agency for persons with disabilities
State of Florida

Consumer/Representative Training 2014

Rick Scott
Governor

Barbara Palmer
Director

Introductions

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

- Identify the Five Principles of Self Determination
- Describe the roles and responsibilities of Participant, Representative, Consultant, Regional and State Office
- Describe different provider types
- Demonstrate how to write a Purchasing Plan
- Describe how to submit a Purchasing Plan
- Describe how to properly manage a CDC+ Budget
- Demonstrate how to reconcile the account

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

CDC+ Participant Notebook (under revision)

Appendix to the CDC+ Participant Notebook

http://apdcares.org/cdcplus/participants

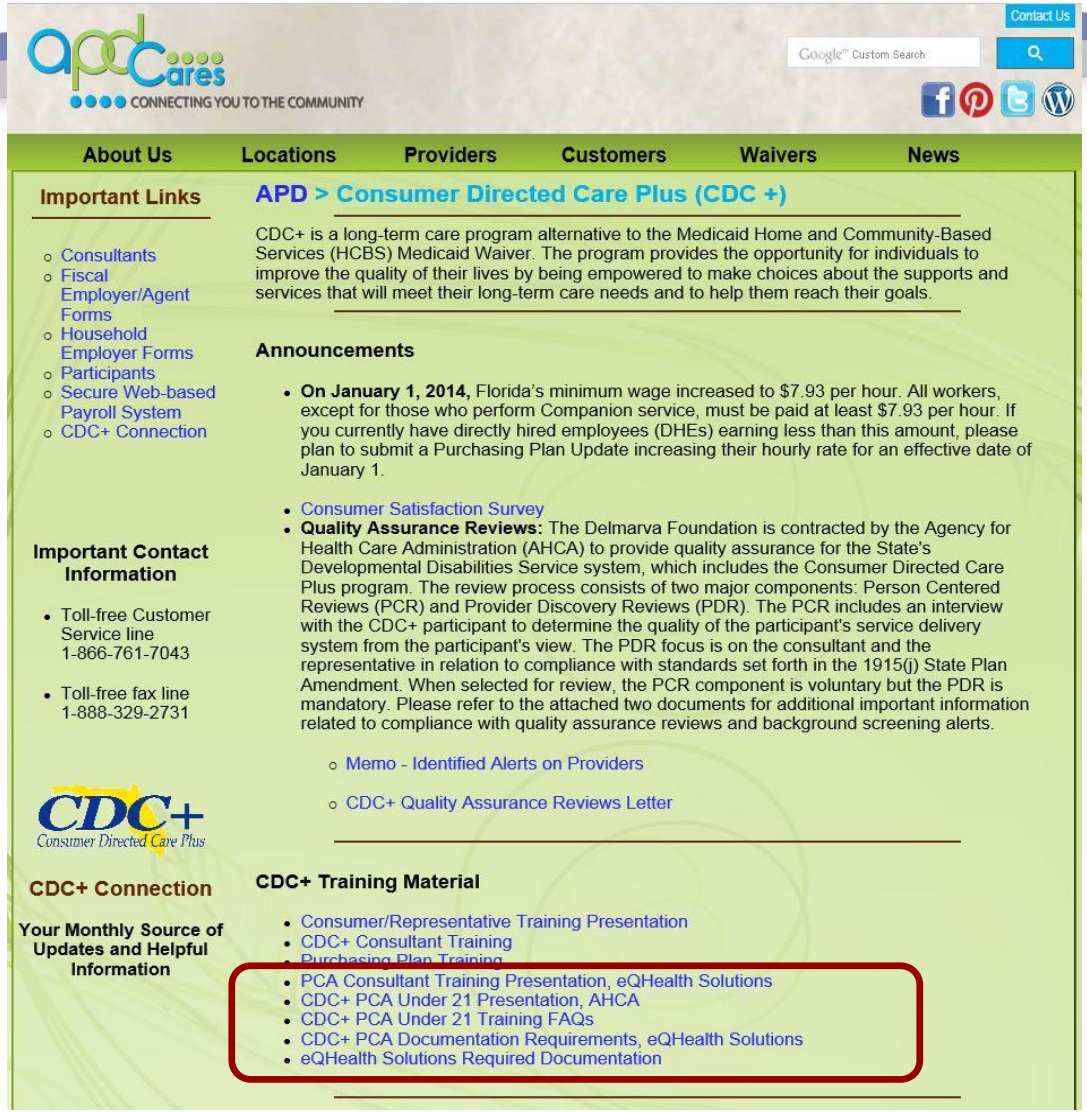
PCA Under 21

eQHealth Solutions

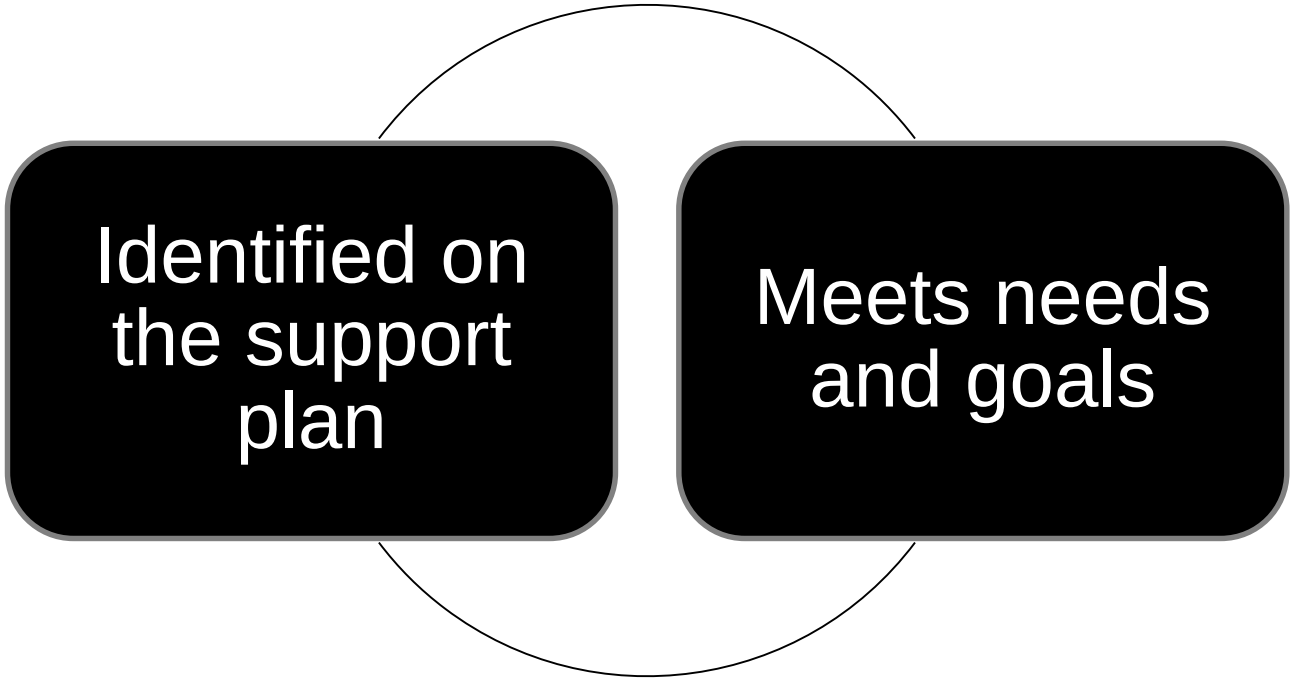
6-month maximum

Change requires Plan update

PCA forms on CDC+ website



Allowable Purchases



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

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 Participant Notebook:
  http://apdcares.org/cdcplus/docs/appendix/service-codes.xls

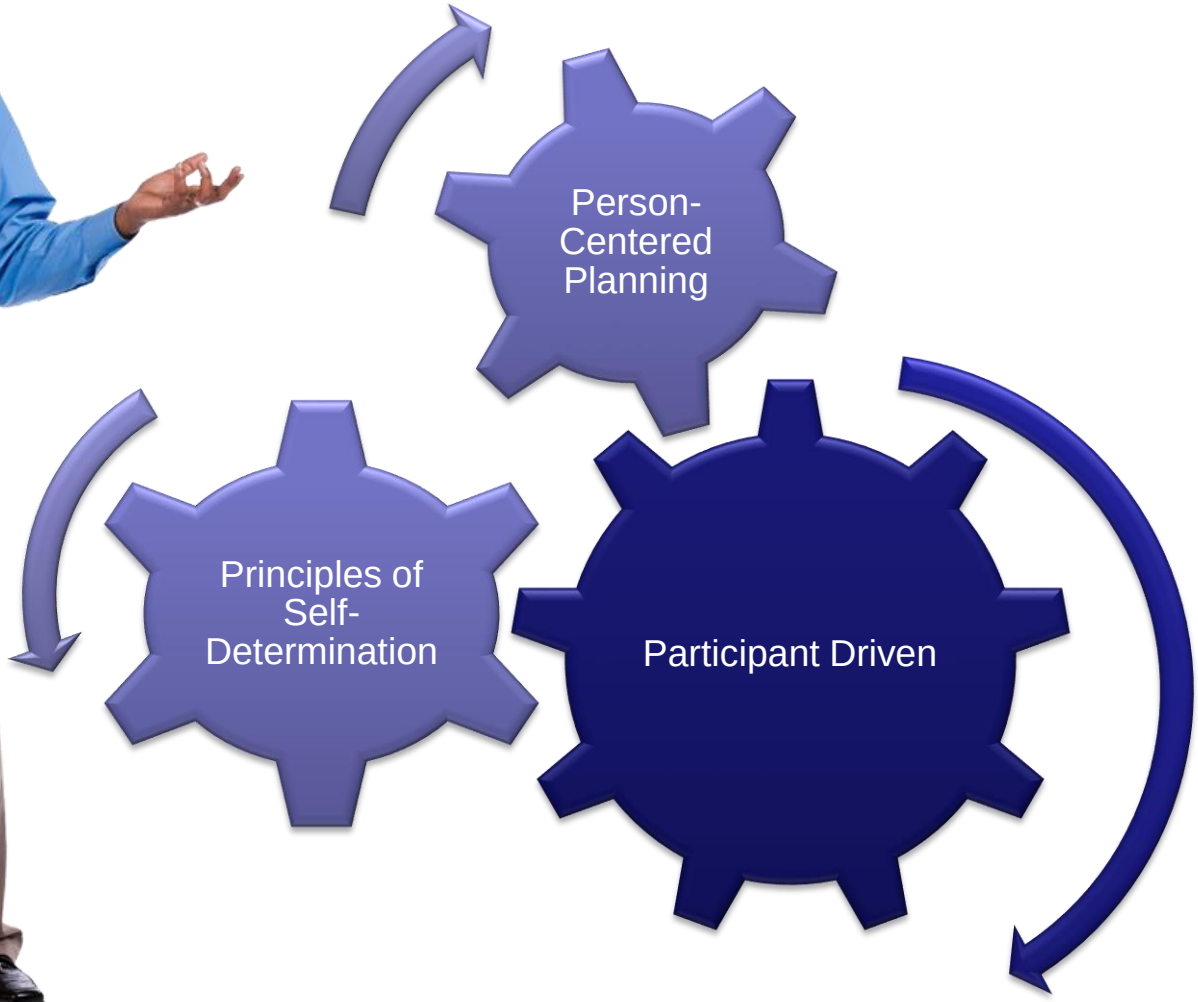
CDC+
Consumer-Directed Care Plus

2000
- Consumer Directed Care (CDC)

Jan 2004
- Consumer Directed Care Plus (CDC+)

Mar 2008
- CDC+ (permanent Medicaid State Plan Option)

What is CDC+ All About?



Responsibility

Control

Support

Authority

Freedom

The Participant 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

- Participant
- Representative
- Consultant
- Regional Liaison
- State Office

Role of Participant (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 Participant, 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 Participant
- Unpaid Advocate; at least 18 years of age
- Sign an agreement with the Participant
- Readily available to Participant 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 participant/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 participant account activity

Role of the Consultant, continued

- Keeps active contact with Participant
  - ✓ Monthly – by phone
  - ✓ Bi-annually – two face-to-face per year, one of which must be in the participant'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

- Reviews Purchasing Plans
- Facilitates employee background screening
- Bridges the communication between participant, 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

Quality Assurance Requirement

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

Steps for CDC+ Participant Enrollment

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

Steps for CDC+ Participant 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+ Participant 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) after reviewing and approving the application and enrollment packets
- Participant chooses supports and services
- Participant interviews potential providers

Steps for CDC+
Participant Enrollment, continued

Participant will…

- Ensure providers complete background screening requirements
- Send to the CDC+ consultant for review
  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

Steps for CDC+ Participant Enrollment, continued

- Consultants must receive Plan by the 5th of the month for enrollment on the 1st of the following month
- Allow at least 3-4 weeks for processing
- CDC+ Customer Service
  - Notifies participants when they are authorized to start on CDC+
  - Provides employee ID numbers

Steps for CDC+
Participant Enrollment, continued

Participants can avoid delays in enrollment by ensuring that the Purchasing Plan and Provider Packets are free of errors and missing or incomplete information

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

Calculating the Monthly Budget

- Budget calculation worksheet (Participant 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 receives100% 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

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

Cost Plan Dates:	7/1/2013	to	6/30/2014	This calculation to is to determine the monthly budget for CDC+ Purchasing Plan Effective:	10/1/2013

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	$ 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**	

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

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

Drag and drop the red circle onto the correct monthly budget.

OR **4% CALC**

$	2,753.18
	0.92
$	2,532.93
$	(110.13)
This is the CDC+ Monthly Budget	**$ 2,422.80**

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

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.

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				$ -
				$ -

Calculation of STE

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.
				$ -
				$ -
				$ -
				$ -

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

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 participant'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)

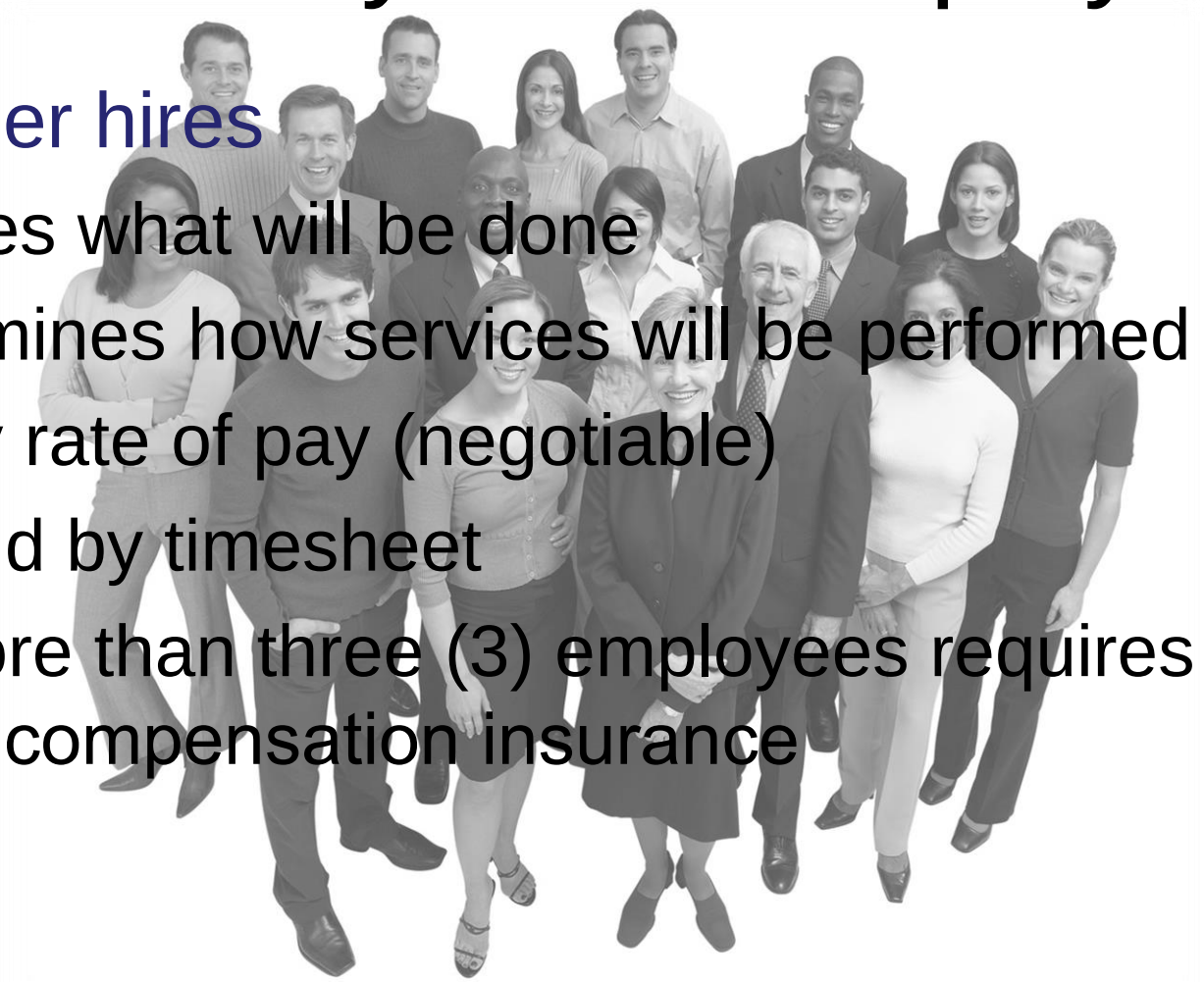
How to Find, Hire and Manage Providers?

- 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
- **Participant 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

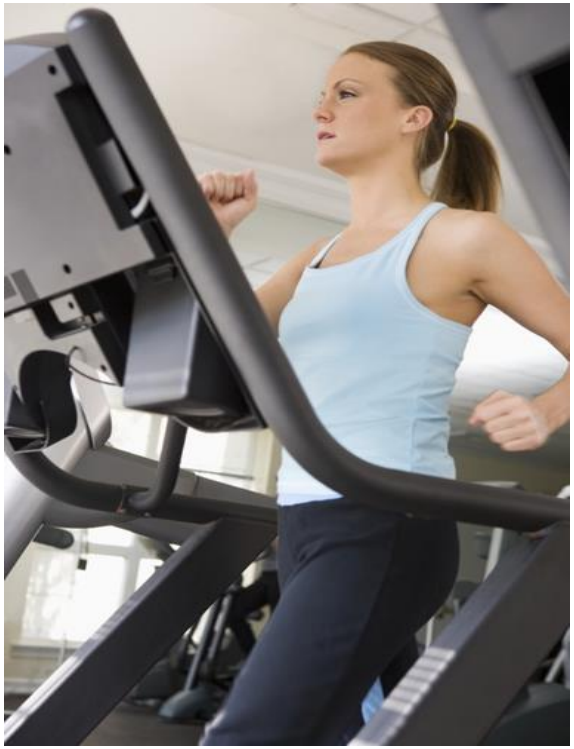
- This is a decision that needs to be carefully considered by the employee.
- Visit IRS.gov to look at the Household Employer's Tax Guide, IRS Publication 926 and www.myflorida.com/dor to look at the Employer Guide to Unemployment Tax, UCT- 800002

Offering Benefits at No Additional Cost

- Value your employees
- Pay at fair wage (must follow minimum wage requirements – as of 1/1/14 $7.93 an hour)
- Companion is only service exempt from min. wage
- 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

Purchasing Plan Exercise

- Walk through the Purchasing Plan review process



Purchasing Plan – Appendix E

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

Purchasing Plan – Timelines

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

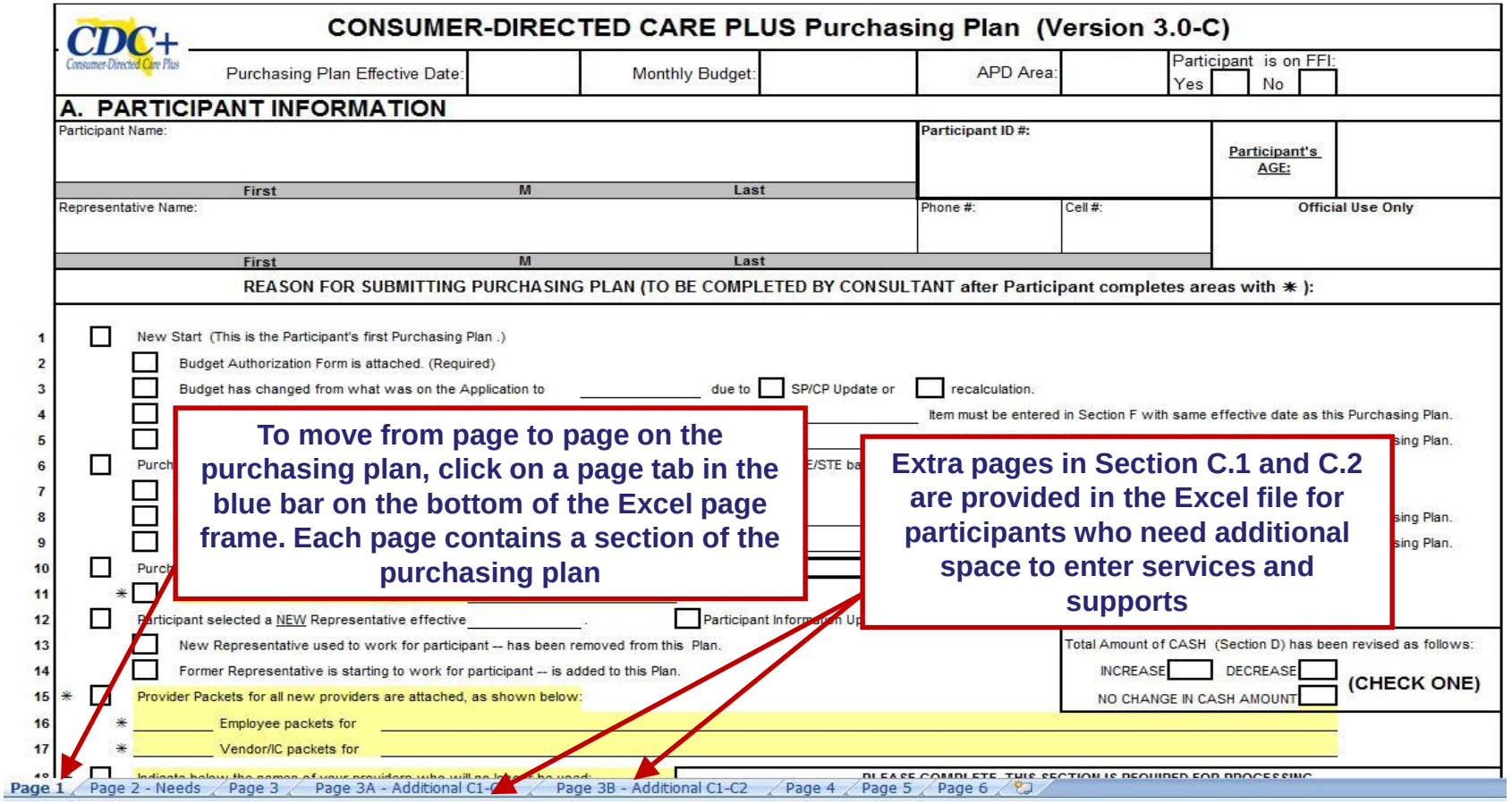
Purchasing Plan Instructions

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

Q & A (time permitting)

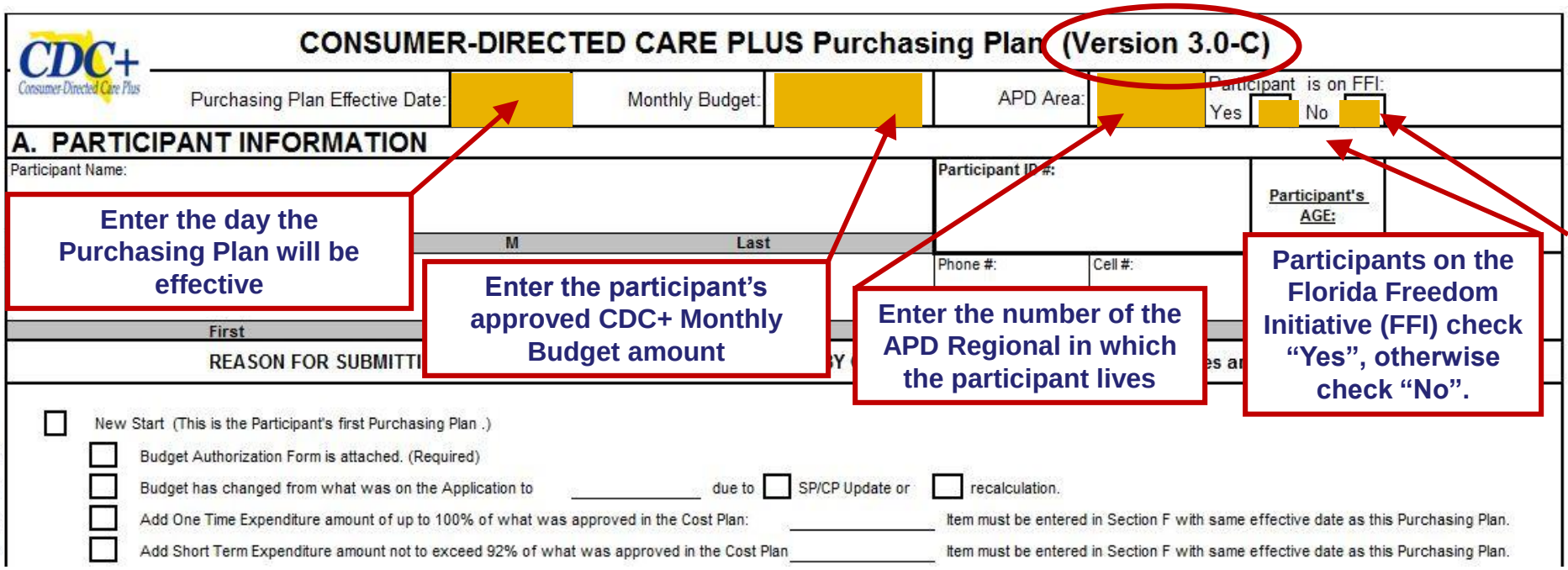
Lunch Break

The CDC+ Purchasing Plan



CDC+ Purchasing Plan
Page 1 - Top

Provide the required information



Enter the day the Purchasing Plan will be effective

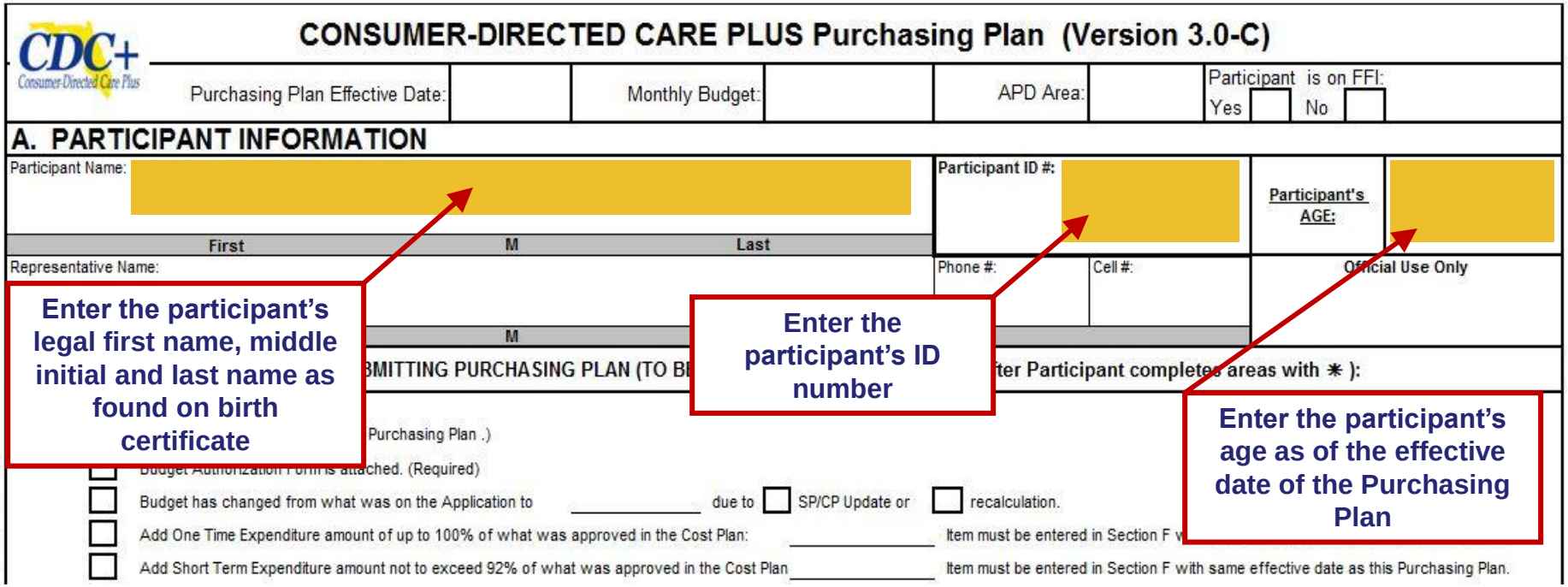
Enter the participant's approved CDC+ Monthly Budget amount

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

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

Purchasing Plan - Page 1

Section A – Participant Information



CDC+ Consumer-Directed Care Plus

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

Purchasing Plan Effective Date: | Monthly Budget: | APD Area: | Participant is on FFI: Yes ☐ No ☐

A. PARTICIPANT INFORMATION

Participant Name: (First / M / Last) | Participant ID #: | Participant's AGE:

Representative Name: | Phone #: | Cell #: | Official Use Only

...BMITTING PURCHASING PLAN (TO BE ... ter Participant completes areas with ✳):

1 ... Purchasing Plan .)

2 ☐ Budget Authorization Form is attached. (Required)

3 ☐ Budget has changed from what was on the Application to _____ due to ☐ SP/CP Update or ☐ recalculation.

4 ☐ 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 ☐ 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.

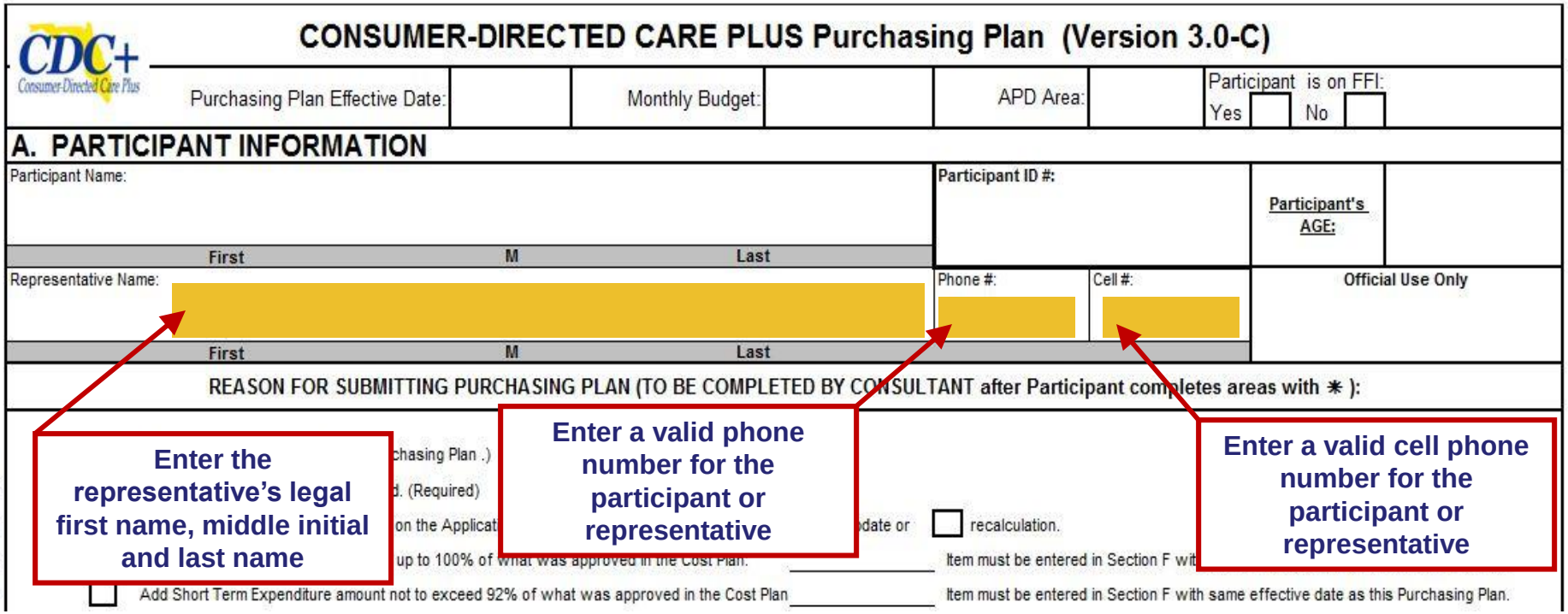
Enter the participant's legal first name, middle initial and last name as found on birth certificate

Enter the participant's ID number

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

Purchasing Plan - Page 1

Section A – Participant Information (continued)



CDC+ Consumer-Directed Care Plus

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

Purchasing Plan Effective Date: | Monthly Budget: | APD Area: | Participant is on FFI: Yes ☐ No ☐

A. PARTICIPANT INFORMATION

Participant Name: (First / M / Last) | Participant ID #: | Participant's AGE:

Representative Name: (First / M / Last) | Phone #: | Cell #: | Official Use Only

REASON FOR SUBMITTING PURCHASING PLAN (TO BE COMPLETED BY CONSULTANT after Participant completes areas with ✳):

1 ☐ chasing Plan .)
2 d. (Required)
3 on the Applicat ☐ date or ☐ recalculation.
4 up to 100% of what was approved in the Cost Plan. _____ Item must be entered in Section F wit
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.

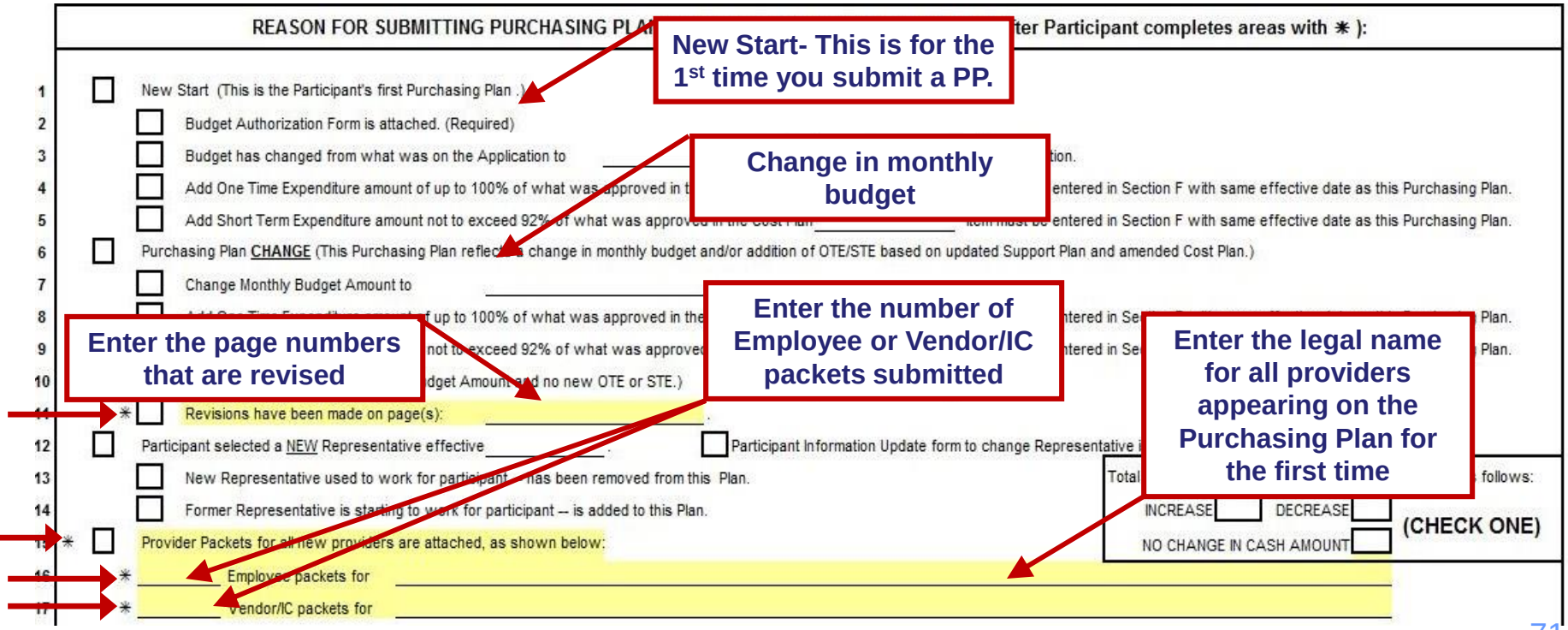
Enter the representative's legal first name, middle initial and last name

Enter a valid phone number for the participant or representative

Enter a valid cell phone number for the participant or representative

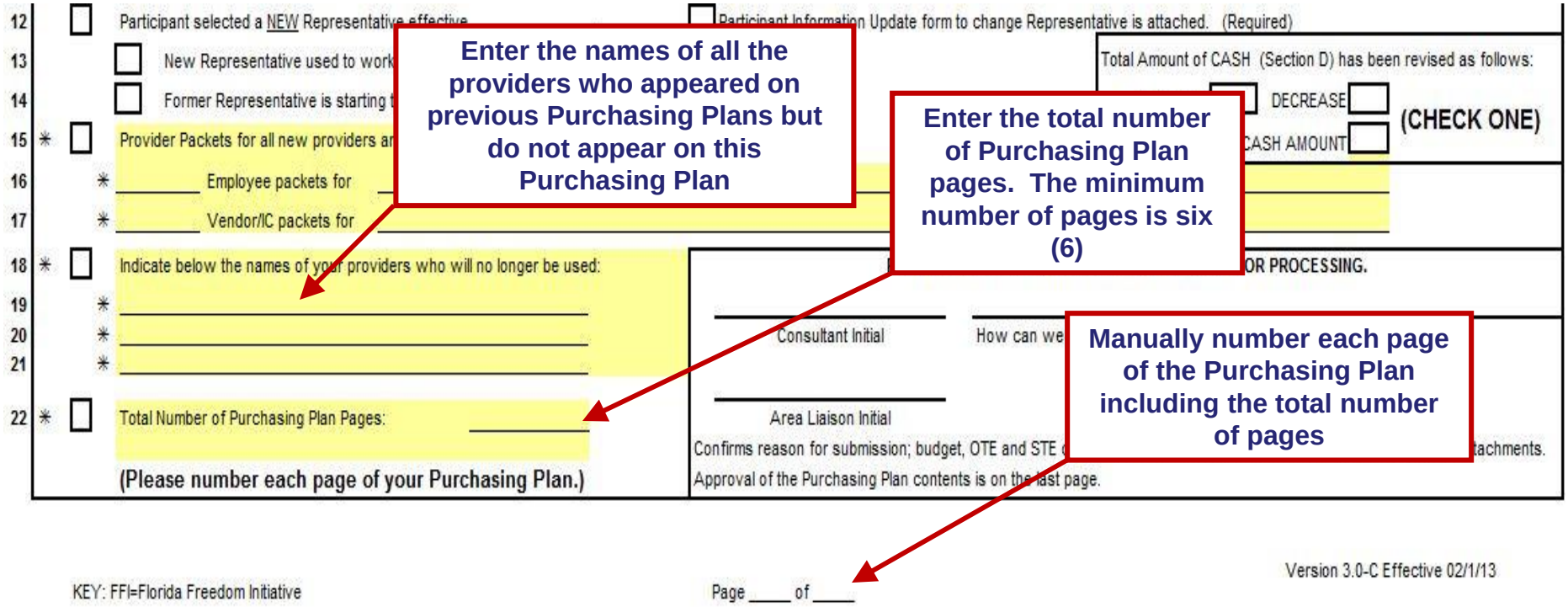
Purchasing Plan - Page 1

Section A – Reason for Submitting Purchasing Plan



Purchasing Plan - Page 1

Section A – Reason for Submitting Purchasing Plan (continued)



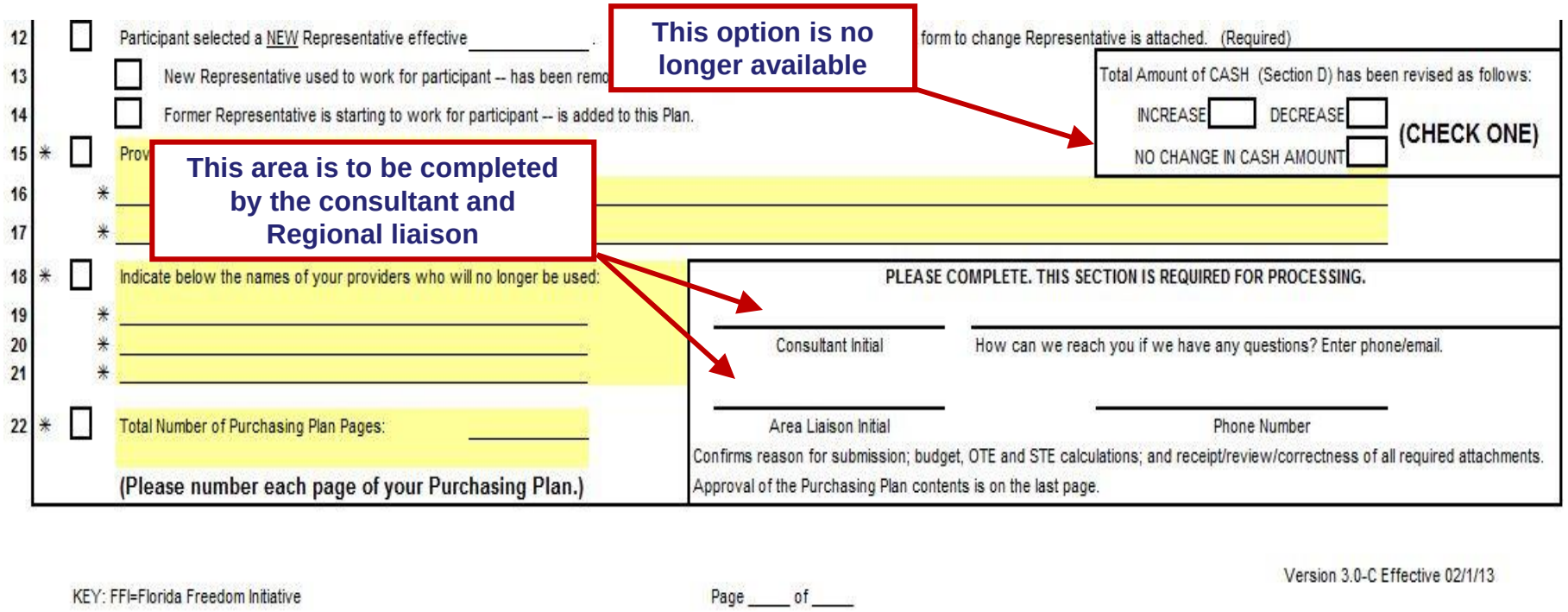
Enter the names of all the providers who appeared on previous Purchasing Plans but do not appear on this Purchasing Plan

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)



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.

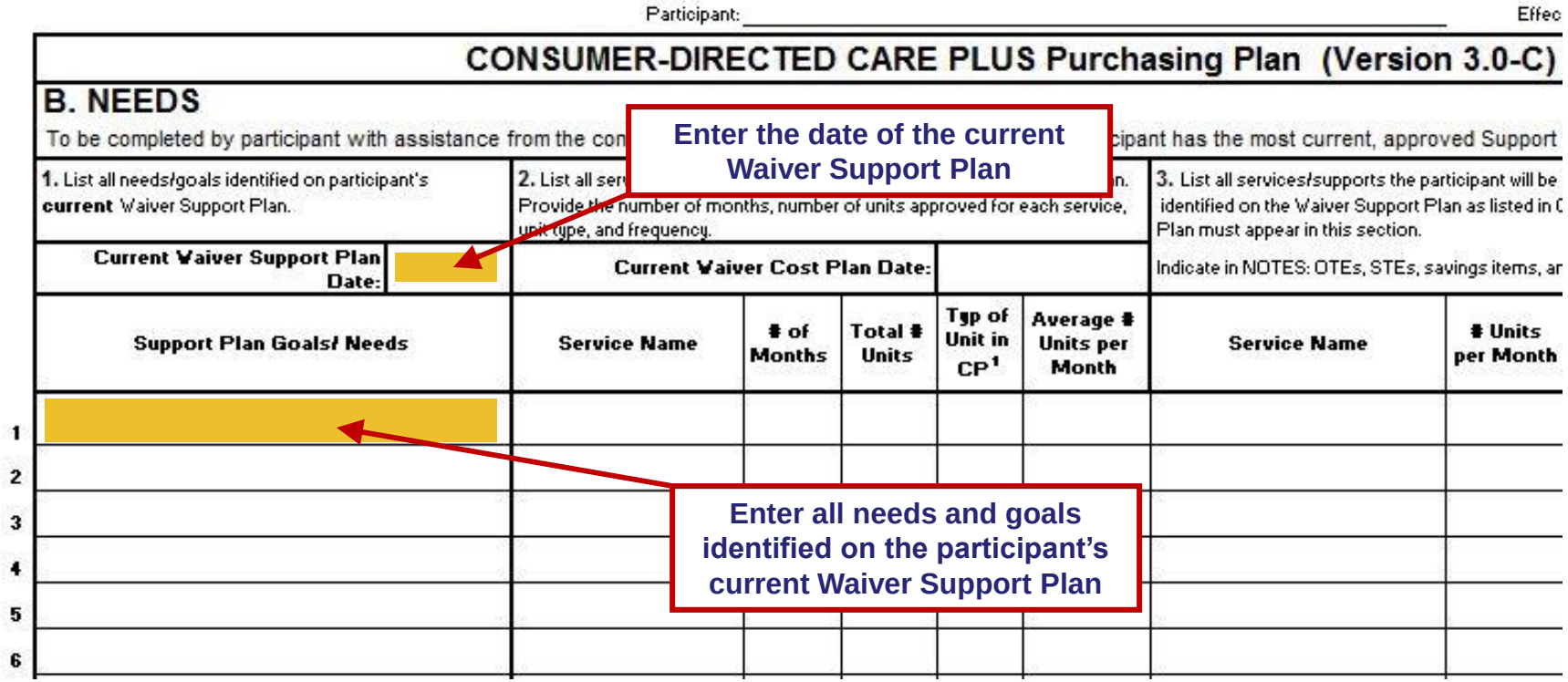
	1. List all needs/goals identified on participant's	2. List all services and supports approved on the current Waiver Cost Plan. ...r of months, number of units approved for each service, ...ency. ...nt Waiver Cost Plan Date:					3. List all services/supports the participant will be using to meet the 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.			
		...me	# of Months	To... U...				...its ...onth	Typ of Unit in PP²	NOTES: OTEr, STEr, Savings items, Natural Support
1										
2										
3										
4										

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

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

Purchasing Plan - Page 2

Section B – Needs – Column 1



Participant: _____ Effec

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

B. NEEDS

To be completed by participant with assistance from the con… …cipant has the most current, approved Support

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

2. List all ser… …n. 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…

Current Waiver Support Plan Date:

Current Waiver Cost Plan Date:

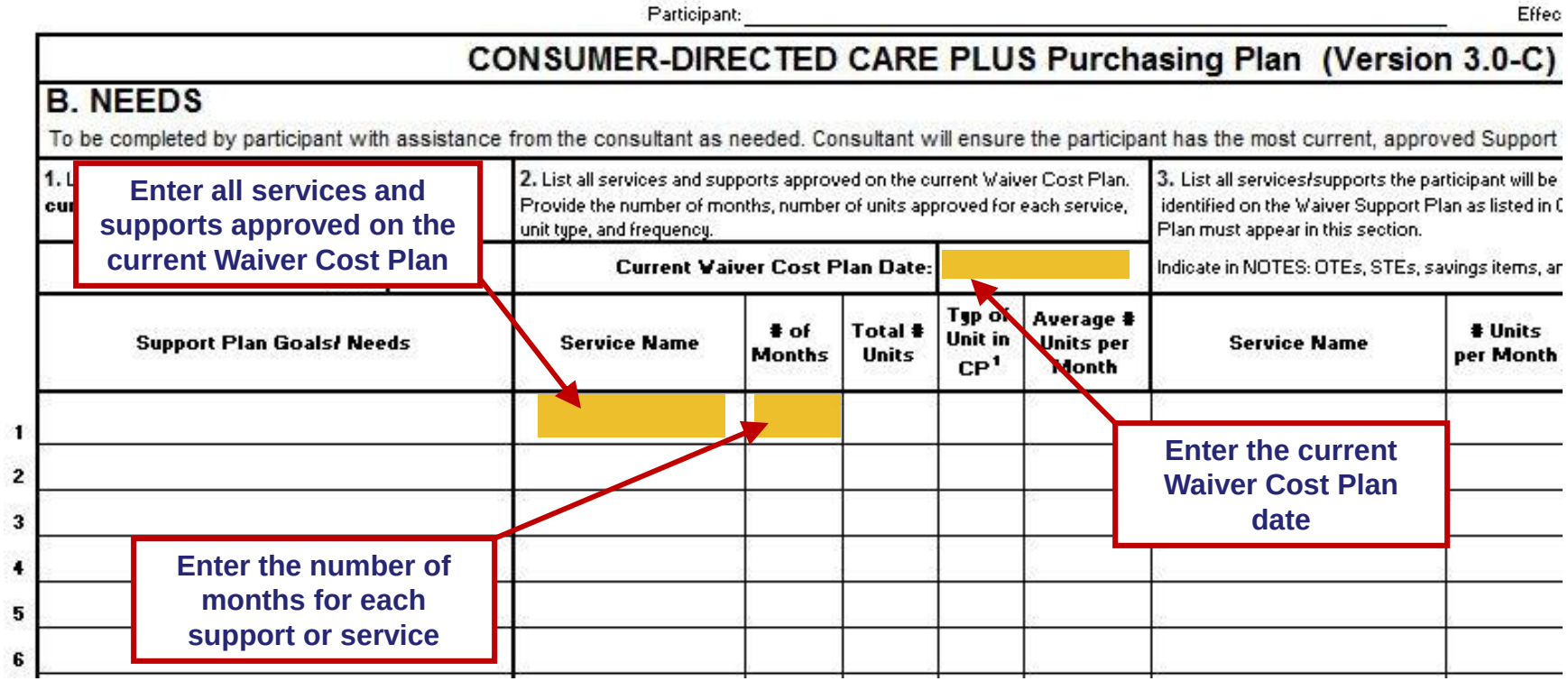
	Support Plan Goals/ Needs	Service Name	# of Months	Total # Units	Typ of Unit in CP[1]	Average # Units per Month	Service Name	# Units per Month
1								
2								
3								
4								
5								
6								

Enter the date of the current Waiver Support Plan

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

Purchasing Plan - Page 2

Section B – Needs – Column 2



Participant: _____ Effec

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. L cur

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.

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								

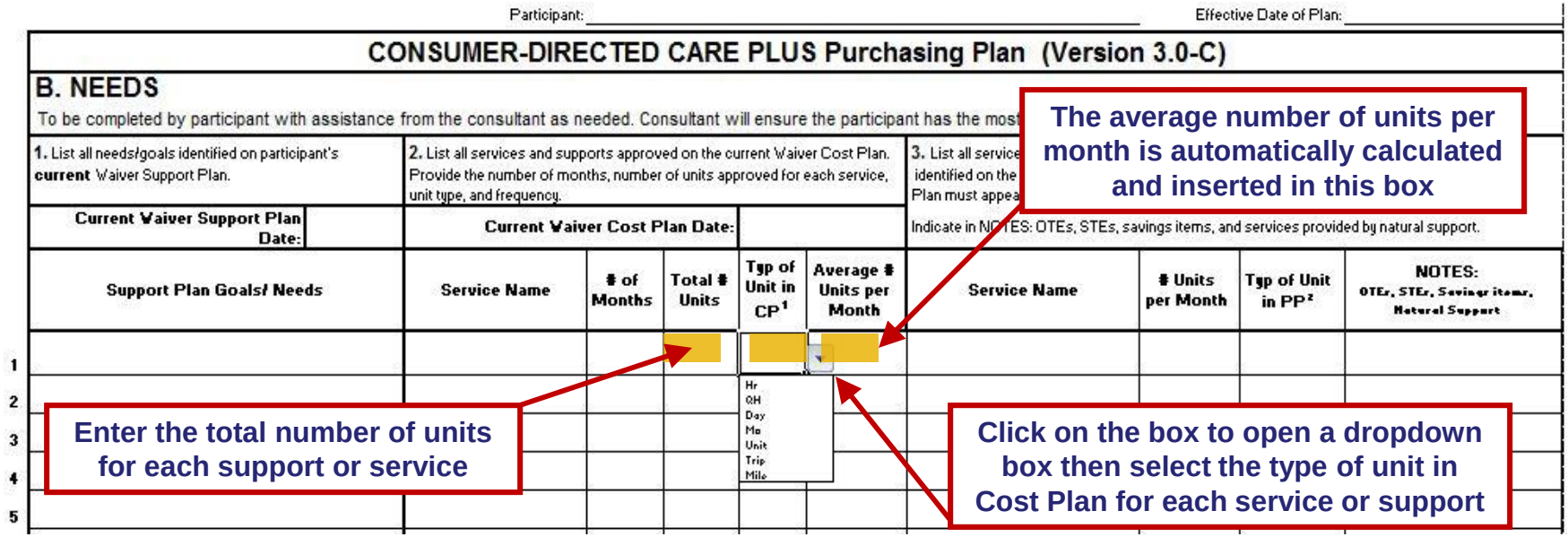
Enter all services and supports approved on the current Waiver Cost Plan

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 service identified on the Plan must appea
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	Typ of Unit in CP[1]	Average # Units per Month	Service Name	# Units per Month	Typ of Unit in PP[2]	NOTES: OTEs, STEs, Savings items, Natural Support
1										
2										
3										
4										
5										

Hr
6H
Day
Mo
Unit
Trip
Mile

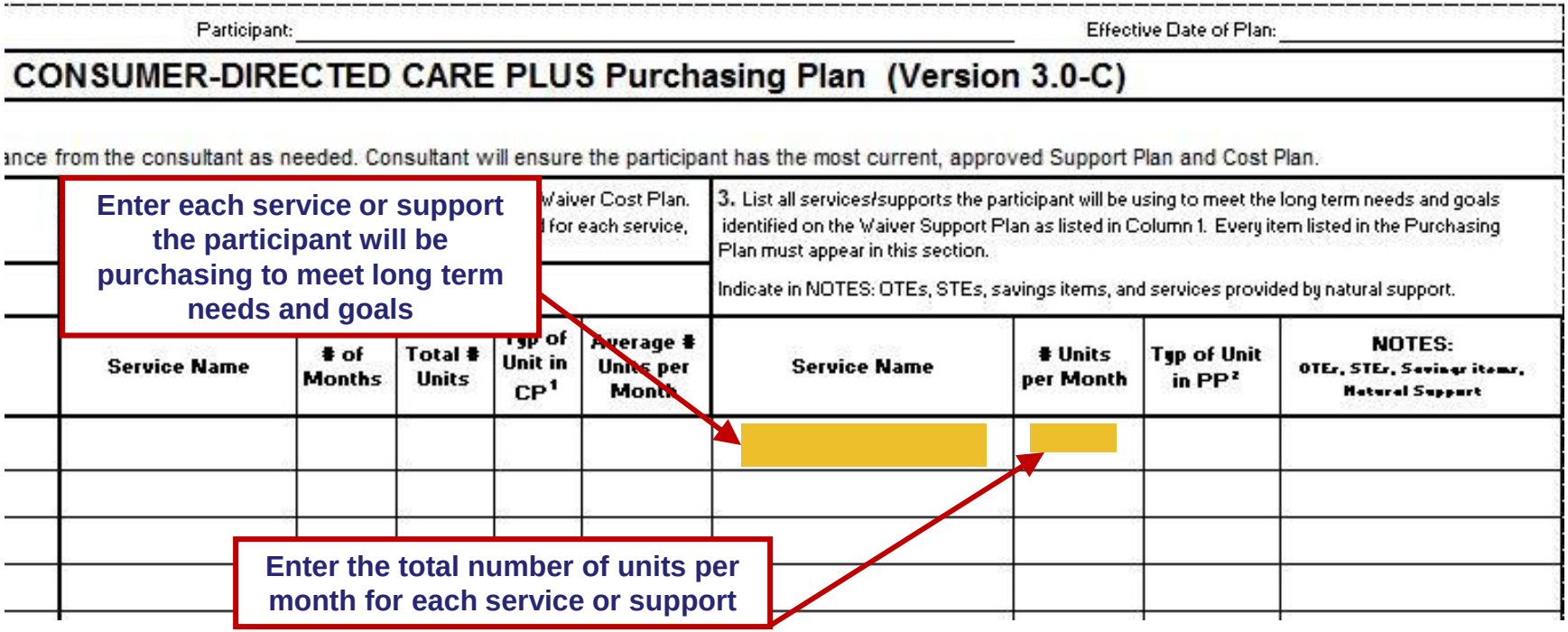
The average number of units per month is automatically calculated and inserted in this box

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.

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.

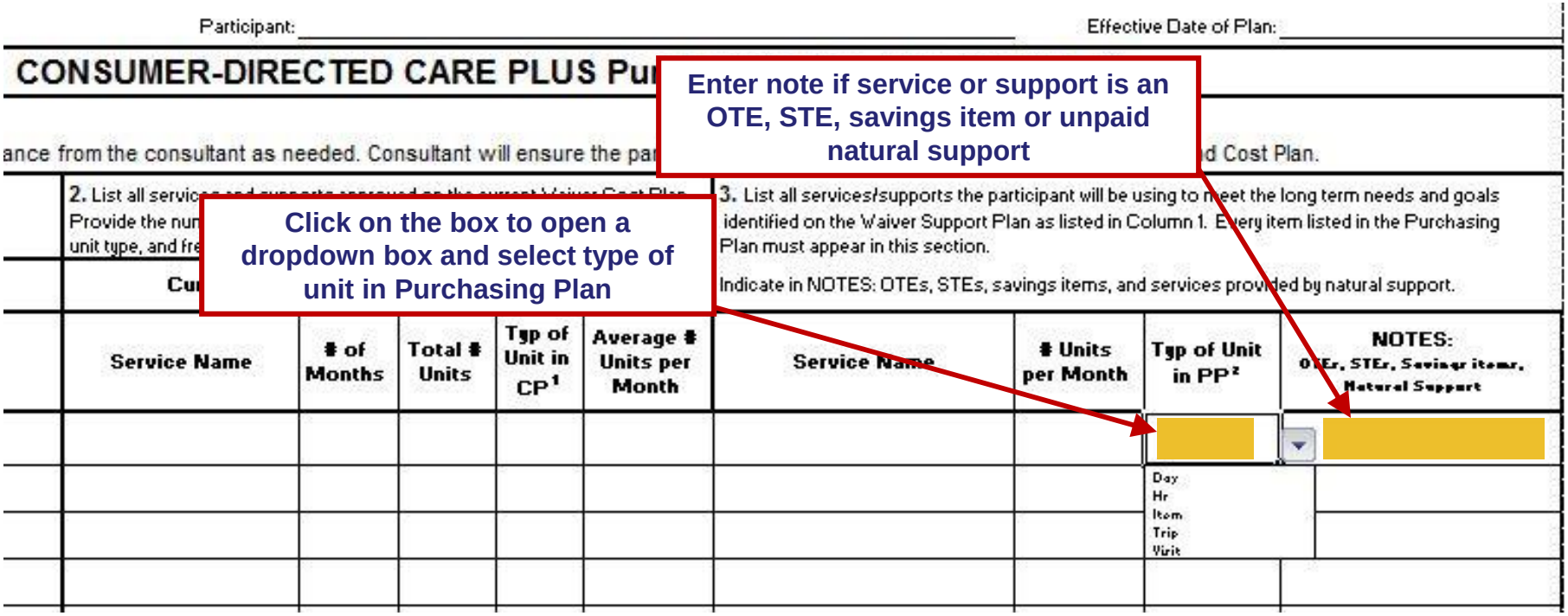
Service Name	# of Months	Total # Units	Typ of Unit in CP[1]	Average # Units per Month	Service Name	# Units per Month	Typ of Unit in PP[2]	NOTES: OTEs, STEs, Savings items, Natural Support

Enter each service or support the participant will be purchasing to meet long term needs and goals

Enter the total number of units per month for each service or support

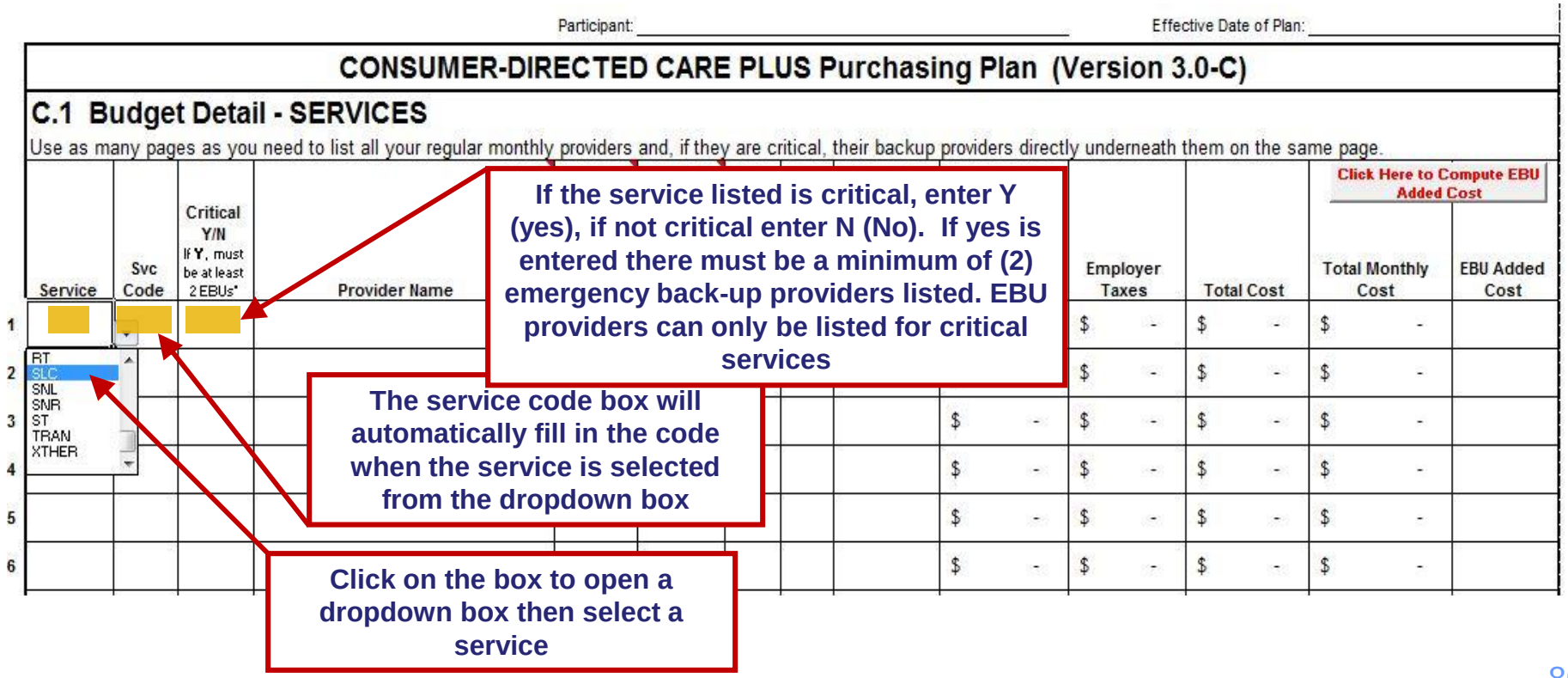
Purchasing Plan - Page 2

Section B – Needs – Column 3



Purchasing Plan - Page 3

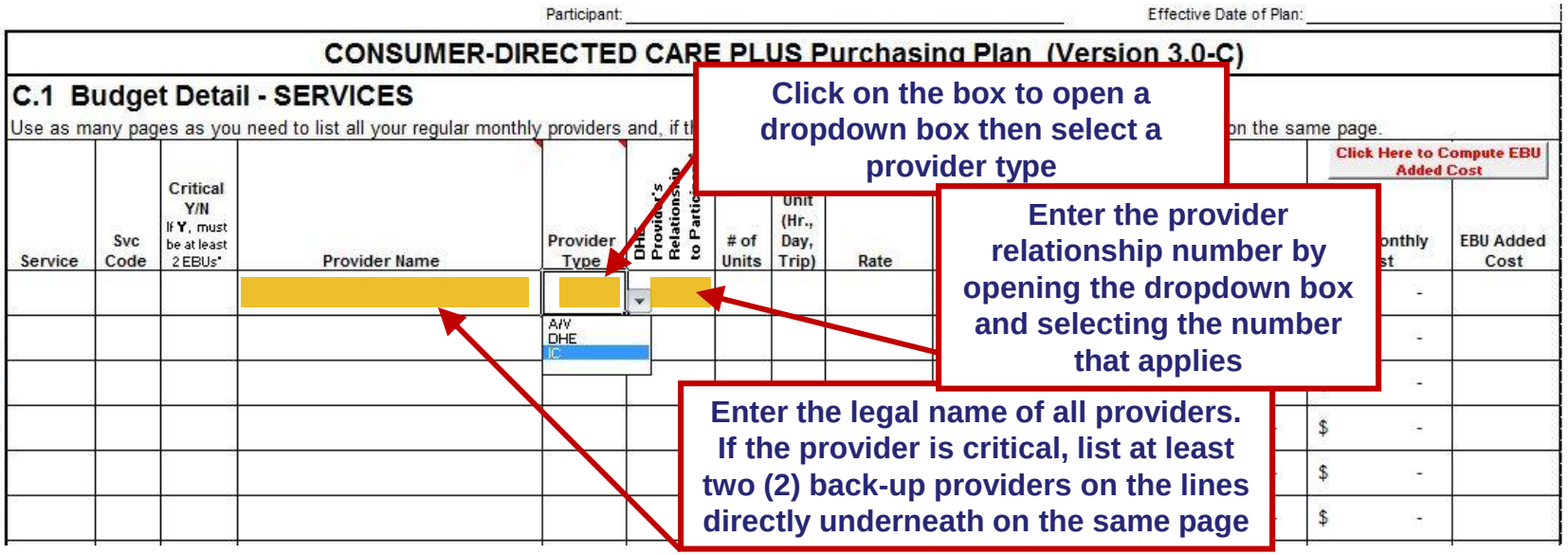
Section C.1 – Budget Details – Services



Purchasing Plan - Page 3

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

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



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								Hr. Day Trip		$ -	$ -	$ -	$ -	
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

ed to list all your regular monthly providers and, if they are critical, their backup providers directly underneath them on th

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
						$ -	$ -	$ -	$ -	
						$ -	$ -	$ -	$ -	
						$ -	$ -	$ -	$ -	
						-	$ -	$ -	$ -	

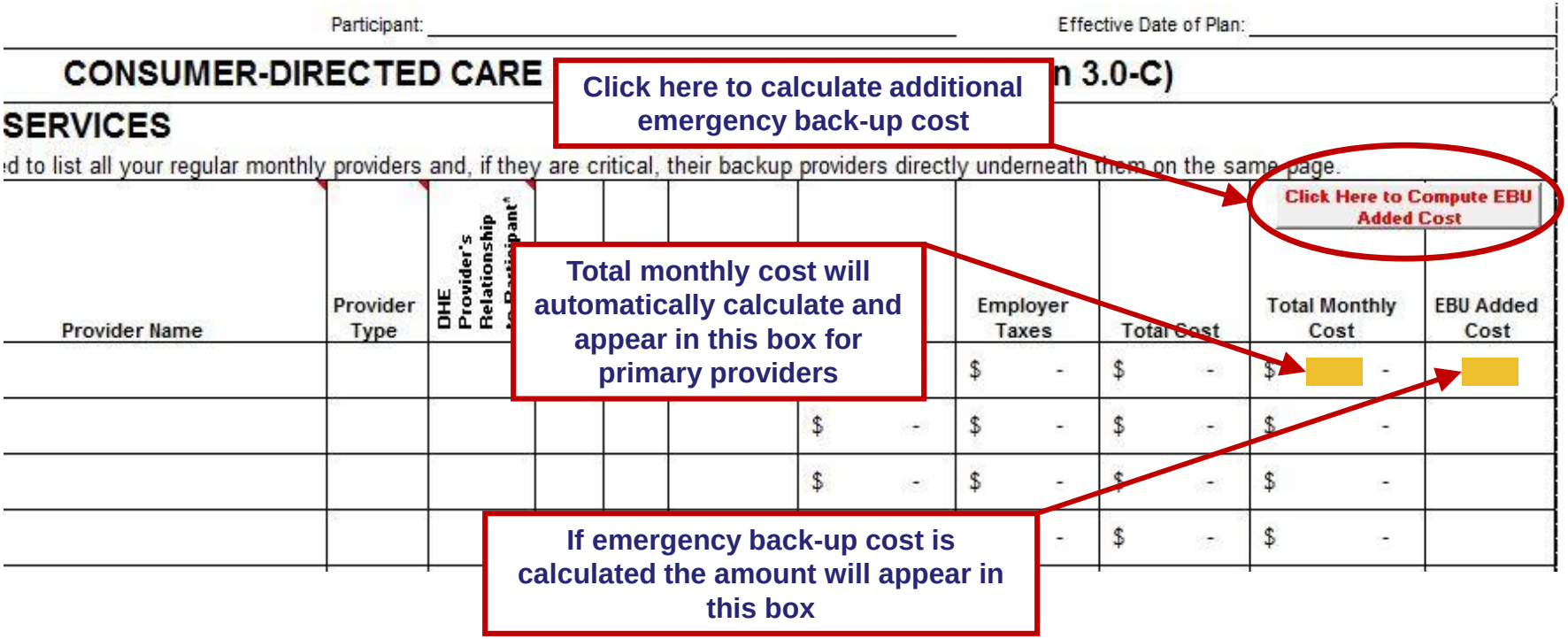
Provider total cost automatically calculates

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

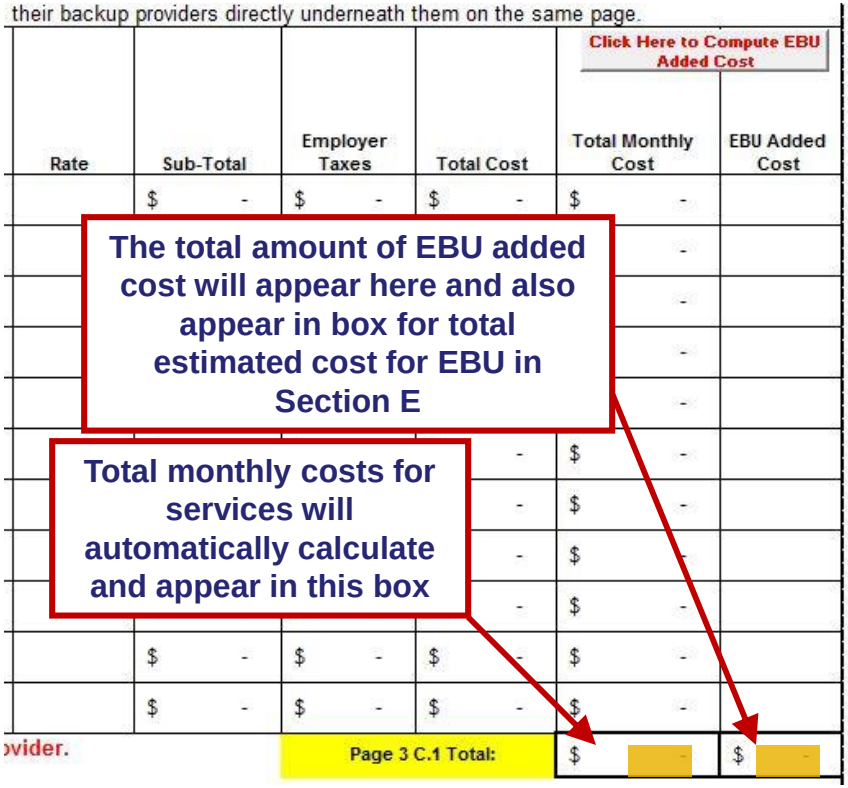
Purchasing Plan - Page 3

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



Purchasing Plan - Page 3

Section C.1 – Budget Details – Services – Totals

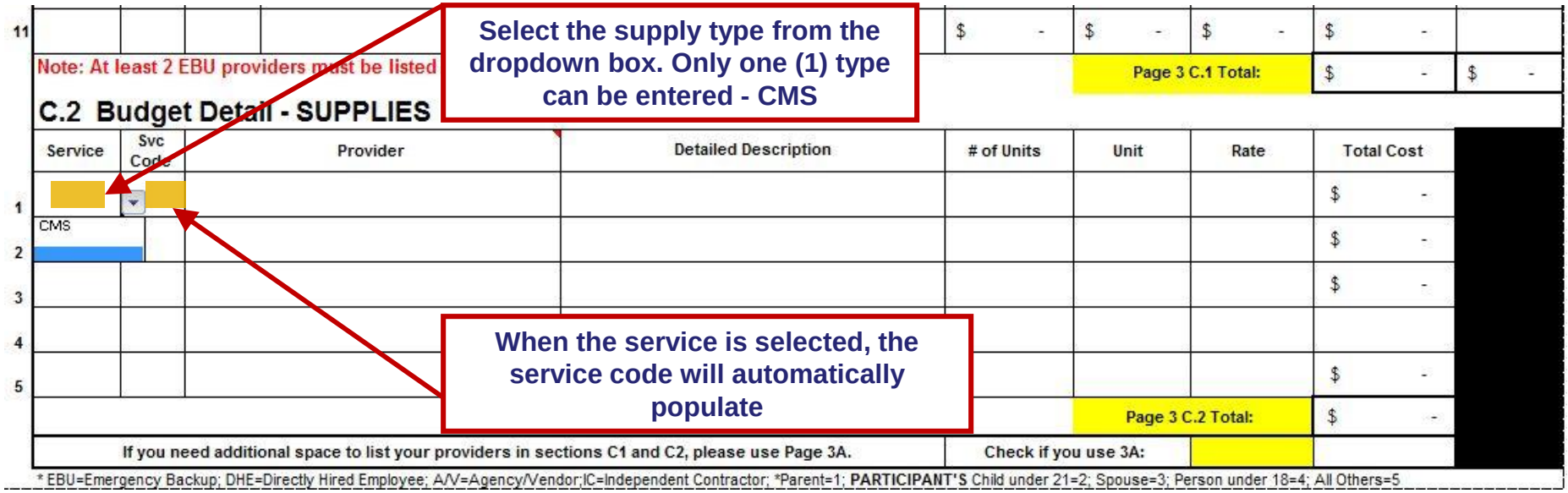


Purchasing Plan - Page 3

Section C.2 – Budget Details – Supplies

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

CMS – Consumable Medical Supplies (63)



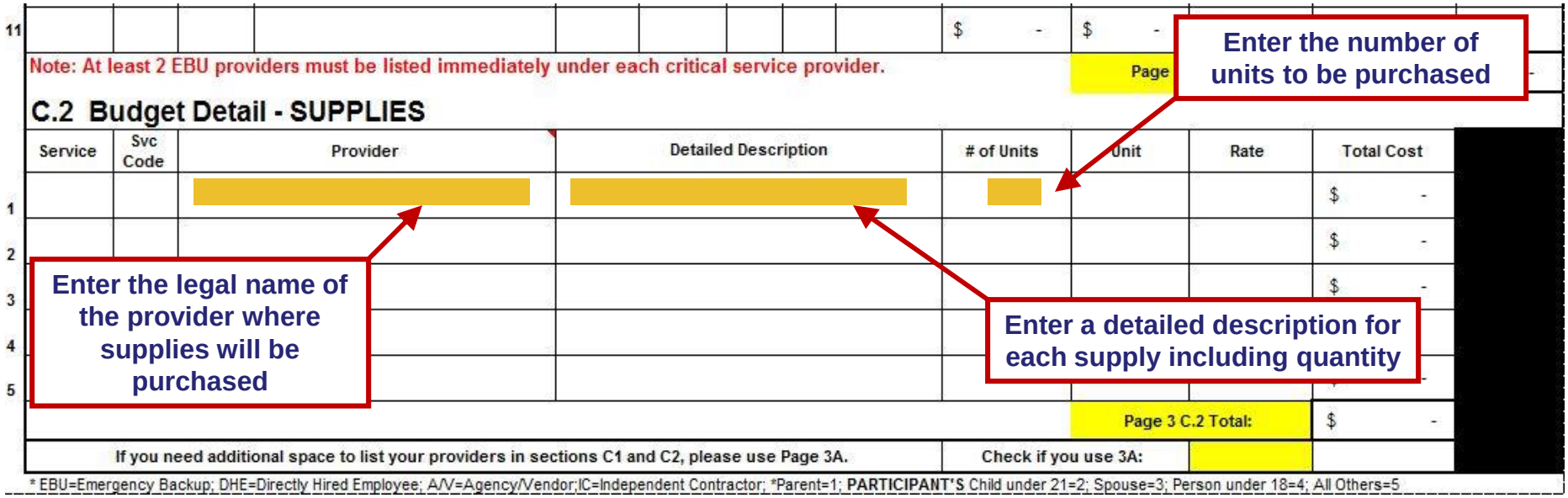
Purchasing Plan - Page 3

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

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

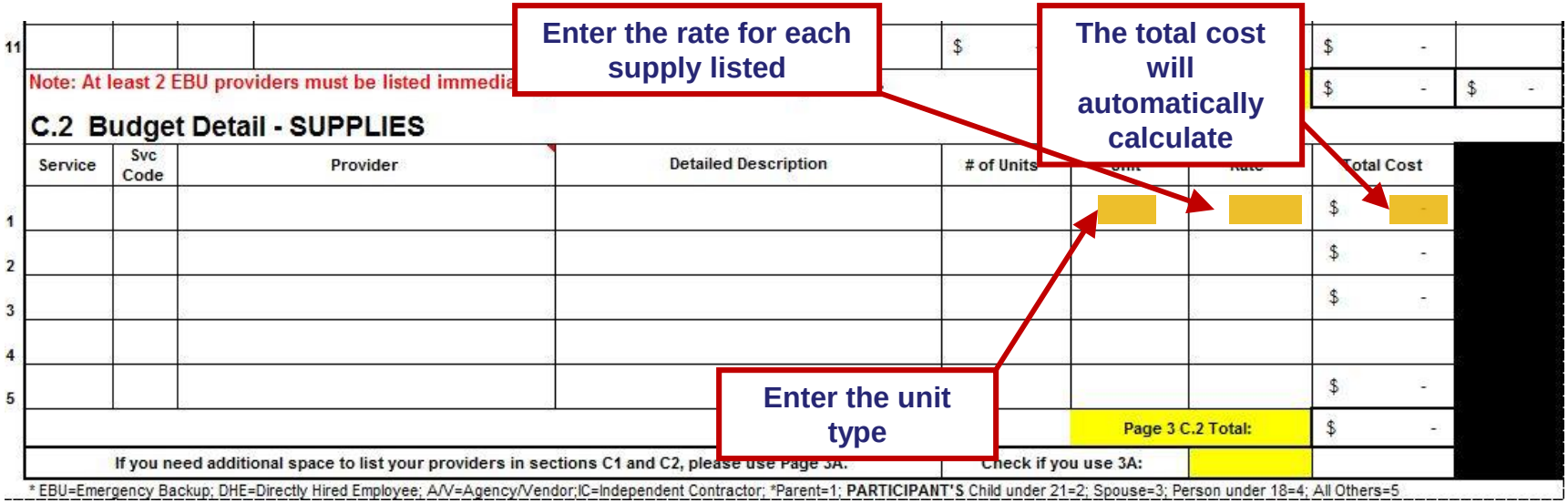
  Examples: Adult Large Diapers (96)

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



Purchasing Plan - Page 3

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



Purchasing Plan - Page 3

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

11								$ -	$ -	$ -	$ -

Note: At least 2 EBU providers must be listed immediately under each critical service provider. Page 3 C.1 Total: $ - $ -

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:

* 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

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

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							$ -
3							$ -
4							$ -
5							$ -
6							$ -

Option 1. Section E - Savings

Option 2. Section C.1 & C.2 – Services/Supplies

Purchasing Plan - Page 4

Section D – Budget Details – Cash Purchases – Total

You will receive a check for this amount each month to make ONLY 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.

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 participant's Purchasing Plan

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 (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	Rate	Sub-Total	Employer Taxes	Total Estimated Cost	Last Date Purchase Will be Made	Actual Date Purchase was Made or Completed
									$ -		
1							$ -	$ -	$ -		
2							$ -	$ -	$ -		
3							$ -	$ -	$ -		
4							$ -	$ -	$ -		
5							$ -	$ -	$ -		

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 P

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

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	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 (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	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									$ -	$ -	$ -		
									$ -	$ -	$ -		
									$ -	$ -	$ -		

Svc Code dropdown: 80, 82, 83, 85, 87, 88, 89

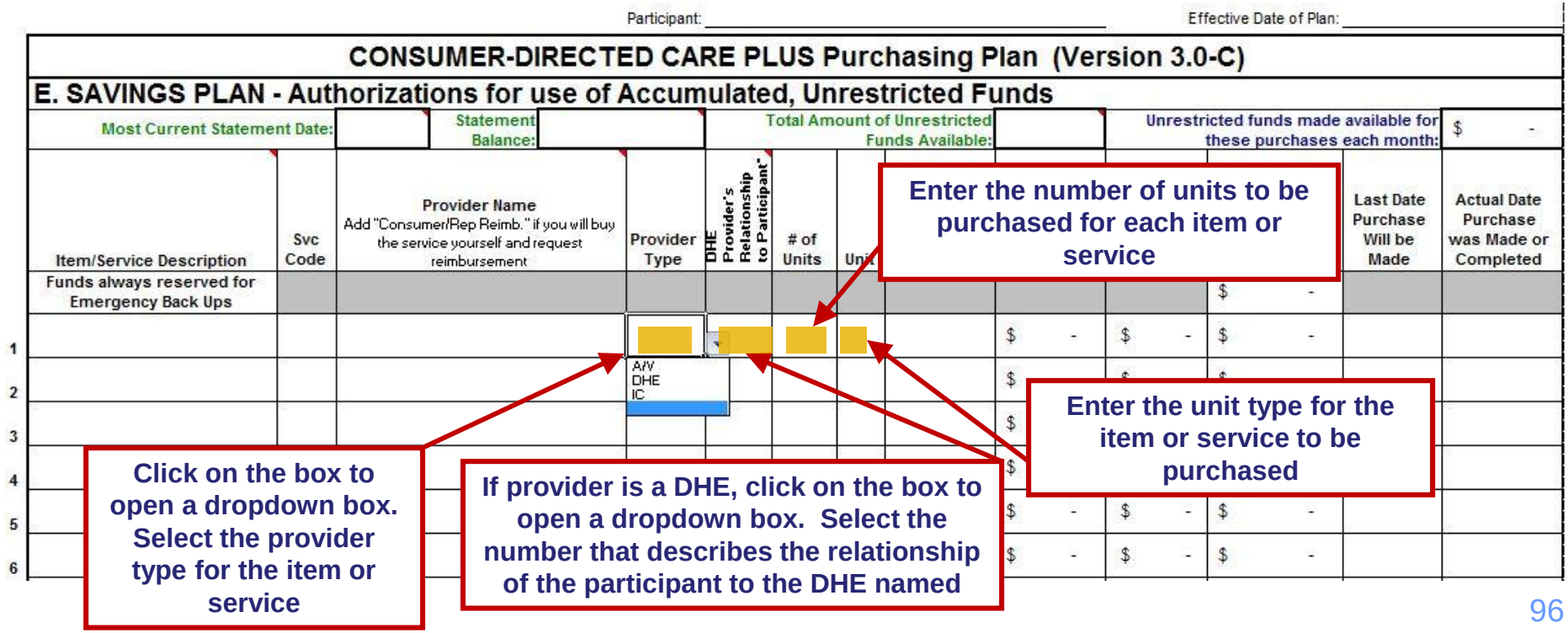
Enter the legal provider name for each item or service

Enter each item or service description

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

Purchasing Plan - Page 5

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



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	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					-			

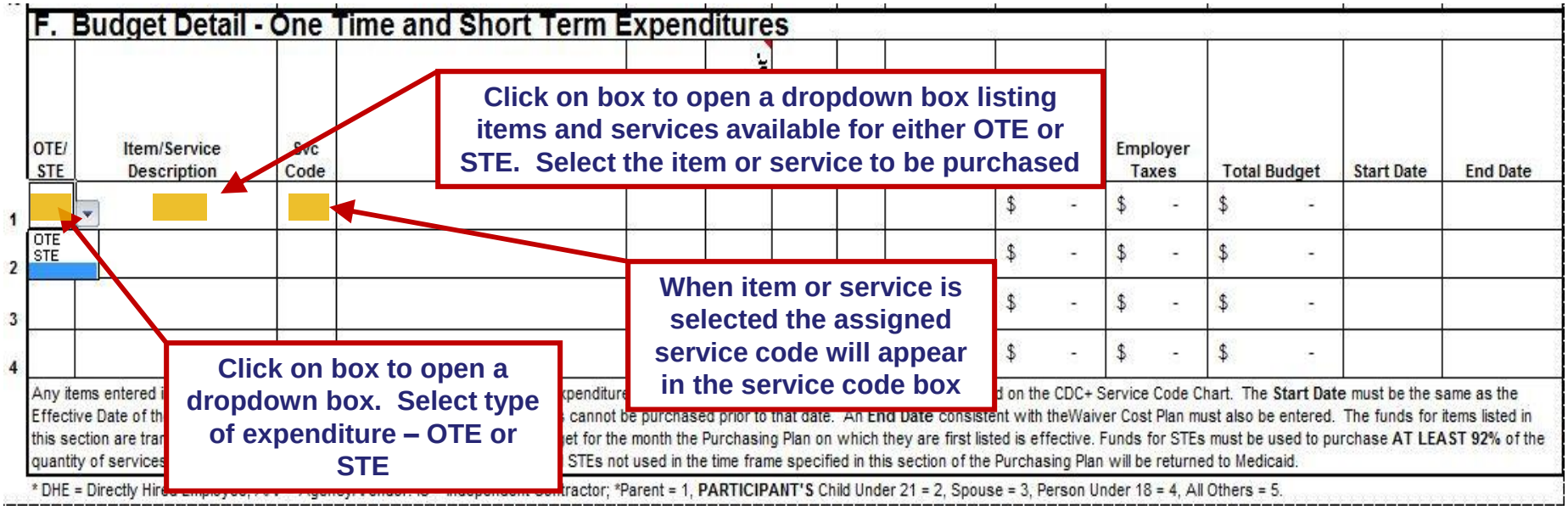
The total estimated cost amount for each item or service will calculate and insert here

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



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										$ -	$ -	$ -		

Any items entered in Section F must meet the E) 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 whic rchased prior to that date. An **End Date** consistent with theWaiver Cost Plan must also be entered. The funds for items listed in this section are transferred to your account i th 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 d in the time frame specified in this section of the Purchasing Plan will be returned to Medicaid.

* DHE = Directly Hired Employee, A/V = Agenc t = 1, **PARTICIPANT'S** Child Under 21 = 2, Spouse = 3, Person Under 18 = 4, All Others = 5.

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

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 Hr Item Trip Visit		$				
3										$				
4										$				

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 def… 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… d prior to that date. An **End Date** consistent with theWaiver Cost Plan must also be entered. The funds for items listed in this section are transferred to your account in a… urchasing 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. … 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 Expendit… specified on the CDC+ Ser… the Effective Date of the Purchasing Plan on which it is first entered, and services canno… nsistent with theWaiver 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 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 theWaiver 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 P

Budget Summary

marizes the expenditures detailed on the previous pages

	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.

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

Purchasing Plan - Page 6

Budget Summary (continued)

Participant: _____ Effective Date of Plan: _____

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

Budget Summary

mmarizes the expenditures detailed on the previous pages of the Purch

	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.

This section no longer applies and should not contain any numbers

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

Purchasing Plan - Page 6

Signatures – Participant 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		ed by all three required signers.)
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 **approved** and may be implemented on the effective date for valid providers unless otherwise indicated below:
		☐ 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 participant or representative must print name then sign and enter date signed on hard copy of form

Purchasing Plan - Page 6

Signatures – Consultant

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:**

$ -

...unt.

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

SIGNATURES (This page must always be newly signed an...

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 **approved** and may be implemented on the effective date for valid providers unless otherwise indicated below:

☐ Approved except for the following sections:

Section _____ Line(s) _____

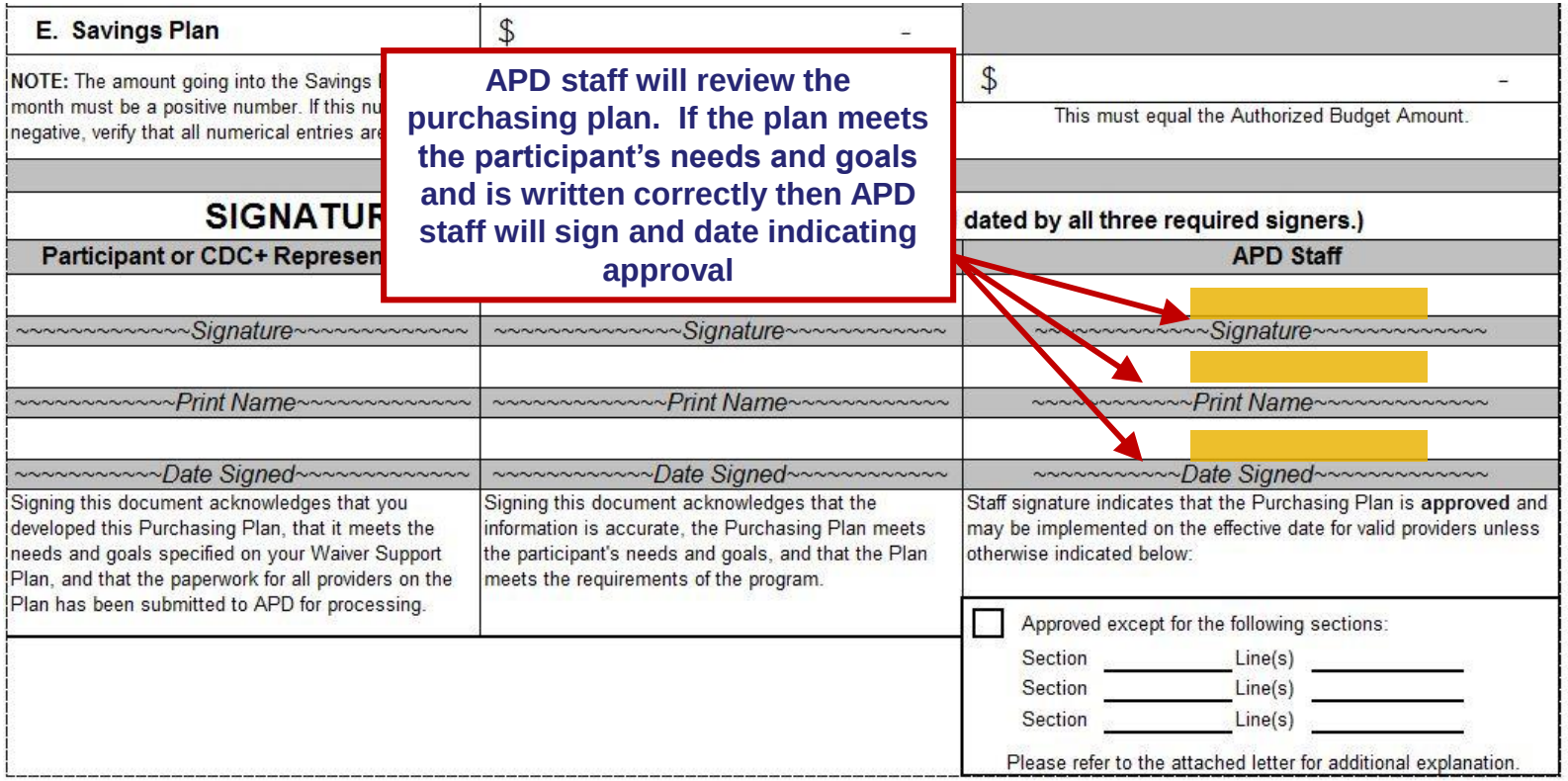
Section _____ Line(s) _____

Section _____ Line(s) _____

Please refer to the attached letter for additional explanation.

Purchasing Plan - Page 6

Signatures – APD Staff



E. Savings Plan	$ -	
NOTE: The amount going into the Savings … month must be a positive number. If this nu… negative, verify that all numerical entries are…		$ - This must equal the Authorized Budget Amount.
SIGNATUR…		…dated by all three required signers.)
Participant or CDC+ Represen…		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 **approved** and may be implemented on the effective date for valid providers unless otherwise indicated below:
		☐ Approved except for the following sections: Section _____ Line(s) _____ Section _____ Line(s) _____ Section _____ Line(s) _____ Please refer to the attached letter for additional explanation.

APD staff will review the purchasing plan. If the plan meets the participant's needs and goals and is written correctly then APD staff will sign and date indicating approval

Purchasing Plan - Page 6

Signatures – APD Staff (continued)

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 (This page must always be newly signed and dated by all three required signers.)

Participant or CDC+ Representative	Consultant	APD Staff
~~Signature~~~~~~~~~~~~~~	~~~~~~~~~~~~~~Signature~~~~~~~~~~~~~~	~~~~~~~~~~~~~~Signature~~~~~~~~~~~~~~
~~Print Name~~~~	~~~	~~~~~~~~~~~~~~Print Name~~~~~~~~~~~~~~
~~Date Signed~~~~	~~~	~~~~~~~~~~~~~~Date Signed~~~~~~~~~~~~~~
Signing this document acknowledges … developed this Purchasing Plan, that … 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.	… 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:

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

☐ 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 Submission Process

Participant 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 participant with ID numbers and start date
- ✓ Provides approved Budget Summary copy

Types of Claims

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

Claims Submission

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

Submitting Payroll

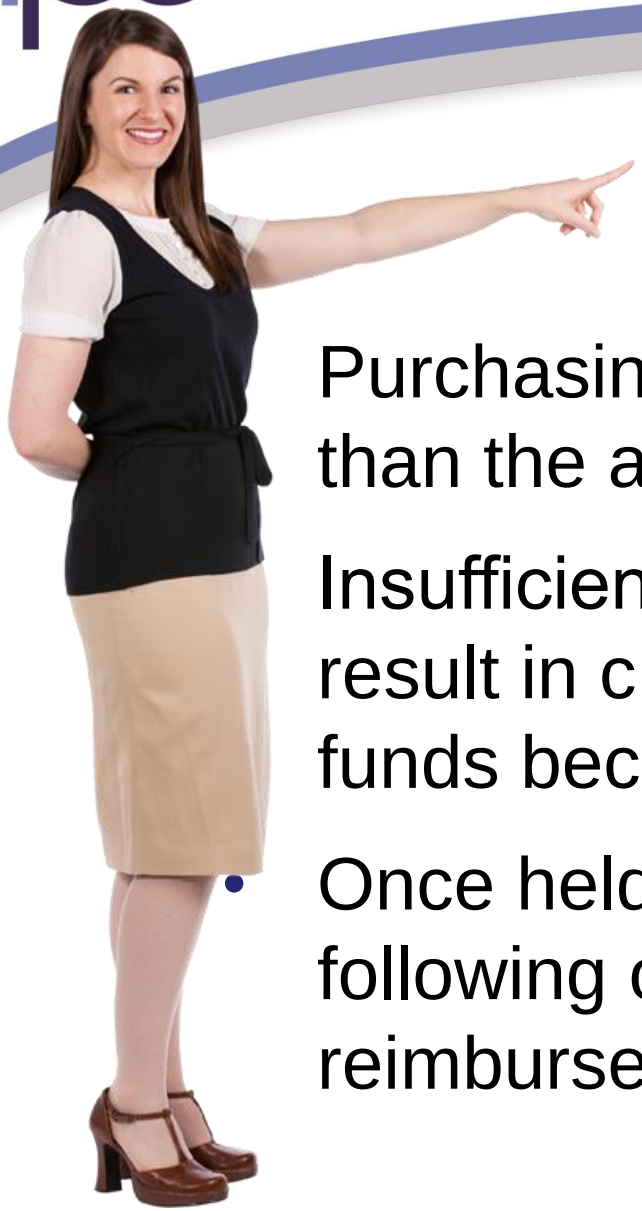
Online Secure Payroll

Interactive Voice Response System (IVR)

CDC+ Customer Service

Managing Monthly Budget

- Spend within CDC+ monthly budget
  - ✓ Use Calendar Participant Notebook Appendix O (2)
  - ✓ Spend consistent with Purchasing Plan
- Overtime - Not good use of funds
- Reconcile Monthly Statements
  - ✓ Participant Notebook Appendix M (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 participants or representatives to correct problems with mismanagement of the program as required by the 1915j State Plan Amendment.
- Developed and signed by participant and consultant
- To be developed immediately when participant/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

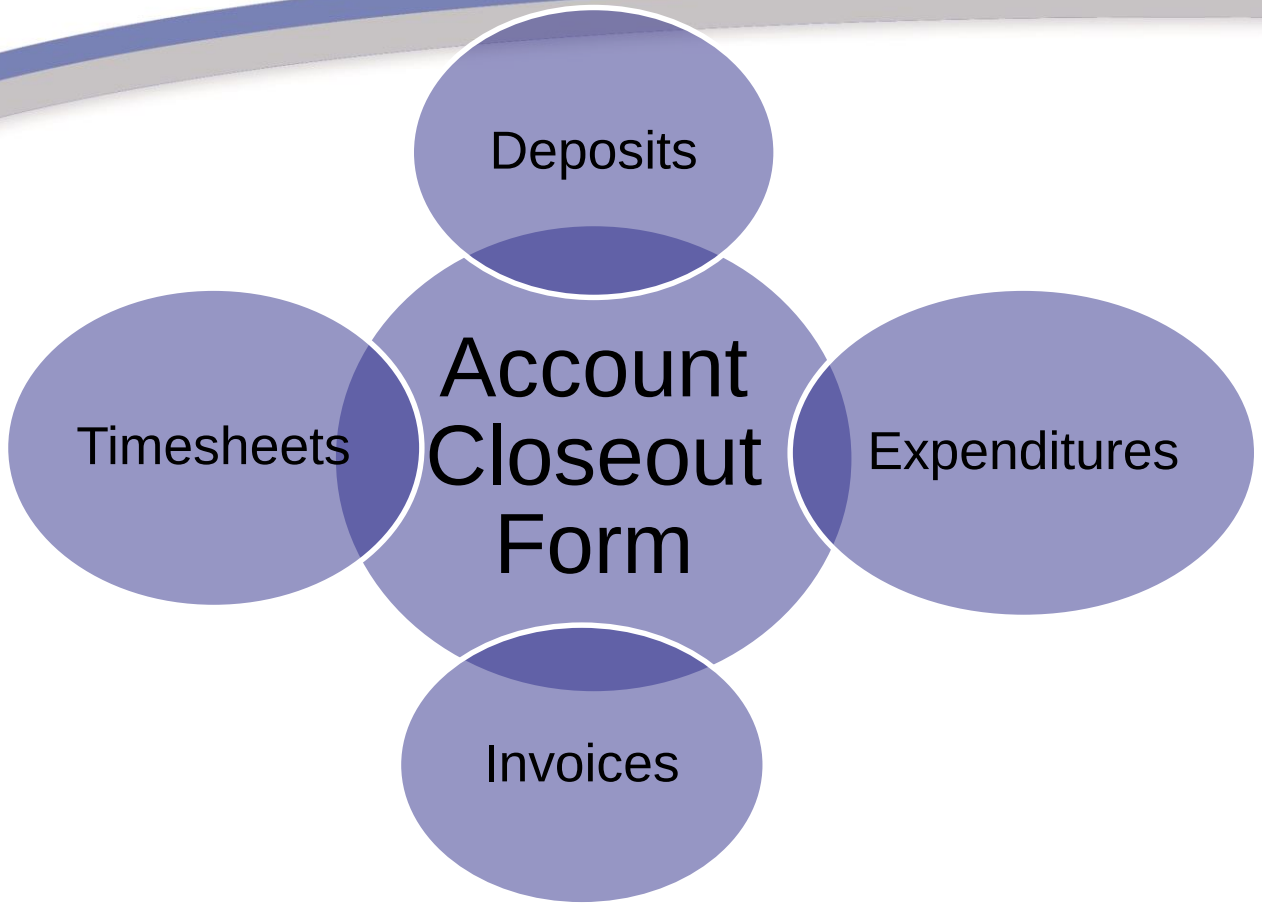
- ✓ WHAT has happened/caused the problem
- ✓ HOW the participant/representative plan to correct the problem
- ✓ WHEN the problem will be corrected
- ✓ WHO is responsible for each step

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+ Participant Information Update Form (Appendix H of the CDC+ Rule Handbook and Participant Notebook Appendix D-XV11)
- CDC+ Account Close-Out Procedure (Participant 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 i 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:

Ivonne Gonzalez

Ivonne.Gonzalez@apdcares.org

850-417-8270

CDC+ Customer Service

1-866-761-7043

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