

agency for persons with disabilities
State of Florida

Training for iBudget Rule Updates 65G-4.0213 through 4.0218, Florida Administrative Code (F.A.C.)

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iBudget Rule Change Information

This training is intended to provide information about the approval process for iBudget Florida waiver services.

Please review the entire rule and new forms here:

<https://www.apd.myflorida.com/waiver/support-coordination/>

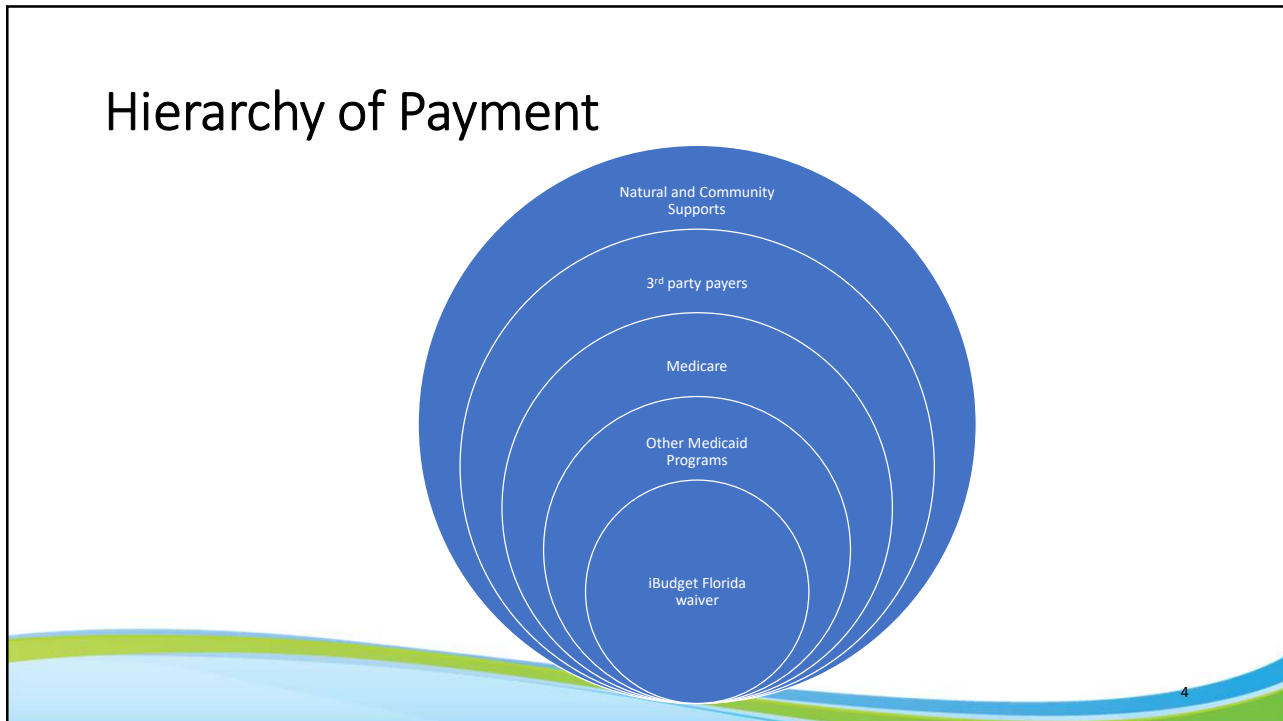
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Learning Objectives

- Understand changes in the iBudget Rule that impact the service approval process
- Gain knowledge of the Verification of Available Services form and its role in requesting waiver services
- Understand changes to the Significant Additional Needs definitions and process
- Understand the documentation requirements for Cost Plans and Significant Additional Needs requests

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Verification of Available Services Form

Ensures that the client has utilized all available services through:

Medicaid
State Plan

School

Private
Insurance

Other benefits

Government
resources

Natural and
community
supports

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When is the Verification of Available Services Form Required?

- All requests for a new or increase in services on the cost plan
- Upon request when APD is making a medical necessity determination



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Verification of Available Services Form

When requesting services through the Significant Additional Needs process, the Verification of Available Services Form must document attempts within the last 30 days to locate supports through other resources.



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Verification of Available Services Form

Verification of Available Services

Client Name: [Click or tap here to enter text.](#) **iConnect ID#:** [Click or tap here to enter text.](#)

WSC Name: [Click or tap here to enter text.](#)

The WSC must use this form to verify and document supports outside of the iBudget Waiver. Reference to Medicaid in this form refers to services provided by the Agency for Health Care Administration and not the Agency for Persons with Disabilities. If the WSC references information or documentation in iConnect, the WSC must state the location specifically (e.g., document name, date submitted, and page #; or note, date entered).

Section A. Natural Supports

Complete this section A. for all clients with natural supports. If the client does not have natural supports, skip to section B.

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Section A: Verification of Available Services

Section A. Natural Supports

Complete this section A. for all clients with natural supports. If the client does not have natural supports, skip to section B.

Statement of Parent, Legal Representative, or Other Caregiver's Health Limitations

1. Describe any health issue, disability, or other concern that the parent, legal representative, or other caregiver has that limits his or her ability to provide services or supports to the client requested through the iBudget Waiver. This may also include responsibilities for providing care to other dependents.

Jane's mother is a single-parent. She currently provides Jane's personal care. However, she is having knee replacement surgery in a couple of months and will not be able to provide care for 6 weeks during her recovery from surgery.

2. Supporting documentation must be attached in iConnect that the WSC relied upon to make this factual statement. Any physical, medical, or mental limitation to care must be corroborated by an appropriate health care practitioner. Is supporting documentation attached in APD iConnect? [Choose an item.](#)

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Section A: Verification of Available Services

Parent, Legal Representative, or Other Caregiver's Work or School Schedule

3. Does the parent, legal representative, or other caregiver's work or school schedule limit his or her ability to provide services and supports to the client requested through the iBudget Waiver? Describe below.

4. Documentation from the parent, legal representative, or other caregiver's employer or school that was relied upon to make this statement must be attached in APD iConnect. Is employer documentation attached in iConnect? [Choose an item.](#)

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Section B – Verification of Available Services

Section B. Services available through other government programs

Complete this section B. for all clients.

1. Managed Care Plan

If the client is not enrolled in a Managed Care Plan, skip to B.2.

- I. Name of Managed Care Plan: [Click or tap here to enter text.](#)
- II. Description of services received through the Managed Care Health Plan: [Click or tap here to enter text.](#)

2. Statewide Dental Managed Care Plan

If dental services are not requested through iBudget, skip to B.3.

- I. Why are the dental services not requested through the statewide dental managed care plan? [Click or tap here to enter text.](#)
- II. If services were denied by the dental managed care plan, documentation must be attached in APD iConnect. Is dental denial documentation attached in iConnect? Yes No

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Section B – Verification of Available Services

3. Home Health and Therapy Services – Client Under 21

Complete this B.3. for all clients under the age of 21. If the client is 21 and over, skip to B.4.

- I. Describe Home Health services (including Personal Care and Nursing) that the client is receiving through Medicaid: [Click or tap here to enter text.](#)
- II. If the client is not receiving Home Health or Therapy services, specify the status of accessing these services: [Click or tap here to enter text.](#)

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Section B – Verification of Available Services

4. Therapy Services – Client Age 20 and Older

Complete this B.4. for clients age 20 and over. For clients under age 20, skip to B.5.

- I. Specify the frequency of Therapy services that the client is receiving from Medicaid.

Physical Therapy:

Occupational Therapy:

Respiratory Therapy:

Speech Therapy:

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Section B – Verification of Available Services

5. Applied Behavioral Analysis (ABA) Services

Complete this B.5. for clients under the age of 21 who have service needs related to maladaptive behaviors. Skip to B.6. for clients 21 and over or clients who do not have maladaptive behaviors.

- I. Specify any behavioral services the client is receiving through Medicaid:
- II. If the client is not receiving behavioral services through Medicaid, specify the status:

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Section B – Verification of Available Services

6. Equipment and Supplies

Complete this B.6. for any client requesting consumable medical supplies or durable medical equipment from the iBudget Waiver. Skip to B.7. if no equipment or supplies are requested.

- I. Describe equipment and supplies that are received, including quantity if applicable through Medicaid: [Click or tap here to enter text.](#)
- II. If the client requires equipment and supplies, specify the status of the WSC assisting the client to receive these services through Medicaid: [Click or tap here to enter text.](#)

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Section B – Verification of Available Services

7. Medicare

Complete this B.7. for clients who have Medicare. Skip to B.8. if the client does not have Medicare.

- I. Is the client enrolled on a Medicare Special Needs Plan (D-SNP)? [Choose an item.](#)
- II. Specify the amounts of each service received through Medicare.
Physical Therapy [Click or tap here to enter text.](#)
Occupational Therapy [Click or tap here to enter text.](#)
Speech Therapy [Click or tap here to enter text.](#)
- III. List any other services, not including prescription drugs, that Medicare is providing. [Click or tap here to enter text.](#)

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Section B – Verification of Available Services

8. Educational and Vocational Services

Complete this B.8. for clients who receive educational and/or vocational services. Skip to B.9. if the client does not receive educational and vocational services.

- I. Describe educational and vocational services being received. Include a schedule for when educational and vocational services are delivered. This includes primary, intermediate, secondary, postsecondary, and adult education programs. **John Smith goes to school from 8:30-3:30 on weekdays.**

9. Mental Health Services

If the client does not have a mental health diagnosis skip to B.10.

- I. If the client has a mental health diagnosis, describe the services received at this time.
- II. If no services have been received, describe the reason.

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Section B – Verification of Available Services

10. Other Government Resources (local, state, or federal)

- I. Identify any other government resource(s) the client is receiving.

Ms. Jones attends a volunteer program at the county animal shelter where she is learning how to care for animals.

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Section C – Community Supports and Resources

Section C. Community Supports and Resources

Complete this section C. for all clients.

1. Identify community supports that the client is receiving and describe what the WSC has done to secure such resources for the client in the last year. Identify the specific agencies or organizations contacted, the dates contacted, and the outcomes.

John Doe plays board games at the county's community center once a week. Transportation is provided by his friend that he met at the community center.

WSC contacted ABC Therapeutic Rec on 6/2/2021 and XYZ Respite Centers on 6/3/2021 for recreation opportunities on weekends, but both programs reported that there was no availability.

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Section D– Private Health Insurance

Section D. Private Health Insurance

Complete this section D. for all clients who have private health insurance. For clients who do not have private health insurance, skip this section.

1. Name the insurance carrier(s) and describe the services and supports the client receives through private insurance.

[Click or tap here to enter text.](#)

2. Describe services and supports requested and denied through private insurance.

[Click or tap here to enter text.](#)

3. Is the documentation that the WSC relied upon to make the statement in D.2. attached in iConnect? [Choose an item.](#)

If no, explain why.

[Click or tap here to enter text.](#)

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Signature– Verification of Available Services

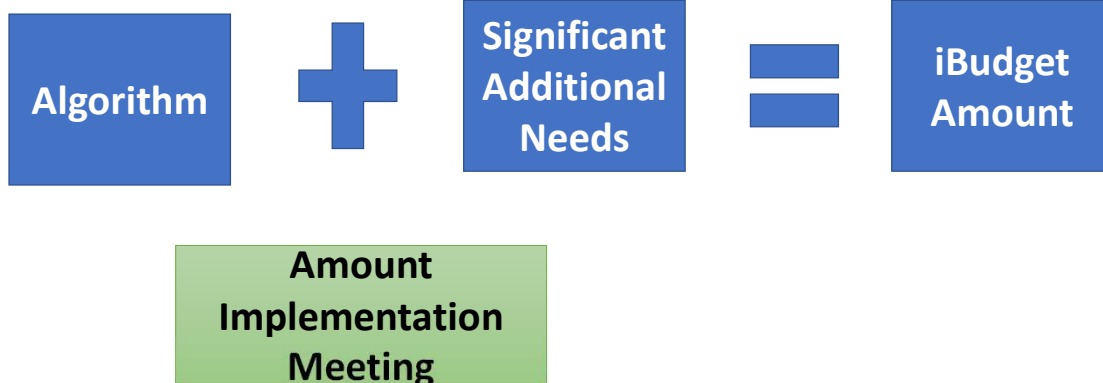
By signing this WSC Verification of Available Services, I verify that I have thoroughly and accurately completed the entire form to the best of my knowledge, and I have performed all reasonable inquiry for my responses described herein. In accordance with the iBudget Waiver Handbook, Rule 59G-13.070, F.A.C., and Florida statutes, which I have read and am familiar with, I understand that it is my responsibility as a WSC to first ensure that the same type of service offered through the Waiver cannot be accessed through other funding sources, such as: natural and community supports, a third-party payer (e.g., private insurance), Medicare, or other Medicaid programs (e.g., Medicaid State Plan or Medicaid managed care plan). I understand that if I violate the terms of this verification, the Agency may terminate my Medicaid Waiver Services Agreement with cause.

WSC Name: _____

WSC Signature (electronic is acceptable): _____ **Date:** [Click or tap here to enter text.](#)

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iBudget Amount



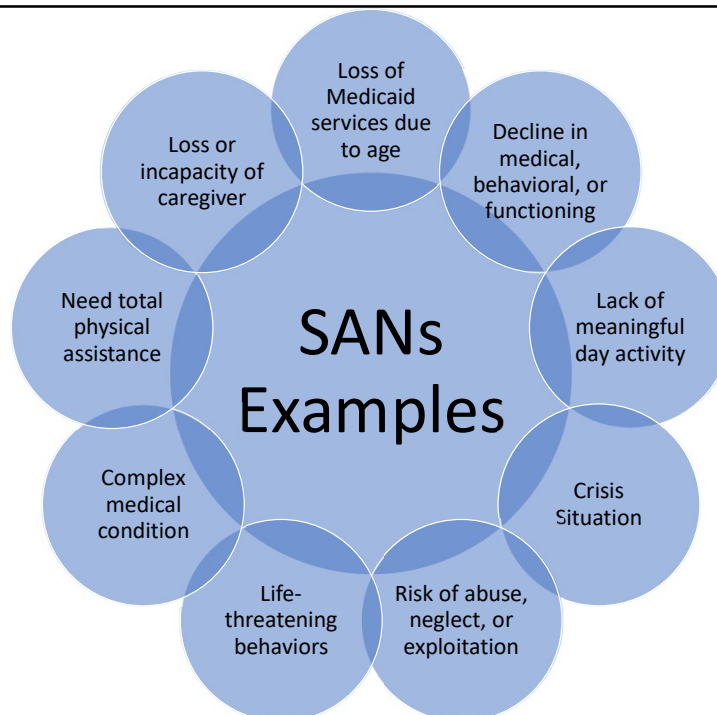
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Significant Additional Needs (SANs) Defined

“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 not met. The term also includes a need for 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. 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.”

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Significant Change in Condition or Circumstance

“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.”

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Examples of Significant Change

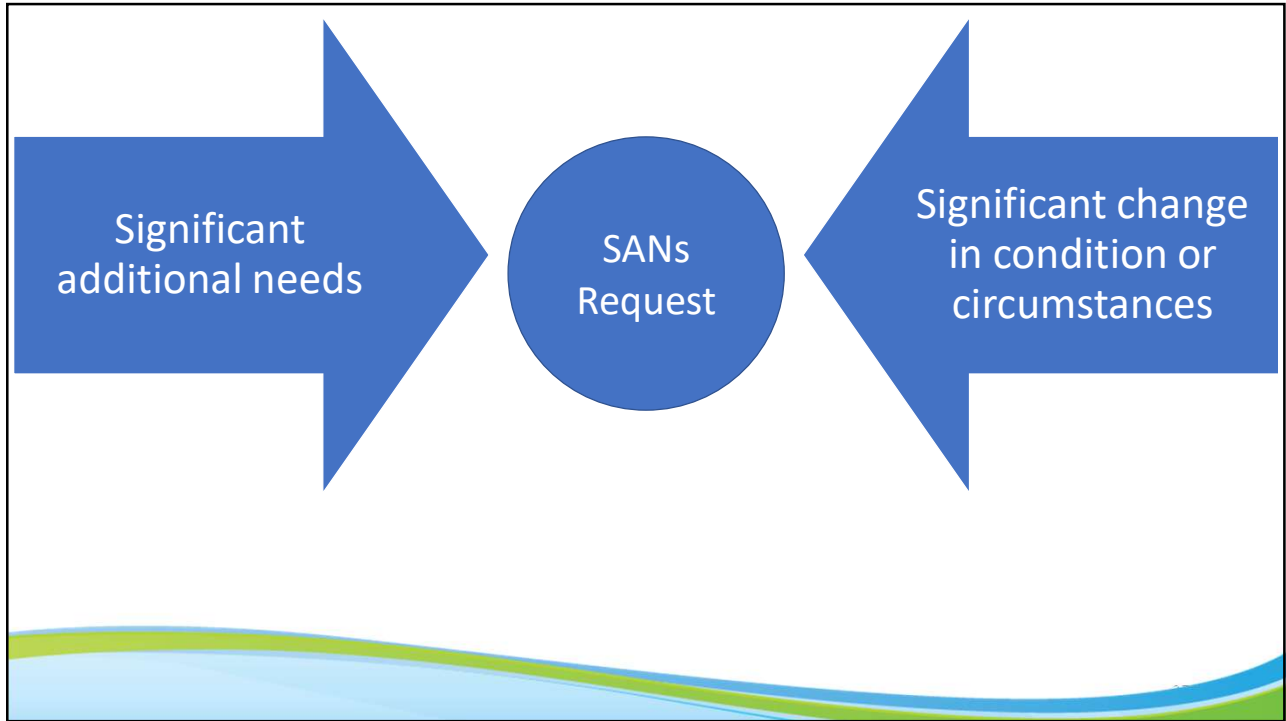
Deterioration in health status that requires that the client receive services at a greater intensity or in a different setting to ensure that client’s health or safety

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

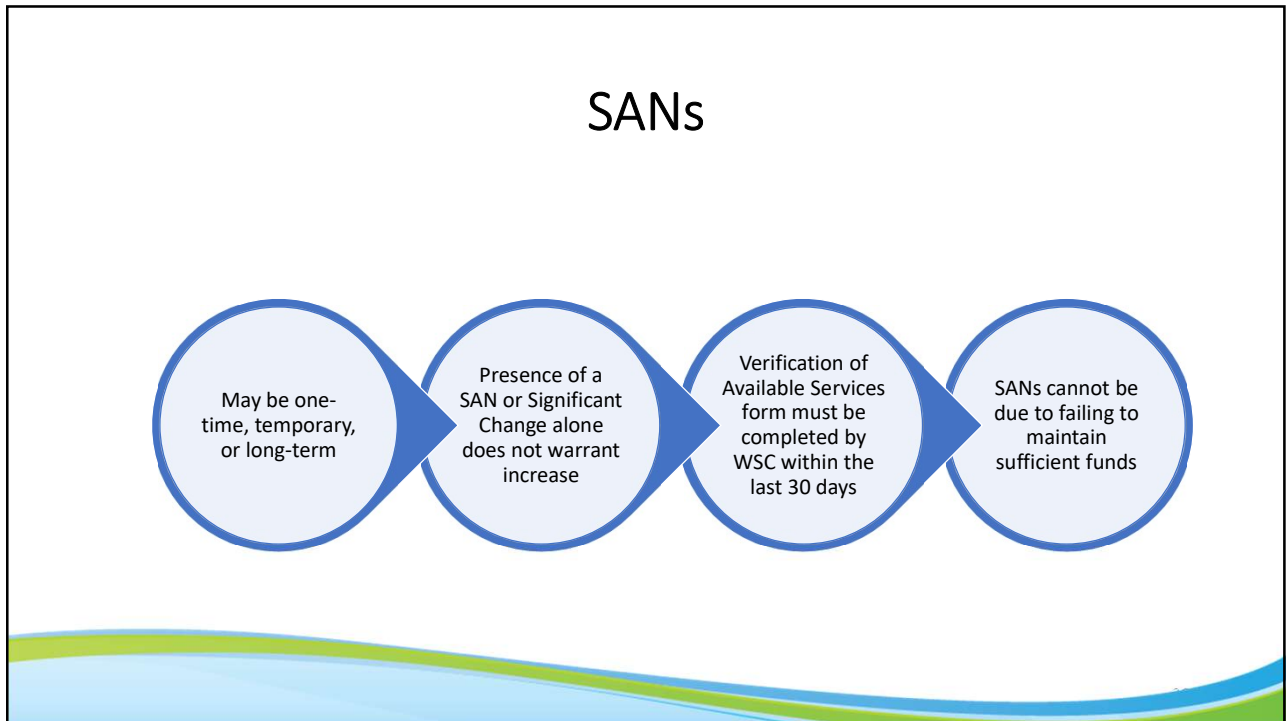
Change in age or living setting resulting in a loss of services funded or otherwise provided from sources other than the Waiver. This may include a change in living setting which requires a different service array or a change in the availability or health status of a primary caregiver that prevents that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

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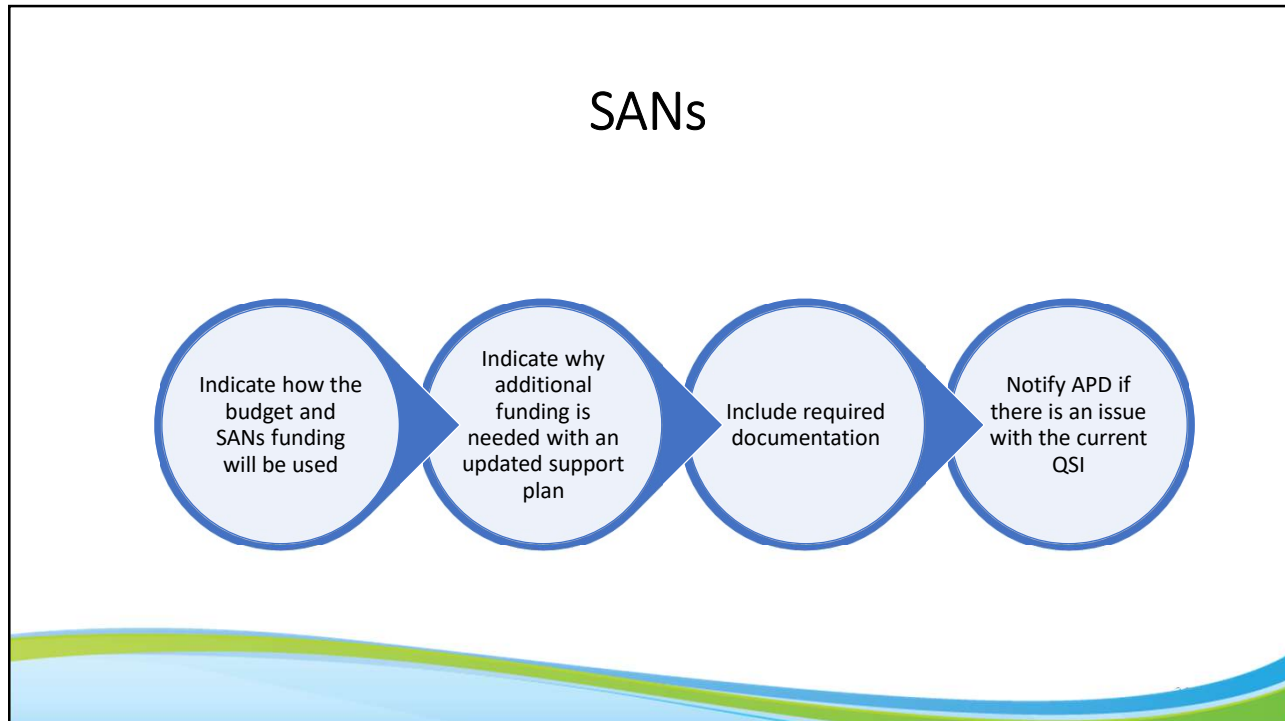
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APD shall close incomplete SANs request. Examples include:

Missing detail regarding current approved services

Unclear whether current services will continue

Unclear of new or increased services requested

Missing complete Verification of Available Services form with supporting documentation

Missing certifications of SANs criteria

Incorrectly submitted in the APD iConnect system

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When AIM Worksheet is NOT required:

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.

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Documentation for Service Requests

WSC Job Aid for Cost Plans and Significant Additional Needs Documentation

CLIENT NAME: Click or tap here to enter text. iCONNECT ID: Click or tap here to enter text.


Date: Click or tap here to enter text. WSC NAME: Click or tap here to enter text.

When submitting a Cost Plan or SANs request, WSCs must follow the requirements in iBudget Rules 65G-4.0213 through 65G-4.0218, *Florida Administrative Code* (F.A.C.), and the iBudget Handbook, Rule 59G-13.070, F.A.C. Submitting complete documentation streamlines the process and avoids extra requests for additional information. Always send the **most recent** information that is **reflective of the current needs** of the client and documents the issues of concern.

Sections A and B are relevant to SANs submissions. Section C contains service specific documentation requirements for all services requested on a cost plan.

Section A. Checkpoint for All SANs Submissions

	Actions to be taken prior to submitting a SAN request	WSC Check Point
1	WSC tried to meet the needs within the current cost plan.	<input type="checkbox"/>
2	WSC moved unallocated funds to meet needs, but funds were not sufficient to cover the need	<input type="checkbox"/>
3	WSC moved funds from unused services to meet needs, but funds were not sufficient to meet the need	<input type="checkbox"/>
4	WSC submitted the Certification of Available Services form within the last 30 days and submitted it to APD in accordance with 65G-4.0213, F.A.C.	<input type="checkbox"/>



Use this Job Aid to know what documentation to include in APD iConnect with SANs or Cost Plans.

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Job Aid

Section A: Checkpoint for All SANs Submissions

	Actions to be taken prior to submitting a SAN request	WSC Check Point
1	WSC tried to meet the needs within the current cost plan.	<input type="checkbox"/>
2	WSC moved unallocated funds to meet needs, but funds were not sufficient to cover the need	<input type="checkbox"/>
3	WSC moved funds from unused services to meet needs, but funds were not sufficient to meet the need	<input type="checkbox"/>
4	WSC submitted the Certification of Available Services form within the last 30 days and submitted it to APD in accordance with 65G-4.0213, F.A.C.	<input type="checkbox"/>
5	Support Plan and applicable amendments are current in the APD iConnect system.	<input type="checkbox"/>
6	SANs request is completed accurately in APD iConnect.	<input type="checkbox"/>
7	QSI is reflective of the client's current functional, behavioral, and physical status, and completed within the last three years. If the QSI does not reflect current information, the WSC notified APD immediately of the change. The WSC can indicate the date that APD was notified of the need for the new assessment in the request.	<input type="checkbox"/>

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Job Aid

Section B: Significant Additional Needs Criteria

	Examples of Documentation for SANs Request based on Type	WSC Check Point
1	<p>Documented history of significant and life-threatening behaviors</p> <ul style="list-style-type: none"> Psychological assessments. Reports from psychiatrist for last 12 months Discharge summaries of any Baker Act 12 months. Behavior assessments, plans, and data If school-aged, current IEP, school behavior If under 21, documentation of attempted services through the Medicaid State F data for the last 12 months for behavioral Medicaid State Plan. Incident Reports or police reports regarding 12 months. Confirmed Behavior Summary Report iConnect. 	<input type="checkbox"/>
7	<p>Permanent or long-term loss or incapacity of a caregiver</p> <ul style="list-style-type: none"> Documentation from doctor(s) regarding caregiver's ability to provide care. Special services or treatment for a serious temporary condition of the caregiver when the service or treatment is expected to ameliorate the underlying condition (fewer than 12 continuous months). 	<input type="checkbox"/>
8	<p>Loss of Medicaid state plan services due to age</p> <ul style="list-style-type: none"> Medicaid Prior Service Authorization for all applicable services, such as personal care assistance and behavioral services. Documentation that other caregivers are not available. 	<input type="checkbox"/>
9	<p>Loss of school-based services due to age</p> <ul style="list-style-type: none"> Documentation of standard diploma if under age 22. Service specific documentation for services requested (see below). 	<input type="checkbox"/>
2	<p>A complex medical condition that requires a licensed nurse on an ongoing basis delegated to a non-licensed person</p> <ul style="list-style-type: none"> Documentation from physician(s) or other medically necessary situations. Prescription by physician, advanced practice nurse (APRN), or physician assistant with a 	

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Job Aid

- Include services logs, progress notes, quarterly, and monthly summaries for three most recent months.
- Prescriptions, treatment plans, assessments, and plans of care should be less than a year old.
- The BASE Form should be less than a year old and less than six months when Behavior Assistant services are requested.
- For CDC+ clients, if the client is hiring someone who is not a waiver provider, service logs, quarterly summaries, and daily progress notes are not needed.

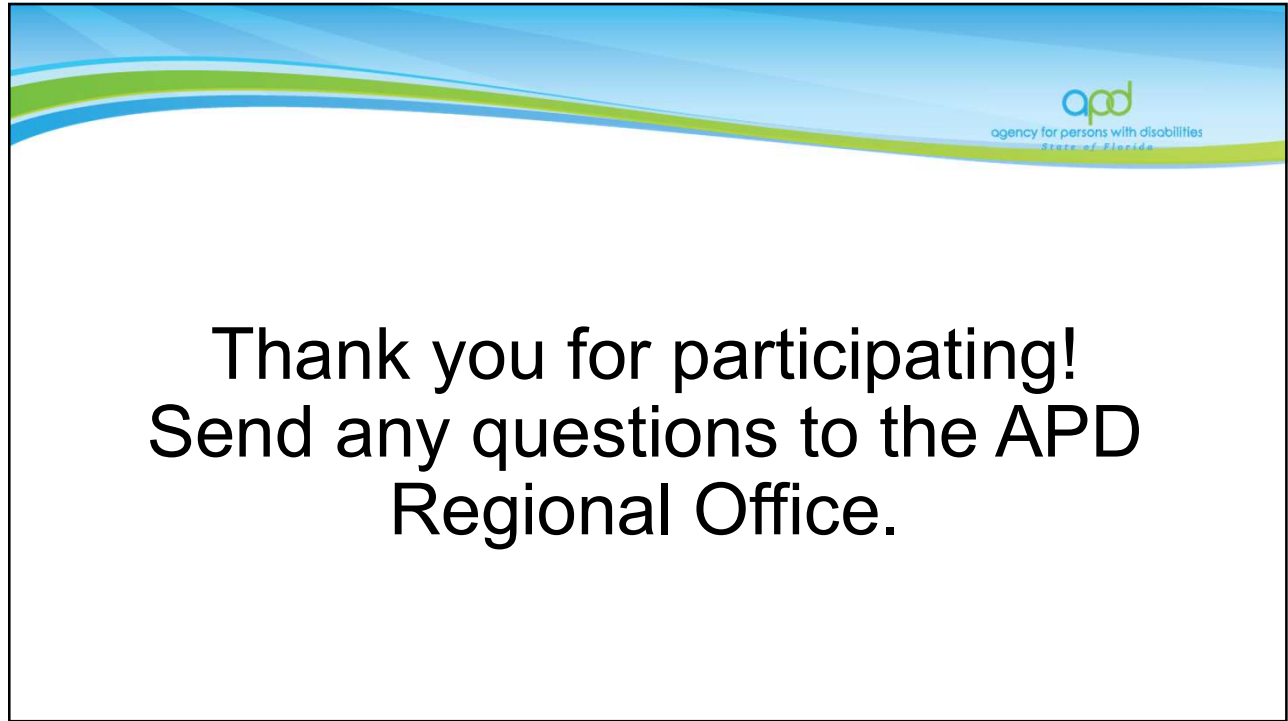
Service	Service Specific Documentation Requirements	WSC Check Point
Adult Dental Services	New and Continued Services: <ul style="list-style-type: none"> • Invoice or treatment plan listing each procedure and negotiated cost 	<input type="checkbox"/>
Behavior Analysis Services	New Service <ul style="list-style-type: none"> • Copy of assessment report, if completed • If assessment has not been completed, the support plan or other documentation describes the behaviors requiring intervention with dates. Continuation <ul style="list-style-type: none"> • Service logs • Graphic displays from the last quarter of acquisition and reduction target behaviors 	<input type="checkbox"/>

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Emergency Situations

- Notify the APD Regional Office immediately!
- Provide the APD Regional Office with the updated support plan, cost plan, and supporting documentation within three days of becoming aware of the emergency

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**Thank you for participating!
Send any questions to the APD
Regional Office.**