



agency for persons with disabilities
State of Florida



Consumer/Representative Training 2016

Rick Scott
Governor

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Introductions

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Submit questions throughout this presentation via chat or to:
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Training Objectives

Review Overall
Philosophy

Review CDC+
Operations

Share Policy &
Procedural
Changes/Updates



Learning Outcomes



Explain the benefits of a consumer-Driven program



Describe the decisions consumers are authorized to make as household employers



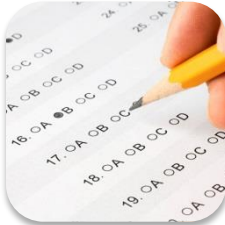
Explain the Five Principles of Self-Determination



Describe critical requirements of the CDC+ Program



Requirements



Complete an Assessment after the training is completed



Score 85% or better to pass and receive Certificate of Completion



Program Toolbox

CDC+ Rule Handbook

Appendix to the CDC+
consumer Notebook

The screenshot shows the 'CDC+ > Consumers' page. It features a navigation menu with 'About Us', 'Locations', 'Providers', 'Customers', 'Waivers', and 'News'. A table lists documents, with two items highlighted in red boxes: 'CDC+ Handbook' and 'Appendix to Participant Notebook (November 2009)'. The page also includes 'Important Links', 'Important Contact Information', and the CDC+ logo.

Document	Description
CDC+ Handbook	Developmental Disabilities Medicaid Waivers Consumer-Directed Care Plus Program Coverage, Limitations, and Reimbursement Handbook
Appendix to Participant Notebook (November 2009)	This section provides all the forms used by participants in the CDC+ program. Just "click" on the document you want to review. Each appendix title contains a description of every document listed in that appendix title. The appendix will be updated periodically as forms are revised. Forms published on the Web site are the most recent forms, so please refer to this Web site often.

<http://apdcare.org/cdcplus/consumers>



PCA Under 21

eQHealth Solutions

6-month maximum

Change requires Plan update

PCA forms on CDC+ website

The screenshot shows the CDC+ website with a navigation bar containing: About Us, Locations, Providers, Customers, Waivers, News. Below the navigation bar is a search box and social media icons for Facebook, Pinterest, Twitter, and WordPress. The main content area is divided into several sections:

- Important Links:** Consultants, Fiscal Employer/Agent Forms, Household Employer Forms, Participants, Secure Web-based Payroll System, CDC+ Connection.
- Important Contact Information:** Toll-free Customer Service line (1-866-761-7043), Toll-free fax line (1-888-329-2731).
- CDC+ Connection:** Your Monthly Source of Updates and Helpful Information.
- APD > Consumer Directed Care Plus (CDC+):** A long-term care program alternative to the Medicaid Home and Community-Based Services (HCBS) Medicaid Waiver. The program provides the opportunity for individuals to improve the quality of their lives by being empowered to make choices about the supports and services that will meet their long-term care needs and to help them reach their goals.
- Announcements:**
 - On January 1, 2014, Florida's minimum wage increased to \$7.93 per hour. All workers, except for those who perform Companion service, must be paid at least \$7.93 per hour. If you currently have directly hired employees (DHEs) earning less than this amount, please plan to submit a Purchasing Plan Update increasing their hourly rate for an effective date of January 1.
 - Consumer Satisfaction Survey
 - Quality Assurance Reviews: The Delmarva Foundation is contracted by the Agency for Health Care Administration (AHCA) to provide quality assurance for the State's Developmental Disabilities Service system, which includes the Consumer Directed Care Plus program. The review process consists of two major components: Person Centered Reviews (PCR) and Provider Discovery Reviews (PDR). The PCR includes an interview with the CDC+ participant to determine the quality of the participant's service delivery system from the participant's view. The PDR focus is on the consultant and the representative in relation to compliance with standards set forth in the 1915(j) State Plan Amendment. When selected for review, the PCR component is voluntary but the PDR is mandatory. Please refer to the attached two documents for additional important information related to compliance with quality assurance reviews and background screening alerts.
 - Memo - Identified Alerts on Providers
 - CDC+ Quality Assurance Reviews Letter
- CDC+ Training Material:**
 - Consumer/Representative Training Presentation
 - CDC+ Consultant Training
 - Purchasing Plan Training
 - PCA Consultant Training Presentation, eQHealth Solutions
 - CDC+ PCA Under 21 Presentation, AHCA
 - CDC+ PCA Under 21 Training FAQs
 - CDC+ PCA Documentation Requirements, eQHealth Solutions
 - eQHealth Solutions Required Documentation



Allowable Purchases

Identified on
the support
plan

Meets needs
and goals



Allowable & Unallowable Purchases

- **Allowable purchases** (CDC+ Rule Handbook pgs.1-5, 3-8)
Related to long-term care needs and directly related to disability and health condition
- **Unallowable purchases** (CDC+ Rule Handbook pgs.1-19, 3-9)
Available through Medicaid, Medicare, at no charge through community resource. Any service not specifically provided under the CDC+ program
- **Duplication of Services** (CDC+ Rule Handbook pgs. 3-8)
- If time in and time out on an employee's time sheet are the same as time in an time out on another employee's timesheet for the same Consumer, such time recording is considered a duplication of services and is unallowable.

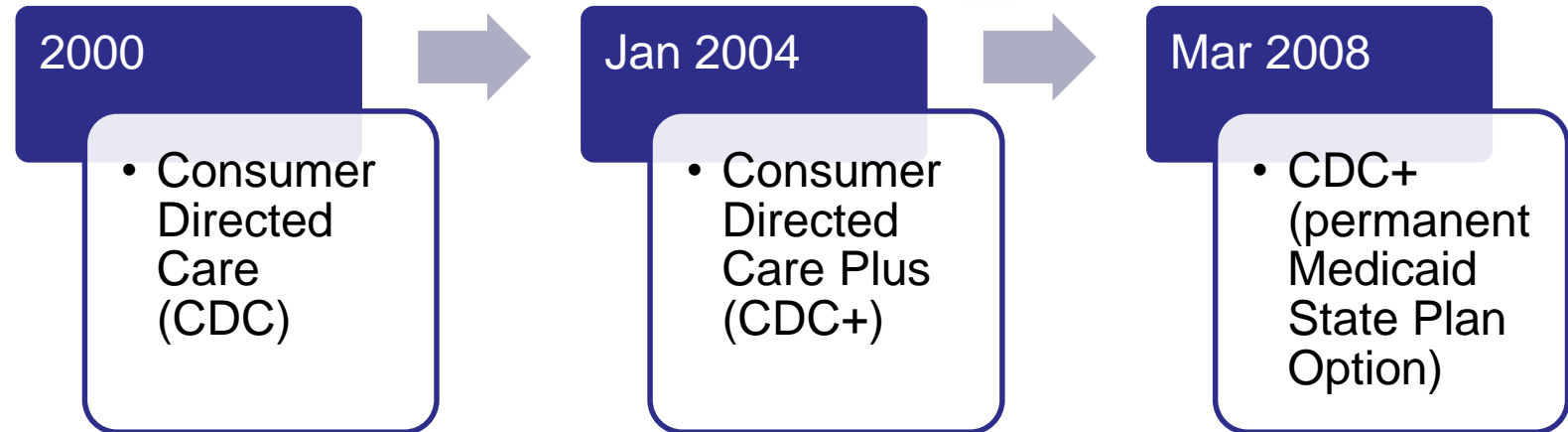


CDC+ Program Services

- Every service contains a definition to include: Descriptions, limitations, special conditions, provider qualifications and service type. (CDC+ Rule Handbook Chapter 4)
- Service codes and abbreviations can be found in the Service Code Chart
Appendix I of the consumer Notebook:
<http://apdcares.org/cdcplus/docs/appendix/service-codes.xls>

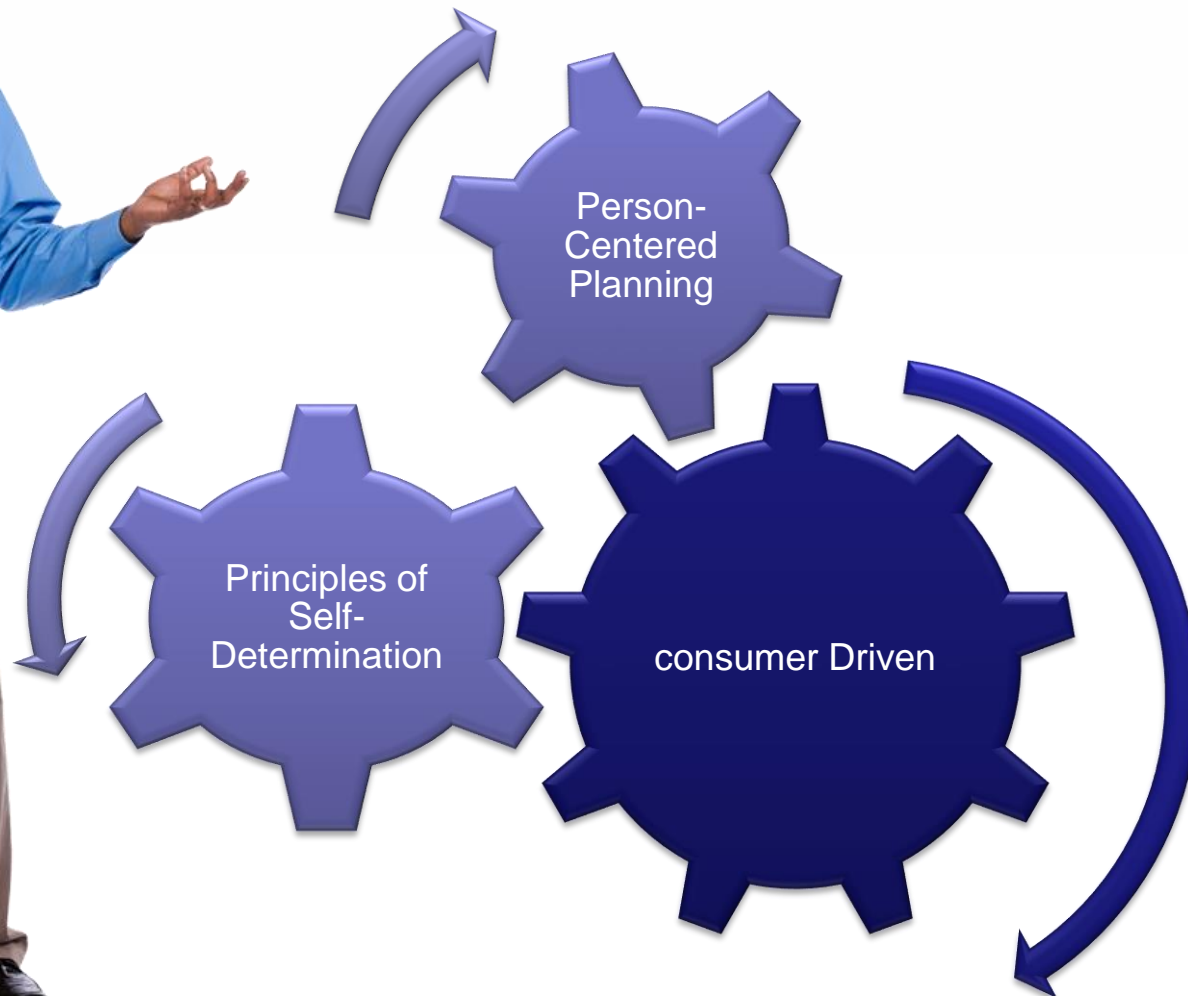


CDC+
Consumer-Directed Care Plus





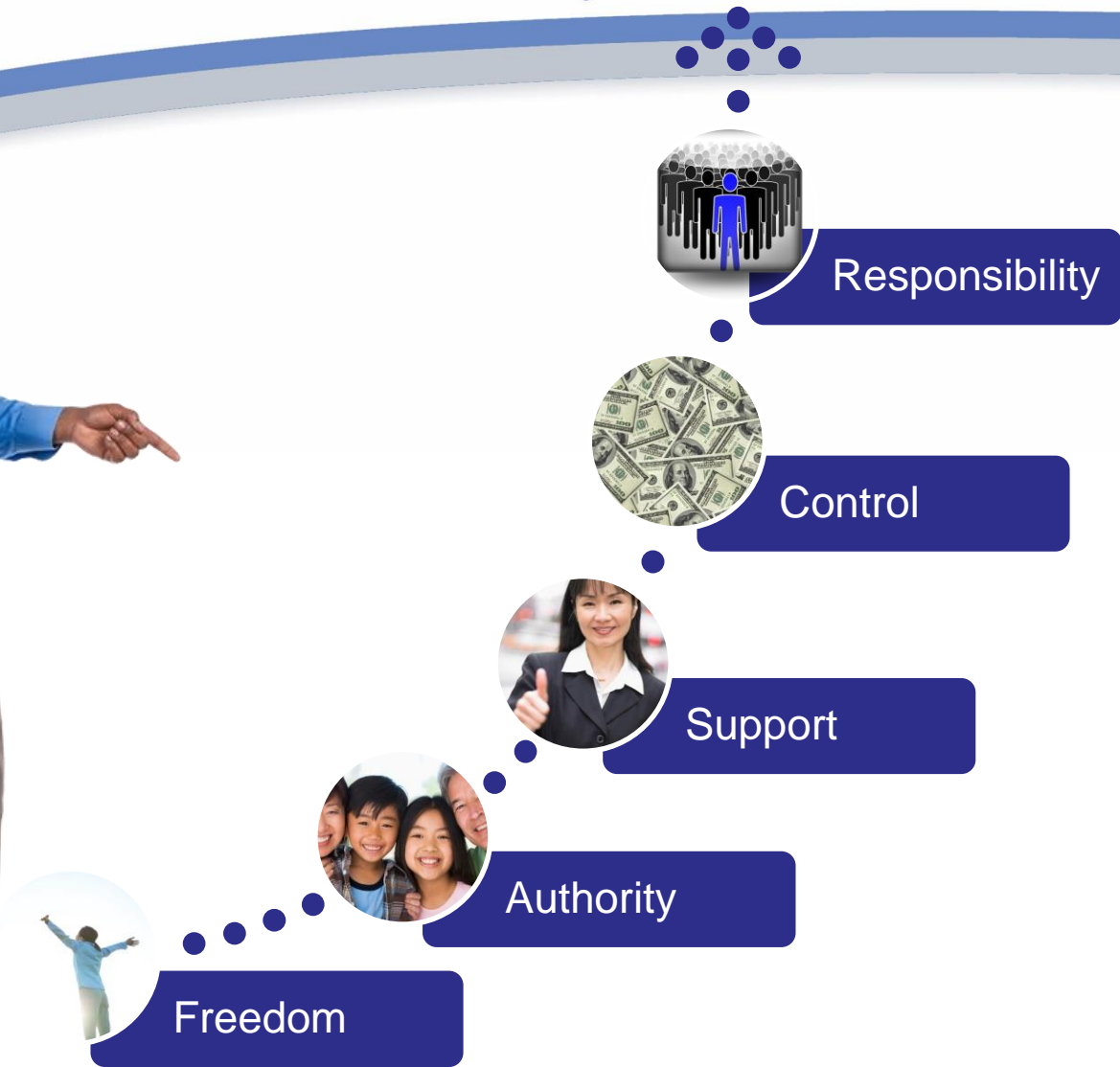
What is CDC+ All About?





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The consumer Controls

WHAT

WHO

WHEN

WHERE

HOW



How Does CDC+ Work

- Consumer driven
- Exchange waiver budget for a reduced budget
- CHOICE and FLEXIBILITY of supports/services
- Not limited to the same services as the waiver
- Find and hire your own providers
- Submit claims to pay providers
- Manage monthly budget responsibly



CDC+ Eligibility and Enrollment Requirements

- Enrolled in the DD/HCBS iBudget waiver
- Able to direct own care
- Live in family or own home



Roles and Responsibilities



**SECTION B: Consumer, Representative
Consultant, Liaison & Fiscal Employer Agent**



Learning Outcomes



Describe the roles and responsibilities of consumer (consumer)



Describe the roles and responsibilities of representative



Describe the roles and responsibilities of consultant



Describe the roles and responsibilities of Regional liaison and State Office



Role of consumer (Consumer) (when representative not selected)

- Authorized signer
- Decision maker
- Employer
Examples include: write job descriptions, negotiate pay rates, ensure L2 background screening is complete
- Develops Purchasing Plan



Role of consumer, continued

- Maintains accurate and complete records, and keeps them for at least six years
- Spends CDC+ budget responsibly
- Complies with training and monitoring requirements
- Develops Emergency Backup Plan (CDC+ Rule Handbook pg. 3-3)



Role of CDC+ Representative

- Same role as consumer
- Unpaid Advocate; at least 18 years of age
- Sign an agreement with the consumer
- Readily available to consumer and Consultant
- Responsible for appropriate use of public money
- Attends required trainings
- Participates in quality assurance reviews



Role of the Consultant

- Waiver Support Coordinator
- Sign a consumer/consultant agreement
- Assists with transitioning to and from the waiver
- Provides on-going technical assistance
- Assists consumer/representative with the development of the Purchasing Plan, but does NOT write it
- Reviews and signs off on CDC+ documents



Role of the Consultant, continued

- Responsible for appropriate use of public money
- Complies with training and monitoring requirements
- Develops, implements, and monitors Corrective Action Plans (CAP) as necessary
- Develops and updates support plan
- Ensures cost plan is updated and approved
- Monitors and reviews consumer account activity



Role of the Consultant, continued

- Keeps active contact with consumer
 - ✓ Monthly – by phone
 - ✓ Bi-annually – two face-to-face per year, one of which must be in the consumer's place of residence
- Monitors the consumer's health, safety and welfare
- Reports neglect, abuse, or exploitation
- Ensures Medicaid eligibility



Role of the CDC+ Regional Liaison

- Ensures consumer's waiver cost plan is approved
- Reviews Purchasing Plans
- Serves as the local program operations manager
- Ensures Corrective Actions Plans are completed
- Bridges the communication between consumer, consultant, and State Office



Role of State Office

- Authorizes CDC+ Budget
- Administer the CDC+ program
- Develop & interpret policy
- Quality Assurance Monitoring
- Provide customer service & technical assistance
- Develop and update CDC+ training materials
- Conduct initial & on-going training





Fiscal / Employer Agent (F/EA) State office con't

- Requests and receives monthly budget
- Assigns provider ID number
- Pays service claims and employer taxes
- Sends monthly statements
- Monitor consumer spending
- Monitor consumer eligibility

A photograph of a spreadsheet showing a 'Daily Balance' table with columns for 'Date' and 'Amount'. The data is as follows:

Date	Amount
10/20	\$ 738.97
10/21	526.82
10/22	590.53
10/23	524.21
10/24	362.24
10/25	308.42
10/27	



Quality Assurance Requirement

- Consultant
- consumer
 - ✓ Person-Centered Review
 - ✓ Provider Discovery Review



Steps for CDC+ consumer Enrollment

- Expresses interest
- Completes training
- Passes Readiness Review
- Selects a CDC+ Consultant



Steps for CDC+ consumer Enrollment, continued

- Application Packet
 - ✓ 2 page application document
- Enrollment Packet
 - ✓ 8821 – IRS
 - ✓ 2678 – IRS
 - ✓ Fiscal Informed Consent
 - ✓ Program Consent Form
 - ✓ Representative Agreement



Steps for CDC+ consumer Enrollment, continued

- Consultant reviews and submits application and enrollment packets to State Office
- State Office calculates monthly budget and issues a Budget Authorization Form (BAF)
- consumer chooses supports and services
- consumer interviews potential providers



CDC+ consumer Enrollment, cont'd

- Ensure providers complete Level 2 background screening

Please follow new screening process as of May 25, 2015 via Care Provider Background Screening Clearinghouse. Register by going to:

<https://apps.ahca.myflorida.com/SingleSignOnPortal>

ORI & OCA # = will be generated once rep registers and sends agreement along with photo ID to DCF.

- New employees will initiate a screening, select live scan vendor, make appointment, print appointment request form, and bring to live scan vendor.



Background Screening Requirements in F.S. 435.04 & 435.06 & CDC+ Rule 3-2

- Every provider is subject to Background Screening provisions of section 409.221(4)(i), and Chapter 435, F.S.; including family members.
- Providers who have been arrested for a disqualifying offense and who are awaiting disposition of the offense shall not provide services. Disqualifying offenses are listed in section 435, F.S.
- Failure to comply with Background Screening requirements, may lead to disenrollment from the program.
- Provider may not provide services or render care to a CDC+ consumer unless an exemption from disqualification has been granted by APD.

Visit <http://apdcare.org/cdcplus/consumers/CDC+ Handbook>



CDC+ consumer Enrollment, continued

CDC+ consultant must receive from consumer

1. Completed employee and vendor packets
 2. Draft copy of 1st Purchasing Plan
- ✓ Complete all requested revisions to the Purchasing Plan (if necessary)
 - ✓ Sign and submit final Plan to consultant
 - ✓ Consultants must receive Plan by the 5th of the month for enrollment on the 1st of the following month



Steps for CDC+ consumer Enrollment, continued

- Allow at least 3-4 weeks for processing
- CDC+ Customer Service
 - ✓ Notifies consumers when they are authorized to start on the CDC+ Program
 - ✓ Provides employee ID numbers

****Continue to use your waiver providers until the transition to CDC+ is complete**



Learning Outcomes



Explain the difference between iBudget Florida and the CDC+ program



Explain the process for completing a Budget Calculation Worksheet



List three resources consumers need for developing a Purchasing Plan



Explain when to use a Purchasing Plan Change, Update and Quick Update



Calculating the Monthly Budget

- Budget calculation worksheet (consumer Notebook Appendix D(3))
- Current approved DD/HCBS iBudget Waiver Cost Plan
- Discount rate - 8% of the annual cost plan
- Administrative fee - 4% or max amount of \$160.00 per month



Calculating the Monthly Budget, continued

- STE-Short Term Expenditure & OTE - One Time Expenditure
- Consultant fee is not part of monthly budget (billed directly through FMMIS)
- Unused CDC+ funds can be reinvested back to Medicaid.



OTE/STE Expenditures

- **One Time Expenditure-** The consumer receives 100% of the authorized waiver amount. Cannot be spent on any other service. There are only three OTEs:
 - ✓ Durable Medical Equipment
 - ✓ Environmental Modifications
 - ✓ Vehicle Modifications
- **Short Term Expenditure-** Services approved on the waiver cost plan for 6 months or less, or are periodic in nature. Cannot be spent on any other service— ex. Dental, Assessments



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CONSUMER ID #:	0012345	CONSUMER INITIALS:	EE	AREA	10
				CREATED BY (INITIALS)	IG

Cost Plan Dates:	7/1/2013	to	6/30/2014	This calculation is to determine the monthly budget for CDC+ Purchasing Plan Effective:	10/1/2013
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Enter each approved Service Plan* in the Cost Plan, below:							
A	B Brief service name	C Begin Date	D End Date	E # of months in Service Plan	F Total Service Plan Amt	G Monthly Service Plan Amount (Col. F/Col. E)	
# 1	PersonSup	07/01/13	06/30/14	12	\$ 7,200.00	\$ 600.00	
# 2	Life Skills	07/01/13	06/30/14	12	\$ 8,870.40	\$ 739.20	
# 3	PT	07/01/13	06/30/14	12	\$ 5,340.80	\$ 445.07	
# 4	Trans	07/01/13	06/30/14	12	\$ 8,049.60	\$ 670.80	
# 5	ST	07/01/13	06/30/14	12	\$ 3,204.98	\$ 267.08	
# 6	Supplies	07/01/13	06/30/14	12	\$ 372.40	\$ 31.03	
# 7				1	\$ -	\$ -	
# 8				1	\$ -	\$ -	
# 9				1	\$ -	\$ -	
# 10				1	\$ -	\$ -	
# 11				1	\$ -	\$ -	
# 12				1	\$ -	\$ -	
# 13				1	\$ -	\$ -	
# 14				1	\$ -	\$ -	
# 15				1	\$ -	\$ -	
	Total				\$ 33,038.18	\$ 2,753.18	
	Multiply total Monthly CP Amount by:					0.92	0.04
					\$ 2,532.93	\$ 110.13	
					\$ (160.00)		
	This is the CDC+ Monthly Budget					\$ 2,372.93	
					\$ 2,753.18	4% CALC	
					0.92		
					\$ 2,532.93		
					\$ (110.13)		
	This is the CDC+ Monthly Budget					\$ 2,422.80	

If this figure is \$4,000 or more, use \$160 for fees.

If less than \$4,000, use the 4% calculation for fees.

Attach this spreadsheet to the consumer's Purchasing Plan CHANGE.

Be sure the consumer has a copy of the cost plan and this calculation.

* Enter only the services that the consumer uses every month. Do not enter any expired service plans. Do not enter consultant services or funds for either OTEs or STEs as defined by CDC+. Funds for OTEs and STEs are not included in the calculation of the consumer's monthly budget. Funds for OTEs and STEs are given to the consumer over and above the monthly budget amount in the first month the service or support is authorized on the Purchasing Plan (i.e., page 1 reflects the OTE or STE full authorized amount and Section F shows the amount the participant has been able to negotiate with each provider.) **NOTE:** The effective date of the OTE/STE in Section F must be the same as the Purchasing Plan effective date in order for the funds for the OTE/STE in Section F to be transferred to the consumer's CDC+ account.

Calculation of OTE					Calculation of STE				
The ONLY services and supports approved in the Cost Plan that are considered OTEs for CDC+ are Environmental Modifications, Vehicle modifications, and Therapeutic or Adaptive Equipment.					Includes all assessments, evals, installation of PERS, and services/supports authorized for periodic use or for a specific period of time six months or less, and the time is limited for a reason other than the end of the cost plan.				
Brief service name	Service Plan Begin Date	Service Plan End Date	Total Service Plan Amt	Maximum to be authorized in Purchasing Plan.	Brief service name	Service Plan Begin Date	Service Plan End Date	Total Service Plan Amt	Maximum to be authorized in Purchasing Plan.
EM				\$ -					\$ -
VE				\$ -					\$ -
Equipment				\$ -					\$ -



iBudget FL and CDC+

iBudget FL - Medicaid Waiver Seven (7) Service Families

- Life Skills Development
- Supplies & Equipment
- Personal Supports
- Residential Services
- Therapeutic Supports
- Transportation
- Dental

*** must use Medicaid Waiver providers and established rates





iBudget and CDC+ (cont.)

CDC+ Program Services

(8% + 4 % = 12% reduced budget)

iBudget FL services PLUS...

- ▶ Advertising
- ▶ Seasonal Camp
- ▶ Gym Membership
- ▶ Over the Counter Medications
- ▶ Personal Emergency Response
- ▶ Parts & Repair
- ▶ Therapeutic Equipment
- ▶ Specialized Training
- ▶ Other Therapies

*** Save up for these services or additional hours...





Morning Break

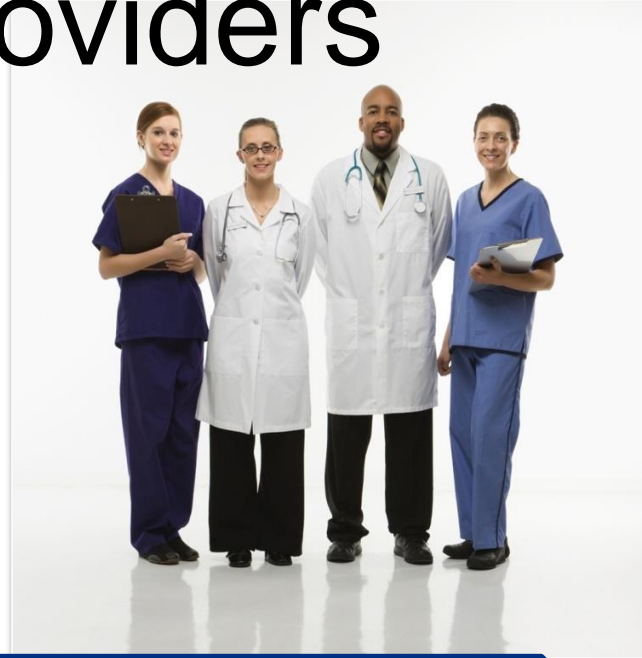
Q & A to follow





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CDC+ Services and Support Providers



**SECTION C: Provider Information,
Background Screening and Pay Rates**



Learning Outcomes



Describe the different CDC+ provider types



Distinguish between Agency/Vendor, Independent Contractor and Directly Hired Employee payment methods



Identify required forms for hiring providers



Explain background screening requirements



Restricted Services

- Professionally licensed/certified providers
- Allocated budget cannot be used on another service; funds reinvested
- The consumer must purchase at least 92% of the units of measure that are approved in the Cost Plan.
- Regional Office approval



Restricted Services

Adult Dental Services	Behavior Analysis Services	Behavior Analysis Assessment	Behavior Assistant Services	Dietitian Services
Durable Medical Equipment and Supplies	Environmental Modifications	Occupational Therapy	Occupational Therapy Assessment	Personal Emergency Response System Installation
Physical Therapy	Physical Therapy Assessment	Private Duty Nursing	Respiratory Therapy	Respiratory Therapy Assessment
Skilled Nursing	Specialized Mental Health Services	Speech Therapy	Speech Therapy Assessment	Vehicle Modifications



Unrestricted Services (CDC+ Rule Handbook pgs. 4-3, 4-4)



- Non-medical nature services
- Meet the consumer's needs and goals
- Don't need to be identical to or the same quantity
- 8% Unused restricted funds can be used to purchase unrestricted services not listed on the cost plan.



Unrestricted Services

Adult Day Training	Advertising	Companion Services	Consumable Medical Supplies	Gym Membership
In-Home Support Services	Other Therapies	Over-the-Counter Medications	Parts and Repairs for Therapeutic or Adaptive Equipment	Personal Care Assistance
Personal Emergency Response System (PERS)	Residential Habilitation Services	Respite Care	Seasonal Camp	Specialized Training
Supported Employment	Supported Living Coaching	Transportation		



Critical Services

- Any service, determined by the consumer or representative as being so important that without this service, the consumer's health, safety, or welfare would be at risk.
- Requires two emergency backup providers
- Personal Care Assistance (PCA) service is **ALWAYS** considered a critical service



Provider Types



Agency/Vendor
(AV)



Independent
Contractor (IC)



Directly Hired
Employee (DHE)



How to Find, Hire and Manage Providers?

- Identify service/support being purchased
- Type of provider needed
- Finding employees to work for you (Appendix E of the Notebook)
- Advertising can be paid by CDC+



How to Find, Hire and Manage Providers, continued

- Background Screenings
 - ✓ Level 2 for all providers listed on a Purchasing Plan
 - ✓ Valid for 5 years - provided there is not a break in service of 90 days or more
- Employee Packets (Appendix G Notebook)
- Vendor Packets (Appendix H Notebook)



Directly Hired Employees

Consumer hires

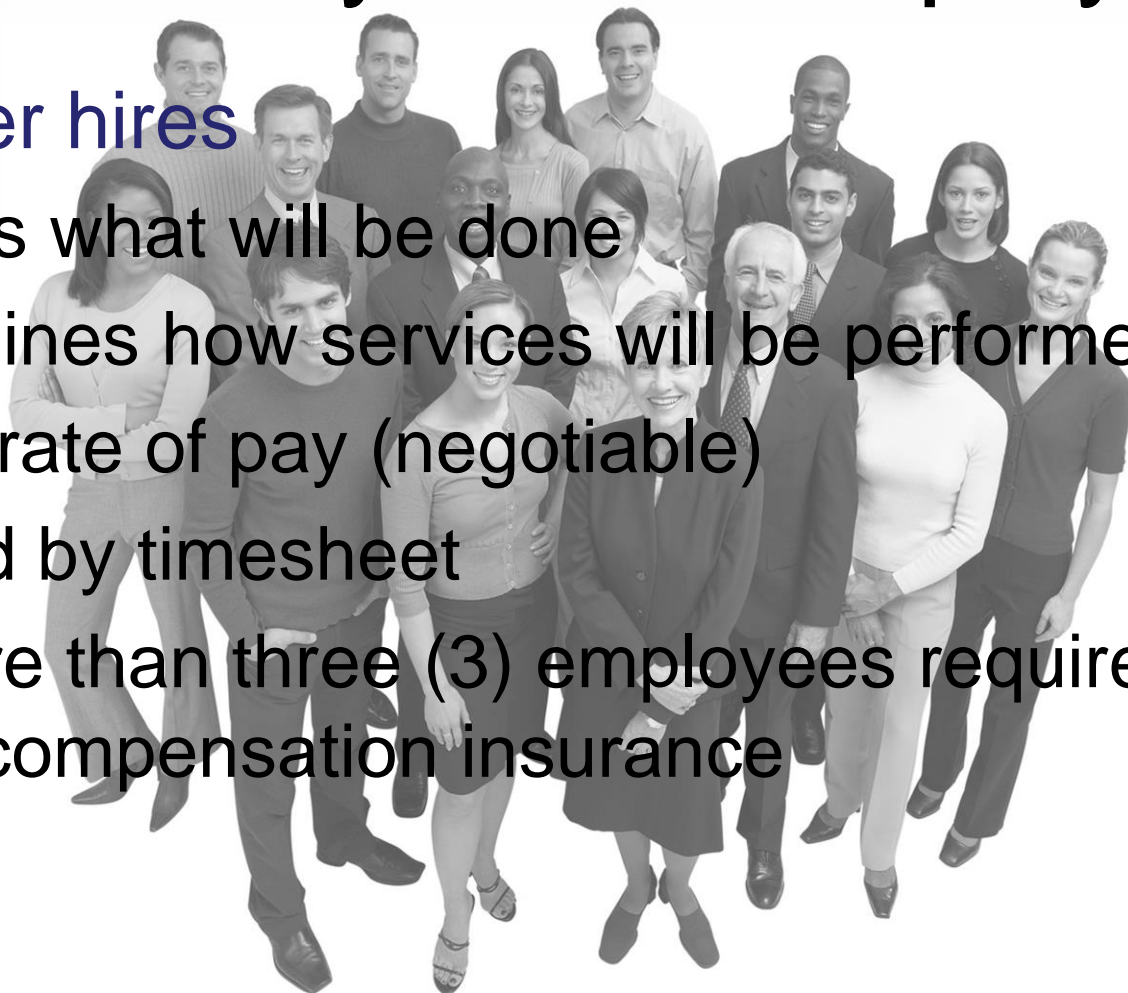
Decides what will be done

Determines how services will be performed

Hourly rate of pay (negotiable)

Paid by timesheet

Note: More than three (3) employees requires
worker's compensation insurance





Agency/Vendors and Independent Contractors

- **A person or business**
- Provides written description of services
- **consumer controls/directs only the result of work performed**
- Paid by invoice
- **No taxes withheld or paid**





Forms Needed for Hire

Agency/Vendor (A/V) or independent contractor (IC)

Vendor / Independent
Contractor Information Form

Internal Revenue Service
(IRS) Form W – 9

Background Screening
Clearance Letter

Affidavit of Good Moral
Character (notarized)

Directly Hired Employee (DHE)

Employee Information Form

Internal Revenue Service (IRS)
Form W - 4

Department of Homeland Security
(DHS) Form I – 9

Background Screening Clearance
Letter

Affidavit of Good Moral Character
(notarized)

Direct Deposit Form (EFT)- include a copy of a pre-printed voided check



Payment Options for CDC+ Providers

- Rapid! PayCard® Visa® Payroll Card
- Direct Deposit Form (EFT)- include a copy of a pre-printed voided check



Hiring an Employee

Directly Hired Employee

- Telephone screening
- Suggested Interview questions
- Basic job duties
- Explain the way you want the job done
- Have them bring picture I.D. & SS card
- Have forms ready



Hiring Friends and Family

Benefits to consider

- ✓ More dependable relationship
- ✓ Easier to find
- ✓ Safer
- ✓ Live-ins

Risks to consider

- ✓ Firing may be harder to do
- ✓ It may be more difficult to direct their work
- ✓ And...



CAUTION!!!

- Public Assistance could be affected
- Consumers are employers
- If you hire your parents, your spouse, your child (under the age 21), or anyone under age 18, they do not earn eligible wages that will count toward Social Security or Medicare benefits.
- If you hire your parent, your spouse, or your child (under age 21), to work for you as a DHE in CDC+, they do not earn eligible wages and do not qualify for unemployment compensation.



Caution, continued

- This is a decision that needs to be carefully considered by the employee.
- Visit IRS.gov to look at the Household Employer's Tax Guide, IRS Publication 926 and www.myflorida.com/dor to look at the Employer Guide to Unemployment Tax, UCT- 800002
-



Offering Benefits at No Additional Cost

- Value your employees
- Pay at fair wage (must follow minimum wage requirements – as of 1/1/15 \$8.05 an hour)
- Be flexible if they need time off-sick
- Use your backup providers
- Spread the hours between two (2) employees
- Compliment your employees
- Make the job interesting and fulfilling



Provider Eligibility for Federal Income Tax Exemption

On January 3, 2014, the Internal Revenue Service (Service) issued **Notice 2014-7**, addressing the income tax treatment of certain payments to an individual care provider under a state Home and Community-Based Services waiver (Medicaid Waiver) program. For more information including Q & A's, please go to www.irs.gov/Individuals/Certain-Medicaid-Waiver-Payments-May-Be-Excludable-From-Income





Purchasing Plan Exercise

- Walk through the Purchasing Plan review process





Purchasing Plan – Appendix J

- Describes how CDC+ monthly budget will be spent to meet needs and goals
 - ✓ Authorizes services/supports
 - ✓ Authorizes providers
- Developed by consumer or Representative; Consultant may provide technical assistance and guidance (CDC+ Rule Handbook Appendix J)



Purchasing Plan – Timelines

Person Responsible	Activity	Due Date
consumer (Representative)	Complete Purchase Plan; submit to Consultant	By the 5 th of the month
Consultant	Review and sign; submit to Regional Liaison	By the 10 th of the month
Regional Liaison	Review and sign; submit to State Office	By the 20 th of the month



Purchasing Plan Types

- New Purchasing Plan
- Purchasing Plan Change
- Purchasing Plan Update
- Quick Update



Purchasing Plan Change

Change in the monthly budget

Adding a One-Time or Short-Term Expenditure

Effective 1st day of month



Immediately submit a Purchasing Plan Change anytime there is a budget change to the consumer's Support Plan/Cost Plan



Purchasing Plan Update

Hire a new employee or agency/vendor

Change the rate of pay

Purchase different services or supports

**Increase the number of hours of a restricted
or unrestricted service**

Decrease the number of hours of an unrestricted
service

Add a new Savings item

Effective 1st day of month





Quick Update

Replace a current authorized provider

Change a vendor in Savings, OTE or STE

Change only the estimated date of purchase for a Savings item or the End Date of an OTE or STE

Add or replace a service or support in the Savings Section

Add an emergency back-up provider



Purchasing Plan Sections

The CDC+ purchasing plan consists of:

- ✓ Page 1 – Section A – Basic Information
- ✓ Page 2 – Section B – Needs and Goals
- ✓ Page 3 – Section C.1 and C.2 – Services and Supplies
- ✓ Page 4 – Section D – Cash (no longer available)
- ✓ Page 4 – Bottom of Section D – Justification for Savings items in Section E
- ✓ Page 5 – Sections E and F – Savings Plan and OTEs/STEs
- ✓ Page 6 – Budget Summary and Signatures





Purchasing Plan Instructions

- **Open blank purchasing plan**
- **Follow along slide by slide**
- **Reference tools**





Q & A (time permitting)
Lunch Break





The CDC+ Purchasing Plan

		CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)			
Purchasing Plan Effective Date:		Monthly Budget:	APD Area:	Participant is on FFI: Yes <input type="checkbox"/> No <input type="checkbox"/>	
A. PARTICIPANT INFORMATION					
Participant Name:			Participant ID #:		Participant's AGE:
First	M	Last			
Representative Name:			Phone #:	Cell #:	Official Use Only
First	M	Last			
REASON FOR SUBMITTING PURCHASING PLAN (TO BE COMPLETED BY CONSULTANT after Participant completes areas with *):					
1	<input type="checkbox"/> New Start (This is the Participant's first Purchasing Plan.)				
2	<input type="checkbox"/> Budget Authorization Form is attached. (Required)				
3	<input type="checkbox"/> Budget has changed from what was on the Application to _____ due to <input type="checkbox"/> SP/CP Update or <input type="checkbox"/> recalculation.				
4	<input type="checkbox"/> _____ Item must be entered in Section F with same effective date as this Purchasing Plan.				
5	<input type="checkbox"/> _____				
6	<input type="checkbox"/> Purch _____				
7	<input type="checkbox"/> _____				
8	<input type="checkbox"/> _____				
9	<input type="checkbox"/> _____				
10	<input type="checkbox"/> Purch _____				
11	* <input type="checkbox"/> _____				
12	<input type="checkbox"/> Participant selected a <u>NEW</u> Representative effective _____ <input type="checkbox"/> Participant Information Up _____				
13	<input type="checkbox"/> New Representative used to work for participant -- has been removed from this Plan.				
14	<input type="checkbox"/> Former Representative is starting to work for participant -- is added to this Plan.				
15	* <input type="checkbox"/> Provider Packets for all new providers are attached, as shown below:				
16	* _____ Employee packets for _____				
17	* _____ Vendor/IC packets for _____				
18	<input type="checkbox"/> _____				
19	<input type="checkbox"/> _____				
20	<input type="checkbox"/> _____				
21	<input type="checkbox"/> _____				
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30	<input type="checkbox"/> _____				
31	<input type="checkbox"/> _____				
32	<input type="checkbox"/> _____				
33	<input type="checkbox"/> _____				
34	<input type="checkbox"/> _____				
35	<input type="checkbox"/> _____				
36	<input type="checkbox"/> _____				
37	<input type="checkbox"/> _____				
38	<input type="checkbox"/> _____				
39	<input type="checkbox"/> _____				
40	<input type="checkbox"/> _____				
41	<input type="checkbox"/> _____				
42	<input type="checkbox"/> _____				
43	<input type="checkbox"/> _____				
44	<input type="checkbox"/> _____				
45	<input type="checkbox"/> _____				
46	<input type="checkbox"/> _____				
47	<input type="checkbox"/> _____				
48	<input type="checkbox"/> _____				
49	<input type="checkbox"/> _____				
50	<input type="checkbox"/> _____				
				Total Amount of CASH (Section D) has been revised as follows: INCREASE <input type="checkbox"/> DECREASE <input type="checkbox"/> (CHECK ONE) NO CHANGE IN CASH AMOUNT <input type="checkbox"/>	

To move from page to page on the purchasing plan, click on a page tab in the blue bar on the bottom of the Excel page frame. Each page contains a section of the purchasing plan

Extra pages in Section C.1 and C.2 are provided in the Excel file for consumers who need additional space to enter services and supports



CDC+ Purchasing Plan

Page 1 - Top

Provide the required information

		CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)			
Purchasing Plan Effective Date:		Monthly Budget:		APD Area:	
				Participant is on FFI:	Yes <input type="checkbox"/> No <input type="checkbox"/>
A. PARTICIPANT INFORMATION					
Participant Name:			Participant ID#:		Participant's AGE:
M Last			Phone #:	Cell #:	
First					
REASON FOR SUBMITTING					
<input type="checkbox"/> New Start (This is the Participant's first Purchasing Plan .) <input type="checkbox"/> Budget Authorization Form is attached. (Required) <input type="checkbox"/> Budget has changed from what was on the Application to _____ due to <input type="checkbox"/> SP/CP Update or <input type="checkbox"/> recalculation. <input type="checkbox"/> Add One Time Expenditure amount of up to 100% of what was approved in the Cost Plan: _____ item must be entered in Section F with same effective date as this Purchasing Plan. <input type="checkbox"/> Add Short Term Expenditure amount not to exceed 92% of what was approved in the Cost Plan _____ item must be entered in Section F with same effective date as this Purchasing Plan.					

Enter the day the Purchasing Plan will be effective

Enter the consumer's approved CDC+ Monthly Budget amount

Enter the number of the APD Regional in which the consumer lives

consumers on the Florida Freedom Initiative (FFI) check "Yes", otherwise check "No".



Purchasing Plan - Page 1

Section A – consumer Information

		CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)			
Purchasing Plan Effective Date:		Monthly Budget:	APD Area:	Participant is on FFL: Yes <input type="checkbox"/> No <input type="checkbox"/>	
A. PARTICIPANT INFORMATION					
Participant Name:			Participant ID #:	Participant's AGE:	
First	M	Last			
Representative Name:			Phone #:	Cell #:	Official Use Only
M			Enter Participant completes areas with *):		
1 Purchasing Plan .)					
2 <input type="checkbox"/> Budget Authorization Form is attached. (Required)					
3 <input type="checkbox"/> Budget has changed from what was on the Application to _____ due to <input type="checkbox"/> SP/CP Update or <input type="checkbox"/> recalculation.					
4 <input type="checkbox"/> Add One Time Expenditure amount of up to 100% of what was approved in the Cost Plan: _____ Item must be entered in Section F w					
5 <input type="checkbox"/> Add Short Term Expenditure amount not to exceed 92% of what was approved in the Cost Plan _____ Item must be entered in Section F with same effective date as this Purchasing Plan.					

Enter the consumer's legal first name, middle initial and last name as found on birth certificate

Enter the consumer's ID number

Enter the consumer's age as of the effective date of the Purchasing Plan



Purchasing Plan - Page 1

Section A – consumer Information (continued)

		CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)			
Purchasing Plan Effective Date:		Monthly Budget:	APD Area:	Participant is on FFI: Yes <input type="checkbox"/> No <input type="checkbox"/>	
A. PARTICIPANT INFORMATION					
Participant Name:			Participant ID #:		Participant's AGE:
First	M	Last			
Representative Name:			Phone #:	Cell #:	Official Use Only
First	M	Last			
REASON FOR SUBMITTING PURCHASING PLAN (TO BE COMPLETED BY CONSULTANT after Participant completes areas with *):					
1	Enter the representative's legal first name, middle initial and last name		Enter a valid phone number for the consumer or representative		Enter a valid cell phone number for the consumer or representative
2	Purchasing Plan.)		date or <input type="checkbox"/> recalculation.		Item must be entered in Section F with same effective date as this Purchasing Plan.
3	d. (Required)				
4	on the Applicat				Item must be entered in Section F with same effective date as this Purchasing Plan.
5	up to 100% of what was approved in the Cost Plan.				
	<input type="checkbox"/> Add Short Term Expenditure amount not to exceed 92% of what was approved in the Cost Plan				



Purchasing Plan - Page 1

Section A – Reason for Submitting Purchasing Plan

REASON FOR SUBMITTING PURCHASING PLAN (After Participant completes areas with *):

1 New Start (This is the Participant's first Purchasing Plan.)

2 Budget Authorization Form is attached. (Required)

3 Budget has changed from what was on the Application to _____.

4 Add One Time Expenditure amount of up to 100% of what was approved in the _____ entered in Section F with same effective date as this Purchasing Plan.

5 Add Short Term Expenditure amount not to exceed 92% of what was approved in the Cost Plan _____ item must be entered in Section F with same effective date as this Purchasing Plan.

6 Purchasing Plan CHANGE (This Purchasing Plan reflects a change in monthly budget and/or addition of OTE/STE based on updated Support Plan and amended Cost Plan.)

7 Change Monthly Budget Amount to _____

8 Add One Time Expenditure amount of up to 100% of what was approved in the _____ entered in Se _____ Plan.

9 Add Short Term Expenditure amount not to exceed 92% of what was approved _____ entered in Se _____ Plan.

10 Change Monthly Budget Amount and no new OTE or STE.)

11 * Revisions have been made on page(s): _____

12 Participant selected a NEW Representative effective _____ Participant Information Update form to change Representative _____

13 New Representative used to work for participant _____ has been removed from this Plan.

14 Former Representative is starting to work for participant – is added to this Plan.

15 * Provider Packets for all new providers are attached, as shown below:

16 * _____ Employee packets for _____

17 * _____ Vendor/IC packets for _____

Total _____ follows: INCREASE DECREASE NO CHANGE IN CASH AMOUNT (CHECK ONE)

New Start- This is for the 1st time you submit a PP.

Change in monthly budget

Enter the page numbers that are revised

Enter the number of Employee or Vendor/IC packets submitted

Enter the legal name for all providers appearing on the Purchasing Plan for the first time



Purchasing Plan - Page 1

Section A – Reason for Submitting Purchasing Plan (continued)

12	<input type="checkbox"/>	Participant selected a <u>NEW</u> Representative effective _____	<input type="checkbox"/>	Participant Information Update form to change Representative is attached. (Required)
13	<input type="checkbox"/>	New Representative used to work _____	Total Amount of CASH (Section D) has been revised as follows:	
14	<input type="checkbox"/>	Former Representative is starting _____	<input type="checkbox"/>	DECREASE <input type="checkbox"/> (CHECK ONE)
15	* <input type="checkbox"/>	Provider Packets for all new providers are _____	<input type="checkbox"/>	CASH AMOUNT <input type="checkbox"/>
16	*	_____ Employee packets for _____		
17	*	_____ Vendor/IC packets for _____		
18	* <input type="checkbox"/>	Indicate below the names of your providers who will no longer be used:	OR PROCESSING.	
19	*	_____	Consultant Initial _____ How can we _____	
20	*	_____	Area Liaison Initial _____	
21	*	_____	Confirms reason for submission; budget, OTE and STE _____ Attachments.	
22	* <input type="checkbox"/>	Total Number of Purchasing Plan Pages: _____	Approval of the Purchasing Plan contents is on the last page.	

(Please number each page of your Purchasing Plan.)

Enter the names of all the providers who appeared on previous Purchasing Plans but do not appear on this Purchasing Plan

Enter the total number of Purchasing Plan pages. The minimum number of pages is six (6)

Manually number each page of the Purchasing Plan including the total number of pages



Purchasing Plan - Page 1

Section A – Reason for Submitting Purchasing Plan (continued)

12	<input type="checkbox"/>	Participant selected a <u>NEW</u> Representative effective _____.	This option is no longer available	form to change Representative is attached. (Required)
13	<input type="checkbox"/>	New Representative used to work for participant -- has been removed.		Total Amount of CASH (Section D) has been revised as follows: INCREASE <input type="checkbox"/> DECREASE <input type="checkbox"/> NO CHANGE IN CASH AMOUNT <input type="checkbox"/> (CHECK ONE)
14	<input type="checkbox"/>	Former Representative is starting to work for participant -- is added to this Plan.		
15	* <input type="checkbox"/>	Provider _____	This area is to be completed by the consultant and Regional liaison	
16	* _____			
17	* _____			
18	* <input type="checkbox"/>	Indicate below the names of your providers who will no longer be used:		PLEASE COMPLETE. THIS SECTION IS REQUIRED FOR PROCESSING.
19	* _____		_____ Consultant Initial	How can we reach you if we have any questions? Enter phone/email.
20	* _____			
21	* _____		_____ Area Liaison Initial	_____ Phone Number
22	* <input type="checkbox"/>	Total Number of Purchasing Plan Pages: _____		Confirms reason for submission; budget, OTE and STE calculations; and receipt/review/correctness of all required attachments. Approval of the Purchasing Plan contents is on the last page.

(Please number each page of your Purchasing Plan.)



Purchasing Plan - Page 2

Section B – Needs

Participant:

Effective Date of Plan:

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)

B. NEEDS

To be completed by participant with assistance from the consultant as needed. Consultant will ensure the participant has the most current, approved Support Plan and Cost Plan.

1. List all needs/goals identified on participant's

2. List all services and supports approved on the current Waiver Cost Plan.

3. List all services/supports the participant will be using to meet the long term needs and goals identified on the Waiver Support Plan as listed in Column 1. Every item listed in the Purchasing Plan must appear in this section.

The consumer's name will automatically fill in from the information provided on the first page

Current Waiver Cost Plan Date:

Indicate in NOTES: OTEs, STEs, savings items, and services provided by natural support.

The plan's effective date will automatically fill in from the information provided on the first page

	Service Name	# of Months	Total Units	Units per Month	Type of Unit in PP ²	NOTES: OTE, STE, Savings items, Natural Support
1						
2						
3						
4						



Purchasing Plan - Page 2

Section B – Needs – Column 1

Participant: _____ Effect _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)

B. NEEDS

To be completed by participant with assistance from the consumer. Participant has the most current, approved Support Plan.

1. List all needs/goals identified on participant's current Waiver Support Plan.
 2. List all services/supports. Provide the number of months, number of units approved for each service, unit type, and frequency.
 3. List all services/supports the participant will be identified on the Waiver Support Plan as listed in C. Plan must appear in this section.

Current Waiver Support Plan Date: Current Waiver Cost Plan Date: Indicate in NOTES: OTEs, STEs, savings items, ar

	Support Plan Goals/ Needs	Service Name	# of Months	Total # Units	Typ of Unit in CP ¹	Average # Units per Month	Service Name	# Units per Month
1								
2								
3								
4								
5								
6								

Enter the date of the current Waiver Support Plan

Enter all needs and goals identified on the consumer's current Waiver Support Plan



Purchasing Plan - Page 2

Section B – Needs – Column 2

Participant: _____ Effective Date: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)

B. NEEDS

To be completed by participant with assistance from the consultant as needed. Consultant will ensure the participant has the most current, approved Support

1. List all services and supports approved on the current Waiver Cost Plan								2. List all services and supports approved on the current Waiver Cost Plan. Provide the number of months, number of units approved for each service, unit type, and frequency.				3. List all services/supports the participant will be identified on the Waiver Support Plan as listed in C. Plan must appear in this section. Indicate in NOTES: OTEs, STEs, savings items, ar	
Support Plan Goals/ Needs		Current Waiver Cost Plan Date:											
		Service Name	# of Months	Total # Units	Type of Unit in CP ¹	Average # Units per Month	Service Name	# Units per Month					
1													
2													
3													
4													
5													
6													

Enter all services and supports approved on the current Waiver Cost Plan

Enter the current Waiver Cost Plan date

Enter the number of months for each support or service



Purchasing Plan - Page 2

Section B – Needs – Column 2 (continued)

Participant: _____ Effective Date of Plan: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)

B. NEEDS

To be completed by participant with assistance from the consultant as needed. Consultant will ensure the participant has the most

1. List all needs/goals identified on participant's current Waiver Support Plan.

2. List all services and supports approved on the current Waiver Cost Plan. Provide the number of months, number of units approved for each service, unit type, and frequency.

3. List all services identified on the Plan must appear

The average number of units per month is automatically calculated and inserted in this box

Current Waiver Support Plan Date:

Current Waiver Cost Plan Date:

Indicate in NOTES: OTEs, STEs, savings items, and services provided by natural support.

	Support Plan Goals/ Needs	Service Name	# of Months	Total # Units	Average # Units per Month		Service Name	# Units per Month	Typ of Unit in PP ²	NOTES: OTE, STE, Savings items, Natural Support
					Type of Unit in CP ¹					
1										
2										
3										
4										
5										

Enter the total number of units for each support or service

Click on the box to open a dropdown box then select the type of unit in Cost Plan for each service or support



Purchasing Plan - Page 2

Section B – Needs – Column 3

Participant: _____ Effective Date of Plan: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)

ance from the consultant as needed. Consultant will ensure the participant has the most current, approved Support Plan and Cost Plan.

<p>Enter each service or support the consumer will be purchasing to meet long term needs and goals</p>					Waiver Cost Plan. for each service,	3. List all services/supports the participant will be using to meet the long term needs and goals identified on the Waiver Support Plan as listed in Column 1. Every item listed in the Purchasing Plan must appear in this section.		
						Indicate in NOTES: OTEs, STEs, savings items, and services provided by natural support.		
Service Name	# of Months	Total # Units	Type of Unit in CP ¹	Average # Units per Month	Service Name	# Units per Month	Type of Unit in PP ²	NOTES: OTEr, STEr, Savings items, Natural Support
<p>Enter the total number of units per month for each service or support</p>								



Purchasing Plan - Page 2

Section B – Needs – Column 3

Participant: _____

Effective Date of Plan: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan					Enter note if service or support is an OTE, STE, savings item or unpaid natural support			
<p>2. List all services and supports received on the current Waiver Cost Plan. Provide the number of units, frequency, and frequency of service. Consultant will ensure the participant is receiving the most appropriate services and supports. Consultant will ensure the participant is receiving the most appropriate services and supports.</p>					<p>3. List all services/supports the participant will be using to meet the long term needs and goals identified on the Waiver Support Plan as listed in Column 1. Every item listed in the Purchasing Plan must appear in this section. Indicate in NOTES: OTEs, STEs, savings items, and services provided by natural support.</p>			
Service Name	# of Months	Total # Units	Typ of Unit in CP ¹	Average # Units per Month	Service Name	# Units per Month	Typ of Unit in PP ²	NOTES: OTEr, STEr, Savings itemr, Natural Support
							<div style="border: 1px solid gray; padding: 2px;"> </div>	
							Day Hr Item Trip Visit	

Click on the box to open a dropdown box and select type of unit in Purchasing Plan



Purchasing Plan - Page 3

Section C.1 – Budget Details – Services

Participant: _____

Effective Date of Plan: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)

C.1 Budget Detail - SERVICES

Use as many pages as you need to list all your regular monthly providers and, if they are critical, their backup providers directly underneath them on the same page.

Service	Svc Code	Critical Y/N If Y, must be at least 2 EBUs*	Provider Name	Employer Taxes	Total Cost	Click Here to Compute EBU Added Cost	
						Total Monthly Cost	EBU Added Cost
1				\$ -	\$ -	\$ -	-
2	RT SIC SNL SNR ST TRAN X'THER			\$ -	\$ -	\$ -	-
3				\$ -	\$ -	\$ -	-
4				\$ -	\$ -	\$ -	-
5				\$ -	\$ -	\$ -	-
6				\$ -	\$ -	\$ -	-

If the service listed is critical, enter Y (yes), if not critical enter N (No). If yes is entered there must be a minimum of (2) emergency back-up providers listed. EBU providers can only be listed for critical services

The service code box will automatically fill in the code when the service is selected from the dropdown box

Click on the box to open a dropdown box then select a service



Purchasing Plan - Page 3

Section C.1 – Budget Details – Services (continued)

- Direct Hire Employee (DHE) provider relationship numbers:
 - 1 = Parent or step-parent
 - 2 = consumer’s child or stepchild under age 21
 - 3 = Spouse
 - 4 = Person under 18 currently in high school (not consumer’s child or stepchild)
 - 5 = All others

Participant: _____ Effective Date of Plan: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)											
C.1 Budget Detail - SERVICES											
Use as many pages as you need to list all your regular monthly providers and, if the provider is critical, list at least two (2) back-up providers on the lines directly underneath on the same page.											
Service	Svc Code	Critical Y/N If Y, must be at least 2 EBUs*	Provider Name	Provider Type	DHE Provider's Relationship to Participant	# of Units	Unit (Hr., Day, Trip)	Rate	Monthly Cost	EBU Added Cost	
1											
2											
3											
4											
5											
6											

Click on the box to open a dropdown box then select a provider type

Enter the provider relationship number by opening the dropdown box and selecting the number that applies

Enter the legal name of all providers. If the provider is critical, list at least two (2) back-up providers on the lines directly underneath on the same page



Purchasing Plan - Page 3

Section C.1 – Budget Details – Services (continued)

Participant: _____

Effective Date of Plan: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)

C.1 Budget Detail - SERVICES

Use as many pages as you need to list all your regular monthly providers and, if they are critical, their backup providers directly underneath them on the same page.

[Click Here to Compute EBU Added Cost](#)

Service	Svc Code	Critical Y/N If Y, must be at least 2 EBUS*	Provider Name	Provider Type	DHE Provider's Relationship to Participant*	# of Units	Unit (Hr., Day, Trip)	Rate	Sub-Total	Employer Taxes	Total Cost	Total Monthly Cost	EBU Added Cost
1									\$ -	\$ -	\$ -	\$ -	
2									\$ -	\$ -	\$ -	\$ -	
3									\$ -	\$ -	\$ -	\$ -	
4									\$ -	\$ -	\$ -	\$ -	
5									\$ -	\$ -	\$ -	\$ -	
6									\$ -	\$ -	\$ -	\$ -	

Enter the number of units for each service

Enter the cost per unit for each service

Click on the box to open a dropdown box then select the unit type



Purchasing Plan - Page 3

Section C.1 – Budget Details - # of Units:

- 22 weekdays in a month
Monday - Friday workweek
- 9 weekend days in a month
Saturday and Sunday workweek
- 31 calendar days in a month
Always plan for the maximum number of days in a month



Purchasing Plan - Page 3

Section C.1 – Budget Details – Services (continued)

Participant: _____

Effective Date of Plan: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)

SERVICES

Required to list all your regular monthly providers and, if they are critical, their backup providers directly underneath them on this form.

Provider Name	Provider Type	DHE Provider's Relationship to Participant*	# of Units	Unit (Hr., Day, Trip)	Rate	Sub-Total	Employer Taxes	Total Cost	Total Monthly Cost	EBU Added Cost
						\$ -	\$ -	\$ -	\$ -	
						\$ -	\$ -	\$ -	\$ -	
						\$ -	\$ -	\$ -	\$ -	
						\$ -	\$ -	\$ -	\$ -	

Provider total cost automatically calculates

The sub-total automatically calculates and the amount will appear in this box

Employer taxes automatically calculate and the amount will appear in this box



Purchasing Plan - Page 3

Section C.1 – Budget Details – Services – EBU Added Cost

Participant: _____

Effective Date of Plan: _____

CONSUMER-DIRECTED CARE SERVICES			Section 3.0-C)				
Provider Name	Provider Type	DHE Provider's Relationship to Participant*	Employer Taxes	Total Cost	Total Monthly Cost	EBU Added Cost	
			\$ -	\$ -	\$ -		
			\$ -	\$ -	\$ -		
			\$ -	\$ -	\$ -		
			\$ -	\$ -	\$ -		

Click here to calculate additional emergency back-up cost

Click Here to Compute EBU Added Cost

Total monthly cost will automatically calculate and appear in this box for primary providers

If emergency back-up cost is calculated the amount will appear in this box

Participant should list all your regular monthly providers and, if they are critical, their backup providers directly underneath them on the same page.



Purchasing Plan - Page 3

Section C.1 – Budget Details – Services – Totals

their backup providers directly underneath them on the same page.

				Click Here to Compute EBU Added Cost	
Rate	Sub-Total	Employer Taxes	Total Cost	Total Monthly Cost	EBU Added Cost
	\$ -	\$ -	\$ -	\$ -	
	\$ -	\$ -	\$ -	\$ -	
	\$ -	\$ -	\$ -	\$ -	
Provider.					
			Page 3 C.1 Total:	\$ -	\$ -

The total amount of EBU added cost will appear here and also appear in box for total estimated cost for EBU in Section E

Total monthly costs for services will automatically calculate and appear in this box



Purchasing Plan - Page 3

Section C.2 – Budget Details – Supplies

- Only one (1) supply type can be listed:

CMS – Consumable Medical Supplies (63)

11						\$ -	\$ -	\$ -	\$ -	
Note: At least 2 EBU providers must be listed				Select the supply type from the dropdown box. Only one (1) type can be entered - CMS				Page 3 C.1 Total:	\$ -	\$ -
C.2 Budget Detail - SUPPLIES										
	Service	Svc Code	Provider	Detailed Description	# of Units	Unit	Rate	Total Cost		
1		▼						\$ -		
2	CMS							\$ -		
3								\$ -		
4								\$ -		
5								\$ -		
								Page 3 C.2 Total:	\$ -	
If you need additional space to list your providers in sections C1 and C2, please use Page 3A.						Check if you use 3A:				

* EBU=Emergency Backup; DHE=Directly Hired Employee; AV=Agency/Vendor; IC=Independent Contractor; *Parent=1; PARTICIPANT'S Child under 21=2; Spouse=3; Person under 18=4; All Others=5



Purchasing Plan - Page 3

Section C.2 – Budget Details – Supplies (continued)

- List all supply providers and detailed descriptions for each supply including quantity

Examples: Adult Large Diapers (96)

Adult Large Diapers (96), 1 case Wipes (6), 2 boxes Bed Pads (24) = 1 unit

<p>Note: At least 2 EBU providers must be listed immediately under each critical service provider.</p>								Page	
C.2 Budget Detail - SUPPLIES									
Service	Svc Code	Provider	Detailed Description	# of Units	Unit	Rate	Total Cost		
							\$ -		
							\$ -		
							\$ -		
Page 3 C.2 Total:							\$ -		
If you need additional space to list your providers in sections C1 and C2, please use Page 3A.						Check if you use 3A:			

Enter the number of units to be purchased

Enter the legal name of the provider where supplies will be purchased

Enter a detailed description for each supply including quantity

* EBU=Emergency Backup; DHE=Directly Hired Employee; A/V=Agency/Vendor; IC=Independent Contractor; *Parent=1; PARTICIPANT'S Child under 21=2; Spouse=3; Person under 18=4; All Others=5



Purchasing Plan - Page 3

Section C.2 – Budget Details – Supplies (continued)

11									\$			\$	-			
Note: At least 2 EBU providers must be listed immediately.													\$	-	\$	-
C.2 Budget Detail - SUPPLIES																
Service	Svc Code	Provider	Detailed Description	# of Units	Unit	Rate	Total Cost									
1							\$									
2							\$	-								
3							\$	-								
4							\$	-								
5							\$	-								
								Page 3 C.2 Total:	\$	-						
If you need additional space to list your providers in sections C1 and C2, please use Page 3A.										Check if you use 3A:						
<small>* EBU=Emergency Backup; DHE=Directly Hired Employee; A/V=Agency/Vendor; IC=Independent Contractor; *Parent=1; PARTICIPANT'S Child under 21=2; Spouse=3; Person under 18=4; All Others=5</small>																

Enter the rate for each supply listed

The total cost will automatically calculate

Enter the unit type



Purchasing Plan - Page 3

Section C.2 – Budget Details – Supplies (continued)

11									\$ -	\$ -	\$ -	\$ -		
<p>Note: At least 2 EBU providers must be listed immediately under each critical service provider.</p>										<p>Page 3 C.1 Total:</p>		\$ -	\$ -	
<p>C.2 Budget Detail - SUPPLIES</p>														
Service	Svc Code	Provider	Detailed Description	# of Units	Unit	Rate	Total Cost							
1							\$ -							
2							\$ -							
3							\$ -							
4							\$ -							
5							\$ -							
										<p>Page 3 C.2 Total:</p>		\$ -	\$ -	
<p>If you need additional space to list your providers in sections C1 and C2, please use Page 3A.</p>										<p>Check if you use 3A:</p>				

The total will calculate and insert in the box at the bottom of the total cost column

Check box to indicate if additional page 3A is used to complete this section

* EBU=Emergency Backup; DHE=Directly Hired Employee; A/V=Agency/Vendor; IC=Independent Contractor; *Parent=1; PARTICIPANT'S Child under 21=2; Spouse=3; Person under 18=4; All Others=5



Purchasing Plan - Page 4

Section D – Budget Details – Cash Purchases - **Discontinued**

Participant: _____

Effective Date of Plan: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)

D. Budget Detail - Purchases to be made with CASH

This option is no longer available

	Service Category	Service Code	Detailed Description of Each Item	of Units	Unit Type	Rate	Total Cost
1							\$ -
2			Option 1. Section E - Savings				\$ -
3			Option 2. Section C.1 & C.2 – Services/Supplies				\$ -
4							\$ -
5							\$ -
6							\$ -



Purchasing Plan - Page 4

Section D – Budget Details – Cash Purchases – Total

You will receive a check for this amount each month to make <u>ONLY</u> the above purchases: \$	
-	
Explain below how purchases requested in Section E meet your needs/goals, or increase your independence. Use this section also to provide any additional information APD should know in order to assist with their approval of this Purchasing Plan.	
<div style="border: 2px solid red; padding: 10px;"><p>In this area, enter an explanation on how purchases requested in Section E will meet the needs and goals or increase independence. Also, enter any additional information that would assist APD staff in approving the consumer's Purchasing Plan</p></div>	



Purchasing Plan - Page 5

Section E – Savings Plan – Authorizations for Use of Accumulated, Unrestricted Funds

Participant: _____

Effective Date of Plan: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)

E. SAVINGS PLAN - Authorizations for use of Accumulated, Unrestricted Funds

Most Current Statement Date:		Statement Balance:	Total Amount of Unrestricted Funds Available:					Unrestricted funds made available for these purchases each month:			\$	-
Provider Name <small>Add "Consumer/Rep Reimb." if you will buy the service yourself and request reimbursement.</small>		Provider Type	DHE Provider's Relationship to Participant*	# of Units	Unit	Rate	Sub-Total	Employer Taxes	Total Estimated Cost	Last Date Purchase Will be Made	Actual Date Purchase was Made or Completed	
							\$ -	\$ -	\$ -			
							\$ -	\$ -	\$ -			
							\$ -	\$ -	\$ -			
							\$ -	\$ -	\$ -			
							\$ -	\$ -	\$ -			

Enter the most current statement date (mm/yyyy)

Enter the ending balance on the current statement

Enter the total amount of unrestricted funds available



Purchasing Plan - Page 5

Section E – Savings Plan – Authorizations for use of Accumulated, Unrestricted Funds (continued)

Participant: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan												
E. SAVINGS PLAN - Authorizations for use of Accumulated, Unrestricted Funds												
Most Current Statement Date:		Statement Balance:		Total Amount of Unrestricted Funds Available:					Amount available for these purchases each month:			
Item/Service Description	Svc Code	Provider Name <small>Add "Consumer/Rep Reimb." if you will buy the service yourself and request reimbursement</small>	Provider Type	DHE Provider's Relationship to Participant*	# of Units	Unit	Rate	Sub-Total	Employer Taxes	Total Estimated Cost	Last Date Purchase Will be Made	Actual Date Purchase was Made or Completed
Funds always reserved for Emergency Back Ups										\$ -		
1								\$ -	\$ -	\$ -		
2									\$ -	\$ -		
3									\$ -	\$ -		
4									\$ -	\$ -		
5									\$ -	\$ -		

Unrestricted funds made available for savings plan purchases each month

The accumulated unrestricted funds must always be reserved and available for use by emergency back-ups

The total estimated cost amount is forwarded from the Budget Detail Services section EBU Added Cost total



Purchasing Plan - Page 5

Section E – Savings Plan – Authorizations for use of Accumulated, Unrestricted Funds (continued)

Participant: _____

Effective Date of Plan: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)

E. SAVINGS PLAN - Authorizations for use of Accumulated, Unrestricted Funds

Most Current Statement Date:		Statement Balance:	Total Amount of Unrestricted Funds Available:				Unrestricted funds made available for these purchases each month:		\$	-		
Item/Service Description	Svc Code	Provider Name <small>Add "Consumer/Rep Reimb." if you will buy the service yourself and request reimbursement</small>	Provider Type	DHE Provider's Relationship to Participant	# of Units	Unit	Rate	Sub-Total	Employer Taxes	Total Estimated Cost	Last Date Purchase Will be Made	Actual Date Purchase was Made or Completed
Funds always reserved for Emergency Back Ups								\$ -	\$ -	\$ -		
1	<input type="text"/>	<input type="text"/>						\$ -	\$ -	\$ -		
2	<input type="text"/>	<input type="text"/>						\$ -	\$ -	\$ -		
3	<input type="text"/>	<input type="text"/>						\$ -	\$ -	\$ -		
4	<input type="text"/>	<input type="text"/>						\$ -	\$ -	\$ -		

Enter the legal provider name for each item or service

Click on box to open the dropdown box containing service code numbers. Select the correct service code for the item or service listed

Enter each item or service description



Purchasing Plan - Page 5

Section E – Savings Plan – Authorizations for use of Accumulated, Unrestricted Funds (continued)

Participant: _____

Effective Date of Plan: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)

E. SAVINGS PLAN - Authorizations for use of Accumulated, Unrestricted Funds

Most Current Statement Date:		Statement Balance:	Total Amount of Unrestricted Funds Available:		Unrestricted funds made available for these purchases each month:		\$	-
Item/Service Description Funds always reserved for Emergency Back Ups	Svc Code	Provider Name Add "Consumer/Rep Reimb." if you will buy the service yourself and request reimbursement	Provider Type	DHE Provider's Relationship to Participant	# of Units	Unit	Last Date Purchase Will be Made	Actual Date Purchase was Made or Completed
							\$ -	
							\$ -	
							\$ -	
							\$ -	
							\$ -	
							\$ -	
							\$ -	
							\$ -	
							\$ -	

Enter the number of units to be purchased for each item or service

Enter the unit type for the item or service to be purchased

Click on the box to open a dropdown box. Select the provider type for the item or service

If provider is a DHE, click on the box to open a dropdown box. Select the number that describes the relationship of the consumer to the DHE named



Purchasing Plan - Page 5

Section E – Savings Plan – Authorizations for use of Accumulated, Unrestricted Funds (continued)

Participant: _____

Effective Date of Plan: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)

E. SAVINGS PLAN - Authorizations for use of Accumulated, Unrestricted Funds

Most Current Statement Date:		Statement Balance:	Total Amount of Unrestricted Funds Available:					Unrestricted funds made available for these purchases each month: \$ -				
Item/Service Description	Svc Code	Provider Name <small>Add "Consumer/Rep Reimb." if you will buy the service yourself and request reimbursement</small>	Provider Type	DHE Provider's Relationship to Participant	# of Units	Unit	Rate	Sub-Total	Employer Taxes	Total Estimated Cost	Last Date Purchase Will be Made	Actual Date Purchase was Made or Completed
Funds always reserved for Emergency Back Ups										\$ -		
1							\$ -	\$ -	\$ -			
2							\$ -	\$ -	\$ -			
3							\$ -	\$ -	\$ -			
4							\$ -	\$ -	\$ -			
5							\$ -	\$ -	\$ -			
6							\$ -	\$ -	\$ -			

Enter the rate per unit for each item or service

Sub-total will automatically calculate and appear in this box

If applicable, employer taxes will calculate. The amount will appear in the employer taxes box



Purchasing Plan - Page 5

Section E – Savings Plan – Authorizations for use of Accumulated, Unrestricted Funds (continued)

Participant: _____

Effective Date of Plan: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)

E. SAVINGS PLAN - Authorizations for use of Accumulated, Unrestricted Funds

Most Current Statement Date:		Statement Balance:		Total Amount of Unrestricted Funds Available:		Unrestricted funds made available for these purchases each month:		\$ -	
Item/Service Description	Svc Code	Provider Name Add "Consumer/Rep Reimb." if you will buy the service yourself and request reimbursement	Sub-Total	Employer Taxes	Total Estimated Cost	Last Date Purchase Will be Made	Actual Date Purchase was Made or Completed		
Funds always reserved for Emergency Back Ups					\$ -				
1			\$ -	\$ -	\$ -				
2					\$ -				
3					\$ -				
4									
5									

The total estimated cost amount for each item or service will calculate and insert here

Enter the estimated date the item will be purchased. This will always be the last day of the month (mm/dd/yyyy)

Enter the actual date the item was purchased. (mm/dd/yyyy)



Purchasing Plan - Page 5

Section F – Budget Detail – One Time and Short Term Expenditures

F. Budget Detail - One Time and Short Term Expenditures									
OTE/STE	Item/Service Description	SVC Code	Employer Taxes	Total Budget	Start Date	End Date			
1			\$ -	\$ -	\$ -				
2			\$ -	\$ -	\$ -				
3			\$ -	\$ -	\$ -				
4			\$ -	\$ -	\$ -				

Any items entered in this section are transactions for the month the Purchasing Plan on which they are first listed is effective. Funds for STEs must be used to purchase AT LEAST 92% of the quantity of services in the time frame specified in this section of the Purchasing Plan will be returned to Medicaid.

* DHE = Directly Hired Employee; ** Agency Person; *** Independent Contractor; *Parent = 1, PARTICIPANT'S Child Under 21 = 2, Spouse = 3, Person Under 18 = 4, All Others = 5.

Click on box to open a dropdown box listing items and services available for either OTE or STE. Select the item or service to be purchased

When item or service is selected the assigned service code will appear in the service code box

Click on box to open a dropdown box. Select type of expenditure – OTE or STE



Purchasing Plan - Page 5

Section F – Budget Detail – OTEs and STEs (continued)

F. Budget Detail - One Time and Short Term Expenditures													
OTE/STE	Item/Service Description	Svc Code	Provider	Provider Type	DHE Provider's Relationship to Participant*	# of Units	Unit	Rate	Sub-Total	Employer Taxes	Total Budget	Start Date	End Date
1									\$ -	\$ -	\$ -		
2				A/V DHE IC					\$ -	\$ -	\$ -		
3									\$ -	\$ -	\$ -		
4									\$ -	\$ -	\$ -		

Enter the legal provider name for each item or service

Click on the box to open a dropdown box. Select the provider type for item of services

Any items entered in Section F must meet the Effective Date of the Purchasing Plan on which this section are transferred to your account in quantity of services approved on your Waiver
 * DHE = Directly Hired Employee, A/V = Agency
) or a Short Term Expenditure (STE), as specified on the CDC+ Service Code Chart. The **Start Date** must be the same as the purchased prior to that date. An **End Date** consistent with the Waiver Cost Plan must also be entered. The funds for items listed in the Purchasing Plan on which they are first listed is effective. Funds for STEs must be used to purchase **AT LEAST 92%** of the d in the time frame specified in this section of the Purchasing Plan will be returned to Medicaid.
 t = 1, PARTICIPANT'S Child Under 21 = 2, Spouse = 3, Person Under 18 = 4, All Others = 5.



Purchasing Plan - Page 5

Section F – Budget Detail – OTEs and STEs (continued)

F. Budget Detail - One Time and Short Term Expenditures													
OTE/STE	Item/Service Description	Svc Code	Provider	Provider Type	DHE Provider's Relationship to Participant*	# of Units	Unit	Rate	Sub-Total	Employer Taxes	Total Budget	Start Date	End Date
1									\$ -	\$ -	\$ -		
2							Day		\$				
3							Hr		\$				
4							Item		\$				
							Trip		\$				
							Visit		\$				

Enter the number of units to be purchased for each item or service

Click on box to open dropdown box. Select the unit for each item or service

Enter rate in dollar amount for item or service to be purchased

Any items entered in Section F must meet the definition of a Short Term Expenditure (STE), as specified on the CDC+ Service Code Chart. The **Start Date** must be the same as the Effective Date of the Purchasing Plan on which it is entered. An **End Date** consistent with the Waiver Cost Plan must also be entered. The funds for items listed in this section are transferred to your account in a Purchasing Plan on which they are first listed is effective. Funds for STEs must be used to purchase **AT LEAST 92%** of the quantity of services approved on your Waiver Cost Plan. Funds for OTEs and STEs not used in the time frame specified in this section of the Purchasing Plan will be returned to Medicaid.

* DHE = Directly Hired Employee, A/V = Agency/Vendor, IC = Independent Contractor; *Parent = 1, PARTICIPANT'S Child Under 21 = 2, Spouse = 3, Person Under 18 = 4, All Others = 5.



Purchasing Plan - Page 5

Section F – Budget Detail – OTEs and STEs (continued)

F. Budget Detail - One Time and Short Term Expenditures													
OTE/STE	Item/Service Description	Svc Code	Provider	Provider Type	DHE Provider's Relationship to Participant*	# of Units	Unit	Rate	Sub-Total	Employer Taxes	Total Budget	Start Date	End Date
1									\$ -	\$ -	\$ -		
2									\$ -	\$ -	\$ -		
3									\$ -	\$ -	\$ -		
4									\$ -	\$ -	\$ -		

Sub-total will automatically calculate and appear in this box

If DHE employer tax is calculated, the amount will appear here

The total budget for each item or service will calculate and appear here

Any items entered in Section F must meet the definition of either a One Time Expenditure or a Short Term Expenditure. The Effective Date of the Purchasing Plan on which it is first entered, and services cannot be provided before this date. The Provider Type and DHE Provider's Relationship to Participant must be consistent with the Waiver Cost Plan. Funds for OTEs and STEs not used in the time frame specified in this section of the Purchasing Plan will be returned to Medicaid.

* DHE = Directly Hired Employee, A/V = Agency/Vendor, IC = Independent Contractor; *Parent = 1, PARTICIPANT'S Child Under 21 = 2, Spouse = 3, Person Under 18 = 4, All Others = 5.



Purchasing Plan - Page 5

Section F – Budget Detail – OTEs and STEs (continued)

F. Budget Detail - One Time and Short Term Expenditures												
OTE/ STE	Item/Service Description	Svc Code	Provider	Provider Type	DHE Provider's Relationship to Participant*				Employer Taxes	Total Budget	Start Date	End Date
1								\$ -	\$ -	\$ -		
2								\$ -	\$ -	\$ -		
3								\$ -	\$ -	\$ -		
4								\$ -	\$ -	\$ -		

Enter the start date for each item or service (mm/dd/yyyy)

Enter the end date (mm/dd/yyyy). This is the same date as the end date of the item funding

Any items entered in Section F must meet the definition of either a One Time Expenditure (OTE) or a Short Term Expenditure (STE), as specified on the CDC+ Service Code Chart. The Start Date must be the same as the Effective Date of the Purchasing Plan on which it is first entered, and services cannot be purchased prior to that date. An End Date consistent with the Waiver Cost Plan must also be entered. The funds for items listed in this section are transferred to your account **in addition to** your monthly budget for the month the Purchasing Plan on which they are first listed is effective. Funds for STEs must be used to purchase **AT LEAST 92%** of the quantity of services approved on your Waiver Cost Plan. Funds for OTEs and STEs not used in the time frame specified in this section of the Purchasing Plan will be returned to Medicaid.

* DHE = Directly Hired Employee, A/V = Agency/Vendor, IC = Independent Contractor; *Parent = 1, PARTICIPANT'S Child Under 21 = 2, Spouse = 3, Person Under 18 = 4, All Others = 5.



Purchasing Plan - Page 6

Budget Summary

Participant: _____

Effective Date of Plan: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan

Budget Summary

Summarizes the expenditures detailed on the previous pages

The service and supplies amount is automatically populated. It is the sum of Sections C.1 total and C.2 total of the Purchasing Plan

The authorized budget amount is automatically populated. It is the amount that was entered as the monthly budget on the top of Page 1

Authorized Budget Amount:	\$	_____	-
---------------------------	----	-------	---

Planned Expenditures:

C. Services/Supplies	\$	_____	-
D. Cash	\$		-
E. Savings Plan	\$		-

NOTE: The amount going into the Savings Plan each month must be a positive number. If this number is negative, verify that all numerical entries are correct.

Total Monthly Expenditures:	\$		-
------------------------------------	----	--	---

This must equal the Authorized Budget Amount.



Purchasing Plan - Page 6

Budget Summary (continued)

Participant: _____

Effective Date of Plan: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)

Budget Summary

This section no longer applies and should not contain any numbers

Summarizes the expenditures detailed on the previous pages of the Purchasing Plan.

The total monthly expenditures is the total authorized budget amount

The Savings Plan amount will automatically populate. The amount is unrestricted funds made available each month in Section E

Authorized Budget Amount:		
Planned Expenditures:		
C. Services/Supplies	\$	-
D. Cash	\$	-
E. Savings Plan	\$	-
Total Monthly Expenditures:	\$	-

NOTE: The amount going into the Savings Plan each month must be a positive number. If this number is negative, verify that all numerical entries are correct.

This must equal the Authorized Budget Amount.

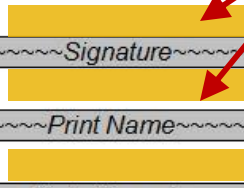


Purchasing Plan - Page 6

Signatures – consumer or CDC+ Representative

E. Savings Plan	\$ -	
NOTE: The amount going into the Savings Plan each month must be a positive number. If this number is negative, verify that all numerical entries are correct.	Total Monthly Expenditures:	\$ -
		This must equal the Authorized Budget Amount.
SIGNATURES		
Participant or CDC+ Representative	Consultant	APD Staff
_____	_____	_____
~~~~~Signature~~~~~	~~~~~Signature~~~~~	~~~~~Signature~~~~~
_____	_____	_____
~~~~~Print Name~~~~~	~~~~~Print Name~~~~~	~~~~~Print Name~~~~~
_____	_____	_____
~~~~~Date Signed~~~~~	~~~~~Date Signed~~~~~	~~~~~Date Signed~~~~~
Signing this document acknowledges that you developed this Purchasing Plan, that it meets the needs and goals specified on your Waiver Support Plan, and that the paperwork for all providers on the Plan has been submitted to APD for processing.	Signing this document acknowledges that the information is accurate, the Purchasing Plan meets the participant's needs and goals, and that the Plan meets the requirements of the program.	Staff signature indicates that the Purchasing Plan is <b>approved</b> and may be implemented on the effective date for valid providers unless otherwise indicated below:
		<input type="checkbox"/> Approved except for the following sections: Section _____ Line(s) _____ Section _____ Line(s) _____ Section _____ Line(s) _____ Please refer to the attached letter for additional explanation.

The consumer or representative must print name then sign and enter date signed on hard copy of form





# Purchasing Plan - Page 6

## Signatures – Consultant

<b>E. Savings Plan</b>	\$ -	
NOTE: The amount going into the Savings Plan each month must be a positive number. If this number is negative, verify that all numerical entries are correct.	<b>Total Monthly Expenditures:</b>	\$ -
<b>SIGNATURES</b> (This page must always be newly signed and dated)		
<b>Participant or CDC+ Representative</b>	<b>Consultant</b>	<b>APD Staff</b>
~~~~~Signature~~~~~	~~~~~Signature~~~~~	~~~~~Signature~~~~~
~~~~~Print Name~~~~~	~~~~~Print Name~~~~~	~~~~~Print Name~~~~~
~~~~~Date Signed~~~~~	~~~~~Date Signed~~~~~	~~~~~Date Signed~~~~~
Signing this document acknowledges that you developed this Purchasing Plan, that it meets the needs and goals specified on your Waiver Support Plan, and that the paperwork for all providers on the Plan has been submitted to APD for processing.	Signing this document acknowledges that the information is accurate, the Purchasing Plan meets the participant's needs and goals, and that the Plan meets the requirements of the program.	Staff signature indicates that the Purchasing Plan is approved and may be implemented on the effective date for valid providers unless otherwise indicated below:
		<input type="checkbox"/> Approved except for the following sections: Section _____ Line(s) _____ Section _____ Line(s) _____ Section _____ Line(s) _____ Please refer to the attached letter for additional explanation.

The consultant must print name then sign and enter date signed on hard copy of form



Purchasing Plan - Page 6

Signatures – APD Staff

E. Savings Plan	\$ -	
NOTE: The amount going into the Savings Plan each month must be a positive number. If this number is negative, verify that all numerical entries are correct.		\$ - This must equal the Authorized Budget Amount.
APD staff will review the purchasing plan. If the plan meets the consumer's needs and goals and is written correctly then APD staff will sign and date indicating approval		
SIGNATURE Participant or CDC+ Representative		APD Staff (dated by all three required signers.)
~~~~~Signature~~~~~	~~~~~Signature~~~~~	~~~~~Signature~~~~~
~~~~~Print Name~~~~~	~~~~~Print Name~~~~~	~~~~~Print Name~~~~~
~~~~~Date Signed~~~~~	~~~~~Date Signed~~~~~	~~~~~Date Signed~~~~~
Signing this document acknowledges that you developed this Purchasing Plan, that it meets the needs and goals specified on your Waiver Support Plan, and that the paperwork for all providers on the Plan has been submitted to APD for processing.	Signing this document acknowledges that the information is accurate, the Purchasing Plan meets the participant's needs and goals, and that the Plan meets the requirements of the program.	Staff signature indicates that the Purchasing Plan is <b>approved</b> and may be implemented on the effective date for valid providers unless otherwise indicated below:
		<input type="checkbox"/> Approved except for the following sections: Section _____ Line(s) _____ Section _____ Line(s) _____ Section _____ Line(s) _____ Please refer to the attached letter for additional explanation.



# Purchasing Plan - Page 6

## Signatures – APD Staff (continued)

<b>E. Savings Plan</b>	\$ -	
NOTE: The amount going into the Savings Plan each month must be a positive number. If this number is negative, verify that all numerical entries are correct.	<b>Total Monthly Expenditures:</b>	\$ - This must equal the Authorized Budget Amount.
<b>SIGNATURES</b> (This page must always be newly signed and dated by all three required signers.)		
<b>Participant or CDC+ Representative</b>	<b>Consultant</b>	<b>APD Staff</b>
~~~~~Signature~~~~~	~~~~~Signature~~~~~	~~~~~Signature~~~~~
~~~~~Print Name~~~~~		~~~~~Print Name~~~~~
~~~~~Date Signed~~~~~		~~~~~Date Signed~~~~~
Signing this document acknowledges that I have reviewed and approved the Purchasing Plan, that I understand the participant's needs and goals specified on your Waiver Support Plan, and that the paperwork for all providers on the Plan has been submitted to APD for processing.	I have reviewed and approved the Purchasing Plan, that I understand the participant's needs and goals, and that the Plan meets the requirements of the program.	Staff signature indicates that the Purchasing Plan is approved and may be implemented on the effective date for valid providers unless otherwise indicated below:
		<input type="checkbox"/> Approved except for the following sections: Section _____ Line(s) _____ Section _____ Line(s) _____ Section _____ Line(s) _____ Please refer to the attached letter for additional explanation.

Any exceptions will be indicated in the approval exception box. Follow-up by consumer or representative is required



Purchasing Plan Submission Process

consumer Responsibilities:

- ✓ Double-check all information
- ✓ Minimum six (6) completed pages
- ✓ Submit all required paperwork
- ✓ Retain copies
- ✓ Submit by 5th of the month



Purchasing Plan Submission Process

Consultant Responsibilities:

- ✓ Review for accuracy
- ✓ Sign the Purchasing Plan
- ✓ Submit by 10th of the month

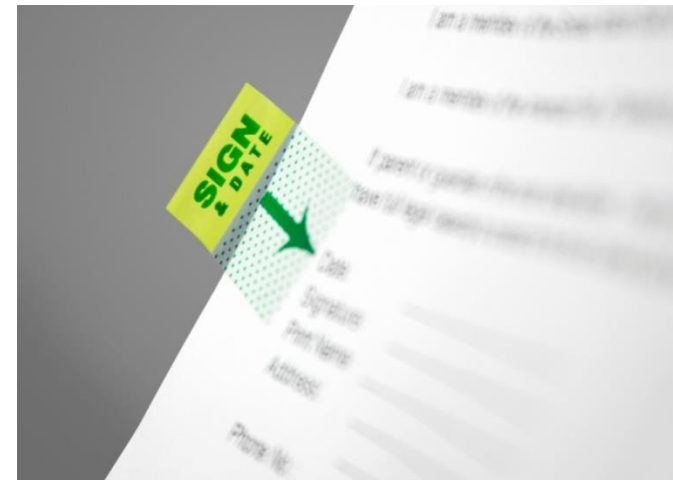




Purchasing Plan Submission Process

Regional Office Responsibilities:

- ✓ Review for accuracy and signatures
- ✓ Ensure all documents enclosed
- ✓ Submit by 20th of the month





Purchasing Plan Approval Process

CDC+ State Office:

- ✓ Reviews submitted documents
- ✓ Returns if revisions are needed
- ✓ Approves and processes documents
- ✓ Assigns provider identification (ID) numbers
- ✓ Contacts new consumer with ID numbers and start date
- ✓ Provides approved Budget Summary copy





Program Activities



**SECTION E: Payroll, Reimbursement,
Corrective Action Plan and Disenrollment**



Learning Outcomes



Explain two outcomes that can result from program mismanagement



Explain two things that can happen for continuously overspending the CDC+ budget



Explain the process for submitting and processing provider payments



Explain the process utilized for paying PENDED claims



Types of Claims

- Directly Hired Employees
 - ✓ Time Sheets (CDC+ Rule Handbook Appendix G-2)
- Vendors (AV, IC)
 - ✓ Invoice
 - ✓ Must be tracked (consumer Notebook Appendix K (3,4))
- Rep Reimbursements (Savings, OTE/STE)
 - ✓ Receipt
 - ✓ Must be tracked (consumer Notebook Appendix K (6))



Claims Submission

- Bi-weekly payroll
 - ✓ Pay Schedule (CDC+ consumer Notebook Appendix O (4))
- CDC+ work week (12:00am midnight Monday - 11:59pm Sunday)



Submitting Payroll



Online Secure Payroll



**Interactive Voice Response
System (IVR)**



CDC+ Customer Service

Warning

CDC+ Secure Web-based Payroll System

is for the exclusive use of current CDC+ consumers and their authorized representatives.

Unauthorized use or access of this application or its resources is strictly

prohibited. Information and its resources may only be used or accessed by explicitly authorized individuals.

Unauthorized use or access of this application or its resources will be prosecuted to the fullest extent of all applicable United States Federal and State of Florida laws.

For more questions regarding your authorization to use this application or its resources, call 1-866-761-7043 Toll Free.

UserName

Password

APD CDC+ Secure Web-based Payroll System

MAIN MENU

is where you are to enter your CDC+ timesheets, invoices, and reimbursement requests.

ing information in this system does not guarantee payment. Payment depends on entry of all information based on your approved Purchasing Plan and availability of funds in your account.

r you have entered and submitted each timesheet, invoice, or reimbursement st, a new screen will appear and will give you a tracking number and instructions on how to check the status of your payment request.

PLEASE SELECT THE FORM YOU WANT TO ENTER

Employee Weekly Timesheet

Agency/Vendor or Independent Contractor Invoice

Consumer or Representative Reimbursement Request

Consumer Statement

Check Transaction Status



agency for persons with disabilities

State of Florida

Employee Weekly Timesheet

Consumer ID: 00000
Employee: 000173 Prev_First_Name1817 Prev_Last_Name1817
THIS IS YOUR TRACKING NUMBER ASSIGNMENT: 1811
Submitted on: 11/4/2009 4:55:18 PM and Passed Adjudicator

Please write down your tracking number or print a copy for your records. It is very important (and it is the consumer/representative responsibility) to check the tracking status and that the consumer/representative use the issued tracking number(s) to check transaction status for each submitted claim a few hours after you enter each timesheet, invoice, or request for reimbursement. If you receive a tracking number of 0 (zero) you need to call Customer Service as soon as possible because this timesheet or invoice has processed incorrectly.

Week: 10/26/2009-11/01/2009 Employee ID: 000173 Prev_First_Name1817 Prev_Last_Name1817

Service Code	Plan/Section	EDD	Hours	Minutes	Total
811	Services	H	27	46	27.75

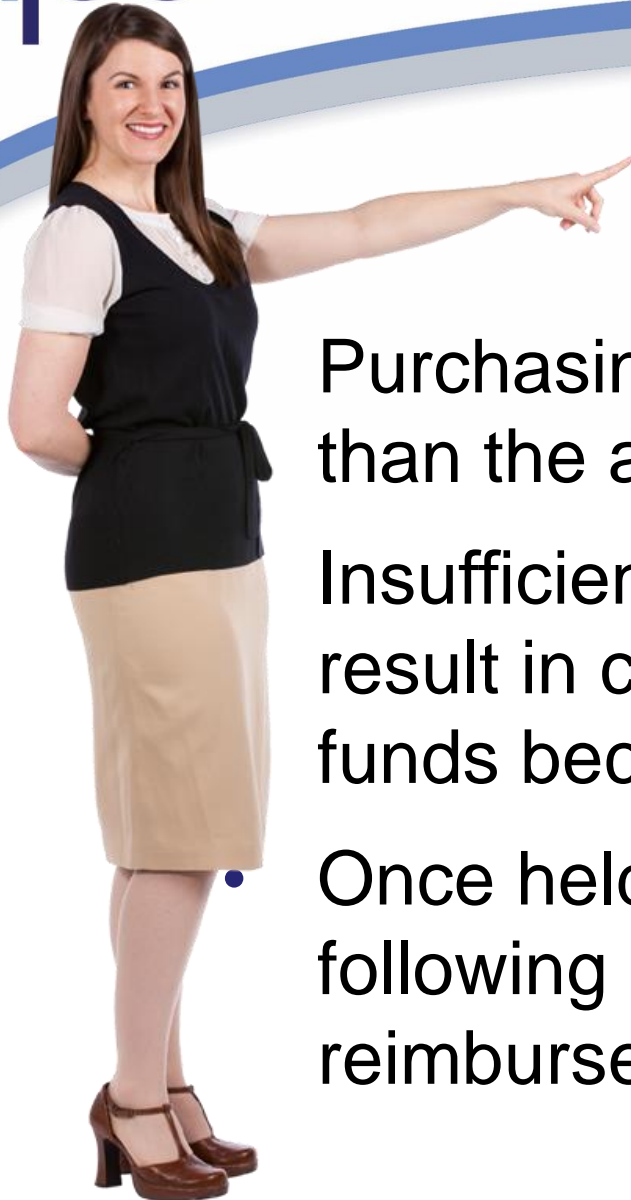
Enter New Timesheet Print Timesheet

©2009 Agency for Persons with Disabilities
This application is best viewed in the following browsers:
Microsoft Internet Explorer 8.0 or higher



Managing Monthly Budget

- Spend within CDC+ monthly budget
 - ✓ Use Calendar consumer Notebook Appendix O (2)
 - ✓ Spend consistent with Purchasing Plan
- Overtime - Not good use of funds
- Reconcile Monthly Statements
 - ✓ consumer Notebook Appendix L (2)
 - ✓ Track current account balance between statements



Overspending

Purchasing supports or services greater than the amount that is authorized

Insufficient funds in a consumer's account result in claims being held until additional funds become available.

- Once held, claims will be reviewed in the following order: timesheets, invoices, reimbursements. PEND payments



Budget Mismanagement

- Budget mismanagement will lead to either
 - ✓ Corrective Action Plan (CAP) (Appendix N)
Not “entitled” to a CAP before other sanctions can occur
 - or
 - ✓ Disenrollment and return to the Waiver





Corrective Action Plan (CAP)

- A tool to assist consumers or representatives to correct problems with mismanagement of the program as required by the 1915j State Plan Amendment.
- Developed and signed by consumer and consultant
- To be developed immediately when consumer/representative
 - ✓ Purchases inconsistently with the approved Purchasing Plan
 - ✓ Overspends
 - ✓ Does not produce receipts, timesheets and invoices upon request
 - ✓ Puts health and safety at risk



Corrective Action Plan (CAP), continued

(Page 1-23 & 1-24 of the CDC+ Rule Handbook)

The CAP plan addresses

- ✓ WHAT has happened/caused the problem
- ✓ HOW the consumer/representative plan to correct the problem
- ✓ WHEN the problem will be corrected
- ✓ WHO is responsible for each step



Involuntary Disenrollment

**Remain eligible
for DD/HCBS
Waiver**

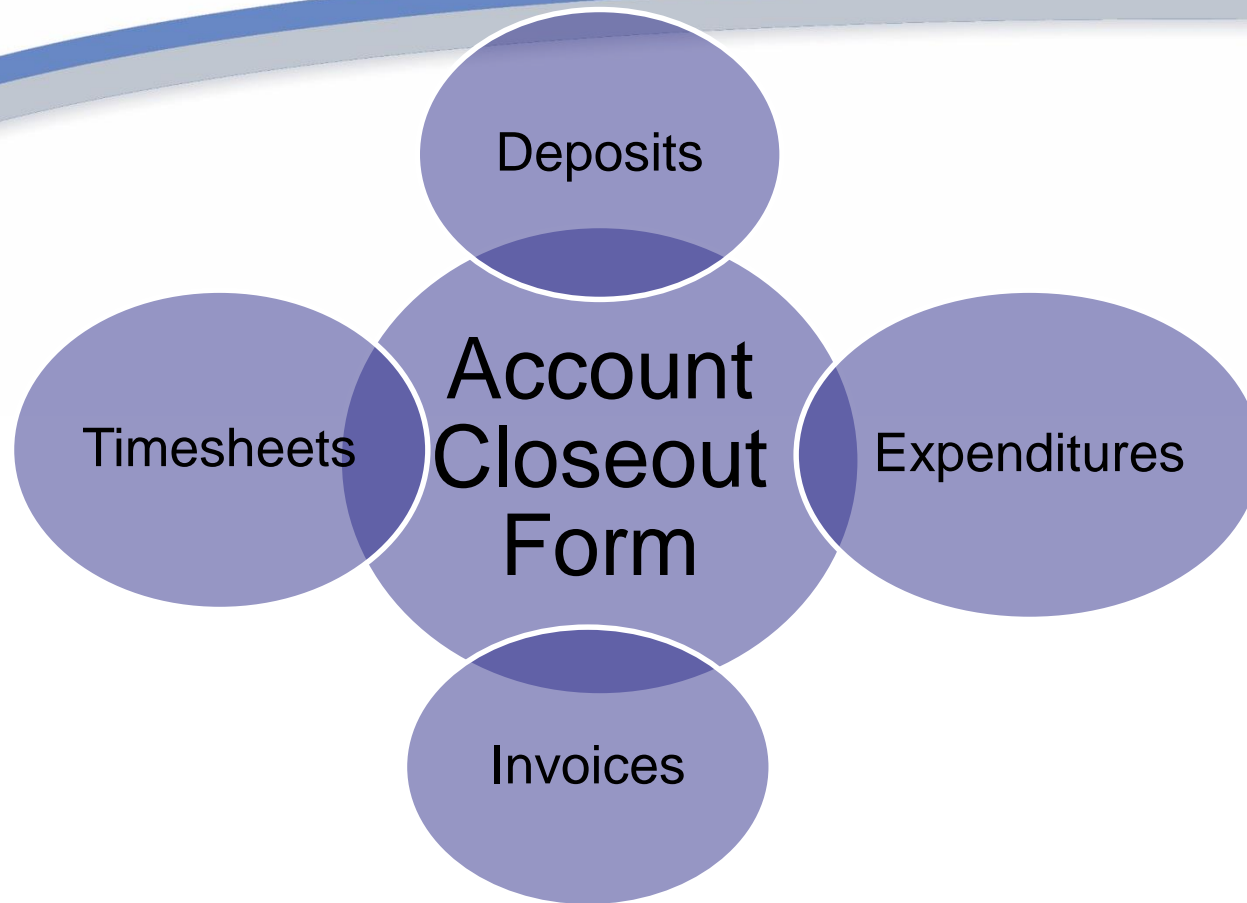
**Continue
services
through
traditional
waiver service
and programs**

**Does not
prevent
recoupment of
improperly
used Medicaid
funds or
resources**

Voluntary Disenrollment

- Consumer elects to discontinue participation in the Consumer-Directed Care Plus (CDC+) program
- (Page 1-10; 1-21 through 1-23 of the CDC+ Rule Handbook)





- CDC+ consumer Information Update Form (Appendix H of the CDC+ Rule Handbook and consumer Notebook Appendix D-XV11)
- CDC+ Account Close-Out Procedure (consumer Notebook Appendix M(3))



Terms to Review

- ✓ **Roles and Responsibilities**
- ✓ **Critical Service**
- ✓ **Restricted Service**
- ✓ **STE- Short Term Expenditure**
- ✓ **Pended Claims**
- ✓ **Representative Reimbursement**
- ✓ **CAP- Corrective Action Plan**



Congratulations! **You have completed the** **Representative Training**



- ✓ **Complete and submit the Course Assessment in order to receive a Certificate of Completion Readiness Review**

<http://apd.myflorida.com/cdc-plus/refreshform1.php>

Evaluations

<http://www.surveymonkey.com/s/HF5GNDH>

You will be contacted if you need to retake the Assessment.

- ✓ **Pass with 85% or better**



Thank you for your participation

For additional questions, please call:

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CDC+ Customer Service

1-866-761-7043

CDC+ Website <http://apdcares.org/cdcplus/>