



Florida Medicaid

CONSUMER-DIRECTED CARE PLUS PROGRAM COVERAGE, LIMITATIONS, AND REIMBURSEMENT HANDBOOK

Agency for Health Care Administration
October 2015



CONSUMER-DIRECTED CARE PLUS PROGRAM
COVERAGE, LIMITATIONS, AND REIMBURSEMENT HANDBOOK
UPDATE LOG

How to Use the Update Log

Introduction

The update log provides a history of the handbook updates. Each Florida Medicaid handbook contains an update log.

Obtaining the Handbook Update

When a handbook is updated, the Medicaid provider will be notified. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at <http://portal.flmmis.com/FLpublic>.

Medicaid providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Services Contact Center at 1-800-289-7799.

Explanation of the Update Log

Providers can use the update log below to determine if updates to the handbook have been received.

Update describes the change that was made.

Effective Date is the date that the update is effective.

UPDATE	EFFECTIVE DATE
New Handbook	July 2012
Revised Handbook	October 2015

CONSUMER-DIRECTED CARE PLUS PROGRAM
 COVERAGE, LIMITATIONS, AND REIMBURSEMENT HANDBOOK
 TABLE OF CONTENTS

Chapter and Topic	Page
Introduction to the Handbook	
Overview	i
Handbook Use	ii
Characteristics of the Handbook	iii
Handbook Updates	iv
Chapter 1 – Introduction, Legal Program Requirements, General Definitions	
Overview	1-1
Legal Program Requirements	1-2
General Definitions	1-4
Eligibility	1-20
Enrollment	1-20
Disenrollment	1-21
Chapter 2 – Roles and Responsibilities	
Overview	2-1
Roles and Responsibilities	2-1
Chapter 3 – Program Operations	
Overview	3-1
Requirements for Background Screening	3-2
Emergency Backup Plan	3-3
Budget	3-4
Purchasing Plan	3-4
Purchasing Plan Requirements	3-5
Chapter 4 – CDC+ Program Services	
Overview	4-1
Restricted Services	4-3
Unrestricted Services	4-4
Adult Day Training	4-5
Adult Dental Services	4-5
Advertising	4-6
Behavior Analysis Services	4-7
Behavior Analysis Assessment	4-13
Behavior Assistant Services	4-14
Companion Services	4-17
Consumable Medical Supplies	4-19
Dietitian Services	4-22
Durable Medical Equipment and Supplies	4-23
Environmental Modification	4-24
Gym Membership	4-26
In-Home Support Services	4-26
Occupational Therapy	4-27
Occupational Therapy Assessment	4-28
Other Therapies	4-29
Over-The-Counter Medications	4-29

Parts and Repairs for Therapeutic or Adaptive Equipment	4-30
Personal Care Assistance	4-31
Personal Emergency Response System (PERS)	4-32
Personal Emergency Response System (PERS) Installation.....	4-33
Physical Therapy.....	4-34
Physical Therapy Assessment.....	4-35
Private Duty Nursing	4-35
Residential Habitation Services	4-37
Respiratory Therapy.....	4-38
Respiratory Therapy Assessment.....	4-39
Respite Care	4-39
Seasonal Camp.....	4-41
Skilled Nursing	4-42
Specialized Mental Health Services.....	4-43
Specialized Training.....	4-44
Speech Therapy.....	4-45
Speech Therapy Assessment.....	4-46
Supported Employment.....	4-46
Supported Living Coaching.....	4-47
Transportation	4-48
Vehicle Modification	4-51

Chapter 5 – Fiscal Operation

Overview	5-1
----------------	-----

Chapter 6 – Quality Assurance

Overview	6-1
Quality Improvement Tools	6-1

Appendices

Appendix A: CDC+ New Participant Training Program Affirmation Form.....	A-1
Appendix B: CDC+ New Participant Training Registration	B-1
Appendix C: CDC+ Participant Refresher Training Program Affirmation Form.....	C-1
Appendix D: CDC+ Participant Refresher Training Registration	D-1
Appendix E: CDC+ Purchasing Plan	
CDC+ Purchasing Plan (Version 3.0-C)	E-1
CDC+ Budget Detail – Services and Supplies.....	E-4
CDC+ Budget Detail – Purchases to be made with Cash	E-7
CDC+ Savings Plan – Authorizations for use of Accumulated, Unrestricted Funds and One Time & Short Term Expenditures	E-8
CDC+ Budget Summary	E-9
Appendix F: CDC+ Quick Update to My Purchasing Plan.....	F-1
Appendix G: Florida CDC+ Weekly Timesheet.....	G-1
Appendix H: CDC+ Participant Information Update Form	H-1

INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter outlines the three Florida Medicaid policy handbooks that all enrolled providers must comply with in order to obtain reimbursement. This chapter also describes the format used for the handbooks and instructs the reader on how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid program
- Coverage and limitations handbooks explain covered services, their limits, who is eligible to receive them, and any corresponding fee schedules. Fee schedules can be incorporated within the handbook or separately
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid

The current Florida Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at <http://portal.flmmis.com/FLpublic>.

Federal and State Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act
 - Title 42 of the Code of Federal Regulations
 - Chapter 393, Florida Statutes
 - Chapter 409, Florida Statutes
 - Rule Division 59G and 65G, Florida Administrative Code
-

In This Chapter

This chapter contains:

TOPIC	PAGE
Overview	i
Handbook Use	ii
Characteristics of the Handbook	iii
Handbook Updates	iv

Handbook Use

Purpose

The purpose of the Medicaid handbooks is to educate the Medicaid provider about policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients.

The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.

Recipient

Term used to describe an individual enrolled in Florida Medicaid.

**Provider
General
Handbook**

Information that applies to all providers regarding the Florida Medicaid program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook.

**Coverage and
Limitations
Handbook**

Each coverage and limitations handbook is named for the service it describes. A provider who renders more than one type of Medicaid service will have more than one coverage and limitations handbook with which they must comply.

**Reimbursement
Handbook**

Most reimbursement handbooks are named for the type of claim form submitted.

Characteristics of the Handbook

Format	The format of the handbook represents a reader-friendly way of displaying material.
Label	Labels are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.
Information Block	<p>Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines.</p> <p>Each block is identified or named with a label.</p>
Chapter Topics	Each chapter contains a list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.
Note	Note is used to refer the reader to other important documents or policies contained outside of this handbook.
Page Numbers	Pages are numbered consecutively within each chapter throughout the handbook. The chapter number appears as the first digit before the page number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Handbook Updates

Update Log

The first page of each handbook will contain the update log.

Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received.

Each update will be designated by an “Update” and the “Effective Date.”

Handbook Update Classifications

The Medicaid handbooks will be updated as needed. Updates are classified as either a:

- Replacement handbook – Major revisions resulting in a rewrite of the existing handbook, without any underlines and strikethroughs throughout the rulemaking process.
 - Revised handbook – Minor revisions resulting in modification of the existing handbook identified during the rulemaking process by underlines and strikethroughs.
-

Handbook Effective Date

The effective date of a handbook is the month and year that will appear on the final published handbook. The provider can check this date to ensure that the material being used is the most current and up to date.

Identifying New Information

New information or information moved from one place to another within the handbook will be identified by an underline on draft versions of the handbook during the development and proposed stages of the rulemaking process (e.g., new information).

Identifying Deleted Information

Deleted information will be identified by a line through the middle of the selected text on draft versions of the handbook during the development and proposed stages of the rulemaking process (e.g., ~~deleted information~~).

Final Published Handbook

The adopted and published version of the handbook will not have underlines (indicating insertions) and text with strikethroughs (indicating deletions).

CHAPTER 1
INTRODUCTION, LEGAL PROGRAM REQUIREMENTS,
GENERAL DEFINITIONS

Overview

Background

The United States Deficit Reduction Act (DRA) of 2005, Section 6087, was enacted into law on February 8, 2006 (Pub.L.109-171); amending section 1915 of the Social Security Act to add a new paragraph (j), the State Plan Amendment Option, for self-direction of certain Medicaid services. Section 1915(j) of the Medicaid State Plan Amendment enables states to offer a self-directed service delivery model for personal assistance services as a State plan option. The 1915(j) Medicaid State Plan Amendment authorized programs enable beneficiaries to pay legally liable relatives directly for personal assistance services identified in the service plan and budget.

Through the US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), the Agency for Health Care Administration (AHCA) is responsible for administration of Title XIX of the Social Security Act, Medicaid, and the administration of the 1915(j) Medicaid State Plan Amendment / Consumer-Directed Care Plus program (CDC+).

The Agency for Health Care Administration (AHCA), as the designated single state agency for Medicaid, administers the Developmental Disabilities (DD) Individual Budgeting (iBudget) Waiver. Through an interagency agreement, the Agency for Persons with Disabilities (APD) is the state agency responsible for the program operation of the iBudget Waiver and the CDC+ program.

Purpose

The purpose of the Consumer-Directed Care Handbook is to provide the requirements and policies of the Consumer-Directed Care Plus (CDC+) program to iBudget Waiver Consumers, providers, and stakeholders.

Legal Authority

The CDC+ program operates under the authority of section 1915(j) Medicaid State Plan Amendment of the Social Security Act and governed by Title 42, Code of Federal Regulations (CFR) Part 441, Chapter 393, Florida Statutes, and Section 409.221 of Florida Statutes.

Overview, continued

Program Requirement

CDC+ is a Florida Medicaid program that permits certain Consumers to self-direct their own Personal Assistance Services. For the purpose of this program, Consumers must be enrolled in the 1915(c) iBudget Waiver.

In This Chapter

This chapter contains:

TOPIC	PAGE
Overview	1-1
Legal Program Requirements	1-2
General Definitions	1-4
Eligibility	1-20
Enrollment	1-20
Disenrollment	1-21

Legal Program Requirements

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Federal Regulation 45 CFR Parts 160 and 164 list Privacy Rule Standards for Privacy of Individually Identifiable Health Information.

Protected Health Information (PHI)

Includes any demographic information whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in electronic or any other form or medium. Federal Regulation for handling Personal Health Information is found in 45 CFR Parts 160 and 164.

Abuse Reporting

In accordance with Florida Statutes (F.S.) Chapter 39 (children) and Chapter 415 (adults): Anyone who fails to report known or suspected cases of abuse, neglect, or exploitation is a criminal offense. Criminal and administrative penalties will also be pursued. Abuse can be reported by calling the Florida Abuse Hotline, which is a statewide, toll-free telephone number, at 1-800-96-ABUSE (1-800-962-2873), or by sending a faxed statement of the Abuse Hotline's statewide toll-free fax number, 24 hours a day, 7 days a week, at (1-800-914-0004), and by calling the police. For individuals with speech or hearing impairments, TDD access is gained by dialing 1-800-453-5145.

Legal Program Requirements, continued

Additional Reporting Requirements

Direct service providers shall report knowledge or suspicion of abuse, neglect, exploitation, or sexual misconduct to their supervisors who will be required to report this information to the local APD office (in accordance with established APD reporting procedures). Any person who knowingly and willfully prevents another person from reporting known or suspected abuse is guilty of a misdemeanor of the first degree, punishable as provided in sections 775.082 or 775.083 Florida Statutes.

Confidentiality

Agreement not to use or disclose any information concerning a client receiving services under this handbook for any purpose prohibited by state or federal law or regulation, except with the written consent of a person legally authorized to give that consent or when authorized by law. This includes compliance with: the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d, and all applicable regulations provided in 45 CFR Parts 160, 162, and 164; and 42 CFR, Part 431, Subpart F, relating to the disclosure of information concerning Medicaid applicants and Consumers.

Due Process Consumer Rights

Due Process rights allow Consumers to appeal decisions under two authorities:

- Title 42, subsection 431.200 of the Code of Federal Regulations and Section 65-2.042 through Section 65-2.066, Florida Administrative Code, provides for fair hearings which are used to challenge or appeal actions relating to Medicaid services; and
- Chapter 120, Florida Statutes, provides for administrative hearings. These hearings challenge actions related to services funded by state general revenue money. Providers of Medicaid services may also request administrative hearings.

A Fair Hearing may be requested in accordance with 42 C.F.R. §431.200.

Worker's Compensation

Chapter 440, Florida Statutes addresses worker's compensation for employees throughout the state regarding injuries, disabilities and compensation payments.

In accordance with sub-section 440.02(17)(b)2, Florida Statutes, employers who employ four or more directly hired employees who provide services during a calendar month must purchase Workers Compensation Insurance.

Minimum Wage

The hourly rate of pay required by either the State of Florida or the Federal Government that an employer must minimally pay their employees. These rates are established for Florida in s.448.110, F.S., and for the Federal Government in the Fair Labor Standards Act.

General Definitions

Medicaid Provider Handbooks

This handbook is intended for use by CDC+ providers that render services to eligible Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains information about specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which describes the Florida Medicaid program.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at <http://portal.flmmis.com/FLpublic>. All of the Florida Medicaid provider handbooks are incorporated by reference in Rule Division 59G, F.A.C.

Abuse, Neglect and Exploitation (Chapters 415 & 39, F.S.)

Any occurrence of Abuse, Neglect or Exploitation of an iBudget Waiver Consumer is mandated to be reported by waiver providers. Abuse, neglect, and abandonment of a child are defined in section 39.01, Florida Statutes, and abuse, neglect, and exploitation of an adult are defined in section 415.102, Florida Statutes.

Any CDC+ provider or Representative who has a confirmed case of abuse, neglect, exploitation, or abandonment will be prohibited from any further participation in the CDC+ Program.

Any person who knows, or has reasonable cause to suspect that a person with a developmental disability is being abused, neglected, or exploited is required to report such knowledge or suspicion to the Florida Abuse Hotline at 1-800-96-ABUSE or 1-800-962-2873. This includes incidents of self-neglect.

Account Reconciliation

Account Reconciliation occurs when the unexpended balance in the Consumer's records matches the unexpended balance in the Consumer's monthly statement. Charges are subtracted from the Consumer's balance; deposits are added. Invoices and Timesheets that have been submitted for payment but have not yet been written are deducted from the statement balance. When these steps are completed, the Consumer's balance and the balance shown on the statement should be equal.

Agency for Health Care Administration (AHCA)

AHCA administers Florida Medicaid as mandated by the Florida Legislature and stated in Chapter 20, Florida Statutes. As the chief health policy and planning entity for the state of Florida, AHCA is primarily responsible for the state's Medicaid program, the licensure of the state's health care facilities and the sharing of health care data through the Florida Center for Health Information and Policy Analysis. Since CDC+ is a Medicaid program, AHCA serves as the single state Medicaid agency and works directly with the federal government on matters relating to CDC+ Program as a 1915(j) Medicaid State Plan Amendment.

General Definitions, continued

Agency for Persons with Disabilities (APD)

The Agency specifically tasked by the State of Florida with serving the needs of Floridians with developmental disabilities. In accordance with an Interagency Agreement with AHCA, APD is the operating agency for the iBudget Waiver and responsible for implementing the CDC+ program in coordination and collaboration with AHCA rules and federal law.

Agency/Vendor

A person or business that provides services and supports to a Consumer under the CDC+ program. This is a general term that includes Independent Contractors, for profit and not-for profit agencies, and companies that sell supplies, and provide services. Agency or Vendors are paid from an invoice rather than a timesheet.

Agency or Vendor Information

The required Agency or Vendor materials to be completed and submitted to the Fiscal/Employer Agent (F/EA) in order to enroll a newly hired Agency or Vendor with the F/EA so the Agency or Vendor can be paid.

Allowable Purchases

Purchases approved on the Consumer's Purchasing Plan that relate to the long term care needs or need for community supports as identified in the Consumer's Support Plan.

Note: See Appendix E for a copy of the CDC+ Purchasing Plan, February 14, 2012. The CDC+ Purchasing Plan is available by photocopying it from Appendix E.

Approved Assessment

An approved assessment is a valid tool that is designed to provide a rational basis for the allocation of waiver funds to an individual with developmental disabilities enrolled in the iBudget Waiver. The assessment is completed at least every three years or as determined necessary by the Consumer and the consultant, based on the changing needs and condition of the Consumer.

Area CDC+ Liaison

The Area CDC+ Liaison is an individual APD employee in each APD Area Office who is the primary contact person for that area's CDC+ program. This person is also referred to by those working in the CDC+ program as the Area Liaison.

Regional Offices (APD)

The 14 designated regions in the state from which APD provides services to persons with disabilities.

General Definitions, continued

Background Screening

A Background Screening is a criminal history check, pursuant to Chapter 435 and section 408.809, Florida Statutes, that must be conducted to determine if a person has either been arrested or convicted of a crime. Background Screenings must include, but not be limited to, fingerprinting for statewide criminal history records checks through the Florida Department of Law Enforcement, and national criminal records checks through the Federal Bureau of Investigation, and may include local criminal records checks through local law enforcement agencies.

Budget Allowance

This term is defined as cited in section 409.221(4) (c), Florida Statutes as the budget allowance or an amount of money made available each month to a CDC+ Consumer to purchase needed long-term care services. This is also referred by APD as the “monthly budget.”

CDC+ New Participant Training Program Affirmation Form

The CDC+ New Participant Training Program Affirmation Form is to be completed by the Consumer or Representative, if applicable. This form affirms that the Consumer or Representative has completed the CDC+ New Participant Training program.

Note: See Appendix A for a copy of the CDC+ New Participant Training Program Affirmation Form, effective July 2010. The CDC+ New Participant Training Program Affirmation Form is available by photocopying it from Appendix A.

CDC+ New Participant Training Registration

In order to enroll in the CDC+ program, Consumers or their Representatives, if applicable must complete the CDC+ New Participant Training Registration. This registration ensures that the Consumer or Representative is registered for the CDC+ New Participant Training and has accepted the terms of enrollment into the CDC+ program.

Note: See Appendix B for a copy of the CDC+ New Participant Training Registration Form, July 2012, The CDC+ New Participant Training Registration Form is available by photocopying it from Appendix B.

General Definitions, continued

CDC+ Participant Information Update Form

The CDC+ Participant Information Update Form must be completed by the Consultant in the event that a Consumer's, Representative's, or Consultant's information changes.

Note: See Appendix H for a copy of the CDC+ Participant Information Update Form, November 1, 2009. The CDC+ Participant Information Update Form is available by photocopying it from Appendix H.

CDC+ Participant Refresher Training Program Affirmation Form

The CDC+ Participant Refresher Training Program Affirmation Form affirms that the Consumer or Representative, if applicable, has completed the CDC+ Participant Refresher Training program.

Note: See Appendix C for a copy of the CDC+ Participant Refresher Training Program Affirmation Form, March 1, 2011. The CDC+ Participant Refresher Training Program Affirmation Form is available by photocopying it from Appendix C.

CDC+ Participant Refresher Training Registration

In order to complete the CDC+ Participant Training, the CDC+ Participant Refresher Training must be submitted to APD. This form also indicates acceptance of the terms of the CDC+ program.

Note: See Appendix D for a copy of the CDC+ Participant Refresher Training Registration, March 1, 2011. The CDC+ Participant Refresher Training Registration is available by photocopying it from Appendix D.

CDC+ Workweek

The official workweek, in regard to employee timesheets of the CDC+ program, begins at 12:00 a.m. mid-night on Monday and ends on Sunday at 11:59 p.m.

Centers for Medicare and Medicaid Services (CMS)

CMS is the Federal agency, a branch of the United States Department of Health and Human Services (HHS), responsible for administering both Medicare and Medicaid programs.

General Definitions, continued

Central Record

A file or a series of continuation files, maintained by the consultant, where in the following documentation must be recorded, stored, and made available for review:

- Consumer demographic data including emergency contact information;
- Parental or guardian contact data;
- Permission forms;
- Results of assessments;
- Evaluations and medical and medication information;
- Copies of all information submitted to the APD Area Office to update Consumer demographic data as required by the CDC+ program;
- Legal data such as guardianship papers, court orders and release forms;
- The annual Medicaid eligibility document for each Consumer. This helps to assure the state that there are no ongoing issues with Consumers being ineligible for Medicaid because of a missed meeting or other situation that could have been taken care of by completing a document or attending a meeting; and
- Service delivery information including the current Support Plan, Cost Plan or written authorization of services (i.e., APD-approved Purchasing Plan and all associated updates), implementation plans, case notes, documentation of monthly Consumer contacts, documentation of required face-to-face visits, copies of the Consumers' monthly statements, and final account close-out documentation when a Consumer disenrolls from the CDC+ program, as required.

The central record is the property of APD and follows the Consumer if the Consumer's consultant changes.

Consultant

A support coordinator, as defined in section 393.063(37), F.S., who has received specific training in Consumer self-direction to assist Consumers enrolled in CDC+ and their families or Representatives in identifying and choosing supports and services through the CDC+ program. A Consultant provides technical assistance to Consumers or their Representatives in meeting their responsibilities under the CDC+ program, as defined in section s. 409.221 (4)(c)2., F.S.

Consumer

An iBudget Waiver Consumer who has chosen to participate in the CDC+ program, has met the enrollment requirements, and has received an approved monthly budget allowance [identified as "Consumer" in s. 409.221, F.S.].

If the Consumer has selected a Representative, it is understood that the Representative will fulfill any responsibilities addressed in this document on behalf of the Consumer. Consumers shall be allowed to choose the providers of services, as well as when and how the services are provided. Providers may include a Consumer's neighbor, friend, spouse, or relative [s. 409.221 (4)(f), F.S.].

General Definitions, continued

Consumer-Directed Care Plus (CDC+)

This program allows enrolled persons to choose the providers of services and to direct the delivery of services, to best meet their long-term care needs. The program operates to nurture the autonomy of those citizens of the state, of all ages, who have disabilities by providing the long-term care services they need in the least restrictive, appropriate setting. The CDC+ program is based on the principles of self-determination and person-centered planning.

Corrective Action Plan (CAP)

A federal requirement for addressing and correcting a major issue or problem the Consumer has in managing the 1915(j) CDC+ program or budget. If the Consumer is not making purchases in accordance with his approved budget or Purchasing Plan, APD staff or the Consultant must complete a Corrective Action Plan (CAP) with the Consumer. Consumers must sign that they understand the implications of the CAP as well as follow the required action. The CAP must be implemented immediately and all purchases should reflect the CAP by the next monthly Consultant review. If the Consumer's purchases are still outside the guidelines of the CDC+ program, the budget or Purchasing Plan, or the time period set forth in the CAP, then the Consumer will be disenrolled from the program and returned to the iBudget Waiver.

Cost Plan

A document used on behalf of Consumers in the iBudget Waiver listing all prior approved services on the Support Plan that have been requested for the Consumer and the allowed maximum spending for each waiver service. The Cost Plan for each Consumer is updated annually based on the results of the support planning process to reflect current needs and situations. Services must be approved as medically necessary by APD or its contracted prior approval entity prior to service delivery.

Critical Service

A service determined by the Consumer or their family as so important that in absence of the service, the Consumer's health, safety, or welfare would be at risk or the family situation would be at risk. Consumers or their Representatives must insure that every provider of a critical service has two emergency backup providers. In CDC+, Personal Care Assistance (PCA) is a critical service and is required to be listed as a critical service on the Purchasing Plan.

Developmental Disabilities iBudget Waiver

Under Florida Medicaid optional services, the iBudget Waiver provides additional community support and services to qualifying Medicaid enrolled recipients. Recipients diagnosed with developmental disabilities may have access to this option to avoid institutional placement.

General Definitions, continued

Developmental Disability	A developmental disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely [Section 393.063(9), Florida Statutes].
<hr/>	
Direct-Care Staff	An individual who provides direct, hands-on care to the Consumer.
<hr/>	
Directly Hired Employee (DHE)	Individuals who are directly hired by a Consumer or Representative, not through an agency, to provide long-term care services. The Consumer or Representative has the right to control the details of how, when, and where the services are performed. This is true even when the Consumer or Representative gives the employee freedom of action to perform the services. The Consumer or Representative (employer) is responsible for withholding, reporting and remitting appropriate employee, and employer taxes. Directly hired employees are paid based on a timesheet rather than an invoice.
<hr/>	
Disenrollment	Voluntary or involuntary removal from participation in the CDC+ program. Upon disenrollment from CDC+ the Consumer may access waiver services through traditional means [1915(j) State Plan Amendment].
<hr/>	
Down Syndrome	A disorder caused by the presence of an extra chromosome 21[Section 393.063(13), Florida Statutes].
<hr/>	
Emergency Backup Plan	<p>A written document, federally required by the 1915(j) that describes the alternative service delivery methods that will be used under any of the following circumstances:</p> <ul style="list-style-type: none"> • If a primary provider of a critical service fails to report to work or otherwise cannot perform the job at the time and place required; • If the Consumer's Representative becomes unavailable, permanently or temporarily, to perform the roles and responsibilities of the Representative; • If a personal emergency occurs, such as a house fire, an accident in which the Consumer was injured, or loss of a caregiver for the Consumer; • If a community-wide emergency occurs which requires evacuation, such as a hurricane; or • If an unexpected shortage of state funds occur, such as a state budget shortfall, or a required cut in program funds.
<hr/>	

General Definitions, continued

Emergency Backup Plan, continued

The personal emergency portion of the document will allow the Consumer to identify circumstances that would cause an emergency for him/her based upon his unique needs. The document also addresses ways to assure that the needs of the individual are met should an unexpected shortage of funds occur.

Emergency Backup Provider (EBP)

A directly hired employee, Agency/Vendor, or unpaid natural support specifically identified on the Consumer's Purchasing Plan to provide a service that has been identified by the Consumer as critical, in the event the primary provider of the critical service cannot provide the service [1915(j) Medicaid State Plan Amendment].

Employer

Refers to the CDC+ Consumer, who is the employer of record.

Enrollment

The submission and processing of all enrollment documents required by APD and the F/EA enable the CDC+ program applicant to be officially enrolled and to begin managing a budget in the CDC+ program. CDC+ enrollment is complete when the Consumer's first Purchasing Plan has been approved and entered into the CDC+ Purchasing Plan application system by APD.

Family Home

A residence occupied as primary by the Consumer and member(s) of his or her immediate family, which include children, parents, siblings, stepchildren, stepparents, stepsiblings, and in-laws.

Family Member

The Consumer's parents, stepparents, siblings, stepsiblings, grandparents, step-grandparents, children, stepchildren or spouse.

Fiscal/Employer Agent (F/EA)

The F/EA is responsible for reviewing and processing employment information, paying Agency or Vendors and Independent Contractors, paying employees, and withholding and paying state and federal taxes and other required withholdings on behalf of the CDC+ Consumer, who is the employer of record.

Goals

The long and short term desires and ambitions of the Consumer as identified by the Consumer and the Consumer's family, if appropriate, during the support planning process and written on the Consumer's support plan and identified in the Person Centered Planning Process (PCPP).

General Definitions, continued

Independent Contractor (IC)	A person or business that may include a limited liability company or partnership who performs services for the Consumer under an express or implied agreement. As a general rule the Consumer has the right to control or direct only the result of the work performed not the methods for accomplishing the result. The Consumer neither withholds nor pays any taxes on behalf of Independent Contractors. Independent Contractors are paid from an invoice rather than a timesheet.
Initial Application Letter	Information provided to a potential applicant of the CDC+ program.
Invoice	A bill submitted by a vendor or independent contractor to a Consumer to request payment for services rendered.
Live-in Employee	A live-in CDC+ employee is a directly hired employee whose legal residence is the same as that of the Consumer.
Local Review Committee (LRC)	The peer review committee required by Rule 65G-4.008, F.A.C., to oversee and review all behavior analysis services.
Medicaid Waiver/iBudget	Persons enrolled in the CDC+ program must be iBudget Waiver recipients before they can enroll in the CDC+ program.
Medicaid Waiver Provider	A service provider who has executed an agreement with APD and meets all Medicaid requirements. When a Medicaid waiver provider is hired by a Consumer in the CDC+ program, that provider is responsible for keeping the same records required for Consumers receiving services through the iBudget Waiver.

General Definitions, continued

Medical Necessity

Medicaid reimburses services that are determined medically necessary and do not duplicate another provider's service.

Rule 59G-1.010, Florida Administrative Code (F.A.C.) defines "medically necessary" or "medical necessity" as follows:

"[T]he medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program and not be experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider."

"(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service."

Monthly Statement

A document provided by the F/EA to the Consumers, consultants and APD on a monthly basis that shows the beginning and ending balance of the Consumer's account along with the detail of all deposits into and expenditures from the account during a given month.

Needs

The essential supports and services identified during the support planning process and written on the support plan as necessary to maintain the Consumer's health and safety.

One-Time Expenditure (OTE)

Funds earmarked for durable medical or adaptive equipment, a home modification, or a vehicle modification that has been approved as medically necessary on a Consumer's Cost Plan.

General Definitions, continued

Overspend	Overspending occurs when the Consumer purchases supports/services in an amount greater than is authorized for purchase on a monthly basis, in accordance with the Consumer's current approved Purchasing Plan. A CDC+ Consumer is considered to overspend when services provided during a particular month are paid for using funds deposited in and intended for a subsequent month. For example, the monthly budget intended to purchase services provided in March is deposited in March. The Consumer cannot use funds deposited in March to pay for services provided in February.
Own Home	<p>A primary place of residence occupied by the Consumer, which is not a community care facility, health facility, facility licensed pursuant to section 393.067, Florida Statutes, assisted living facility, or family home in which the parent, guardian or guardian advocate of the Consumer resides.</p> <p>A Consumer's own home is a place that a Consumer chooses to own or rent.</p>
Payment Methodology	The adjustment factor applied to a Consumer's Cost Plan to determine the monthly budget allowance [1915(j) State Plan Amendment].
Payroll (Pay Period)	The schedule established by APD for paying Consumers' directly hired employees, Independent Contractors and Agency or Vendors for services rendered.
Person-Centered Planning Process (PCPP)	The CDC+ program is centered on the "person," the individual, the Consumer. The PCPP begins when the Consumer communicates their needs, hopes, and goals when developing the Support Plan. CDC+ offers a framework that supports what is important to the Consumer in the present, current stage of life and increases the individual's options for self-determination (42 CFR Part 441).
Prior Service Authorization (PSA)	All individuals enrolled and receiving services funded by the iBudget Waiver must have Prior Service Authorization (PSA) reviews of services based on medical necessity, which is a federal and state requirement for the provision of Medicaid services. The purpose of the PSA reviews is to ensure that individuals receive medically necessary services at the appropriate intensity, frequency and duration, and in a cost-effective manner (s. 409.905 and s. 409.913, F.S.).

General Definitions, continued

Program Self-Assessment

The Program Self Assessment requires each APD program office to evaluate its CDC+ program. The Quality Advisory Committee (QAC) also reviews the Program Self Assessment. The final document must be approved by AHCA. The main purpose of the Program Self Assessment is to assist the program office in identifying program goals, having a plan to meet the goals, ensuring the goals are met and aiding the program office in re-assessing itself in an ongoing capacity. The Program Self Assessment also alerts the program office of unmet goals or issues that APD might need to address so the program office continues to excel in its efforts [1915(j) State Plan Amendment].

Provider

For purposes of the CDC+ the term “provider” includes all types of service providers in the program including:

- A Consumer or Representative employed caregiver for whom the Consumer is the employer of record; also referred to as a directly hired employee; and
- A person licensed or otherwise permitted to render services eligible for payment under this program for which the Consumer is not the employer of record; referred to as an Agency, Vendor, or an Independent Contractor. iBudget Waiver enrolled providers may also be hired by the CDC+ Consumer or Representative as an Agency, Vendor, or Independent Contractor following the CDC+ provider enrollment process.

CDC+ Provider types:

- **iBudget Waiver Provider:** enrolled Medicaid provider with APD and AHCA meeting minimum qualifications, training, and Background Screening requirements required for Medicaid provider enrollment;
 - **Agency/Vendor:** a person or business that provides services and supports to a Consumer under the CDC+ program. This is a general term that includes Independent Contractors, for profit and not-for profit agencies, and companies that sell supplies, and provide services. Agency or Vendors are paid from an invoice rather than a timesheet;
 - **Independent Contractor (IC):** A person or business that may include a limited liability company or partnership who performs services for the Consumer under an express or implied agreement. As a general rule the Consumer has the right to control or direct only the result of the work performed not the means and methods for accomplishing the result. The Consumer neither withholds nor pays any taxes on behalf of Independent Contractors. Independent contractor are paid from an invoice rather than a timesheet; and
-

General Definitions, continued

Provider, continued

- **Directly Hired Employee (DHE):** Individuals who are directly hired by a Consumer or Representative, not through an agency, to provide long-term care services. The Consumer or Representative has the right to control the details of how, when, and where the services are performed. This is true even when the Consumer or Representative gives the employee freedom of action to perform the services. The Consumer or Representative (employer) is responsible for withholding, reporting and remitting appropriate employee, and employer taxes. Directly hired employees are paid based on a timesheet rather than an invoice.
-

Purchasing Plan

A written spending plan that details the services and supports the Consumer or Representative may purchase with the CDC+ monthly budget allocation. Upon approval by the APD or its prior authorization entity and entered into the CDC+ Purchasing Plan application system by the APD Area Office liaison, the Purchasing Plan becomes the service authorization for the Consumer's spending.

Purchasing Plan Change

A service or support revision made to a Purchasing Plan that affects the amount of funds to be added to the Consumer's CDC+ account based on an updated Cost Plan.

Purchasing Plan Update

A service or support revision made to a Purchasing Plan that does not affect the amount of funds to be added to the Consumer's CDC+ account.

Quality Advisory Committee (QAC)

A group of key program stakeholders chosen to develop a comprehensive CDC+ quality assurance plan and advise APD on program improvement based on data reported from satisfaction surveys, needs assessment results, and Consumer and Consultant monitoring. The QAC may include Consumers, program staff, Consultants, Consumer-Representatives, care-givers, APD staff, AHCA staff, external reviewers (if applicable), and community advocates. All reporting data is shared with the QAC. The QAC consists of a maximum of six members. All members are trained by APD in expectations, roles and responsibilities, federal and state laws and program policies and procedures. The QAC will advise APD of the areas in which the program should be improved and will aid in setting the priorities for improvement. The QAC reviews all program policies, Consultant and Consumer brochures and training materials per the 1915(j) Medicaid State Plan Amendment.

General Definitions, continued

Readiness Review

A readiness review is an open book assessment for new and existing Consumers or their Representatives and new and existing Consultants who participate in a CDC+ program training to determine the level of preparedness for managing their own care or providing Consultant services. The readiness review will be developed by the APD Central Office staff in coordination with staff from AHCA and will include items such as CDC+ program documentation requirements, timelines, roles and responsibilities, and policies/procedures unique to the CDC+ program. The readiness review will be updated, as needed, to reflect changes in policies and procedures that pertain to CDC+.

The readiness review includes questions regarding:

- Program philosophy, rules and procedures;
 - Roles and responsibilities;
 - Tax information specifically related to the CDC+ program;
 - CDC+ service requirements;
 - Purchasing Plan requirements;
 - Monthly budget requirements;
 - Spending requirements;
 - Documentation requirements;
 - Corrective Action Plans;
 - Required timelines; and
 - Enrollment and disenrollment.
-

Reimbursement

Reimbursement is the process of paying back a Consumer who has used his or her own personal funds to make an approved purchase on the Purchasing Plan.

Reinvestment

Periodically identifying and reclaiming unexpended funds that have not been designated for a specific use by the Consumer and approved by the APD Area Office.

Representative

A Representative is an uncompensated individual designated by the Consumer to assist in managing the Consumer's budget allowance and needed services [ss. 409.221 (4)(c)(6), F.S.]. The CDC+ Representative advocates for and acts on behalf of the Consumer in his or her CDC+ matters.

General Definitions, continued

Restricted Services

Services that are approved on a Consumer's Cost Plan, which may be prescribed by a physician, and require providers to have professional licensure or certification.

Funds approved for a restricted service in the Consumer's iBudget Cost Plan must be spent in CDC+ to purchase at least 92% of the units of measure approved for that same service. The remaining funds may be used to purchase more of the same service or other services in CDC+.

Savings

Unrestricted funds in a Consumer's monthly budget allowance that are specifically allocated for a specific service in a future month on the Consumer's Purchasing Plan. Savings does not include excess funds that are not allocated for a specific future purchase. If a Consumer's Purchasing Plan does not allocate all funding from the Consumer's monthly budget, any unallocated funds shall be reinvested.

Self Determination

The concept of self-determination within Medicaid acknowledges the rights of people with disabilities to take charge of and responsibility for their own lives. In the CDC+ program, there are five principles of self-determination:

- Freedom
People have the freedom to decide where and with whom they will live;
- Authority
People have the authority to decide how they will live their lives;
- Support
People have the support they need to make decisions;
- Control
People have control over the resources needed for their support; and
- Responsibility
People have responsibility for their decisions and actions.

"Self-determination" exemplifies an individual's freedom to exercise the same rights as all other citizens, authority to exercise control over funds needed for one's own support, including prioritizing these funds when necessary, responsibility for the wise use of public funds, and self-advocacy to speak and advocate for oneself in order to gain independence and ensure that individuals with a developmental disability are treated equally. [s.393.063, F.S.]

Short Term Expenditures (STE)

A support or service approved in the Consumer's Cost Plan that is for periodic purchases during the year or time-limited services not to exceed 6 months.

General Definitions, continued

State Mandated Representative	A State Mandated Representative is a Representative who is required by the State should a Consumer demonstrate the inability to self-direct, after receiving additional counseling, information, training or assistance.
Start-up Materials	The documents signed by the Consumer and required to be submitted to the Fiscal/Employer Agent at the time of enrollment into CDC+. These documents authorize APD to act as the F/EA for the Consumer and to withhold and pay state and federal taxes on behalf of the Consumer as an employer of record of a household business.
Support Plan	<p>An individualized plan of supports and services designed to meet the needs and goals of a Consumer enrolled in the iBudget Waiver. The plan is based on the preferences, interests, talents, attributes and needs of a Consumer.</p> <p>All Consumers must be able to request a change to their support plan based on a change in needs or health status. Service plans must be reviewed annually by the Consultant, or whenever necessary due to a change in a Consumer's needs or health status.</p>
Timesheet	The form that documents the time a Consumer's directly hired employee provided services to or for a Consumer.
Unallowable Purchases	Specific services and supports that are not permitted to be purchased with funds provided under the CDC+ program.
Unexpended Fund	Funds that have not been identified for a specific purpose and not been spent by the Consumer.
Unrestricted Services	Services and supports of a non-medical nature that a CDC+ Consumer may purchase so long as the service clearly meets the Consumer's needs and related goals identified on their Support Plan. Such services do not have to be identical to or in the same quantity as the services funded in the Cost Plan. Some limitations apply.
Workweek	The CDC+ workweek is established by APD as the Fiscal/Employer Agent for all Consumers and their directly hired employees. The workweek starts at 12:00AM every Monday and ends at 11:59PM every Sunday. Pursuant to the Fair Labor Standards Act, a workweek is seven consecutive 24-hour days.

Eligibility

Requirements for Eligibility

Individuals eligible to participate in the CDC+ program for persons with developmental disabilities and Down syndrome, as defined in s.393.063, F.S. must:

- Be enrolled in the Individual Budgeting Waiver (also known as the iBudget Waiver).
 - Reside in their own or family home, in accordance with 42 USC 1396n(j)(1); which states, "Self-directed personal assistance services may not be provided under this subsection to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage."
 - Not have been previously disenrolled from the CDC+ program due to their mismanagement or inappropriate use of Medicaid funds. Additionally, any CDC+ Representative who has been previously disenrolled from the CDC+ program for mismanagement or inappropriate use of Medicaid funds will not be permitted to participate in the CDC+ program in any capacity.
-

Enrollment

Requirements for Enrollment

In order to enroll in the CDC+ program individuals must:

- Select a CDC+ representative, if needed;
 - Participate in orientation/training and complete the CDC+ New Participant Training Registration and the CDC+ New Participant Training Program Affirmation Form;
 - Select a Waiver Support Coordinator who is also a CDC+ Consultant;
 - Sign CDC+ required agreements;
 - Complete and pass the Readiness Review with at least a score of 85%;
 - Complete and submit CDC+ program enrollment materials;
 - Complete and submit the F/EA enrollment documents;
 - Write an Emergency Backup Plan with the assistance of the consultant;
 - If needed, advertise for, interview, and hire employees;
 - Process required Background Screening and employment documentation for all directly hired employees;
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Enrollment, continued

Requirements for Enrollment, continued

- If needed, hire Agency or Vendors and Independent Contractors to provide supports and services. Process the Agency or Vendor information employment materials;
- Write a Purchasing Plan that meets the Consumers needs and goals as identified on the Support Plan, with the assistance of the CDC+ consultant; and
- Submit the Purchasing Plan and provider employment documentation for all employees, Agency or Vendors, and Independent Contractors identified on the plan to the consultant to present to the APD Area Office for approval.

When a Consumer's first Purchasing Plan has been approved and entered in the CDC+ Purchasing Plan Application System, the Consumer may begin self-directing services under the CDC+ program.

Employees, Independent Contractors, and Agency or Vendors must be assigned a Fiscal Employer Agent (F/EA) provider ID number before providing any services to a Consumer.

Disenrollment

Overview

The Area CDC+ Liaison is responsible for notifying the Consumer or Representative in writing of the agency's intent to disenroll the Consumer from CDC+ program; that the Consumer may return to the iBudget Waiver and of the Consumer's right to appeal with due process. The Consumer has the right to appeal the decision to disenroll within the time frame specified in the notice [42CFR 431.211 and 42CFR 431.220].

APD notifies the Agency who inputs the CDC+ disenrollment date into the Medicaid system. Upon disenrollment from CDC+ the Consumer may still access waiver services through traditional means.

The consultant is responsible for ensuring the Consumer's traditional iBudget Waiver services are set to begin on the first of the month after disenrollment from CDC+.

If the Consumer dies or is placed in a residential facility on an emergency basis, the Consultant must complete and submit to the APD CDC+ Liaison the required notice to stop the budget on the last day of the appropriate month, and must provide the date of disenrollment.

Disenrollment, continued

Overview, continued

When a Consumer disenrolls from CDC+, the Consumer or Representative is responsible for ensuring all outstanding bills for services and supports provided have been paid, and that the Consumer's records are in agreement with the final monthly statement after disenrollment. If the Consumer's reconciled account balance is overspent at the time of disenrollment, the Consumer or Consumer's Representative is responsible for paying the overspent amount back to APD by writing a check in the amount owed payable to the CDC+ Program.

The Consumer must provide final reconciliation documents to the APD Area Office along with all CDC+ records.

Unexpended funds of the disenrolled Consumer are collected through reinvestment process and are reinvested in the iBudget Waiver to serve others and help keep the CDC+ program cost effective.

Voluntary Disenrollment

A Consumer may elect to discontinue participation in the CDC+ program at any time.

In the event disenrollment is requested by the Consumer or the Representative, the Consumer's Consultant completes documentation to disenroll the Consumer, specifying that the disenrollment was initiated by the Consumer or Representative, and forwards the documentation to APD program staff. All disenrollments are effective the first day of the month following receipt of the disenrollment form [1915(j) Medicaid State Plan Amendment].

Involuntary Disenrollment

Consumers who are disenrolled from CDC+ remain eligible for the iBudget Waiver and shall continue to receive services through the iBudget Waiver service and programs after disenrollment.

Disenrollment from CDC+ does not limit APD's ability to seek any other administrative resolution available, including the finding of recoupment of Medicaid funds or resources that were improperly used.

The circumstances under which a Consumer may be involuntarily disenrolled from self-directing personal assistance services, and returned to the traditional service delivery model are noted below. Consumers may be disenrolled by Consultants and APD program directors [1915] Medicaid State Plan Amendment].

Disenrollment, continued

Involuntary Disenrollment, continued

Reasons for involuntary disenrollment include:

- Consumer moved out of state;
- Temporary or permanent long-term care facility admission;
- Hospitalization for more than 30 consecutive days;
- Loss of Medicaid eligibility;
- Loss of waiver eligibility;
- Representative not available if necessary for participation;
- Death of Consumer;
- Mismanagement of budget or services or for failure to follow the provisions of this handbook;
- Consumer health or safety at risk;
- Consumer can no longer be served safely in the community; or
- Admission to a licensed facility (group home, ALF, etc.)

Corrective Action Plan (CAP)

If a Consumer or Representative has demonstrated an inability to effectively manage the CDC+ services or budget, the Consumer or Representative may be required to comply with a Corrective Action Plan (CAP). A CAP shall include the opportunity for the Consumer and Representative to access additional information, counseling, training or assistance regarding the CDC+ program.

A CAP shall be issued prior to involuntary disenrollment for a first-time violation of the CDC+ program rules unless the violation 1) involved an immediate threat to the Consumer's health, safety, or welfare, or 2) if the violation cannot be remedied through additional information, counseling, training or assistance.

If any circumstances that would require a CAP occur after one has been initiated, the Consumer or Representative shall be involuntarily disenrolled from CDC+. A CDC+ Consultant must notify the APD Area Office within 3 business days if the Consultant is aware the Consumer or Representative has failed to follow the conditions stated in the Consumer's CAP.

A Corrective Action Plan may be required if:

- A Representative is not available, but is necessary for participation;
 - The Consumer or Representative has been unable to manage the CDC+ budget or services;
 - The Consumer's health or safety is at risk;
 - The Consumer or Representative can no longer be served safely in the community;
 - The Consumer or Representative has failed to properly screen providers; and
 - The Consumer or Representative has failed to comply with the requirements of the CDC+ program.
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Disenrollment, continued

Corrective Action Plan (CAP),
continued

A CAP shall be initiated by either APD staff or by the Consumer's consultant; however the Consultant is responsible for developing the CAP with the Consumer or Representative and following through to ensure the Consumer is complying with the corrective action. Consumers must sign the CAP to indicate they understand and agree to the terms of the CAP. Failure to follow the required actions of the CAP must result in the Consumer's disenrollment from the CDC+ program and return to the iBudget Waiver.

If a Consumer or Representative has improperly used Medicaid funds or resources, the CAP may require that the funds are recovered by the CDC+ Program.

Re-Enrollment

A Consumer who has voluntarily disenrolled from CDC+ may reenroll, provided:

- The Consumer complied with all requirements of the CDC+ program;
- The Consumer's CDC+ account does not have a negative balance; and
- The Consumer's health or safety was not at risk.

A Consumer who has been involuntarily disenrolled due to mismanagement of the CDC+ budget or services or has been disenrolled because of a risk to the Consumer's health or safety may not be eligible to reenroll in the CDC+ program.

State Mandated Representative

If the Consumer has been provided additional information, counseling, training or assistance and is still unable to effectively manage the CDC+ services or budget, APD may initiate involuntary disenrollment or may require that the Consumer use a State Mandated Representative.

CHAPTER 2 ROLES AND RESPONSIBILITIES

Overview

Introduction

This Chapter describes roles and responsibilities of Consumers, Representatives, Consultants, Direct Hired Employees, Agency or Vendors, Providers, the Agency for Health Care Administration (AHCA), and the Agency for Persons with Disabilities (APD).

In This Chapter

This chapter contains:

TOPIC	PAGE
Overview	2-1
Roles and Responsibilities	2-1

Roles and Responsibilities

Consumer Responsibilities

- Be the authorized signer of all required CDC+ program documents unless a CDC+ Representative has been selected;
 - Be the only authorized signer of all F/EA enrollment documents;
 - Communicate needs, preferences, and expectations about services being purchased to the Representative, if applicable, and the Consultant, and service provider, Agency, Vendor, or directly hired employee (DHE);
 - Write a job description for each service provider, identifying what is expected from the employee or individual who is hired for the job, the total number of hours the employee or individual will be expected to work and the rate of pay that is being offered for the position;
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Roles and Responsibilities, continued

Consumer Responsibilities, continued

- Submit the Background Screening materials required for all providers that are not enrolled as Medicaid waiver providers to the Consultant for processing by APD;
 - Ensure directly hired employees sign a job description, receive the required employee training materials, and sign an employee/employer agreement;
 - Ensure Agency or Vendors and Independent Contractors provide the correct Federal Tax ID Number for completion of the Agency or Vendor information;
 - Choose providers of CDC+ funded services as well as when and how they will perform those services;
 - Adhere to IRS publication 926 Household Employers Tax Guide;
 - Develop the Purchasing Plan to specify how the monthly budget will be used to meet Personal Assistance Services (PAS) needs, and how other identified needs and goals might be met through generic, community supports, and Medicaid state plan services. The Purchasing Plan must be developed in accordance with this rule and instructions provided by APD;
 - Provide the Fiscal/Employer Agent (F/EA) with all information necessary for provider payments and tax requirements per APD program instructions;
 - Submit all payroll documents to the F/EA for payment in a timely manner, as specified by program requirements;
 - Terminate the employment of an employee or services of an Agency or Vendor who does not perform or take action as specified in their job description or in an employer/employee agreement;
 - Maintain all payroll-related documents in an organized manner for at least six years, in accordance with Medicaid records retention requirements;
 - Cooperate with quality assurance monitoring responsibilities of the Consumer as defined in this rule;
 - If disenrolled from the program, turn over all CDC+ files to the APD Area Office, close out the CDC+ account with the assistance of the CDC+ Consultant, and reimburse the CDC+ program if recoupment is required;
 - Not overspend their monthly budget allowance from CDC+ funds;
 - Be responsible and financially liable for repayment of funds used in excess of what was authorized in the Consumer's CDC+ monthly budget;
 - Purchase approved items authorized in the Savings section of the Purchasing Plan only when sufficient funds have been accumulated to pay for the service or support at the time of purchase;
 - Not be reimbursed from CDC+ funds for paying a directly hired employee or independent contractor from the Consumer's personal funds;
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Roles and Responsibilities, continued

Consumer Responsibilities, continued

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- Complete the application process and receive comprehensive procedural CDC+ training, unless they have selected a CDC+ Representative to manage the program for them;
 - Attend annual refresher CDC+ training and pass an annual readiness review, unless they have selected a CDC+ Representative. This includes completion of the CDC+ Participant Refresher Training Program Affirmation Form and the CDC+ Participant Refresher Training Registration (see Appendices C and D);
 - Choose a new Representative within 30 days from the date that the current Representative ends agreement with the Consumer;
 - Select a Representative if they are unable to demonstrate through corrective action that they can manage the CDC+ program without assistance;
 - Consumer support plans must be reviewed annually, or whenever necessary due to a change in a Consumer's needs or health status;
 - Not disclose any CDC+ username, user ID, or password to any unauthorized persons, such as providers of CDC+ services;
 - Be responsible for complying with any Corrective Action Plan (CAP) that is developed for the Consumer.
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Representative

"Representative" means an uncompensated individual designated by the Consumer to assist in managing the Consumer's budget allowance and needed services. [s. 409.221(4)(c)6, F.S.]

The Representative of the Consumer enrolled in the CDC+ program will be trained and provided with materials to assist the Consumer in implementing self-direction of budget allowance and approved CDC+ services.

Roles and Responsibilities, continued

Representative Responsibilities

- Be at least 18 years of age;
 - Be available to the Consumer or Consultant as needed to perform all required responsibilities for the CDC+ program;
 - Involve the Consumer in decisions regarding the Consumer's needs, wishes, services, budget and satisfaction with services;
 - Not be paid to provide any services or supports to the Consumer while serving in the role of Representative;
 - Not be an owner, co-owner, stockholder of, or in any way benefit from, any profit or not-for-profit business authorized to provide services to or for the Consumer;
 - Successfully complete the CDC+ Representative application process and receive procedural training on the CDC+ program before officially acting as the Representative;
 - Sign an agreement with the Consumer to act on the Consumer's behalf;
 - Sign all CDC+ required program materials on behalf of the Consumer except the IRS and Florida Department of Revenue documents which must be signed by the Consumer as the employer of record;
 - Manage CDC+ financial responsibilities and oversee services received on the Consumer's behalf;
 - Assist the Consumer to develop the Purchasing Plan in accordance with program instruction;
 - Cooperate with CDC+ quality assurance monitoring requirements for Representatives as defined in this rule;
 - Be responsible for complying with any Corrective Action Plan (CAP) written for the Consumer, and assist the Consumer with meeting the actions required in the CAP;
 - Be responsible and financially liable for repayment of funds used in excess of what was authorized in the Consumer's CDC+ monthly budget;
 - Keep the Consumer's CDC+ information confidential;
 - Not disclose any username, user ID or password associated with the Consumer to unauthorized persons;
 - Ensure the Consumer's health and safety is not at risk as a result of any action or oversight related to the CDC+ program;
 - Accept the Consumer's right to change Representatives and work with the Consumer to transition Representatives as needed;
 - Attend annual required CDC+ Representative procedural training and complete readiness review on behalf of the Consumer;
 - Complete required Background Screening prior to being approved to provide services on a Consumers Purchasing Plan as an Emergency Backup Provider under Natural Supports;
 - Spend in accordance with the Consumer's current authorized Purchasing Plan; and
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Roles and Responsibilities, continued

Representative Responsibilities, continued

- Submit all payroll documents to the F/EA for payment in a timely manner, as specified by program requirements.
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Consultant Responsibilities

In terms of responsibility to the Consumer, the Consultant must:

- Provide on-going assistance to Consumers and Representatives to manage program requirements and to ensure the Consumer is informed of all program updates;
 - Document any perceived Consumer risks during the Consumer's semi-annual home visit or more frequently if needed, and address solutions with APD staff as needed;
 - Assess the Consumer compliance with all requirements of the CDC+ program and assist or adjust as needed;
 - Encourage and support the Consumer in making independent choices about services, purchases, and employees;
 - Accept all Consumers who select the provider for Consultant services. APD may grant exceptions to this requirement in writing;
 - Continually assess and monitor the Consumer's risk for abuse, neglect and exploitation;
 - Ensure the Consumer's Medicaid eligibility by providing all assistance necessary to maintain Medicaid benefits;
 - Assist disenrolled Consumers with the final close out of their CDC+ account by assuring that all timesheets and invoices for services provided during the time the Consumer was on CDC+ have been submitted for payment and documented;
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Roles and Responsibilities, continued

Consultant Responsibilities, continued

- Have monthly contact with the Consumer as defined in the sections on Consultant Services in this chapter. Monthly contact may be in the form of phone calls or in person, whichever is the preferred method of the Consumer. Documentation of home visits and monthly contact must be in the central record of each Consumer [1915(j) Medicaid State Plan Amendment] Documentation by electronic communication is also acceptable by APD;
- Assist the Consumer to identify or modify needs and goals. All Consumers must be able to request a change to their support plan based on a change in needs or health status; and
- Review support plans annually, or whenever necessary due to a change in a Consumer's service needs or supports.

In terms of responsibility to APD and AHCA, the Consultant must:

- Have Medicaid Provider and Medicaid Waiver Services Agreements in effect with the Agency for Health Care Administration and the Agency for Persons with Disabilities respectively;
 - Receive training and certification from APD in the philosophy of self-direction, and person-centered planning;
 - Enroll as a Medicaid provider of CDC+ Consultant services. Annually complete the CDC+ refresher training;
 - Sign a Consumer/Consultant agreement and notify APD of selection as the Consumer's Consultant before officially acting as the CDC+ Consultant;
 - Maintain all required program materials in the Consumer's central file;
 - Cooperate with quality assurance monitoring;
 - Assure that all certification and registration requirements are submitted to the APD Area Office and assure that all providers of Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook services meet the qualifications stated in the Handbook;
 - Notify APD within 15 business days of any changes to the Consultant's name, address, Medicaid provider number, contact information, or agency affiliation;
 - Develop and implement a Corrective Action Plan (CAP) within five business days of becoming aware if the Consumer or the Consumer's Representative have failed to comply with any requirements of the CDC+ Program;
 - Inform the APD CDC+ Liaison within two business days of becoming aware if a Consumer or Representative fails to adhere to a Corrective Action Plan;
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Roles and Responsibilities, continued

Consultant Responsibilities, continued

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- Monitor the transition of Consumers between the iBudget Waiver to CDC+ to ensure that the provision of services are not interrupted;
 - Notify APD no later than five business days of becoming aware of a change in the Consumer's demographic information, including any changes in guardianship or competency. This information should be completed and submitted to APD using the CDC+ Participant Information Update Form;
 - Notify APD no later than 5 business days of becoming aware of a Consumer's death or admission to a hospital or residential facility. This information should be completed and submitted to APD using the CDC+ Participant Information Update Form;
 - Notify APD no later than 10 business days prior to the planned disenrollment of the Consumer for any reason other than death, emergency hospital admission or residential placement. This information should be completed and submitted to APD using the CDC+ Participant Information Update Form;
 - Comply with the "Core Assurances for Providers of Developmental Disabilities" included in the Appendix of the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook;
 - Use an incident reporting system as specified in the iBudget Waiver and report all incident information to the APD program office. This will aid in monitoring of incident reporting and follow-up as well as possible discovery of abuse or neglect [1915(j) Medicaid State Plan Amendment];
 - Document all Consumer-related contacts with the Consumer, Representative, APD Area Office, and APD central office in the Consumer's central record;
 - Assist Consumers in transferring back to the iBudget Waiver in the event of disenrollment from CDC+ so there is no interruption in services;
 - Assist to develop an emergency back-up plan prior to enrollment in the CDC+ program and assure that the plan is updated annually, or more frequently, as needed. A copy of the emergency back-up plan should be included in each Consumer's central record;
 - Provide all necessary budget information to the Consumer within 3 calendar days of each renewal of or change to the Consumer's Cost Plan;
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Roles and Responsibilities, continued

Consultant Responsibilities, continued

- Provide technical assistance when the Consumer or Representative is developing a Purchasing Plan. A Consultant shall not develop a Purchasing Plan for a CDC+ Consumer or Representative;
 - Review and sign the Purchasing Plan if the proposed services comply with all rules and regulations of the CDC+ program;
 - Notify the APD Area Office upon becoming aware of any purchased services a Consumer or Representative has made that are not authorized in the Purchasing Plan or that are purchased in excess of the Purchasing Plan;
 - Provide technical assistance and support to new Representatives selected by the Consumer;
 - Conduct face-to-face contacts as required. Face-to-face contacts shall accomplish the following:
 - Assist the Consumer to reach the goals stated on the support plan and Purchasing Plan;
 - Monitor the health and well-being of the Consumer, look for indicators of fraud, abuse, neglect, or exploitation and report these indicators to the proper authorities within 24 hours;
 - Monitor the Consumer's involvement in the community;
 - Assist the Consumer to make informed choices and to advocate for his or her self; and
 - Follow-up on the Consumer's or Representative's concerns.
-

Roles and Responsibilities, continued

Consultant Services

A consultant must:

- Visit the Consumer in his or her home or at a community activity no less than once per six-month period. At least one face-to-face contact per year must be in the Consumer's home. Documentation of face to face visits must be in the central record for each Consumer.
 - Have a monthly contact with the Consumer. Monthly contact may be in the form of a phone call or in person, whichever is the preferred method of the Consumer. The Consultant must document each monthly contact in the Consumer's central record. The Consultant must perform and document the following tasks for each monthly contact:
 - Review the Consumer's monthly statement with the Consumer or Representative and determine whether the Consumer or Representative has complied with the Purchasing Plan;
 - Document the monthly contact and review the monthly statement. This must include, but is not limited to:
 - Verification that the Consumer or Representative has submitted all provider timesheets and invoices in a timely manner;
 - Identification of any budget management problems; and
 - Identification of any circumstances that require a Corrective Action Plan or disenrollment from CDC+.
 - Review all provider materials to assure that the items are complete whenever there is a change to the Consumer's Purchasing Plan.
-

Directly Hired Employee

The CDC+ Consumer is responsible for assuring that all directly hired employees are given materials that detail the steps necessary to assist the Consumer to implement self-direction of their budget allowance and approved services.

Directly Hired Employee Responsibilities

- Submit information necessary, and in accordance with Chapter 435 and section 408.809, F.S., for the required Background Screening prior to serving the Consumer;
 - Submit the employee materials at the time of hire;
 - Complete, sign and submit a timesheet to the Consumer or Representative at the end of each workweek listing the specific time worked (in hours and quarter hours) for each service on each day worked;
 - Provide only the supports and services and the number of hours agreed upon at the time of hire in accordance with the specific details and instructions explained in a job description and an employer/employee agreement; and
 - Review and sign a service provider job description which identifies what is expected from the employee that is hired for the job, the total number of hours the employee will be expected to work and the rate of pay that is being offered for this position.
-

Roles and Responsibilities, continued

Agency or Vendors

A person or business that provides services and supports to a Consumer under the CDC+ program. Agency or Vendors are paid from an invoice rather than a timesheet.

Agency or Vendors Responsibilities

- Provide to the Consumer a copy of the Background Screening results for each direct-care staff who works for the Agency or Vendor prior to providing services to the Consumer;
 - Provide a written description of the services that will be provided by the Agency or Vendor;
 - Submit to the Consumer or Representative the Agency or Vendor information at the time of hire;
 - Comply with the Background Screening provisions of section 409.221, Chapter 435, and section 408.809, Florida Statutes for each direct-care staff. As required by these provisions, an Agency or Vendor may not allow any direct-care staff to render services to a client prior to the completion of the Background Screening process;
 - Provide only the services and the number of hours agreed upon at the time of hire;
 - Work in accordance with the Consumer's specific needs and goals as indicated in the Support Plan and as instructed by the Consumer or Representative; and
 - Review and sign a service provider job description which identifies what is expected from the service provider, including negotiated hours and rates.
-

APD Responsibilities

APD or its designated agent shall:

- Conduct initial and ongoing CDC+ procedural-based training for Consumers, Representatives and consultants, and CDC+ Area Liaisons;
 - Initiate training prior to the development of the budget/Purchasing Plan. In this training, the Consumer is given lists of roles and responsibilities, which provides a detailed description of the roles and responsibilities of the Consumer in the program and a detailed description of the roles, responsibilities and support functions of the Consultant, APD staff, Representative, Agency or Vendors and providers;
 - Ensure that Consumers are provided in writing with due process rights for a fair hearing in the event that a service is denied, terminated or suspended. Chapter 120, Florida Statutes, provides direction for fair hearings;
 - Distribute instructional manuals for consultants, Consumers/Representatives, and Directly Hired Employees detailing procedures described in this rule;
-

Roles and Responsibilities, continued

**APD
Responsibilities,**
continued

-
- Ensure that all reported incidents of abuse, neglect or exploitation within the CDC+ program will be compiled and included in the annual report to Agency for Health Care Administration. The incidents will be logged by type of incident and must include appropriate action taken to remedy the situation; and
 - Correctly calculate the Consumer's CDC+ monthly budget for new enrollees, and existing Consumers whose service authorizations have changed (either decreased or increased), and provide the monthly budget information to the Consumer via their Consultant.
-

**State Agency
Statutory
Roles and
Responsibilities**

AHCA's and APD's roles and responsibilities include the following
s. 409.221(4)(g)1.-5., F.S.:

- Assessing each Consumer's functional needs, helping with the service plan (support plan), and providing ongoing assistance with the service plan;
 - Offering the services of consultants who shall provide training, technical assistance, and support to the Consumer;
 - Completing the Background Screening for providers;
 - Approving fiscal intermediaries; and
 - Establishing the minimum qualifications for all caregivers and providers and being the final arbiter of the fitness of any individual to be a caregiver or provider.
-

CHAPTER 3
PROGRAM OPERATIONS

Overview

Introduction

This chapter describes the operational processes for direct-care staff employee Criminal Background Screening, Budget, and Purchasing Plan Requirements

APD oversees the day to day operations of the CDC+ program. When a Consumer is enrolled and trained in CDC+ procedures, the following program operations are initiated by APD on behalf of the Consultant, Consumer, Representative and employees, Independent Contractors or Agency or Vendors hired to perform services on behalf of the Consumer. APD will provide instructions and training regarding program requirements for Consumers, Representatives and Consultants.

In This Chapter

This Chapter contains:

TOPIC	PAGE
Overview	3-1
Requirements for Background Screening	3-2
Emergency Backup Plan	3-3
Budget	3-4
Purchasing Plan	3-4
Purchasing Plan Requirements	3-5

Criminal Background Screening

Provider criminal Background Screening for direct-care staff is mandated by state law for all providers of Medicaid services. Background Screenings are mandatory for all CDC+ providers of direct-care including family members. All individuals who render direct-care to a Consumer enrolled in this program must either:

- Be a Medicaid enrolled provider who received a Background Screening at the time of their enrollment into the Medicaid program (and who remains in good standing with the Medicaid program); or
- Pass a level 2 Background Screening prior to rendering any support or services to the Consumer.

Requirements for Background Screening

Overview

All providers in the CDC+ program, including family members, are subject to the Background Screening provisions of section 409.221(4)(i), Chapter 435, and section 408.809, F.S.; CDC+ Consumers and Representatives shall not hire or allow provision of services until the completion of the Background Screening process.

No person who has been found guilty of, entered a plea of nolo contendere or guilty to, or been adjudicated delinquent and the record has not been sealed or expunged for a disqualifying offense may provide CDC+ services without receiving an exemption from the Agency for Persons with Disabilities (APD). 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 Chapter 435, and section 408.809, F.S.

Failure to comply with the Background Screening requirements of sections 409.221(4)(i), section 408.809, and Chapter 435, F.S., may lead to disenrollment from the CDC+ program.

Attestation

In compliance with s. 435.05(2), F.S, every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer.

Consequences for Violation

Any provider who has been disqualified by APD, based on a negative Background Screening results, may not provide services or render care to a CDC+ Consumer unless an exemption from disqualification has been granted by the APD. It is the responsibility of the affected employee to contest disqualification or to request exemption from disqualification.

Requirements for Background Screening, continued

Consequences for Violation, continued

Any provider or Representative required to undergo employment screening who refuses to cooperate or refuses to submit the information necessary to complete the screening, including fingerprints when required; must be disqualified for employment in such position or, if employed, must not be allowed to continue serving a CDC+ Consumer. If a provider is arrested for a disqualifying offense, the provider must cease providing services to the CDC+ Consumer.

Emergency Backup Plan

Overview

Each CDC+ Consumer is required to develop an emergency back-up plan before starting to manage a budget on CDC+, and the plan must be reviewed and updated, if necessary, during the annual support planning process.

The personal emergency portion of the emergency backup plan will allow the Consumer to identify circumstances that would cause an emergency based upon his unique needs. The emergency backup plan should describe the alternative service delivery methods that will be used under any of the following circumstances:

- In the event a primary provider of a critical service fails to report to work or otherwise cannot perform the job at the time and place required;
 - In the event the Representative becomes unavailable, permanently or temporarily, to perform the roles and responsibilities of the Representative;
 - In the case of a personal emergency such as a house fire, an accident in which the Consumer was injured, or loss of a loved one who is a caregiver for the Consumer;
 - In the event of a community-wide emergency which required evacuation such as a hurricane or a terrorist attack; or
 - If an unexpected shortage of funds were to occur such as a state budget shortfalls or a required a cut in program funds.
-

Budget

Determining the Budget Allowance

A CDC+ Consumer's monthly budget is based on the cost of services that a Consumer has been approved to receive under the iBudget Waiver.

A Consumer's monthly budget is calculated from the current approved Cost Plan. Using only the services that the Consumer receives annually, services are divided by the number of months authorized. Those amounts are totaled to determine the total monthly Cost Plan amount. The CDC+ payment methodology is applied to the monthly Cost Plan amount. Based on this methodology, the CDC+ Consumer exchanges the total budget of their current approved Medicaid cost plan for a smaller budget that has greater flexibility, in accordance with the self-direction model established in section 1915(j) State Plan Amendment.

Managing a CDC+ Budget Allowance

When an individual's monthly budget has been determined and their enrollment in the CDC+ program is finalized, the Consumer's first Purchasing Plan will be completed. When the Purchasing Plan has been approved by APD the Consumer may begin managing the CDC+ monthly budget.

Purchasing Plan

Overview

The purpose of the Purchasing Plan is to:

Describe how the Consumer plans to spend the CDC+ budget and to:

- Ensure the Consumer knows how much money is available to spend each month;
- Help keep the Consumer "on track" in order to prevent overspending; and
- Inform the Consumer's consultant of his plans for services when a designated primary provider is unable to provide a critical service as an Emergency Backup Provider.

The Consumer or his Representative must develop and complete a CDC+ Purchasing Plan to show a plan for spending the budget each month. A Purchasing Plan has different sections in which to list the providers who are hired by the Consumer and the other items that need to be purchased. A Consumer is encouraged to save funds to accumulate each month to take advantage of good prices on approved consumable medical supplies or to cover additional hours of personal care or respite service that might be needed.

Purchasing Plan, continued

Overview, continued

A Consumer's needs identified on the support plan and iBudget Cost Plan result in funding for specific services and supports that have been determined to be medically necessary. A Consumer must be able to meet those identified needs with the supports and services specified on the Purchasing Plan. The Purchasing Plan must be developed in a way that is cost effective and stretches the Consumer's monthly funds to the greatest extent possible. A CDC+ Consumer's ability to negotiate a lower rate of pay for services will not affect the amount of services approved on the Consumer's Cost Plan.

The Savings section of the Purchasing Plan is to be used for the Consumer's needed supports and services that are not purchased on a monthly basis. When a Purchasing Plan is updated to add a new service, support, or a new provider, the effective date of the approved, updated Purchasing Plan is the first day of a given month. This is the first day a new service or support can be purchased or a new provider can begin to provide a service if the required paperwork to enroll the provider with the F/EA has been submitted and a Provider ID # has been assigned. All Purchasing Plan changes and updates must be received by the APD Area Office no later than the 10th of the month prior to the effective date of the approved change. If a new provider begins providing services before the effective date of the Purchasing Plan, the Consumer will be responsible for paying the provider from their own funds. The Consumer must also use his personal funds for any items purchased prior to the effective date of the approved Purchasing Plan.

Purchasing Plan Requirements

Effective Date

The effective date entered on a Consumer's approved Purchasing Plan is the date that the services on that Purchasing Plan are authorized by APD to begin. The effective date is always the first day of a calendar month. Providers of any new services that appear on the Purchasing Plan must not begin to provide the service until all provider materials are processed, a provider ID # is issued and it is the first of the month specified on the Purchasing Plan.

Note: See Appendix E for a copy of the CDC+ Purchasing Plan, February 14, 2012. The CDC+ Purchasing Plan is available by photocopying it from Appendix E.

Needs and Goals

All services authorized on a Consumer's Purchasing Plan must meet the Consumer's needs and goals that have been identified on the Consumer's iBudget Waiver support plan. The relationship between the Consumer's iBudget Waiver support plan and Cost Plan and the services on the Purchasing Plan must be specified in the Needs section of the Purchasing Plan.

Purchasing Plan Requirements, continued

Monthly Services and Supports

The Consumer or Representative must budget for all monthly services and supports in the Services section of the Purchasing Plan. Services and supports purchased on a regular, monthly basis must not be entered in the Savings section of the Purchasing Plan. The provider of every service in the Services section must be named on the plan before the Purchasing Plan can be approved.

Workers Compensation

In accordance with Section 440.02(17)(b)(2), Florida Statutes, employers who employ four or more Directly Hired Employees who provide services during a calendar month must purchase Workers Compensation Insurance. This insurance may be purchased with Unrestricted CDC+ funds.

Employer Taxes

The Consumer must budget for employer taxes to be paid with CDC+ funds. The Consumer must ensure that the relationship of the employee to the Consumer is accurately documented so that taxes are withheld correctly and paid to the Internal Revenue Service (IRS) and Florida Department of Revenue. If the provider relationship information provided by the Consumer is found to be in error, the Consumer will be personally responsible for paying any back taxes and penalties resulting from the error.

Purchasing Plan Requirements, continued

Changing Rate of Pay for a Directly Hired Employee

A change in a DHE's pay rate may occur only on the first day of a work week. If a DHE with a new pay rate is entered on a Purchasing with an effective date that occurs after the start of a workweek, the employee must be paid the former rate of pay for the remainder of the work week. The new rate of pay will take effect on the following Monday at 12 midnight.

One Time Expenditures and Short Term Expenditures (OTE/STE)

The funds for any services in the Consumer's purchase plan that meet the definition of One Time or Short Term Expenditures are provided to the Consumer in a lump sum amount in the month authorized on the Purchasing Plan so the funds will be available to the Consumer when needed.

Unexpended funding provided for Restricted services and expired OTEs and STEs are subject to reinvestment. A schedule of reinvestment must be developed and implemented by APD. A request for expenditure may be submitted to the APD Area Office for approval.

Limitations on One Time Expenditures

Funding for One Time Expenditures is provided to the Consumer at 100% of the funding authorized in the Cost Plan; it is not reduced by the discount or administrative rate.

Funding for One Time Expenditures cannot be used for any purchase other than the purchase authorized in the Cost Plan. If any funding provided to the Consumer for a One Time Expenditure is not utilized during the period of time authorized on the Purchasing Plan the funds must be recouped.

Limitations on Short Term Expenditures

Funding for Short Term Expenditures (STE) is provided to the Consumer at 92% of the funding authorized in the Cost Plan. The Consumer will plan to purchase at least 92% of the amount of the same service authorized on the Cost Plan. The Consumer must indicate on the Purchasing Plan the rate of pay that has been negotiated with the provider for each unit of service specified on the Purchasing Plan.

Funding provided to the Consumer for a STE that is not utilized within the period of time authorized on the Purchasing Plan must be reinvested.

If the STE is a single item, including an assessment, an evaluation, or an installation of a personal emergency response system, and the Consumer cannot negotiate a rate low enough to pay for the service with the funding provided for the STE, the Consumer must accumulate unexpended Unrestricted services funding in Savings in sufficient amount to pay for the balance of the STE.

Purchasing Plan Requirements, continued

Justification for Purchases from Savings

Every service and support requested to be purchased from the Savings section of the Purchasing Plan must be justified in writing when the Purchasing Plan is submitted for approval, unless the item requires prior approval of APD Central Office as specified in limitations for Restricted or Unrestricted services. The justification must explain how the service or support is consistent with an assessed need, necessary to ensure the Consumer's health or safety or to increase independence, and is feasible based on the Consumer's monthly Savings.

Duplication of Services

If time in and time out on an employee's time sheet are the same as time in and time out on another employee's timesheet for the same Consumer, such time recording is considered a duplication of services and is unallowable.

An employee's hourly rate of pay as shown on a Consumer's Purchasing Plan is for a full hour provided solely to that Consumer. If one employee provides services to more than one Consumer during a span of time, the number of hours entered on each Consumer's Purchasing Plan must reflect the number of full hours of service each Consumer will receive. The number of hours worked and entered on the employee's timesheet must be only that portion of time that best reflects total time spent solely with each Consumer.

Allowable Purchases

Any item that is an allowed purchase using CDC+ funds must be related to the Consumer's long-term care needs or need for community supports as identified in the Consumer's support plan. Before a Consumer may purchase services or supports, the services or supports must be approved as being clearly associated with meeting the Consumer's identified needs and goals. A complete list of services available in the CDC+ Program is included in Chapter 4 of this Handbook.

Purchasing Plan Requirements, continued

Unallowable Purchases

The CDC+ budget MAY NOT be used for purchases such as:

- Payments to someone to be the CDC+ Representative;
- Gifts for workers, family or friends;
- Loans to the Consumer's workers;
- Rent or mortgage payments;
- Utility payments (e.g., electric, water gas, telephone, sewer, garbage services);
- Clothing;
- Groceries of a general nature (with the exception of special foods required because of the Consumer's disability to maintain nutritional status);
- Lottery tickets;
- Alcoholic beverages;
- Entertainment activities;
- Entertainment devices, such as televisions, stereos, radios, or VCRs;
- Swimming pools or spas;
- General purpose furniture;
- Educational equipment or supplies;
- Lessons, such as Karate, that are not therapeutic;
- General repairs and maintenance to a vehicle;
- Normal repairs or maintenance to home for Consumers.

Note: For more information about exceptions requirements to normal repairs or maintenance to the home, see the Limitations and Special Conditions section under In Home Supports in Chapter 4 of this handbook.

- Repairs/maintenance to general purpose equipment;
- Tobacco products;
- Services which will meet the Consumer's needs but are available, without charge, from community organizations;
- Anything that is not directly related to the Consumer's disability and related health condition. For example, CDC+ does not allow personal hygiene items or consumable medical supplies that would be purchased for anyone in the general population as a necessary cost of living, such as soap, toothbrush, shampoo, tissues, and similar toiletries; or
- Items or services, which are available through other funding sources such as Medicare, the Medicaid State Plan, local school system, or vocational rehabilitation.

While a CDC+ Consumer has more choice, flexibility, and control over their care, a Consumer must act responsibly and use the funds only for intended and authorized use. This includes accurate record keeping in accordance with this handbook and applicable state and federal regulations. Consumers who are not able to manage their funds responsibly may face reinvestment of their misused funds and disenrollment from the CDC+ program.

Purchasing Plan Requirements, continued

Purchasing Plan Updates and Changes

A Consumer's monthly budget is calculated based on the Consumer's approved Cost Plan. The Consumer's Cost Plan is determined in the same manner as the iBudget Waiver, pursuant to Sections 59G and 65G of the Florida Administrative Code and Chapter 393, Florida Statutes. If there is a change to the Consumer's Cost Plan, the Consumer or Representative shall immediately develop a new CDC+ Purchasing Plan that conforms to the Consumer's new Cost Plan. The new Purchasing Plan shall indicate how the services in the Purchasing Plan will meet the needs and goals identified in the Consumer's support plan.

There are three methods that can be used to revise a Purchasing Plan:

- **Purchasing Plan Change.** A Purchasing Plan Change is required if the Consumer's monthly budget has changed or if the Consumer adds or removes a One-Time Expenditure or a Short Term Expenditure from the Purchasing Plan.
- **Purchasing Plan Update.** A Purchasing Plan Update is required if the Consumer wishes to add, replace or remove a provider, revise a rate of pay, revise the number of units of a service, or add or remove a service that does not require an adjustment of the Consumer's monthly budget.
- **Purchasing Plan Quick Update.** A Purchasing Plan Quick Update if the Consumer wishes to make any of the following Purchasing Plan edits during the middle of the month:
 - Replace a current authorized provider with a new provider;
 - Revise the Savings or One-Time and Short Term Expenditure sections of the Purchasing Plan to authorize reimbursement to the Consumer or Representative;
 - Add or replace an item in the Savings section; and
 - Add an emergency backup provider in the Services section.

All Purchasing Plan changes and Purchasing Plan updates are effective on the first day of the selected calendar month. A Purchasing Plan quick update is effective on the date indicated by the Consumer. The Purchasing Plan must be submitted to the APD Area Office by the Consultant by the 10th of the month prior to the selected calendar month. A Consumer or Representative must complete a Purchasing Plan quick update at least 7 calendar days in advance of the time the action is to occur.

If there are no changes in the Consumer's needs, the monthly budget amount entered into the CDC+ Purchasing Plan database remains unchanged. The Consumer is not required to resubmit a CDC+ Purchasing Plan if the Consumer does not need to make any revisions to providers, rates, or services.

Note: See Appendix F for a copy of the CDC+ Quick Update to My Purchasing Plan, June 1, 2009. The CDC+ Quick Update to My Purchasing Plan is available by photocopying it from Appendix F.

CHAPTER 4
CDC+ PROGRAM SERVICES

Overview

In This Chapter

This chapter contains:

TOPIC	PAGE
Overview	4-1
Restricted Services	4-3
Unrestricted Services	4-4
Adult Day Training	4-5
Adult Dental Services	4-5
Advertising	4-6
Behavior Analysis Services	4-7
Behavior Analysis Assessment	4-13
Behavior Assistant Services	4-14
Companion Services	4-17
Consumable Medical Supplies	4-19
Dietitian Services	4-22
Durable Medical Equipment and Supplies	4-23
Environmental Modification	4-24
Gym Membership	4-26
In-Home Support Services	4-26
Occupational Therapy	4-27
Occupational Therapy Assessment	4-28
Other Therapies	4-29
Over-The-Counter Medications	4-29
Parts and Repairs for Therapeutic or Adaptive Equipment	4-30
Personal Care Assistance	4-31
Personal Emergency Response Systems (PERS)	4-32
Personal Emergency Response System (PERS) Installation	4-33
Physical Therapy	4-34
Physical Therapy Assessment	4-35
Private Duty Nursing	4-35
Residential Habitation Services	4-37
Respiratory Therapy	4-38
Respiratory Therapy Assessment	4-39
Respite Care	4-39
Seasonal Camp	4-41
Skilled Nursing	4-42
Specialized Mental Health Services	4-43
Specialized Training	4-44
Speech Therapy	4-45

Overview, continued

In This Chapter, continued

This chapter contains:

TOPIC	PAGE
Speech Therapy Assessment	4-46
Supported Employment	4-46
Supported Living Coaching	4-57
Transportation	4-48
Vehicle Modification	4-51

Developmental Disabilities iBudget Waiver Services

CDC+ Consumers may purchase all services available in the 1915(c) Developmental Disabilities iBudget Waiver as defined below except for residential habilitation services provided in a residential setting.

Individualized Goods, Supports, and Services

In addition to the services available in the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, CDC+ Consumers may purchase services specific to self-direction programs called Individualized Goods, Supports and Services. Providers of Individualized Supports and Services do not have to be enrolled Medicaid providers. Cost of services or rates for Individualized Supports and Services are negotiable.

All Individualized Supports and Services must be specific to and consistent with the symptoms or confirmed diagnosis of the Consumer’s developmental disability and be linked to an assessed need or related goal established in the Consumer’s support plan.

All Individualized Goods, Supports, and Services must meet all of the following criteria:

- Be related to a need or goal identified in the support plan;
- Be for the purpose of increasing independence or substituting for human assistance, to the extent the expenditures would otherwise be made for that human assistance;
- Promote opportunities for community living and inclusion;
- Be able to be accommodated within the Consumer’s budget without compromising the Consumer’s health or safety; and
- Be provided to, or directed exclusively toward, the benefit of the Consumer.

Overview, continued

Provider Qualifications and Responsibilities

All CDC+ service providers must be at least 16 years of age and must satisfy the qualifications and requirements for the service that is provided. CDC+ providers must also comply with the Background Screening requirements of this handbook, the provisions of section 409.221(4)(i), Florida Statutes, and the provisions of Chapter 435 and section 408.809, Florida Statutes.

Restricted Services

Description

Services that are approved on a Consumer's iBudget. Cost Plan, which may be prescribed by a physician, and require providers to have professional licensure or certification.

Consumers that have been approved for the iBudget Waiver which corresponds with a Restricted service listed below must obtain at least 92% of the units of measure approved for that service or the corresponding Individualized Service. These services shall be included in the Services section or the Short Term Expenditures section of the Purchasing Plan. CDC+ funding not used during the number of months authorized by the Cost Plan shall be recovered by APD annually and returned to the iBudget Waiver.

If a Restricted service or an iBudget Waiver service is considered a "critical service", all emergency backup providers must have the same credentials and provide the same service as the primary provider.

If a CDC+ Restricted service was not approved on the Consumer's iBudget Cost Plan, the Consumer may purchase the service through CDC+ if:

- The service meets the Consumer's needs or related goals identified in the Consumer's Support Plan;
- The Consumer receives prior approval for the service from the APD Area Office; and
- The Consumer has accumulated sufficient Unexpended, Unrestricted funds in the Savings section of the Purchasing Plan to pay for the service.

Purchasing Restricted Services

Specific purchasing rules apply to Restricted services.

For all Restricted services, the Consumer must use the CDC+ Monthly Budget to purchase at least 92% of the units of measure approved for the same services on the current iBudget Cost Plan. Unexpended restricted funds cannot be used to purchase other services in CDC+.

Restricted Services, continued

Purchasing Restricted Services, continued

If the Consumer wishes to purchase a Restricted service not funded in the Consumer's iBudget Cost Plan, the Consumer or Representative must request approval from the APD Area Office to purchase the service from Unspent Unrestricted funds in the Savings section of their CDC+ Purchasing Plan. In order for the APD Area Office CDC+ Liaison to approve the purchase from Savings, the Consumer or Representative must provide to the liaison written explanation of how the service or support will benefit the Consumer. A service may only be approved if there are sufficient Unrestricted funds accumulated in the Savings section of the Consumer's CDC+ Purchasing Plan.

Unless otherwise indicated in the service description, a prescription is not needed to purchase a Restricted service from Savings.

Even if the Restricted service is purchased from Savings, the provider must meet all provider qualifications stated in this handbook for that service.

Unrestricted Services

Description

Unrestricted services are services and supports that a CDC+ Consumer may purchase provided the service clearly meets the Consumer's needs and goals as identified on the iBudget Support Plan.

A CDC+ Consumer may purchase any Unrestricted service if the service is individualized, specific, and consistent with the symptoms or confirmed diagnosis of the Consumer's developmental disability and is linked to an assessed need or goal established in the Consumer's support plan.

Unrestricted services must meet all criteria as stated in the Individualized Goods, Supports, and Services section of this chapter.

Adult Day Training

Description	Training programs intended to support the participation of Consumers in daily, meaningful, valued routines of the community. ADT services stress training in the activities of daily living, self-advocacy, adaptive and social skills, and are age and culturally appropriate.
Limitations and Special Conditions	Emergency Backup Providers for ADT may be providers of companion or respite services.
Provider Qualifications	<p>Providers of ADT services must be designated by the APD Area Office as an adult day training center unless waived in writing by the Area Office, the provider shall meet the minimum qualifications for staff and staffing as designated in the iBudget Waiver handbook for ADT.</p> <p>Providers must be an Agency/Vendor.</p>
Service Type	<p>Unrestricted.</p> <p>If approved on the Consumer's iBudget Cost Plan on an on-going basis, the service does not have to be purchased in the same quantity, amount or duration as funded in the iBudget Waiver Cost Plan. Unused funds can be used to purchase other services.</p> <p>If approved on the Consumer's iBudget Cost Plan on a temporary basis (6 months or less), then it must be entered on the CDC+ Purchasing Plan as a Short Term Expenditure and would become a Restricted service.</p>

Adult Dental Services

Description	Dental treatments and procedures for adults that are not otherwise covered by the Medicaid state plan.
Limitations Special Conditions	<p>Limited to Consumers 21 years of age or older. Dental treatments and procedures may not be purchased solely for cosmetic purposes.</p> <p>Adult dental services may only be provided by an Agency or Vendor or Independent Contractor.</p>
Provider Qualifications	Providers of adult dental services must be dentists licensed in accordance with Chapter 466, Florida Statutes.

Adult Dental Services, continued

Service Type	Restricted
	The Consumer must use their CDC+ monthly budget to purchase at least 92% of the units of measure approved for this service in the iBudget Cost Plan. This service is considered a Short Term Expenditure in that it is approved on the iBudget Cost Plan on a periodic basis.
Advertising	
Description	This service is for classified advertisements placed in local newspapers or for other paid paper or Web advertising to find qualified service providers to work for the Consumer.
Limitations and Special Conditions	Copies of advertisements and proof of cost must be maintained by the Consumer to document the purchase. Advertising services may not provide a direct or indirect financial benefit for relatives of the Consumer.
Provider Qualifications	Providers must be Independent Contractor or Agency/Vendor.
Service Type	Unrestricted
	This service is unique to the CDC+ program and not available under the iBudget Waiver. Therefore, it may only be purchased in CDC+ by using Unspent Unrestricted funds in the savings section of the Purchasing Plan.

Behavior Analysis Services

Description

Behavior analysis services are provided to assist Consumers to learn new, or increase existing, functionally equivalent replacement skills directly related to existing challenging behaviors. Challenging behaviors include those behaviors exhibited by the Consumer that pose risk of harm to the Consumer or others (i.e., aggression, self-injury, property destruction, behaviors that prevent inclusion in normal settings, or behaviors that the Consumer does not exhibit with sufficient proficiency or skill to prevent harm to the Consumer or others, including resisting basic hygiene, refusal to take medications, etc.).

Behavior analysis includes the design, implementation, and evaluation of systematic environmental modifications that assist in understanding a Consumer's behavior and to produce significant change in the Consumer's behavior that is socially meaningful. Behavior analysis uses direct observation and measurement of a Consumer's behavior and environment to identify contextual factors, conditions influencing motivation, stimulus events occurring prior to behavior, as well as reinforcement and other consequences that affect these practical changes in behavior.

The services are designed to facilitate ongoing changes in the Consumer's environment, the interactional styles of caregivers, and the contingencies for the Consumer's behavior provided by other people in order to make lasting improvements in the Consumer's behavior. Training for parents, caregivers, and staff is integral to the implementation of a behavior analysis services plan as is the monitoring of procedural integrity and program effectiveness.

Assessing Challenging Behaviors

The practice of behavior analysis and assessment is defined in Rule 65G-4.009, F.A.C. Behavior analysis support plans that include behaviors identified in Rule 65G-4.010, F.A.C., require submission to the LRC chair for review, within five working days of implementation, by certified behavior analysts or persons licensed pursuant to Chapter 490 or Chapter 491, F.S., meeting provider qualifications.

In order to determine when and in what situations the Consumer's challenging behavior occurs, the Consumer's behavior is assessed to identify functional relationships between a particular behavior and the Consumer's environment. A variety of techniques, including positive reinforcement, are used in order to produce practical behavior change.

Behavior Analysis Services, continued

**Assessing
Challenging
Behaviors**, continued

Behavior analysis does not rely on cognitive therapies and expressly excludes psychological testing, neuropsychology, psychotherapy, sex therapy, psychoanalysis, hypnotherapy and long-term counseling as treatment modalities. Services provided by behavior analysts with limited experience in the problem area or by behavior analysts who are not BCBA's with three years of experience or licensure under Chapter 490 or 491, F.S., should receive oversight and approval of services with a more experienced behavior analyst or with the above described highest level of certification.

Plan Requirements

Behavior analysis services should be initiated with a plan for maintaining and generalizing behavioral improvements, as well as an initial criteria for the reduction and fading of behavioral services. As caregivers show increasing competence in delivering the implementation plan, and the Consumer's target behaviors are responding to effective treatment, the plan should set forth target behavior criteria to be achieved by the Consumer that lead to a specified reduction in the level of service. Subsequent to the initial plan, an updated fading plan must be addressed, at a minimum, as part of the annual report.

The written annual report (3rd Quarterly Report or 9th Monthly Report) for behavior analysis services should include:

- Summary of program fidelity monitoring and any relevant environmental or medical factors affecting behavior.
- Graphic and narrative summary of all target behaviors identified in the behavior analysis services plan (BASP).
- Analysis of data and summary of progress, identifying whether each target behavior has improved or not since the last quarter and since baseline.
- Future plans, recommendations or changes for current or other supports and services, if any.

Delivery of behavior analysis services is a complex process that includes assessing, planning, and training directly with the Consumer as well as with others supporting the Consumer, at times when the Consumer is present or absent.

Behavior Analysis Services, continued

Direct Services

Direct services provided to the Consumer, caregivers, or staff, or other providers, include:

- Conducting an analog functional analysis.
 - Observation of the Consumer for descriptive functional assessment.
 - Observation of the Consumer for ongoing assessment, evaluation and data collection.
 - Interview, observation, feedback regarding interactions of caregivers, staff and other providers.
 - Training or modeling procedures and training caregivers, staff, or other providers.
 - Probing new procedures with Consumer.
 - Behavior plan development and revision.
 - Direct training of the Consumer.
-

Indirect Services

Indirect services provided to support behavioral programming include the daily progress notes documenting the activities, data collection, and analysis.

In addition, indirect activities that occur when the Consumer is not present that are required to support behavior analysis can include behavior plan development and revision, graphing and analysis of data, providing consultation to other professionals, presentation of a Consumer's behavior plan to the APD LRC, and attending meetings relevant to the Consumer's treatment, including the Consumer's treatment team, psychiatrist, and school related meetings. Providers can only bill for indirect services up to a maximum of 25 percent of the total units for the cost plan year. In those cases, where service hours are limited to four hours or less per month, an average of one hour per month maximum can be billed for indirect services.

Limitations and Special Conditions

In all cases, behavior analysis services must be provided in the setting(s) relevant to the behavior problems being addressed.

A Consumer must receive no more than 16 quarter hour units of behavior analysis service per day. A unit is defined as a 15 minute time period or portion thereof.

These services can be provided in the Consumer's place of residence, while providing life skills development services, or anywhere in the community.

This service can be provided concurrently (at the same time and date) with another service. These services are not to be provided in the school system or take the place of services required under provisions of the Individuals with Disabilities Education Act (IDEA).

Behavior Analysis Services, continued

**Limitations and
Special Conditions,**
continued

Behavioral assessments are limited to one per year. These assessments are reimbursed at the usual and customary rates, unless specifically authorized by the APD regional behavior analyst. Providers cannot bill more than 16 quarter hours per day, or 496 quarter hours per month, and no more than 5,840 quarter hours per year.

**Provider
Qualifications**

Providers of behavior analysis must have licensure or certification on active status at the time services are provided. Levels have been established based on specific credentials that also indicate fee variation. Providers of this service must have one or more of the following credentials:

- **Level 1-** Board certified behavior analyst, master's or doctoral level; or a person licensed under Chapter 490 or 491, F.S., (psychologist, school psychologist, clinical social worker, marriage and family therapist, or mental health counselor), with evidence of work samples and work history of more than three years of experience in the application of applied behavior analysis procedures to persons with exceptional needs, post-certification, or licensure.
 - **Level 2-** Board certified behavior analyst, master's or doctoral level, Florida certified behavior analyst with a master's degree or higher, or a person licensed under Chapter 490 or 491, F.S., (psychologist, school psychologist, clinical social worker, marriage and family therapist, or mental health counselor) with evidence of work samples and work history, of at least one year supervised experience in the application of applied behavior analysis procedures to persons with exceptional needs.
 - **Level 3-** Florida certified behavior analyst with a bachelor's degree, associate's degree, or high school diploma, or board-certified assistant behavior analyst. Level 3 providers are required to show evidence of at least one hour per month of supervision from a professional who meets the requirements of a Level 1 or Level 2 board certified behavior analyst.
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Behavior Analysis Services, continued

**Provider
Qualifications,**
continued

Diplomas or degrees earned in other countries shall be accompanied by authentication documentation that the degree is equivalent to the educational requirements for the position.

Providers of behavior analysis services must be an independent contractor or work for an agency or vendor. A behavior analysis provider cannot be a directly hired employee.

Service Type

Restricted

The Consumer must use their CDC+ monthly budget to purchase at least 92% of the units of measure approved for this service in the iBudget Cost Plan.

Behavior Analysis Assessment

Description

The systematic evaluation of environmental variables/conditions for the purpose of changing behaviors to produce socially significant improvements in human behavior based on the principles of behavior identified through the experimental analysis of behavior. Procedures used must include observation of the person in his various environments and collection of data regarding behaviors, and might involve interviews with significant persons in those environments, review of records and occasionally systematic manipulation of variables.

Limitations

Behavioral assessments are limited to one per year. These assessments are reimbursed at the usual and customary rates, unless specifically authorized by the APD regional behavior analyst. Providers cannot bill more than 16 quarter hours per day, or 496 quarter hours per month, and no more than 5,840 quarter hours per year.

Provider Qualifications

A behavior analysis assessment must only be provided by a certified behavior analyst that meets the standards as required in of Chapter 65G-4, Florida Administrative Code.

Behavior analysis assessments must only be provided by an agency, vendor, or independent contractor.

Service Type

Restricted

This service is considered a Short Term Expenditure as it is approved on the iBudget Cost Plan on a periodic basis.

Behavior Assistant Services

Description

Behavior assistant services provide support in implementing the behavior analysis services plan created by the certified behavior analyst or qualified licensed provider. All behavior assistant services provided must be authorized in a behavior assistant plan contained within the behavior analysis services plan.

Behavior assistant services are designed for Consumer s receiving behavior analysis services in one or more of the following circumstances:

- Health and safety needs that are a direct result of the Consumer's challenging behaviors that pose a documented risk to the Consumer in the community and can result in a loss of the current living environment and placement in a more restrictive setting. Documentation can include, but is not limited to, police reports, hospitalization reports, medical reports, incident reports, or other records that will substantiate the severity and frequency of the behavior.
- Other paid or unpaid services or supports requiring time-limited instruction on learning how to carry out the behavior plan effectively.
- For a time-limited period during transitional residential changes, such as movement from Intensive Behavior Residential Habilitation to Behavior Focused Residential Habilitation.
- For a limited time period during other significant life changes when challenging behaviors are likely to increase and new caregivers need to be trained to ensure a successful transition.

Plan Requirements

The behavior assistant must maintain a copy of the behavior plan. The provider's focus is working with the caregivers to provide them with the skills to execute the procedures as detailed in the behavior analysis services plan, rather than provide direct intervention to the Consumer.

Covered Services

Behavior assistant services include:

- Directly intervening with the Consumer during the initial stages of treatment to stabilize the identified behavior within a short period of time.
- Implementing procedures developed by the behavior analyst and included on the behavior assistant support plan.
- Directly intervening in the presence of caregivers to train the caregiver or evaluate the caregiver's skills needed to implement or maintain the behavior analysis services plan.
- Systematically transferring the implementation of procedures to the caregivers.
- Observing, monitoring, providing feedback to caregivers.
- Implementing the behavior analysis services plan.
- Collecting data on Consumer behavior.
- Copying forms and documents.
- Maintaining materials for data collection.
- Communicating with the supervising behavior analyst.

Behavior Assistant Services, continued

Documentation Requirements

The behavior assistant must maintain daily progress notes, thoroughly documenting the Consumer's activities, interventions conducted by the behavior assistant, observations, data collection, and planning. Daily progress notes must be signed by the behavior analyst supervising the behavior assistant.

Behavior assistants must receive and maintain documentation of supervision by a certified behavior analyst provider for at least one hour per month or more, as deemed appropriate by the LRC chairperson or APD regional behavior analyst. Supervision should include the behavior analyst's direct observation of the behavior assistant working with the Consumer, their caregivers, or other providers. The behavior assistant must maintain documentation of supervision, including the date, beginning and ending time, and description of the activities conducted during the supervision session.

Limitations and Special Conditions

Behavior assistant services are provided for up to six months and are limited on the iBudget Cost Plan to a maximum of eight hours per day. Individuals requiring over six hours per day must have monthly reviews by the LRC chair or regional behavior analyst. Review of this service may occur as a desk review with required submission of behavioral graphs and evidence of caregiver competency provided by the supervising behavior analyst.

These services can be provided in the Consumer's place of residence or setting(s) relevant to the behavior problems being addressed, but typically with the primary caregivers present. Behavior analysis cannot be provided in a public or private school setting.

These services are supplementary to those offered through the public school system with a focus on transferring instructional control to caregivers in naturally-occurring situations. These services are not to be provided in a school setting or take the place of services required under provisions of IDEA.

Once paid or unpaid supports gain the skills and abilities needed to assist the Consumer to function more independently and in less challenging ways, the behavior assistant services should be faded out and discontinued. Exceptions to the six month duration may be made, depending on extenuating circumstances related to the competencies of the primary caregiver in carrying out the behavior analysis services plan. Extensions for the behavior assistant service can be granted increments of up to 30 days through monthly reviews by the APD regional office operations manager or designee, in consultation with the APD regional behavior analyst.

Behavior Assistant Services, continued

**Limitations and
Special Conditions**,
continued

Fading of behavior assistant services must occur, as the long-term caregivers become competent in the procedures and assume more of the responsibilities for implementing the plan. In those cases where behavior assistant services are provided but there is a consistent trend of no progress or targeted behaviors are getting worse, then these services may be terminated or aggressively faded upon recommendation of the area regional behavior analyst.

The services of a behavior assistant must be approved by the LRC chair or regional behavior analyst, as defined in Rule 65G-4.008, F.A.C., and monitored by a person who is certified in behavior analysis or licensed under Chapter 490 or 491, F.S., in accordance with Rule 65G-4.009 and 65G-4.010, F.A.C.

The behavior analyst can bill simultaneously for direct supervision of the behavior assistant.

**Provider
Qualifications**

Providers of this service must be age 18 years and older and have at least:

- Two years of experience providing direct services to recipients with intellectual disabilities or one of the following:
 - At least 120 hours of direct services to recipients with complex behavior problems, as defined in Rule 65G-4.010(2), F.A.C.
 - Ninety classroom hours of instruction in applied behavior analysis

Behavior Assistant Services, continued

Provider Qualifications, continued

- Twenty contact hours of instruction in a curriculum meeting the requirements specified by the APD central office and approved by the APD designated behavior analyst. Instruction must be provided by a person meeting the qualifications of any category of behavior analysis provider as described in this handbook. At least half of the 20 hours of instruction must include real-time visual and auditory contact with an individual having behavior problems (either face-to-face or through electronic means) for initial certification.
 - Either a certificate of completion or a college or university transcript and a course content description, verifying the applicant successfully completed the required instruction, will be accepted as proof of instruction.
 - The 90 classroom hours of instruction specified above shall also count as meeting the requirements of the 20 contact hours specified in this section.
- Eight hours of supplemental training in general behavior analysis skills for annual continuing education requirement, determined by the local regional office behavior analyst.
- Training in an APD approved emergency procedure curriculum consistent with Rule 65G-8.002, F.A.C., where providers will be working with recipients with significant behavioral challenges.

Diplomas or degrees earned in other countries must be accompanied by authentication documentation that the degree is equivalent to the educational requirements for the position.

Providers of behavior assistant services must be an independent contractor or work for an agency or vendor. A behavior assistant provider cannot be a directly hired employee.

Service Type

Restricted

The Consumer must use their CDC+ monthly budget to purchase at least 92% of the units of measure approved for this service in the iBudget Cost Plan. This service is limited to six months and must be entered on the CDC+ Purchasing Plan as a Short Term Expenditure. Thirty day extensions must also be entered on the CDC+ Purchasing Plan as Short Term Expenditures (as approved by the APD regional office operations manager or designee in consultation with the APD regional behavior analyst). The CDC+ Consumer may also purchase behavior assistant services using authorized unspent CDC+ funds in the Consumer's Savings Plan section of their Purchasing Plan.

Companion Services

Description

Companion services consist of non-medical care, supervision and socialization/community inclusion activities provided to an adult to support the Consumer in daily valued routines in the community. A companion provider may also assist the Consumer with such tasks as self-care needs, meal preparation, laundry and shopping; however, these activities shall not be performed as discrete services. This service does not entail hands-on medical care. Providers may also perform light housekeeping tasks, incidental to the care and supervision of the Consumer. The service provides access to community-based activities and should be defined as activities most likely to result in increased ability to access community resources. Companion services may be scheduled on a regular, long-term basis.

Companion services are not merely diversional in nature, but are related to a specific outcome or goal(s) of the Consumer. Examples of acceptable companion activities include, but are not limited to, volunteer activities performed by the Consumer as a pre-work activity; job exploration and shadowing; going to the library, getting a library card, learning how to use the library and checking out books or videos for personal use; shopping for groceries; accessing general public resources; developing acquaintances, friendships, and other social supports; or going to an animal shelter to learn about animals, and volunteering or assisting at the animal shelter.

Companion Services, continued

Limitations and Special Conditions

Companion services are limited to adults 21 years of age or older.

May be approved on a case-by-case basis for minors who are home schooled (not homebound education from the public school system) who without this service would not have opportunities for community inclusion.

If the provider plans to transport the Consumer in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car registration, and 3) insurance.

This service cannot be provided concurrently (at the same time) with adult day training, Personal Care Assistance, in-home support services supported employment and residential habilitation services.

Provider Qualifications

Providers of companion services may be home health or hospice agencies licensed in accordance with Chapter 400, parts III and IV, F.S. If providing this service as an agency or group provider, using more than one employee to provide companion services and billing for their services, the provider must be registered as a sitter or companion provider in accordance with section 400.509, F.S. if not licensed as a home health agency or a hospice.

Directly Hired Employees are not required to be licensed, certified, or registered if they bill for and are reimbursed only for services personally rendered.

Minimum qualifications for a companion, whether an employee of an Agency, Vendor, or a Directly Hired Employee include: be at least 16 years of age and have one year of experience working in a medical, psychiatric, nursing or child care setting, or in working with Consumers having developmental disabilities. Routine care for a relative who has a developmental disability is considered experience working with Consumers with developmental disabilities. College, vocational or technical training from an accredited institution can substitute at the rate of 30 semester, 45 quarter or 720 classroom hours for the required experience.

Service Type

Unrestricted

If approved on the Consumer's iBudget Cost Plan on an on-going basis, the service does not have to be purchased in the same quantity, amount or duration as funded in the iBudget Cost Plan. Unused funds can be used to purchase other services.

If approved on the Consumer's iBudget Cost Plan on a temporary basis (6 months or less), then it must be entered on the CDC+ Purchasing Plan as a Short Term Expenditure and would become a Restricted service.

Consumable Medical Supplies

Description

Consumable medical supplies are those non-durable supplies and items that enable Consumers to increase their ability to perform activities of daily living. Consumable medical supplies are of limited usage and must be replaced on a frequent basis. Supplies covered under the CDC+ program must meet all of the following conditions:

- Be related to a Consumer's specific medical condition;
- Not be provided by any other program;
- Be the most cost-beneficial means of meeting the Consumer's need; and
- Not primarily for the convenience of the Consumer, provider, or family.

Consumable medical supplies covered by the CDC+ program are listed under Limitations Special Conditions.

Limitations and Special Conditions

Consumable medical supplies cannot duplicate supplies provided by the Medicaid Durable Medical Equipment (DME) and Medical Supplies Program state plan services. Refer to the Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook and Fee Schedules for additional information on Medicaid state plan coverage. Supplies not available under the Medicaid state plan or that are available in insufficient quantity to meet the needs of the Consumer may be purchased by the CDC+ program.

All supplies shall have direct medical or remedial benefit to the Consumer and must be related to the Consumer's developmental disability.

Consumable medical supplies covered by the CDC+ program are listed below. Some items have specific requirements or limitations.

- Diapers, including pull-ups, adult diapers or adult disposable briefs for individuals age 21 or older;
 - Wipes;
 - Disposable gloves when a Consumer requires personal care that exposes the caregiver to body fluids. Latex-free gloves will be authorized when the Consumer's or the caregiver's physician certifies that the Consumer or caregiver has a latex allergy or that there is a probable expectation that the Consumer or caregiver may have a latex allergy (i.e., Consumers with spina-bifida). Disposable gloves are only available for purchase when Medicaid state plan services allowable units are exhausted and additional gloves are determined to be medically necessary;
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Consumable Medical Supplies, continued

Limitations and Special Conditions, continued

- Surgical masks, when prescribed by a physician and are:
 - Worn by a Consumer with a compromised immune system as a protection from infectious disease; or
 - Worn by a caregiver who must provide a treatment that requires strict, sterile procedure in which they are trained to provide care to a Consumer who has a compromised immune system and who must be protected at all cost from exposure to any airborne organisms or substances;
 - The physician must renew the prescription quarterly.
- Disposable or washable bed or chair pads and adult sized bibs;
- Ensure or other food supplements, not covered by the Medicaid state plan, when determined necessary by a licensed dietitian. Consumers who require nutritional supplements must have a dietitian's assessment documenting such need. The assessment shall include documentation of weight fluctuation;
- Feeding tubes and supplies not covered by Medicaid state plan and prescribed by a physician. Excludes supplies for a Consumer who qualifies for food supplements under the Medicaid state plan or Medicare;
- Dressings not covered by the Medicaid state plan that are required for a caregiver to change wet to dry dressing over surgical wounds or pressure ulcers, and prescribed by a physician;
- Hearing aid batteries, cords and routine maintenance and cleaning prescribed by an audiologist.
- Bowel management supplies include laxatives, suppositories and enemas determined necessary for bowel management by the Consumer's physician.

If multiple Agency or Vendors are enrolled to provide this service, the Consumer shall be encouraged to select from among the eligible Agency or Vendors based on an item's availability, quality and best price.

Provider Qualifications

Items not contained on this list that meet the definition of consumable medical supplies may be approved through exception by APD. To request an exception, a physician must prescribe the item. The statement from the physician must delineate how the item is medically necessary, how it is directly related to the Consumer's developmental disability, and that, without this supply the Consumer cannot continue to reside in the community. Items specifically excluded in this handbook will not be approved through exception.

Consumable Medical Supplies, continued

**Provider
Qualifications,**
continued

The request will be reviewed by the APD physician or nurse to determine compliance with the standards for medical necessity and to determine whether the requested item fairly meets the service definition. Consumable medical supplies must be directly and specifically related to the Consumer's disability. Items of general use such as: toothbrushes, toothpaste, toothpicks, floss, deodorant, feminine hygiene supplies, bath soap, lotions, razors, shaving cream, mouthwash, shampoo, cream rinse, tissues, aspirin, Tylenol, Benadryl, nasal spray, creams, ointments, vapor rub, powder, over-the-counter antihistamines, decongestants and cough syrups, clothing, etc., are not covered. Supplies for investigational or experimental use are not covered.

A prescription submitted for supplies, diets, over-the counter medications, vitamins, herbs, etc., which has general utility or is generally available to the general population without a prescription, does not change the character of the item for purposes of coverage in this category.

Educational supplies are not consumable medical supplies and are not covered by the CDC+ program. These supplies are expected to be furnished by the local school system.

Consumable medical supplies are approved for a year at a time. The CDC+ program does not allow for payment or reimbursement of copayments for consumable medical supplies covered by third party insurance.

Note: The Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook and Fee Schedules are available on the Medicaid fiscal agent's Web site at <http://portal.flmmis.com/FLpublic>. The handbook is incorporated by reference in 59G-4.070. F.A.C.

Providers must be in compliance with all applicable Florida laws and licensing requirements necessary to provide the requested medical supplies. Independent Agency or Vendors may also provide these services within the CDC+ program. Retail stores shall hold local occupational licenses or permits, in accordance with Chapter 205, F.S. Other providers of consumable medical supplies include home health or hospice agencies, pharmacies, medical supply companies, durable medical equipment suppliers and Agency or Vendors such as discount stores and department stores. Home health and hospices shall be licensed in accordance with state law. Pharmacies shall hold a permit to operate, issued in accordance with state law. Medical supply companies and durable medical equipment suppliers shall hold local occupational licenses or permits, in accordance with state law. Assistive technology suppliers and practitioners shall be certified through the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

Consumable Medical Supplies, continued

Service Type	<p>Unrestricted</p> <p>If approved on the Consumer's iBudget Cost Plan on an on-going basis, the service does not have to be purchased in the same quantity, amount or duration as funded in the iBudget Cost Plan. Unused funds can be used to purchase other services.</p> <p>If approved on the Consumer's iBudget Cost Plan on a temporary basis (6 months or less), then it must be entered on the CDC+ Purchasing Plan as a Short Term Expenditure and would become a restricted service.</p>
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Dietitian Services

Description	<p>Dietitian services are those services prescribed by a physician that are necessary to maintain or improve the overall physical health of a Consumer. Services include assessing the nutritional status and needs of a Consumer; recommending an appropriate dietary regimen, nutrition support and nutrient intake; and providing counseling and education to the Consumer, family, and direct service staff. The services may also include the development and oversight of nutritional care systems that promote a Consumer's optimal health.</p>
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Limitations and Special Conditions	<p>Dietitian services require a physician's prescription. They are a Restricted service.</p>
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Provider Qualifications	<p>A dietician or nutritionist licensed in accordance with Chapter 468, part X, Florida Statutes. Provider may be an Independent Contractor or Agency/Vendor.</p>
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Service Type	<p>Restricted</p> <p>The Consumer must use his or her CDC+ monthly budget to purchase at least 92% of the units of measure approved for this service in the iBudget Cost Plan. If approved on the Consumer's iBudget Cost Plan on a temporary basis (6 months or less), then it must be entered on the CDC+ Purchasing Plan as Short Term Expenditure.</p> <p>Dietitian assessment is considered a Short Term Expenditure.</p>
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Durable Medical Equipment and Supplies

Description

Therapeutic, adaptive or other equipment/devices required by the Consumer to assist him/her in controlling and maneuvering within his environment. Equipment/devices that will increase the Consumer's independence and decrease reliance on others.

Limitations and Special Conditions

Description of item and how the item will increase the Consumer's independence or substitute for human assistance.

Generators may be purchased only if the requirements as specified in the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook are met.

Provider Qualifications

To be an approved CDC+ Agency, Vendor, or Provider, a DME and medical supply entity must, at a minimum, meet all of the following criteria:

- Be in compliance with all applicable laws relating to qualifications or licensure. All licenses must be current and valid, with an address on the license that is the same address as the physical location of the DME and medical supply business; and
 - Be accredited from one of the accrediting organizations listed below:
 - Joint Commission on Accreditation of Healthcare Organization;
 - Community Health Accreditation Program;
 - Healthcare Quality Association on Accreditation;
 - National Board of Accreditation for Orthotic Suppliers;
 - Board for Orthotist/Prosthetist Certification;
 - Accreditation Commission for Healthcare;
 - National Association of Boards of Pharmacy;
 - Commission on Accreditation of Rehabilitation Facilities;
 - American Board for Certification in Orthotics, Prosthetics, and Pedorthics, Inc.; and
 - The Compliance Team.
 - The provider must unless otherwise exempt, meet the minimum standards for home medical equipment providers; and
 - The provider must unless otherwise exempt, provide proof of current HME licensure; and
 - The provider must be an active DME and medical supply provider location, furnishing reimbursable DME and medical supplies and services to the general public within the past six months; and
 - The provider must meet any other specific requirements listed in this chapter.
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Durable Medical Equipment and Supplies, continued

Service Type

Restricted

Providers may be Independent Contractor or Agency/Vendor:

This service is considered a One Time Expenditure (OTE). OTEs are funded in CDC+ at 100% of the funding on the iBudget Cost Plan. Funds approved in the Cost Plan for this service cannot be used in CDC+ for any other service.

Environmental Modifications

Environmental Modifications

Physical adaptations to the Consumer's home that enable the Consumer to function with greater independence in the home.

Environmental Accessibility Adaptations (EAA) are those physical adaptations to the home that are required as indicated on the Consumer's support plan and are "medically necessary" to avoid institutional placement of the Consumer and enable him to function with greater independence in the home. A Home Accessibility Assessment is an independent assessment by a professional rehabilitation engineer or other specially trained and certified professional to determine the most cost-beneficial and appropriate accessibility adaptations for a Consumer's home.

Home Accessibility Assessments may also include pre-inspection of up to three houses a Consumer or family is considering for purchase, review of ceiling lift and track systems, van conversions, and oversight and final inspection of any approved EAA.

If the construction is not completed by the independent assessor, the assessor can still provide construction oversight and a final inspection. The assessment may also include pre-purchase inspection of up to three homes identified by a Consumer or family to determine the best design to meet the Consumer's needs and any potential adaptations that may be required to make the home accessible.

Limitations and Special Conditions

CDC+ Consumers must have an environmental modification assessment administered before any modifications can be authorized.

Environmental modifications cannot be of general utility, such as carpeting, roof repair, central air conditioning, etc. Environmental modifications must provide a direct medical or remedial benefit to the Consumer. Environmental modifications may not add square footage of the home.

If the total cost of modifications exceeds \$3,500.00, the Consumer must obtain a minimum of 3 bids from licensed general contractors.

Environmental Modifications, continued

Limitations and Special Conditions, continued

Environmental modifications to a rental property may not exceed \$3,500.00 Prior to modification of a rental property; the Consumer must determine what modifications, if any, the landlord will cover. All required building permits must be obtained.

Since environmental modifications are an OTE they are funded in CDC+ at 100% of the funding of the Cost Plan.

Provider Qualifications

Providers of Environmental Accessibility Adaptation (EAA) services include licensed general or independent licensed contractors, electricians, plumbers, carpenters, architects and engineers. Any enrolled EAA provider who provides construction work must present a qualified business number, as required in section 489.119, F.S. In accordance with section 489.113, F.S., subcontractors of a qualified business must hold the required state certificate or registration in that trade category. Engineers must be licensed in accordance with Chapter 471, F.S., and must have one year of experience in environmental adaptation assessment and remodeling or be Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certified. Architects must be licensed in accordance with Chapter 481, F.S., and must have one year of experience in environmental adaptation assessment and remodeling or be RESNA certified. Contractors and electricians must be licensed in accordance with Chapter 489, F.S. Plumbers must be licensed in accordance with Chapter 489, F.S. Carpenters and other Agency or Vendors must hold local occupational licenses or permits, in accordance with Chapter 205, F.S. Other professionals who may provide environmental accessibility adaptations assessments include providers with experience in the field of environmental accessibility adaptation assessment, with RESNA certification, and an occupational license.

Subcontractors of a qualified business must hold the required state certificate or registration in that trade category, in accordance with section 489.113, F.S.

Service Type

Restricted

This service is considered a One Time Expenditure (OTE). OTEs are funded in CDC+ at 100% of the funding on the iBudget Cost Plan. Funds approved in the Cost Plan for this service cannot be used in CDC+ for any other service.

The Environmental Modification Assessment is considered a Short Term Expenditure (STE).

Gym Membership

Description Regular or periodic membership in a gym to participate in a program specifically designed to maintain the maximum health of the Consumer.

Provider Qualifications Providers must be in compliance with all applicable laws to provide gym services as an Independent Contractor, who is a Florida licensed trainer or exercise physiologist, or as an Agency or Vendor in a business licensed as a gym.

Service Type Unrestricted

This service is unique to the CDC+ program and not available under the iBudget Waiver. Therefore, it may only be purchased in CDC+ by using Unspent Unrestricted funds.

In-Home Support Services

Description Services that provide the Consumer with assistance from a support worker. The support worker may provide companionship and personal care and may assist with or perform activities of daily living and other duties necessary to maintain the Consumer in their home. The support worker may perform grocery shopping, housekeeping, and cooking responsibilities or may conduct training to teach daily living skills.

The support worker, to the extent properly qualified and licensed, may maintain the Consumer's home and property as a clean, sanitary and safe environment. The support worker's services may include heavy household chores to make the home safer, such as washing floors, windows and walls; tacking down loose rugs and tiles; replacing a broken window; or moving heavy items or furniture, only if this service cannot be performed by the Consumer (or family member) in the home.

Service may include transportation in order for the provider to accompany the Consumer to activities in the community that are most likely to result in the Consumer's ability to access community resources without paid support.

Limitations and Special Conditions If the Consumer who is 21 years of age or older lives with the provider, and the residence is the provider's primary residence, the Consumer's costs paid by CDC+ for home cleaning, maintenance or repair are to be shared equally with the provider and any other adults in the home.

If the Consumer is under the age of 21 and living in the family home, the Consumer's costs paid by CDC+ for home cleaning, maintenance or repair are to be shared by the family to the degree the other family members contributed to the conditions necessitating cleaning, repair or maintenance. CDC+ funds are to be used only for the Consumer's share of home upkeep.

In-Home Support Services, continued

Provider Qualifications

Providers of in-home support services are:

- Directly Hired Employees or Agency or Vendors;
- Must be at least 18 years of age;
- Have at least a high school diploma or equivalent; and
- One year of experience working in a medical, psychiatric, nursing or childcare setting or working with Consumers who have a developmental disability. Care for a relative who has a developmental disability is considered experience working with Consumers with developmental disabilities.

Service Type

Unrestricted

If approved on the Consumer's iBudget Cost Plan on an on-going basis, the service does not have to be purchased in the same quantity, amount or duration as funded in the iBudget Cost Plan. Unused funds can be used to purchase other services.

If approved on the Consumer's iBudget Cost Plan on a temporary basis (6 months or less), then it must be entered on the CDC+ Purchasing Plan as a Short Term Expenditure and would become a restricted service.

Occupational Therapy

Description

Occupational therapy services are services prescribed by a physician that are necessary to produce specific functional outcomes in self-help, adaptive, and sensory motor skill areas, and assist the Consumer to control and maneuver within the environment.

Limitations and Special Conditions

The Medicaid State Plan Therapy Services Program provides occupational therapy services to Consumers under the age of 21. CDC+ Consumers of this service must be age 21 and older.

The service may be purchased without a prescription only if purchased with Unrestricted Unspent funds available in the savings section of the Purchasing Plan.

Occupational Therapy, continued

Provider Qualifications	Occupational therapists, occupational therapy aides, or occupational therapy assistants, licensed in accordance with Chapter 468, part III, Florida Statutes. Occupational therapy aides and assistants must be supervised by an occupational therapist in accordance with the requirements of their professional licenses. CDC+ Consumers' service provider may be an Independent Contractor or Agency/Vendor.
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Service Type	<p>Restricted</p> <p>The Consumer must use his or her CDC+ monthly budget to purchase at least 92% of the units of measure approved for this service in the iBudget Cost Plan. If approved on the Consumer's iBudget Cost Plan on a temporary basis (6 months or less), then it must be entered on the CDC+ Purchasing Plan as Short Term Expenditure.</p>
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Occupational Therapy Assessment

Description	An assessment that determines the amount, duration, and scope of occupational therapy that is necessary for a Consumer.
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Limitations and Special Conditions	<p>An Occupational Therapy Assessment may only be purchased if prescribed by a physician and is limited to Consumers 21 years of age or older. Occupational Therapy Assessment is provided by the Medicaid State Plan for Consumers under 21 years of age.</p> <p>The service may be purchased without a prescription only if purchased with Unrestricted Unspent funds available in the savings section of the Purchasing Plan.</p>
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Provider Qualifications	An Occupational therapy assessment may only be provided by an Occupational Therapist, licensed in accordance with Chapter 468, F.S. who is an Agency, Vendor, or Independent Contractor.
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Service Type	<p>Restricted</p> <p>This service is considered a Short Term Expenditure.</p>
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Other Therapies

Description

Therapies other than those specifically named under this Handbook, or Individualized Supports and Services. Such therapies include but are not limited to art and music therapy.

The term therapy is not the same as "lessons." The specific therapy purchased must be identified in the Purchasing Plan in order to be considered for approval by the APD Area Office.

Limitations and Special Conditions

May be provided in addition to a therapy approved on the Consumer's Cost Plan.

Provider Qualifications

All therapies in this category must be provided by a properly certified or licensed provider of the therapeutic service.

Providers must be in compliance with all applicable laws necessary to provide therapeutic services.

Service Type

Unrestricted

This service is unique to the CDC+ program and not available under the iBudget Waiver. Therefore, it may be purchased in CDC+ by using Unspent Unrestricted funds and must be entered in the savings section of the Consumer's Purchasing Plan.

Over-the-Counter Medications

Description

Non-prescription items specifically designed for medical purposes which are documented as necessary to maintain the maximum health of the Consumer.

Limitations and Special Conditions

Items must be uniquely required due to the Consumer's disability and health issues.

Provider Qualifications

The United States Food and Drug Administration (FDA) decides whether a medicine is safe enough to sell over-the-counter. Providers may be drug store and other retail merchants that sell over the counter medications. Providers must be in compliance with all applicable state laws and licensing requirements necessary to provide the requested medications.

Provider must be an Agency or Vendor.

Over-the-Counter Medications, continued

Service Type

Unrestricted

This service is unique to the CDC+ program and not available under the iBudget Waiver. Therefore, it may only be purchased in CDC+ by using Unspent Unrestricted funds and must be entered in the savings section of the Consumer's Purchasing Plan.

Parts and Repairs for Therapeutic or Adaptive Equipment

Description

Parts and repairs needed to enable the Consumer to continue to use adaptive or therapeutic equipment previously purchased through Medicaid State Plan, the iBudget Waiver, or CDC+ that would otherwise have to be replaced. May include the purchase of maintenance agreements.

Limitations and Special Conditions

Purchase of maintenance agreements must be fully described on the Purchasing Plan, including the item the maintenance agreement covers, the date the item was originally purchased, and the length of time the agreement covers.

Provider Qualifications

Providers must be in compliance with all applicable Florida laws and licensing requirements necessary to provide the requested parts and repairs.

Provider may be an Independent Contractor, Agency, or Vendor.

Service Type

Unrestricted

This service is unique to the CDC+ program and not available under the iBudget Waiver. Therefore, it may only be purchased in CDC+ by using Unspent Unrestricted funds and must be entered in the savings section of the Consumer's Purchasing Plan.

Personal Care Assistance

Description

Assistance with eating, meal preparation, bathing, dressing, personal hygiene, and activities of daily living. Also includes light housekeeping when these activities are essential to the health, safety, and welfare of the Consumer and when no one else is available to perform them. Personal Care Assistance may not be used solely for supervision.

Limitations and Special Conditions

Personal Care Assistance is always considered a “critical service”, and requires a minimum of 2 emergency backup providers. Children under 21 years of age must have this service prior authorized by the Medicaid utilization management. An Agency or Vendor as specified by the Medicaid State Plan. Also, Personal Care Assistance may be purchased from Unrestricted Unspent funds as identified and approved in the Purchasing Plan.

Provider Qualifications

Providers of personal care assistance may be home health or hospice agencies, licensed in accordance with Chapter 400, parts III or IV, F.S. Providers may also be Directly Hired Employees. Directly Hired Employees are not required to be licensed, certified, or registered.

Employees of agencies and Directly Hired Employees shall be at least 16 years of age and have at least one year of experience working in a medical, psychiatric, nursing or childcare setting or working with Consumers who have a developmental disability. Routine care for a relative who has a developmental disability is considered experience working with Consumers with developmental disabilities. College, vocational or technical training equal to 30 semester hours, 45 quarter hours or 720 classroom hours may substitute for the required experience.

Service Type

Unrestricted

If approved on the Consumer’s iBudget Cost Plan on an on-going basis, the service does not have to be purchased in the same quantity, amount or duration as funded in the iBudget Cost Plan. Unused funds can be used to purchase other services.

If approved on the Consumer’s iBudget Cost Plan on a temporary basis (6 months or less), then it must be entered on the CDC+ Purchasing Plan as a Short Term Expenditure and would become a restricted service.

Personal Emergency Response System (PERS)

Description

A personal emergency response system is an electronic communication system that enables a Consumer to secure help in the event of an emergency. The Consumer may also wear a portable "help" button that allows for mobility while at home or in the community. The system is connected to the person's phone and programmed to signal a response center. When the "help" button is activated, qualified personnel are dispatched to the Consumer's location.

This is a personal "alert" system, not a home security system.

Limitations and Special Conditions

A personal emergency response system is limited to those Consumers who live alone or who live in a family home and are alone for significant parts of the day and have no regular caregiver for extended periods of time. A cell phone does not meet the definition of a personal emergency response system. This service does not include the cost for the telephone or telephone lines.

This service pays the PERS monthly monitoring.

Place of Service

A personal emergency response system shall be provided in the Consumer's own home or apartment or the family's home or apartment. A mobile "help button" is also available for the Consumer to wear while engaged in a community activity.

Provider Qualifications

Providers must be in compliance with all applicable Florida laws and licensing requirements necessary to provide the requested emergency system. Provider may be an Independent Contractor or Agency/Vendor.

Service Type

Unrestricted.

This service does not have to be purchased in the same quantity, amount or duration as funded in the iBudget Cost Plan. Unused funds can be used to purchase other services.

Personal Emergency Response System (PERS) Installation

Description

Installation of an electronic communication system that enables an individual to secure help in the event of an emergency. This is a personal “alert” system, not a home security system.

Limitations and Special Conditions

May only be purchased by Consumers who live in their own homes or if the Consumer lives in the family and is alone for significant parts of the day or has no regular caregiver for extended periods of time.

A cell phone does not meet the definition of a personal emergency response system.

Provider Qualifications

Providers shall be licensed electrical contractors, alarm system contractors, contract agencies for Community Care for the Elderly (CCE), Community Care for Disabled Adults (CCDA) Programs, or hospitals. Freestanding equipment may also be purchased from independent Agency or Vendors, such as discount or home improvement stores, but these Agency or Vendors may not provide monitoring.

Electrical or alarm system contractors shall be licensed in accordance with Chapter 489, Part II, Florida Statutes. Hospitals shall be licensed in accordance with Chapter 395, Florida Statutes. Independent Agency or Vendors shall hold local occupational licenses or permits, in accordance with Chapter 205, Florida Statutes.

Providers must be an Agency, Vendor, or Independent Contractor.

Service Type

Restricted

This service is considered a Short Term Expenditure as it is approved on the iBudget Cost Plan on a periodic basis. The funds cannot be used for any other service.

Physical Therapy

Description

Physical therapy is a service prescribed by a physician that is necessary to produce specific functional outcomes in ambulation, muscle control, and postural development and to prevent or reduce further physical disability. In addition, this service may include training and monitoring direct care staff and caregivers to ensure they are carrying out therapy goals correctly.

Limitations and Special Conditions

Physical therapy services are available through the Medicaid Therapy Services Program state plan services to Consumers under the age of 21. CDC+ Consumers must be age 21 and older.

The service may be purchased without a prescription only if purchased with Unrestricted Unspent funds available in the savings section of the Purchasing Plan.

Provider Qualifications

Providers of physical therapy and assessment services shall be licensed as physical therapists and physical therapist assistants in accordance with Chapter 486, F.S. The provider may be an independent Contractor or Agency/Vendor.

Note: The Florida Medicaid Therapy Services Coverage and Limitations Handbook and the Florida Medicaid Hospital Services Handbook are available on the Medicaid fiscal agent's Web site at <http://portal.flmmis.com/FLpublic>. The therapy handbook is incorporated by reference in 59G-4.320, F.A.C. and the hospital handbook in 59G-4.160, F.A.C.

Service Type

Restricted

The Consumer must use his or her CDC+ monthly budget to purchase at least 92% of the units of measure approved for this service in the iBudget Cost Plan. If approved on the Consumer's iBudget Cost Plan on a temporary basis (6 months or less), then it must be entered on the CDC+ Purchasing Plan as Short Term Expenditure.

Physical Therapy Assessment

Description	An assessment that determines the amount, duration, and scope of physical therapy that is necessary for a Consumer.
Limitations and Special Conditions	Limited to Consumers 21 years of age or older. A physical therapy assessment may be purchased if prescribed by a physician. The service may be purchased without a prescription only if purchased with Unrestricted Unspent funds available in the savings section of the Purchasing Plan.
Provider Qualifications	A physical therapy assessment may only be provided by a physical therapist, licensed in accordance with Chapter 468, F.S. Physical therapy assessments may only be provided by an Agency, Vendor, or Independent Contractor.
Service Type	Restricted This service is considered a Short Term Expenditure as it is approved on the iBudget Cost Plan on a periodic basis.

Private Duty Nursing

Description	Private duty nursing services are prescribed by a physician and consist of individual, continuous nursing care provided by registered or licensed practical nurses. Nurses must provide private duty nursing services in accordance with Chapter 464, F.S.
Limitations and Special Conditions	Private duty nursing services are available through the Medicaid Home Health Program state plan services to children under the age of 21 with complex medical needs. To be eligible for this service, a Consumer must require active nursing interventions on an ongoing basis. Consumer must have a Physician's prescription for this service.

Private Duty Nursing, continued

Limitations and Special Conditions, continued

Service may be, but is not required to be, provided in the Consumer's own home or family home. The Consumer's parent can be trained by the nurse to perform the medical procedures prescribed. If the service provided by the nurse is determined by the Consumer to meet the definition of "critical" and the Consumer's parent has been trained to perform the procedures, the parent may be an emergency backup, but only as an unpaid natural support.

The service may be purchased without a prescription only if purchased with Unrestricted Unspent funds available in the savings section of the Purchasing Plan.

Provider Qualifications

Providers of private duty nursing services shall be nurses registered or licensed in accordance with Chapter 464, F.S. Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), HIV/AIDS and infection control is required within 30 days of initially providing private duty nursing services. Proof of annual or required updated training shall be maintained on file for review.

Provider may be an Independent Contractor, Agency, or Vendor.

Service Type

Restricted

The Consumer must use his or her CDC+ monthly budget to purchase at least 92% of the units of measure approved for this service in the iBudget Cost Plan. If approved on the Consumer's iBudget Cost Plan on a temporary basis (6 months or less), then it must be entered on the CDC+ Purchasing Plan as Short Term Expenditure.

Residential Habilitation Services

Description

Services provide supervision and specific training activities that assist the Consumer to acquire, maintain or improve skills related to activities of daily living. This service focuses on personal hygiene skills such as bathing and oral hygiene; homemaking skills such as food preparation, vacuuming and laundry; and on social and adaptive skills that enable the Consumer to reside in the community. This training is provided with direction from the Consumer, parent, or Representative, and reflects the Consumer's goals from their current support plan.

Limitations/Special Condition

An implementation plan must be developed with direction from the Consumer and reflecting the goals from the Consumer's current Support Plan.

Provider Qualifications

Provider must be at least 18 years of age and have a high school diploma or equivalent and one year of experience working in a medical, psychiatric, nursing or child care setting or in working with persons who have a developmental disability.

Service Type

Unrestricted

If approved on the Consumer's iBudget Cost Plan on an on-going basis, the service does not have to be purchased in the same quantity, amount or duration as funded in the iBudget Cost Plan. Unused funds can be used to purchase other services.

If approved on the Consumer's iBudget Cost Plan on a temporary basis (6 months or less), then it must be entered on the CDC+ Purchasing Plan as a Short Term Expenditure and would become a restricted service.

Respiratory Therapy

Description

Respiratory therapy is a service prescribed by a physician and relates to impairment of respiratory function and other deficiencies of the cardiopulmonary system. Treatment activities include ventilator support, therapeutic and diagnostic use of medical gases, respiratory rehabilitation, management of life support systems, bronchopulmonary drainage, breathing exercises and chest physiotherapy. The provider determines and monitors the appropriate respiratory regimen and maintains sufficient supplies to implement the regimen. The provider may also provide training to direct care staff to ensure adequate and consistent care is provided.

Limitations and Special Conditions

Respiratory therapy and assessment services are available through the Medicaid Therapy Services Program state plan services for Consumers under the age of 21. Services for these Consumers may not be purchased under the CDC+ program.

This service is usually provided in the Consumer's place of residence.

The service may be purchased without a prescription only if purchased with Unrestricted Unspent funds available in the savings section of the Purchasing Plan.

Provider Qualification

Licensed respiratory therapist in accordance with Chapter 468, Part V, F.S. Provider may be an Independent Contractor or Agency/Vendor.

Service Type

Restricted

The Consumer must use his or her CDC+ monthly budget to purchase at least 92% of the units of measure approved for this service in the iBudget Cost Plan. If approved on the Consumer's iBudget Cost Plan on a temporary basis (6 months or less), then it must be entered on the CDC+ Purchasing Plan as Short Term Expenditure.

Respiratory Therapy Assessment

Description	An assessment that determines the amount, duration, and scope of respiratory therapy that is necessary for a Consumer.
Limitations and Special Conditions	<p>Limited to Consumers 21 years of age or older.</p> <p>A respiratory therapy assessment may be purchased if prescribed by a physician.</p> <p>The service may be purchased without a prescription only if purchased with Unrestricted Unspent funds available in the savings section of the Purchasing Plan.</p>
Provider Qualifications	<p>A respiratory therapy assessment may only be provided by a respiratory therapist, licensed in accordance with Chapter 468, Part V, F.S.</p> <p>Respiratory therapy assessments may only be provided by an Agency, Vendor, or Independent Contractor.</p>
Service Type	<p>Restricted</p> <p>This service is considered a Short Term Expenditure as it is approved on the iBudget Cost Plan on a periodic basis.</p>

Respite Care

Description	Supportive care and supervision provided to a Consumer when the primary caregiver is unable to perform these duties due to a planned brief absence, an emergency absence, or when the caregiver is available but temporarily physically unable to care for or supervise the Consumer for a brief period. The purpose of respite is to enable the Consumer's primary caregiver(s) to have a break from the normal caregiving routine.
Limitations and Special Conditions	<p>Respite cannot be provided by Directly Hired Employees (DHE) who are also the parents or primary caregiver of a Consumer. These funds cannot be used to compensate a parent for providing care to a minor who does not reside in the same home as the parent.</p> <p>If the Consumer is age 18 years of age or older and the primary caregiver is the custodial parent, respite may be provided by the absent parent. Respite care service providers are not reimbursed separately for transportation and travel cost. These costs are integral components of respite care services and are included in the basic fee. The provider must bill for only those hours of direct contact with the Consumer(s).</p>

Respite Care, continued

Limitations and Special Conditions, continued

If funding for respite services was approved on the Consumer's Cost Plan, those funds can be used to purchase other services, in accordance with established rules, as long as the services clearly meet the Consumer's needs and goals as identified on the iBudget support plan and the initial need for respite care is met by a natural support.

The Purchasing Plan must provide an explanation of the parental role if a parent is shown as the provider of this service.

Most Consumers who require respite care services do not need the services of a registered or licensed practical nurse. Nurses should only be employed to perform this service when the Consumer has a complex medical condition. If a nurse provides this service, a prescription will be necessary.

This service may be billed by the day or the hour. Only Independent Contractors or Agency or Vendors can bill by the day.

Provider Qualifications

Providers of respite care services may be licensed residential facilities, licensed home health or hospice agencies, licensed nurse registries, or agencies that specialize in services for Consumers with developmental disabilities.

Independent Contractors, Agency or Vendors and Directly Hired Employees may also provide this service. Independent Contractors, Agency or Vendors, Directly Hired Employees and employees of agencies may be registered or licensed practical nurses or persons at least 16 years of age with one year of experience working in a medical, psychiatric, nursing or child care setting or working with recipients with developmental disabilities. Routine care of a relative who has a developmental disability is considered experience working with Consumers with developmental disabilities. College, vocational or technical training equal to 30 semester hours, 45 quarter hours or 720 classroom hours may substitute for the required experience.

Independent Contractors, Agency or Vendors and Directly Hired Employees, who are not nurses, are not required to be licensed, certified, or registered if they bill for and are reimbursed only for services personally rendered. Nurses who render respite care services as Independent Contractors, Agency or Vendors and Directly Hired Employees shall be licensed in accordance with Chapter 464, F.S.

Respite Care, continued

Service Type

Unrestricted

If approved on the Consumer's iBudget Cost Plan on an on-going basis, the service does not have to be purchased in the same quantity, amount or duration as funded in the iBudget Cost Plan. Unused funds can be used to purchase other services.

If approved on the Consumer's iBudget Cost Plan on a temporary basis (6 months or less), then it must be entered on the CDC+ Purchasing Plan as a Short Term Expenditure and would become a restricted service.

Seasonal Camp

Description

Attendance at a camp session that enables the Consumer to be included in age-appropriate activities while also learning to handle his disability and manage his environment with greater independence.

Limitations and Special Conditions

Documentation to justify attendance at a seasonal camp must be provided by the Consumer to the APD Area Office prior to entering it on the Purchasing Plan. Documentation must include information on the camp, a schedule or curriculum of events, the reason for attending, the dates the Consumer is planning to attend, and the requested amount of CDC+ funds and documentation of camp accreditation, if available. CDC+ funds may be considered for other costs to attend. If early registration is available, CDC+ funds will pay for only early registration fees.

This service does not cover transportation costs to or from a seasonal camp.

Immediate family members of the Consumer may not be an owner or manager of a seasonal camp and may not receive any financial gain from the camp services

Provider Qualifications

Providers of Camp Services must have proof of First Aid and CPR training.

American Camp Association (ACA) Accreditation required for staff qualifications, training, and emergency management to ensure compliance standards. The ACA provider must collaborate with experts from The American Academy of Pediatrics, the American Red Cross, and other youth service agencies to assure the most current research-based standards and practices for camp operation.

Providers may be an Independent Contractor or Agency/Vendor.

Seasonal Camp, continued

Service Type Unrestricted

This service is unique to the CDC+ program and not available under the iBudget Waiver. Therefore, it may only be purchased in CDC+ by using Unspent Unrestricted funds and must be entered in the savings section of the Consumer's Purchasing Plan.

Skilled Nursing

Description Part-time or intermittent nursing care provided by a registered or licensed practical nurse within the scope of Florida's Nurse Practice Act in accordance with Chapter 464, F.S.

Limitations and Special Conditions

Skilled nursing services are available through the Medicaid Home Health Program state plan services to children under the age of 21 with complex medical needs.

Consumer must have a Physician's prescription for this service.

Service may, but is not required to, be provided in the Consumer's own home or family home.

The Consumer's parent can be trained by the nurse to perform the medical procedures prescribed for the nurse. If the service provided by the nurse is determined by the Consumer to meet the definition of "critical" and the Consumer's parent has been trained to perform the procedures, the parent may be an emergency backup, but only as an unpaid natural support.

Provider Qualifications

Licensed Practical Nurse or Registered Nurse licensed in accordance with Chapter 464, F.S. Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), HIV/AIDS and infection control is required within 30 days of initially providing skilled nursing services. Provider may be an Independent Contractor or Agency/Vendor.

Service Type Restricted

The Consumer must use his or her CDC+ monthly budget to purchase at least 92% of the units of measure approved for this service in the iBudget Cost Plan. If approved on the Consumer's iBudget Cost Plan on a temporary basis (6 months or less), then it must be entered on the CDC+ Purchasing Plan as Short Term Expenditure.

Specialized Mental Health Services

Description

Specialized Mental Health Services for persons with developmental disabilities are services provided to maximize the reduction of a Consumer's mental illness and restoration to the best possible functional level. Specialized mental health services focus on the unique treatment of psychiatric disorders and rehabilitation for impairments for persons with developmental disabilities and mental illness. These services include specialized individual, group and family therapy provided to Consumers using techniques appropriate to this population. Specialized mental health services include information gathering and assessment, diagnosis, development of a plan of care (treatment plan) in coordination with the Consumer's support plan, mental health interventions designed to help the Consumer meet the goals identified on the support plan, medication management and discharge planning. This specialized treatment will integrate the mental health interventions with the overall service and supports to enhance emotional and behavioral functions.

Limitations and Special Conditions

This service supplements mental health services available under the Medicaid Community Behavioral Health Program state plan services. Mental health services are available to Consumers with diagnosed mental illnesses who can benefit from and participate in therapeutic services provided under the Medicaid Community Behavioral Health Program.

Provider Qualifications

Providers of Specialized Mental Health Services must be:

- Psychiatrists licensed in accordance with Chapter 458 or 459, F.S.;
- Psychologists licensed in accordance with Chapter 490, F.S.; or
- Clinical social workers, marriage and family therapists or mental health counselors licensed in accordance with Chapter 491, F.S.

Providers of Specialized Mental Health Services must have two years experience working with Consumers dually diagnosed with mental illness and developmental disabilities.

Provider may be an Independent Contractor or Agency/Vendor.

Service Type

Restricted

The Consumer must use his or her CDC+ monthly budget to purchase at least 92% of the units of measure approved for this service in the iBudget Cost Plan. If approved on the Consumer's iBudget Cost Plan on a temporary basis (6 months or less), then it must be entered on the CDC+ Purchasing Plan as Short Term Expenditure.

Specialized Training

Description

Training provided to the Consumer that must be related to a Consumer's identified goals and needs, such as learning a specific skill to assist with improved quality of life, increased independence, or obtaining employment. Training may include conferences, specifically related to Consumer's disability or health condition.

Limitations and Special Conditions

Consumers must provide documentation to justify attendance at a conference it must be provided by the Consumer to the APD Area Office and approved by the APD Central Office prior to entering it on the Purchasing Plan. Documentation must include information on the event, the reason for attending, the dates the Consumer is planning to attend, and the requested amount of CDC+ funds. CDC+ funds cannot be used for meals, but may be considered for other reasonable costs to attend. If early registration is available, CDC+ funds will pay for only early conference registration fees. Excludes conferences that are of a general nature or that do not entirely focus on the Consumer's specific disability or disabilities.

Provider Qualifications

All CDC+ Specialized Training service providers must be at least 16 years of age and must satisfy the qualifications and requirements for the particular service that is the subject of the training being provided to the Consumer.

A Specialized Training service provider may be an Independent Contractor, an Agency, or Vendor.

Service Type

Unrestricted

This service is unique to the CDC+ program and not available under the iBudget Waiver. Therefore, it may only be purchased in CDC+ by using Unspent Unrestricted funds and must be entered in the savings section of the Consumer's Purchasing Plan.

Speech Therapy

Description

Speech Therapy is a service prescribed by a physician and is necessary to produce specific functional outcomes in the communication skills of a Consumer with a speech, hearing or language disability. The service may also include a speech therapy assessment, which does not require a physician's prescription. In addition, this service may include training and monitoring of direct care staff and caregivers, to ensure they are carrying out therapy goals correctly.

Limitations and Special Conditions

CDC+ Consumers must be 21 years of age or older and have a physician's prescription.

Speech Therapy and assessment services are available through the Medicaid Therapy Services Program state plan services for Consumers under the age of 21. Services for these Consumers may not be purchased under the CDC+ program.

The service may be purchased without a prescription only if purchased with Unrestricted Unspent funds available in the savings section of the Purchasing Plan.

Provider Qualifications

Providers of speech therapy and assessment services shall be speech language pathologists and speech-language pathology assistants licensed by the Department of Health, in accordance with Chapter 468, Part I, F.S., and may perform services within the scope of their licenses. Speech therapists may also provide and bill for the services of a licensed or certified speech therapy assistant. Only licensed speech therapists can perform assessments. Speech-language pathologists with a master's degree in speech language pathology who are in their final clinical year of training may also provide this service. Speech-language assistants must be supervised by a speech language pathologist in accordance with the requirements of their professional licenses, per Chapter 468, Part I, F.S.

Provider may be an Independent Contractor or Agency/Vendor.

Service Type

Restricted

The Consumer must use his or her CDC+ monthly budget to purchase at least 92% of the units of measure approved for this service in the iBudget Cost Plan. If approved on the Consumer's iBudget Cost Plan on a temporary basis (6 months or less), then it must be entered on the CDC+ Purchasing Plan as Short Term Expenditure.

Speech Therapy Assessment

Description	An assessment that determines the amount, duration, and scope of speech therapy that is necessary for a Consumer.
Limitations and Special Conditions	<p>Limited to Consumers 21 years of age or older.</p> <p>A speech therapy assessment may only be purchased if prescribed by a physician. The service may be purchased without a prescription only if purchased with Unrestricted Unspent funds available in the savings section of the Purchasing Plan.</p>
Provider Qualifications	<p>A speech therapy assessment may be provided by a speech language pathologist therapist, licensed by the Department of Health in accordance with Chapter 468, Part I, F.S.</p> <p>Speech therapy assessments may only be provided by an Agency, Vendor, or Independent Contractor.</p>
Service Type	<p>Restricted</p> <p>This service is considered a Short Term Expenditure.</p>

Supported Employment

Description	Provides training and assistance through a variety of activities to support Consumers in sustaining paid employment. Paid employment should be at or above minimum wage unless the Consumer is operating a small business. The provider must assist with the acquisition, retention, or improvement of skills related to accessing and maintaining such employment or developing and operating a small business.
Limitations and Special Conditions	<p>Service may be provided to Consumers 21 years of age or over.</p> <p>Providers of this service must develop and work from a time-limited employment plan for the Consumer with outcome-based activities designed to meet employment goals identified in the Consumer's Support Plan. An employment plan would include, based on Consumer needs, a reasonable period of time for job development (approximately 2 months), a reasonable period of time to obtain employment, and a period of on the job follow-along to support the Consumer in the job until the Consumer is able to work without continued support from the provider.</p>

Supported Employment, continued

Provider Qualifications Consumers may hire a Medicaid waiver trained supported employment provider or a non-Medicaid waiver provider to assist them in obtaining employment skills and finding employment. Providers must be at least 18 years of age.

Service Type Unrestricted

If approved on the Consumer’s iBudget Cost Plan on an on-going basis, the service does not have to be purchased in the same quantity, amount or duration as funded in the iBudget Cost Plan. Unused funds can be used to purchase other services.

If approved on the Consumer’s iBudget Cost Plan on a temporary basis (6 months or less), then it must be entered on the CDC+ Purchasing Plan as a Short Term Expenditure and would become a restricted service.

Supported Living Coaching

Definition Training and assistance, in a variety of activities, to support Consumers who live in their own homes or apartments. The Consumer’s living setting must meet the requirements set forth in rule 65G-5.004, Florida Administrative Code (F.A.C.), and may include assistance with locating appropriate housing; the acquisition, retention or improvement of skills related to activities of daily living such as personal hygiene and grooming; household chores; meal preparation; shopping; personal finances and the social and adaptive skills necessary to enable Consumers to reside in their own home.

Limitations and Special Conditions Limited to Consumers 18 years of age or older.

The provider and the provider’s immediate family cannot be the Consumer’s landlord nor have any interest in the ownership of the housing unit, as required by 65G-5.004, F.A.C.

Consumers who live in family homes or foster homes are not eligible for these services unless the Consumers have indicated in their support plan that they have a goal of moving into their own home or apartment.

Provider Qualifications Providers of supported living services shall comply with requirements found in the Medicaid Waiver Services Agreement, Core Assurances, Chapter 65G-5, F.A.C., and those specified in the iBudget handbook.

Providers may be an Independent Contractor, Agency, or Vendor.

Supported Living Coaching, continued

Service Type

Unrestricted

If approved on the Consumer’s iBudget Cost Plan on an on-going basis, the service does not have to be purchased in the same quantity, amount or duration as funded in the iBudget Cost Plan. Unused funds can be used to purchase other services.

If approved on the Consumer’s iBudget Cost Plan on a temporary basis (6 months or less), then it must be entered on the CDC+ Purchasing Plan as a Short Term Expenditure and would become a restricted service.

Transportation

Description

Transportation services are the provision of rides to and from the Consumer’s home and community-based services, enabling the Consumer to receive the supports and services identified on the Purchasing Plan, when such services cannot be accessed through natural (i.e., unpaid) supports.

Transportation services funded through CDC+ shall be used only for Consumers who have no other means to get to a service identified on the Purchasing Plan. Family members, neighbors or friends who already transport the Consumer, or who are capable of transporting the Consumer at no cost to the APD, shall be encouraged to continue their support of the Consumer. Consumers who are capable of using the fixed route public transit system to access services on their Purchasing Plan shall be encouraged to use that method of transportation.

This service is not available for transporting a Consumer to school through 12th grade. Transportation to and from school is the responsibility of the public school system. Vehicles shall not carry more passengers than the vehicle’s registered seating capacity. Driver and driver’s assistant(s) are considered passengers. Boarding assistance shall be provided as necessary or as requested by the Consumer being transported. Such assistance shall include opening the vehicle door, fastening the seat belt, securing a wheelchair, storage of mobility assistance devices, and closing the vehicle door. Consumers shall not be carried. Drivers and drivers’ assistants shall not assist passengers in wheelchairs up or down more than one step, unless it can be performed safely as agreed by the Consumer, Consumer’s guardian, or Consumer’s Representative. Drivers and drivers’ assistants shall not provide any assistance that is unsafe for the driver, the driver’s assistant, or the Consumer. Drivers, drivers’ assistants or escorts provided by the provider to accompany the Consumer shall be trained in CPR, disease transmission, and use of the onboard first aid kit. In accordance with section 316.613, F.S., children five years of age or younger must be transported in a federally-approved child restraint device.

Transportation, continued

Description,
continued

The provider must have the installation of the child restraint device and the positioning of the child checked at a local authorized child safety seat fitting station or by a certified child seat safety technician. For children from four through eight years of age, a separate carrier, an integrated child seat, or a booster seat with appropriately positioned safety belt, as appropriate for the child's size and age, may be used. In Florida, every county sheriff's office and city police station serves as a fitting station and every traffic law enforcement officer has been trained to provide assistance. In vehicles that also have side-impact air bags, children and adults less than 100 pounds must be transported as close to the middle of the back as possible.

A first aid kit equivalent to Red Cross Family Pak #4001 and an A-B-C fire extinguisher shall be carried on board the vehicle at all times when transporting Consumers.

When the vehicle is in motion, all mobility devices (wheelchairs, scooters, etc.) shall be secured with appropriate tie-downs, regardless of whether or not a person is physically positioned in the mobility device; and cell phone, fire extinguisher, first aid kit, and any other such items that could become airborne in the event of a sudden stop or accident must be secured.

Limitations

Providers of adult day training, companion services, in-home support services, Personal Care Assistance, residential habilitation, respite care, specialized mental health services, Consultant and supported living coaching may not bill separately for transportation that is an integral part of the provision of their primary service.

In order for providers of adult day training, companion services, in-home support services, Personal Care Assistance, residential habilitation, respite care, specialized mental health services, support coordination and supported living coaching to bill separately for transportation provided between a Consumer's place of residence and the site of a distinct waiver service, or between waiver service sites when the service at each site is provided by a different provider, they must qualify for and enroll as a transportation provider.

Transportation services are available through the Medicaid Non-Emergency Transportation Program state plan program to transport Consumers to Medicaid eligible medical appointments and services. CDC+ funds shall not be used when the Consumer's trip is for a Medicaid State Plan service except for copayments. When a transportation provider is paid by the Medicaid State Plan to transport a Medicaid Consumer to an eligible service, the Consumer will be charged a copayment, which can be paid for using CDC+ funds approved in the savings section of the Purchasing Plan. When the Consumer uses a CDC+ provider for transportation to a service listed on the Purchasing Plan and the provider is paid with CDC+ funds, the provider shall not charge the Consumer a copayment. Providers may bill for their service by the hour if a Directly Hired Employee, or by the hour or trip, if an Agency/Vendor.

Transportation, continued

Limitations and Special Conditions

Can be used to purchase monthly bus passes, if the Consumer can use the bus to go to CDC+ services, or to meet the needs and goals identified on Support Plan.

In vehicles with passenger-side air bags, children under the age of 12 and frail adults must be transported in the back seat.

This service may not be used to transport the Consumer to or from school through grade 12. Relatives of the Consumer may only be reimbursed for mileage. Mileage reimbursement may be approved the provider is an unpaid natural support. A trip log is maintained showing beginning and ending odometer reading and total number of miles driven to and from named destinations, date, and time. Trip destinations are related to the services/supports on the Purchasing Plan. Amount of reimbursement is calculated using the approved state mileage reimbursement rate.

All documentation is maintained in the Consumer's central record.

Provider Qualifications

- Drivers shall be at least 18 years old;
- Drivers shall possess a valid driver's license;
- Drivers shall provide proof of automobile liability insurance which shall be a minimum of \$100,000 per person and \$300,000 per incident covering the vehicle in which the Consumer is transported;
- Drivers shall have a safe driving record as indicated by having no major traffic violations in the previous 3 years and having no more than 2 minor traffic violations in the previous five years. The driver shall provide a copy of his or her complete driving record to the Consumer prior to employment. Such record may be obtained from the Florida Division of Motor Vehicles. Cost of obtaining the complete driving record shall be paid by the provider;
- Providers must be in compliance with all applicable laws and licensing requirements necessary to transport the Consumer. All providers of transportation services must possess a valid driver's license, provide proof of vehicle registration on the vehicle that is being used to transport the Consumer and maintain the vehicle in safe operating condition; and
- Provider may be Directly Hired Employee, Agency, or Vendor.

Service Type

Unrestricted

If approved on the Consumer's iBudget Cost Plan on an on-going basis, the service does not have to be purchased in the same quantity, amount or duration as funded in the iBudget Cost Plan. Unused funds can be used to purchase other services.

If approved on the Consumer's iBudget Cost Plan on a temporary basis (6 months or less), then it must be entered on the CDC+ Purchasing Plan as a Short Term Expenditure and would become a restricted service.

Vehicle Modifications

Definition

Adaptation to the Consumer's family-owned or Consumer-owned vehicle that is necessary for the Consumer to drive the vehicle or be transported in the vehicle.

Limitations and Special Conditions

Van adaptation includes lifts, tie downs, raised roof or doors in a family owned or individually owned full-size van. The conversion of mini-vans is limited to the same modifications, but excludes the cost to modify the frame (e.g., lower the floor) to accommodate a lift. Van modifications must be necessary to ensure accessibility of the Consumer with mobility impairments when the vehicle is the Consumer's primary mode of transportation. Only one set of modifications per vehicle is allowed, and only one modification will be approved in a five-year period. No adaptations will be approved for an additional vehicle if CDC+ funds have paid for adaptations to another vehicle during the five-year period.

The vehicle modified must also have a life expectancy of at least five years. This is to be documented with an inspection by an Automotive Service Excellence (ASE) certified mechanic. The lift approved cannot then exceed 2 ½ times the NADA (blue book) value for the make, model and mileage on the van. Purchase of a vehicle and any repairs or routine maintenance to the vehicle is the responsibility of the Consumer or family.

Payments for repair to adaptations after the warranty expires may be approved by APD. Many automobile manufacturers offer a rebate of up to \$1,000 to Consumers purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the Consumer or family is required to submit documented expenditures of modifications to the manufacturer. If the rebate is available it must be applied to the cost of the modifications. If a Consumer or a family purchases a used vehicle with adaptive equipment already installed, the waiver may not be used to fund the vehicle purchase or any portion of the purchase related to the adaptive equipment already installed.

Provider Qualifications

Providers must be in compliance with all applicable laws and licensing requirements necessary to provide the requested modification.

Provider may be an Independent Contractor, Agency, or Vendor.

Service Type

Restricted

This service is considered a One Time Expenditure (OTE). OTEs are funded in CDC+ at 100% of the funding on the iBudget Cost Plan. Funds approved in the Cost Plan for this service cannot be used in CDC+ for any other service.

CHAPTER 5
FISCAL OPERATION

Overview

In This Chapter

This chapter contains:

TOPIC	PAGE
Overview	5-1

Description

This chapter describes the responsibilities of the Fiscal/Employer Agent (F/EA) relevant to Payroll, Tax Reporting, Monthly Statements, Recoupment, Reinvestment of Unexpended funds.

Fiscal/Employer Agent (F/EA)

APD, as the CDC+ operating agency for the iBudget Waiver, may elect to serve as the fiscal agent/employer (F/EA) or to contract this function as determined necessary.

The F/EA operates under Section 3504 of the Internal Revenue Service Code and Revenue Procedure 70-6. The F/EA may further utilize the services of a subagent to perform certain required duties of the F/EA. The Consumer gives the F/EA legal authority to process payroll to withhold and pay employment related taxes. The F/EA collects and reviews documents included in employee and Agency or Vendor packets, and verifies tax information for Consumers, employees, Agency or Vendors, and CDC+ Representatives.

Payroll

The documents in the employee and vendor packets provide the F/EA with the legal authority to withhold, report, and pay taxes to the Internal Revenue Service (IRS) and the Florida Department of Revenue on the Consumer's behalf.

- When payroll information is submitted by the Consumer or Representative either online or via telephone the F/EA must;
 - Verify service codes for authorization on the Purchasing Plan;
 - Make direct deposits to vendors and employees who have requested direct deposit service;
 - Mail pay checks to the Consumer or Representative; and
 - Mail pay stubs for direct deposits to the Consumer or Representative.
- The F/EA must make accounting adjustments to submitted claims for over and underpayments, and returned payments to be made against the Consumer account; and
- The F/EA must perform stop-pay and check re-issues against a submitted and processed claim when a check is lost, stale dated, issued for incorrect amount or any valid reason requiring a check be reissued.

Overview, continued

Unclaimed Payments

Funds placed in a Medicaid Consumers' accounts specifically to reimburse the CDC+ providers for services (that is, if the amounts placed in the Consumers' accounts are calculated based upon the CDC+ providers claims) then these funds should be treated as uncashed checks pursuant to 42 C.F.R. Section 433.40 and returned to AHCA.

Tax Reporting

The F/EA, with the authorization of the Consumer or Representative, must process IRS Form SS-4 to obtain a Federal ID Number for the Consumer during participation in CDC+. The F/EA must process a State of Florida, Department of Revenue, DR-1 Application to request an unemployment account number for each Consumer that will authorize the Consumer to report unemployment taxes and wages for his or her directly hired employees.

Additionally, for the CDC+ program, the F/EA is required to:

- Withhold federal income tax and the employee's share of Medicare and Social Security tax from each employee's pay check in accordance with federal tax laws and pays those taxes to the IRS;
 - Withhold garnishments and other voluntary withholdings;
 - Withhold from the Consumer's CDC+ budget the employer's share of Medicare and Social Security taxes and Federal and State Unemployment Taxes on behalf of each employee and pay those employment-related taxes to the IRS and to the Florida Department of Revenue;
 - Submit state and federal quarterly and annual reports as required by the IRS or Florida Department of Revenue;
 - Issue IRS Forms W-2 and 1099-MISC annually and mail to the employees and vendors. The F/EA must issue W-2 (c)'s and corrected Form 1099-MISC as necessary;
 - Return to the Consumer's CDC+ account any overpaid Federal Unemployment Tax Authority (FUTA) or State Unemployment Tax Authority (SUTA) taxes;
 - Return any employer and employee taxes collected in excess of the IRS filing requirements;
 - Address any Department of Revenue (DOR) or IRS issues on behalf of the Consumer as it pertains to the employer tax filings; and
 - Upon a Consumer's disenrollment from CDC+, request that the IRS and DOR deactivate the Consumer's Federal Employee Identification Number (FEIN) and State Unemployment Insurance (SUI) numbers.
-

Overview, continued

Monthly Statements

The F/EA acts as the banker for each CDC+ Consumer by receiving the monthly budget allocation from AHCA and maintaining it in an account in the name of the Consumer.

The F/EA must produce an account statement at the end of each month of service provision which must be sent to all Consumers who participated in CDC+ that month. The statement must show the amount of money that was deposited each month, the transactions, claims, and employer tax withholdings that were made during the month, and the amount of unexpended funds remaining in the Consumer's account at the end of each month.

**Return of
Unexpended Funds**

The F/EA must at least annually, or as directed by AHCA, identify and reclaim unexpended funds that have not been designated for a specific use by the Consumer and approved by the APD Area Office.

CHAPTER 6
QUALITY ASSURANCE

Overview

In This Chapter

This chapter contains:

TOPIC	PAGE
Overview	6-1
Quality Improvement Tools	6-1

Description

This chapter describes the Quality Assurance and Improvement Plan and Quality Improvement Tools including Consumer Satisfaction Survey, Toll Free Helpline, Email Requests, Monitoring of Consultants, and Quality Advisory Committee (QAC).

Quality Assurance and Improvement Plan

Quality Assurance standards and conditions for program monitoring are based on the requirements as defined in Florida Medicaid’s State Plan Amendment Option section 1915 (j).

The State’s quality assurance and improvement plan describes how AHCA and APD must conduct activities of quality improvement in order to determine that the program meets assurances, corrects deficiencies and initiates program for improvement.

Quality improvement tools developed for CDC+ are components of the CDC+ quality management plan. These tools include: Consumer satisfaction surveys, toll-free helpline, results of the Person Centered review process, data reports, a Quality Advisory Committee, and monitoring of Consultants and Consumers.

Quality Improvement Tools

Consumer Satisfaction Survey

The survey is distributed to CDC+ Consumers by APD or its designated agent on an annual basis. The surveys will be accompanied by a letter explaining how the survey will be conducted and contain clear instructions on how the information must be collected from Consumers.

Quality Improvement Tools, continued

Toll Free Helpline and Email Requests

APD must maintain a toll free phone number dedicated to CDC+ that is staffed during normal business hours to address payment issues, questions about budget/Purchasing Plans, and general program questions. The toll free CDC+ telephone number will be published in all CDC+ correspondence mailed to Consumers and on APD's website.

Calls and emails into the helpline and e-mail addresses will be logged, researched and responded to within 24 hours, Monday through Friday between 8:00 A.M. and 5:00 P.M. Eastern Standard Time (EST) excluding state holidays [1915(j) State Plan Amendment].

APD must keep record logs of all issues received on the helpline that describe the type of caller (Consumers/Representatives or Consultants) and how quickly the call was answered or resolved. APD must document follow up on any issues including how the issue was resolved.

Person Centered Reviews

The CDC+ program is centered on the "person," the individual, the Consumer. The person-centered review process begins when the Consumer communicates their needs, hopes, and goals when developing the Support Plan. CDC+ offers a framework that supports what is important to the Consumer in the present, current stage of life and increases the individual's options for self-determination (42 CFR Part 441). Person-Centered is an approach, developed from the Consumer's perspective rather than that of the program or resource, used to provide the services and supports necessary to meet the Consumer's needs.

The person-centered review process assists a Consumer to: (1) identify person-centered supports and services; (2) enhance service delivery in a manner that supports the achievement of individually determined outcomes; and (3) make improvements in the provider's service delivery system.

APD will monitor and report to AHCA whether Consumer goals have been reached. Assessment must be based on determination that the goal has been met and the Consumer's desire to change current goals. The monitoring must also incorporate information from Consumers concerning health, safety, and welfare, their service needs, and their feelings regarding the program. The APD Area Offices must follow up on pertinent Consumer issues noted in monitoring.

Quality Improvement Tools, continued

Monitoring of Consultant

Monitoring of the CDC+ Consultant by APD or Contracted Quality Assurance entity consisted of review of the following:

- Documentation of the Consumer's choice of Consultant;
- Documentation of Consultant's training by CDC+ APD program staff in the overall philosophy of self-direction and in the operations of the CDC+ program;
- Documentation of Medicaid Waiver Service Provider Agreement for Consultant services;
- Documentation of training, certification, and provider requirements as required on the iBudget Waiver for support coordination services; and
- APD must conduct specific Consultant monitoring to include desk reviews and individual Consumer interviews. Desk reviews will be conducted based on a random sampling of all Consultants. [1915(j) State Plan Amendment].

The Central Record held by the Consultant must include all necessary documentation for that Consumer. Documentation includes items such as:

- The annual Medicaid eligibility determination;
- A completed Person-Centered Review Process; and
- Monthly contact, noted by the Consultant, and documented visits with the Consumer in their home or community activity occurring no less than once per six-month period. Monthly contact may be in the form of phone calls or in person, whichever is the preferred method of the Consumer.

Monthly Consumer contact and program review must be documented by the Consultant and include topics such as review of Monthly Budget Statement with the Consumer and that services are purchased according to the Purchasing Plan.

All Consultants must use an incident reporting system as specified in the iBudget handbook and all incident information must be reported to the APD program office. The incident information will be compiled and included with the annual report to Agency for Health Care Administration (AHCA). The incidents will be logged by type of incident and must include appropriate action taken to remedy the situation [1915(j) State Plan Amendment].

The Central Record must include an annual Medicaid Eligibility document for each Consumer. The level of care for the Consumer must be reassessed by the Consultant and documented to maintain the Consumer's Medicaid eligibility.

Quality Improvement Tools, continued

Monitoring of Consultant,
continued

Consultants will not assume responsibility for developing the Purchasing Plan, but will review and approve the plan to ensure that proposed services are adequate, purchases are cost-effective and related to the Consumer's needs, and that an emergency back-up plan is in place. The Consultant reviews the proposed Purchasing Plan with the Consumer or Representative and others identified by the Consumer.

Provider Discovery Review

The Provider Discovery Review (PDR) process is a component of the quality management plan used to evaluate the extent to which Consumer goals and needs are being met as well as to determine compliance and accountability with Medicaid, AHCA and APD standards.

Provider Discovery Reviews occur as part of the quality assurance monitoring. Consumers or their Representatives, as applicable, are responsible for cooperating with the PDR process. The PDR process includes interviews and record reviews with the Consumer or Representative.

Provider Discovery Reviews conducted by APD or the Contracted Quality Assurance entity consists of a review of the following:

- Support Plan/Cost Plan;
- Purchasing Plan;
- Representative Agreement;
- Monthly Statements;
- Timesheets (Appendix G);
- Invoices;
- Employee Files including Background Screening documentation;
- Agency or Vendor files;
- Emergency Back-up Plan; and
- Corrective Action Plan.

APD will monitor and report to AHCA whether Consumer goals have been reached and the status of program compliance. The monitoring must also incorporate information from Consumers concerning health, safety, and welfare, and their service needs. The APD Area Offices must follow up on pertinent Consumer issues noted in monitoring.

Quality Improvement Tools, continued

Quality Advisory Committee

The Quality Advisory Committee (QAC) is comprised of key program stakeholders. All APD reporting data is shared with the QAC. Along with reviewing data, the QAC will look at other ways to improve the program and make suggestions to APD and AHCA. The QAC will meet on a quarterly basis. The QAC may include Consumers, program staff, Consultants, Consumer/Representatives, care givers, APD agency staff, AHCA staff, Quality Assurance Contractor (if applicable), and community advocates or stakeholders. APD will recommend members for the QAC as appropriate, and AHCA will serve as the approval authority [1915(j) State Plan Amendment].

The CDC+ QAC will consist of a maximum of six members. All members will be trained by APD or its agent in CDC+ expectations, roles and responsibilities, and related federal laws for state program policies and procedures.

The QAC also reviews and approves the CDC+ APD Program Self Assessment. The CDC+ Program Self Assessment is developed by the APD Central Office and must be approved by AHCA. The assessment asks the APD Central Office to evaluate itself with statements such as:

- Consumers, family members and advocates help design, develop, operate and evaluate the program; and
- Can Consumers determine which services to use and can they select, hire and dismiss their workers?

The main purpose of the Self Assessment is to assist the APD Area Office in identifying program goals, having a plan to meet the goals, ensuring the goals are met and aiding the Area Office in re-assessing itself in an ongoing capacity. The Self Assessment also alerts the APD Area Office of unmet goals or issues that may need to be addressed [1915(j) State Plan Amendment].

The QAC will advise each APD Area Office of the areas identified in which the program should improve itself and will aid in setting the priorities for required improvement [1915(j) State Plan Amendment].

APD will deliver the yearly CDC+ Program Self-Assessment to the Quality Advisory Committee (QAC). The APD Area Offices must be in compliance with the performance indicators for the CDC+ program. If an APD Area Office is not in compliance, they must work on program improvement activities as indicated by the QAC. This will provide APD staff with the assistance of the QAC, to monitor program progress as well as modify performance indicators as necessary.

APPENDIX A
CDC+ NEW PARTICIPANT TRAINING PROGRAM
AFFIRMATION FORM

CDC+ New Participant Training Program Affirmation Form

(for use with handwritten Review Questions)

I affirm that I have completed the Consumer-Directed Care Plus New Participant Training program. I also understand and acknowledge that if goods and/or services are purchased that are not approved in my Consumer-Directed Care Plus (CDC+) monthly budget and Purchasing Plan that I will be **PERSONALLY LIABLE** for payment of the cost of those goods and/or services.

NEW PARTICIPANT TRAINING

COURSE TITLE

DATE

NAME (Printed)

ADDRESS

NAME (Signature)

DATE

List All Consumer / Participant ID Numbers

_____	_____	_____
_____	_____	_____
_____	_____	_____

IMPORTANT: This form and completed Review Questions must be signed and copies forwarded to your local Agency for Persons with Disabilities (APD) Area Office and CDC+ Consultant or Waiver Support Coordinator within 30 days after completion of the training. Retain a copy in each Consumer / Participant's records. A Certificate of Completion will be sent to the name and address listed. If this form is not signed and received by all parties listed above within 30 days after the completion of the training, the training will be considered incomplete and must be retaken.

Effective July 2012 incorporated into Rule #59G-13.088

APPENDIX B
CDC+ NEW PARTICIPANT TRAINING
REGISTRATION

Registration

CDC+ User Registration

To complete your CDC+ Participant Training, Please enter the requested information below and select 'Done'

Training Course Title: **New Participant Training**

Please Enter Your Name

Please Enter Your Address

Street

City

State

Zip Code

Please Enter Today's Date (dd/mm/yyyy)

Please Enter Your Email Address

Provide Participant ID Number or Name:

ID Number or Name

I understand it is my responsibility to forward a copy of my certificate to the CDC+ Consultant and the local APD Area Office within 30 days after the completion of the training session.

I affirm that I have completed the Consumer-Directed Care Plus training course listed above.

I also understand and acknowledge that if goods and services are purchased that are not in my Consumer-Directed Care Plus (CDC+) Monthly Budget and Purchasing Plan that I will be PERSONALLY LIABLE for payment of the cost of those goods and/or services.

Please make a selection below to acknowledge your acceptance or denial of the terms stated above

I ACCEPT

I DECLINE

Effective July 2012 incorporated into Rule #59G-13.088

APPENDIX C
CDC+ PARTICIPANT REFRESHER TRAINING PROGRAM
AFFIRMATION FORM

CDC+ Participant Refresher Training Program Affirmation Form

(for use with handwritten Review Questions)

I affirm that I have completed the Consumer-Directed Care Plus (CDC+) Participant Refresher Training program. I also understand and acknowledge that if goods and/or services are purchased that are not approved in my Consumer-Directed Care Plus Monthly Budget and Purchasing Plan that I will be **PERSONALLY LIABLE** for payment of the cost of those goods and/or services.

PARTICIPANT REFRESHER TRAINING

COURSE TITLE

DATE

NAME (Printed)

ADDRESS

NAME (Signature)

DATE

List All Consumer / Participant ID Numbers

_____	_____	_____
_____	_____	_____
_____	_____	_____

IMPORTANT: This form and completed Review Questions must be signed and copies forwarded to your local Agency for Persons with Disabilities (APD) Area Office and CDC+ Consultant within 30 days after completion of the training. Retain a copy in each Consumer / Participant's records. A Certificate of Completion will be sent to the name and address listed. If this form is not signed and received by all parties listed above within 30 days after the completion of the training, the training will be considered incomplete and must be retaken.

Effective March 1, 2011 incorporated into Rule #59G-13.088

APPENDIX D
CDC+ PARTICIPANT REFRESHER TRAINING
REGISTRATION

Registration

CDC+ User Registration

To complete your CDC+ Participant Training, Please enter the requested information below and select 'Done'

Training Course Title: **Participant Refresher Training**

Please Enter Your Name

Please Enter Your Address

Street

City

State

Zip Code

Please Enter Today's Date (dd/mm/yyyy)

Please Enter Your Email Address

Provide All Participant ID Numbers:

ID Number

I understand it is my responsibility to forward a copy of my certificate to the CDC+ Consultant and the local APD Area Office within 30 days after the completion of the training session.

I affirm that I have completed the Consumer-Directed Care Plus training course listed above.

I also understand and acknowledge that if goods and services are purchased that are not in my Consumer-Directed Care Plus (CDC+) Monthly Budget and Purchasing Plan that I will be PERSONALLY LIABLE for payment of the cost of those goods and/or services.

***Please make a selection below to acknowledge your acceptance or denial of the terms stated above**

I ACCEPT

I DECLINE

Effective March 1, 2011 incorporated into Rule #59G-13.088

APPENDIX E
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 _____			Phone #:	Cell #:	Official Use Only
Representative Name:					
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"/> 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.				
6	<input type="checkbox"/> Add Short Term Expenditure amount not to exceed 52% of what was approved in the Cost Plan: _____ Item must be entered in Section F with same effective date as this Purchasing Plan.				
8	<input type="checkbox"/> 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	<input type="checkbox"/> Change Monthly Budget Amount to _____				
8	<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.				
8	<input type="checkbox"/> Add Short Term Expenditure amount not to exceed 52% of what was approved in the Cost Plan: _____ Item must be entered in Section F with same effective date as this Purchasing Plan.				
10	<input type="checkbox"/> Purchasing Plan UPDATE (No Change in Budget Amount and no new OTE or STE.)				
11	* <input type="checkbox"/> Revisions have been made on page(s): _____				
12	<input type="checkbox"/> Participant selected a NEW Representative effective _____ <input type="checkbox"/> Participant information Update form to change Representative is attached. (Required)				
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.				
16	* <input type="checkbox"/> Provider Packets for all new providers are attached, as shown below:				
18	* _____ 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:				
19	* _____				
20	* _____				
21	* _____				
22	* <input type="checkbox"/> Total Number of Purchasing Plan Pages: _____				
PLEASE COMPLETE. THIS SECTION IS REQUIRED FOR PROCESSING.					
Consultant Initial _____			How can we reach you if we have any questions? Enter phone/email.		
Area Liaison Initial _____			Phone Number _____		
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.)					

KEY: FFI=Florida Freedom Initiative

Page ____ of ____

Version 3.0-C Effective 02/14/12

Effective February 14, 2012 incorporated into Rule#59G-13.088

October 2015

Consumer-Directed Care Plus Program Coverage, Limitations, and Reimbursement Handbook

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 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/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: CTEs, STEs, savings items, and services provided by natural support.
Current Waiver Support Plan Date:	Current Waiver Cost Plan Date:	
Support Plan Goal/ Needs	Service Name	Service Name
	# of Months	# Units per Month
	Total # Units	Typ of Unit in PP ²
	Typ of Unit in CP ¹	Average # Units per Month
		NOTES: CTEs, STEs, Savings Items, Natural Support
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		

1. Cost Plan unit type includes: Quarter Hour; Day; Trip; Month; Unit; or Mile
 2. Purchasing Plan unit type includes: Hour; Day; Trip; Item; or Visit

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	Svo Code	Critical Y/N If Y, must be at least 2 EBU's*	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									\$ -	\$ -	\$ -	\$ -			
6									\$ -	\$ -	\$ -	\$ -			
8									\$ -	\$ -	\$ -	\$ -			
7									\$ -	\$ -	\$ -	\$ -			
8									\$ -	\$ -	\$ -	\$ -			
9									\$ -	\$ -	\$ -	\$ -			
10									\$ -	\$ -	\$ -	\$ -			
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	Svo Code	Provider	Detailed Description	# of Units	Unit	Rate	Total Cost								
1							\$ -								
2							\$ -								
3							\$ -								
4															
6							\$ -								
							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

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 EBU's*	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									\$ -	\$ -	\$ -	\$ -		
6									\$ -	\$ -	\$ -	\$ -		
8									\$ -	\$ -	\$ -	\$ -		
7									\$ -	\$ -	\$ -	\$ -		
8									\$ -	\$ -	\$ -	\$ -		
9									\$ -	\$ -	\$ -	\$ -		
10									\$ -	\$ -	\$ -	\$ -		
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										\$ -				
6										\$ -				
If you need additional space to list your providers in sections C1 and C2, please use Page 3A.											Page 3 C.2 Total:		\$ -	
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

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 <small>If Y, must be at least 2 EBU's*</small>	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
11									\$ -	\$ -	\$ -	\$ -	
12									\$ -	\$ -	\$ -	\$ -	
13									\$ -	\$ -	\$ -	\$ -	
14									\$ -	\$ -	\$ -	\$ -	
15									\$ -	\$ -	\$ -	\$ -	
16									\$ -	\$ -	\$ -	\$ -	
17									\$ -	\$ -	\$ -	\$ -	
18									\$ -	\$ -	\$ -	\$ -	
19									\$ -	\$ -	\$ -	\$ -	
20									\$ -	\$ -	\$ -	\$ -	
Note: At least 2 EBU providers must be listed immediately under each critical service provider.											Page 3A C.1 Total:	\$ -	\$ -
C.2 Budget Detail - SUPPLIES													
Service	SVC Code	Provider	Detailed Description				# of Units	Unit	Rate	Total Cost			
6										\$ -			
7										\$ -			
8										\$ -			
9										\$ -			
10										\$ -			
If you need additional space to list your providers in sections C1 and C2, please use Page 3B.											Page 3A C.2 Total:	\$ -	\$ -
Check if you use 3B:													

* 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

Participant: _____ Effective Date of Plan: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)						
D. Budget Detail - Purchases to be made with CASH						
Service Category	Service Code	Detailed Description of Each Item to be Purchased (Required)	# of Units	Unit Type	Rate	Total Cost
1						\$ -
2						\$ -
3						\$ -
4						\$ -
5						\$ -
6						\$ -
7						\$ -
8						\$ -
9						\$ -
You will receive a check for this amount each month to make <u>ONLY</u> the above purchases:						\$ -
<p>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.</p>						

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	Is Provider's Relationship to Participant?	# of Units	Unit	Rate	Sub-Total	Employer Taxes	Total Estimated Cost	Deadline Purchase Will be Made	
Funds always reserved for Emergency Back Ups										\$ -		
1								\$ -	\$ -	\$ -		
2								\$ -	\$ -	\$ -		
3								\$ -	\$ -	\$ -		
4								\$ -	\$ -	\$ -		
5								\$ -	\$ -	\$ -		
6								\$ -	\$ -	\$ -		
7								\$ -	\$ -	\$ -		
8								\$ -	\$ -	\$ -		
9								\$ -	\$ -	\$ -		
10								\$ -	\$ -	\$ -		
F. Budget Detail - One Time and Short Term Expenditures												
OTE/STE	Item/Service Description	Svc Code	Provider	Provider Type	Is Provider's Relationship to Participant?	# of Units	Unit	Rate	Sub-Total	Employer Taxes	Total Budget	End Date
1									\$ -	\$ -	\$ -	
2									\$ -	\$ -	\$ -	
3									\$ -	\$ -	\$ -	
4									\$ -	\$ -	\$ -	

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

Participant: _____ Effective Date of Plan: _____

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-C)		
Budget Summary		
This page summarizes the expenditures detailed on the previous pages of the Purchasing Plan.		
	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.
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~~~~~	~~~~~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

APPENDIX F  
CDC+ QUICK UPDATE TO  
MY PURCHASING PLAN



**Quick Update to My Purchasing Plan that was Effective:** _____

<b>Participant's Name:</b>	<b>Participant's ID #:</b>
----------------------------	----------------------------

**A. Reason for this Quick Update: (You MUST Check one of the following and complete any blanks.)**

- Replace current authorized provider with new provider. Current provider's last day: _____. New provider starts: _____. (B-C)
- Change vendor in Savings, OTE or STE to authorize participant/representative reimbursement starting _____. (B-C)
- Change the Estimated Date of Purchase for a Savings item, or the End Date for an OTE or STE. (B-C)
- Add or replace a service or support in the Savings section of the Purchasing Plan section starting _____. (B-D or D)
- Add a provider ONLY AS an additional emergency backup provider starting _____. (D ONLY)

**B. Current Entry to be Replaced/Changed (You MUST Circle One: R E S T¹):**

Service Code	Description:	Provider's Name:	Critical ²	Provider Type	DHE Rel	# of Units	Rate	Sub Total	Employer Tax:	Total \$	Date ³
			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> E								

A COPY OF THE PAGE OF THE PURCHASING PLAN ON WHICH THE CURRENT ENTRY APPEARS MUST BE ATTACHED.

**C. Replace/Change Above Entry, as follows:**

Service Code	Description:	Provider's / Payee's Name:	Critical	Provider Type	DHE Rel	# of Units	Rate	Sub Total	Employer Tax:	Total \$	Date ⁴
SAME	SAME		Same as Above								

**D. Add the following Entry (You MUST Circle One: R S⁵):**

Service Code	Description:	Provider's Name:	EBU	Provider Type	DHE Rel	# of Units	Rate	Sub Total	Employer Tax:	Total \$	Date ⁶
			<input type="checkbox"/> Y <input type="checkbox"/> N								

PROVIDER ID#: _____ OR  NEW PROVIDER PACKET IS ATTACHED (REQUIRED FOR ALL NEW PROVIDERS.)

**This form cannot be used for retroactive replacements/changes or additions; all changes must be in the future. Participant, Consultant, Area Liaison and Central Office staff must attach their copy of the approved Quick Update to the Purchasing Plan that is being updated, as specified at the top of the form.**

PARTICIPANT/REPRESENTATIVE SIGNATURE	PARTICIPANT/REPRESENTATIVE (PRINT/TYPE NAME)	DATE
CONSULTANT SIGNATURE	CONSULTANT (PRINT/TYPE NAME)	DATE
APD AREA _____ LIAISON SIGNATURE	AREA LIAISON (PRINT/TYPE NAME)	DATE

¹ R = Services; E = Ong Time Expenditure; S = Savings; T = Short Term Expenditure  
² Circle one: If the current provider is the primary provider, circle Y for yes, N for no; if the current provider is an emergency backup provider, circle E. Applies only to Services Section.  
³ Date = estimated date of purchase or end date; complete only if the current item is in the Savings, One Time or Short Term Expenditure section.  
⁴ Date = estimated date of purchase or end date; complete only when replacing the provider of a Savings, One Time or Short Term Expenditure.  
⁵ R = Services; S = Savings. These are the only sections of the Purchasing Plan to which additions may be made using this form.  
⁶ Date = estimated date of purchase; complete only if the item is being added to the Savings section

APPENDIX G  
FLORIDA CDC+  
WEEKLY TIMESHEET



APPENDIX H  
CDC+  
PARTICIPANT INFORMATION  
UPDATE FORM



## Participant Information Update Form



**Participant Name:**

**Participant ID#:**

	First	Last	
<b>What to Update</b>			<b>Provide Only the Information to be Updated</b>
<input type="checkbox"/> <b>Participant</b>	Effective Date		<input type="checkbox"/> Name Change* or Correction _____ <input type="checkbox"/> Address _____ <input type="checkbox"/> City, St, Zip, County _____ <input type="checkbox"/> Phone (indicate type ) _____ <input type="checkbox"/> Email Address _____ * A legal name change requires supporting legal documentation.
<input type="checkbox"/> <b>Current Representative</b> <input type="checkbox"/> <b>No Representative</b> <input type="checkbox"/> <b>New Representative</b> ___ Parent ___ Spouse ___ Other Rel ___ Friend	Effective Date		<input type="checkbox"/> Name _____ <input type="checkbox"/> Address _____ <input type="checkbox"/> Phone _____ <input type="checkbox"/> Email Address _____ If changing from Rep to <b>No Rep</b> , <input type="checkbox"/> Participant has been fully trained in CDC+. If <b>New Representative</b> : <input type="checkbox"/> Representative fully trained in CDC+. <input type="checkbox"/> Representative Agreement executed.
<input type="checkbox"/> <b>Legal Status</b> (If minor, <u>enter</u> name, address, and phone number of parents OR Legal Guardian. If adult has Legal Representative, <u>enter</u> name, address, and phone number of Legal Representative. Use all lines)	Effective Date		<input type="checkbox"/> Minor: <b>Parental Guardian</b> _____ <input type="checkbox"/> Minor: <b>Other Legal Guardian*</b> _____ <input type="checkbox"/> Competent Adult: no legal guardian _____ <input type="checkbox"/> Adult: <b>Legal Representative*</b> _____ has authority over medical decisions and/or government benefits. <input type="checkbox"/> *Consultant has filed legal document in consumer's primary file.
<input type="checkbox"/> <b>New Consultant</b> (Use Consultant Registration Update Form to update consultant name, address, phone, email, agency affiliation, etc.)	Effective Date		Name: _____ Medicaid <u>Treating</u> Provider # for CDC+: _____ <input type="checkbox"/> Participant-Consultant Agreement has been executed. <input type="checkbox"/> ABC has been updated. <b>Copy of ACLM3 Screen is attached.</b>
<input type="checkbox"/> <b>Stop Budget (Dis-enrollment)</b>  <input type="checkbox"/> <b>Reinstate budget</b> <b>NOTE:</b> In order to be reinstated, consumer's date of <u>dis-enrollment</u> cannot be greater than 12 months prior to reinstatement date AND upon dis-enrollment, participant must have indicated a desire to return to the program.	Stop Date (LAST OF MONTH)  Reinstate Date (FIRST OF MONTH)		<b>Indicate Reason for Dis-enrollment (required) from either area A or B, below:</b> <b>A. Mandatory Dis-enrollment as a result of:</b> <input type="checkbox"/> Death of participant DATE: _____ <input type="checkbox"/> Residential placement DATE: _____ <input type="checkbox"/> Participant Moved out of State DATE: _____ <input type="checkbox"/> Hospitalization > 30 days DATE: _____ <input type="checkbox"/> Loss of Medicaid eligibility > 90 days Last Day Eligible: _____ <input type="checkbox"/> Loss of Waiver eligibility Last Day Eligible: _____  <b>B. If either of the following, indicate why:</b> <input type="checkbox"/> Participant/representative request <b>OR</b> <input type="checkbox"/> APD staff/consultant initiated <input type="checkbox"/> Representative not available <input type="checkbox"/> Representative not available <input type="checkbox"/> Inability to manage program <input type="checkbox"/> Inability to manage program <input type="checkbox"/> Inability to manage budget <input type="checkbox"/> Inability to manage budget <input type="checkbox"/> Consumer health/safety at risk <input type="checkbox"/> Consumer health/safety at risk <input type="checkbox"/> <b>Copy of Participant Account Close-Out Form is attached (required)</b>

Consultant Signature	Date	Print Consultant <u>and</u> Agency Name
Area Liaison Signature	Date	Print Name <u>and</u> APD Area Office #

11/1/09

Effective November 1, 2009 incorporated into Rule #59G-13.088