STATE OF FLORIDA
AGENCY
OPERATING PROCEDURE

AGENCY FOR PERSONS
WITH DISABILITIES (APD)
TALLAHASSEE, January 1, 2006

Medwaiver issues

UNIFORM PROCEDURES FOR THE DETERMINATION OF RESIDENTIAL HABILITATION SERVICES AND THE SUBMISSION OF PRIOR SERVICE AUTHORIZATION PACKAGES

1. Purpose.

This operating procedure describes a uniform methodology for APD area office staff and designated contractors to follow in determining the appropriate number of medically necessary residential habilitation service units in a variety of service delivery settings for consumers enrolled in the Medicaid Developmental Disabilities Home and Community-Based Services (DD/HCBS) Waiver program. This operating procedure also delineates the process for submission of prior service authorization (PSA) packages that include residential habilitation waiver services. This operating procedure is not intended to deter any provider from obtaining community support from funding sources other than the State. However, in no instance will the Medicaid DD/HCBS Waiver program pay for services paid or payable from other public or private funds.

2. Scope.

This operating procedure applies to all residential habilitation waiver services (with the exception of intensive behavioral residential habilitation services) requested by or rendered to persons with developmental disabilities who live in licensed residential facilities. It applies to services rendered by service providers classified and receiving payment in accordance with the Handbook and the residential habilitation rate matrix model (i.e., payment rates based on the number of hours of direct care staff support provided to the consumer).

3. Explanation of Terms. For the purposes of this operating procedure, the following terms mean:

a. Direct Care Staff. An individual whose primary responsibility is the day to day, hands-on support of consumers with developmental disabilities, including training and instruction, and assistance with activities of daily living. Direct care staff can be either employees of an agency or be self-employed, so long as at least 90% of their work activities include the provision of daily face-to-face supports to consumers.

b. Handbook. The Developmental Services Waiver Services Medicaid Coverage & Limitations Handbook, dated October 2003, and incorporated by reference in Agency for Health Care Administration (AHCA) rule 59G-8.200, F.A.C. The Handbook can be found at the AHCA website: http://floridamedicaid.acs-inc.com/index.jsp.

c. Licensed Residential Facility - A facility providing room and board, and other services in accordance with the licensing requirements for the facility type. Community-based consumers with developmental disabilities may receive DD/HCBS Waiver services while residing in:

1) Group and foster homes licensed by APD in accordance with chapter 393, F.S., and chapter 65B-6, F.A.C.

2) A residential habilitation center, licensed by APD under chapter 393, F.S., and chapter 65B-6, F.A.C., and any other type of community-based licensed facility having a capacity of 16 or more persons, if the consumer has continuously resided at the facility since August 8, 2001, or prior to this date.

3) A comprehensive transitional education program facilities (CTEP), licensed by APD in accordance with chapter 393, F.S., and chapter 65B-6, F.A.C.

4) Assisted Living Facilities (ALFs) and Transitional Living Facilities licensed by the Agency for Health Care Administration (AHCA) in accordance with parts III and VIII of chapter 400, F.S.

d. Medically Necessary. A set of conditions established by the Agency for Health Care Administration for determining the need for and appropriateness of Medicaid funded services for an enrolled consumer. As provided in rule 59G-1.010(166), F.A.C., "medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered, meets the following conditions:

1) Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2) 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;

3) Be consistent with generally accepted professional medical standards as defined by the Medicaid program, and not be experimental or investigational;

4) 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

5) Be furnished in a manner not primarily intended for the "convenience" of the consumer, the consumer's caregiver, or the provider.

e. Prior Service Authorization (PSA) Contractor. A private APD-contracted entity that conducts reviews of waiver service requests for the purposes of ensuring that such services are medically necessary and meet Handbook exclusions, limitations, and requirements.

f. Residential Habilitation. Supervision and specific training activities that assist the consumer 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 consumer to reside in the community. This training is provided in accordance with a formal implementation plan, developed with direction from the consumer and reflects the consumer's goals from their current support plan.

g. Support Plan. An individual or family plan developed, implemented, and revised in accordance with s. 393.0651, F.S. The plan is based on the preferences, interests, talents, attributes and needs of a consumer. The consumer directs the plan development (with assistance from

parents and legal guardian or guardian advocate, as appropriate) and shall receive a copy of the plan and any revisions made to the plan. The support plan must be completed in a format provided by APD and according to the instructions provided by APD.

h. Waiver Support Coordinator. An enrolled waiver provider of support coordination services that is selected by the consumer enrolled in the waiver (or their family/guardian) to assist the consumer 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 consumer or guardian, waiver support coordinators may be assigned by the area office (subject to the consumer 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 consumer needs. They also initiate and oversee the process of assessment and reassessment of the consumer's level of care and the review of support plans at such intervals as described in the support coordination section of the Handbook.

4. Determination of Medically Necessary Residential Habilitation Hours.

a. The consumer's waiver support coordinator is responsible for gathering the information necessary to determine the need for and the amount (or intensity) of residential habilitation the consumer requires. The amount is based on the number of hours of direct care support required to meet the needs of the individual consumer. In making such determination, all relevant information should be considered including, but not limited to, information obtained by the waiver support coordinator, service providers, family, guardian, the consumer, and APD staff such as behavior analysts, medical case managers, or licensure/monitoring staff. Written documentation (such as assessments, individual education plans (IEPs), individual cost plan (ICG) results, etc.) may also be submitted for review and consideration during the process.

b. A list of questions or considerations which must be used in the determining the amount of needed staffing hours are included as Attachment 1. The waiver support coordinator is responsible for ensuring that each item in this document is completed. This document must be included with all PSA packages submitted to the PSA contractor for every new request for residential habilitation services or requests for increases in the intensity of residential habilitation services.

c. It is essential that the correct residential habilitation rate model be applied (i.e., matrix rate, live-in daily rate, or hourly rate). The residential habilitation live-in model should be used in establishing rates for consumers living in licensed residential facilities of three or fewer residents **if** that rate is determined to be more cost effective than the residential habilitation matrix rate **and** it successfully meets the individual needs of the consumer in that facility.

d. While provider input is a crucial element, it is ultimately the responsibility of APD, or its designated agent, to determine and authorize the number of medically necessary residential habilitation service hours needed by consumers residing in licensed residential facilities. *Further, residential habilitation hours are to be based upon the needs of the individual consumer and not upon the facilities staffing levels.* Thus, if a provider's level of staffing during a particular shift results in the provision of 5 hours of staff support to a consumer, those 5 hours would only be deemed to be billable residential habilitation hours if the consumer requires that level of staff support during that shift, as documented in their support plan and approved cost plan.

5. Determination of Residential Habilitation Staffing Levels.

a. New Residential Habilitation Requests.

1) Newly-Licensed Residential Facilities.* In estimating the level of staffing required for a facility providing residential habilitation services for the first time, APD staff shall consider the anticipated occupancy of the facility, and the needs of the individual consumers who will be living there and receiving residential habilitation services.

(a) Determining Residential Habilitation Hours. APD Area office staff should complete the following steps :

i Gather all relevant information regarding the needs of consumers in the facility as described in #4 above and review.

ii Estimate (with input from providers and other parties as needed) the number of residential habilitation hours required for each consumer who will reside in the facility.

iii Complete the Excel spreadsheet titled "Worksheet for Determining Residential Habilitation Staffing Hours in a Licensed Home" (Attachment 2) using the licensed capacity (adjusted for the number of residents expected to require residential habilitation services) and anticipated staffing needs of incoming residents (based upon the projected characteristics of expected residents). If the home is licensed for 6 beds and one of the beds is designated for respite then the calculation should use 5 consumers receiving residential habilitation.

iv Verify that the resulting number of residential habilitation staffing hours is appropriate to meet consumer need by comparing the Worksheet to previous determinations of consumer need, or for new consumers, the previously described need estimates.

v Evaluate the number of authorized residential habilitation hours for newly-licensed residential facilities on at least an annual basis to ensure that consumer needs are being met and that the hours of staff support were determined appropriately. It is recommended that this activity be completed as part of the re-licensure process for APD licensed residential facilities, and on at least an annual basis for those consumers living in non-APD licensed facilities such as ALFs.

vi If the need for residential habilitation hours changes for a consumer (e.g., due to the addition, deletion, expansion, or subtraction of a meaningful day activity), the waiver support coordinator shall be responsible for conducting a re-evaluation of the consumer's staffing level within 30 days following the change and, as appropriate, initiating the submission of an amended cost plan to reflect any change in the intensity of the residential habilitation services.

(b) Prior to completion of the steps listed above, APD staff may give newly-licensed residential facility providers the published rates so they will have a general idea

* For the purposes of this operating procedure, the term "newly-licensed residential facilities" includes existing licensed residential facilities that are rendering residential habilitation services for some or all of their residents for the first time.

of the reimbursement they may expect to receive based upon the staffing needs of the consumers they expect to serve. It is important to emphasize that rates cannot be firmly established until the incoming residents are identified and their specific and medically necessary need for staff support is known.

2) New Consumers of Residential Habilitation. Determining residential habilitation staffing levels for consumers moving from their family home or from supported living into a residential facility presents unique challenges since a previously-established baseline of staffing needs does not exist.

(a) The waiver support coordinator should first estimate the hours of residential habilitation needed for the consumer.

(b) The waiver support coordinator should then present the consumer's needs to the prospective licensed residential facility operator in order to derive the number of direct care staffing hours per day which the facility would need to add in order to meet the new consumer's needs. *Remember the current average number of hours received by the existing group home residents is not automatically the appropriate amount of hours for the new resident.*

b. Determining Staffing Levels for Residents who have Significantly Different Needs. In residential settings, it will be a common occurrence to find consumers who require the same number of residential habilitation hours to meet their training needs. However, some individuals will have staffing needs that vary significantly from the norm for that facility. In such cases, the additional residential hours for that consumer should be calculated separately using a separate Worksheet (Attachment 2). For the purposes of this operating procedure, a consumer is considered to have "significantly different needs" from the other residents of the facility if there exists a difference of four or more hours of required staff support between him/her and at least one other resident.

1) Whenever more than one worksheet is used for calculating staffing levels in a single residential facility, APD staff should ensure that staff hours are not duplicated. In other words, include on the separate worksheet only those staff hours which have a 1:1 resident to staff ratio. The amount of staffing time this consumer "shares" with at least one other resident should be included in the spreadsheet which captures the staffing hours for those other residents. This will prevent APD from issuing duplicative payment for staff hours that are shared among consumers.

2) The number of daily residential habilitation hours for a consumer does not typically represent a 1:1 staffing ratio. In most cases, the number of residential habilitation training and supervision hours rendered by staff is shared between multiple consumers living in a home. A critical part of the calculation therefore involves distinguishing between 1:1 residential habilitation hours and shared residential habilitation hours. In order to prevent the artificial increase in the number of residential habilitation hours for all residents of a new home, it is critical that those residents requiring a large number of 1:1 hours have those hours calculated via a separate spreadsheet.

c. Movement of Consumers Between Licensed Residential Facilities. When a consumer moves from an established residential facility to another established facility, the residential habilitation hours at a new home should typically not exceed the number of residential habilitation hours previously rendered at a prior placement. Additional residential habilitation hours should not typically be requested solely to facilitate transitions; these

situations should be handled through requests for additional residential nursing hours, behavior analysis hours, or some other temporary service increase. Whenever feasible, the waiver support coordinator should submit such requests all at the same time, along with the caveat that the requests pertain to the provision of services for a time-limited period. However, if it is determined that the additional support required by the consumer would most appropriately be handled via the provision of additional residential habilitation hours, then a request which reflects the short-term duration of the additional services may be submitted. *The movement of a consumer into a new home should also not result in residential habilitation hour increases for the other residents. The provider should supply only the additional number of daily residential habilitation hours needed to serve the added consumer.*

6. Prior Service Authorization (PSA) Involving Residential Habilitation Services.

   a. New Service Requests. Prior to the addition of residential habilitation services as a new service, the services must be prior approved by the designated PSA contractor. Therefore, when residential habilitation represents a new waiver service for a particular consumer, the waiver support coordinator must complete and send a PSA package documenting the need for the new service to the APD Area Office. Within 3 working days of receipt, the area office will review the documentation to ensure conformity with the methodology described in this operating procedure. Following this review, the area office will return the PSA package to the waiver support coordinator (along with the name and telephone number of the APD staff member who reviewed the request). The reviewing APD staff member shall also clearly indicate on the PSA package if they desire a PSA reviewer to contact them for a consultation. The waiver support coordinator will then forward the PSA package to the designated PSA contractor for the official determination of medical necessity.

   b. Requests for Increases in Intensity of Services. If an increase in the number of residential habilitation hours is requested for a particular consumer, the waiver support coordinator must also complete and send a PSA package documenting the need for increase in the amount of services to the APD Area Office. Within 3 working days of receipt, the area office will review the documentation to ensure conformity with the procedure enumerated within this operating procedure. Following the review, the area office will return the PSA package to the waiver support coordinator (along with the name and telephone number of the APD staff member who reviewed the request). The reviewing APD staff member shall also clearly indicate on the PSA package if they desire a PSA reviewer to contact them for a consultation. The waiver support coordinator will then forward the PSA package to the designated PSA contractor for the official determination of medical necessity.

   c. APD Area Office Staff Role. If necessary (or requested by APD staff), a reviewer from the PSA contractor may call the APD Area Office staff member who reviewed the residential habilitation component of the PSA package for a consultation. The staff member or his/her designee must respond to the PSA reviewer's telephone call prior to the end of the next working day following the call in order to facilitate the timely completion of the PSA review process. This telephone consultation may serve as one of the components used to assist the PSA contractor's determination of medical necessity.

   d. The APD Area Office will be notified of the PSA contractor's decision regarding both new requests for residential habilitation as well as requests for increases in the intensity of residential habilitation services. For determinations which will result in: (1) the denial of the residential habilitation service; or (2) the denial of the service increase, the APD area office shall have 3 working days (beginning with the first full working day following receipt of the

determination) to provide the PSA contractor with additional information for re-consideration.

7. Verification of Hours. APD staff should remain vigilant in ensuring that APD only pays for the level of staff support that is needed to meet the needs of the consumer. As always, providers must render only the approved/authorized amount, duration, and scope of services to the consumers they serve. Deviations from this may result in recoupment of Medicaid payments (if services are billed beyond the authorized level) or other disciplinary actions (if services are provided at a level less than what was authorized and approved as necessary).

   In order to ensure the integrity of Medicaid expenditures while protecting the health and safety of consumers, APD staff should conduct sample staffing pattern evaluations by writing down the number of staff on duty, including their official job titles (to ensure that other professionals such as nurses or behavior analysts, for example, may be distinguished from direct care staff members) and the names of the consumers present as part of the routine monthly monitoring and annual re-licensure visits. This information should be noted on the monthly monitoring or annual licensure checklist. On a monthly basis, APD area staff shall conduct a verification review of at least ten different homes in order to determine if the staffing patterns observed during the last 3 months' site visits are consistent with the authorized levels of residential habilitation services for the residents of the homes until all homes within the area which provide residential habilitation services to at least one of its residents are reviewed. When every home in the area has been reviewed at least once, the process will repeat on an ongoing basis. This review should be done to ensure that the total number of daily staffing hours needed to support the consumers in the home are actually being rendered as well as to verify that 1:1 staffing ratio and other recommended and/or authorized direct care staffing services are actually being implemented by the provider. Discrepancies revealed during these verification reviews should be investigated and handled in accordance with established procedures.

8. Awake Overnight Staff. When awake overnight staff are needed to meet health and safety needs, APD staff should estimate the number of hours that overnight direct care staff would typically be expected to be awake and working directly with consumers. Residential habilitation hours should not include hours used to staff homes with sleeping staff who are present in the event of an emergency. These hours are covered in the program-related component of the residential habilitation rate model.

9. Sexual Abuse Considerations. In accordance with the memorandum on *Residential Placement Considerations in Preventing Sexual Violence*, dated January 7, 2004 (Attachment 3), and issued to APD staff, when consumers with previously documented histories of sexual battery, as described in s. 794.011, F.S., choose to live in licensed residential facilities, it is imperative that APD staff ensure that an adequate level of staffing (encompassing both training and supervision) is available and provided immediately following the placement.

10. Service Authorizations. Assuming the test of medical necessity is met, each consumer may be authorized to receive up to either 350 days of residential habilitation services under the residential habilitation *matrix* rate model, or 365 days of residential habilitation services under the residential habilitation *live-in* rate model over the course of their cost plan year. APD staff should ensure that cost plans do not exceed this maximum number of billable days, particularly in situations where consumers change residential service providers. In addition, service authorizations should be issued in such a manner that the annual cap applies to the consumer's cost plan year (as opposed to the fiscal year, calendar year, or other date span).

11. Effective Dates. The effective date of the rate should coincide with the date services begin for the consumer. It is recommended that whenever possible these new rates be effective on the first day of the month following their determination.

12. Emergency Situations. APD staff have both the ability and the obligation to issue temporary service authorizations regarding either new residential habilitation requests or increases in the amount of residential habilitation hours for a consumer in an emergency situations where the health or safety of that consumer or others is at risk. Such authorizations must be consistent with the policies delineated within APD OP 04-002, Emergency Waiver Services and Cost Plan Approvals Made by Area APD Offices.

13. Requests for Increases in Residential Habilitation Hours. Requests for increases in the number of residential habilitation hours may be approved by APD staff (or contracted PSA reviewers) only in cases where either: (1) the needs of the consumer have changed, resulting in an increased need for residential habilitation services; or (2) additional documentation has become available subsequent to the initial establishment of services which would justify the need for an increase in the number of residential habilitation hours.

14. Fair Hearing Rights. APD continues to afford all individuals fair hearing rights in accordance with 42 CFR §431, subpart E, which requires the provision of "fair hearings" to challenge or appeal actions relating to the authorization of Medicaid services. Primary responsibility for the issuance of due process notification letters lies with either APD or its designated PSA contractor - depending upon which entity issued the decision to deny or reduce the number of residential habilitation hours for a particular consumer. Consumers impacted by such decisions are entitled to request a fair hearing during which APD staff and/or a reviewer from APD's designated PSA contractor will represent APD in defense of the decision being appealed. Therefore, it is important to always maintain documentation supporting the medically necessary staffing needs of consumers.

BY DIRECTION OF THE DIRECTOR:

(Signed original copy on file)

SHELLY BRANTLEY
DIRECTOR

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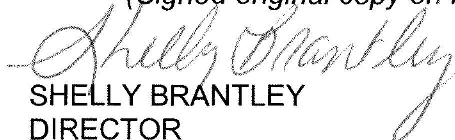

SHELLY BRANTLEY
DIRECTOR

Attachment 1

CONSIDERATIONS TO BE USED IN DETERMINING
MEDICALLY NECESSARY HOURS OF DAILY STAFF SUPPORT

The information derived from the following list of questions should be used to help determine the average daily amount of direct care staffing hours medically necessary to meet an individual consumer's needs. This list is by no means intended to be exhaustive and/or exclusive. In fact, any and all relevant information (either verbal or written) which is available and accessible, should be considered throughout this process in order to ensure the most precise match between consumer need and funded hours of staff support.

A. Program Participation.

Does the consumer attend school or a meaningful day activity during daytime hours?

If yes, what is the frequency of absences from school or their day activity (that would necessitate staff support in the residential facility during the day)?

B. Functional Status.

Does the consumer eat and drink independently? If not, what level of staff support would be required (either via verbal prompts or physical assistance)?

What is the consumer's level and means of ambulating?

Does the consumer fall frequently while ambulating, thereby requiring staff intervention to ensure safety?

What is the consumer's ability to transfer (e.g., from sitting to standing, standing into bed, etc.)?

What staff support would be required with toileting? Is the consumer incontinent of bowel or bladder? Does the consumer have an indwelling catheter or colostomy?

What is the consumer's ability to meet his/her ongoing personal hygiene needs?

How much staff support would be required with clothing selection, dressing and undressing?

How efficiently (and with what level of staff support, if any) could the consumer safely evacuate the residential facility in the event of emergency?

Does the consumer typically sleep through the night? If not, how often (and for how long) are they awake and what do they do when they awake during the night?

C. Behavioral Risk Status.

Does the consumer currently have a behavior program that would require staff involvement to carry out?

Is the consumer taking psychotropic medications? If yes, do any of these medications elicit side effects that would require staff support and/or intervention?

Does the consumer exhibit self-injurious behaviors? If so, what are they, how often do they occur, when do they typically occur, and how will they be addressed when they do occur?

Does the consumer exhibit behaviors which may cause others harm? If so, what are they, how often do they occur, when do they typically occur, and how will they be addressed when they do occur?

Does the consumer exhibit behaviors which may cause damage to property? If so, what are they, how often do they occur, when do they typically occur, and how will they be addressed when they do occur?

Does the consumer exhibit socially inappropriate behaviors? If so, what are they, how often do they occur, when do they typically occur, and how will they be addressed when they do occur?

Does the consumer exhibit any other unusual, disruptive, or repetitive behaviors that would require staff intervention and/or supervision in order to prevent their occurrence?

Are physical, mechanical, or chemical restraints or protective equipment used to deal with the consumer's maladaptive behaviors?

What is the consumer's risk of elopement and/or getting lost in the community?

Does the consumer have a history of criminal activity which would require a high level of staff supervision?

D. Physical Status.

Does the consumer have a history or diagnosis of stomach ulcers, vomiting, reflux, or any other gastrointestinal concerns?

Does the consumer have seizures? If yes, what are their severity, frequency, duration and how are they managed?

Is the consumer at risk for skin breakdown (which would necessitate staff intervention such as repositioning during the night)?

Are there specific nutritional needs required by the consumer?

Does the consumer possess any other medical issues which would impact their need for staff support? Describe in detail.

ATTACHMENT 2

APD OP 04-003, revised 1/1/06

WORKSHEET FOR DETERMINING RESIDENTIAL HABILITATION STAFFING HOURS IN A LICENSED HOME

SITE (NAME OR ADDRESS) ______________________ Behavioral Home? Yes___ No___

PROVIDER NAME ______________________ MEDICAID ID: ______________

DISTRICT NUMBER ______________________ PREPARED BY: ______________

INSTRUCTIONS

The estimate needs to be for a full year adjusted for the different kinds of weeks (i.e., standard weeks, weeks with holidays in them, and weeks where either there is no school, or the ADT or work site is closed).

DEFINITION OF DIRECT CARE STAFF HOUR :

A direct care staff hour must have two components: (a) the person is hired to perform or is performing service tasks related to residential habilitation; and (2) most (90% or more) of staff time is spent with the client.

1. Fill out only one schedule for each type of week for each provider / site. Also indicate **yes** or **no** if the entire site is behavioral residential habilitation.
2. Enter the number of direct care staff hours per shift in the white blocks. Do not put numbers in any of the shaded areas.
3. Collect from each provider for each licensed home the number of direct care staff hours provided for the week indicated in the upper left above the schedule.

STANDARD WEEK, (No holidays or closures) : AND THERE ARE : ______ OF THESE IN THE YEAR (Standard = 42 weeks)

Indicate which week chosen.

Number of Direct Care Staff hours / awake	TOTAL	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM Staff Hours 6:00 a.m. to 2:00 p.m.								
PM Staff Hours 2:00 p.m. to 10:00 p.m.								
Night Staff Hours 10:00 p.m. to 6:00 a.m.								
Sub-total hours each day								
Total Hours per week								
Average daily awake staff hours								
Number of people living here:								
Hours per day per person								

HOLIDAY WEEK, (Thanksgiving) : AND THERE ARE : ______ OF THESE IN THE YEAR (Standard = 10 weeks)

Indicate which week chosen.

Number of Direct Care Staff hours / awake	TOTAL	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM Staff Hours 6:00 a.m. to 2:00 p.m.								
PM Staff Hours 2:00 p.m. to 10:00 p.m.								
Night Staff Hours 10:00 p.m. to 6:00 a.m.								
Sub-total hours each day								
Total Hours per week								
Average daily awake staff hours								
Number of people living here:								
Hours per day per person								

CLOSURE WEEK, (School, ADT or Work Site) : AND THERE ARE : ______ OF THESE IN THE YEAR (No Standard)

Indicate which week chosen.

Number of Direct Care Staff hours / awake	TOTAL	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM Staff Hours 6:00 a.m. to 2:00 p.m.								
PM Staff Hours 2:00 p.m. to 10:00 p.m.								
Night Staff Hours 10:00 p.m. to 6:00 a.m.								
Sub-total hours each day								
Total Hours per week								
Average daily awake staff hours								
Number of people living here:								
Hours per day per person								

Weeks Reported: *SHOULD BE EQUAL TO 52 ! ! !*

This is your average hours per client of direct care staff for the clients listed for this site:

FLORIDA DEPARTMENT OF
CHILDREN
& FAMILIES

Jeb Bush
Governor

Jerry Regier
Secretary

MEMORANDUM

DATE: January 7, 2004

TO: Developmental Disabilities Program Administrators and Placement Coordinators, Suncoast Region, Districts (1-4) (7-15)

FROM: Shelly Brantley, Director of Developmental Disabilities

SUBJECT: Residential Placement Considerations in Preventing Sexual Violence

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Research indicates that those individuals who have perpetrated at least one previous act of sexual violence will most likely commit another such act if afforded the opportunity. While it generally does not garner significant media attention, the fact is that some individuals with developmental disabilities themselves have been identified as the perpetrators of sexual violence against other disabled consumers (who are often unable to defend themselves and/or report such incidences).

As we continue implementing the individual components of our Zero Tolerance Initiative, one of the most important and immediate ways that the Department can facilitate the prevention of client-on-client sexual violence within our licensed residential facilities involves taking certain safety measures during the placement process. Specifically, when consumers with previous histories of sexual violence choose to live with other individuals with developmental disabilities in residential settings, it is imperative for district/region staff to ensure that an adequate level of staff training, oversight, and supervision (as well as the provision of behavior analysis services as appropriate) is available and provided immediately following the placement. Considering that the severity of certain cognitive, behavioral and/or physical impairments may inherently engender greater consumer vulnerability, the characteristics of the other residents of the facility should be considered as well (prior to the final placement decision) in order to lessen the opportunity for sexual violence.

I appreciate and acknowledge the ongoing efforts of our district/region staff members in the successful implementation of our Zero Tolerance Initiative. If you have specific questions or require additional information concerning any of our Zero Tolerance activities, please feel free to contact Tom Rice at (850) 414-7649 or Suncom 994-7649.