DEPARTMENT OF CHILDREN AND FAMILIES
Agency for Persons with Disabilities

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65G-4.0213 Definitions.

For the purposes of this chapter, the term:

(1) "Agency" means the Agency for Persons with Disabilities.

(2) "Allocation Algorithm" means the mathematical formula based upon statistically validated relationships between client characteristics (variables) and the client's level of need for services provided through the Waiver as set forth in Rule 65G-4.0214, F.A.C., and as provided in section 393.0662(1)(a), F.S.

(3) "Allocation Algorithm Amount" means the result of the Allocation Algorithm apportioned according to available funding.

(4) "Amount Implementation Meeting Worksheet" or "AIM Worksheet" means a form used by the Agency for new Waiver enrollees, and upon recalculation of a client's algorithm, to:

(a) Communicate a client's Allocation Algorithm Amount;

(b) Identify proposed services based upon the Allocation Algorithm Amount; and

(c) Identify additional services, if any, should the client or their legal representative feel that any Significant Additional Needs of the client cannot be met within the Allocation Algorithm Amount. The Amount Implementation Meeting Worksheet – APD Form 65G-4.0213 A, effective 7-1-21, is hereby adopted and incorporated by reference, and is available at _____ .

(5) "Approved Cost Plan" means the document that lists all Waiver services that have been authorized by the Agency for the client, including the anticipated cost of each approved Waiver service, the provider of the approved service, and information regarding the provision of the approved service.

(6) "Available Service" means a support that is covered, authorized, or provided by a government program not operated by the agency, a community program, a third party such as a private health insurance company, or provided

by a natural support.

(7) “Client” has the same meaning as provided in section 393.063(7), F.S.

(8) “Client Advocate” has the same meaning as provided in section 393.063(8), F.S, and includes legal counsel if designated by the client or the client’s legal representative.

(9) “Client Review” means the Agency’s review of information submitted by a WSC to determine if the request meets significant additional needs criteria.

(10) “Community Supports” means resources or services accessible to a client as a member of the community. This includes, but not limited to, resources available through organizations such as faith-based, cultural, geographic, non-profit, for-profit, and community groups.

(11) “Handbook” means the Florida Medicaid Developmental Disabilities Waiver Services Coverage and Limitations Handbook, as adopted by Rule 59G-13.070, F.A.C. (effective October 2020) and available at https://www.flrules.org/gateway/reference.asp?No=Ref-12102.

(12) “Health and Safety” includes emotional, behavioral, mental, and physical health and safety.

(13) “iBudget” means the Home and Community-Based Services Medicaid Waiver program under section 409.906, F.S., that consists of the Waiver service delivery system utilizing individual budgets required pursuant to section 393.0662, F.S., and under which the Agency for Persons with Disabilities operates the Home and Community-Based Services Waiver.

(14) “iBudget Amount” means the total amount of funds that have been approved by the Agency, pursuant to the iBudget Rules, for a client to spend for Waiver services during a fiscal year.

(15) “iBudget Rules” means Rules 65G-4.0213 through 65G-4.0218, F.A.C., and are the rules which implement and interpret iBudget Amounts.

(16) “Legal Representative” means:

(a) For clients under the age of 18 years, the legal representative or health care surrogate appointed by the Florida court to represent the child or anyone designated by the parent(s) of the child to act on the parent(s)’ behalf (e.g., due to military absence).

(b) For clients age 18 years or older, the legal representative could be the client, anyone designated by the client through a Power of Attorney or Durable Power of Attorney, a medical proxy under chapter 765, F.S., or anyone appointed by a Florida court as a guardian or guardian advocate under chapter 393 or 744, F.S.

(17)(a) “Medically necessary” or “medical necessity,” as defined in the Handbook, means that the medical or allied care, goods, or services furnished or ordered must meet 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 determined by the Medicaid program, and not 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 recipient, the recipient’s caretaker, or the provider.

(b) 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.

(18) “Natural Support” means unpaid supports that are or may be provided voluntarily to the client in lieu of Waiver services and supports. Any determination of the availability of natural supports includes, but is not limited to consideration of the client’s caregiver(s) age, physical and mental health, travel and work or school schedule, responsibility for other dependents, sleep, and ancillary tasks necessary to the health and well-being of the client.

(19) “Person-centered planning” means a planning approach directed by a client with long term care needs, intended to identify the strengths, capacities, preferences, needs, and desired outcomes of the client. The client or legal representative determines the other participants in this process for the purposes of assisting the client to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community setting and to facilitate health, safety, and well-being.

(20) “Qualified Organization” means an organization which employs support coordinators who serve clients that receive Agency services and is determined by the Agency to have met all of the requirements of section 393.0663(2), F.S., the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, and chapter 65G-14, Florida Administrative Code.

(21) “Questionnaire for Situational Information” or “QSI” effective 5-21-15 means an assessment instrument used by the Agency to determine a client’s needs in the areas of functional, behavioral, and physical status. The QSI

is adopted by the Agency as the current valid and reliable assessment instrument and is hereby incorporated by reference. The QSI is available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-07075.

(22) "QSI Assessor" means an Agency employee who has been certified by the Agency in the administration of the QSI.

(23) "Service Authorization" means an Agency notification that authorizes the provision of specific Waiver services to a client and includes, at a minimum, the provider's name and the specific amount, duration, scope, frequency, and intensity of the approved service.

(24) "Service Families" means eight categories that group services related to: Life Skills Development, Supplies and Equipment, Personal Supports, Residential Services, Support Coordination, Therapeutic Supports and Wellness, Transportation and Dental Services. The Service Families include the following services:

(a) Life Skills Development, which includes:

1. Life Skills Development Level 1 (companion services),

2. Life Skills Development Level 2 (supported employment); and

3. Life Skills Development Level 3 (adult day training).

(b) Supplies and Equipment which includes:

1. Consumable Medical Supplies,

2. Durable Medical Equipment and Supplies,

3. Environmental Accessibility Adaptations; and

4. Personal Emergency Response Systems (unit and services).

(c) Personal Supports, which includes:

1. Services formerly known as in-home supports, respite, personal care and companion for clients age 21 or older, living in their own home or family home and also for those at least 18 but under 21 living in their own home; and

2. Respite Care (for clients under 21 living in their family home).

(d) Residential Services, which includes:

1. Standard Residential Habilitation,

2. Behavior Focused Residential Habilitation,

3. Intensive Behavior Residential Habilitation,

4. Enhanced Intensive Behavior Residential Habilitation

5. Medical Enhanced Intensive Behavior Residential Habilitation

6. Live-In Residential Habilitation,

7. Special Medical Home Care; and

8. Supported Living Coaching.

(e) Waiver Support Coordination.

(f) Therapeutic Supports and Wellness, which includes:

1. Private Duty Nursing,

2. Residential Nursing,

3. Skilled Nursing,

4. Dietician Services,

5. Respiratory Therapy,

6. Speech Therapy,

7. Occupational Therapy,

8. Physical Therapy,

9. Specialized Mental Health Counseling,

10. Behavior Analysis Services; and

11. Behavior Assistant Services.

(g) Transportation; and

(h) Dental Services, which consists of Adult Dental Services.

(25) “Significant” means of considerable magnitude or considerable effect.

(26) “Significant Additional Needs” or “SANs” means, as provided in section 393.063(39), F.S., an additional need for medically necessary services which would place the health and safety of the client, the client’s caregiver, or the public in serious jeopardy if it is not met. The term also includes services to meet an additional need that the client requires in order to remain in the least restrictive setting, including, but not limited to, employment services and transportation services. The Agency may provide additional funding only after the determination of a client’s initial allocation amount and after the WSC has documented the availability of non-Waiver resources on the Verification of Available Services form. Examples of SANs that may require long-term support include, but are not limited to, any of the following:

(a) A documented history of significant, potentially life-threatening behaviors, such as recent attempts at suicide, arson, nonconsensual sexual behavior, self-injurious behavior requiring medical attention, dementia, or age-related behaviors that present significant health and safety risks,

(b) A complex medical condition that requires active intervention by a licensed nurse on an ongoing basis that cannot be taught or delegated to a non-licensed person,

(c) A need for total physical assistance with activities of daily living such as eating, bathing, toileting, grooming, dressing, personal hygiene, lifting, transferring or ambulation;

(d) Permanent or long-term loss or incapacity of a caregiver;

(e) Loss of services authorized under the state Medicaid plan or through the school system due to a change in age;

(f) Significant decline in medical, behavioral or functional status;

(g) Lack of a meaningful day activity needed to foster mental health, prevent regression or engage in meaningful community life and activities;

(h) One or more of the situations described in Rule 65G-1.047, F.A.C., Crisis Status Criteria; and

(i) Risk of abuse, neglect, exploitation, or abandonment that can be mitigated with Waiver services.

(27) “Significant change in condition or circumstance” means a significant change or deterioration in a client’s health status, an actual or anticipated change in the client’s living situation, a change in the caregiver relationship or the caregiver’s ability to provide supports, loss of or deterioration of his or her home environment, or loss of the client’s spouse or caregiver. Examples of a significant change include:

(a) A deterioration in health status that requires that the client receive services at a greater intensity or in a different setting to ensure that client’s health or safety;

(b) Onset of a health, environmental, behavioral, or medical condition that requires that the client receive services at a greater intensity or in a different setting to ensure the client’s health or safety; or

(c) A change in age or living setting resulting in a loss of services funded or otherwise provided from sources other than the Waiver. This may include a change in living setting which requires a different service array or a change in the availability or health status of a primary caregiver that prevents that caregiver from continuing to provide support.

(28) “Support plan” means an individualized and person-centered plan of supports and services designed to meet the needs of a client enrolled in the iBudget. The plan is based on the preferences, interests, talents, attributes and

needs of a client, including the availability of natural supports.

(29) “Temporary basis” means a time period of less than 12 months.

(30) “Verification of Available Services” means a form completed by the WSC to enable the Agency to certify and document that the client has utilized all available services through the Medicaid State Plan, school-based services, private insurance, other benefits, and any other resources, such as local, state, and federal government and non-government programs or services and natural or community supports, that might be available prior to requesting Waiver funds. The Verification of Available Services documents and verifies that the iBudget Waiver is the payer of last resort. A valid and accurate Verification of Available Services is a condition precedent to the authorization of services. The Verification of Available Services – APD Form 65G-4.0213 B, effective 7-1-21, is hereby adopted and incorporated by reference and is available at _____.

(31) “Waiver” means the iBudget operated by the Agency.

(32) “Waiver Support Coordinator” or “WSC” means an employee of a qualified organization as defined in section 393.0663, F.S., who is selected by the client or the client’s legal representative to assist the client and family in identifying their capacities, needs, and resources; finding and gaining access to necessary supports and services; coordinating the delivery of supports and services; advocating on behalf of the client and family; maintaining relevant records; and monitoring and evaluating the delivery of supports and services to determine the extent to which they meet the needs and expectations identified by the client, family, and others who participated in the development of the support plan with person-centered planning.

(33) “WSC Job Aid for Cost Plans and Significant Additional Needs Documentation” means a form that identifies the documentation required for each service requested in the cost plan. The documentation identified by this form is a material part of each request. The WSC Job Aid for Cost Plans and Significant Additional Needs Documentation – APD Form 65G-4.0213 D, effective 7-1-21, is hereby adopted and incorporated by reference and is available at _____.

(34) This Rule shall be reviewed, and if necessary, renewed through the rulemaking process five years from the effective date.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.063, 393.0662, 409.906 FS. History–New 7-7-16, Amended 7-1-21.

65G-4.0214 Allocation Algorithm.

(1) To establish the Allocation Algorithm Amount for any client who has not previously had a QSI assessment, a QSI assessment must be completed prior to calculating the Allocation Algorithm Amount under subsection (2).

(a) The QSI assessor shall arrange for a face-to-face meeting with the client and, if available, the client's legal representative. The WSC shall attend the face-to-face meeting with consent of the client or the client's legal representative. If the client or the client's legal representative is not capable of fully responding to all of the assessment questions, at least one participant with day-to-day knowledge of the client's care should participate.

(b) A copy of the completed QSI evaluation and scores shall be provided to the client and WSC.

(c) Upon receiving QSI results if the client or his or her legal representative identifies an error in the QSI results the WSC shall notify the Agency in writing setting forth the details of the error. At any time, the client or WSC can prepare a statement to be maintained in client's Central File identifying any concerns with the QSI assessment score or responses. If any error is identified in the QSI assessment the Agency shall review the error to determine if any adjustments are needed. The Agency shall inform the WSC of the result of the review and provide a revised Allocation Algorithm Amount, if appropriate, within 15 working days of notification of the error. The WSC shall in turn notify the client or the client's representative.

(d) The client or WSC may request a reassessment any time there has been a significant change in circumstance or condition that would impact any of the questions used as variables in the algorithm determination. The Agency shall arrange for a reassessment at the earliest possible time in accordance with the circumstances, complete the reassessment, and notify the client and WSC of the results within 60 days of the request for reassessment. This section shall not be construed to require the Agency to wait for the completion of a QSI in order to address an emergency situation of the client.

(2) To calculate the Allocation Algorithm for each client, the following weighted values, as applicable, shall be summed, and the resulting total then squared:

(a) The base value for all clients, 27.5720;

(b) If the client is age 21 to 30, 47.8473;

(c) If the client is age 31 or older, 48.9634;

(d) If the client resides in supported or independent living, or the client resides in a licensed facility and does not receive residential habilitation services, 35.8220;

(e) If the client resides in a licensed residential facility that is designated to provide Standard or Live-In residential

habilitation services, 90.6294;

(f) If the client resides in a licensed residential facility with a Behavior Focus designation, 131.7576;

(g) If the client resides in a licensed residential facility with an Intensive Behavior designation, 209.4558;

(h) If the client resides in a licensed residential facility that is a Comprehensive Transitional Education Program or provides Special Medical Home Care, 267.0995;

(i) The sum of the scores on the client questions in the QSI Behavioral Status Subscale (Questions 25-30), multiplied by 0.4954;

(j) If the client resides in the family home, the sum of the scores on the client questions in the QSI Functional Status Subscale (Questions 14-24), multiplied by 0.6349;

(k) If the client resides in supported or independent living, the sum of the scores on the client questions in the QSI Functional Status Subscale (Questions 14-24), multiplied by 2.0529;

(l) If the client resides in supported or independent living, the sum of the scores on the client questions in the QSI Behavioral Status Subscale (Questions 25-30), multiplied by 1.4501;

(m) The client's score on QSI Question 16, multiplied by 2.4984;

(n) The client's score on QSI Question 18, multiplied by 5.8537;

(o) The client's score on QSI Question 20, multiplied by 2.6772;

(p) The client's score on QSI Question 21, multiplied by 2.7878;

(q) The client's score on QSI Question 23, multiplied by 6.3555;

(r) The client's score on QSI Question 28, multiplied by 2.2803;

(s) The client's score on QSI Question 33, multiplied by 1.2233;

(t) The client's score on QSI Question 34, multiplied by 2.1764;

(u) The client's score on QSI Question 36, multiplied by 2.6734; and(v) The client's score on QSI Question 43, multiplied by 1.9304.

(3) The squared result of the sum of the applicable values of paragraphs (2)(a) through (v), above, then apportioned according to available funding, is the client's Allocation Algorithm Amount.

(4) This Rule shall be reviewed, and if necessary, renewed through the rulemaking process five years from the effective date.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.063, 393.0662 FS. History–New 7-7-16,

Amended 7-1-21.

65G-4.0215 General Provisions.

(1) Medical necessity alone is not sufficient to authorize a service under the Waiver; in addition:

(a) With the assistance of the WSC, the client must utilize all available State Plan Medicaid services, school-based services, private insurance, natural supports, and any other resources that may be available to the client before expending funds from the client's iBudget Amount for support or services. As an example, State Plan Medicaid services for children under the age of 21 typically include personal care assistance, therapies, consumable medical supplies, medical services, and nursing;

(b) The services must be within Waiver coverages and limitations; and

(c) The cost of the services must be within the Allocation Algorithm Amount unless there is a significant additional need demonstrated.

Failure to meet the above criteria shall result in a denial of a request for additional funding.

(2) WSCs shall coordinate with the clients they serve to ensure that services are selected from all available resources to keep the annual cost of services within the client's iBudget Amount while maintaining the client's health and safety.

(3) Prior to authorizing new or increased services or at the time of a medical necessity review, the Agency must certify and document within the client's cost plan that the client has used all available services authorized under the Medicaid State Plan; school-based services; private insurance; local, state, and federal government and non-government programs or services; natural or community supports; and any other benefit or resource that may be available to the client before using funds from the iBudget to pay for supports and services.

(a) The iBudget Waiver is the payor of last resort.

(b) A valid and accurate Verification of Available Services form is a condition precedent to the authorization of services. To enable the Agency to certify and document that the client has utilized all available services pursuant to section 393.0662(3), F.S., the WSC must complete and submit the Verification of Available Services to the Agency:

1. At the time of any requests to add or increase services, or

2. Upon request from the Agency when it is making determinations of medical necessity for Waiver services.

(4) Cost Plan Flexibility.

(a) After the client's proposed cost plan is approved, he or she may change the services in his or her Approved

Cost Plan provided that such change does not jeopardize the health and safety of the client and meets medical necessity.

(b) When changing the services within the Approved Cost Plan, the client and his or her WSC shall ensure that sufficient funding remains allocated for unpaid services that were authorized and rendered prior to the effective date of the change.

(c) Clients enrolled in iBudget will have flexibility and choice to budget or adjust funding among the following services without requiring additional authorizations from the Agency, provided the client's overall iBudget Amount is not exceeded and all health and safety needs are met:

1. Life Skills Development 1,

2. Life Skills Development 2,

3. Life Skills Development 3, within the approved ratio,

4. Durable Medical Equipment,

5. Adult Dental,

6. Personal Emergency Response Systems,

7. Environmental accessibility adaptations,

8. Consumable Medical Supplies,

9 Transportation,

10. Personal Supports up to $16,000,

11. Respite up to $10,000.

(d) Medically necessary services will be authorized by the Agency for covered services not listed above if the cost of such services are within the client's iBudget Amount and in accordance with subsection 65G-4.0215(1), F.A.C. The Agency shall authorize services in accordance with criteria identified in section 393.0662(1)(b), F.S., medical necessity requirements of section 409.906, F.S., subsection 59G-1.010(166), F.A.C., Handbook limitations, and the authority under Title 42 of the Code of Federal Regulations, Part 440, Section 230(d).

(f) Service authorization and any modifications to it must be received by the provider prior to service delivery. This includes changes to the authorization as a result of clients redistributing funds within their existing cost plan.

(5) Consumer Directed Care Plus (CDC+): clients enrolled in the CDC+ program are subject to iBudget Rule 65G-4.0214, subsections 65G-4.0215(1), (2) and (7), and Rules 65G-4.0216, 65G-4.0217, 65G-4.0218, F.A.C.

(6) Approval, Denial, or Closure of Applications.

(a) iBudget Waiver providers must have applied through the Agency for Persons with Disabilities to ensure that they meet the minimum qualifications to provide iBudget Waiver services. iBudget Waiver providers must also be enrolled as a Medicaid provider through the Agency for Health Care Administration. However, providers do not have to provide Medicaid State Plan services in order to provide Waiver services.

(b) To enroll as a provider for iBudget Waiver services, the provider must first submit an application to the Agency or Persons with Disabilities using the Regional iBudget Provider Enrollment Application – WSC – APD Form 65G-4.0215 A, effective date 7-1-2021, for Waiver Support Coordinator applications, which is available at _____ , or the Regional iBudget Provider Enrollment Application – Non-WSC – APD Form 65G-4.0215 B, effective date 7-1-2021, for all other provider applications, which is available at _____ . These forms are hereby incorporated by reference. The qualifications to provide services are identified in the Handbook.

(c) The Agency will review the application and approve or deny complete applications within 90 days of receipt; the Agency will close incomplete applications.

1. The Agency will only consider complete applications that include all required information and meet the requirements delineated in this chapter, the iBudget Handbook, and section 393.0663, F.S. An application is complete upon the Agency's receipt of all requested information and correction of any error or omission for which the applicant was notified.

2. If the Agency receives an incomplete application, the Agency will notify the applicant. The applicant will have 45 calendar days from the date of the notice to submit the documentation, information, or make any corrections designated in the notice. If the applicant does not complete the application within 45 days of the notice, the application must be closed by the Agency. After an application is closed, all documentation and information submitted will no longer be considered, and a new complete application must be submitted for consideration by the Agency. The closure of an application is not Agency action and will not be considered substantively by the Agency in any subsequent application.

(d) If a Waiver provider wishes to, expand by providing additional services, expand services geographically, or expand from solo to agency, the provider must notify the Agency regional office by submitting a Provider Expansion Request form – APD Form 65G-4.0215 C, effective date _____, which is hereby incorporated by reference and is available at _____ . The Agency regional office must approve any expansion prior to the provision of expanded services. The qualifications to provide or expand services are identified in the Handbook.

(7)(a) When a client is enrolled in the iBudget, that client remains enrolled in the Waiver position allocated unless the client becomes disenrolled due to one of the following conditions:

1. The client or client's legal representative chooses to terminate participation in the Waiver.

2. The client moves out-of-state.

3. The client loses eligibility for Medicaid benefits and this loss is expected to extend for a lengthy period.

4. The client no longer needs Waiver services.

5. The client no longer meets level of care for admission to an ICF/IID.

6. The client no longer resides in a community-based setting but moves to a correctional facility, detention facility, defendant program, or nursing home or resides in a setting not otherwise permissible under Waiver requirements.

7. The client is no longer able to be maintained safely in the community.

If a client is disenrolled from the Waiver and becomes eligible for reenrollment within 365 days that client can return to the Waiver and resume receiving Waiver services. If Waiver eligibility cannot be re-established or if the client who has chosen to disenroll has exceeded this time period, the client cannot return to the Waiver until a new Waiver vacancy occurs and funding is available. In this instance, the client is added to the Waiting List of clients requesting Waiver participation. The new effective date is the date eligibility is re-established or the client requests re-enrollment for Waiver participation.

(b) Providers are responsible for notifying the client's WSC and the Agency if the provider becomes aware that any of the conditions of paragraph (a) or (c), exists.

(c) If a client or legal representative refuses to cooperate with the provision of Waiver services in any of the following ways: develop a cost plan or support plan, participate in a required QSI assessment or other approved Agency needs assessment tool, or refuse to annually sign the Waiver eligibility worksheet that establishes a level of care, then the Agency will review the circumstances to determine if the client should be removed from the Waiver for failing to comply with specific eligibility requirements. Any such decision by the Agency shall provide written notice to the client, the client's legal representative and the WSC, at least 30 days before terminating services.

(d) Clients denied services shall have the right to a fair hearing. Clients are exempted from this provision if they do not have the ability to give informed consent and do not have a legal representative. The Agency shall not remove a client from the Waiver due to non-compliance if it directly impacts the client's health, safety, and welfare.

(8) This Rule shall be reviewed, and if necessary, renewed through the rulemaking process five years from the

effective date.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.063, 393.0662, 409.906 FS. History–New 7-7-16, Amended 9-12-18, 7-1-21.

65G-4.0216 Establishment of the iBudget Amount.

(1) The iBudget Amount for a client shall be the Allocation Algorithm Amount, as provided in Rule 65G-4.0214, F.A.C., plus any approved Significant Additional Needs funding as provided in Rule 65G-4.0218, F.A.C.

(2) The Agency will determine the iBudget Amount consistent with the criteria and limitations contained in the following provisions: sections 409.906 and 393.0662, F.S.; and Rules 59G-13.080, 59G-13.081, and 59G-13.070, F.A.C.

(3) Significant Additional Needs Review:

(a) The first time the Allocation Algorithm Amount is calculated, the WSC will discuss the Allocation Algorithm Amount with the client, and, if available, the client's legal representative and, if available and applicable, the client advocate, in order to determine if the client has any Significant Additional Needs.

(b) The WSC shall discuss the services requested with the client or the client's legal representative, and, if available and applicable, the client advocate.

(c) The Agency will conduct a Client Review to determine whether services requested meet health and safety needs and waiver coverage and limitations. The AIM Worksheet must be completed as part of the Client Review and submitted to the Agency within 30 days of receipt of the new Allocation Algorithm Amount.

(d) The Agency will issue a decision of the iBudget Amount within 30 days of receipt of the AIM Worksheet. The client and his or her legal representative will be advised of the Agency's decision for the amount of the client's final iBudget Amount within 30 days.

1. If additional documentation is requested, the deadline for the Agency's response shall be extended to 60 days following the receipt of the original request.

2. The Verification of Available Services form is a material part of the request form. Failure to include the Verification of Available Services form is a basis for denial.

(e) The Agency shall approve an increase to the iBudget Amount if additional funding is required to meet the Significant Additional Needs subject to the provisions of the iBudget Rules. The Agency, upon completion of its review shall notify in writing the client, the WSC, and the client advocate, if any, of its decision.

(4) After the iBudget Amount is established, if a client remains in the same living setting and experiences a significant change in condition or circumstances where the proposed needs cannot be met within the current iBudget Amount, the WSC shall request services through the significant additional needs process without the calculation of a new algorithm or the completion of the AIM Worksheet.

(5) iBudget Amounts are pro-rated as appropriate based on the length of time remaining in the fiscal year.

(6) The Agency shall ensure that the sum of all clients' projected expenditures do not exceed the Agency's annual appropriation.

(7) This Rule shall be reviewed, and if necessary, renewed through the rulemaking process five years from the effective date.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.063, 393.0662, 409.906 FS. History–New 7-7-16, Amended 7-1-21.

65G-4.0217 iBudget Cost Plan.

(1) When a client's iBudget Amount is determined, the WSC must submit a cost plan proposal, which includes a completed Verification of Available Services form, that reflects the specific Waiver services and supports (paid and unpaid) that will assist the client to achieve identified goals, and the provider of those services and supports, including natural supports. The cost plan proposal is derived from person-centered planning. The Verification of Available Services form is a material part of the cost plan proposal. Failure to include the Verification of Available Services form will result in a denial of the cost plan.

(2) The WSC shall provide documentation for requested services as specified in Section C of the WSC Cost Plan and Significant Additional Needs Job Aid to document medical necessity and compliance with Handbook coverage and limitations.

(3) Each client's proposed iBudget cost plan shall be reviewed and approved by the Agency in conformance with the iBudget Rules and the Handbook. Any conflict between the Handbook and these iBudget Rules shall be resolved in favor of these rules.

(4) For a client to begin receiving a specific Waiver service, that service must have been listed in an Approved Cost Plan and the service authorization must have been issued to the provider prior to the delivery of service.

(5) Clients must budget their funds so that their needs are met throughout the plan year. All clients shall allocate iBudget funding each month for Waiver support coordination services, which is a required service under the Waiver.

(6) This Rule shall be reviewed, and if necessary, renewed through the rulemaking process five years from the effective date.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.063, 393.0662, 409.906 FS. History–New 7-7-16, Amended 7-1-21.

65G-4.0218 Significant Additional Need Funding.

(1) Supplemental funding for Significant Additional Needs (SANs) may be of a one-time, temporary, or long-term in nature.

(2) The presence of a significant additional need or significant change in condition or circumstance alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the algorithm.

(3) A client's annual expenditures for home and community-based services Medicaid Waiver services may not exceed the limits of his or her iBudget. The total of all clients' projected annual iBudget expenditures may not exceed the Agency's appropriation for Waiver services.

(4) SANs can only be approved after the determination of a client's initial allocation amount and after the WSC has documented the availability of non-Waiver resources on the Verification of Available Services form. Nothing in this section prohibits the authorization of emergency services on a temporary basis through the Agency. Requests for SANs require:

(a) The client to have a significant additional need as defined in this chapter; and

(b) A significant additional need cannot be created by failing to maintain sufficient funds to cover services previously authorized in accordance with subsections 65G-4.0215(2) and (5), F.A.C.

(5) The WSC shall submit a SANs request that reflects the specific Waiver services and supports that will assist the client to meet identified needs, with all required supporting documentation as specified in the WSC Job Aid for Cost Plans and Significant Additional Needs Documentation. The documentation identified in the WSC Job Aid is material to the SANs requests. The Agency must close or deny the SANs request without such documentation.

(a) The SANs request shall be submitted indicating how the current budget allocation and requested SANs funds would be used. The request should also include an explanation of why additional funding is needed, and any additional documentation appropriate to support the request.

(b) The SANs request shall be submitted with an updated support plan, which must include an explanation of why additional funding is needed and indicate how the current budget allocation and requested SANs funds would be used.

The request must include documentation appropriate to support the request in accordance with the WSC Job Aid for Cost Plans and Significant Additional Needs Documentation form.

(c) Documentation of attempts within the last 30 days prior to submitting the SANs request to locate natural or community supports, third-party payers, or other sources of support to meet the client's health and safety needs must also be documented and verified by the WSC on the Verification of Available Services form.

(d) If there are any concerns about the accuracy of the QSI results, the WSC shall submit this as well.

(6) If a client's iBudget Amount includes Significant Additional Needs beyond what was determined by the Allocation Algorithm, and the Agency determines that the intensity, frequency or duration of the service(s) is no longer medically necessary, the Agency will adjust the client's services to match the current need.

(7)(a) The Agency will not consider incomplete SANs requests due to lacking material information to determine whether SANs criteria are met. A SANs request is incomplete if it does not:

1. Provide detail the client's current approved services, including the number and type of units and dollar amount for each service. The client to staff ratio, if applicable, must also be included;

2. Clearly indicate whether the current approved services are requested to continue on an annualized basis;

3. Clearly identify any new or increased services being requested in the current fiscal year and on an annualized basis, if applicable to that service type;

4. Include a complete Verification of Available Services form;

5. Include documentation to support the information provided in the Verification of Available Services Form, or identify the location of the currently valid documentation in the designated data management system;

6. Place the request in the proper status for submission in the designated data management system; or

7. Include certification that the request meets the criteria for SANs.

(b) The Agency shall close incomplete SANs requests upon receipt.

(8) The Agency will request the documentation and information necessary to evaluate a client's increased funding requests based on the client's needs and circumstances. The documentation will vary according to the funding request and may include the following as applicable: support plans, results from the Questionnaire for Situational Information, cost plans, expenditure history, current living situation, interviews with the client and his or her providers and caregivers, prescriptions, data regarding the results of previous therapies and interventions, assessments, and provider documentation.

(9) Within 30 days of receipt of a request for SANs funding, and adjustments in the client's service array, the Agency shall approve, deny (in whole or in part), or request additional documentation concerning the request.

(a) If the request does not include all necessary documentation, the Agency shall provide the client and WSC with a written notice of what additional documentation is required. The client or WSC shall provide the documentation within 10 days, or notify the Agency in writing that the client wishes the Agency to render its decision based upon the documentation provided.

(b) If additional documentation is requested, the deadline for the Agency's response shall be extended to 60 days following the receipt of the original request. If the client has not received a notice from the Agency approving, denying or requesting additional information within 60 days, the client or WSC may notify the Agency in writing of such failure to issue a timely notice and the Agency shall have 20 days from receipt of the Notice to approve or deny the request.

(c) Failure of the Agency to issue this Notice within 20 days shall mean the requested funding for services are authorized as of the 21st day, and the client and service providers may treat the authorization as an approval.

(10) Individual and Family Supports (IFS) funding may cover temporary emergency services pursuant to chapter 65G-13, F.A.C., while requests for Significant Additional Needs are being processed.

(11) This Rule shall be reviewed, and if necessary, renewed through the rulemaking process five years from the effective date.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.063, 393.0662, 409.906 FS. History–New 7-7-16, Amended 7-1-21.