determining the need for and appropriateness of Medicaid funded services for an enrolled beneficiary.

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 beneficiaries on the waiver. This transportation service is not reimbursed separately from the primary waiver service.

Person-centered is an approach, developed from the beneficiary's perspective rather than that of the program or resource, used to provide the services and supports necessary to meet the beneficiary's needs.

Personal Outcome means the major expectation(s) that a beneficiary has during their life. The beneficiary's expectations for the services and supports they receive are defined by these outcomes, which may also be referred to as their personal goals.

Personal Outcome Process is the process used, with the beneficiary, to assess how to obtain the outcomes they consider most important in their lives. This process includes getting to know the beneficiary and the significant people in their 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 DS/HCBS waiver services listed in the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations handbook.

Provider Self-Assessment is an evaluation completed by the provider reviewing its organizational capabilities required to meet the beneficiary's outcomes or goals and the service requirements identified in the Medicaid Waiver Services Agreement, the Developmental Services Waiver Services Florida Medicaid 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 their authorized agent. Those providers deemed non-compliant with these Assurances and/or requirements found in the Developmental Services Waiver Services Florida Medicaid 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 beneficiary and employee or two or more beneficiaries at the time services are being rendered, or when a beneficiary is in the physical custody of the department, which results in one or more beneficiaries or employees receiving medical treatment by a licensed health care professional.
- b. Beneficiary Death. A person whose life terminates 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, Child Death Review Procedures.
- c. Beneficiary Injury or Illness. A medical condition of a beneficiary 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 beneficiary committed to, or securely detained in, a Department of Children and Families mental health or developmental services forensic facility covered 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 beneficiaries who are in the physical custody of the department.
- g. Sexual Battery. An allegation of sexual battery by a beneficiary on a beneficiary, employee on a beneficiary, or beneficiary on an employee as evidenced by medical evidence or law enforcement involvement.
- h. Suicide Attempt. An act which clearly reflects the physical attempt by a beneficiary to cause his or her own death while in the physical custody of the department or a departmental contracted or certified provider, which results in bodily injury requiring medical treatment by a licensed health care professional.

The reporting procedures do not replace the abuse, neglect and exploitation reporting system. Regardless of their status as an event in beneficiary 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.

Retail Outlet means any provider that derives fifty percent or more of its revenue from the sale of goods to the general public and is not engaged in any business that is specifically targeting beneficiary'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 beneficiaries 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 beneficiary, or assisting the beneficiary or family to access supports and services on their own. These services may be provided through waiver and other Medicaid State Plan services, as well as 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 beneficiary. This plan is based upon the preferences, interests, talents, attributes and needs of a beneficiary. The beneficiary 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 beneficiary. The ultimate goal of each plan, whenever possible, shall be to enable the beneficiary to live a dignified life in the least restrictive setting, appropriate to the beneficiary'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 beneficiary 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 who is selected by the beneficiary enrolled in the waiver (or guardian) to assist beneficiary'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 beneficiaries with developmental disabilities, as specified in s. 393.13, F.S., "The Bill of Rights of Persons Who are Developmentally Disabled."
3. The provider will comply with all federal, state and local laws and ordinances pertaining to the operation and requirements of the provider's business.

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 beneficiary 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 beneficiary to select non-waiver funded supports available to the general community from among those activities or experiences that meet the beneficiary's needs and preferences;
 - (b) Opportunities for the beneficiary to select providers of Medicaid State Plan services from among those providers enrolled in the Medicaid waiver program, and that also meet the beneficiary's needs and expectations;

- (c) Opportunities for the beneficiary to select providers of waiver services from those eligible to provide waiver services and enrolled in the Medicaid program, meeting the beneficiary's needs and expectations;
- (d) Opportunities for the beneficiary to change providers of supports and services;
- (e) Opportunities for the beneficiary 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 beneficiary to end their participation in the waiver.

2.0 PROGRAM REQUIREMENTS

- A. The provider will not disclose or use any information concerning a beneficiary who is receiving services under the waiver, without the written consent of the beneficiary or the beneficiary'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 beneficiary 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 is responsible for the expenditure of all funds appropriated to the Department by the Florida Legislature for beneficiary's receiving services from Developmental Disabilities and Developmental Services 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 beneficiaries' 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 beneficiary. 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 beneficiary's permission, to participate in the discussion of the beneficiary's record, the beneficiary's progress, the extent to which the beneficiary'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 beneficiary, the guardian, family and friends.
- H. The provider agrees, with the beneficiary's permission, to provide information about the beneficiary to assist in the development of the support plan, and to attend the support planning meeting when invited by the beneficiary, family member or guardian.

- I. The provider agrees, to provide the beneficiary with opportunities for relevant training, achieve their personal goals, and to expand their 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 beneficiary's support plan and approved cost plan.
- J. It is the responsibility of the Developmental Services Home and Community-Based Services Waiver program providers, and employees of waiver providers who furnish non-reimbursed transportation services to beneficiary's as part of one or more primary waiver service(s) and who are not reimbursed for such transportation, to meet the following requirements. The provider must be able to show, at time of enrollment, proof of valid driver's license, car registration and insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date and is responsible for notifying the District Office of all traffic violations, with the exception of parking tickets, immediately.
- K. The provider understands and agrees to provide and bill for those services that have been authorized and approved by the District on the beneficiary'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 beneficiary 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 beneficiaries served;
- 3. Recognition of abuse and neglect and required reporting procedures;
- 4. Development and implementation of the required documentation for each waiver service.
- 5. The Medicaid Waiver Services Agreement and its Attachments. The Developmental Services Waiver Services Florida Medicaid 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 beneficiaries served by the provider and required for specific services listed in the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations handbook, for which the provider is enrolled and eligible to provide.

The provider shall maintain on file for review, adequate and complete documentation to verify their participation, and the participation of their 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 beneficiary served by the provider:

- A. Notifying the District and other providers of issues concerning:
 1. The beneficiary's continued eligibility for waiver services. Any provider that becomes aware of a beneficiary's loss of Medicaid benefits shall immediately contact the beneficiary's support coordinator.
 2. The possibility of losing Medicaid eligibility. Any provider that becomes aware of a beneficiary's pending loss of Medicaid benefits shall immediately contact the beneficiary's 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 beneficiary;
 2. Involvement of law enforcement agencies; and
 3. Concerns about abuse, neglect, or exploitation and reporting of abuse, and reportable events.
 4. Death of a beneficiary.

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 beneficiaries 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 beneficiaries 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 beneficiary'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 beneficiary 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 beneficiary's served;
 5. Policies and procedures to ensure the smooth transition of the beneficiary 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 s.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;
 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 Providers 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 Services Waiver Services Florida Medicaid 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 beneficiary'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 beneficiary's receiving services; and c) annual beneficiary 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 who are unrelated to their beneficiaries, in accordance with s. 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 5 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 Services Waiver Services Coverage and Limitations handbook, including copies of licenses, certificates, high school and/or college diplomas and certified college transcripts as required.

3.3 Changes in Provider Status

- A. The provider understands and agrees that the Department and beneficiaries served will be notified of any change, sale or transfer of ownership. Beneficiaries 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 waiver service delivery 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 contract that sufficiently and properly reflect all services provided and revenues and expenditures of funds provided by the Department under this contract. All records pertinent to this Agreement, including information stored in electronic media, shall be retained for a period of at least five (5) years after the completion date of the contract. If a state or federal audit has been initiated and audit findings have not been resolved at the end of five (5) years, the records shall be retained until resolution of the audit findings or any litigation, which may be based on the terms of this contract. 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 beneficiaries in the care of, or receiving services from, the provider. If a single trust account is maintained for all beneficiary's personal funds, a separate accounting must be maintained for each beneficiary'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 beneficiary's personal funds be co-mingled with the any other funds, including those of the provider or any of its employees.
- 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 on a beneficiary 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 beneficiary 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 beneficiary's receiving services from the Department.
- B. The provider shall not, nor shall employees of the provider, solicit beneficiary'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 an beneficiary to request a support or service, select a support or service vendor or participate in an activity, regardless of whether or not the beneficiary 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 beneficiary served by the provider. The provider will:
 - 1. Document all service provision clearly and legibly, in accordance with the Developmental Services Waiver Services Florida Medicaid 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 beneficiary's record prior to submitting an invoice for services rendered;
 - 3. Maintain documentation in accordance with procedures specified in these contract documents, including the specific service requirements identified in the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations handbook, for each participant being served, as well as for each waiver service being provided. The Department, Agency or their authorized representative retains the right to review a beneficiary'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 representative for monitoring purposes.
- B. The provider understands and agrees that the Department is the final authority on all matters pertaining to paid services or goods purchased with funds appropriated to the Department for beneficiaries who receive services through the waiver.

3.8 Payment Provisions

- A. The provider understands and agrees that all bills for duly authorized and rendered services shall be billed solely through the Department's Allocation, Budget and Contract Control (ABC) system.

No bills will be submitted directly to Medicaid's fiscal agent. Invoices 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 from the same provider and will only pay for those services authorized and directly related to the beneficiary's goals as identified in his current support plan and that are authorized on the beneficiary's current and approved cost plan.
- C. The provider understands and agrees that payment from the Medicaid fiscal agent is made to a provider who is determined eligible by a District Office and has executed a Medicaid Waiver Services Agreement. The provider further understands that payment is contingent upon their enrollment in Medicaid as a waiver provider for Developmental Services 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 beneficiary 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. The provider understands and agrees that payment of services for beneficiaries placed out-of-District will be made at the same rate for those beneficiaries being served by the provider in the host District.
- G. Payment shall not be made for services not rendered.
- H. The provider understands and agrees that the Department is under no obligation to fund or fill vacancies created, under any circumstance.

3.9 Recoupment of Funds

- A. The provider understands and agrees that the Department 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 or not billed through the Department's ABC system 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 beneficiary, family, and/or guardian and the provider. These procedures do not preclude appropriate requests for a hearing, nor do they preempt the beneficiary, 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 beneficiary, family and/or guardian within 30 days of beginning services and annually thereafter;
 2. Those grievance procedures will be communicated in clear, understandable language to the beneficiary, their family or guardian. Responses to grievances will be provided verbally and in writing at the beneficiary's level of comprehension and in the language understood by the beneficiary; and
 3. That a log of all grievances filed by beneficiaries, families or guardians will be maintained for review and will include the following information:
 - (a) The name of the person making the complaint and their relationship to the beneficiary 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 beneficiaries 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) 494-5840
690-5840

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

(352) 955-5192
625-5192

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

<u>Area 5</u> <i>Suncom</i>	(727) 552-1191 513-2659	<u>Serving:</u> Pasco and Pinellas counties
<u>Area 6</u> <i>Suncom</i>	(813) 871-7600 512-8290	<u>Serving:</u> Hardee, Highlands, Hillsborough, Manatee, and Polk counties
<u>Area 7</u> <i>Suncom</i>	(407) 245-0862 344-0862	<u>Serving:</u> Brevard, Orange, Osceola, and Seminole counties
<u>Area 8</u> <i>Suncom</i>	(941) 338-2620 748-2620	<u>Serving:</u> Charlotte, Collier, DeSota, Glades, Hendry, Sarasota, and Lee Counties
<u>Area 9</u> <i>Suncom</i>	(561) 881-5080 264-5080	<u>Serving:</u> Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie counties
<u>Area 10</u> <i>Suncom</i>	(954) 202-3200 423-3200	<u>Serving:</u> Broward county
<u>Area 11</u> <i>Suncom</i>	(305) 499-2000 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 Services Home and Community-Based Waiver.

<u>District 1</u> <i>Suncom</i>	(850) 595-8344 695-8344	<u>District 9</u> <i>Suncom</i>	(561) 837-5564 252-5564
<u>District 2</u> <i>Suncom</i>	(850) 487-1992 277-1992	<u>District 10</u> <i>Suncom</i>	(954) 467-4218 453-4218
<u>District 3</u> <i>Suncom</i>	(352) 955-5793 625-5793	<u>District 11</u> <i>Suncom</i>	(305) 377-5029 452-5029
<u>District 4</u> <i>Suncom</i>	(904) 992-2440 876-2440	<u>District 12</u> <i>Suncom</i>	(386) 947-4026 380-4026
<u>Suncoast Region</u> <i>Suncom</i>	(813) 558-5540 514-5540	<u>District 13</u> <i>Suncom</i>	(352) 330-2162 895-6287
<u>District 7</u> <i>Suncom</i>	(407) 245-0440 344-0440	<u>District 14</u> <i>Suncom</i>	(941) 619-4100 561-4236
<u>District 8</u> <i>Suncom</i>	(941) 338-1572 722-1572	<u>District 15</u> <i>Suncom</i>	(561) 467-3792 240-3792

Appendix F

Consumer Wait List

1. Beneficiary Application and Eligibility Determination

Individuals shall be considered for determination of eligibility for the Developmental Services 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 (page 10 of this appendix). 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 (5) 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 beneficiaries and, at the time of application, are also Developmental Disabilities (DD) beneficiaries: the eligibility determination shall be made within ten (10) working days of receipt of the completed application by the District.
 - (2) For those who are not DD beneficiaries but are Medicaid beneficiaries: 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 beneficiaries but are not Medicaid beneficiaries: A notice shall also be promptly sent to the applicants advising 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 beneficiaries nor Medicaid beneficiaries: 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 (10) 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 point in 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 their placement on the waiting list for the waiver. Notification should be provided within ten (10) 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 waiver services is not entitlement to waiver services. The final determination of the applicants 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 the 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 (page 13 of this appendix). 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 legal guardian makes a request for a crisis determination. The assessment for crisis should be completed within five (5) 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 20th 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 their situation, which may affect their status for crisis determination, they 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 on 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 their placement onto 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 for 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 they are 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 a sister 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, sexes 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 or her 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 or her 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 or her physical and/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 and/or physical, functional, or behavioral capabilities of the individual.
 - (vii) The intensity and scope of services needed by the individual makes him or her 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 or her 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 (5) 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 (5) 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 beneficiary on the waiver and of the funding allocated to serve the beneficiary.
 - (3) The beneficiary or legal guardian must complete and sign the Developmental Services Waiver Eligibility Worksheet.

- (4) The beneficiary, family or legal guardian will select a waiver support coordinator to assist the beneficiary.
- E. When a beneficiary is enrolled on the waiver, the waiver position allocated to the beneficiary is theirs until they become ineligible or choose to discontinue waiver services. If the beneficiary 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.

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Developmental Services/
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 DS/HCBS waiver program. This individual is or is not a current beneficiary 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)

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 Services Home and Community-Based Services waiver.

DS/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)

DS/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:

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**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 DS/HCBS waiver services.

District _____

Beneficiary 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, FSTS 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 Florida Status Tracking Survey. 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 on the functional section of the Florida Status Tracking Survey.

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.)

Preparer's Signature/Title
(Must be an employee of DCF)

Date

Recommendation

Yes

No

Reviewing Behavioral Analyst/Title

Date

Recommendation

Yes

No

District Medical Quality Assurance Staff

Date

Recommendation

Yes

No

District Developmental Disabilities
Program Administrator

Date

List Documents Attached:



Developmental Disabilities Program Wait List Form

Last Name: _____ First Name: _____ M.I.: _____

District/Region: _____ Level of Need: _____ SSN: _____

Date DS/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	
<input type="checkbox"/> Ambulation Deficits <input type="checkbox"/> Sensory Deficits <input type="checkbox"/> Chronic Health Problems	<input type="checkbox"/> Behavior Problems <input type="checkbox"/> Autism <input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Epilepsy <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Prader-Willi Syndrome	<input type="checkbox"/> Self Care <input type="checkbox"/> Understanding and use of language <input type="checkbox"/> Learning	<input type="checkbox"/> Mobility <input type="checkbox"/> Self Direction <input type="checkbox"/> Capacity for independent living

Medicaid Beneficiary? 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 DS/HCBS Waiver: _____

* This is the date used to identify an individual's order of placement on the waiver wait list.
CF-DS 3066, Feb 00 (revised)